GOT DIABETES GRANT PROGRAM

Program Introduction

Funding Year: 2020

Who We Are and What We Do	The StayWell Guam Diabetes Foundation, ("The Foundation"), a non-profit organization, offers a grant program to assist qualifying individuals in obtaining medical services, supplies and prescriptions as needed to manage a diabetes diagnosis. This private and confidential program provides support to eligible individuals, who, without our assistance, could not afford medicines, supplies and services. Individuals with insurance may still qualify for this program if they attest that they have special circumstances of financial and medical hardship and their income meets the program criteria. This program is funded by donations to The Foundation and support will be made available as funding is available for all qualified candidates. The maximum annual funding amount per qualified applicant is currently $250. Completed applications can be submitted by fax, mail or by dropping it at our office in Maite. ***Grants will be issued on a first come first served basis.*** ➢ Your completed application plus all supporting documents establish your place in line. ➢ That is the ONLY criteria used to determine the order in which grants are issued.
Our Goal	The goal of The Foundation is to provide support for services, prescriptions and supplies as need to manage a diabetes diagnosis. In short, our goal is to get support *DIRECT TO THE PATIENT*.

520 Route 8
Maite, Guam 96910

Phone: 671.922.0117
Fax: 671.922.0120

GOT DIABETES GRANT PROGRAM

Program Introduction Continued

Program Guidelines

To qualify, you must meet ALL of the requirements listed below:

- You are a permanent, legal resident of the Island of Guam.
- Either of the following:
  - **a.** Receipts incurred within the last 60 days for prescriptions, supplies and services needed to manage your diabetes diagnosis that have the applicants name on them to support the expenses indicated on page 4 **OR**
  - b. Physician's certification of your diabetes diagnosis
- Your annual household income is less than the annual Adjusted Gross Income limit listed below:

Total Number of Persons in your Household	Annual Adjusted Gross Income *
1	$38,280
2	$51,720
3	$65,160
4 or more	$78,600

** Note: These income limits are 300% of the 2020 Federal Poverty Guidelines. Visit www.aspe.hhs.gov/poverty for more information on the Federal Poverty Level.*

How do I Apply?

1. Review and complete the Application.
2. Proof of income documents as noted on page 3. Keep original documents for your records.
3. Receipts substantiating amount listed on page 4.
4. Review and Initial Section 2 – Applicant Certification and Agreement on page 5.
5. Review and sign Section 2 – Applicant Certification and Agreement on page 6.
6. Review and sign Section 3 – Protected Health Information page 7
7. Provide/Show proof of identity – Guam Driver's License or Identification.
8. Proof of Guam residency – copy of utility bill in applicant's name or a mayor's letter.
9. Completed applications, and copies of documents can be submitted to the Foundation via mail, fax, email or dropped off at our office in Maite.
10. Once your application is received
    - a. If complete -
      - i. You will be notified it is in review
      - ii. This establishes your place in the que
      - iii. If approved and funding is available, a debit card will be issued to you
      - iv. If denied, you will be notified
    - b. If incomplete, the application and all documents will be returned

PLEASE NOTE:

- If incomplete or additional information is needed, you will be notified
- For additional application assistance, please call 671.921.0117 ext. 1109. We are here to help

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GOT DIABETES GRANT PROGRAM

Section 1 - Application

Applicant Information

All Fields are required. Please print clearly.

Name: (Last) ________________________________ (First) _____________________ (MI)___

Mailing Address:____

Village:____________________________________ , Guam Zip: _____________________

Phone #: (____) _________-___________ Alternate #: (____) _________-______________

Email Address: ____

Village where you live: _________________________ Date of Birth: ___________________

Income Information

Number of persons living in your household, including applicant: _____________

Total household annual (yearly) adjusted gross income: $___________________

Proof of income – **provide copies only, no originals**: Send at least 1 document that shows your income, such as last year's Federal Income Tax return, W2 or Social Security statement. These documents will ONLY be returned if your application is incomplete.

