DIABETES ASSOCIATION OF ATLANTA

75 Marietta St., NW., Suite 304 |Atlanta, Georgia |30303
Phone: 404-527-7150 ext. 112 **Fax:** 404-527-7149
www.diabetesatlanta.org

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)
  - If you have no income, please provide us with a wage statement from the department of labor
- Copy of current prescriptions signed and dated within the past 12 months
- Have no insurance coverage

Once Approved:

1. **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.
2. **$30 co-pay for 6 months of coverage (can be paid over the six months*)***

To request an application please call 404-527-7152 to speak with the Medical Assistance Program Coordinator or download an application from our website at www.diabetesatlanta.org

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PERSONAL

Name:_____ DOB:____/_____/_____

Address:_____

City:_____ County:_____ Zip Code:_____

Primary Phone:_____ Email:_____

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: ☐ Live on your Own ☐ Rent ☐ Live with Family/Friend

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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	$_____	

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MEDICAL INFORMATION

Your Primary Care Doctor/Clinic Treating your Diabetes

Name:_____

Address:_____Suite_____

City:_____ Zip Code:_____

Phone:_____

Have you been to the hospital/emergency room within the past 12 months for your diabetes? Yes☐ No ☐ If so, when?(date):

Which Hospital/Emergency Room were you admitted to?:

When was your diabetes detected? Month_____Year_____

Circle the type of diabetes that you have: Type 1 Type 2

DIABETES MEDICATIONS YOU CURRENTLY TAKE:

Name	Amount (mgs)	How Often?	Type(Pen/Vial/Pill)

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

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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. Make an effort to 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 support.
6. I understand this assistance is not renewable.

I promise the information given in this report is true and accurate to the best of my knowledge. I give permission to DAA to release any information about me to my doctors and healthcare

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
75 Marietta St., NW., Suite 304
Atlanta, GA 30303
TEL: 404-527-7150
FAX: 404-527-7149

Office Use Only
Date of Contact:
Class Date:
Approval Date:
Notes: