PEI Glucose Sensor Program - INITIAL

Health PEI

Family Contribution Assessment and Release of Information

Individual who requires the glucose sensor (Please Print)					
Last Name		**First Name**		**Middle Initial**	
PHN #		**DOB**			
Address (Mailing address)					
Street # and Name				Apt#	
City / Town		Province		Postal Code	
Home Telephone	( )	Cell	( )		
Email address to communicate with Program Administrator					

If the above named individual is <u>under age 19,</u> please indicate living arrangements:

☐ Both parents ☐ One parent ☐ Other (specify)_____

- **Parents/ Guardian are to complete Section A on next page** and then proceed to page 3.

If the above named individual is <u>age 19 or over</u>, please indicate current status:

☐ Single (including widowed or divorced)

If single are you a full-time student?

- **If YES**:
  - The young adult who is a full-time student, <u>please sign the consent below</u>
  - The parent / guardian (s) of the full-time student (i.e. the dependant) are to complete **Section A on page 2**
- **If NO**, go directly to **Section B** on page 3.

☐ Married/Common–law:

- go directly to **Section B** on page 3

<u>Consent of young adult aged 19 to 24 years, who is a full-time student</u>:

If you are living <u>as a dependant</u> (ex: high school or university student, full time):

- you must review / sign the consent below, giving permission for your parent / guardian to apply on your behalf
- your parent / guardian must complete the application and sign the Declaration on page 3
- you sign the Glucose sensor Agreement on page 4

I, _____, born _____ being 19 years of age or older, consent to my
(print name) (yyyy/mm/dd)

parent/s making this application on my behalf for funding assistance under the PEI Glucose Sensor Program

_____ Date: _____
Signature of Young Adult (yyyy/mm/dd)

Please <u>mail</u> *completed application to:
Glucose Sensor Program Administrator
Four Neighborhoods Health Center,
152 St Peter's Road, Charlottetown, PE, C1A 5P8

* *Faxed or electronic /scanned copies will <u>not</u> be accepted*

Toll Free Contact information:
1-833-335-0538
diabetesadminofficer@ihis.org

SECTION A:

Household Information for Applicant on behalf of a Dependent (Under age 19 or a full-time student aged 19 to 24)

Parent / Legal Guardian of individual noted on page 1					
Last Name		First Name		Middle Initial	
Social Insurance Number		Date of birth			
Spouse / Partner (Of Parent / Legal Guardian)					
Last Name		First Name		Middle Initial	
Social Insurance Number		Date of birth			
Address ☐ Same as noted on page 1					
Street # and Name				Apt #	
City / Town		Province		Postal Code	
Cell phone	( )	Home telephone	( )		
Email address					

Does the parent/ guardian, or spouse / partner have:	
Third party health insurance that would cover part or all of the cost of glucose sensors?	☐ Yes ☐ No (*proceed to page 4)*
If "yes" to above, please provide the following information	
Name of health insurance company	
Terms of Coverage (e.g. insurance pays 80% of costs of continuous glucose sensor, or intermittently scanned glucose sensor)	If you are not aware of your coverage, please contact your insurance company to inquire
If there is **more than one plan** that provides coverage, please provide information on the additional health plan	
Name of health insurance company	
Terms of Coverage	If you are not aware of your coverage, please contact your insurance company to inquire ☐ You must pay full cost at the pharmacy and then submit your receipts to your insurance company for reimbursement

If you have private health insurance, please answer the following statement:	
When purchasing glucose sensors at your pharmacy… • If you are not aware, please contact your insurance company to inquire	☐ The pharmacy can direct-bill your insurance company at the time of purchase ☐ You must pay full cost at the pharmacy and then submit your receipts to your insurance company for reimbursement

Upon completion of the above section, please proceed to:

- **Page 4:** ***Declaration and Consent*** **AND**
- **Page 5:** ***Client / Family Agreement for Glucose Sensors***
- **Page 6: Your <u>health care provider</u> is to complete –** ***Special Authorization Request (only needs to be completed at time of <u>initial</u> application, i.e. not annually)***

Personal information, including health information, on this form is collected by Health PEI under the authority of Section 31(c) of the *Freedom of Information and Protection of Privacy Act and*/or the *Health Information Act* for the purposes of determining your eligibility for the PEI Glucose Sensor Program, for evaluating the program and for other purposes permitted by law. Your information will be collected, used and disclosed only as permitted by law. For more information, visit www.healthpei.ca/yourprivacy or contact the Health PEI Provincial Diabetes Clinical Leader at (902) 368-4243.

