

Health PEI PEI Insulin Pump and Glucose Sensor Program – INITIAL

Family Contribution Assessment and Release of Information

This application is for (check all that apply) : <input type="checkbox"/> New insulin pump <input type="checkbox"/> Pump supplies <input type="checkbox"/> Glucose sensors					
Individual who requires the above listed devices (Please Print)					
Last Name		First Name		Middle Initial	
PHN #		DOB			
Address (Mailing address)					
Street # and Name				Apt#	
City / Town		Province		Postal Code	
Cell phone ()		Home phone ()			
Email address to communicate with Program Administrator					
If the above named individual is <u>under age 19</u>, please indicate living arrangements:					
<input type="checkbox"/> Both parents <input type="checkbox"/> Mother only <input type="checkbox"/> Father only <input type="checkbox"/> Other (specify) _____					
<ul style="list-style-type: none"> Parents/ Guardian are to complete Section A on Page 2 					
If the above named individual is <u>age 19 or over</u>, please indicate current status:					
<input type="checkbox"/> Single (including widowed or divorced) If single are you a full-time student?			<input type="checkbox"/> Married/Common law:		
<ul style="list-style-type: none"> If YES: <ul style="list-style-type: none"> The young adult who is a full-time student, please <u>sign the consent below</u> The parent / guardian (s) of the full-time student (i.e. the dependent) are to complete Section A on page 2. If NO: <ul style="list-style-type: none"> Go directly to Section B on page 3. 			<ul style="list-style-type: none"> 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 <u>living as a dependent</u> (ex: high school or university student, full time):					
<ul style="list-style-type: none"> you must review / sign the consent below, giving permission for your parent / guardian to apply on your behalf your parent / guardian must complete Section A on page 2 and sign the Declaration on page 4 As an adult, you must sign the Release of Information consent on page 5 and the Glucose Sensor Agreement on page 6 					
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					
_____ Signature of Young Adult				Date: _____ (yyyy/mm/dd)	

<p>Please <u>mail</u> * completed application to: Insulin Pump Program Administrator Health PEI, 16 Garfield Street, Charlottetown, PE, C1A 6A5</p> <p><small>* Faxed or electronic /scanned copies will <u>not</u> be accepted</small></p>	<p>Toll Free Contact information: 1-833-335-0538 diabetesadminofficer@ihis.org</p>
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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
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Social Insurance Number

Spouse / Partner (Of Parent / Legal Guardian)

Last Name	First Name	Middle Initial
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Social Insurance Number

Address of parent/ guardian Same as noted on page 1

Street # and Name	Apt #
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City / Town	Province	Postal Code
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Cell phone ()	Home Telephone ()
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Email Address

Does the parent/ guardian, or spouse / partner have:

Third party health insurance that would cover part or all of the cost of insulin pump and pump supplies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you answered "No" to <u>both</u> questions proceed to page 4
Third party health insurance that would cover part or all of the cost of glucose sensors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

If "yes" to above, please provide the following information

Name of health insurance company

Terms of Coverage For pump, pump supplies and glucose sensors	If you are not aware of your coverage, please contact your insurance company to inquire
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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 For pump, pump supplies and glucose sensors	If you are not aware of your coverage, please contact your insurance company to inquire
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If applying for coverage under the Glucose Sensor Program, please answer the following:

When purchasing glucose sensors at your pharmacy... • If you are not aware, please contact your insurance company to inquire	<input type="checkbox"/> The pharmacy can direct-bill your insurance company at the time of purchase
	<input type="checkbox"/> 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 Consent for Release of Personal Health Information**
- **If you are also applying for coverage under the Glucose Sensor Program, please forward these additional two documents with your application**
 - **Page 6: You are to complete – Client / Family Agreement for Glucose Sensors**
 - **Page 7: Your health care provider is to complete – Special Authorization Request (only needs to be completed at time of initial 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 Health PEI Insulin Pump Program and the Health 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 not a full time student)

Information of Applicant

Last Name		First Name		Middle Initial	
Applicant's Social Insurance Number					

Information of Spouse / Partner (if applicable)

Last Name		First Name		Middle Initial	
Social Insurance Number					

Do you or your spouse / partner have:

Third party health insurance that would cover part or all of the cost of insulin pump and pump supplies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you answered "No" to <u>both</u> questions proceed to page 4
Third party health insurance that would cover part or all of the cost of glucose sensors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Name of health insurance company

Terms of Coverage For pump, pump supplies and glucose sensors	If you are not aware of your coverage, please contact your insurance company to inquire
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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 For pump, pump supplies and glucose sensors	If you are not aware of your coverage, please contact your insurance company to inquire
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If applying for coverage under the Glucose Sensor Program, please answer the following:

When purchasing glucose sensors at your pharmacy... (If you are not aware, please contact your insurance company to inquire)	<input type="checkbox"/> The pharmacy can direct-bill your insurance company at the time of purchase
	<input type="checkbox"/> 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**
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Declaration and Consent

Health PEI

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

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.

Name of insulin pump user:		PHN	
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**Consent for Release of Personal Health Information
Insulin Pump Program**

Health PEI

Personal health information is required to be released to key partners as part of the business process and continuous quality improvement of the Insulin Pump Program. Personal health information will be used and disclosed only for:

- assessing, verifying and approving eligibility for the program
- the administration, monitoring and evaluation of the program
- facilitating communication between the pump / pump supplies vendor, Health PEI and the applicant

These partners include the Health PEI Insulin Pump Program Administration Office, the selected pump vendor and their approved subcontractor(s), employees of Health PEI, and the Provincial Diabetes Program to ensure a fair administration, monitoring and evaluation of the program. The collection use and disclosure of your personal health information will be limited to only the information required to manage these specific functions. We are committed to protecting personal health information and will only disclose it as permitted by the *Health Information Act*.

The IPP Administration Office will inform the selected vendor and their approved subcontractor(s) of the family contribution that will be required towards the purchase of the pump and supplies. The vendor and their approved subcontractor(s) will also inform the Administration Office of the mailing address and tracking number of the orders when shipped and report returns or discontinuation of supplies and/or insulin pumps as well as misuse of supplies.

This Family Contribution Assessment Form will be stored in a secure filing system with access limited to authorized users. Precautions are in place to ensure that this information is appropriately secure, in accordance with government and Health PEI guidelines.

As well, all collected information from the necessary application forms, will be entered into a database that may be used within Health PEI, to evaluate the Insulin Pump Program and to identify opportunities for improvement. In addition, the vendors and their approved subcontractors may provide Health PEI with pump device and supply usage information. This data will be kept in a secure database, with access limited to authorized users. The database and all records with the Health PEI Insulin Pump Program, diabetes clinics and the IPP Administration Office will be retained in accordance with the appropriate Health PEI record retention schedule.

The vendor and their approved subcontractor(s) may offer a variety of services such as access to a vendor supported website for personal health information and insulin pump data download and analysis. I /We understand that I/We use these services or resources at my/our own risk and the services and resources are not endorsed in whole or in part by the Government of Prince Edward Island, Health PEI, or the Insulin Pump Program.

If an applicant is less than nineteen (19) years of age, the legal guardian or parent must sign the form.

Name of Parent / Guardian	Signature	Date (YYYY/MM/DD)
Name of Parent / Guardian	Signature	Date (YYYY/MM/DD)
Name of applicant if adult	Signature of adult applicant	Date (YYYY/MM/DD)

Health PEI

Client/ Family Agreement for Glucose Sensors

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)

Glucose Sensor Program

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) <input type="checkbox"/> Libre or <input type="checkbox"/> Libre 2 <ul style="list-style-type: none"> • For patients age 4 and over • Sensor wear time = 14 days • Dispense period = 28 days 	<input type="checkbox"/> Dexcom <ul style="list-style-type: none"> • For patients age 2 and over • Sensor wear time = 10 days • Dispense period = 30 days 	<input type="checkbox"/> Medtronic <ul style="list-style-type: none"> • For patients age 2 and over • Sensor wear time = 7 days • Dispense period = 35 days
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Section 4- Type of insulin therapy

Insulin Pump brand: <input type="checkbox"/> Medtronic <input type="checkbox"/> Tandem <input type="checkbox"/> Omnipod	<input type="checkbox"/> Multiple daily injections of insulin (<i>please specify below</i>) <ul style="list-style-type: none"> • Basal insulin (<i>name</i>) _____ Number of injections per day _____ • Bolus insulin (<i>name</i>) _____ Number of injections per day _____
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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 discontinuing 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 dependents. 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 “Dependent”?

A dependent 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 Insulin Pump Program?

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

Total Household Income Ranges	Percentage of Coverage
\$0 to \$20,000	100%
\$20,001 to \$40,000	95%
\$40,001 to \$50,000	90%
\$50,001 to \$100,000	70%
\$100,001 and above	60%

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 <i>(every 26 to 35 days depending on sensor type)</i>	
	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 have private health insurance that provides partial coverage for glucose sensors, your co-payment will be either 20% of the standard copay (as noted in the table above) or the amount