

NEW JERSEY STATE ORGANIZATION OF CYSTIC FIBROSIS
PHARMACEUTICAL SERVICES FOR ADULTS WITH CYSTIC FIBROSIS
P.O. Box 3648 • Wayne • New Jersey 07474
(973) 595-1232 • FAX (973) 595-1718

APPLICATION FORM

PROGRAM REQUIREMENTS:

1. **Diagnosis of Cystic Fibrosis verified by CF doctor.**
2. **Must be a New Jersey resident.**
3. **Must be 18 years or older.**
4. **Individual annual income less than \$44,319/year.**

COMPLETE THE APPLICATION AND RETURN WITH ALL REQUIRED DOCUMENTATION TO:

New Jersey State Organization
Of Cystic Fibrosis
P.O. Box 3648
Wayne, NJ 07474-3648

DOCUMENTS NEEDED TO PROCESS YOUR APPLICATION ARE:

- Completed "**Application**"
 - Copy of your **New Jersey driver's license AND birth certificate**
- Completed "**Insurance Affidavit**"
 - Copies of all current **health insurance cards**
- Signed and notarized "**Income and Acceptance Affidavit**"
 - Copy of your **2009 Federal Income Tax Return with all W2's and/or your SSI Benefits Statement**
- Signed and completed "**Pathmark Selection Form**" OR "**Wegman's Selection Form**" You can only shop at one or the other.

Failure to submit ALL of the above items will delay your acceptance into the Adult Program.

NEW JERSEY STATE ORGANIZATION OF CYSTIC FIBROSIS
PHARMACEUTICAL SERVICES FOR ADULTS WITH CYSTIC FIBROSIS

GRANT APPLICATION FORM
PLEASE FILL IN ALL REQUIRED INFORMATION
(Part 1 of 2)

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ EMAIL _____

SOCIAL SECURITY # _____ SEX _____ RACE _____

DATE OF BIRTH _____ PLACE OF BIRTH _____

MARITAL STATUS _____ AGE WHEN DIAGNOSED WITH CF _____

1. PLEASE LIST ALL FAMILY MEMBERS (PARENTS, SPOUSE, SIBLINGS, CHILDREN)

<u>NAME</u>	<u>DATE OF BIRTH</u>	<u>RELATIONSHIP</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. NAMES AND ADDRESS OF PARENTS

NAMES _____

ADDRESS _____ PHONE # _____

3. **ARE YOU EMPLOYED?** _____ **A STUDENT?** _____ **ON SOCIAL SECURITY?** _____

OTHER

(a) IF EMPLOYED, PLEASE SUPPLY NAME, ADDRESS AND PHONE # OF EMPLOYER

EMPLOYER _____ PHONE # _____

ADDRESS _____

FULL OR PART TIME _____ OCCUPATION _____

(b) IF A STUDENT, PLEASE SUPPLY NAME AND ADDRESS OF SCHOOL, AND MAJOR

SCHOOL _____ DEGREE _____

ADDRESS _____ FULL OR PART TIME _____

(Part 2 of 2)

4. INCOME

INDIVIDUAL ANNUAL INCOME FROM ALL SOURCES _____
(ATTACH A COPY OF RECENT US TAX FORM 1040, WITH ALL W2'S, AND/OR SOCIAL SECURITY STATEMENT)

5. LIST ALL PEOPLE AND ORGANIZATIONS CONTRIBUTING TO YOUR FINANCIAL SUPPORT

<u>NAME</u>	<u>ADDRESS/PHONE#</u>	<u>ANNUAL AMOUNT OF SUPPORT</u>
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6. CURRENT CF PHYSICIAN: _____

ADDRESS _____ PHONE # _____

7. CURRENT NUTRITIONIST OR DIETITIAN: _____

ADDRESS _____ PHONE # _____

8. LIST YOUR CURRENT PRESCRIPTION MEDICATIONS:

9. LIST YOUR CURRENT NUTRITIONAL SUPPLEMENTS:

10. IN CASE OF EMERGENCY PLEASE CONTACT: _____

PHONE # _____ RELATIONSHIP _____

I certify that the information given on this application is true and correct.

Date _____

SIGNATURE OF APPLICANT

NEW JERSEY STATE ORGANIZATION OF CYSTIC FIBROSIS
PHARMACEUTICAL SERVICES FOR ADULTS WITH CYSTIC FIBROSIS

INSURANCE AFFIDAVIT

FOR THE GRANT YEAR JULY 1, 2010 – JUNE 30, 2011

INCLUDE COPIES OF ALL INSURANCE CARDS

HEALTH INSURANCE

I AM COVERED FOR HEALTH INSURANCE _____

MEDICARE _____ MEDICAID _____ FAMILY _____

PLAN NAME _____ POLICY OR ID # _____

ADDRESS _____

PHONE # _____

EFFECTIVE DATE _____ ANNUAL DEDUCTIBLE _____

MY CO-PAYMENT IS _____

SECONDARY COVERAGE, IF ANY

PLAN NAME _____ POLICY OR ID # _____

ADDRESS _____

PHONE # _____

EFFECTIVE DATE _____ ANNUAL DEDUCTIBLE _____

MY CO-PAYMENT IS _____

PRESCRIPTION DRUGS

PLAN NAME _____ POLICY OR ID # _____

ADDRESS _____

PHONE # _____

EFFECTIVE DATE _____ ANNUAL DEDUCTIBLE _____

MY CO-PAYMENT IS _____

() I DO NOT HAVE medical insurance coverage () I DO NOT HAVE prescription coverage
() I WILL HAVE prescription insurance coverage starting _____.

I understand that if my medical and/or prescription insurance coverage should change in any way, I MUST notify the New Jersey State Organization of Cystic Fibrosis immediately. Furthermore, I understand that if I have provided false information, I agree to pay back all benefits I have received from "Financial Assistance for Adults with Cystic Fibrosis" to NJSOCF.

DATE _____

SIGNATURE OF APPLICANT

PLEASE PRINT NAME

Sworn to and subscribed before me this
_____ day of _____, 2010.

A Notary Public of the State of New Jersey

NEW JERSEY STATE ORGANIZATION OF CYSTIC FIBROSIS
PHARMACEUTICAL SERVICES FOR ADULTS WITH CYSTIC FIBROSIS

INCOME AND ACCEPTANCE AFFIDAVIT

FOR THE GRANT YEAR JULY 1, 2010 – JUNE 30, 2011

According to the terms of the “Financial Assistance for Adults with Cystic Fibrosis”, the definition of income is “wages, dividends, interest and any other income received from all sources. Spousal or family income must not be considered. However, half of interest and/or dividends from any investments held jointly will be considered income.”

Based on this definition of income, I attest that my individual total income does not exceed \$44,319.

I understand that if I have provided erroneous information, I agree to pay back all benefits I have received to the New Jersey State Organization of Cystic Fibrosis (NJSOCF).

Furthermore, I understand that if I have supplied false information, I shall be disqualified.

The continuation of benefits and the payment of monthly allowances as stated in my “Budgeted Payments List” are at the discretion of the NJSOCF. NJSOCF reserves the right to reduce or change any amounts paid on my behalf.

The New Jersey State Organization of Cystic Fibrosis shall not be held liable for any breach of the agreement because of the absence of available funding.

Under the terms of this agreement, I understand I must submit my Federal Income Tax Return with all my W-2’s, and my spouse’s, if applicable. If I did not file a tax return, I must submit my SSI/SSA Benefits Statement, or any other proof of income received in the year.

DATE _____

SIGNATURE OF APPLICANT

PLEASE PRINT NAME

Sworn to and subscribed before me
this _____ day of _____, 2010.

