Breathe for Bea

https://www.breatheforbea.org

Breathe for Bea Foundation Financial Assistance Application

Aid overview and application instructions

Aid Details: Currently, we are giving up to $500 for each approved request. However, this amount is set at the discretion of the Foundation and may be increased under certain circumstances. As our Foundation grows, it is our hope to increase the maximum amount of assistance we can provide.

Eligibility Criteria: The Breathe for Bea Foundation is currently only able to offer assistance to patients and families that are U.S. citizens. Please include documents along with this application that provide proof of residency and citizenship.

Selection Criteria: The Foundation will take into consideration each applicant's financial need at the time that the application is received.

Application Instructions: Please read the instructions below. If you have any questions, please email us at info@breatheforbea.org.

1. Complete this entire application – including all relevant sections to you - and please submit all requested additional information, including proof of U.S. citizenship, recent pay stub(s) or income tax return(s), a letter from your doctor confirming a diagnosis of Cystic Fibrosis, and copies of unpaid bills and/or expenses that you are asking for help with. If there are items that are not relevant to you, write N/A.
2. Mail the completed application and all supporting documents to:

   Breathe for Bea Foundation
   11 Richfield Circle
   Carver, MA 02330

   You may also email the completed application and all supporting documents to info@breatheforbea.org.
3. Once we receive the completed application, including all requested supporting documents, the Foundation will review and will contact you and any other necessary contacts if we have any questions about your request, or need to clarify or verify any information. We try to review applications in a timely manner, but if assistance is needed immediately, please contact us directly. Once we have come to a decision on an application, we will get in touch to discuss. Rest assured that all applications will be reviewed and responded to.

Personal Information of the Individual with Cystic Fibrosis

Date of Request: _____

Name: First: _____ Last: _____

Gender: _____

Age: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Phone #: _____

What type of health insurance coverage do you have? _____

What is your yearly deductible? _____

What is your co-payment? _____

Please provide the name of your CF hospital/clinic/treatment center and its contact info:

_____

Please provide your CF facility social worker's name and his or her contact info:

_____

Please provide the name of your physician and his or her contact info:

_____

What are you seeking assistance with? Prescriptions/hospital or doctor's bills/surgery costs? Please be specific:

_____

Have you applied for financial aid from the Breathe for Bea Foundation before? _____

Did you receive any aid? _____

Are you currently receiving financial assistance from any other sources? If yes, please list:

_____

How did you learn about the Breathe for Bea Foundation? _____

Fill this Section Out Only if Person Requesting Assistance is Not the Individual with Cystic Fibrosis

Name: First: _____ Last: _____

Relationship to Individual with Cystic Fibrosis: _____

Fill this Section Out Only if the Individual with Cystic Fibrosis is an Adult

Applicant's Yearly Income: _____

Marital Status (married/single): _____

Spouse Name (if married): _____

Spouse's Yearly Income (if married): _____

Please include a copy of pay stub(s) or most recent income tax return(s)

Fill this Section Out Only if the Individual with Cystic Fibrosis is a Minor (or if an Adult and Parent(s) Still Support(s))

Mother's Name: _____

Address (if same as individual with CF's address, write same):

_____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Mother's Yearly Income: _____

Email: _____

Phone Number: _____

Father's Name: _____

Address (if same as mother's address, write same):

_____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Father's Yearly Income: _____

Email: _____

Phone Number: _____

Please include a copy of pay stub(s) or most recent income tax return(s)

Are there any other children in the family? If yes, please list ages:

_____

Applicant's Request for Aid

1. Please describe in detail, in one or two paragraphs, the financial assistance you are requesting, why you need it at this time, and how the Breathe for Bea Foundation could provide it to you.

2. Please send a copy of **only** the item(s) that you need assistance with, such as the below examples. Please note that **these are only examples**.

    1. A copy of unpaid bills from the hospital, doctor, or pharmacy
    2. A copy of hotel expenses incurred while child or spouse is in the hospital
    3. A copy of un-reimbursed medical equipment

Please note that if you are applying for help with certain bills, such as hospital bills, it may be possible to receive aid directly from the source of the bill. If you have been denied aid by these sources, please provide us with their letter of denial.

3. Please send a letter from your doctor confirming a diagnosis of Cystic Fibrosis.
4. Please provide proof of residency and citizenship of individual with CF, such as a photocopy of birth certificate or driver's license, as well as proof of residency and citizenship of the person who assistance is being requested for, if different than the individual with CF.

Consent to Review Financial Information

I give permission to the Breathe for Bea Foundation to view the information on this application and the information in all submitted additional documents.

Applicant's Signature: _____ Date _____

Complete the below section if you are providing financial information for anyone other than yourself.

Signature: _____ Relationship to Applicant: _____ Date: _____

Signature: _____ Relationship to Applicant: _____ Date: _____

Signature: _____ Relationship to Applicant: _____ Date: _____

****All financial information will be kept strictly confidential****

Application Certification

The Breathe for Bea Foundation is a non-profit organization committed to raising funds for individuals with Cystic Fibrosis, as well as families with a loved one with CF to care for. The need for assistance and the number of applications for aid received by the Foundation may exceed our resources. Consequently, the Foundation cannot guarantee that all applicants will receive funding from the Foundation. All aid is provided on a case by case basis within the sole discretion of the Foundation. The application process has no exclusions as to race, ethnicity, gender, age, sexual orientation or family characteristics.

I certify that the information presented in my application is accurate and complete. I understand and agree that any inaccurate information, misleading information or omission will be cause for the invalidation of any financial aid offered to me. I also understand and agree that the Breath for Bea Foundation may verify any and all parts of my application materials.

Applicant's Signature: _____ Date: _____

Parent/Guardian Signature (if applicant is under the age of 18):

_____ Date: _____