# Medical Assistance Program

Upon approval, client may receive **up to 6 months** of assistance for diabetes medicines and supplies.

**Requirements**

- **Completed Application**
- **Proof of residence within 13 county service area of Metro Atlanta**
- **Proof of income (copy of income tax return or pay stubs or department of labor statement)**
- **If you have no income, please provide us with a statement from the department of labor**
- **Copy of prescription signed and dated within the past 12 months**
- **Have no insurance coverage**

**Once Approved:**

- **Complete diabetes education class and follow up appointments**
  - It is required to attend the diabetes education class **before** assistance starts. Failure to attend class will forfeit your application.
- **$30 co-pay for 6 months of coverage (can be paid over the six months)**

***To request an application please call 404-527-7150 and listen to the prompts for the medical assistance program or download an application from our website at [www.diabetesatlanta.org](http://www.diabetesatlanta.org)***

Diabetes Association of Atlanta, Inc.
100 Edgewood Ave, Suite 1004
Atlanta, Georgia 30303
**Phone:** 404-527-7150 **Fax:** 404-527-7149
www.diabetesatlanta.org

Diabetes Association of Atlanta

## MEDICAL ASSISTANCE PROGRAM APPLICATION

**PERSONAL**

Name:_____ County:_____

Address:_____

City:_____ Zip Code:_____

Home Phone:_____ Email:_____

DOB:_____ Social Security#:_____

Sex: □ Male □ Female

Race: □ Black □ White □ Hispanic □ Asian □ Other

Marital Status: □ Single □ Married □ Divorced □ Widowed

Please list an Emergency Contact Person:

Name:_____ Relationship:_____ Phone:_____

**INSURANCE INFORMATION**

Are you covered by Medical Insurance? □ NO □ YES
If Yes, Company?_____

Are you on Medicaid? □ NO □ YES

Are you on Medicare? □ NO □ YES

**FAMILY/LIVING ARRANGEMENTS** _____ *Number Of People Living With You*

Names:

_____

_____

_____

_____

Housing: □ Own □ Rent □ Live with Family/Friend

**MONTHLY HOUSEHOLD INCOME (**Attach copies of income for 2 months for every person in your household that contributes to your income)

**Self:** (Check all that apply)

Employer: _____ Work#: _____

| | Amount (before anything is taken out) | How Often Paid |
|---|---|---|
| □ Job | $_____ | □ Weekly □ Every 2 Weeks □ Monthly |
| □ Worker's Comp | $_____ | □ Weekly □ Every 2 Weeks □ Monthly |
| □ Pension Plan | $_____ | |
| □ Social Security | $_____ | |
| □ Veterans | $_____ | |
| □ Child Support | $_____ | |
| □ Alimony | $_____ | |
| □ Other | $_____ | |

**Spouse:** (Check all that apply)

Employer: _____ Work# _____

| | Amount (before anything is taken out) | How Often Paid |
|---|---|---|
| □ Job | $_____ | □ Weekly □ Every 2 Weeks □ Monthly |
| □ Worker's Comp | $_____ | □ Weekly □ Every 2 Weeks □ Monthly |
| □ Pension Plan | $_____ | |
| □ Social Security | $_____ | |
| □ Veterans | $_____ | |
| □ Child Support | $_____ | |
| □ Alimony | $_____ | |
| □ Other | $_____ | |

**Other:** (Check all that apply)

Employer: _____ Work# _____

| | Amount (before anything is taken out) | How Often Paid |
|---|---|---|
| □ Job | $_____ | □ Weekly □ Every 2 Weeks □ Monthly |
| □ Worker's Comp | $_____ | □ Weekly □ Every 2 Weeks □ Monthly |
| □ Pension Plan | $_____ | |
| □ Social Security | $_____ | |
| □ Veterans | $_____ | |
| □ Child Support | $_____ | |
| □ Alimony | $_____ | |
| □ Other | $_____ | |

**MEDICAL INFORMATION**

Doctor/Clinic Treating your Diabetes

Name:_____

Address:_____Suite_____

City:_____ Zip Code:_____

Phone:_____ Fax:_____

**When was your diabetes detected?** Month_____Year_____ *Type of diabetes Type 1* □

*Type 2* □

**DIABETES MEDICATIONS**

| Name | Amount (mgs) | How Often? |
|---|---|---|
| | | |
| | | |

*Do you have a glucose monitor?* □ Yes □ No

*If yes what kind?* _____

**ASSISTANCE NEEDED**

List the diabetes medicines and supplies you are asking DAA (Diabetes Association of Atlanta) for assistance with. Supplies include (syringes, glucose testing strips, glucose meter, etc.)

_____ _____

_____ _____

_____ _____

***Please provide a copy of all diabetes prescriptions***

**REFERRED BY:**

How did you hear about the Diabetes Association Medical Assistance Program?
Health Dept.____ Physician____ United Way 211____ Other_____

Have you ever received benefits/education from this Agency in the past? □ Yes □ No

If yes, what type of assistance?
10 hr Education Class___ Emergency Medical Assistance___

If yes, what year?_____

*I agree to the following:*

1. *Complete a 10-hour self-management program with the Diabetes Association of Atlanta.*
2. *Complete three, six, and twelve month follow-up appointments.*
3. *Notify the Diabetes Association of Atlanta of any changes in address, phone number, employment, income status, and Medicare/Medicaid benefits.*
4. *Request physician to fax changes in prescriptions to the Diabetes Association office (404-527-7149).*
5. *Improve blood glucose control as indicated by my HgA1c lab results. If my HgA1c level increases excessively, I agree to be re-evaluated by an educator for continuation of the medical assistance.*
6. *I understand this assistance is not renewable.*

*I understand that failure to comply with the above may result in ineligibility for the medical assistance*

*Signature:*_____

*Date:*_____

Please mail your application to:
The Diabetes Association of Atlanta, Inc
100 Edgewood Avenue NE, Suite 1004
Atlanta, GA 30303
404-527-7150
FAX: 404-527-7149

Office Use Only

Approval Date:_____ Pharmacy:_____

| Medicines | Supplies |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |