Maine Municipal Employees Health Trust (MMEHT)

NOTE: You must have participated in a previous TDES© Program in order to qualify for TDES²!

TDES²! APPLICATION FORM

Please return your completed application to us in the postage paid envelope provided **(Please Print Clearly)**

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

We would like to know *how confident* you are in doing certain activities. For each of the following questions, please circle the number that corresponds to your confidence that you can do the tasks regularly at the present time.

1. How confident do you feel that you can eat your meals every 4 to 5 hours every day, including breakfast every day?	not at all confident	1	2	3	4	5	6	7	8	9	10 totally confident
2. How confident do you feel that you can follow your diet when you have to prepare or share food with other people who do not have diabetes?	not at all confident	1	2	3	4	5	6	7	8	9	10 totally confident
3. How confident do you feel that you can choose the appropriate foods to eat when you are hungry (for example snacks)?	not at all confident	1	2	3	4	5	6	7	8	9	10 totally confident
4. How confident do you feel that you can exercise 15 to 30 minutes 4 to 5 times a week?	not at all confident	1	2	3	4	5	6	7	8	9	10 totally confident
5. How confident do you feel that you can do something to prevent your blood sugar from dropping when you exercise?	not at all confident	1	2	3	4	5	6	7	8	9	10 totally confident
6. How confident do you feel that you know what to do when your blood sugar level goes higher or lower than it should be?	not at all confident	1	2	3	4	5	6	7	8	9	10 totally confident
7. How confident do you feel that you can judge when the changes in your illness mean you should visit the doctor?	not at all confident	1	2	3	4	5	6	7	8	9	10 totally confident
8. How confident do you feel that you can control your diabetes so that it does not interfer with the things you want to do?	not at all confident	1	2	3	4	5	6	7	8	9	10 totally confident

For Office Use Only: Pre - Assessment Self-Efficacy Average:_____ Over→

Learning needs and Interest

NOTE: You must have participated in a previous TDES© Program in order to qualify for TDES²!

- **Will you switch to Medicare at age 65? Yes_____ No____**

- Please tell us a little about the Telephonic Diabetes Education and Support Training Program you attended:

  When? _____ Where? _____

  Name(s) of Educator(s)_____

- 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?_____

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

All TDES²! contacts are done by telephone

- ❑ Bridgton Hospital, 10 Hospital Drive, Bridgton
- ❑ Cary Medical Center, 163 Van Buren Rd., Caribou
- ❑ Eastport Health Care, 30 Boynton Street, Eastport
- ❑ Houlton Regional Hospital, 20 Hartford Street, Houlton
- ❑ Maine General Medical Center-Augusta Campus, Ballad Center, 6 East Chestnut Street, Augusta
- ❑ Millinocket Regional Hospital, 200 Somerset St., Millinocket
- ❑ Mount Desert Island Hospital, 10 Wayman Lane, Bar Harbor
- ❑ NLH AR Gould Hospital 140 Academy Street, Presque Isle
- ❑ NLH Eastern Maine Medical Center, Diabetes, Endocrine & Nutrition Center, 905 Union St., Suite 11, Bangor
- ❑ NLH Maine Coast Memorial Hospital, 50 Union St., Ellsworth
- ❑ NLH Mayo Regional Hospital, Diabetes & Nutrition Center, Suite 500, 891 West Main St., Dover-Foxcroft
- ❑ Penobscot Bay Medical Center, Diabetes & Nutrition Care Center, 170 Pleasant Street, Rockland
- ❑ Redington-Fairview General Hospital, 46 Fairview Ave., Skowhegan
- ❑ Rumford Hospital, Franklin St., Rumford
- ❑ Stephen's Memorial Hospital, 181 Main Street, Norway

Authorization Statement

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

- I understand that these diabetes education and support services are voluntary programs.
- I understand that completion of the 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 understand by signing the Authorization for Use and Disclosure of Protected Health Information form, I am allowing my health provider, diabetes educator, and MCD Public Health to have access to my health information.
- I agree to communicate (typically by the telephone) with my diabetes educator according to the program requirements.
- 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 copays wil 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 copays 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 also understand if my insurance coverage should change during my enrollment, I MUST notify TDES© staff at 207-622-7566 Ext 252 immediately to determine if I will continue to quality for the TDES© program.

Print 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. **Redisclosure of Information-** Any information used and/or disclosed may be subject to redisclosure 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