CDBF recognizes the benefit for exercise for those with Cystic Fibrosis. The information requested below is confidential and necessary to help determine the degree of need for each applicant. If questions please contact Ginny Dieruf @ 406-581-9002 or at www.breathinisbelievin.org

APPLICATION GUIDELINES

- **Due to limited available funding each month, Cody Dieruf Benefit Foundation is not able to approve all Fit For Life Grants, but we will do the best that we can.**
- **Please allow up to 10 days of approval and processing of grant**
- **CDBF Grants are approved grant funds for up to a certain amount (to be determined) & will be paid directly to the designated activity provider or organization. Funds will not be paid to the grant recipient .**
- **CDBF will consider all completed applications.**
- **If denied an applicant can reapply for the same, or different activity with a new application**
- **Only 1 grant can be awarded per recipient per year, per activity**
- **Applicants agree to provide feedback during the year.**

INDIVIDUAL GRANT REQUEST

DATE APPLIED_____

Have you applied to anyone else for this type of scholarship?_____ Amount given_____

How many in your household have CF?_____

FIRST NAME: _____LAST NAME: _____

AGE_____DATE OF BIRTH_____(M)___(F)____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

***DAY PHONE:_____*EVENING PHONE:_____*E-MAIL_____**

May CDBF provide you with updates and mailings? Yes_____ NO_____

This Scholarship will be used for: ACTIVITY: _____

<u>ACTIVITY INFORMATION:</u> Please be specific as possible when providing the following information. If any information is missing or left blank we will not be able to process your request.

Name of Business or Organization where funds will be paid to:_____

PROGRAM ACTIVITY:_____

Address:_____City_____State____Zip_____

Email:_____Contact Person (if applicable)_____

START DATE_____DURATION OF ACTIVITY_____

Program Fee:_____

Photograph

***Please include a RECENT photo of yourself involved in a physical activity and describe below where and when the picture is from, and the story that describes what we are looking at.**

_____
_____
_____
_____
_____

(May continue on separate sheet if necessary and we will attach)

***If you have received a CDBF grant in the past please include a photo of yourself participating in the activity your last grant helped fund).**

Please note that photos will not be returned and may be used for publicity purposes

Digital copies strongly preferred, please e-mail to gdieruf@breathinisbelievin.org with your name in the subject line

Attach a 500 word essay on why this program is helpful to you. example:

Why do you need a CDBF grant to be able to participate in your chosen activity?

Please describe how you believe your chosen activity will help you manage your Cystic Fibrosis? How did you chose your activity?

How often do you typically exercise? (Please be specific as possible)

What other activities do you enjoy participating Has your previous exercise improved your lung functions? Do you believe this activity has given you body strength, self confidence, and an overall sense of fulfillment? Include anything else as to why this type of activity is gratuitous.

Is there anything else you would like us to know about you?

Would you be willing to participate in a questionnaire survey at end of your activity to help us see if there is any impact on your quality of life from this grant.
Yes_____NO____

CONTRACT OF AGREEMENT

Please read and initial EACH of the points below, and upon agreeing to these conditions sign at the bottom of the page.

_____ I understand I am undertaking the activities requested in this application under my own (child's) risk, and will not hold CDBF nor any of their partners, liable for any injury or negative health impact related to this activity.

_____I understand the spirit of these funds is to help improve my lifestyle, which includes my physical, emotional, and social well-being. I will do my best to use this CDBF grant to improve my life, and to use it toward on-going activities that I believe to be beneficial to my health.

_____ I will not sell, trade or profit from any goods or serviced rendered with this CDBF grant.

_____I understand that CDBF will send form to CF doctor to review and request endorsement of the activities requested in this application.

_____I will do my best to provide photos, e-mail feedback, and complete questionnaires for CDBF to help determine the impact of this program on my well-being, and to help improve the programs of CDBF

_____I will update CDBF with any address, e-mail, or phone changes.

_____ I give permission to CDBF to use my photographs, application, question responses, e-mail content, thank you notes, etc. to help demonstrate the impact of this program to the public through the CDBF website, Facebook page, Twitter account other social media. (OPTIONAL)

Applicant's Signature_____-
Date_____

EMERGENCY CONTACT: NAME:_____RELATIONSHIP_____
ADDRESS:_____CITY:_____STATE_____
E-MAIL_____PHONE:_____

CONSENT: By signing here I give my permission to CDBF to discuss my condition with my doctors, other healthcare providers, or other organizations regarding the activities I would like to use my grant towards if necessary.
Signature:_____

FOR YOUTH REGISTRATION ONLY:

FATHERS NAME:_____EMPLOYMENT_____

MOTHERS NAME:_____EMPLOYMENT:_____
Email _____

PARENTS/GUARDIAN
SIGNATURE:_____

I give permission to use my child's photo on CDBF website, social media and other publications:_____

PARTICIAPANT/ PARENT/ GUARDIAN SIGNATURE_____
DATE:_____

SCHOLARSHIPS ARE FUNDED BY VERTEX PHARMACEUTICAL IN COLLABORATION WITH THE FOLLOWING CF NON PROFITS

CFLF
Cystic Fibrosis Lifestyle Foundation

coach-D inc.

Miles for Cystic Fibrosis

breathin' is believin'
CODY DIERUF BENEFIT FOUNDATION FOR CYSTIC FIBROSIS

FOR OFFICE USE ONLY:

DATE RECEIVED:_____DATE APPROVED:_____DATE NOTIFIED:_____

PROGRAM FEE:$_____LESS SCHOLARSHIP AMT:$_____FEE PAID:____

CDBF SIGNATURE:_____

Uniting communities and families living with Cystic Fibrosis by raising awareness, providing emotional and financial assistance, encouraging health management, and inspiring life experiences.

CF Physician

Physician Name:_____E-Mail_____

CF Care Center:_____Address_____City_____S-tate____Zip_____

Contact Person_____Position_____Phone_____

Dear CF Care Provider,
We have received an application from the applicant listed above for Fit For Life Program through CDBF. Part of our review process is to verify with their CF care provider their current health status.

Please fill out the top portion of this page yourself, then have your CF care provider fill out the rest of this page and the following page.

1. How long have you treated this patient?_____

2. How would you rate their compliance with medications and treatments on a scale of 1-10 (10 being 100% compliant.)

Circle one: 1 2 3 4 5 6 7 8 9 10

3. Do you endorse their participation in the activity listed above as potentially beneficial to their health? _____

4. Do you have any concerns about their participation in these activities? _____

As the primary CF care provider for the patient listed above, I support and encourage their participation in physical activity as a part of their well-being. I understand that CDBF is not promoting any form of interaction between CF patients, and the funds being applied for are strictly for individual purposes of promoting recreation as an additive measure of airway clearance. I feel that he/she is an excellent candidate to receive a Fit For Life grant through CDBF.

CF Physician (Signature) **CF Physician (Print Name** **DATE**
_____ _____ _____