

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 <small>(yyyy/mm/dd)</small>			
Address (Mailing address)					
Street # and Name				Apt#	
City / Town			Province	Postal Code	
Home Telephone ()		Cell ()			
Email address to communicate with Program Administrator					
Name of Current Pump Company _____ Date of Purchase of Current Pump (mm/yr) _____					
If you are renewing benefits under the Glucose Sensor Program, what brand of sensor are you currently using ? <input type="checkbox"/> Dexcom <input type="checkbox"/> Freestyle Libre <input type="checkbox"/> Freestyle Libre "2" <input type="checkbox"/> Medtronic					
<u>Terms and Conditions for Renewal</u> To renew your benefits under the Insulin Pump Program (and Glucose Sensor Program where applicable), you must confirm / agree to the following statements. By checking the boxes below, you indicate that you have read and agree with the statement.					
<input type="checkbox"/> I confirm that I have filed my most recent PEI income tax return with the Canada Revenue Agency					
<input type="checkbox"/> I confirm that I am currently enrolled in the Insulin Pump Program and / or the Glucose Sensor Program					
<input type="checkbox"/> I am currently under the care and management of a diabetes physician specialist or Certified Diabetes Educator (or Health PEI Provincial Diabetes Program Diabetes Educator)					
<input type="checkbox"/> I am willing to continue to use the insulin pump (and glucose sensor where applicable) properly and to use the data from this technology to make safe and effective diabetes management decisions					
<input type="checkbox"/> I am willing to continue to share my diabetes information with my healthcare team to optimize my diabetes management and attend regular follow-up appointment with my diabetes care provider / diabetes team.					
If the above named individual is <u>under age 19</u>, please indicate living arrangements:					
<input type="checkbox"/> Both parents <input type="checkbox"/> One parent <input type="checkbox"/> Other (specify) _____					
<ul style="list-style-type: none"> • 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:					
<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 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. 			<ul style="list-style-type: none"> • go directly to Section B on page 3 		
<hr/>					
Please <u>mail or email</u> completed renewal application to: Insulin Pump / Glucose Sensor Program Administrator Four Neighborhoods Health Center, 152 St Peter's Road, Charlottetown, PE, C1A 5P8			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 <input type="checkbox"/> 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 the cost of insulin pump and glucose sensors?	<input type="checkbox"/> Yes
	<input type="checkbox"/> No (<i>proceed to page 4</i>)

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 insulin pump, 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, and are applying for glucose sensor coverage, please answer the following statement:

When purchasing glucose sensors at your pharmacy...	<input type="checkbox"/> The pharmacy can direct-bill your insurance company at the time of purchase
<ul style="list-style-type: none"> If you are not aware, please contact your insurance company to inquire 	<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

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 not a full time student)

Information of Applicant who requires the diabetes supplies

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 the cost of insulin pump and glucose sensors?	<input type="checkbox"/> Yes
	<input type="checkbox"/> No (<i>proceed to page 4</i>)
If "yes" to above, please provide the following information	
Name of health insurance company	
Terms of Coverage <small>(e.g. insurance pays 80% of costs of insulin pump and / or glucose sensor)</small>	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, and are applying for glucose sensor coverage, please answer the following statement:

When purchasing glucose sensors at your pharmacy...	<input type="checkbox"/> The pharmacy can direct-bill your insurance company at the time of purchase
<ul style="list-style-type: none"> If you are not aware, please contact your insurance company to inquire 	<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 the next page, **Declaration and Consent**

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.

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.