

# Saskatchewan Aids to Independent Living (SAIL) Insulin Pump Program – Client Registration

Drug Plan and Extended Benefits Branch  
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Regina, SK S4S 6X6  
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Email: EHB@health.gov.sk.ca

- Complete the Client Registration form for your files
- Register by email **ATTN: CLIENT REGISTRATION Insulin Pump Program** and allow a minimum of 72 hours for confirmation

## Client Information (Please Print)

Last Name					First Name					Middle Initial
Saskatchewan Health Services Number (9 digits)										Date of Birth
										mm dd yyyy

## Confirmation of Client’s Eligibility for an Insulin Pump

- Client has Type 1 diabetes  
*Client has demonstrated ongoing and sustained practice of the following diabetes-related activities for a minimum of 6 months prior to the insulin pump trial:*
- There is demonstration of involvement of the candidate in their personal diabetes management.
- Blood glucose monitoring four (4) or more times per day or appropriate use of a continuous glucose monitor (CGM) or flash glucose monitor (FGM).
- Consistency and accuracy in carbohydrate counting.
- Ability to self-assess and take action based on blood glucose results.
- Safe and effective management of hypoglycemia and hyperglycemia.
- A commitment to long-term diabetes follow-up through regular assessments occurring at least annually (every 12 months) by a diabetes education program, diabetes educator, or their authorized specialist physician.
- Expressed expectations or goals that are in line with potential outcomes of pump therapy.
- No unacceptable burden of diabetic ketoacidosis as determined by a diabetes education program, diabetes educator, or their authorized specialist physician.
- Consistent A1C monitoring at an interval of approximately every three (3) to six (6) months, or as deemed appropriate by a diabetes education program, diabetes educator, or their authorized specialist physician.

*Note – applications will be considered incomplete if all criteria are not confirmed.*

## Physician’s Certification of Eligibility

To be completed by an endocrinologist or another specialist physician who is associated with an SHA Diabetes Education Program and has experience with insulin pump management

Name (PLEASE PRINT)	Telephone Number (include area code)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Diabetes Education Program: \_\_\_\_\_

## Diabetes Educator’s Certification of Eligibility

*To be completed by an SHA diabetes educator or a SAIL Registered CDE® who contributed to the assessment of the criteria.*

Name (PLEASE PRINT)	Telephone Number (include area code)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Certification of Completed Insulin Pump Trial

*To be completed by an SHA diabetes educator or a SAIL Registered CDE® who contributed to the assessment of the criteria.*

- The candidate was assessed through the SHA diabetes education program process or received educational training through a SAIL registered CDE®.
- Client continues to demonstrate acceptable standards of personal diabetes management.
- Client has completed a trial period (up to three months) that confirms that the Insulin Pump is medically appropriate for use. *(May be waived for replacement pumps only)*
- A certified pump trainer has confirmed that the client has an adequate level of knowledge to operate the pump and safe use of the device is achieved.

Date client started the Insulin Pump: \_\_\_\_\_

Name (PLEASE PRINT)	Telephone Number (include area code)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Insulin Pump and/or Supplies Specifications**

<b>Client requirements:</b>	
<input type="checkbox"/> Insulin pump and supplies	<input type="checkbox"/> Insulin pump supplies only
Insulin Pump Brand:	Date Insulin pump was started:
Insulin Pump Model:	Brand and model of current insulin pump:

**Client Consent and Authorization and Confirmation of Responsibility**

The collection of personal health information on this form by the Ministry of Health is necessary for the purposes of assessing and verifying eligibility for the SAIL Insulin Pump Program and for other purposes related to the administration of that program.  Yes

In accordance with the Health Information Protection Act (Saskatchewan), and with your expressed consent, selected personal health information on this form may be used by or disclosed to appropriate employees of the SHA and the insulin pump supplier (as selected by the applicant and designated on this form). This information will only be provided on a need-to-know basis with your consent.

I consent to the collection, use and disclosure of my personal health information for the purpose outlined above, only for the period of time that I am eligible for benefits under the SAIL Insulin Pump Program. I understand that if I wish to withdraw this consent I may do so at any time by writing the SAIL program at the address on this form. I understand that withdrawal of consent would mean that I am no longer eligible for benefits.

I understand that the **insulin pump trial period** can be up to three months. During this time, the SHA Diabetes Education Program will assess the appropriateness of the pump for me and confirm that I have an adequate level of the knowledge and practices for the safe use of the device. During the three-month period, the pump may be returned to the company and the trial ended, based on medical reasons such as allergy to infusion set or other reasons the diabetes education program, diabetes educator, or the authorized specialist physician deems necessary. I understand I would then be responsible for returning the pump to the company and I may be charged with the full cost of the insulin pump if I fail to do so within the return policy period (determined by the company).  Yes

I am aware of the Insulin **Pump Program Renewal Policy**, which occurs every five years. I understand that I am not eligible for additional Insulin Pump Program grant funding for the purchase of a new insulin pump prior to five years.  Yes

**Insulin Pump Program Discontinuation.** I understand that coverage for insulin pump supplies may be discontinued at any time for a minimum of six months on the recommendation of a specialist physician if it is determined that the Insulin pump is no longer appropriate for my care.  Yes

I am committed to maintaining long-term diabetes follow-up through regular assessments occurring at least annually (every 12 months) by a diabetes education program, diabetes educator, or my authorized specialist physician.  Yes

***I have read and understand the Client Consent and Authorization and Confirmation of Responsibility.***

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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