

PLEASE complete each item on the application form so that we can quickly process your application. Your answers to these questions will be kept completely confidential.

Section A	Contact and Household Information Please tell us who you are and how to contact you.		
NAME – Include your full name, including middle initial	First Name	Middle Initial	Last Name
PHONE – Give us a number where you can be reached if we need to contact you for more information	Home Phone # Area code () ____ - _____		Cell Phone # Area code () ____ - _____
HOME ADDRESS – This is the place where you currently live. You must show that you have been a NYS resident for at least the last 12 months. Written proof of residence must be provided (see Section G, page 6)	Street		Apt#
	City	State	Zip Code County
How long have you lived at this address?	_____ <input type="checkbox"/> Months <input type="checkbox"/> Years		
MAILING ADDRESS (if different from above)	Street		Apt#
	City	State	Zip Code County
Please list any other address that you have lived at during the last twelve months:			
OTHER ADDRESS	Street		Apt#
	City	State	Zip Code County
	Dates lived at this address	FROM _____ / _____ Month Year	TO _____ / _____ Month Year
EMAIL ADDRESS – List your email address			
HOUSEHOLD MEMBERS – List each person who lives with you and check the box that best describes the person’s relationship to you. (attach additional page(s) if necessary)			
NAME	RELATIONSHIP TO YOU		
	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other relative <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other		
	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other relative <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other		
	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other relative <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other		
	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other relative <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other		
Where did you hear about this program?	<input type="checkbox"/> Social Worker <input type="checkbox"/> CF Center <input type="checkbox"/> Website <input type="checkbox"/> Current Enrolled Program Participant <input type="checkbox"/> Other _____		

Section B Personal Information

SEX – Check one	<input type="checkbox"/> Male <input type="checkbox"/> Female
DATE OF BIRTH – Fill in the month, day, and year you were born. Written proof of age must be provided (see Section G, page 6)	____/____/____ Month Day Year
SOCIAL SECURITY NUMBER – Include your full Social Security #	____-____-____
MARITAL STATUS – Check one	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated

Section C Citizenship

Are you a United States citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes , Skip to Section D If No , answer each of the following questions:
What is your immigration status?		
Do you have a Permanent Resident Card (often referred to as Green Card or Form I-551)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes , what is your registration #?
NOTE: Written proof of citizenship for non-United States citizens must be provided (see Section G, page 6.)		

Section D CF Center Information

Do you receive care at a CF Center?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, which one?
Does a social worker provide services to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, what is the name and phone number of the social worker?
	Name
	Phone number

Section E Health Insurance Information

Do you have health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If No , go to Section E1. If Yes , skip to Section E2.
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Section E2 Health Insurance Policy Information

Policy #1 (Primary Health Insurance)

1. Contact Information	Name of Insurance Company	Telephone # Area () _____ - _____ code	Policy or member ID #
	Address - Street	City	State

Address - Street	City	State	Zip Code
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POLICYHOLDER'S NAME (if different from applicant)	Group # (if any)
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Which of the following medical expenses are covered by this insurance policy? (check all that apply)

Hospitalization Physicians' Visits Home Health Care Medical Equipment Prescription Drugs

Other(s) (please list) _____

2. Do you pay a premium for this insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If No , skip to Question 3 in this section. If Yes , answer each of the following questions:
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2a. How much is the premium for this policy?	\$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly
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3. Do you have prescription drug coverage under this insurance policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If No , skip to Question 4 in this section. If Yes , please answer each of the following questions:
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3a. Do you pay a co-pay for any of your medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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3b. Is there a maximum dollar amount that this policy will pay for prescriptions per year?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	If Yes , what is the maximum dollar amount per year? \$ _____
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3c. Does your insurance require that you use a specific pharmacy or pharmacies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes , list the pharmacies you use. _____ _____
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4. Is this insurance policy currently covering your CF-related expenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No If No , is this due to a waiting period related to a pre-existing condition? <input type="checkbox"/> No <input type="checkbox"/> Yes - Date the waiting period will end: ____/____/____ Month Day Year
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5. Do you have medical providers who do not accept this insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes , which of your providers do not accept this insurance? Physician(s) _____ Pharmacy _____ Home Health Agency _____ Hospital _____ (attach additional page(s) if necessary)
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NOTE: If this is your only Health Insurance Policy, skip to Section F, page 5. If you have an ADDITIONAL Health Insurance Policy, please complete Section E3.

Section E3 Health Insurance Policy Information

Additional Policy (Secondary Health Insurance)

1. Contact Information	Name of Insurance Company	Telephone # Area () ____ - ____ code	Policy or member ID #
	Address - Street	City	State Zip Code

POLICYHOLDER'S NAME (if different from applicant)	Group # (if any)
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Which of the following medical expenses are covered by this insurance policy? (check all that apply)

Hospitalization Physicians' Visits Home Health Care Medical Equipment Prescription Drugs

Other(s) (please list) _____

2. Do you pay a premium for this insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If No , skip to Question 3 in this section. If Yes , answer each of the following questions:
2a. How much is the premium for this policy?	\$_____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	

3. Do you have prescription drug coverage under this insurance policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If No , skip to Question 4 in this section. If Yes , please answer each of the following questions:
3a. Do you pay a co-pay for any of your medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3b. Is there a maximum dollar amount that this policy will pay for prescriptions per year?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	If Yes , what is the maximum dollar amount per year? \$_____
3c. Does your insurance require that you use a specific pharmacy or pharmacies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes , list the pharmacies you use. _____ _____

4. Is this insurance policy currently covering your CF-related expenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If No , is this due to a waiting period related to a pre-existing condition? <input type="checkbox"/> No <input type="checkbox"/> Yes - Date the waiting period will end: ____/____/____ Month Day Year
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5. Do you have medical providers who do not accept this insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes , which of your providers do not accept this insurance? Physician(s) _____ Pharmacy _____ Home Health Agency _____ Hospital _____ (attach additional page(s) if necessary)
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Section F Employment and Income

If you are currently unemployed, please check the box(es) which best describe your current status:

- Permanent disability
 Homemaker
 Student
 Temporary disability
 Retired
 Other (please specify) _____

Please check all sources of your income. You must include documentation or verification of each source of income. Acceptable documentation is listed below.

Your Sources of Income	Your Spouse's Sources of Income	Acceptable Forms of Documentation
<input type="checkbox"/> Wages, salaries, tips, and commissions, including overtime and training	<input type="checkbox"/> Wages, salaries, tips, and commissions, including overtime and training	Current wage stubs, statements from employers, business records.
<input type="checkbox"/> Self-employment	<input type="checkbox"/> Self-employment	Business or income tax records.
<input type="checkbox"/> Dividends or interest from stocks, bonds, savings, etc.	<input type="checkbox"/> Dividends or interest from stocks, bonds, savings, etc.	Statements from financial institutions. Income tax records.
Other income:	Other income:	
<input type="checkbox"/> Social Security benefits	<input type="checkbox"/> Social Security benefits	Copy of 1099 statement or check stub
<input type="checkbox"/> Rental income	<input type="checkbox"/> Rental income	Copy of receipt or rent check(s)
<input type="checkbox"/> Unemployment benefits	<input type="checkbox"/> Unemployment benefits	Copy of check stub
<input type="checkbox"/> Child Support	<input type="checkbox"/> Child Support	Copy of cancelled check
<input type="checkbox"/> Alimony	<input type="checkbox"/> Alimony	Copy of cancelled check
<input type="checkbox"/> Pensions/Retirement	<input type="checkbox"/> Pensions/Retirement	Copy of annual statement or check stub
<input type="checkbox"/> Any other income	<input type="checkbox"/> Any other income	Copy of statement(s) or check stub(s)

Section G Documentation Required with Application

Please submit proof to verify each of the following:

