Clear Form

Print Form

PEI Glucose Sensor Program – RENEWAL

Family Contribution Assessment and Release of Information

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					

What brand of sensor are you currently using?

☐ **Freestyle Libre** ☐ **Dexcom** ☐ **Medtronic Guardian**

Terms and Conditions for Renewal

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.

*** 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).*

To renew your benefits under the Glucose Sensor Program, you must confirm / agree to the following statements. By checking the boxes below, you indicate that you have read and agree with the statement.

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

☐ I confirm that I am currently enrolled in the Glucose Sensor Program

☐ I am currently taking at least 3 insulin injections per day or using an insulin pump for diabetes management

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 A on next page** and then proceed to page 3.

If the above-named individual is aged 19 or over, please indicate current status:

☐ Single (including widowed or divorced)

As a single person, are you a full-time student?

- **If YES**:
  - The parent / guardian (s) of the full-time student (i.e. the dependant) are to complete **Section A on page 2**
- **If NO**, go directly to **Section B** on page 3.

☐ Married/Common law:

- go directly to **Section B** on page 3

Please mail or e-mail completed renewal application to:

Glucose Sensor Program Administrator
PEI Pharmacare
PO Box #2000
Charlottetown, PE C1N 7N8

Toll Free Contact information:

1-833-335-0538
diabetesadminofficer@ihis.org

SECTION A:

Household Information on behalf of a Dependent (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 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 costs 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 B:

Household Information for Independent Applicant (Age 19 or over, AND <u>not</u> 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	
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 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 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:	
<u>When purchasing glucose sensors at your pharmacy…</u> *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 the last page: *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 cost data in order to verify claims billed to the Drug Cost Assistance Program

I/We, the undersigned, agree to notify the Department of Health and Wellness 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 taxation year 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	Signature (*written signature required, no electronic)*	Date (*yyyy/mm/dd)*
Name of Spouse	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.