SECTION B:

Household Information for Independent Applicant (Age 19 or over, AND <u>not</u> a full time student)

Information of Applicant who requires the glucose sensor					
Last Name		First Name		Middle Initial	
Applicant's Social Insurance Number					
Spouse / Partner (if applicable)					
Last Name		First Name		Middle Initial	
Social Insurance Number		Date of birth			

Do you or your spouse / partner have:	
Third party health insurance that would cover part or all of the cost of glucose sensors?	☐ Yes ☐ No *(proceed to page 4)*
If "yes" to above, please provide the following information	
Name of health insurance company	
Terms of Coverage (e.g. insurance pays 80% of costs of continuous glucose sensor, or intermittent / flash glucose sensor)	If you are not aware of your coverage, please contact your insurance company to inquire
If there is **more than one plan** that provides coverage, please provide information on the additional health plan	
Name of health insurance company	
Terms of Coverage	If you are not aware of your coverage, please contact your insurance company to inquire

If you have private health insurance, please answer the following statement:	
<u>When purchasing glucose sensors at your pharmacy…</u> • *If you are not aware, please contact your insurance company to inquire*	☐ The pharmacy can direct-bill your insurance company at the time of purchase
	☐ You must pay full cost at the pharmacy and then submit your receipts to your insurance company for reimbursement

Upon completion of the above section, please proceed to:

- **Page 4: *Declaration and Consent* <u>AND</u>**
- **Page 5: *Client / Family Agreement for Glucose Sensors***
- **Page 6: Your <u>health care provider</u> is to complete – *Special Authorization Request (only needs to be completed at time of <u>initial</u> application, i.e. not annually)***

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Declaration And Consent

I/We, the undersigned, declare that the information provided on this application is true and correct to the best of my/our knowledge.

I/We, the undersigned, understand that refusing to submit information or knowingly furnishing false or incomplete information is an offence under the *Drug Cost Assistance Act*.

For the purpose of verifying program eligibility, I/we authorize Health PEI to obtain information from:

- My employer, my insurer, and my plan administrator regarding private insurance coverage;
- The Provincial Health Plan (the Plan) regarding my eligibility for health services and release of my PHN;
- Retail pharmacies, to access prescription drug information in order to verify claims

I/We, the undersigned, agree to notify Health PEI of any changes to the household, insurance coverage, or any other factor which may affect my level or eligibility of coverage.

I/We, the undersigned, hereby consent to the release by the Canada Revenue Agency (CRA), of income, expense and identifying information from income tax returns or from other sources, copies of notices of assessment or reassessment, and copies of information slips (for example, T2202A, T3, T4 and T5 slips) filed with CRA. The information will be relevant to and used solely for the purpose of determining and verifying my eligibility and entitlement for assistance, and collecting overpayments of assistance under the Drug Cost Assistance Programs identified above.

A parent or legal guardian may provide consent for all dependents under the age of 18.

This authorization is valid for the two taxation years preceding the date of this application, the current taxation year and each subsequent consecutive taxation year for which I apply for assistance under the Drug Cost Assistance Programs identified above.

I understand that there are risks associated with sending personal health information to an unsecured email address, including a risk that my information could be accessed by someone else in transit. I accept the risks and request that Health PEI send my personal health information to me at the email address I have provided.

Name of Applicant	Signature	Date (yyyy/mm/dd)
Name of Spouse (if applicable)	Signature	Date (yyyy/mm/dd)

By signing above, I certify that the information given on this application and in any documents attached is correct, complete, and fully discloses my household conditions.

I understand that a false statement constitutes fraud and may result in recovery of any benefits paid.

I acknowledge that it is my responsibility to report any change to the information provided within 30 days of the change coming into effect.

Client/ Family Agreement for Glucose Sensors

Health PEI

Note: *In this Agreement, "I" refers to the individual, (and/or the parent/ guardian, as appropriate) who will be using the glucose sensor;*

I _____ wish to apply for benefits under the Health PEI Glucose Sensor Program.

Please check (√) each box to indicate you have read and agree with each statement.

- ☐ I am under the care and management of a primary care provider (doctor/ NP), physician specialist or Certified Diabetes Educator (or Health PEI Provincial Diabetes Program Diabetes Educator)
- ☐ I am knowledgeable in how to use the sensor appropriately
- ☐ I have knowledge of what sensor technology can do and how it can benefit my diabetes care
- ☐ I am willing to use the sensor properly and to use the data from this technology to make safe and effective diabetes management decisions
- ☐ I am willing to share my sensor information with my healthcare team to optimize my diabetes management
- ☐ I am prepared to attend regular follow-up appointments with my diabetes care provider / diabetes team.
- ☐ I am aware that I have to reapply annually by July 1st each year or my benefits under this program will cease. Prior to reapplying I must have submitted my income tax return to Canada Revenue Agency for the previous year.

Preferred method of communication with Program Administrator:

- ☐ Via email at the following address: _____
- ☐ Via regular mail at the address provided on the first page

_____	_____	_____
Name of Client (print)	Client signature (if age 19 and over)	Date (*yyyy/mm/dd)*

If under age 19:

_____	_____	_____
Name of Parent / Caregiver (print)	Name of Parent / Caregiver (signature)	Date (*yyyy/mm/dd)*

Special Authorization Request
Glucose Sensor Program

Health PEI

HEALTH CARE PROVIDER: PLEASE COMPLETE ALL SECTIONS. INCOMPLETE APPLICATIONS WILL BE RETURNED

This form must be completed by your Health Care Provider i.e. Physician / Nurse Practitioner or Certified Diabetes Educator (or Health PEI Provincial Diabetes Program Diabetes Educator) and submitted with your completed application.

