Do-Rights Grant Assistance Program Application

The Do-Rights is a nonprofit 501(c)(3) organization that offers a patient assistance program ("Program") to help qualifying diabetes patients obtain certain supplies and medications at lower costs. This Application Form is for patients who would like to apply to receive a grant to purchase necessary supplies and/or medication(s) from the Do-Rights Grant Program.
Please complete and submit by email **grant*program@dorights.org***, or you may choose to apply online at **www.DoRights.org.**

What supplies & medications are provided by the Do-Rights Grant Program?

Group 1 Supplies & Medications	Group 2 Supplies & Medications
Insulin Pump and/or Pump upgrade (~$1,000), plus up to 12 months of pump & sensor supplies	**Insulin** - any brand**,** including Basaglar® (glargine injection) or **BAQSIMI**™ (glucagon) nasal powder
Not to exceed $2,500 during the 12 month grant	**Not to exceed $600 during the 12 month grant**

Who qualifies for the Program?

To qualify, you must meet the requirements listed below:

- You are a permanent, legal resident of the United States, Puerto Rico, or U.S. Virgin Islands.
- Your healthcare provider has prescribed supplies & medications listed above.
- You have limited insurance coverage, including Medicaid, full Low Income Subsidy (LIS, "Extra Help") or Veterans (VA) Benefits. *(I will not submit any claim for reimbursement to any third party or government insurer for any product provided to me through the Do-Rights.)* Your
- annual household income is less than the Annual Adjusted Gross Income Limit listed below:

Total Number of People in your Household (including you)	**Annual Adjusted Gross Income Limit** Based on 2025 Federal Poverty Level (FPL) Guidelines. See www.aspe.hhs.gov/poverty for more information.	
	Group 1 Medications (at or below 450% FPL)	**Group 2 Medications (at or below 550% FPL)**
1	$70,425	$86,075
2	$95,175	$116,325
3	$119,925	$146,575
4	$144,675	$176,825
5	$169,425	$207,075
6	$194,175	$237,325

How do I apply?

1. **Complete** the Patient Section (pages 2-3); **sign** the Patient Certification on page 3.
2. **Ask** your healthcare provider to **complete** the Healthcare Provider/Prescriber Section (page 4), and **sign** and return.
3. **Email** the following documents to *program@DoRights.org*
   a) The completed and signed application **(including the Healthcare Provider's Section).**
   b) A copy of proof-of-income documentation, such as last year's Federal Income Tax return, a wage statement (IRS Form W-2), or Social Security Benefit Statement (Form SSA-1099),

Send copies of supporting documentation only. Do not send original statements (documentation provided to Do-Rights Grants Program will not be returned).

After we review your application, we will send a letter notifying you of whether you qualify for the Do-Rights Grants Program. If you qualify for Do-Rights Grant Program:

- You will receive a letter notifying you of enrollment.
- You will be enrolled for 12 months. If you are Medicare Part D patient, you will be enrolled through the end of the calendar year.

If you do not qualify for Do-Rights Grant Program, we will send a notice to you.

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PATIENT SECTION

All fields are required. Please print clearly.

Patient Name: (Last)		(First)		(MI)	
Date of Birth: (Month/Day/Year)		Preferred Phone:	(_______) ________ - ____________		
Address:					
City:		State:		Zip:	
Email Address:					

Patient Income Information

Number of persons living in your household, including you:		Total household annual (yearly) adjusted gross income:	
You must submit proof of income with your application			

Insurance Information

Do you have insurance? (check all that apply)

☐ Medicaid	☐ Medicare Part D	☐ Private/Commercial Insurance (e.g., employer sponsored plan, Health Insurance Marketplace plan)
☐ VA or Military	☐ None	☐ Other:

Authorization to Receive Text Message Notifications [Optional]

If your application is **approved**, we can send you text messages about the Program throughout your enrollment period. These text messages are optional. You can participate in Do-Rights Grant Program without signing up for text messages.

When you sign up for the text messages (by providing your cell phone number below), you must agree to the following conditions:

- Do-Rights Grant Program will send an autodialed, pre-recorded text message (Standard text message and data rates apply).
- You can opt out at any time by calling 804-317-8201
- Do-Rights Program is not responsible if a communication is not delivered due to technical difficulties like server issues, phone carrier outages, or discontinued service.
- Be aware that anyone who can open or have access to your phone might see your text messages.
- If your mobile operator is not participating in this service you will not receive messages.
- These text messages are NOT reminders to take your medication. You are responsible to take your medication as prescribed.

To receive text messages, you must provide your cell phone number: ______________________________

Short Essay [required]

Do-Rights Grant Program requires you to answer the following questions (in a up to 500 work essay) Please attach your essay to this application.

- How will these funds impact your diabetes managment and life?
- How can we be assured you will use these funds to make a positive change in your life?

Authorization to Speak with Authorized Representative [Optional]

You may provide the names of one or more people with whom you authorize the Do-Rights to speak with on your behalf about this application or your participation in the Do-Rights Grant Program.

These people can provide or receive your personal information as necessary until you terminate their authority. Their authority will not automatically terminate once we process your application. Their authority will terminate at the end of your enrollment period.

By providing the name(s) below, you certify that individuals are aware and agree that you will provide their name & contact information to Do-Rights Grant Program for the purpose of serving as your authorized representative.

