Cystic Fibrosis Foundation *Compass* Request Form

Please use this form to request assistance from the CF Foundation *Compass*

- Are you currently insured? ☐YES ☐NO
- Would you like assistance with applying for Social Security benefits? ☐YES ☐NO
- Are you experiencing issues with coverage and/or reimbursement of drugs or therapies by insurance? ☐YES ☐NO
- Do you need help applying for financial assistance for costs associated with drugs or therapies? ☐YES ☐NO
- Would you like to be contacted by a *Compass* case manager for assistance? ☐YES ☐NO

Patient Information:

First Name:		**Last Name:**	
Date of Birth:		**Gender:** ☐M ☐F	**Marital Status:**
Home Street Address:			
City:	**County:**	**State:**	**Zip Code:**
Home Phone #:		**Cell Phone #:**	
Email Address:			
Has the patient been diagnosed with CF? ☐YES ☐NO		**Is applicant under the age of 18?** ☐YES ☐NO If YES, enter parent/guardian information in the space(s) below:	
What is your relationship to the person with CF?			
Name:	**Relationship:**	**Phone #:**	
Name:	**Relationship:**	**Phone #:**	

Patient's Provider Information:

CF Physician/Provider's Name:		**Care Center Coordinator/ Case Manager's Name:**	
Facility/Care Center's Name:		**Provider's Email Address:**	
Provider's Phone #:		**Provider's Fax #:**	
Patient's Pharmacy Information:		**Pharmacy's Phone #:**	
Specialty Pharmacy Information:		**Specialty Pharmacy's Phone #:**	
Prescribed CF drug(s): **1)**	**2)**	**3)**	**4)**
5)	**6)**	**7)**	**8)**

Patient's Health Insurance Information: *(Please include most current information)*

Primary Insurance Company's Name:
Subscriber's Member ID:
Primary Insurance's Member Services Phone #:
Secondary Insurance Company's Name:
Subscriber's Member ID:
Secondary Insurance's Member Services Phone #:

CONSENT FOR *COMPASS* TO PROVIDE SERVICES

Cystic Fibrosis Foundation (CFF) *Compass* provides various services to assist people with cystic fibrosis (CF) and their caregivers. These services, which *Compass* may change from time to time, may include helping you obtain insurance coverage, financial assistance, social services, etc. Before *Compass* can try to help you, you must complete this two-part consent form.

Part I of this form lets *Compass* collect certain information about you, to use the information on your behalf, and to represent you with third parties as we try to assist you, as further described below. Part II lets *Compass* disclose information about you to third parties to try to assist you, as described further below.

PART I. CONSENT FOR *COMPASS* TO COLLECT INFORMATION ABOUT YOU AND REPRESENT YOU

1. Eligibility [*Pick (a) or (b), as appropriate*]

(a) *Where the person with CF is the applicant.* I attest that I, _____, (name of person with CF) have been diagnosed with cystic fibrosis (CF).

- OR -

(b) *Where someone else is applying on behalf of the person with CF*. I am requesting services on behalf of _____ (name of person with CF) and I attest that he or she has been diagnosed with cystic fibrosis (CF). I attest that I am the legal representative of the person with CF and have the legal authority to act on his or her behalf to seek these services from *Compass*. Examples of a person with legal authority include: a parent of a minor; a court-appointed guardian; a person with power of attorney for health care decisions; or the executor or administrator of an estate. I understand and acknowledge that I may be subject to legal action if I misrepresent my legal authority with regard to the person with CF. [*Note – if you are* applying *on behalf of a person with CF, please answer the remaining questions on his or her behalf.*]

2. *Accuracy of Information I Provide to CFF* – The information I provide *Compass* is accurate to the best of my knowledge.

3. *Compass May Obtain My Personal Information – Compass* has my consent to request personal information about me from sources that *Compass* considers relevant to the services I have asked *Compass* to provide. Depending on what I have asked *Compass* to help me with, *Compass* may need to obtain personal information about me from my health insurer or pharmacy benefits plan, my health care providers (including pharmacies), my landlord or mortgage company, employer, device manufacturer or pharmaceutical company, nonprofit organizations, case managers or care coordinators, or any other source relevant to the type of services I requested. I expect *Compass* to use its judgment in seeking the information needed for the services I am seeking. If I do not want *Compass* to contact a particular healthcare provider or other entity whose information I provide to *Compass*, I will list those entities here: _____

4. *Compass to Act as My Representative* – I authorize *Compass* staff to act as my representative and make inquiries and requests on my behalf when interacting with third parties to help provide me the services that I requested. The services I am seeking will be discussed by me and *Compass* staff.

5. *Permission to Record My Phone Calls* – I consent to the recording of my telephone calls with *Compass.* Calls are recorded for quality purposes, training, and to help *Compass* provide appropriate services. The information contained in your recording(s) may be used to train new hires, audit compliance with internal procedures, troubleshoot case management services and customer service concerns.