SECTION 1 – PATIENT INFORMATION

PERSONAL HEALTH NUMBER (PHN)	PATIENT (FAMILY) NAME	PATIENT (GIVEN) NAME(S)
DATE OF BIRTH (YYYY/MM/DD) | |	PATIENT'S MAILING ADDRESS	

Section 2 – Requester's Information

NAME AND MAILING ADDRESS	APPLICATION DATE YYYY MM DD
	REQUESTER'S TELEPHONE #
	REQUESTER'S FAX #

Section 3- Sensor Detail Information as per Health Canada approval

REQUESTED SENSOR

Freestyle Libre (choose one)

☐ Libre or ☐ Libre 2

- **For patients age 4 and over**
- **Sensor wear time = 14 days**
- **Dispense period = 28 days**

☐ Dexcom

- **For patients age 2 and over**
- **Sensor wear time = 10 days**
- **Dispense period = 30 days**

☐ Medtronic

- **For patients age 2 and over**
- **Sensor wear time = 7 days**
- **Dispense period = 35 days**

Section 4- Type of insulin therapy

Insulin Pump brand:

☐ Medtronic
☐ Tandem
☐ Omnipod

☐ Multiple daily injections of insulin (*please specify below*)

- Basal insulin *(name)* _____ Number of injections per day _____
- Bolus insulin *(name)* _____ Number of injections per day _____

Section 5- Confirmation of Eligibility - initial and renewal

Patients must meet the following criteria for special authorization:

For the treatment of patients who are **on multiple daily injections of insulin** (3 or more injections / day) **OR** an **insulin pump AND**

☐ The patient is under the care & management of a primary care provider, physician specialist or CDE / Health PEI PDP diabetes educator
☐ The patient demonstrates the capacity to use the sensor appropriately
☐ The patient demonstrates a reasonable understanding of what sensor technology can do and how it can benefit their diabetes care
☐ The patient affirms a willingness to use the sensor properly & to use the data to make safe & effective diabetes management decisions

OTHER COMMENTS (IF APPLICABLE)

Discontinuation Request (Complete only if Special Authorization)

I authorize Health PEI to discontinue to Special Authorization for eligibility under the Glucose Sensor Program as this patient no longer meets the eligibility criteria. This has been discussed with the patient / caregiver.

Name of Health Care Provider _____ Effective Date of Discontinuation _____

Signature of Health Care Provider

Health PEI may request additional documentation to support this Special Authorization Request. Personal information, including health information, on this form is collected by Health PEI under the authority of Section 31(c) of the *Freedom of Information and Protection of Privacy Act and*/or the *Health Information Act* for the purposes of determining your eligibility for the PEI Glucose Sensor Program, for evaluating the program and for other purposes permitted by law. Your information will be collected, used and disclosed only as permitted by law. For more information, visit www.healthpei.ca/yourprivacy or contact the Health PEI Provincial Diabetes Clinical Leader at (902) 368-4243.

REQUESTER'S SIGNATURE (REQUIRED)_____**DATE:** _____

Please retain this page for information purposes

How do we define "Household"?

A household means a person, the person's spouse, if the person has a spouse, and any dependants. No person may be considered to be part of more than one household.

How do we define "Spouse"?

A spouse is a person who is married to you or with whom you are living in a marriage-like relationship. A spouse may be of the same gender.

How do we define "Dependant"?

A dependant is a child of a person or the person's spouse, who

- is under 19 years of age and does not have a spouse, or
- is 19 years of age or over but under 25 years of age, is a full- time student and does not have a spouse;

What if I am single, 19 years of age or over and still living with my family?

If you are 19 years of age or over, and **NOT** a full-time student, you must complete your own registration form. If you live with your parents, are NOT a full-time student and do not have a spouse or dependents, you are a family of one for our purposes. Do not include your parents' names or their incomes on your registration form

How do we define "Household Income"?

Household income means the total income of the persons in a household, other than any dependents. For each household member, use Line 15000 (Total Income) from the preceding year's tax return, and deduct any amounts reported on lines # 21000 (Split–Pension Amount), # 21400 (Child Care Expenses), # 22000 (Support Payments Made).This amount represents each individual's income for the purpose of Drug Program coverage. Add together the individual amounts for each household member identified above to determine total household income.

How do we calculate coverage under the Glucose Sensor Program?

Take the household income you just calculated; determine which income range you fall under:

Total Household Income Ranges	**Estimated co-pay per dispense to be paid at any PEI Pharmacy** *(every 26 to 35 days depending on sensor type)*	
	No private insurance	**With private insurance***
$0 to $20,000	$0.00	$0.00
$20,001 to $40,000	$10.00	$2.00
$40,001 to $50,000	$20.00	$4.00
$50,001 to $100,000	$60.00	$12.00
$100,001 and above	$80.00	$16.00

***** If you <u>have</u> private health insurance that provides partial coverage for glucose sensors, your co-payment will be either 20% of a standard copay as noted in the table above or the amount remaining after payment by your private insurance whichever is less: