Print Form

INSULIN PUMPERS Foundation

Pump Assistance Program Application and Eligibility Form

Subject to your meeting and maintaining the eligibility requirements, Insulin Pumpers may provide a donated insulin pump to your physician or health care provider on your behalf. ***In the event the Patient is under the age of 18 years old, a parent or legal guardian must sign on the Patient's behalf***.

Patient Demographic Information

Last Name | First Name | Initial

Date of Birth | ◯ Male ◯ Female | SSN

Parent or Guardian if Patient is under 18

Last Name | First Name | Initial

Patient must be a resident of the United States

Address | Phone Number

City | State | Zip Code | Cell Number

email

Health Care Provider Information

endo or prescribing physician

Clinic or Practice Name

Endo or Physician Name

Address 1 | Phone Number

Address 2 | Fax Number

City | State | Zip Code

Insurance Information

☐ Check if covered by MediCare or MediCaid and skip to the next question

Insurance Company

Address 1 | Policy Number

City | State | Zip Code | Phone Number

Financial Information

spouse's name

Name

Address

City State Zip Code

☐ Check if address is same as previous page and skip to the next question.

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spouse's employer ☐ unemployed

Name Phone Number

Address Fax Number

City State Zip Code Monthly Income

YOUR employer ☐ unemployed

Name Phone Number

Address Fax Number

City State Zip Code Monthly Income

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income tax paid last year

child support paid last year

child support received last year

payments to IRA or Keough

payments to tax deferred pension or savings

untaxed IRA distributions

untaxed pension distributions

exempt interest income

other untaxed income

Total assets, including but not limited to stocks, bonds, collectibles, precious metals, commodities, real property (less loan ammounts)

☐ receive SSI benefits?

☐ receive WIC benefits?

☐ receive food stamps / SNAP?

☐ receive TANF benefits?

In the event the Patient is under the age of 18 years old, a parent or legal guardian must sign on the Patient's behalf.

I/we certify that the foregoing information is true and complete to the best of my/our knowledge.

Date: _____ Date: _____

_____ _____

patient signature (parent or guardian if under 18) spouse

INSTRUCTIONS and Checklist

- ☐ complete and sign this form
- ☐ attach prior 2 years federal income tax form 1040
- ☐ complete and attach federal Tax Information Form 8821
- ☐ complete and attach Authorization to Release Medical Informtion
- ☐ complete and attach the Patient Agreement
- ☐ attach a $50. 00 check or money order for the application fee

Mail the completed application and attachments

TO:

INSULIN PUMPERS FOUNDATION
558 Valley Way
Milpitas, CA 95035-4106