tdes Telephonic Diabetes Education & Support

APPLICATION FORM

Maine Municipal Employees Health Trust (MMEHT)

NOTE: If you participated in a previous TDES© Program, STOP you may not qualify, please call us at 207-622-7566 EXT 252 to see if you do.

If you have completed the TDES© program, you may be eligible for TDES^2! Please contact us for details.

NEXT: **Please print your answers to the following questions and return this application** in the envelope provided or fax to 1-866-226-9892. Contact Project Coordinator at 207-622-7566 ext. 252 for assistance.

CONTACT INFORMATION

Name: Mrs. Ms. Mr. **Employee Retiree Dependent (circle the one that applies)**	
Home Mailing Address: **City/State/Zip**	
Anthem Identification Number:	**Anthem Group Number:**
Day Phone:	**Evening Phone:**
Employer:	**Work Address:**
Optional: work e-mail	**Optional: home /day e-mail**
Primary Health Care Provider Name and Address:	
City/State	**Phone:**
Specialist's Name	**Phone:**
Best Time(s) to Reach You by Phone	**Today's Date**

- Do you have any plans to leave the State of Maine for one month or longer while you are participating in this program? ____No ____Yes If yes, what state and for how long?_____

- Date of birth: _____ (month/day/year) Will your insurance change to Medicare at age 65? Yes_____No____

Personal Characteristics optional survey questions

1. a Your sex: ____Male ____Female 1. b. Which of the following best describes you? _____White/Caucasian _____Native American _____ Hispanic or Latin _____ Black or African American (not Hispanic or Latin) ___Asia/Pacific Islander ____Other _____ Prefer not to answer
2. Occupation _____Work schedule/hours_____
3. Is English your primary language for speaking and reading?_____
4. Do you like to use a computer and e-mail for communication? Yes ☐ No ☐
5. Do you currently participate or have you previously participated in a diabetes education and training?
   ☐ No – Skip to Question #8. ☐ Yes – If yes, what type: ☐ Group Classes **and/or** ☐ One-on-one with a diabetes educator

HEALTH INFORMATION

6. What kind of diabetes do you have? Check: _____Type 1 _____ Type 2 _____Pre diabetes
7. About how long have you had diabetes?_____ 10. Do you use an insulin pump? ☐ No ☐ Yes
8. Do you have high blood pressure? ☐ No ☐ Yes
9. Do you have high cholesterol? ☐ No ☐ Yes
10. Do you have other health problems? ☐ No ☐ Yes Please describe:_____

_____

11. Please list <u>all</u> medications you take:_____

_____

12. Please add any other comments or questions you may have:

_____

_____

Please select your choice of educational programs from the following locations by checking the appropriate box.

- ❑ Bridgton Hospital, 10 Hospital Drive, Bridgton
- ❑ Cary Medical Center, 163 Van Buren Rd., Caribou
- ❑ Central Maine Medical Center, 300 Main Street, Lewiston
- ❑ Houlton Regional Hospital, 20 Hartford Street, Houlton
- ❑ Inland Hospital, 200 Kennedy Memorial Drive, Waterville
- ❑ Maine General Medical Center-Augusta Campus,157 Capitol Street, Augusta
- ❑ Mayo Regional Hospital, Diabetes & Nutrition Center, Suite 500, 891 West Main St., Dover-Foxcroft
- ❑ Millinocket Regional Hospital, 200 Somerset St., Millinocket
- ❑ Mount Desert Island Hospital, 10 Wayman Lane, Bar Harbor
- ❑ Northern Light A.R. Gould, Fort Fairfield Health Center, Fort Fairfield (formerly known as The Aroostook Medical Center)
- ❑ Northern Light Blue Hill Hospital, 65 Water Street, Blue Hill
- ❑ Northern Light Eastern Maine Medical Center, 905 Union Street, Suite 11, Bangor
- ❑ Northern Light Health Endocrinology & Diabetes Care@ Inland Hospital, 180 Kennedy Memorial Drive, Waterville
- ❑ Northern Light Maine Coast Hospital, 50 Union St., Ellsworth
- ❑ Northern Light Sebasticook Valley Hospital, 487 North Maine Street, Pittsfield
- ❑ Penobscot Bay Medical Center, Diabetes & Nutrition Care Center, 170 Pleasant Street, Rockland
- ❑ Redington-Fairview General Hospital, 46 Fairview Ave., Skowhegan
- ❑ St. Joseph's Hospital, 360 Broadway, Bangor
- ❑ Stephen's Memorial Hospital, 181 Main Street, Norway

*If none of the above Diabetes Programs are local to you, it is possible to do the entire program over the telephone. Please contact the TDES© Project Coordinator at 207-622-7566 ext. 252 for further details.

Thank you for filling out this questionnaire.
By sharing your personal experiences, the diabetes educator will be better able to support you
in the decisions you make everyday about your health and diabetes care.
ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Authorization Statement

Please read the following statement, sign and date where indicated:

- I understand that this is a voluntary program.
- I understand that completion of this application is a condition of participation.
- I understand that I can withdraw from the program at any time by communicating my wishes with the diabetes educator.
- I understand you will contact my doctor for his/her approval of my entry into the diabetes program.
- I understand that my personal information will be kept confidential and only shared with my diabetes educators and my personal doctor.
- I agree to communicate at least monthly with a diabetes educator, usually by telephone.
- I agree to participate in the diabetes education and support process to the best of my ability.