Insurance Information

Do you have insurance? **Check all that apply**

- ☐ Medicaid
- ☐ Medicare Part D Full Low Income Subsidy (LIS/"Extra Help")
- ☐ MIP
- ☐ None
- ☐ Private/Commercial Insurance Name: ____________________
- ☐ VA or Military
- ☐ Supplemental Insurance: __________________________
- ☐ Other

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Section 1 – Application continued

Let us know who we can share your information

If you would like to provide the name(s) of an individual(s) whom you authorize to speak with the Foundation on your behalf about this application or your participation in the Staywell Foundation Grant Program, please identify the individual(s) below.

An authorized representative has the authority to interact with the Foundation on an applicant's behalf with respect to the Staywell Foundation Grant Program and can provide or receive your personal information about the application as necessary until we receive a cancellation notice terminating their authority. Their authority will not automatically terminate once we process your application.

By providing the name(s) below, I certify that the individual(s) is aware and has consented to my disclosure of their name to the Guam Staywell Diabetes Foundation for the purpose of serving as my authorized representative.

1. ____ ___________________________

Print Name of Authorized Representative ***Phone Number***

2. ____ ___________________________

Print Name of Authorized Representative ***Phone Number***

[ ] ***Initial here if you DECLINE having an Authorized Representative***

What are you spending

Current monthly Out of Pocket Costs for Diabetes Related Treatments:

	Estimated	Attached Receipts
Prescriptions		
Medical Services		
Other Supplies		

Receipts with applicant's name are needed to support the above referenced amounts in the absence of a Physician's Certification.

Physician Information

All Fields are required. Please print clearly.

Doctor's Name: (Last) ________________________________(First) ___________________ (MI)___

Office Address: ____

Village:____ , Guam Zip: _______________________

Phone #: (____) _________-_____________ Clinic: ______________________________________

GOT DIABETES GRANT PROGRAM

Section 2 – Applicant Certification and Agreement

Certification and Agreement

I CERTIFY (AGREE) THAT THE FOLLOWING STATEMENTS ARE TURE:

- I am a permanent, legal resident of the island of Guam.
- My healthcare provider has prescribed either services, supplies or medications as indicated in this application.
- All of the information contained in this application are true and correct.

Initial

I consent to the sharing, use and receipt of information about me as described:

When you sign below, you are authorizing any pharmacy, healthcare provider and or others who are in possession of your personal information, including health information to share information about you with the Foundation, its affiliates, employees, agents, vendors and business partners who may be assisting with the administration of the Staywell Foundation Grant program ("Receiving Entities"), including health information; in addition, you understand and are authorizing the Receiving Entities to share, use and disclose your information for the purposes of operating the program.

Initial

The Receiving Entities may receive, share and use the following information:

- Information on this application.
- Information about your medical conditions, treatment, current and future medications and insurance information.
- Other information the Receiving Entities may need to evaluate the application.
- The receiving Entities may share your information with your healthcare providers and pharmacists.
- Your healthcare providers and pharmacists may share your information with the Receiving Entities.
- To review your application and to contact you or your healthcare provider, if necessary, for that review.
- To justify the use of donated funds for the Receiving Entities' internal purposes involving other patient assistance and charitable programs.
- To your pharmacies and healthcare providers relating to your participation in the Staywell Foundation Grant Program, including personal information and information about your medications.

Initial

GRANT PROGRAM

Section 2 – Applicant Certification and Agreement continued

Certification and Agreement

BY MY SIGNATURE BELOW, I ALSO AGREE TO THE FOLLOWING:

