



APPLICATION FOR INSULIN AND TOWNSHIP CLAIM

State Form 687 (R2 / 1-04)

Approved by State Board of Accounts, 2004

STATE OF INDIANA
Department of Health

- INSTRUCTIONS:**
1. Indiana Code 16-41-19 authorizes **townships** to supply insulin to its residents in need of insulin treatment who are financially unable to purchase insulin.
 2. **BLANK FORMS** are supplied by the State Department of Health to local health officers who, in turn, supply physicians, on request.
 3. Prepare a separate form for each patient.
 4. **COMPLETED FORMS** go from the provider to the local health officer to the Township Trustee. Local health officers will make a copy or extract information (IC 16-41-19-8), sign the form and **immediately** forward the original to the Township Trustee for payment.
 5. This claim is payable from the Poor Relief Fund not otherwise appropriated, without appropriation. (Indiana Code 16-41-19-7)
 6. IC 16-41-19-7 states in part "(b) A township is not responsible for paying for biologicals as provided in subsection (a)(2) if the township trustee has evidence that the individual has the financial ability to pay for the biologicals. (c) After being presented with a legal claim for insulin being furnished to the same individual a second time, a township trustee may require the individual to complete and file a standard application for poor relief in order to investigate the financial condition of the individual claiming to be indigent. The trustee shall immediately notify the individual's physician that: (1) the financial ability of the individual claiming to be indigent is in question; and (2) a standard application for poor relief must be filed with the township. The township shall continue to furnish insulin under this section until the township trustee completes an investigation and makes a determination as to the individual's financial ability to pay for insulin."

				Date of application (month, day, year)	
APPLICATION (Physician or Advanced Practice Nurse fill in)					
Resident of:		Township		County	
Name of patient		Age	Sex	☐ Female ☐ Male	Race
Address (number and street)					
City, state, ZIP code					
If patient is child, name of parent or guardian					
Type of insulin	Name of manufacturer		Number of vials	Vial size (ml)	Units (ml)
Physician's or Advance Practice Nurse Statutory Affirmation: "I solemnly affirm that the free biologicals applied for will be administered to the person named above, and it is my belief after inquiry that the person is financially unable to pay for the biologicals." (IC 16-41-19-4)					
Signature of physician or advanced practice nurse statutory affirmation				Telephone number ()	
TOWNSHIP CLAIM (claimant fill in)					
Name of claimant (provider)					
Address of claimant (number, street, city, state, ZIP code)					
DATE PROVIDED	DESCRIPTION OF INSULIN PROVIDED	NUMBER PROVIDED	ITEM PRICE	TOTAL	
			\$	\$	
			\$	\$	
			\$	\$	
I certify the foregoing account is just and correct, not in excess of market price, the amount claimed is legally due, after allowing all just credits, and no part of the same has been paid. (IC 5-11-10-1; IC 16-41-19-5; IC 16-41-19-6)					
Signature of claimant / provider				Date signed (month, day, year)	

PATIENT'S RECEIPT	I have received the insulin under "Insulin Provided," above.
Signature patient, parent or guardian	Date signed (month, day, year)

LOCAL HEALTH OFFICER	Reviewed and copy retained.
Signature local health officer or authorized employee	Date signed (month, day, year)

Township Trustee to complete reverse side.

Check or Warrant number
Date approved for payment (<i>month, day, year</i>)
Signature of Trustee
Township

I have examined the within claim and hereby certify as follows:

- ☐ That it is in proper form.
☐ That it is duly authorized as required by law.
☐ That it is based upon statutory authority.
☐ That it is apparently ☐ Correct ☐ Incorrect
in the sum of \$ _____.

Signature of disbursing officer

INSULIN CLAIM
(Indiana Code 16-41-19)

Paid to:
Amount
\$
Paid from: