

# Cystic Fibrosis Application for Assistance



P.O. Box 6044 ▪ Bozeman, MT 59771 ▪ (406)587-5055 ▪ www.breathin/sbelievin.org

**UNLESS OTHERWISE STATED, ALL QUESTIONS MUST BE ANSWERED COMPLETELY**  
(Please print clearly)

Applicant Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_  
 Daytime Phone: \_\_\_\_\_ Home: \_\_\_\_\_  
 Email (optional): \_\_\_\_\_  
 Person(s) with CF: \_\_\_\_\_  
 Date of Birth of Person(s) with CF: \_\_\_\_\_  
 Relationship of Applicant to Person(s) with CF:  
 \_\_\_\_\_

Please check the type of assistance sought:  
 Out-of-area travel expenses  
 Insurance deductibles / Out-of-pocket medical costs  
 Special life experience

For Office Use Only	
Assistance Type:	_____
Eligibility Confirmed:	_____
Approved:	Date: _____
Amount:	_____
Date Processed:	Initials: _____
Special Terms:	_____
_____	
Report waived (sufficient documentation attached)	_____
Report Received:	_____
Authorized Signature:	_____

Have you previously applied for financial assistance from the Cody Dieruf Benefit Foundation?  
 Yes \_\_\_\_\_ No \_\_\_\_\_

Household Members [include adult couples and legal dependants]	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### **Documentation of Cystic Fibrosis**

*Please attach a signed letter from the Cystic Fibrosis (CF) patient's health care provider and/or medical record(s) confirming a diagnosis of Cystic Fibrosis for each individual for whom assistance is sought under this application. This documentation is required in order to receive assistance from the Cody Dieruf Benefit Foundation. All information/documentation will be held in the strictest confidence by the Foundation. This information only needs to be provided with the first application for assistance.*

**Household Financial Information**

All Applicants must complete this section. All financial information will be held in the strictest confidence by the Cody Dieruf Benefit Foundation and will never be released to third-parties unless required by law. This section will be valid for a period of one year, and does not need to be re-submitted with every application for assistance. The Foundation will notify you when your one year period has expired and this section is again required.

Employer \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Monthly Gross Income \$ \_\_\_\_\_  
Other Monthly/Yearly Income [please specify period, amount & source(s)] \$ \_\_\_\_\_

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Spouse's Name \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_  
Spouse's Work Phone \_\_\_\_\_ Monthly Gross Income \$ \_\_\_\_\_  
Other Monthly/Yearly Income [please specify period, amount & source(s)] \$ \_\_\_\_\_

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Annual Total Gross Household Income \$ \_\_\_\_\_

Other Income Sources (please check if applicable and included above, and attach relevant documentation)

___ Social Security	___ VA Assistance	___ Retirement/Pension
___ Disability	___ Life Insurance	___ Alimony/Child Support
___ Unemployment	___ Workman's Comp	___ Public Assistance
___ Other: Please list _____		

**ASSETS**

Cash on hand (including checking) \$ \_\_\_\_\_  
Savings \$ \_\_\_\_\_  
Stocks/Bonds/Retirement funds \$ \_\_\_\_\_  
Vehicles Model \_\_\_\_\_ Year \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_  
                  Model \_\_\_\_\_ Year \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_  
Home (estimated market value) \$ \_\_\_\_\_  
Other Assets \_\_\_\_\_ \$ \_\_\_\_\_  
**Total Assets** \$ \_\_\_\_\_

**LIABILITIES**

Bank Loans \$ \_\_\_\_\_  
Credit Cards (total) \$ \_\_\_\_\_  
Home Mortgage (total) \$ \_\_\_\_\_ Rent \_\_\_\_\_ Own \_\_\_\_\_  
School Loans \$ \_\_\_\_\_  
Other Liabilities \_\_\_\_\_ \$ \_\_\_\_\_  
**Total Liabilities** \$ \_\_\_\_\_

NET WORTH

**Total Assets Minus Total Liabilities** \$ \_\_\_\_\_

FIXED MONTHLY EXPENSES

House Payment/Rent \$ \_\_\_\_\_

Utilities \$ \_\_\_\_\_

Telephone(s) \$ \_\_\_\_\_

Medical Bills \$ \_\_\_\_\_

Prescription Drugs \$ \_\_\_\_\_

Insurance \$ \_\_\_\_\_

Groceries \$ \_\_\_\_\_

Child Care \$ \_\_\_\_\_

Child Support \$ \_\_\_\_\_

Other \_\_\_\_\_ \$ \_\_\_\_\_

**Total Monthly Expenses** \$ \_\_\_\_\_

**PROOF OF INCOME:** *A copy of one of the following must accompany your application.*

- Federal Tax Return (most recent).
- Current Pay Stub (of Applicant and Spouse)

[THIS SPACE INTENTIONALLY LEFT BLANK]

**OUT-OF-AREA TRAVEL EXPENSE ASSISTANCE**

Complete this section *only* if applying for this type of assistance.

If this travel has not yet occurred, please provide reasonable estimates to the best of your knowledge and ability.

Medical reason for required travel \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has this travel already occurred? Yes \_\_\_\_\_ No \_\_\_\_\_ Dates of travel \_\_\_\_\_

Length of stay and/or estimated of length of stay \_\_\_\_\_

Days of work missed (only if non-paid days) \_\_\_\_\_

Spouse's days of work missed (only if non-paid days) \_\_\_\_\_

Destination [hospital/clinic and City and State] \_\_\_\_\_

One-way mileage from your home to hospital/clinic (if automobile travel) \_\_\_\_\_

Number of persons who traveled, including CF patient \_\_\_\_\_

Relationship to CF patient of all persons who traveled \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Travel Expenses**

Airline travel	\$ _____	
Other mode of travel (excluding automobile)	\$ _____	Please specify mode _____
Hotel	\$ _____	
Food	\$ _____	
Additional child care expenses		
incurred as a result of the travel	\$ _____	
Miscellaneous associated expenses	\$ _____	
<b>TOTAL TRAVEL EXPENSES</b>	<b>\$ _____</b>	

*If travel has already occurred, copies of receipts for all listed expenses must be attached.  
If travel has not yet occurred, please retain your receipts, as copies of such receipts will need to be filed with your assistance report that is due with three months following qualified travel.*

**INSURANCE DEDUCTIBLES AND OUT-OF-POCKET MEDICAL EXPENSE ASSISTANCE**

Complete this section *only* if applying for this type of assistance.

If expenses have not yet been incurred, please provide reasonable estimates to the best of your knowledge and ability.

**Insurance Deductibles**

Are you applying for assistance with insurance deductibles? Yes\_\_\_\_ No\_\_\_\_

(If yes, complete this section. If no, leave this section blank and move on to the out-of-pocket cost section)

Insurance Carrier(s) for CF patient(s)\_\_\_\_\_

Deductible (yearly or otherwise) that must be paid out-of-pocket \_\_\_\_\_

Have you paid or will you have to pay this full deductible for the current calendar year? Yes\_\_\_\_ No\_\_\_\_

Is this entire amount related to necessary cystic fibrosis medical care? Yes\_\_\_\_ No\_\_\_\_

If no, amount related to medical care for other household members w/o CF \_\_\_\_\_

*Please attach insurance documentation showing this yearly deductible and proof that you have had to pay and/or must pay this entire amount in the current calendar year.*

**Other Out-Of-Pocket Medical Costs**

Are you applying for assistance with out-of-pocket medical costs? Yes\_\_\_\_ No\_\_\_\_

(If yes, complete this section. If no, leave this section blank)

Reason for out-of-pocket cost(s) [please be specific] \_\_\_\_\_

Are these costs related to CF medical care, CF health maintenance, etc. which provide some health benefit to the CF patient? Yes\_\_\_\_ No\_\_\_\_

Has the CF patient’s medical provider prescribed, recommended, and/or suggested the medication, medical equipment, or other expenditure listed above? Yes\_\_\_\_ No\_\_\_\_

If yes, provide the name and telephone number of the medical provider \_\_\_\_\_

Description of Item	Cost
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

Are any part of these costs paid for by insurance of any type? Yes \_\_\_ No \_\_\_

If yes, what amount is paid for by insurance? \_\_\_\_\_

Insurance Company \_\_\_\_\_

*Please provide documentation of the portion covered by insurance.*

**Total Out-Of-Pocket Cost** (total cost of item(s) you are seeking assistance for minus any portion paid for by insurance)

\$ \_\_\_\_\_

Have you already paid these out-of-pocket costs? Yes \_\_\_ No \_\_\_ Partially \_\_\_

If partially, how much have you paid? \$ \_\_\_\_\_ How much remains unpaid? \$ \_\_\_\_\_

*Please attach receipts, estimates and/or other documentation for these out-of-pocket costs.*

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**SPECIAL LIFE EXPERIENCE ASSISTANCE**

Complete this section *only* if applying for this type of assistance.

If expenses have not yet been incurred, please provide reasonable estimates to the best of your knowledge and ability.

Description of CF Patient’s Desired Special Life Experience \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Personal Statement:** If the CF patient is old enough and/or able to write or express themselves, please attach a short statement (one to three pages) prepared by the patient or orally explained by the patient and recorded by the Applicant or other person explaining what experience they would like to have, why this experience is important to them, and how the experience will make their life better. If the patient is too young or unable to write or express their special life experience, the Applicant is asked to submit a personal statement on behalf of the patient.

Estimated Cost(s) of Special Life Experience \$ \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Please attach receipts, documentation, and/or estimates of such costs if available.*

If the Cody Dieruf Benefit Foundation decides to provide financial assistance for a special life experience, the Foundation would like your permission to use your story and/or photo in one or more of the media listed below. We ask that you check all the boxes that are acceptable to you. It is very helpful to the Foundation when you choose to accept all of the options as it helps raise awareness and donations for local CF assistance. The Cody Dieruf Benefit Foundation respects the privacy of individuals and will only use a recipient’s first name when using their story and/or photograph. If you would like us to take special consideration, please provide a clear explanation. Please note that only the special experience will be publicized, not the actual amount of assistance. Moreover, this publicizing applies only to assistance for a special life experience. Applicants and/or CF patients’ names will never be used to publicize assistance the Foundation provides for medical travel and/or insurance deductibles and out-of-pocket expenses.

Please check the line next to all media that is acceptable to you.

- Newspaper, Radio, TV
- Cody Dieruf Benefit Foundation web site, [www.breathinisbelievin.org](http://www.breathinisbelievin.org)
- Cody Dieruf Benefit Foundation direct mailings and/or emails
  
- Please do not use my story and/or photo in any of the above media.

*If you would like, please feel free to attach a photo of the person(s) with CF and/or their family.  
(Not required)*

**EMERGENCY NEED**

If your financial need for assistance with out-of-area medical travel and/or insurance deductibles and out-of-pocket costs is emergent, please check here and the Foundation will do its best to expedite your application.

**\_\_\_\_Please Expedite Application**

Why is assistance needed on an emergency basis? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Funds needed by \_\_\_\_\_

Date

**Please note: The Cody Dieruf Benefit Foundation makes no promise or guarantee that funds can be made available before this date, even if this application is approved.**

**VERIFICATION**

Under penalties of perjury, I affirm that I meet the eligibility requirements set forth in Part I of the General Instructions for this Application for Assistance and that the above information, given to the Cody Dieruf Benefit Foundation, is true and correct to the best of my knowledge. I authorize the Cody Dieruf Benefit Foundation to verify any or all information given. I understand that if I receive financial assistance pursuant to this application, I am obligated to provide and hereby agree to provide the Cody Dieruf Benefit Foundation with an expenditure report (and supporting receipts/documentation) within three (3) months of receipt of any Foundation funds, as fully described in the instructions accompanying this application. I further understand this requirement may be waived by the Cody Dieruf Benefit Foundation if (1) expenses are paid by the Foundation directly to doctors, hospitals, drug companies, insurance companies, hotels, airlines or other vendors/entities and/or (2) if this application is for expenses which have already occurred and for which I have attached sufficient documentation.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

*If you have any questions regarding this application, please contact Anne Rhodes at [anne@breathinbelievin.org](mailto:anne@breathinbelievin.org) or (303)345-3747.*

If, after reviewing your application, the Cody Dieruf Benefit Foundation requires additional information to process your application, you will be contacted at the address and/or phone numbers listed on page one of this application. Thank you!