1. Print Name of Authorized Representative ***& Email Address***	2. Print Name of Authorized Representative **& Email Address**

You can remove Authorized Representative(s) at any time by emailing Do Rights Grants Program at grantprogram@dorights.org

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PATIENT CERTIFICATION (AGREEMENT)

I understand & certify that:

- Do-Rights will decide if I qualify for the Program. I understand that my application might not be approved.
- Do-Rights may change or end the Program, or terminate my enrollment in the Program, at any time.
- **Do-Rights does not charge a fee to apply for participation in the Program**. I am not required to use a third party who charges a fee to help with my enrollment, and if I use a third party who charges a fee to help with my enrollment or refills of my medication, this money is not paid to Do-Rights.
- If approved, my enrollment in the Program will expire at the end of the calendar year (if I am a Medicare Part D patient) or after 12 months. After my enrollment expires, I will need to reapply to the Program.

I certify (agree) that:

- I am a permanent, legal resident of the United States, Puerto Rico, or U.S. Virgin Islands.
- My application is complete and accurate. I have been truthful about my insurance coverage and income.
- I will promptly provide documentation that proves the information I have provided in this application, if needed by Do-Rights, including after any decision regarding qualification for the Program (failure to promptly provide complete and accurate documentation when requested may result in immediate termination of application review or removal from the Program if application has already been approved).
- If my application is approved:
  - I will notify Do-Rights of changes to my income or insurance status.
  - **I will not submit any claim for reimbursement to any third party or government insurer for any product provided to me through the Do-Rights.**
  - If I have Medicare Part D coverage, I will not seek to have the cost/value associated with the medication I receive through the Program counted as out-of-pocket costs for prescription drugs.
  - If I have Medicare Part D coverage, I will inform my Part D Plan about my enrollment in Do-Rights Grant Program.
  - I will not sell, trade, or transfer any medication I receive through the Program.

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

Do-Rights Grant Program needs some information about you. 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, and release records, about you with Do-Rights and their affiliates, employees, agents, vendors, and business partners who may be assisting with the administration of Do-Rights (“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.

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

- Information in this application.
- Information about your medical conditions, treatment, current and future medications, and insurance information.
- Other information the Receiving Entities may obtain to operate Do-Rights Grant Program.
- 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.

The Receiving Entities may share your information for the following purposes:

- To review your application to determine your eligibility and to contact you or your healthcare provider, if necessary, for that review.
- To help operate Do-Rights Grant Program and for the Receiving Entities’ internal purposes involving other patient assistance and charitable programs.
- To contact your pharmacies and healthcare providers relating to your participation in Do-Rights Grant Program, including personal information and information about your prescription medications.
- To measure program performance and make program improvements
- We only ask for and share the information that we need to operate the program. We do not ask for any information that we don’t need, but we may receive some if health records are sent to us.
- You don’t have to give permission to share your information with Do-Rights Grant Program, but we may not be able to assist you without it.

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

- This authorization allows those who rely on it to release Protected Health Information to Do-Rights for 1 year from the date I have signed it.
- After your information has been shared, it may no longer be covered by federal and state privacy laws (such as HIPAA), and it may be shared again.
- **AFTER RECIEVING THE GRANT, I AGREE TO DO A PROMOTIONAL VIDEO AND PHOTO FOR THE DO-RIGHTS.**
- I understand that I can cancel my consent at any time by sending a written notice to Do-Rights Grant Program at the address on this application. If I cancel my consent, I will no longer qualify for Do-Rights Grant Program. My healthcare providers will not share my information 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 Do-Rights 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.

______________________________ Applicant or Legal Guardian Signature (Signature Required) **Date:** ______________

Applicant Printed Name: ______________________________

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Healthcare Provider's/Prescriber's Confirmations and Agreements:

By signing below, I (the "Prescriber") certify to the following statements:

- I prescribed the medication described below (the "Medication") to the patient listed on this form ("Patient") based on my independent clinical judgment that treatment with this Medication for the Patient is medically necessary.
- Prior to signing this form, I have ensured the Patient is aware of, has consented to, and has directed my disclosure of their information to Do-Rights Grant Program so that Do-Rights Grant Program may contact the patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the patient therapy.
- I will give Do-Rights Grant Program 90 days advance notice if I need to assign this agreement, in full or in part, to another Prescriber.
- I am a licensed prescriber, and I will comply with and abide by the dispensing laws applicable to the state in which I am prescribing, receiving, storing, and dispensing the Medication. I also will comply with applicable laws related to disposal of, and will properly dispose, unused Medication.
- I understand that Do-Rights Grant Program has the right to revise or terminate the Program at any time.
- The information I provided is accurate to the best of my knowledge.

My signature below attests to my understanding and agreement to the above program requirements.

Prescriber Signature: ______________________________ Date: ____________________

Name of prescriber: ______________________________
Please print name

______________________________ DOB: ____________________
Name of Do-Rights Grant Program applicant *Please print name*

Description of Diabetes Medications:

____

____

____

If you do not have an upcoming appointment with your Prescriber, you may scan a copy of your Pharmacy's Insulin Prescription and submit with your application. (We will ask that you complete this "Prescriber Confirmation" at a later date)

Privacy Notice:
We may use and save your personal information to meet legal or regulatory obligations that are in the legitimate interest of Do-Rights Grant Program, to fulfill legitimate and lawful business purposes in accordance with Do-Rights Grant Program record retention policies and applicable laws and regulations, and to respond to lawful requests by public authorities, including to comply with national security or law enforcement requests.

We provide reasonable physical, electronic and procedural safeguards to protect information we work with and maintain. We limit access to your information to authorized employees, agents, contractors, vendors, subsidiaries, and business partners, or others who need such access to information to carry out their assigned roles and responsibilities on behalf of Do-Rights Grant Program. Please be aware, although we try to protect the information we work with and maintain, no security system can prevent all potential security breaches. We do not sell personal information.

You may submit a request by contacting us using one of the methods listed below.
You may make any of the above requests by contacting us at:

Do-Rights Grant Program, PO Box 131, Manakin Sabot, VA 23103-9998 email: ***grantprogram@dorights.org***

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