- I understand that my authorization to release my Protected Health Information (PHI) allows a healthcare provider relying on this authorization to release my PHI to the Receiving Entities for one year from the date it is signed, and then I need to apply again to the Staywell Guam Diabetes Foundation.
- I understand that if my information is shared in this manner, federal and state privacy laws may no longer protect my PHI and may not prohibit its further disclosure; however, the Receiving Entities have committed to use and disclose my PHI only as stated in this form.
- I understand if I do not sign or refuse to sign this form, I will **NOT** be eligible for the Staywell Foundation Grant Program.
- I understand that I can cancel my consent at any time by sending a written notice to the Foundation at the address on this application. If I cancel my consent, I will no longer qualify for the Staywell Foundation Grant Program. My healthcare providers will no longer share my PHI with the Receiving Entities after the date that the Receiving Entities receive and process my cancellation letter., but this will not affect information or disclosures shared before that time. Additionally, once my cancellation is received and processed by the Receiving Entities, my participation in the Staywell Foundation Grant Program will be terminated, and after my participation is terminated, the Receiving Entities will only maintain and use my information for legal and regulatory purposes.
- I agree to follow the rules and conditions of the Foundation.
- I have been provided a copy of this authorization.
- I understand that the Foundation will decide if I qualify for this program. I understand that my application might not be approved.
- I agree to notify the Foundation of changes to my income or insurance status that may impact my eligibility for the Staywell Foundation Grant Program.
- I understand the Foundation may change or end this program at any time without advance notice.
- I understand and agree that if a Receiving Entity asks, I will provide documentation that proves the information I have certified in this application is true, correct and complete.
- I understand that the Foundation does not charge a fee for participation in the Staywell Foundation Grant Program. The Foundation is not affiliated with third parties who charge a fee for help with enrollment or medication refills. These third parties may reference the Staywell Foundation Grant Program with permission of the Foundation. I am not required to use a third party who charges a fee to help with my enrollment, and if I used a third party who charges a fee to help with my enrollment or refills of my medication, this money is not paid to the Foundation.

By my signature below, I also agree to the following:

- This authorization allows those who rely on it to release my Protected Health Information for 1 year from the date I have signed it. After my PHI has been shared, it may no longer be covered by federal and state privacy laws (such as HIPAA), and it may be shared again.
- I understand I can cancel my consent at any time by sending a written notice to the StayWell Guam Diabetes Foundation at the address on this application.
- I authorize the Foundation to use my name and image in any form in any media whatsoever for purposes of promoting the Staywell Foundation Grant Program or other Foundation Programs.

Signature Required | Date

Printed Name

GOT DIABETES GRANT PROGRAM

Section 3 – Authorization to Use or Disclose Protected Health Information (PHI)

Protected Health Information (PHI)

As required by the Health Insurance portability and Accountability Act of 1996, The Staywell Guam Diabetes Foundation, Inc. may not use or disclose your health information except as provided in our Applicant Certification and Agreement without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of the form and returning it to our office.

INFORMATION OF INDIVIDUAL

Name: ______________________________________ Phone #: ____________________

Mailing Address:____

Village:______________________, Guam Zip: _____________DOB: __________________

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Doctor or Clinic:____

Mailing Address:____

Village:____________________________________ , Guam Zip: _____________________

Phone #: (____) _________-____________

Doctor or Clinic:____

Mailing Address:____

Village:____________________________________ , Guam Zip: ____________________

Phone #: (____) _________-____________

INFORMATION TO BE DISCLOSED: ☐ All Medical Information ☐ All Insurance Information

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrent of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _______ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by submitting a written notice stating my intent to revoke this authorization to the Staywell Guam Diabetes Foundation. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.

Signature Required Date

GRANT PROGRAM

Section 4 – Application Submission

Next Steps

If you have any questions regarding the Staywell Guam Diabetes Foundation Grant Program

Please call **671.922.0117 ext. 1109**
between the hours of 9 am to 4 pm PST for assistance.

To submit your application, complete the following steps:

1. Provide ALL the information requested on the application form.

    - You may fill in the fields online and print it for submission. The website for the Foundation is as follows:

      Staywellguamdiabetesfoundation.org

      OR

    - You may print out the form and fill it out by hand using black or blue ballpoint pen

2. Provide all required supporting Documents

3. Submit completed applications via fax, email, mail or they can be dropped off at our office

    FAX Number: **671.922.0120**

    Email: **nroberto@staywellguam.com**

    OR

    Office and mailing Address:
    Staywell Guam Diabetes Foundation
    520 Route 8
    Maite, Guam 96910