Miles for Cystic Fibrosis BreatheStrong Grant

Miles for Cystic Fibrosis
BreatheStrong Grant Application

Checklist:

_____Completed Application (All pages of the application must be completed and submitted together)

_____ Photo of applicant doing a physical activity (Digital copy preferred, e-mail to bpenuel@milesforcf.org)

_____ Signed Consent and Contract

_____ Physician Forms, 2 pages (Completed by CF Physician)

_____ Copy of bill/invoice (if applicable)

_____ Copy of application to be kept for personal records (Optional, but highly recommended)

Mail to: M4CF
Attn: Grant applications
PO Box 2984, Tucker GA 30085

E-mail to: bpenuel@milesforcf.org
Fax to: 770- 934- 0746

Miles for Cystic Fibrosis BreatheStrong Grant

MFCF BreatheStrong Grant
Application Guidelines

- **Due to limited available funding each month, Miles for Cystic Fibrosis may not be able to approve all BreatheStrong grant requests.**

- BreatheStrong Grants are for up to $500. Approved grant funds will be paid directly to the designated activity provider or billing organization. Funds will not be paid directly to the grant recipient. Please include a bill or invoice for services or other means for paying the provider.

- Preference will be given to applicants who's requests are for ongoing activities as opposed to one-time events.

- MFCF will only consider complete applications, with all questions answered and a photo attached. If information is missing, a letter of denial will be sent.

- If an applicant is denied, they may reapply for the same, or a different activity, with a new application as soon as they would like.

- Grants are reviewed on a monthly basis. Grant recipients may reapply every 12 months. Only one grant can be awarded per recipient per year.

- We ask that applicants agree to provide feedback during the year and at one-year follow-up.

- Applicants are to provide a thank you note or letter to Miles for Cystic Fibrosis upon notification of grant approval.

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BreatheStrong Grant Request

Date:_____

Have you received a MFCF BreatheStrong grant before? No _____Yes____
If yes, when? _____

- **Personal Information**

First name:_____ Last name:_____
Address:_____
City:_____ State: Zip:_____
Phone:_____(_____)_____(**Please circle one**: Home/Cell/Work)
E-mail:_____
*Must be an active account that MFCF can use to contact you

Age:_____ Date of Birth _____/_____/_____ Gender: M F

- **Emergency Contact (Parent if under age 18):**

Name:_____Relationship:_____
Address:_____
Town/State/Zip: _____
E-mail:_____Phone: (_____)_____

- **Consent**

By signing here I give my permission to MFCF to discuss my condition with my doctors, other healthcare providers, or other organizations regarding the activities I would like to use my grant towards. I also give my persmission to MFCF to request medical information from my CF healthcare providers including my FEV-1 lung scores. I understand that in compliance with HIPAA regulations MFCF will keep any of my medically sensitive information confidential.

Signature:_____

I also give consent for my (child's) photo/name to be used on the MFCF website, or on other publications as needed.

Signature:_____

If under the age of 18:

Parent's name(s): _____

Parent's signature(s): _____

_____

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Activity Request Information

Please be as specific as possible when providing the following information. If any information is mising or left blank we will not be able to process your request. Please look up any missing information before submitting your application.

Type of activity or sport: _____

(i.e., Gym membership, dance lessons, tennis lessons, yoga classes, etc.)

Name of business or organization to whom funds will be paid: _____

_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone number: (____)_____ **E-mail:** _____

Contact Person (if applicable): _____

Start date of activity: _____

(If there is no specific date, write ASAP)

Duration of activity: _____

(Ex. one year, 6 months, 4 weeks, etc.)

Amount requested: $_____

($500 Maximum)

To expedite payment, please attach a bill, invoice, or other document that would allow direct payment to the business or organization.

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Application Questions

- **Why do you want a BreatheStrong grant to participate in your chosen activity?**

- **Please describe how you believe your chosen activity will help you manage your Cystic Fibrosis? How did you choose your activity?**

- **How often do you typically exercise? (Please be as specific as possible)**

- **What other activities do you enjoy participating in?**

- **Is there anything else you would like us to know about you?**

(Continue on a separate sheet if necessary)

Would you be willing to participate in a questionnaire survey at intake and again at 12 months to help us see if there is any impact on your quality of life from this grant?

_____ Yes _____ No

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Contract of Agreement

Please read and ***initial EACH*** of the points below, and upon agreeing to these conditions sign at the bottom of the page.

