

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 \$44,273/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 **2010 Federal Income Tax Return with all W2’s, 1099’S and/or your SSI Benefits Statement**
- Signed “**Signature Form**” for Pathmark, A&P or Wegmans. You can only shop at one or the other
- Signed “**Patient Authorization for Health Information Disclosure**” (HIPPA compliant)

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 _____ 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, 1099'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>

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, 2011 – JUNE 30, 2012

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 "Pharmaceutical Services for Adults with Cystic Fibrosis" to NJSOCF.

DATE _____

SIGNATURE OF APPLICANT

PLEASE PRINT NAME

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

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, 2011 – JUNE 30, 2012

According to the terms of “Pharmaceutical Services 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 \$44,273.

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 are at the discretion of 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 _____, .

A Notary Public of New Jersey

**PATIENT AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE
(HIPPA 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 HIPPA 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.

Signature

Date _____

Print Name

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

SIGNATURE FORM

PATHMARK, A&P or WEGMANS

Please sign and complete Signature Form for your Food & Nutritional Supplements ID card.

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

DATE: _____

SIGNATURE _____

PRINT YOUR NAME _____

FOR ADDITIONAL CARD:

SIGNATURE _____

PRINT NAME _____

RELATIONSHIP TO YOU _____

FOR OFFICE USE:

CLIENT NUMBER _____

STORE NUMBER _____

STORE NAME _____