Breathing Easy Foundation

Helping Families with Cystic Fibrosis

Application for Assistance

(please print)

____

First Name of Parent   Middle Name   Last Name

____

First Name of Patient   Middle Name   Last Name

_____ _______   ____________________   ________________

Male Female   Patient Date of Birth   Patient Age

____   ________________

Mailing Address   Apartment #

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City   State   County   Zip

____________________   ____________________   ____________________

Home Phone   Cell Phone   E-mail Address

Patients Medical Status

Cystic fibrosis____Lung transplant____Diabetes____other ________________________

Household Income   Parent Income Information:

Name of Employer____

Employed full time_____Part Time_____ Spouse P/T______Full time_____Insured____

______Social Security _____Supplemental Security _____Disability _____Other

If other explain source____

Other Household members Income

Name of Member______________________Name of Employer________________

Employed full time____Part time____Social Security____Disability____Other______

If other explain____

Name of Healthcare Coverage

Insurance name______________________Medicare part A____ Medicare A/B_____

Medicaid_______Katie Beckett Waiver______COBRA______No insurance__________

Out of Pocket_________________ Deductable____________________

Financial Status Information

All people who live in your home are counted as your **household**, including adults, children, grandparents, non-related renters etc.
Income is counted for everyone living in the home. Any social programs that give help, SSI, renters, food stamps, child support, public assistance, social security, disability income, etc. should be included.

Name of Patient____

Family Assets:

		AUTOMOBILES		
		Year	Make	Owed
Checking account	Amount____________			
Savings account	Amount____________			
Stocks/Bonds	Amount____________			
Retirement Accounts	Amount____________			
Home value	Amount____________			
other property	Amount____________			

Household Net Income (monthly)		Household Expenses (monthly)	
Wages	____________	Mortgage____Rent_____	___________
Spouse income	____________	Gas	___________
Family member	____________	Electricity	___________
Social Security	____________	Water	___________
Disability	____________	Telephone	___________
Retirement	____________	Cell phone	___________
Pension	____________	Food	___________
Food Stamps	____________	Automobile payment	___________
TANF	____________	Gasoline	___________
Rental income	____________	Auto insurance	___________
Dividends	____________	Auto repair	___________
Other	____________	Life insurance	___________
		Health insurance	___________
		Dental	___________
		Medicine	___________
		Doctor visits	___________
Total Income	______________	Charge cards	___________
Total Expenses	______________	Loans	___________
Total Net Income	______________	Child care	___________
		Other	___________

Total expenses ____________

Total income minus total expenses will show the amount of funds available to the family after all bills are paid.

I agree to allow the cystic fibrosis center, my doctors, patient advocates, socials workers, and Breathing Easy Foundation to work together to verify this information.

____ Date ______________________

Signature of Patient, if minor, signature of parent or guardian

Parent/Patient Request Statement

Breathing Easy Foundation is a volunteer charity that raises funds to help families whose members have cystic fibrosis and need help. It may be in the way of finding where a family can get help from pharmaceutical companies, helping with medicines and equipment to paying a light bill because funds have been stretched so far because of this disease.

Below please give a detailed summary of why you are requesting our help and how it will help you and your family. With this information we will evaluate the needs of the patient to determine approval of releasing funds.

It will be good if you would be willing to share your story with others so that our donors will know who and how we have helped. This is what helps keeps the funds coming in so we can help others with this dread disease. We would also like to add you and your family to our family album so a picture sent to us would be nice. Please visit our website to find contact information: www.breathingeasy.org

YOUR STATEMENT HERE

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Patient/parent signature:

Patient Name (print)____

e-mail address____

Healthcare Worker's Statement

Patient's Name:____

Parent/patient e-mail address____

Person filling out form:

Name:______________________________Title:____________________________

Information you can document about the patient that you feel creates the need for our assistance:

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The above can be documented and verified and is a **complete background** on the patient and their reason for needing funds from Breathing Easy Foundation.

Signature Healthcare worker____

______________________ ____
Phone e-mail

Request for Payment Form

Patient's name____

e-mail address____

Amount of request_____________________________

Amount approved_______________________

All funds will be paid directly to the provider, hospital, drug companies or vendors such as utility companies, mortgagees etc, and will be paid only for the person named on the request for funds application

Check reasons for the request for funds apply:

Patient has been hospitalized_____ Caregiver missed work_____

Caregiver lost job_______ non-coverage by insurance_______ Other_____

If other explain____________________________________

Fill out completely:

Amount of Check to be paid to __________________________________

Billing address____
____

Phone number_______________________

Name on account and account number______________________________
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Please provide these items to a representative of Breathing Easy Foundation or to your social worker, or any other person you have spoken to and worked with in making your request for assistance.

Please provide a copy of the bill from the service provider to show the amount needed to be paid.