

ALBERTA MONITORING FOR HEALTH PROGRAM APPLICATION FORM

- This application is for low income Albertans with diabetes who do **NOT** have insurance for their diabetes supplies. **THIS PROGRAM DOES NOT ASSIST WITH THE PURCHASE OF DIABETES MEDICATIONS.**
- This is an application only, it does not guarantee that you are eligible for assistance.
- Once Alberta Monitoring For Health has successfully processed your application you will receive a letter confirming your eligibility. Funding is prorated based on application date.

Incomplete applications will delay processing time.

SECTION A - INFORMATION (PLEASE PRINT)

Last Name: _____ First Name: _____ Initial _____

Date of birth: _____ Phone number: (____) _____
(date and year)

Address: _____ City: _____ Province: _____ Postal Code: _____

Alberta Personal Health Number (PHN): _____ Male Female

The Canadian Diabetes Association, operating the Alberta Monitoring For Health Program, is authorized to collect your PHN under Section 21(1)(a) of the *Health Information Act*, R.S.A. 2000, c.H-5.

SECTION B - DIABETES HISTORY PLEASE CHECK (✓) ALL THAT APPLY

I was first diagnosed with diabetes: _____ (eg. January 2001)

I have been diagnosed with: Type 1 diabetes Type 2 diabetes Gestational diabetes

I currently manage my diabetes with: insulin oral medication diet/exercise

Attach a copy of the prescription or official receipt for your diabetes MEDICATION(S). If you control your diabetes by diet/exercise “ONLY”, attach a copy of your prescription or official receipt for your testing supplies.

I test my blood sugar:

- four times a day three times a day twice a day once a day
 twice a week once a week twice a month monthly
 other, please state: _____

SECTION C - DIABETES EDUCATION PLEASE CHECK (✓) ALL THAT APPLY

I have received diabetes education from: Physician Diabetes Specialist Dietician
 Pharmacist Registered Nurse No one

I have attended a diabetes education class or clinic: Yes No

If yes, where? _____

I have received training for:

- Blood glucose monitor strips Physical activity
 Foot care Diet management

SECTION D - DECLARATION
PLEASE CHECK (✓) ALL THAT APPLY

Please read and check (✓) the following carefully, prior to signing this form.

I hereby certify that:

- I am a full time Alberta resident.
- I have valid Alberta Health Care insurance coverage.

I meet one of the following three family status and income levels:

- Single with an annual, taxable income less than **\$23,598**.
- Married/common law with a combined spousal annual, taxable income less than **\$37,021**.
- Single/married/common law (with dependant children) with a combined family, annual, taxable income less than **\$44,974**.

I declare that:

- I do not have other insurance coverage for diabetes supplies.
- I do not receive diabetes supplies from AISH, Alberta Works or Alberta Child Health Benefit.

I agree to notify Alberta Monitoring for Health if:

- My taxable income rises so that I no longer qualify for this Program, or my family status changes, or I obtain other insurance coverage for my diabetes supplies, or I receive diabetes supplies from AISH, Alberta Works or Alberta Child Health Benefit.
- There is a change to the way my diabetes is managed. (eg. presently on oral medication only and later need insulin.)

I authorize the Canadian Diabetes Association on behalf of Alberta Health and Wellness to verify that I meet the above criteria for the purpose of determining eligibility for the Alberta Monitoring For Health Program. If required, I will provide my most recent Notice of Assessment for income verification.

I also authorize the Canadian Diabetes Association and Alberta Health and Wellness to use the information provided on this form as per section 27 (2) of the *Health Information Act* for the purposes of (a) planning and resource allocation, (b) health system management, (c) public health surveillance and (d) health policy development.

I have read this information and acknowledge that it is true.

(application must be signed and dated for further consideration)

Applicant's/Parent's Signature: _____ Date: _____

Please ensure (✓) the following is done:

- Application is completed in full
- Copy of prescription/receipt is attached

SEND APPLICATION AND COPY OF PRESCRIPTION/RECEIPT TO:

ALBERTA MONITORING FOR HEALTH
Suite 1020 Royal Bank Building
10117 Jasper Avenue NW, Edmonton, AB. T5J 1W8
Phone: 1-800-267-7532 Fax: (780) 409-2634

- I am interested in receiving information on diabetes management from the Canadian Diabetes Association. Call toll free 1-800-563-0032.