_____ (initial) I understand I am undertaking the activities requested in this application under my own (child's) risk, and will not hold Miles for Cystic Fibrosis or any of their partners liable for any injury or negative health impact related to this activity.

_____ (initial) I understand the spirit of these funds is to help improve my lifestyle, which includes my physical, emotional, and social well-being. I will do my best to use this BreatheStrong Grant to improve my life, and to use it toward on-going activities that I believe to be benefical to my health.

_____ (initial) I will not sell, trade or profit from any goods or serviced rendered with this BreatheStrong Grant.

_____ (initial) I understand that MFCF will contact my CF doctor to review and request endorsement of the activities requested in this application.

_____ (initial) I will do my best to provide photos, e-mail feedback, and complete questionnaires for MFCF to help determine the impact of this program on my well-being, and to help improve the programs of MFCF.

_____ (initial) I will send a thank you letter to MFCF when my grant is approved.

_____ (initial) I will update MFCF with any address, e-mail, or phone changes.

_____ (initial) I give permission to MFCF to use my (or my child's) photographs, application question responses, e-mail content, thank you notes, etc. to help demonstrate the impact of this program to the public through the MFCF website, Facebook page, Twitter account, etc. (OPTIONAL)

_____ _____/____/_____

Applicant's Signature Date

_____ _____/____/_____

Parent's Signature (if under 18) Date

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* Please fill out the top portion of this page yourself, then have your CF care provider fill out the rest of this page and the following page. These pages (7 and 8) MUST be completed and included with your application to be considered for approval.

Applicant's Name:_____ Applicant's DOB:_____
Applicant's chosen activity:_____

CF Physician
MFCF BreathStrong Grant- Request for Information

Doctor's Name:_____
CF Care Center:_____
Center Mailing Address:_____
City:_____ State:_____ Zip code: _____
Contact Person:_____ Position: _____
Phone: (_____)_____ E-mail (required):_____

Dear CF Care Provider,
We have received an application from the applicant listed above for a BreatheStrong grant from MFCF. Part of our application review process is to verify with their CF care provider their current health status.

The information we would like from you:

1. How long have you treated this patient?_____
2. How would you rate their compliance with medications and treatments on a scale of 1-10 (10 being 100% compliant.)
   Circle one: 1 2 3 4 5 6 7 8 9 10
3. Do you endorse their participation in the activity listed above as potentially beneficial to their health?_____
   _____
4. Do you have any concerns about their participation in these activities?_____
   _____

As the primary CF care provider for the patient listed above, I support and encourage their participation in physical activity as a part of their well-being. I understand that MFCF is not promoting any form of interaction between CF patients, and the funds being applied for are strictly for individual purposes of promoting recreation as an additive measure of airway clearance. I feel that he/she is an excellent candidate to receive a BreatheStrong Grant through MFCF.

_____ _____ ____/____/____
CF Physician (Signature) CF Physician (Print Name) Date

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CF Physician (Page 2)

MFCF Recreation Grant- FEV- 1 Scores

Applicant's Name:________________________________Applicant's DOB:_____________________

Please list the applicant's FEV-1 scores from the last one to two years, we require a minimum of **at least 4 scores**. If the patient is too young, or unable to provide lung function scores, please explain:

____

____

____

____

Please enter FEV-1 data for the previous 12 months below, starting with the OLDEST and ending with the NEWEST scores. Please use two decimals for the "Score" column.

*Score: ______________ Percentile: ____________________% Date: _____/____/_____

*Score: ______________ Percentile: ____________________% Date: _____/____/_____

*Score: ______________ Percentile: ____________________% Date: _____/____/_____

*Score: ______________ Percentile: ____________________% Date: _____/____/_____

Score: ________________ Percentile: ____________________% Date: _____/____/_____

Score: ________________ Percentile: ____________________% Date: _____/____/_____

Score: ________________ Percentile: ____________________% Date: _____/____/_____

Score: ________________ Percentile: ____________________% Date: _____/____/_____

Score: ________________ Percentile: ____________________% Date: _____/____/_____

Score: ________________ Percentile: ____________________% Date: _____/____/_____

*Minimum of four FEV-1 scores required

Other comments:

____

____

____

The scores listed above have been performed and recorded at an affiliated CF Center under supervision of a CF healthcare provider.

____ ______/______/________

CF Physician (Signature) Date