

Application For Assistance

Please complete the following application as completely as possible. We are trying to keep this as simple and not time consuming. If you have any questions, please call us at (360)556-5180

Assistance is only available for US citizens living in the United States. If any section does not apply to you, please use "NA" so we know you didn't miss that section.

SECTION 1

Patient Information

Patient Name: _____ Minor? Yes ___ No ___
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work/Cell Phone(____) _____
Date of Birth: _____ Gender: Male ___ Female ___

Have you previously applied to BREATHE 4 TOMORROW FOUNDATION?
YES ___ NO ___
If yes, what year? _____

Employer: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Employed Since: _____

SECTION 2

Parent/Guardian Information

Only fill out if applicant is under the age of 18

Name: _____
Relationship to Patient: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work/Cell Phone(____) _____
Date of Birth: _____ Gender: Male ___ Female ___
Employer: _____
Address: _____
City: _____ State: _____ Zip: _____

Telephone: _____ Employed Since: _____

Second Parent/Guardian Information

Name: _____

Relationship to Patient: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work/Cell Phone(____) _____

Date of Birth: _____ Gender: Male _____ Female _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Employed Since: _____

SECTION 3

Insurance Information

ALL APPLICANTS PLEASE COMPLETE THIS SECTION

Please complete for all insurance carriers. If you have no insurance, please indicate "NO INSURANCE". Please include, on separate page if necessary, all information on Medicare, Medigap, State Children's or other programs.

Prescription Drug Coverage

Which insurance carrier currently covers your prescription drugs?

Are you required to use a specific pharmacy? ____ Yes ____ No

Name/Type of pharmacy: _____

1. Primary Insurance Carrier

Health Insurance Carrier: _____

Company Contact (if any): _____ Telephone: _____

Policy ID _____ Group Number _____

Subscriber Name: _____

Social Security Number: _____ Date of Birth: _____

Annual Deductible: Individual \$ _____ Family \$ _____

Annual Out-of-Pocket Limit: \$ _____

Have you reached your out-of-pocket limit? ____ Yes ____ No

Is this policy this policy employer provided? ____ Yes ____ No

Does this policy cover prescription drugs? ____ Yes ____ No

Is there a separate/different deductible? ____ Yes ____ No

If yes, what? _____

Has this insurer ever denied a drug claim? Yes _____ No _____

If yes, please explain: _____

Does this policy pay for medical equipment (nebulizers, vests)?

Yes _____ No _____

2. Secondary Insurance Carrier

Health Insurance Carrier: _____

Company Contact (if any): _____ Telephone: _____

Policy ID _____ Group Number _____

Subscriber Name: _____

Social Security Number: _____ Date of Birth: _____

Annual Deductible: Individual \$ _____ Family \$ _____

Annual Out-of-Pocket Limit: \$ _____

Have you reached your out-of-pocket limit? _____ Yes _____ No

Is this policy this policy employer provided? _____ Yes _____ No

Does this policy cover prescription drugs? _____ Yes _____ No

Is there a separate/different deductible? _____ Yes _____ No

If yes, what? _____

Has this insurer ever denied a drug claim? Yes _____ No _____

If yes, please explain: _____

Does this policy pay for medical equipment (nebulizers, vests)?

Yes _____ No _____

3. Public Programs

Are you currently eligible for any of the following public programs?

Medicare: _____ Yes _____ No

Medicaid: _____ Yes _____ No

Title V (State CF Program): _____ Yes _____ No

Other: _____

SECTION 5

Medical Provider Information

Name of Physician treating the patient for Cystic Fibrosis:

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

SECTION 6

Financial Information

ALL APPLICANTS PLEASE COMPLETE THIS SECTION

Annual Household gross income last calendar year \$ _____ Year _____

Has your annual family income changed significantly this year?

YES _____ NO _____

If yes, please explain: _____

Number of dependent children in the family: _____

SECTION 7

Letter of Intent

Please include a brief explanation of your circumstances and what type of assistance you are applying for (ie: mortgage, gas card, phone card, medication). Please provide anything we didn't cover in this application that you feel like we should know. Remember, we are here to help you, not judge you or make this harder on you. We understand the stresses and if there is anything we can do to make this process easier, please don't hesitate to ask. Thank you!

PATIENT AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

(HIPAA Compliant)

By submitting this application, I, _____, hereby authorize BREATHE 4 TOMORROW FOUNDATION, its agents, employees, and associates, to release and obtain my protected health information (PHI). This medical authorization hereby authorizes physicians, hospitals, and any medical attendant or records custodian to furnish full and complete medical records, applications and information to BREATHE 4 TOMORROW FOUNDATION, 2103 Harrison Ave NW #2-213, Olympia, Washington 98502, {Tel: (360)556-5180} or to any representative from said foundation. Should you have questions with this request, please call us and reference our client's name.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the authorized receipt and may no longer be protected by state and federal law.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire six (6) months from the signature date below. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. I understand that I may refuse to sign this authorization. Should I choose to sign this authorization, I understand that I have the right to request access to my protected health information that may be used or disclosed to individuals that are not subject to HIPAA regulations. I understand that once the PHI is disclosed, it may be redisclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, and insurance companies and even may become public record if filed with a court of law.

I understand that a refusal to sign this form will not result in a denial of health care by the hospital or any other health care provider and that this release has not been coerced by a health care entity or any of its business associates.

This authorization for the protected health information also includes examination reports, hospital records, x-ray /CTscan films, questionnaires, applications, and the furnishing of any other information including opinions.

I have authorized BREATHE 4 TOMORROW FOUNDATION to collect my medical records in connection with _____.

Your full cooperation with BREATHE 4 TOMORROW FOUNDATION is hereby requested. Please do not disclose any medical information to any insurance adjuster or any other person without written authority from myself.

Signature: _____ Signature Date: _____
Birthdate: _____ Social Security Number: ____ - ____ - _____
Print Name (Identify Capacity if P.R.): _____

NOTARY PUBLIC

SWORN TO AND SUBSCRIBED before me this ____ day of _____, 20____, by, _____ who is personally known to me or has produced _____ as identification.

My Commission Expires:

SECTION 7

Documentation Needed

Please submit a copy of the following information with your application:

1. Latest IRS 1040 Form, and W-2 forms
2. Latest pay check stub for patient and parent(s)/guardian(s)
3. Medicaid or Title V denial (if applicable)
4. Insurance denial (if applicable)
5. Copies of bills for which assistance is being requested
6. Proof of diagnosis and condition from treating physician

SECTION 8

Declarations

I verify that the information provided in this application is complete and accurate. I further understand that reported financial information may be verified by an audit as deemed necessary by the BREATHE 4 TOMORROW FOUNDATION I understand that assistance will terminate if the Foundation becomes aware of any documented case of fraud or of medication/services no longer being prescribed for me or the patient on whose behalf this application was completed. I understand that the Foundation reserves the right at any time and without notice to (1) modify the Application Form (2) modify or discontinue any or all of the programs and related eligibility criteria, or (3) terminate assistance at any time.

I authorize the BREATHE 4 TOMORROW FOUNDATION to obtain information on the patients information from the prescribing physician, insurance coverage information from my employer or insurance company and other information related to the treatment of Cystic Fibrosis as necessary to complete the application process or verify the accuracy if any information provided in this application. BREATHE 4 TOMORROW FOUNDATION retains the right to periodically monitor and assess the recipients continued compliance with the goals of the foundation.

Signature _____ Date _____

2103 Harrison Ave NW #2-213
Olympia, Washington 98502
(360) 556-5180