APPLICATION FOR ASSISTANCE

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CODY DIERUF BENEFIT FOUNDATION FOR CYSTIC FIBROSIS

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

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 medic
____ 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____

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.

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 $_____

TOTAL TRAVEL EXPENSES $_____

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.

[*THIS SPACE INTENTIONALLY LEFT BLANK*]

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

____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 Dieruf at annedieruf@yahoo.com 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!