



13 Sunflower Avenue, 1st Floor, Paramus, NJ 07652
201-444-0337
201-444-5580 (fax)

APPLICATION FOR ASSISTANCE

I. REFERRER INFORMATION

Date: _____

Name: _____ Position: _____

Agency Name & Address: _____

Email: _____

Phone: _____ Fax Number _____

Will you be following the applicant? YES _____ NO _____

If no, will the applicant be referred to another agency for follow-up and where?
Please state.

Financial need confirmed by referrer **Signature:** _____

II. APPLICANT DEMOGRAPHIC INFORMATION

Applicant's Name: _____ Age/Date of Birth _____

Address: _____

Female _____ Male _____

1. _____ African-American/Black
2. _____ Asian or Pacific Islander
3. _____ American Indian or Alaskan Native
4. _____ Hispanic/Latino
5. _____ White
6. _____ Race not included above

Please specify _____

Home Phone: _____ Work: _____

How long has the applicant lived in New Jersey? _____

Please attach a utility bill confirming the address.

Is the address listed the applicant's primary address? YES ____ NO ____

If no, please state the applicant's primary address:

Total number of people living in the household: _____

Excluding the applicant, list all members of the household.

Name/Relationship to applicant	Date of Birth	Social Security #
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1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Use an additional page if needed. All members of household must be included.

III. MEDICAL INFORMATION

Please check diabetes type that best describes the applicant.

Type 1 _____ Type 2 _____ Gestational _____

Check which types of services the applicant requires. Please be mindful of using generic drugs when appropriate.

	NO	YES	IF YES, NAME OF PRESCRIPTION/ DOSAGE/FREQUENCY
Insulin	_____	_____	_____
Oral Medication	_____	_____	_____ _____ _____
Lancets	_____	_____	_____
Test Strips	_____	_____	_____
Syringes	_____	_____	_____
Glucagon	_____	_____	_____
Emergency Kit	_____	_____	_____

Allergies: No _____ Yes _____ (If yes, please list)

Name of Physician: _____

Address: _____

Phone: _____ Email: _____

Will this physician be the primary treating physician? YES ____ NO ____

If no, please indicate which physician or clinic (name, address, and telephone number) will be providing ongoing medical treatment:

Name: _____

Phone: _____ Email: _____

IV. FINANCIAL INFORMATION

Please indicate the total household financial record. Be sure to include all income received--explain in detail any unusual circumstances.

Monthly Salary: \$ _____
Source of Salary: _____
Disability Benefit \$ _____
Unemployment Benefit: \$ _____
Interest/Dividends: \$ _____
Stocks/Bonds: \$ _____
Other: \$ _____

Does the applicant have any medical/health insurance policies? Explain benefits and if insurance in force, or date of cancellation.

Indicate which of the following programs the applicant has or intends to apply for:

Applicant Does not Meet Program Criteria	Application To be Submitted	Application Submitted/Pending	Application Denied	Application Approved
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Medicaid	_____	_____	_____	_____
PAAD	_____	_____	_____	_____
City Welfare	_____	_____	_____	_____
Unemployment	_____	_____	_____	_____
SSI	_____	_____	_____	_____
Drug Company Assistance Programs	_____	_____	_____	_____

V. NARRATIVE

Use the space below to explain the circumstances why you are requesting assistance for the applicant.

VI. CERTIFICATION OF APPLICANT

I verify that the information provided on this application is accurate. I authorize the Diabetes Foundation to use this information to assess my eligibility for participation in the medical assistance program. I understand that this assistance will provide one month (renewable for one additional month) worth of supplies. I certify that I do not have the ability to pay for medications at this time and that I am in the process of applying to any programs for which I may be eligible for assistance. It is at the discretion of the Diabetes Foundation, Inc. that each application is approved.

Name of Applicant (Print)

Signature of Applicant

Date

For Diabetes Foundation use:

Document examined by:

Decision: _____

Date: _____