



***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](http://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.

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**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:** \_\_\_\_\_

**ACTIVITY INFORMATION:** 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:** \_\_\_\_\_

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## 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.**

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**(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](mailto: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: \_\_\_\_\_

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**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:** \_\_\_\_\_

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



**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**

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