



**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 nearest relative not living with you

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION**

*Are you covered by Medical Insurance? Company* \_\_\_\_\_ NO YES

*Policy no.* \_\_\_\_\_ *Group no.* \_\_\_\_\_

*If yes, does it pay for diabetes medication/supplies* NO YES

*Are you on Medicaid?* NO YES

*If yes, does it pay for diabetes medicine* NO YES

*Are you on Medicare?* NO YES

**FAMILY/LIVING ARRANGEMENTS**

\_\_\_\_\_ *Number Of People Living With You*

Name	Relationship	Age
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Housing:        Own        Rent        Live with Family/Friend

**MONTHLY HOUSEHOLD INCOME** (Attach copies of income for 2 months for every person living in your house.)

**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: \_\_\_\_\_



*I agree to the following:*

- 1. Complete a 10-hour self-management program with the Diabetes Association of Atlanta within 3 months of pre-assessment.*
- 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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_