Verification is required for:	List of acceptable proof:																				
Residence – proof that you have continuously lived in New York State for the last 12 months	Enclose a copy of ONE of the following: <ul style="list-style-type: none"> ❖ Lease ❖ Rent receipts ❖ Statement from non-relative landlord ❖ Mortgage agreement ❖ Property tax bill ❖ School records 																				
Birth Date	Enclose a copy of ONE of the following: <ul style="list-style-type: none"> ❖ NYS driver’s license ❖ Birth certificate ❖ Baptismal certificate ❖ Passport ❖ Hospital records ❖ Adoption records ❖ Passport 																				
If you have Health Insurance	Enclose a copy of all of your health insurance cards																				
If you do not have Health Insurance	Enclose a copy IF IT APPLIES TO YOU: <ul style="list-style-type: none"> ❖ Medicaid denial 																				
Income	Enclose copies of ALL of the following for both you and your spouse: <ul style="list-style-type: none"> ❖ State/Local income tax return – most recent complete year ❖ Federal income tax return – most recent complete year ❖ W-2’s for all jobs – most recent complete year Enclose copies IF IT APPLIES TO YOU AND/OR YOUR SPOUSE: <table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: left; width: 50%;">For proof of:</th> <th style="text-align: left; width: 50%;">Enclose:</th> </tr> </thead> <tbody> <tr> <td>❖ Self-employment</td> <td>--- business or income tax records</td> </tr> <tr> <td>❖ Dividends or interest from stocks, bonds, savings, etc.</td> <td>--- statements from financial institutions</td> </tr> <tr> <td>❖ Social security benefits and/or additional income</td> <td>--- 1099 statement or check stub</td> </tr> <tr> <td>❖ Rental income</td> <td>--- receipt or rent check(s)</td> </tr> <tr> <td>❖ Unemployment benefits</td> <td>--- check stub</td> </tr> <tr> <td>❖ Child support payments you receive</td> <td>--- cancelled check</td> </tr> <tr> <td>❖ Alimony payments you receive</td> <td>--- cancelled check</td> </tr> <tr> <td>❖ Pensions/retirement income</td> <td>--- annual statement or check stub</td> </tr> <tr> <td>❖ Any other additional income</td> <td>--- statement(s) or check stub(s)</td> </tr> </tbody> </table>	For proof of:	Enclose:	❖ Self-employment	--- business or income tax records	❖ Dividends or interest from stocks, bonds, savings, etc.	--- statements from financial institutions	❖ Social security benefits and/or additional income	--- 1099 statement or check stub	❖ Rental income	--- receipt or rent check(s)	❖ Unemployment benefits	--- check stub	❖ Child support payments you receive	--- cancelled check	❖ Alimony payments you receive	--- cancelled check	❖ Pensions/retirement income	--- annual statement or check stub	❖ Any other additional income	--- statement(s) or check stub(s)
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Citizenship for non-United States citizens	Enclose a copy IF IT APPLIES TO YOU: <ul style="list-style-type: none"> ❖ Naturalization certificate ❖ Permanent Resident Card (often referred to as Green Card or Form I-551) ❖ Official hospital/doctor birth records ❖ Birth Certificate ❖ Passport 																				

Section H

Physician Certification

Please ask your physician to complete the following section:

This patient has a confirmed diagnosis of Cystic Fibrosis.

Physician's Signature

Date

Physician's Name (please print)

Physician's NYS License Number

Section I

Patient Certification

Please sign and return the application with the required documents indicated in Section G.

I certify that the information I have provided in applying for payment under Article 27-G of the Public Health Law is complete and accurate to the best of my knowledge. By signing below, I authorize any holder of medical information about me to release to the NYS Department of Health or its agents or contractors any information needed for payment, including audit, of services rendered to me. Also, I authorize the Adult Cystic Fibrosis Assistance Program to use and disclose my identifiable health information, as needed, to process payment of my health care expenses and for the normal business operations of the program. I request that payment of authorized benefits be made on my behalf by the Adult Cystic Fibrosis Assistance Program.

Your health information is confidential. State and federal law restricts its use and disclosure. You will receive a notice of privacy practices which details how the Adult Cystic Fibrosis Assistance Program uses and discloses the information. Please read that carefully.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE:

_____/_____/_____
Signature Date

Please note: Signature by mark must be witnessed below.

Witness Print name of legal representative (if applicable)

What is your relationship to this individual? _____

RETURN COMPLETED APPLICATION TO:

ADULT CYSTIC FIBROSIS ASSISTANCE PROGRAM
NEW YORK STATE DEPARTMENT OF HEALTH
RIVERVIEW CENTER, 3RD FLOOR WEST
150 BROADWAY
MENANDS, NY 12204

Questions may be directed to the program at (518) 474-1222

For Official Use Only

Date Received ____/____/____

Date Enrolled ____/____/____