***While participating in the 12-month program, I understand prescription drug copays will be waived (paid by the plan) for prescribed diabetes medications (that lower blood glucose) and supplies (including syringes, test strips, and lancets.) I understand the waiver of co pays will begin no later than 45 days following my first appointment. I understand I may call the Health Trust at 1-800-852-8300 within 15 days following my initial appointment to confirm the date that the waiver of co pays will begin. The arrangement will continue for the duration of the 12-month program as long as I remain actively involved by participating in regular phone calls with the diabetes educator.**

If my insurance coverage should change during my enrollment, I must notify MCDPH immediately to determine if I will continue to qualify for the program.

_____**(Initial Here)**

I hereby authorize Medical Care Development to release my personal information to participating clinicians and hospitals for the purpose of my participation in the Telephonic Diabetes Education and Support Program. I understand that my eligibility for benefits, processing and payment of claims, or treatment is not conditioned on giving this authorization or revocation of this authorization. However, if I do not give this authorization or if I revoke this authorization, I will not be allowed to participate in the Telephonic Diabetes Education and Support Program.

A copy of this Application and Authorization is available to me, or to my authorized representative, upon request and will serve as the original. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my information may be re-disclosed by the recipient and no longer protected by federal privacy regulations.

I have the right to cancel this release of information/authorization at any time, except to the extent that the person/company has already taken action on the disclosure provisions contained in this document. If I choose to cancel the release of information/authorization, I must notify *Medical Care Development* in writing that I request a cancellation of this release of information/authorization. This Authorization shall remain effective until revoked in writing by me.

_____ _____ _____

Printed Name Signature Date

Please return this signed authorization and your completed application in the envelope provided

Authorization for Use and Disclosure of Protected Health Information
(Medical Care Development, doing business as MCD Public Health)

Name of Participant: _____ *Date of Birth:* _____
(Please Print)

Address: _____ *Telephone:* _____

Persons or Entities Disclosing or Receiving Protected Health Information

1. The Protected Health Information identified below may be used and/or disclosed **TO** the following persons or entities. *Name & Address: MCD Public Health/TDES© Program, 11 Parkwood Dr., Augusta Me 04330 and the diabetes education center from whom I receive services.*

2. The Protected Health Information identified below may be disclosed **FROM** the following persons or entities (Family Doctor & diabetes education center from which I receive services)

Please print your Family Doctor's Name: _____
(Please Print)

Address: _____ *Phone:* _____

3. **Purpose**-The identified information may be used and/or disclosed for the following purpose(s):
For enrollment in and evaluation of the Telephonic Diabetes Education and Support© Program offered through MCD Public Health and the Diabetes Education site I have selected on the application form.

Specific Authorization to Disclose

I hereby authorize any and all of my health care practitioners and health care facilities to furnish, discuss, use and/or disclose the following *(Please circle the correct response below):*

1. I (DO) (DO NOT) **authorize** the use/disclosure of my complete record including all records of any other health care provider in the possession of the above named provider and all protected health information. (**NOTE:** *Even if you select **"I Do"** please complete 2, 3, and 4 in this section. Failure to complete these sections is deemed a refusal to authorize the disclosure for that information)*

2. I (DO) (DO NOT) authorize the use/disclosure of information, which relates to testing, diagnosis, or treatment of HIV infection, AIDS-related complex or AIDS.

3. I (DO) (DO NOT) authorize use/disclosure of information, which relates to treatment or diagnosis of substance (drug or alcohol) abuse.

4. I (DO) (DO NOT) authorize use/disclosure of information, which relates to treatment or diagnosis for mental health.

5. If you want us to **only use and/or disclose specific protected health information,** complete the following:
I (DO) authorize the use and disclosure of only specific protected health information, which I am describing:

_____

Understanding Your Rights

I Understand:

1. **Re-disclosure of Information-** Any information used and/or disclosed may be subject to re-disclosure by the Recipient and may no longer be subject to HIPAA's protections.
2. **Revocation**-I understand that I may revoke this Authorization, in writing, at any time, by sending a signed, written notification of revocation to the Health Care Provider. I understand that, if I revoke this Authorization, it will not affect actions or disclosures already taken by the Health Care Provider in reliance on the Authorization prior to the Health Care Provider's receipt of the revocation. I understand that the revocation will not be effective if the Authorization was obtained as a condition of obtaining insurance coverage, to the extent that other law provides the insurer with the right to contest a claim under the policy or the policy itself. I also understand that revocation of this Authorization may be the basis for denial of health benefits or other insurance coverage or benefits.
3. **Right to Refuse Authorization-**I understand that I may refuse to authorize the use and/or disclosure of all or part of my health information, but such refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.
4. **Authorization Not Required-**I understand that the Health Care Provider will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure, except: (a) if my treatment is related to research, then an authorization may be required; or (b) if the purpose of the health care is solely to create PHI to provide the PHI to a third-party, then an authorization may be required.
5. **Expiration of Authorization-**I understand that this Authorization shall be in effect until the date OR event set forth below, whichever occurs earlier, at which time this Authorization shall expire. Except as may otherwise be permitted under Maine law, this Authorization is NOT valid for more than thirty (30) months from the date signed.
6. **Copy of Authorization**-I understand that I have a right to receive a copy of this Authorization.
7. **Voluntary**-I understand that I am voluntarily executing this Authorization- *Please sign below:*

Signed: _____ Date: _____

If not signed by the Participant, please provide the following information:

_____

Personal Representative's Printed Name/ Personal Representative's Signature

Relationship to the Individual: _____, Please list Basis of authority to act as Personal Representative (such as Durable Power of Attorney, Appointment by Court, Parent of Minor, Guardian, Court Order):

_____

OFFICE USE ONLY
___ Check here if document conferring Personal Representative Authority is in record