



REACH
FOR THE STARS
FOUNDATION
TO BENEFIT INDIVIDUALS
WITH CYSTIC FIBROSIS

GRANT APPLICATION

**FOR ASSISTANCE WITH
CYSTIC FIBROSIS NEEDS**



**Reach for the Stars Foundation
Application for Assistance**

Patient Information:

Please complete all of the requested information to the fullest extent possible. If a section does not apply to your situation, please note “N/A” in that area.

Assistance is only available to United States Citizens. Requested copies of income documentation must be submitted in order for the application to be fully reviewed. Information may be submitted by fax or mail.

For clarification on any section of the application please call the Reach for the Stars Foundation at 305-865-5588

SECTION 1 – Description of Assistance Requested

Please give a brief description of the assistance requested at this time from the Reach for the Stars Foundation, **including an approximate monetary amount:**

SECTION 2 - Patient Information

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____

Social Security Number: _____ Date of Birth: _____

Gender: ___ Male ___ Female

Have you previously submitted an application to the Reach for the Stars Foundation?
_____ Yes _____ No

If yes, please supply the date. _____

Latest Pulmonary Functions (including height & weight): _____

Employment Information (Patient)

Complete this section only if the patient is employed:

Employer: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Work Telephone: _____ Employed Since: _____

Is the patient a dependent of another individual, as defined for IRS tax reporting purposes on the IRS Form 1040? Yes ___ No ___

SECTION 3 – Parent/Guardian Information

Complete Following Section only if the patient is a dependent of parent or guardian applying on behalf of the patient.

Name: _____

Relationship to Patient: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____

Social Security Number: _____ Date of Birth: _____

Employer: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Work Telephone: _____ Employed Since: _____

Second Parent/Guardian Information

Name: _____

Relationship to Patient: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____

Social Security Number: _____ Date of Birth: _____

Employer: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Work Telephone: _____ Employed Since: _____

SECTION 4 – Health 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 durable medical equipment (nebulizers, compressors)?

____ Yes ____ No

2. Secondary Insurance Coverage

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 durable medical equipment (nebulizers, compressors)?
_____ 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? _____
If yes, please explain:

Number of dependent children in the family: _____

Please provide a description of current special financial needs:

Annual *out-of-pocket* medical expenses (expenses that you incurred that were not reimbursed by insurance) last calendar year.

Hospital \$ _____ Drugs \$ _____

Doctor \$ _____ Other (including deductibles) \$ _____

Health Insurance Premium cost you must pay \$ _____

AUTHORIZATION FOR BANKING AND FINANCIAL RECORDS

Miami, Florida

Date:

Re: Determination of Eligibility of Financial Assistance from the Foundation

TO WHOM IT MAY CONCERN:

This authorizes all banking, financial institutions, credit bureaus, creditors, and any other individuals and/or entities in possession of any financial information related to me to furnish full and complete records to **The Reach for the Stars Foundation to Benefit Individuals with Cystic Fibrosis, Inc., 1025 Kane Concourse, Suite 207, Bal Harbor Islands, Florida 33154, {Tel: (305) 865-5588}**.

This further authorizes the examination of all banking and financial records that will aid representatives of the Foundation to determine whether I am eligible for financial assistance from the Foundation.

You are directed to disclose financial information to no other party.

_____(SEAL)
(Print name here with social security number)

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

I, _____, hereby authorize **The Reach for the Stars Foundation to Benefit Individuals with Cystic Fibrosis, Inc.** 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 Reach for the Stars Foundation to Benefit Individuals with Cystic Fibrosis, Inc., 1025 Kane Concourse, Suite 207, Bay Harbor Islands, Florida 33154, {Tel: (305) 865-5588}** or to any representative from said foundation. Should you have questions with this request, please call us and reference our client's name or date of accident.

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 re-disclosed 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 /CT-scan films, questionnaires, applications, and the furnishing of any other information including opinions.

I have authorized **The Reach for the Stars Foundation to Benefit Individuals with Cystic Fibrosis, Inc.** to collect my medical records in connection with _____.

Your full cooperation with **The Reach for the Stars Foundation to Benefit Individuals with Cystic Fibrosis, Inc.**, is hereby requested. Please do not disclose any medical information to any insurance adjuster or any other person without written authority from myself.

_____ Birth Date: ____/____/_____
Signature **Date**

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

SWORN TO AND SUBSCRIBED before me this ____ day of _____, 200____,
by, _____ who is personally known to me or has produced _____
as identification.

NOTARY PUBLIC

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. 6 months (or more) proof of out-of-pocket expenses
6. **Copies of bills for which assistance is being requested**
7. 24 months of medical and/or hospital history
8. Proof of diagnosis and condition from treating physician
9. Letter from program social worker outlining situation

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 Reach for the Stars 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 Reach For The Stars 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. The Reach for the Stars Foundation retains the right to periodically monitor and assess the recipients continued compliance with the goals of the foundation.

Signature _____

Date _____

Fax or Mail documentation and signed copy of SECTION 8 to:



REACH FOR THE STARS FOUNDATION
1025 Kane Concourse #207
Bay Harbor Islands, FL 33154
Fax: (305) 865-5589

