



CFPAF Application Checklist

The Cystic Fibrosis Patient Assistance Foundation (CFPAF) looks forward to receiving your application. We want to ensure that you send us all necessary components of the application to prevent any delays in processing.

Please use the checklist below to help you in determining the necessary documents. All supporting materials must match the information on the application. Incomplete applications will delay processing times.

- CFPAF application (2 pages total)
 - Ensure that all sections and fields are completed and that the patient has signed and dated the last page of the application
 - Date on application must be current.
- Copy of insurance cards (front and back)
- Household income verification document:
 - Option 1: Page 1 and 2 of Federal Income Tax form (1040). Must be signed and dated.
 - Option 2: If unable to provide a signed 1040, submit a notarized letter AND one of the following supporting documents for each member of the household who earns an income.
 - A W2, a 1099, 3 consecutive paystubs, an Unemployment Insurance award letter, retirement benefit statements, 3 months bank statements showing deposits, or a Supplemental Security/Social Security Disability award letter
 - The notarized letter template may be downloaded from the CFPAF Web site.
- Residency verification document – include ONE item from the list below:
 - Utility bill
 - Mortgage, rent or bank statement
 - Driver's license

You may send us your application and accompanying documents by fax or mail. Application documents are not accepted via e-mail.

Fax (877) 868-5952

Mail Cystic Fibrosis Patient Assistance Foundation
6931 Arlington Road, 2nd Floor
Bethesda, MD 20814

Phone number: (888) 315-4154

Hours of operation: Monday – Friday, 8:30 A.M. – 5:30 P.M. EST

Website address: www.cfpa.org

CFPAF Program Application

Patient Information

Last Name First Name Middle Initial

Date of Birth (mm/dd/yy) Gender Male Female

Home Address City State Zip Code

Home Phone # Cell Phone # E-mail address

Marital Status Single Married Primary Language Spoken English Spanish Other

Is the patient under the age of 18? Yes No If yes, enter parent/guardian information below

Contacts authorized to provide and receive information on patient's behalf:

Name Relationship Phone number

Name Relationship Phone number

Has the patient been diagnosed with CF? Yes No

Current Pharmacy Provider CF Doctor

CF Medications Information: Please list the FDA approval drugs your doctor has prescribed for inhalation, nebulized treatment of cystic fibrosis pulmonary disease, and/or medications for the treatment of pancreatic insufficiency.

CF Medication	Dosage*	Frequency*	Patient payment* Per 30 or 90 day fill	Date of last fill*
Inhaled medicines				
Enzymes		(# per day)		

*Contact your pharmacy if the information is unknown.

- Please check box if you need co-pay assistance.**
- Please check box if you need assistance with completion for Social Security application.**

Insurance

Do you have any form of insurance?

- Medicare Part B Yes No (if yes, complete "benefit section" on the next page)
- Medicare Part D Yes No (if yes, complete "benefit section" on the next page)
- Medicaid Yes No (if yes, complete "benefit section" on the next page)
- Commercial Yes No (if yes, complete "benefit section" on the next page)

Income

Number of people in your household
(Yourself, your spouse and dependents)

Total combined income

(Yourself, your spouse and dependents)

\$ Monthly OR \$ Yearly

Proof of income: Please remember to submit proper proof of household income documentation. Income documents MUST MATCH total combined income listed above.

CFPAF Program Application

Benefit Section

Primary insurer

Phone number

Subscriber

Subscriber DOB (mm/dd/yy)

Relationship to patient

Identification #

Group #

Secondary insurer

Phone number

Subscriber

Subscriber DOB (mm/dd/yy)

Relationship to patient

Identification #

Group #

Other Support (Co-pay Card) Programs

CFPAF requires insured patients to utilize applicable co-pay card programs. Patients will be responsible for any costs that would otherwise be covered by these programs. Please specify each program and enrollment details.**

Name of Program

Medication supported

Co-pay card ID Number

Name of Program

Medication supported

Co-pay card ID Number

Name of Program

Medication supported

Co-pay card ID Number

Name of Program

Medication supported

Co-pay card ID Number

**Please provide copies of cards, enrollment/denial/limit letters from assistance programs.

Consent Information

I **give** CFPAF, the program administrators, permission to:

- Verify the information I submit for accuracy & completeness
- Contact me to ensure I have received program-approved medicines
- Contact me to obtain additional information

I **confirm** that:

- All information in this application, including attachments containing proof of income, is accurate and complete
- I am authorized to sign this application

I **understand** that I can call (888)315-4154 at any time during business hours to:

- Withdraw from the program
- Cancel permission to use my information
- Discuss my enrollment or ask questions

I **understand** that the program will use my information to:

- Determine if I qualify for assistance from the CFPAF
- Identify possible alternative assistance resources for the patient
- Communicate with insurance carriers including Medicare Part D plans
- Administer or improve the program

If **accepted** into the CFPAF program:

- I agree to use my health insurance as primary payment on any therapies approved by the CFPAF.
- I understand that enrollment in the CFPAF is contingent upon availability of funding.
- I agree to inform the CFPAF of any changes to my income or insurance benefits during my enrollment period.
- I am free to seek care from any provider or to switch insurance at my discretion without affecting eligibility.
- I am free to change or add a CFF eligible product, with prior notification to the CFPAF, without affecting eligibility.
- I agree that I will not obtain reimbursement from any other source for the same product/transaction for which CFPAF provides assistance.

Signature of Patient or Legal Guardian

X _____

Date _____

Questions? Call (888) 315-4154 or visit www.cfpa.org