



***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. Please allow a minimum 10 days to process your scholarship. 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 7 days of approval and processing of grant**
- **CDBF Grants are approved grant funds for full amount or 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:** _____

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: _____

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?

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?

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

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 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 give permission CDBF to use my(child's)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** _____

Parent's Signature (if under 18)

Date _____ **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. **Signature:** _____

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.

