

**Making Miracles for Cystic Fibrosis  
GRANT FORM**

**Cystic Fibrosis Patient:**

1. Full Name: \_\_\_\_\_
2. Soc. Sec. No.: \_\_\_\_\_
3. Date of Birth: \_\_\_\_\_
4. Address: \_\_\_\_\_  
\_\_\_\_\_
5. Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (alt) \_\_\_\_\_
6. Name of Insurance Carrier and Plan No. \_\_\_\_\_
7. Is CF Patient Covered by Medicaid? \_\_\_\_\_
8. Is CF Patient Covered by Medicare? \_\_\_\_\_
9. Name Any Government Assistance That CF Patient Receives or Has Received in the Past Five Years: \_\_\_\_\_  
\_\_\_\_\_

10. **CF Patient**

- a) Occupation: \_\_\_\_\_
- b) Employer: \_\_\_\_\_
  - 1) Name and telephone number of person at work who can verify income:  
\_\_\_\_\_
- c) Annual Income for Each of the Past Five Years: \_\_\_\_\_
  - 1) Name all current sources of income and the amount of income from each source: \_\_\_\_\_

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11. **Spouse**

a) Occupation: \_\_\_\_\_

b) Employer: \_\_\_\_\_

1) Name and telephone number of person at spouse's work who can verify income:

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c) Annual Income for Each of the Past Five Years: \_\_\_\_\_

1) Name all current sources of income and the amount of income from each source: \_\_\_\_\_

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12. Full name and date of birth of each member of household who also has Cystic Fibrosis:

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13. Attach a copy of the front page of last year's tax return.

**Applicant: (Only complete if Applicant is different than CF patient)**

1. Full Name: \_\_\_\_\_

2. Relationship to Cystic Fibrosis Patient: \_\_\_\_\_

3. Soc. Sec. No.: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Address, if different than CF Patient: \_\_\_\_\_

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6. Telephone, if different than CF Patient:

(home)\_\_\_\_\_ (work)\_\_\_\_\_ (alt)\_\_\_\_\_

7. Is Applicant Covered by Medicaid?\_\_\_\_\_

8. Is Applicant Covered by Medicare?\_\_\_\_\_

9. Name Any Government Assistance That Applicant Receives:\_\_\_\_\_

\_\_\_\_\_

10. **Applicant**

a) Occupation:\_\_\_\_\_

b) Employer:\_\_\_\_\_

1) Name and telephone number of person at work who can verify income:

\_\_\_\_\_

c) Annual Income for Each of Past Five Years:\_\_\_\_\_

1) Name of current sources of income and the amount of income from each source:\_\_\_\_\_

\_\_\_\_\_

11. **Spouse**

a) Occupation:\_\_\_\_\_

b) Employer:\_\_\_\_\_

1) Name and telephone number of person at work who can verify income:

\_\_\_\_\_

c) Annual Income for Each of the Past Five Years:\_\_\_\_\_

1) Name of current sources of income and the amount of income from each

source: \_\_\_\_\_  
\_\_\_\_\_

12. Full name and date of birth of each member of household who also has Cystic Fibrosis:  
\_\_\_\_\_  
\_\_\_\_\_

13. Attach a copy of the front page of last year's Federal Income Tax return

14. Purpose of Grant Applied For: \_\_\_\_\_

15. State in detail each entity, government agency, charity and/or other entity to which either applicant and/or CF patient has applied for the same or similar grant: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. State why you should be entitled to a grant from Cystic Fibrosis - Hope for Alabama:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. State the amount of money requested: \_\_\_\_\_

18. Name and telephone number of sponsor (nurse, social worker, or other person): \_\_\_\_\_  
\_\_\_\_\_

Applicant and CF Patient agree to allow Making Miracles for Cystic Fibrosis to obtain their medical records and financial records and discuss such records, treatments, financial information,

and/or other information pertaining to Applicant and CF Patient with treating physicians, Alabama Medicaid, Medicare, any insurance company, any government employee, and/or any other person or entity deemed appropriate by Making Miracles for Cystic Fibrosis. Applicant and CF Patient agree to allow Making Miracles for Cystic Fibrosis to use information and/or photographs regarding CF Patient, applicant, and/or their families in the promotion of Making Miracles for Cystic Fibrosis, to include the use of such information in a newsletter, fund raising letter, and/or any other form deemed appropriate by Making Miracles for Cystic Fibrosis.

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Signature of Applicant

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Signature of CF Patient