



## Individual Assistance Application Check List

### Applications

- ✓ \_\_\_\_\_ Have you answered ALL questions on the application? **Due to the volume of applications we receive we cannot call or email you to ask questions – an incomplete application will be returned to you.**
- ✓ \_\_\_\_\_ Did you complete Section 2 and attach a brief statement about your situation?
- ✓ \_\_\_\_\_ Did you sign and date the application?
- ✓ \_\_\_\_\_ Did you complete a REDS Supply Order Form (if you are applying for the free supplies program)?
- ✓ \_\_\_\_\_ Did you complete an IPUMP Assistance Form (if you are applying for an insulin pump)?

### Attachments

- ✓ \_\_\_\_\_ Did you attach copies of supportive financial records that help demonstrate your financial need? **We will not process your application without some evidence of your hardship!** Supporting documents that help us serve you faster include at least one:
  - \_\_\_\_\_ Copy of anything that shows you already qualify for another assistance program (like food stamps, free insulin, etc.)
  - \_\_\_\_\_ Current bank statement or paycheck stub
  - \_\_\_\_\_ Copies of delinquent medical bills
  - \_\_\_\_\_ Letters from insurance companies denying claims or coverage
  - \_\_\_\_\_ Copies of insurance policy restrictions (that shows diabetes is not covered)
  - \_\_\_\_\_ Or *anything* else that shows why you are having a hard time.
- ✓ \_\_\_\_\_ Did you attach a prescription for any of the following if you are requesting them: an insulin pump, insulin pump supplies, pen needles, or syringes? **(We do NOT supply insulin or medications so please do not send a prescription for these items.)**
- ✓ \_\_\_\_\_ Did you attach a copy of your driver's license (or other proof of citizenship)? **We must have this to show that you are the person who submitted the application.**
- ✓ \_\_\_\_\_ Did you complete and attach your HIPAA form (required by law)?

**Disclaimer:** iPump.org, Inc. offers no express or implied promise or guarantee that any assistance will be granted simply because you submit an application. Assistance may be denied or restricted based on available program funding at any given time, or, for any other reason at the sole discretion of the Board. We do not deny assistance based on age, sex, lifestyle, creed, nationality, disability, religion, affiliation, or for any reason other than failure to demonstrate financial and medical need for assistance, or because we lack the resources to help.

**Mail Applications to:** iPump, 2250 Alyssum Avenue, Upland, CA 91784



Consent to the Use and Disclosure of Health Information
Necessary to Process an Assistance Application or
to Provide Any Type of Service or Assistance Through iPump.org, Inc.

As Required by Federal HIPAA Privacy Law

I understand that as part of my receiving assistance through iPump.org, Inc. ("iPump," or "organization"), that iPump originates and maintains health records which may describe my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans or needs for future care or treatment, as well as certain financial and personal information. I understand that this information serves as:

- A basis for processing my application for assistance; and
• A means of communication among the any health professionals, social workers, patient advocates, pharmacies, or others who contribute directly to my health care or in providing goods and/or services related to my health care; and
• A source of information for applying my diagnosis and information to my being considered for, or actually receiving assistance directly or indirectly from or through iPump.

I understand and have been provided with a "Notice of Information Practices for iPump.org, Inc." that provides a more complete description of information uses and disclosures. Further, I understand and agree, that:

- I was given the opportunity to, and have the right to review the "Notice of Information Practices for iPump.org, Inc." prior to signing this consent.
• That iPump reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided.
• I have the right to object to the use of my health information for directory purposes.
• I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations including assistance through iPump, and that the organization is not required to agree to the restrictions requested.
• I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Table with 2 columns: Applicant or Legal Representative of Applicant, Witness to Applicant's Signature. Rows include Print Full Name, Signature, and Date.



## Notice of Information Practices For iPump.org, Inc.

1425 W. Foothill Blvd., Suite 235, Upland, CA 91786

[www.ipump.org](http://www.ipump.org); email [help@ipump.org](mailto:help@ipump.org)

**How We Collect Information About You:** iPump.org, Inc. (iPump) and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

**What We Do Not Do With Your Information:** Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

**How We Do Use Your Information:** Information is only used as is reasonably necessary to process your application which may require communication between iPump and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers that is necessary to verify your medical information is accurate, determine the type of medical supplies you need to manage your diabetes, and/or to obtain or order any type of diabetes supplies or insulin pumps on your behalf.

If you apply or attempt to apply for assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or unwillful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

**Information We Do Not Collect:** We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page ([www.iPump.org](http://www.iPump.org)) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic data through our site. To avoid potential data capture that you visited a diabetes website simply do not click on any of our outside affiliate links.

**Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources:** Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of iPump. We reserve the right to use non-identifying information about our clients (those who do receive services or goods from us) for fundraising and promotional purposes that are directly related to our mission. Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publically used without your consent.



Hope through help.

**Diabetes Assistance Application for an Individual  
Section 1. Applicant Information**

If you are married you must include spouse's income and insurance benefits on this application if you or applicant child benefits from the spouse's income or insurance benefits even if you do not live together.

<b>Applicant</b> or parent if applying for a child	Title	Parent/Applicant's name (first, middle, last)	
	(Mr, Mrs, Ms, etc)	Social Security Number	Driver's license (state & number)
<b>Spouse</b>	Title	Spouse's name (first, middle, last)	
	(Mr, Mrs, Ms, etc)	Social Security Number	Driver's license (state & number)

Parent/Applicant status	Single/Separated [ ]	Married [ ]	Divorced [ ]	Widow/er [ ]
Number of dependents	Self [ ]	Spouse [ ]	Children [ ]	Total [ ]

Applicant or Child's name (first, middle, last name)		Social security number		
Date of birth	Current age	Type of diabetes	Date of Diagnosis	Where child lives
Number of shots daily		On insulin pump?	How often is blood sugar tested daily?	
Is child a full-time college student?		If yes, where do they/you attend?		

**Parent/Applicant Contact Information**

Residential address – no post office boxes – if in a shelter, include contact name of social worker				
City		State	Zip code	
How long at this address?		County of residence		
Parent/ Applicant Contact	Home/Cell phone	Work phone	E-mail address <b>PRINT CLEARLY!!</b>	
Can we e-mail confidential information to applicant's e-mail address above? [ ] Yes [ ] No				
Is it okay to contact applicant at work? [ ] Yes [ ] No				

Information you provide or that we discover during the application process will only be used to determine whether or not we will be able to assist you. We do not share your information with anyone else.



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**Treating physician for person to receive our assistance**

Mailing address of patient’s treating physician – NO P.O. Boxes		
City	State	Zip code
Phone	Name of physician	

**Note:** We must be able to have your physician verify diagnosis, prescriptions, medical needs, and insurance coverage in order to help us provide the right assistance for you. Prescription supplies and insulin pumps may need to be shipped to your doctor for you to pick up.

**Section 2. Biographical Information**

Applications do not let a person tell their entire story. Since we do not use income formulas our Board needs to know about your unique situation to make informed decisions. Therefore, we ask that you attach a separate sheet and briefly tell us something about yourself or your situation that might not be addressed in this application. If you are applying for an insulin pump you **MUST** tell us how you will pay for your monthly insulin pump supplies (we will not be able to help you with monthly supplies).

We reserve the right to excerpt **NON-IDENTIFYING** information to help in our fundraiser efforts (photos, names, and other identifying information will never, ever used without your express permission). **You can be brief, but this is a required part of your application.**

**Section 3. Insurance Information**

**Is your insurance company refusing to pay for diabetes care, supplies, or an insulin pump?** If you are entitled to benefits that your insurance company is not providing to you, please contact us for free legal support to help you resolve your insurance problems before submitting an application for assistance. Many states require that your diabetes care and supplies be covered which may include the cost of an insulin pump when your doctor feels that it is medically necessary for you to properly manage your diabetes.

Does the person you are applying for assistance have any health insurance at all?  Yes  No

**Insurance information** (for the person you are applying to receive the assistance, i.e., self, dependent child, or disabled spouse)

Policy Holder’s Name	Policy/Group #	Insurance company

Is the health insurance (check all that apply):

- |                                       |   |  |
|---------------------------------------|---|--|
| <input type="checkbox"/> Private plan | <input type="checkbox"/> Through employer | <input type="checkbox"/> State or other major medical risk program |
| <input type="checkbox"/> COBRA plan   | <input type="checkbox"/> PPO              | <input type="checkbox"/> HMO                                       |
| <input type="checkbox"/> Medicare     | <input type="checkbox"/> Medicaid         | <input type="checkbox"/> Other (describe)                          |

Please attach a photocopy of your insurance card or copy of an approval or denial letter from any insurance or medical assistance program. If your insurance company is refusing to pay, we may be able to help you.

**Section 4. Financial Information**

Monthly Expense	Average monthly expense	Source of income	Monthly Income (TAKE HOME)
Rent/mortgage		Applicant's job	
All utilities/Phone (combined)		Spouse's job	
Child Support (paid out)		Student's job	
Car payments		Child support (must include as income)	
Loans or credit card payments		Alimony (must include as income)	
Health Insurance/Out of pocket medical expenses		Disability, WIC, Social security, etc. <sup>(2)</sup>	
Groceries		Any form of self-employment	
Tuition or Student Loans		Any & ALL other assistance (churches, family, etc.)	
Other Expenses <sup>(1)</sup>		Other income	
<b>TOTAL EXPENSES</b>		<b>TOTAL INCOME</b>	

**Note (1)** Provide separate sheet itemizing other ongoing expenses.

**Section 5. General Disclaimer and Terms and Conditions**

Please initial each paragraph in the lined spaces below to indicate that you have read, understand, and accept our Disclaimer and Terms and conditions for submitting your application.

\_\_\_\_\_ Under penalty of perjury, I (we) the undersigned certify and swear that all information in this application is current, true, complete, and accurate to the best of my (our) knowledge. Further, I (we) understand that providing false, inaccurate, incomplete, or misleading information constitutes fraud and will result in permanently being denied any assistance from iPump.org, Inc.

\_\_\_\_\_ I (we) understand that iPump.org, Inc. may request additional information as deemed necessary to process my (our) application, including but not necessarily limited to, proof of income, assets, liabilities, employment, insurance, medical records, and citizenship.

\_\_\_\_\_ I (we) have been informed that disbursement for approved applications is not necessarily done on a first-come, first-served basis. Further, I (we) understand that iPump.org, Inc. reserves the right to deny or approve or increase or reduce the amount of assistance I (we) have requested at its sole discretion.

\_\_\_\_\_  
Applicant's Signature & Date

\_\_\_\_\_  
Co-Applicant or Spouse's Signature & Date

**Mail entire application and attachments to:** iPump, 2250 Alyssum Avenue, Upland, CA 91784

**Insulin Pumps for Underinsured Mellitus Patients (IPUMP)  
Guidelines for Recertified Insulin Pump Assistance  
Assistance Application Attachment 3**

Parent/Applicant's Name \_\_\_\_\_

**Recertification Fees**

If you are requesting a free, recertified pump please be advised that either you or your insurance company will be required to pay any recertification fees associated with the insulin pump (sometimes there is no fee, it all depends on the pump and manufacturer).

This fee is **not** due unless you are approved and will be sent a pump AND we have been charged a recertification fee. The fee must be paid prior to sending the insulin pump. If your insurance will not cover this fee you will only be responsible for a maximum of \$200.00 (recertification fees average \$495-\$700/pump).

**You Need a Prescription for an Animas Insulin Pump**

We are currently only offering Animas Corp. recertified insulin pumps. Your doctor **MUST** specifically approve of an Animas pump for your treatment. Prescriptions that just say "pump" or list another company name (i.e., Medtronic, or Cozmo) will not be honored.

**How do you plan to pay for the cost of insulin pump supplies each month?**

We need to make sure that if we invest in helping you obtain an insulin pump that you will be able to afford the cost of supplies. An insulin pump will not do you any good if you cannot afford the \$200-400 per month in supply costs.

- \_\_\_\_\_ My insurance will cover pump supplies, just not the pump
- \_\_\_\_\_ My insurance will cover pump supplies, I just cannot afford the pump co-pay
- \_\_\_\_\_ I have other medical assistance or coverage that will help me pay for supplies
- \_\_\_\_\_ I have no other assistance and will have to pay out of pocket for all pump supplies
- \_\_\_\_\_ My family will help me buy pump supplies
- \_\_\_\_\_ Other (please be specific)

It takes an average of 1-2 months to process an application, recertify a pump, and have it delivered to you.

Applying for a pump is no promise or guarantee that you will receive an insulin pump. The iPump board of directors has the right to deny any applicant. Additionally, even if we approve an applicant, the pump companies that we work with also have a right to deny an individual one of their insulin pumps.

I have read and understand the above guidelines for recertified insulin pumps \_\_\_\_\_  
**Initial and Date**



## Insulin Pumps for Underinsured Mellitus Patients (IPUMP) Assistance Program Disclaimer, Waiver and Release of Liability

Before receiving your insulin pump you will need to read, understand, and sign this form.

### 1.0 Terms and Conditions.

By signing this form I \_\_\_\_\_ understand and agree to the following terms and conditions:

- I understand and agree that unless the IPump.org, Inc. Board of Directors has specifically waived the recertification fee that I am solely responsible for any and all amounts incurred by the recertification of the insulin pump up to a maximum of two hundred dollars (\$200.00).
- I understand and agree that I must purchase all my own insulin-pump supplies and that IPump.org, Inc. is not responsible for purchasing or otherwise providing any insulin-pump supplies, insulin- pump wear, or software for the insulin pump, regardless of whether the supplies or software are optional or necessary for the use of the insulin pump.
- I understand and agree that safe operation of an insulin pump requires training from a licensed and qualified health professional, facility, or insulin-pump manufacturer, and that I am solely responsible for arranging for and obtaining the necessary training. I understand and agree that IPump.org, Inc. is not responsible to train me in the use of the insulin pump, or for referring me to the proper person or facility for training.
- I understand and agree that IPump.org, Inc. is not making any promise or warranty to me concerning the operation of the insulin pump provided to me, or its fitness for my use in light of my medical condition.
- I understand and agree that I am solely responsible for any and all maintenance, repairs, care, and continuing training or education required now and in the future for the insulin pump. I understand that IPump.org, Inc. will not pay for, and is not responsible for, any and all software or insulin-pump upgrades, recalls, repairs, or maintenance that the insulin pump may require once it has been delivered to me.
- I understand that ownership and all responsibilities of ownership are transferred to me.
- I understand and agree that should I no longer use the insulin pump for my own personal medical care I will immediately return the insulin pump to IPump.org, Inc.
- I understand and agree that I am prohibited by federal and state law from giving the insulin pump away to any private individual or facility not licensed to receive insulin pumps.
- I understand and agree that federal and state law forbids me from selling the insulin pump to any individual or business either privately or publicly.

**2.0 Waiver and Release of Liability.** By signing this form I understand and agree to the following terms for Waiver and Release of Liability:

- I understand and agree that I am being provided an insulin pump from IPump.org, Inc. because I requested one from it.
- I understand that the insulin pump that I receive has been donated to IPump.org, Inc. and was then sent by IPump.org, Inc. to the manufacturer for inspection and recertification.

I have read, understand, and agree to the foregoing “Terms and Conditions:” \_\_\_\_\_  
Initial and Date



Insulin Pumps for Underinsured Mellitus Patients (IPUMP) Assistance Program  
Disclaimer, Waiver and Release of Liability (continued)

- I understand and agree that IPump.org, Inc. has not made any promise to me about the condition of the insulin pump, the manner in which it operates, or its fitness for my use given my medical condition.
- I understand and agree that if the insulin pump fails to operate properly, or is recalled, or is defective, I will make no claim against IPump.org, Inc. for any personal injuries or economic damages.
- I understand and agree that if the insulin pump fails to operate properly, or is recalled, or is defective, that IPump.org, Inc. is under no obligation to provide me with a replacement pump, nor to repair or replace the pump provided to me.
- I understand and agree that safe operation of an insulin pump requires training from a qualified professional, and that I am solely responsible for obtaining the necessary training. I agree that I will not make any claim against IPump.org, Inc. that is based in any way on the training that I receive, received, or did not receive, in the operation of the insulin pump provided to me.

By signing below I and by accepting delivery of an insulin pump, I understand and agree that I am waiving and releasing any claim that I might have against IPump.org, Inc., based on any legal theory, that may arise in any way from the use, misuse, performance of, or operation of the insulin pump that I receive. This waiver and release extends to, but is not limited to, claims that arise from the use and/or misuse of, or failure of, or defect in: insulin; the insulin pump and any and all optional and/or necessary supplies including but not limited to tubing, cannula sets, batteries, adhesives, solvents, sterile dressings; or relating to any training or lack thereof concerning use of the insulin pump. This waiver and release extends to all potential claims, including claims for personal injury, economic losses, emotional distress, and death.

Simply put, I agree that I will not make any attempt at any time to hold IPump.org, Inc. responsible or liable for *anything* relating to the insulin pump or its use, or its disposal that it provides to me. This waiver and release extends to claims against IPump.org, Inc. its board members, employees, agents, and affiliates.

**3.0 Signature of Agreement.** By signing below, I understand and agree to all the terms and conditions set forth above in this entire Form IPUMP-DWRL-01, "Insulin Pumps for Underinsured Mellitus Patients (IPUMP) Assistance Program, Disclaimer, Waiver and Release of Liability:"

\_\_\_\_\_  
Print your Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-Applicant's Signature

\_\_\_\_\_  
Date

Mail applications and this form, and any other attachments to: iPump, 2250 Alyssum Avenue, Upland, CA 91784