6. *Permission to Communicate with Me* – *Compass* has my permission to communicate with me by phone, email, or mail regarding the services I request. *Compass* may also later contact me regarding services it thinks may be useful or of interest to me, such as clinical trials, or to invite me to participate in surveys. If I wish to not receive such future communications, I may unsubscribe as indicated in the communication I receive or as directed in CFF's Privacy Statement, available at http://www.cff.org/Privacy-Statement/.

7. *No Guarantees* – I understand and agree that *Compass* only offers certain kinds of services, which may change from time to time, and there are areas outside the scope of *Compass*'s services. I understand that *Compass* is not committing to provide any services to me. If *Compass* does attempt to obtain certain benefits for me, there is no guarantee that such attempts will be successful. I understand that *Compass* may, for any reason, decline assistance or discontinue its efforts on my behalf or discontinue offering all or part of the services it provides to individuals with CF at any time.

8. *Release and Indemnification* – I release and waive all claims against the Cystic Fibrosis Foundation, *Compass*, and their directors, officers, employees, agents, and representatives from all liability for their acts or omissions related to *Compass* services. I agree that I will indemnify the Cystic Fibrosis Foundation, *Compass*, and their directors, officers, employees, agents, and representatives against all losses and expenses arising out of any misrepresentations made by me or any breach by me of my obligations made under this Consent Form.

9. *Duration and Revocation* – This Consent to Representation Form is valid for one year from the signature date below. I may revoke this consent at any time, although revocation will not affect any uses or disclosures of my personal information already made in reliance on this document. Revocation must be made in writing and submitted by fax to 877-868-5952 or mailed to Cystic Fibrosis Foundation *Compass*, 4550 Montgomery Avenue, Suite 1100N, Bethesda, MD 20814.

10. *Other Terms* – I agree that my relationship with *Compass* is further subject to Cystic Fibrosis Foundation Privacy Statement, available at http://www.cff.org/Privacy-Statement/, and Terms of Agreement, available at https://www.cff.org/Terms-of-Agreement/, which are incorporated into this Consent to Representation Form.

<table>
<tr><td>Signature of Applicant (Individual with CF)</td><td>Date</td></tr>
<tr><td>OR
Signature of Personal Representative</td><td rowspan="2">Date</td></tr>
<tr><td>On behalf of Applicant (Name of Individual with CF)</td></tr>
</table>

PART II. CONSENT TO DISCLOSE PERSONAL INFORMATION ABOUT YOU

1. I have asked Cystic Fibrosis Foundation *Compass* to seek to provide me certain services, as specifically discussed between me and *Compass.* To enable *Compass* to assist me with the services I requested, I authorize *Compass* to disclose all personal information, including any health and/or financial information, that *Compass* has about me to third parties that *Compass* believes may be useful and relevant to the specific assistance I have asked *Compass* to provide. *Compass* may use its discretion in determining which of my personal information is relevant and should be disclosed to third parties to meet my needs for the particular services I requested. For example, if I have requested assistance with insurance claims, *Compass* may disclose my health and eligibility information to payers; or if I have requested assistance with housing, *Compass* may disclose my financial and housing information and, if relevant, my medical information, to governmental, nonprofit, or other entities that provide housing assistance.

2. In addition to the persons or entities included above, I may consent during a recorded phone call with *Compass* to have *Compass* share certain information about me to specified individuals, such as giving the provider who referred me to *Compass* a summary of *Compass's* services. If so, I understand that *Compass* will disclose my information as I direct. If I would like *Compass* to disclose my personal information to any additional individuals, I will list them here: (Include family, friends, caregivers, providers, if requested.)

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

3. I understand that if *Compass* discloses my personal information to third parties authorized by me, *Compass* cannot control how those third parties will use or disclose that information. I agree that *Compass* and CFF will not have any liability for actions or omissions taken by such third parties.

4. *Compass* is permitted to disclose my personal information only as permitted by this Consent, applicable law, or the CFF Privacy Statement available at https://www.cff.org/Privacy-Statement/.

5. This Authorization is valid for one year after the date signed by me or my personal representative. I may revoke this Authorization to Disclose Personal Information form at any time in writing, and that any such revocation will not affect information that has already been used or disclosed in reliance upon this document. Revocation must be made in writing and submitted by fax to 877-868-5952 or by mail to Cystic Fibrosis Foundation *Compass*, 4550 Montgomery Avenue, Suite 1100N, Bethesda, MD 20814. I understand I may receive a copy of this Authorization upon request.

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<tr><td>Signature of Applicant (Individual with CF)</td><td>Date</td></tr>
<tr><td>OR
Signature of Personal Representative</td><td rowspan="2">Date</td></tr>
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</table>

Please return **ALL** pages of this form to *Compass* at 1-877-868-5952 (fax), or email at compass@cff.org, or mail a copy to:
Cystic Fibrosis Foundation *Compass*, 4550 Montgomery Avenue, Suite 1100N, Bethesda, MD 20814