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 | diabetes@diabetesatlanta.org

Medical Assistance Program

Upon approval, the client may receive **up to 3 months** of assistance for diabetes medicines and supplies.

Requirement

- 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 or unemployment letter
- Copy of current prescriptions signed and dated within the past 12 months
- Have no insurance coverage (some exceptions apply.)

Once Approved:

DAA will mail you Kroger card which will allow you to fill your prescription. Please allow at least two weeks for delivery after approval.

To request an application please call 404-527-7152 to speak with Marquez Allen, *Medical Assistance Program Coordinator*.

Name: **Date of Birth:**

Address:

City: **County:** **Zip code:**

Primary Phone: **Email:**

Social Security #

Sex: ☐ **Male** ☐ **Female**

Race: ☐ **Black** ☐ **White** ☐ **Hispanic** ☐ **Asian**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Please list an Emergency Contact

Name: **Relationship:** **Phone:**

INSURANCE INFORMATION

Are you covered by Medical Insurance? ☐ Yes ☐ No

If Yes, Company Name?

Are you on Medicaid? ☐ Yes ☐ No

Are you on Medicare? ☐ Yes ☐ No

FAMILY/LIVING ARRANGEMENTS

Number of people living with you :

Names:

Housing: ☐ Live on Your Own ☐ Rent ☐ Live with Family/Friend

MONTHLY HOUSEHOLD INCOME

(Attach copies of your income for two months for every person in the household that contributes to your income)

Self: (Place X for all that apply in the blue box)

Employer: _____ Work #: _____

Amount (before anything is taken out) How Often Paid

☐	Job	$		☐ Weekly	☐ Every two weeks	☐ Monthly	
☐	Worker's Comp	$					
☐	Pension	$		☐ Weekly	☐ Every two weeks	☐ Monthly	
☐	Social Security	$					
☐	Veterans	$					
☐	Child Support	$					
☐	Alimony	$					
☐	Other	$					

Spouse: (Fill in all that apply in the blue box)

Employer: _____ Work #: _____

Amount (before anything is taken out) How Often Paid

☐	Job	$		☐ Weekly	☐ Every two weeks	☐ Monthly	
☐	Worker's Comp	$					
☐	Pension	$		☐ Weekly	☐ Every two weeks	☐ Monthly	
☐	Social Security	$					
☐	Veterans	$					
☐	Child Support	$					
☐	Alimony	$					
☐	Other	$					

Other: (Fill in all that apply in the blue box)

Employer: _____ Work #: _____

Amount (before anything is taken out) How Often Paid

☐	Job	$		☐ Weekly	☐ Every two weeks	☐ Monthly	
☐	Worker's Comp	$					
☐	Pension	$		☐ Weekly	☐ Every two weeks	☐ Monthly	
☐	Social Security	$					
☐	Veterans	$					
☐	Child Support	$					
☐	Alimony	$					
☐	Other	$					

MEDICAL INFORMATION

Primary Physician:

Address:

Suite: *City:* State:

Phone: *Email:*

Have been in the hospital/emergency room within the past 12 months for your diabetes?

☐ **Yes** ☐ **No** **If so, when? Provide date:**

Which hospital/emergency room were you admitted to?

When was your diabetes detected? **Month** **Year**

What type of diabetes do you have? ☐ **Type 1** ☐ **Type 2**

Diabetes medication you are currently taking:

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

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

If yes, what kind of monitor?

ASSISTANCE NEEDED

List the diabetes medicines and supplies you are asking the Diabetes Association of Atlanta (DAA) for assistance with such as glucose test strips, glucose meter, syringes, etc. List items in the below table. Please provide a copy of all diabetes prescriptions.

List	List	List

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I agree to the following:

1. Notify the Diabetes Association of Atlanta of any changes in address, phone number, employment, income status, and Medicare/Medicaid benefits.
2. Request physician to fax changes in prescriptions to the Diabetes Association office (404-527-7149).
3. 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.
4. I understand this assistance is renewable on a case by case basis.

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 save completed application and then email your application to:

diabetes@diabetesatlanta.org

Office Use Only

Date of Contact:

Class Date:

Approval Date:

Notes: