



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.

Applicant 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)
Spouse	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 PRINT CLEARLY!!
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. ⁽²⁾	
Groceries		Any form of self-employment	
Tuition or Student Loans		Any & ALL other assistance (churches, family, etc.)	
Other Expenses ⁽¹⁾		Other income	
TOTAL EXPENSES		TOTAL INCOME	

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