



Abilities Inc. of Florida  
 2735 Whitney Road  
 Clearwater, FL 33760  
 (877) FLA-ACFP Ext. 237

## The Adult Cystic Fibrosis Program APPLICATION

The completion of this form will provide information to determine your status for consideration for admission.

### DEMOGRAPHIC INFORMATION

Name \_\_\_\_\_  
 (First, Middle & Last)

Social Security # \_\_\_\_\_ Referred By: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Place of Birth \_\_\_\_\_  
 (Month/Day/Year) City, State (and country if outside US)

Home Address: \_\_\_\_\_  House  Apartment  
 \_\_\_\_\_ How long at this residence?

Telephone Numbers: Home \_\_\_\_\_  
 Cell \_\_\_\_\_  
 Work \_\_\_\_\_

Marital Status  Single  Married  Separated  Divorced  
 Widowed  Other \_\_\_\_\_

Education Level  High School  Vocational/Tech Training  College \_\_\_\_\_  
 \_\_\_\_\_ Type Degree  
 \_\_\_\_\_ Area of Training/Study

Citizenship: USA  Other: \_\_\_\_\_  
 Language (s): \_\_\_\_\_

Are you a Florida Resident?  Yes  No Do you intend to remain in the State of Florida?  Yes  No

Sex  Male  Female Race/Ethnicity:  White  Black  Hispanic  Asian  
 American Indian  Other \_\_\_\_\_

Do you have a medical diagnosis of Cystic Fibrosis?  Yes  No

### INSURANCE INFORMATION

Do you have health insurance?  Yes  No if Cobra - when does it expire? \_\_\_\_\_

Medicare  Yes  No Medicare # \_\_\_\_\_

SSI  Yes  No SSDI  Yes  No \_\_\_\_\_

Medicaid  Yes  No Medicaid # \_\_\_\_\_

Other Insurance Carrier \_\_\_\_\_  
 Policy # \_\_\_\_\_  Thru Employer?  Cobra?

### FINANCIAL INFORMATION

Income Sources	per Month	Assets
Employment Wages	\$ _____	Checking Acct \$ _____
Social Security	\$ _____	Savings Acct \$ _____
Disability Payments (type) _____	\$ _____	CD's/Stocks/Bonds \$ _____
Interest or Dividends	\$ _____	Life Insurance \$ _____
Alimony or Child Support	\$ _____	Home/Property \$ _____
Other: _____	\$ _____	Car/Truck \$ _____
		Motorcycle/Boat \$ _____
TOTALS	\$ _____	Other: \$ _____

Federal taxes filed for most recent tax year?  Yes  No Copy available?  Yes  No

**EMPLOYMENT INFORMATION**

Are you working:  Full-time  Part-time  Unemployed  Other \_\_\_\_\_  
Average # of hr per week \_\_\_\_\_

Employer Name \_\_\_\_\_  
Address \_\_\_\_\_

How long have you been employed here? \_\_\_\_\_

If unemployed, when were you last employed? \_\_\_\_\_

**SOCIAL SERVICES**

Are you or anyone living in your household currently receiving assistance or services from a state or federal agency?  
(i.e., Food Stamps, Public assistance, housing, etc.) (Please describe the services and who is receiving them)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HOUSEHOLD INFORMATION**

How many people reside/live in your household, including yourself? \_\_\_\_\_

Are you a legal dependent (claimed on income taxes) of another individual?  Yes  No

If yes, whose legal dependent are you? \_\_\_\_\_

Do you have any legal dependents?  Yes  No

If yes, how many? \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Emergency Contact (Name) \_\_\_\_\_  
Relationship? \_\_\_\_\_ Telephone Numbers \_\_\_\_\_ Home \_\_\_\_\_  
Address \_\_\_\_\_ Work \_\_\_\_\_

**PHYSICIAN INFORMATION**

Cystic Fibrosis Physician: \_\_\_\_\_  
Clinic \_\_\_\_\_ Dr. Telephone # \_\_\_\_\_

Clinic Location: \_\_\_\_\_

How often do you normally attend clinic?

Once a month  Once a quarter  Other \_\_\_\_\_

What day of the week?  Monday  Tuesday  Wednesday  Thursday  Friday

Please describe briefly how Cystic Fibrosis affects your functioning in daily life.  
\_\_\_\_\_  
\_\_\_\_\_

Please list all prescribed treatments for Cystic Fibrosis you are receiving.  
\_\_\_\_\_  
\_\_\_\_\_

**DOCUMENTS NEEDED TO SUBMIT**

Please submit a copy of the following documents needed to determine eligibility with your application:

- \_\_\_ Copy of Florida Drivers License or State ID Card
- \_\_\_ SSI/SSDI Award Letter
- \_\_\_ Copy of Social Security Card
- \_\_\_ Copy of Medicaid / Insurance Card
- \_\_\_ List of all prescribed medications
- \_\_\_ List dates of all hospital and emergency room visits for the last 2 years
- \_\_\_ Previous year Tax return
- \_\_\_ Most recent 3 months of bank statements
- \_\_\_ Most current month of pay stubs
- \_\_\_ Signed Participant Responsibility Form

## **CONFIDENTIALITY**

To determine your eligibility for services and to plan and deliver appropriate services, you and your case manager will collect personal information about you. This information may be medical, psychological, environmental, or other information as deemed necessary by you and your case manager in order to provide services to you. Because it is so important to the mutual planning for services, your case manager will need your help in collecting this information. Without your assistance we may not be able to serve you.

This information is considered confidential and will be kept protected at all times. We will use your confidential information only for the purposes of administering this program. We will not release your confidential information to any individuals or agencies not directly related to administering this program, except with your written permission.

You have a right to review your case record and to request corrections as necessary.

## **FREEDOM OF CHOICE**

If you qualify for services under this program:

- You have the right to choose whether or not to enroll in this program
- You have the right to choose any enrolled case management agency to act as your case manager, to the extent that they are available.
- You have the right to choose the service providers from whom you will receive your Adult Cystic Fibrosis Waiver services, to the extent that they are available.
- You have the right to receive the waiver services you need; these may or may not include all the services you want.

## **RIGHT OF APPEAL**

If you are denied participation in this program or denied a service you believe you are eligible to receive, you have the right to appeal the decision.

## **RESPONSIBILITIES**

If you are not currently Medicaid-eligible, you are responsible for submitting a Request for Assistance to the Department of Children and Families.

You are responsible for participating with your case manager in developing your plan of care and for assisting with scheduled services.

You are responsible for keeping scheduled appointments and accepting offered and necessary services.

You are responsible for notifying your case manager when you have problems in obtaining services, when you are dissatisfied with your care, or when there are circumstances that affect your eligibility for Medicaid or this program.

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I hereby make application to enroll in the Adult Cystic Fibrosis Medicaid Waiver Program. I declare that all information provided on this application is true and complete to the best of my knowledge.

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Signature

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Date

Abilities of Florida agrees to comply with Title VI of the Civil Rights Act of 1964, Sections 503-504 of the Rehabilitation Act of 1973, and The Americans with Disability Act of 1990.

Information regarding sex, age, race, national origin, and marital status is collected for statistical reporting only and will not be used for screening purposes.

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