Clear Form

Print Form

PEI Glucose Sensor Program - INITIAL

Family Contribution Assessment and Release of Information

Email to diabetesadminofficer@ihis.org **OR** mail requests to PEI Glucose Sensor Program, P.O. Box 2000, Charlottetown, PE, C1A 7N8

Toll Free Contact Information: 1-833-335-0538

1. Individual who requires the glucose sensor (Please Print)

Last Name		**First Name**		**Middle Initial**	
PHN #		**DOB** (yyyy/mm/dd)			

Address (Mailing address)

Street # and Name				Apt#	
City / Town		Province		Postal Code	
Home Telephone	( )	Cell	( )		
Email address to communicate with Program Administrator					

2. Client/Family Agreement for Glucose Sensors

- In this Agreement, "I" refers to the individual, (and/or the parent/ guardian, caregiver**, substitute decision maker as appropriate) who will be using the glucose sensor.
- Clients 19 years of age or older must complete this section of the agreement themselves unless they do not have the capacity or have given legal authority for another person to act on their behalf.

*** A caregiver is a family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person within a family home environment (i.e. non-institutionalized care).*

I _____ wish to apply for benefits under the PEI Glucose Sensor Program on behalf of:

☐ **myself** ☐ **a dependent (child / youth under age 19)** ☐ **other _____**

Please check (√) each box to indicate you have read and agree with each statement.

☐ The individual requiring the glucose sensor is currently taking at least 3 insulin injections per day or using an insulin pump for diabetes management

☐ I confirm that I (and household family members, where applicable), have filed my most recent income tax return with the Canada Revenue Agency

☐ I am aware that annual renewal of application is required by June 30th each year or benefits under this program will cease.

_____ _____ _____

Name of Client / Parent / Caregiver (print) Signature Date (yyyy/mm/dd)

3a). If the above-named individual is under age 19, please indicate living arrangements:

☐ Both parents ☐ One parent ☐ Other (specify)_____

- **Parents/ Guardian are to complete Section B on next page** and then proceed to page 4.

3b). If the above-named individual is age 19 or over, please indicate current status:

☐ Single (including widowed or divorced)

As a single person, are you a full-time student under the age of 25?

If YES:

- The young adult must sign the consent - **Section A page 2**
- The parent / guardian (s) of the full-time student (i.e. the dependant) are to complete **Section B on page 2**

If NO:

- Go directly to **Section C** on **page 3.**

☐ Married/Common law:

- Go directly to **Section C** on **page 3**

SECTION A: Consent of young adult aged 19 to 24 years, who is a full-time student:

If you are a young adult, aged 19 to 24 years, and living as a dependant (ex: full time student, attending high school or university):

- you must review / sign the consent below, giving permission for your parent / guardian to apply on your behalf
- your parent / guardian must complete the application and sign the Declaration and Consent on page 4

I, _____, born _____, consent to my parent/ guardian making this application
(print name) *(yyyy/mm/dd)*
on my behalf for funding assistance under the PEI Glucose Sensor Program

_____ Date: _____
Signature of Young Adult *(yyyy/mm/dd)*

SECTION B: Household Information on behalf of a Dependant (Under age 19 or a full-time student aged 19 to 24)

Parent / Legal Guardian of individual noted on page 1

Last Name		First Name		Middle Initial	
Social Insurance Number		Date of birth *(yyyy/mm/dd)*			

Spouse / Partner (of Parent / Legal Guardian)

Last Name		First Name		Middle Initial	
Social Insurance Number		Date of birth *(yyyy/mm/dd)*			

Address ☐ Same as noted on page 1

Street # and Name				Apt #	
City / Town		Province		Postal Code	
Cell phone	( )	Home telephone	( )		
Email address					

Does the parent/guardian, or spouse/partner have:

Third party health insurance that would cover part or all of the cost of glucose sensors? ☐ Yes ☐ No (*proceed to page 4)*

If "yes" to above, please provide the following information

Name of health insurance company	
Terms of Coverage (e.g. insurance pays 80% of the cost of the glucose sensor)	**If you are not aware of your coverage, please contact your insurance company to inquire**

If there is **more than one plan** that provides coverage, please provide information on the additional health plan

Name of health insurance company	
Terms of Coverage	**If you are not aware of your coverage, please contact your insurance company to inquire**

If you have private health insurance, please answer the following statement:

When purchasing glucose sensors at your pharmacy… *If you are not aware how to answer this statement, please contact your insurance company to inquire*	☐ The pharmacy can direct-bill your insurance company at the time of purchase
	☐ You must pay full cost at the pharmacy and then submit your receipts to your insurance company for reimbursement

Upon completion of the above section, please proceed to page 4 - *Declaration and Consent*

Personal information, including health information, on this form is collected by the Department of Health and Wellness under the authority of Section 31(c) of the *Freedom of Information and Protection of Privacy Act and*/or the *Health Information Act* for the purposes of determining your eligibility for the PEI Glucose Sensor Program, for evaluating the program and for other purposes permitted by law. Your information will be collected, used and disclosed only as permitted by law.

SECTION C: Household Information for Independent Applicant (Age 19 or over, AND NOT a full-time student)

Information of Applicant who requires the glucose sensor

Last Name		First Name		Middle Initial	
Applicant's Social Insurance Number					

Spouse / Partner (if applicable)

Last Name		First Name		Middle Initial	
Spouse's / Partner's Social Insurance Number		Date of Birth *(yyyy/mm/dd)*			

Do you or your spouse / partner have:

Third party health insurance that would cover part or all of the cost of glucose sensors?	☐ Yes ☐ No *(proceed to page 4)*

If "yes" to above, please provide the following information

Name of health insurance company	
Terms of Coverage (e.g. insurance pays 80% of the cost of the glucose sensor)	**If you are not aware of your coverage, please contact your insurance company to inquire**

If there is **more than one plan** that provides coverage, please provide information on the additional health plan

Name of health insurance company	
Terms of Coverage	**If you are not aware of your coverage, please contact your insurance company to inquire**

If you have private health insurance, please answer the following statement:

When purchasing glucose sensors at your pharmacy… *If you are not aware how to answer this statement, please contact your insurance company to inquire.*	☐ The pharmacy can direct-bill your insurance company at the time of purchase
	☐ You must pay full cost at the pharmacy and then submit your receipts to your insurance company for reimbursement

Upon completion of the above section, please proceed to page 4 - *Declaration and Consent*

Personal information, including health information, on this form is collected by the Department of Health and Wellness under the authority of Section 31(c) of the *Freedom of Information and Protection of Privacy Act and*/or the *Health Information Act* for the purposes of determining your eligibility for the PEI Glucose Sensor Program, for evaluating the program and for other purposes permitted by law. Your information will be collected, used and disclosed only as permitted by law.

Declaration And Consent

I/We, the undersigned, declare that the information provided on this application is true and correct to the best of my/our knowledge.

I/We, the undersigned, understand that refusing to submit information or knowingly furnishing false or incomplete information is an offence under the *Drug Cost Assistance Act*.

For the purpose of verifying program eligibility, I/we authorize the Department of Health and Wellness to obtain information from:

- My employer, my insurer, and my plan administrator regarding private insurance coverage;
- The Provincial Health Plan (the Plan) regarding my eligibility for health services and release of my PHN;
- Retail pharmacies, to access prescription drug information in order to verify claims

I/We, the undersigned, agree to notify the Glucose Sensor Program Administrator of any changes to the household, insurance coverage, or any other factor which may affect my level or eligibility of coverage.

I/We, the undersigned, hereby consent to the release by the Canada Revenue Agency (CRA), of income, expense and identifying information from income tax returns or from other sources, copies of notices of assessment or reassessment, and copies of information slips (for example, T2202A, T3, T4 and T5 slips) filed with CRA. The information will be relevant to and used solely for the purpose of determining and verifying my eligibility and entitlement for assistance and collecting overpayments of assistance under the Drug Cost Assistance Programs identified above.

A parent or legal guardian may provide consent for all dependents under the age of 18.

This authorization is valid for the two taxation years preceding the date of this application, the current taxation year and each subsequent consecutive taxation year for which I apply for assistance under the Drug Cost Assistance Programs identified above.

I understand that there are risks associated with sending personal health information to an unsecured email address, including a risk that my information could be accessed by someone else in transit. I accept the risks and request that the Department of Health and Wellness send my personal health information to me at the email address I have provided.

Name of Applicant/ Parent / Guardian /Attorney	Signature (*written signature required, no electronic)*	Date (yyyy/mm/dd)
Name of Spouse (if applicable)	Signature (*written signature required, no electronic)*	Date (yyyy/mm/dd)

By signing above, I certify that the information given on this application and in any documents attached is correct, complete, and fully discloses my household conditions.

I understand that a false statement constitutes fraud and may result in recovery of any benefits paid.

I acknowledge that it is my responsibility to report any change to the information provided within 30 days of the change coming into effect.

Special Authorization Request

Glucose Sensor Program

HEALTH CARE PROVIDER: PLEASE COMPLETE ALL SECTIONS. INCOMPLETE APPLICATIONS WILL BE RETURNED

This form must be completed by the applicant's Health Care Provider i.e. Physician / Nurse Practitioner or Certified Diabetes Educator (or Health PEI Provincial Diabetes Program Diabetes Educator) and submitted with the completed application.

