**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 $43,301/year.**

## COMPLETE THE APPLICATION AND RETURN IT WITH ALL REQUIRED DOCUMENTS TO:

**NJ State Organization of Cystic Fibrosis**
**PO Box 3648**
**Wayne, NJ 07474-3648**

## THE DOCUMENTS NEEDED TO PROCESS YOUR APPLICATION ARE:

- **Completed "Application".**
  - **Copy of your NJ 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 2008 Federal Tax Return with all W2's and/or your SSI Benefits Statement.**
- **Signed and completed "Pathmark Selection Form".**

***Failure to submit ALL of the above items will delay your acceptance into the 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**________________________**BEST TIME TO CALL**____________________

**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)

| NAME | DATE OF BIRTH | RELATIONSHIP |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## 2. NAME AND ADDRESS OF PARENTS

**NAMES** ____________________________________________________________________________

**ADDRESS**_______________________________________________________**PHONE #** _________________________

**ARE YOU EMPLOYED?**_______**A STUDENT?**______**ON SOCIAL SECURITY?** _____ **OTHER** ______________________________

## 3. IF EMPLOYED, PLEASE SUPPLY NAME, ADDRESS AND PHONE # OF EMPLOYER

**EMPLOYER**_______________________________________________________**PHONE #**_________________________

**ADDRESS** ___________________________________________________________________________

**FULL OR PART TIME** _________________**OCCUPATION**_____________________________________________

## 4. IF A STUDENT, PLEASE SUPPLY NAME AND ADDRESS OF SCHOOL, AND MAJOR

**SCHOOL**______________________________________________ **DEGREE**_________________________________

**ADDRESS**_______________________________________________________ **FULL OR PART TIME** ______________

## 5. 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)

(Part 2 of 2)

**6. LIST ALL PEOPLE AND ORGANIZATIONS CONTRIBUTING TO YOUR FINANCIAL SUPPORT**

| NAME | ADDRESS | PHONE# | ANNUAL $ SUPPORT |
|---|---|---|---|
| | | | $ |
| | | | |
| | | | |

**7. CURRENT CF PHYSICIAN:** ____________________

**ADDRESS** ____________________ **PHONE #** ____________________

**8. CURRENT NUTRITIONIST OR DIETITIAN:** ____________________

**ADDRESS** ____________________ **PHONE #** ____________________

**9. LIST YOUR CURRENT PRESCRIPTION MEDICATIONS:** ____________________

____________________

____________________

____________________

**10. LIST YOUR CURRENT NUTRITIONAL SUPPLEMENTS:** ____________________

____________________

____________________

____________________

**11. 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** ____________________

**PATIENT AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE**
**(HIPAA compliant)**

I, ___________________________________, hereby authorize the **New Jersey State Organization of Cystic Fibrosis,** 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 the **New Jersey State Organization of Cystic Fibrosis, 555 Preakness Avenue, Totowa, New Jersey 07512, (973-595-1232)** or to any representative from said organization. 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 the authorization shall be as valid as the original. 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. 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 regulation.

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

I have authorized the **New Jersey State Organization of Cystic Fibrosis** to receive information in connection with **Pharmaceutical Services for Adults with Cystic Fibrosis.**

Your full cooperation with the New Jersey State Organization of Cystic Fibrosis is hereby requested.

____________________________________________ Date ___________________
**Signature**

____________________________________________
**Print Name**

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

# INCOME AND ACCEPTANCE AFFIDAVIT

**FOR THE GRANT YEAR JULY 1, 2009- JUNE 30, 2010**

**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 $43,301.**

**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,**

**a notary public, this___________**

**day of ______________________, 2009.**

____________________________________

**NOTARY PUBLIC, State of New Jersey**

# NEW JERSEY STATE ORGANIZATION OF CYSTIC FIBROSIS

## *PHARMACEUTICAL SERVICES FOR ADULTS WITH CYSTIC FIBROSIS*
## INSURANCE AFFIDAVIT

## FOR THE GRANT YEAR JULY 1, 2009– JUNE 30, 2010

**INCLUDE COPIES OF ALL INSURANCE CARDS**

***HEALTH INSURANCE***

**PRIVATE_______MEDICARE_______ MEDICAID_______FAMILY CARE_______NO INSURANCE________**

**PLAN NAME___________________________________________POLICY OR ID #___________________________**

**ADDRESS__________________________________________________________________________________**

**_______________________________________________PHONE#________________________________________**

**EFFECTIVE DATE:_________________________ANNUAL DEDUCTIBLE ______________________________**

**MY CO-PAYMENT OR COVERAGE IS: ____________________________________________________________**

***SECONDARY COVERAGE, IF ANY***

**PLAN NAME___________________________________________POLICY OR ID # ___________________________**

**ADDRESS ______________________________________________PHONE#___________________________________**

**EFFECTIVE DATE:_____________________________ANNUAL DEDUCTIBLE ____________________________**

**MY CO-PAYMENT OR COVERAGE IS:_______________________________________________________________**

***PRESCRIPTION DRUGS***

**PRIVATE_______ MEDICARE PART D _______ MEDICAID_______ PAAD_______ NO INSURANCE________**

**PLAN NAME___________________________________________POLICY OR ID # ____________________________**

**ADDRESS ______________________________________________PHONE#___________________________________**

**EFFECTIVE DATE:______________________________ANNUAL DEDUCTIBLE ____________________________**

**MY CO-PAYMENT OR COVERAGE IS :______________________________________________________________**

**I DO NOT HAVE medical insurance coverage: ( ) I DO NOT HAVE prescription insurance 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 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.**

