COVID-19 Cystic Fibrosis Disaster Relief Patients Assistant Program Application

First Name: _____Last Name: _____

Street Address: _____

City, State, Zip: _____

Email: _____ Phone: _____

Birthdate: _____/_____/_____ Gender: _____

Number of people with Cystic Fibrosis in your household (please list): _____

CF Center: _____

Have you applied and received other forms of disaster relief aid: _____

Have you ever been convicted of a crime? _____ If yes, please explain in a separate paragraph.

To be filled out by the patient's social worker/physician.

I authorize that _____ has Cystic Fibrosis, and his or her family is in need of financial assistance.

Social Worker/Physician Signature: _____ Date: _____

Name Social Worker/Physician (Print): _____

Please compile and send by mail the following:

A letter from the patient's social worker/physician stating how much money is needed and where the funds should be allocated. Specify reasons for assistance (i.e., lost wages, COVID-19 diagnosis, etc.). The more detail this letter provides, the more attention the evaluation committee will give your application. Include invoices where applicable. Please note that any grant payment will be made to third parties only. BEF reserves the right to request further documentation.

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 rescission of any grant offered to me. BEF may verify any and all parts of my application materials.

Applicant's signature: _____ **Date:** _____

Please email or mail your completed form and all supporting materials to:

Boomer Esiason Foundation
COVID-19 Cystic Fibrosis Disaster Relief Patient Assistance Program
483 10th Avenue, Suite 300
New York, NY, 10018
Email: covidrelief@esiason.org
Tel: 646-292-7930