A Notary Public of New Jersey

NEW JERSEY STATE ORGANIZATION OF CYSTIC FIBROSIS
PHARMACEUTICAL SERVICES FOR ADULTS WITH CYSTIC FIBROSIS

PATHMARK SELECTION FORM

From the enclosed list of Pathmark stores in New Jersey, please select one store that you will use for making approved purchases of food, nutritional supplements and prescription drugs.

Please note that the Cystic Fibrosis Adult Program participant is the only person permitted to use this card.

DATE: _____

STORE NUMBER _____

STORE NAME _____

SIGNATURE _____

PRINT YOUR NAME _____

FOR OFFICE USE:

CLIENT NUMBER _____

PATHMARK STORES NEW JERSEY BY COUNTY

<u>COUNTY</u>	<u>#</u>	<u>STORE NAME</u>	<u>ADDRESS</u>	<u>CITY</u>
ATLANTIC	575	PLEASANTVILLE	6718 BLACK HORSE PIKE	PLEASANTVILLE
ATLANTIC	587	VENTNOR	5100 WELLINGTON AVE.	VENTNOR
BERGEN	153	HACKENSACK	405 RT. # 17 SOUTH	HACKENSACK
BERGEN	155	N. HACKENSACK	450 HACKENSACK AVE.	HACKENSACK
*BERGEN	177	FORT LEE	1475 BERGEN BOULEVARD	FORT LEE
*BERGEN	181	ELMWOOD PARK	58 BROADWAY	ELMWOOD PARK
BERGEN	190	EDGEWATER COMMON	481 RIVER ROAD	EDGEWATER
BERGEN	194	BERGENFIELD	80 NEW BRIDGE ROAD	BERGENFIELD
BERGEN	198	FAIRLAWN	22-00 MAPLE AVE.	FAIRLAWN
BERGEN	299	RAMSEY	10 TRIANGLE 17 PLAZA	RAMSEY
BURLINGTON	526	EDGEWATER	4355 RT. # 130	EDGEWATER PARK
CAMDEN	546	CHURCH ROAD	989 CHURCH ROAD	CHERRY HILL
CAMDEN	551	LAWNSIDE	130 WHITE HORSE PIKE	LAWNSIDE
*CAMDEN	591	CAMDEN	2881 MT. EPHRAIM AVE.	CAMDEN
CUMBERLAND	595	MILLVILLE	2225 NORTH 2ND STREET	MILLVILLE
ESSEX	125	BELLEVILLE	726 WASHINGTON AVE.	BELLEVILLE
ESSEX	128	BELMONT	115 BELMONT AVE.	BELLEVILLE
ESSEX	186	FERRY STREET	281-295 FERRY STREET	NEWARK
ESSEX	223	BERGEN STREET	167 BERGEN STREET	NEWARK
ESSEX	224	LYONS PLAZA	47-79 LYONS AVE.	IRVINGTON
ESSEX	270	S. ORANGE	407 VALLEY STREET	SOUTH ORANGE
ESSEX	280	MONTCLAIR	35 LACKAWANNA PLAZA	MONTCLAIR
*ESSEX	281	LIVINGSTON	277 EISENHOWER PARKWAY	LIVINGSTON
GLOUCESTER	539	DEPTFORD	1450 CLEMENTS BRIDGE RD.	DEPTFORD
HUDSON	112	JERSEY CITY	321 ROUTE 440 & KELLOGG ST.	JERSEY CITY
HUDSON	114	OLD COLONY SQ.	420 GRAND STREET	JERSEY CITY
HUDSON	178	WEEHAWKIN	4100 PARK AVE.	WEEHAWKIN
HUDSON	180	NORTH BERGEN	2119 69TH ST/TUNNELLY AVE	NORTH BERGEN
HUDSON	189	KEARNY	145 PASSAIC AVE.	KEARNY
MIDDLESEX	425	S. PLAINFIELD	4999 STELTON ROAD	SOUTH PLAINFIELD
MIDDLESEX	527	HOPELAWN	95-100 N. BRUNSWICK AVE	HOPELAWN
MIDDLESEX	535	EDISON	561 RT. # 1	EDISON
MIDDLESEX	536	N. BRUNSWICK	1345 RTE. # 1	N. BRUNSWICK
MIDDLESEX	538	E. BRUNSWICK	50 RACE TRACK ROAD	E. BRUNSWICK
MIDDLESEX	580	WOODBIDGE	1600 ST. GEORGES AVE.	AVENEL
MIDDLESEX	581	OLD BRIDGE	1043 US HWY # 9	OLD BRIDGE
MONMOUTH	571	MARLBORO	120 RT 9-MARLBORO PLAZA	ENGLISHTOWN
MONMOUTH	573	HAZLET	3020 HWY # 35	HAZLET
MONMOUTH	576	HOWELL	4578 HWY # 9	HOWELL
MONMOUTH	577	MIDDLETOWN	1123 HWY # 35	MIDDLETOWN
MORRIS	261	LANDING	175 LAKESIDE BOULEVARD	LANDING
MORRIS	282	PARSIPPANY	1157 RT. 46 EAST	PARSIPPANY
MORRIS	284	KINNELON	25 KINNELON RD.	KINNELON
MORRIS	286	LAKESIDE	757 LAKESIDE CTR. RT 15 NORTH	WOODPORT
*MORRIS	287	WHIPPANY	831 ROUTE 10	WHIPPANY
MORRIS	437	GILLETTE	977 VALLEY ROAD	GILLETTE
OCEAN	578	BRICKTOWN	1930 STATE HWY # 88	BRICK
OCEAN	582	TOMS RIVER	1256 INDIAN HEAD ROAD	TOMS RIVER
OCEAN	594	MANAHAWKIN	517 ROUTE 72 WEST	MANAHAWKIN
PASSAIC	175	BOTANY PLAZA	85 ACKERMAN AVE.	CLIFTON
PASSAIC	185	CLIFTON	895 PAULISON AVE.	CLIFTON
PASSAIC	196	W. PATERSON	1710 PLAZA 46 WEST, ROUTE 46	WEST PATERSON