**PLEASE PRINT NAME_______________________________________________________**

**Date ________________________ Signature____________________________________**

**Sworn to and subscribed before me,**

**a notary public, this___________**

**day of ______________________, 2009.**

**____________________________________**

**NOTARY PUBLIC, State of New Jersey**

**NEW JERSEY STATE ORGANIZATION OF CYSTIC FIBROSIS**

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**P.O. Box 3648 • Wayne • New Jersey 07474**
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# PATHMARK SELECTION FORM

**FROM THE ENCLOSED LIST OF PATHMARK STORES IN NEW JERSEY, SELECT ONE STORE YOU WILL USE FOR MAKING APPROVED PURCHASES OF FOOD, NUTRITIONAL SUPPLEMENTS AND PRESCRIPTION DRUGS.**

**PLEASE NOTE THAT THE PARTICIPANT ON THE PROGRAM IS THE ONLY PERSON PERMITTED TO USE THIS CARD, UNLESS SPECIAL PROVISIONS ARE ARRANGED.**

**DATE _____/_____/_______**

**STORE # ________**

**STORE NAME_______________________________________________**

**PRINT YOUR NAME____________________________________________________**

**CLIENT NUMBER______________________________________________________**

**SIGNATURE__________________________________________________________**

**PATHMARK STORES** **NEW JERSEY BY COUNTY**

| | COUNTY | # | STORE NAME | ADDRESS | CITY |
|---|---|---|---|---|---|
| | ATLANTIC | 575 | PLEASANTVILLE | ROUTE 40 & WOODLAND RD | CARDIFF |
| | 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 | 2110 RT. # 130 | BEVERLY |
| | 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 | 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 | 200 | W. ORANGE | 345 PROSPECT AVE. | WEST ORANGE |
| | ESSEX | 223 | BERGEN STREET | 167 BERGEN STREET | NEWARK |
| | ESSEX | 224 | LYONS PLAZA | 474-79 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 | ROUTE 440 & KELLOGG ST. | JERSEY CITY |
| | HUDSON | 114 | OLD COLONY SQ. | 422 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 | WOODBRIDGE | 1600 ST. GEORGES AVE. | WOODBRIDGE |
| | MIDDLESEX | 581 | OLD BRIDGE | 1043 US HWY # 9 | OLD BRIDGE |
| | MONMOUTH | 571 | MARLBORO | 120 RT 9-MARLBORO PLAZA | ENGLISHTOWN |
| | MONMOUTH | 572 | EATONTOWN | 50 HWY # 36 | EATONTOWN |
| | MONMOUTH | 573 | HAZLET | 3020 HWY # 35 | HAZLET |
| | MONMOUTH | 574 | FREEHOLD | 100 SCHANCK RD. | FREEHOLD |
| | MONMOUTH | 576 | HOWELL | 2216 HWY # 9 | HOWELL |
| | MONMOUTH | 577 | MIDDLETOWN | 1123 HWY # 35 | MIDDLETOWN |

| | | | | | |
|---|---|---|---|---|---|
| | MONMOUTH | 579 | WALL | 1933 HWY # 35 | WALL |
| | 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 | LAKESIDE CTR. RT 15 NORTH | LAKE HOPATCONG |
| * | MORRIS | 287 | WHIPPANY | 831 ROUTE 10 | WHIPPANY |
| | MORRIS | 289 | RANDOLPH | K-MART PLAZA-ROUTE 10 | RANDOLPH |
| | MORRIS | 437 | GILLETTE | 977 VALLEY ROAD | GILLETTE |
| | OCEAN | 578 | BRICKTOWN | 1930 STATE HWY # 88 | BRICKTOWN |
| | OCEAN | 582 | TOMS RIVER | 1334 LAKEWOOD RD. | TOMS RIVER |
| | OCEAN | 594 | MANAHAWKIN | 525 ROUTE 72 WEST | MANAHAWKIN |
| | PASSAIC | 175 | BOTANY PLAZA | 85 ACKERMAN AVE. | CLIFTON |
| | PASSAIC | 185 | CLIFTON | 895 PAULISON AVE. | CLIFTON |
| | PASSAIC | 193 | PATERSON EAST | 498 EAST 30TH STREET | PATERSON |
| | PASSAIC | 196 | W. PATERSON | PLAZA 46 WEST, ROUTE 46 | WEST PATERSON |
| | SOMERSET | 423 | N. PLAINFIELD | 1280 ROUTE 22 | NORTH PLAINFIELD |
| | SOMERSET | 436 | MIDDLESEX | 242 LINCOLN BLVD. | MIDDLESEX |
| | SOMERSET | 438 | SOMERVILLE | 100 VETERANS MEM. DR. | SOMERVILLE |
| | SOMERSET | 440 | HILLSBOROUGH | 315 ROUTE 206 | HILLSBOROUGH |
| | UNION | 288 | ELMORA | 211 ELMORA AVE. | ELIZABETH |
| | UNION | 450 | GARWOOD | 10 SOUTH AVE. | GARWOOD |
| | UNION | 452 | UNION | RT. 22 & SPRINGFIELD RD. | UNION |
| | UNION | 512 | LINDEN | 651 NORTH STILES ST. | LINDEN |

* **NO PHARMACY AVAILABLE**

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