EMORY
UNIVERSITY
SCHOOL OF
MEDICINE

MEDICAL NUTRITION THERAPY FOR PREVENTION (MNT4P)
for inherited metabolic disorders
APPLICATION FORM

2165 N. Decatur Rd. Decatur, GA 30033
Phone: (404) 778-8570 Fax: (404) 778-8562

The Medical Nutrition Therapy for Prevention Program (MNT4P) bridges the coverage gap for patients with inherited metabolic disorders in the state of Georgia. MNT4P provides medical foods, low-protein modified foods, treatment-related supplies and support, and insurance navigation to prevent poor health outcomes and improve health-related quality of life. All applications are reviewed on a case-by-case basis to support MNT4P's mission of ensuring access to medical nutrition therapy for all individuals with inherited metabolic disorders in need, regardless of income status.

Eligibility Criteria:

- ✓ Patient has visited the metabolic clinic in the last 6-12 months.
- ✓ Patient has difficulty accessing medical foods (formula or low-protein modified food).
- ✓ Patient has a diagnosed inherited metabolic disorder.

Checklist for submitting an application:

- ✓ Ensure all sections of the application are completed. Make a copy before sending since no documents will be returned to you.
- ✓ Patient (or parent/guardian) has signed and dated the application.
- ✓ Provide a copy of health insurance card and/or insurance denial letter if applicable.

For assistance in completing the application, please contact:

Tammy Scott
(404) 778-8497
tammy.scott@emory.edu

Saran Gurung
(404) 778-8607
saran.raj.gurung@emory.edu

Fax or mail the completed application and documentation to:

Medical Nutrition Therapy for Prevention Program
2165 N. Decatur Rd.
Decatur, GA 30033

Fax: (404) 778-8562

If the patient is eligible for assistance, a **one month supply** of the medical food (not money) will be shipped immediately, as needed, to the patient's home address. Continued assistance may be provided in the form of approved product/service and/or insurance navigation. Additionally, the MNT4P team will actively support the patient/parents/guardian while they work with their health insurance carrier to overcome barriers to medical food access. Once this application has been submitted, a member of the MNT4P team will contact you.

The MNT4P Program is supported by the Georgia Department of Public Health and the Emory Genetics Metabolic Nutrition Program. For feedback, please contact the Principal Investigator, Rani H. Singh, PhD, RD, LD (rsingh@emory.edu) or Project Manager, Mary Lauren Salvatore, MPH, CHES (mlsalva@emory.edu).

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I. **Patient Information**

Name: Street Address:
Date of Birth: City: State: Zip:
Gender: Phone Number:
Diagnosis: Email Address:

II. **Screening**

1. What is the name of your insurance (if applicable)? _____

2. Do you have any current barriers to managing your inherited metabolic disorder?
☐Yes ☐No

3. If you answered YES to Question 1, which of the following are your barriers related to? Check all that apply.
☐Medical foods (formula, low-protein modified foods, amino acids, supplements)
☐Monitoring my disorder
☐Support related to treatment (insurance, patient registries, treatment supplies)
☐Other: _____

4. Where are you currently getting your medical foods? Check all that apply.
☐Pharmacy ☐Patient assistance program: _____
☐WIC ☐Directly from formula company: _____
☐Metabolic clinic ☐Durable Medical Equipment (DME) company: _____
☐Other: _____

III. **Medical Foods**

5. In the past 12 months, how often have you followed your prescribed diet?
☐Always ☐Sometimes ☐ Never ☐ N/A

6. Do you incorporate low-protein modified foods (LPMF) into your diet?
☐Yes ☐No ☐Not sure ☐ N/A

IV. **Monitoring**

7. How do you monitor your disorder? Check all that apply.
☐Filter paper submission ☐Blood test (plasma amino acids)
☐Regular clinic visits ☐Other: _____
☐Urine Ketostix

8. In the past year, how many times did you send in filter papers?
☐N/A ☐Monthly
☐None ☐4 times
☐Weekly ☐3 times or less

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9. In the past year, how many times did you visit the metabolic clinic?
   ☐None ☐2
   ☐1 ☐3 or more

10. What are the obstacles you have in managing your disorder? Check all that apply.
    ☐High cost of medical foods ☐Travel expense/distance to clinic
    ☐Taste of medical foods ☐Lack of health insurance coverage
    ☐Transportation to clinic ☐Other: _____
    ☐I do not have any obstacles at this time

V. **Support**

11. Is your medical food (formula) covered through any of the following? Please specify.
    ☐Medicaid: _____ ☐Private insurance: _____
    ☐Medicare: _____ ☐Patient assistance program: _____
    ☐WIC ☐Do not have medical foods coverage
    ☐Tricare

12. What has been your biggest obstacle with medical foods (formula) coverage?
    ☐No health insurance ☐High copay or deductible
    ☐Insurance but no coverage ☐Exhausted allowance from assistance program
    ☐Out-of-pocket expense ☐Other: _____
    ☐I do not have any obstacles at this time

13. Have you ever been denied coverage for medical foods (formula)?
    ☐No ☐Yes ☐Reason: _____

14. Is your low-protein modified food (LPMF) covered through any of the following?
    ☐Medicaid: _____ ☐Private insurance: _____
    ☐Medicare: _____ ☐Patient assistance program: _____
    ☐WIC ☐Other: _____
    ☐Tricare ☐Do not have LPMF coverage

15. What has been your biggest obstacle with low-protein modified food (LPMF) coverage?
    ☐No health insurance ☐High copay or deductible
    ☐Insurance but no coverage ☐Exhausted allowance from assistance program
    ☐Out-of-pocket expense ☐Other: _____
    ☐I do not have any obstacles at this time

16. Have you ever been denied coverage for low-protein modified foods (LPMF)?
    ☐No ☐Yes ☐Reason: _____

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17. Does monitoring your disorder require any of the following supplies? Check all that apply.
    ☐Filter papers ☐Scale ☐Shaker bottle ☐Other:_____
    ☐G-tube ☐Lancets ☐Measuring utensils

18. How can the MNT4P Program best assist you in managing your disorder? Check all that apply.
    ☐Insurance navigation ☐Access to medical foods (formula)
    ☐Patient registry ☐Access to low-protein modified food (LPMF)
    ☐Referral to DME ☐Paying for clinic visits
    ☐Access to supplies ☐I do not currently need any assistance
    ☐Filter paper monitoring ☐Connecting with other patients/families
    ☐Other: _____

If you do not need any assistance at this time, you may end the survey now.

VI. Application

Agreement

I understand that any assistance in the form of products or services is contingent upon my ability to meet the eligibility criteria for the MNT4P Program. In the event that I am eligible for assistance, I acknowledge that this assistance is temporary and may be discontinued at any time. I understand that by completing this form, I am not guaranteed to receive medical food or support from MNT4P. I agree that I will notify MNT4P if my insurance situation changes. MNT4P will use my information for purposes of determining patient assistance eligibility. Coverage for MNT4P is provided on a monthly basis until accessibility to medical food is restored. The patient's eligibility for coverage will be re-evaluated every 6 months.

Patient or Guardian's Signature: _____ Date: _____

Representative for Purposes of the Program (if applicable)

I permit the MNT4P Program to speak with the following person(s) about my application and/or care and sign any documents related to the program on my behalf:
Name: _____ Relationship: _____ Phone: _____

Medical Foods Requested (if applicable)
Product: _____
Product: _____

Office Use Only
Approved by: _____
Date: _____