SOMERSET	425	SOUTH PLAINFIELD	3600 PARK AVENUE	SOUTH PLAINFIELD
SOMERSET	436	MIDDLESEX	242 LINCOLN BLVD.	MIDDLESEX
SOMERSET	440	HILLSBOROUGH	315 ROUTE 206	HILLSBOROUGH
UNION	288	ELMORA	211 ELMORA AVE.	ELIZABETH
UNION	450	GARWOOD	10 SOUTH AVE.	GARWOOD
UNION	452	UNION	2463 RT. 22 WEST	UNION
UNION	512	LINDEN	651 NORTH STILES ST.	LINDEN

*** NO PHARMACY AVAILABLE**

NEW JERSEY STATE ORGANIZATION OF CYSTIC FIBROSIS
PHARMACEUTICAL SERVICES FOR ADULTS WITH CYSTIC FIBROSIS

WEGMAN'S SELECTION FORM

You can shop at any of the Wegman's listed below.

Wegmans Bridgewater	724 Route 202 South, Bridgewater, NJ 08807
Wegmans Cherry Hill	2100 Route 70 West, Cherry Hill, NJ 08002
Wegmans Manalapan	55 U.S. Highway 35, Englishtown, NJ 07726
Wegmans Mt. Laurel	2 Centeron Road, Mt. Laurel, NJ 08054
Wegmans Ocean	1104 Highway 35, Ocean, NJ 07712
Wegmans Princeton	240 Nassau Park Boulevard, Princeton, NJ 08540
Wegmans Woodbridge	15 Woodbridge Center Drive, Woodbridge, NJ 07095

NJSOCF will provide you with a Wegman's card.

Please sign this form and return.

DATE: _____

SIGNATURE _____

PRINT YOUR NAME _____

FOR OFFICE USE:

CLIENT NUMBER _____