SECTION 1 – PATIENT INFORMATION

PERSONAL HEALTH NUMBER (PHN)		PATIENT (FAMILY) NAME	PATIENT (GIVEN) NAME(S)
DATE OF BIRTH (YYYY/MM/DD)		PATIENT'S MAILING ADDRESS	

Section 2 – Requester's Information

NAME AND MAILING ADDRESS	APPLICATION DATE
	REQUESTER'S TELEPHONE #
	REQUESTER'S FAX #

Section 3- Type of Sensor Requested (information as per Health Canada approval)

Freestyle		Dexcom	Medtronic
☐ Libre 2 • **Sensor wear = 14 days** • **2 sensors dispensed every 28 days**	☐ Libre 3 plus • **Sensor wear = 15 days** • **2 sensors dispensed every 30 days**	☐ Dexcom G6 or ☐ Dexcom G7 • **Sensor wear time = 10 days** • **3 sensors dispensed every 30 days**	☐ Guardian 3 ☐ Guardian 4* *(*only compatible with 780G insulin pump)* • **Sensor wear time = 7 days** • **5 sensors dispensed every 35 days**

Section 4- Type of insulin administration the patient is currently prescribed / using

Insulin Pump brand:

☐ Medtronic
☐ Tandem
☐ Omnipod

☐ Multiple daily injections of insulin (*please specify below*)

- Basal insulin *(name)* _____ Number of injections per day* *(required)*_____
- Bolus insulin *(name)* _____ Number of injections per day* *(required)*_____

* Patients **must** be on a minimum of **3 insulin injections per day** to qualify for the Glucose Sensor Program

Section 5- Patients/ Parent/ Caregiver ** must meet the following criteria for special authorization:

For the treatment of patients who are **on multiple daily injections of insulin** (3 or more injections / day) **OR** an **insulin pump AND**

☐ The patient is under the care & management of a primary care provider, physician specialist or CDE / Health PEI PDP diabetes educator

☐ The patient/ parent/ caregiver** demonstrates the capacity to use the sensor appropriately

☐ The patient/ parent/ caregiver ** demonstrates a reasonable understanding of what sensor technology can do and how it can benefit diabetes care

☐ The patient/ parent/ caregiver ** affirms a willingness to use the sensor properly & to use the data to make safe & effective diabetes management decisions

** a caregiver is a family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person within a family home environment (i.e. non-institutionalized care).

OTHER COMMENTS (IF APPLICABLE)

The PEI Department of Health and Wellness may request additional documentation to support this Special Authorization Request. Personal information, including health information, on this form is collected by the PEI Department of Health and Wellness under the authority of Section 31(c) of the *Freedom of Information and Protection of Privacy Act and*/or the *Health Information Act* for the purposes of determining your eligibility for the PEI Glucose Sensor Program, for evaluating the program and for other purposes permitted by law. Your information will be collected, used and disclosed only as permitted by law.

REQUESTER'S SIGNATURE (REQUIRED)_____**DATE:** _____

Please retain this page for information purposes

How do we define "Household"?
A household means a person, the person's spouse, if the person has a spouse, and any dependants. No person may be considered to be part of more than one household.

How do we define "Spouse"?
A spouse is a person who is married to you or with whom you are living in a marriage-like relationship. A spouse may be of the same gender.

How do we define "Dependant"?
A dependant is a child of a person or the person's spouse, who

- is under 19 years of age and does not have a spouse, or
- is 19 years of age or over but under 25 years of age, is a full- time student and does not have a spouse;

How to define "Caregiver" under the Glucose Sensor Program?
For purposes of the Glucose Sensor Program, a caregiver is a family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person within a family home environment (i.e. non-institutionalized care).

How to define Attorney?
An attorney is a person who has the authority to act for another person in specified or all legal or financial matters. This authority is provided through a Power of Attorney legal document

What if I am single, 19 years of age or over and still living with my family?
If you are 19 years of age or over, and **NOT** a full-time student, you must complete your own registration form. If you live with your parents, are NOT a full-time student and do not have a spouse or dependents, you are a family of one for our purposes. Do not include your parents' names or their incomes on your registration form

How do we define "Household Income"?
Household income means the total income of the people in a household, other than any dependents. For each household member, use Line 15000 (Total Income) from the preceding year's tax return, and deduct any amounts reported on lines # 21000 (Split–Pension Amount), # 21400 (Child Care Expenses), # 22000 (Support Payments Made). This amount represents each individual's income for the purpose of Drug Program coverage. Add together the individual amounts for each household member identified above to determine total household income.

How do we calculate coverage under the Glucose Sensor Program?
Take the household income you just calculated; determine which income range you fall under:

Total Household Income Ranges	**Estimated co-pay per dispense to be paid at any PEI Pharmacy** *(every 26 to 35 days depending on sensor type)*	
	No private insurance	**With private insurance***
$0 to $20,000	$0.00	$0.00
$20,001 to $40,000	$10.00	$2.00
$40,001 to $50,000	$20.00	$4.00
$50,001 to $100,000	$60.00	$12.00
$100,001 and above	$80.00	$16.00

***** If the applicant / parent(s) have private health insurance that provides partial coverage for glucose sensors, the co-payment will be either 20% of a standard copay as noted in the table above or the amount remaining after payment by private insurance, whichever is less.