FINANCIAL ASSISTANCE FOR CANCER PATIENTS

A Service of Ribbons of Hope-Carbon County Cancer Fund, a Wyoming Non-profit Corporation

OBJECTIVE

The goal of Ribbons of Hope is to raise funds for disbursement to Carbon County residents with cancer. The disbursements shall be given to cancer patients and their families to assist with expenses.

POLICY FOR FINANCIAL ASSISTANCE

Ribbons of Hope is committed to assisting as many Carbon County residents as possible who are diagnosed and being treated for cancer. Therefore, at the beginning of each calendar year, based on available funds, ***Ribbons of Hope*** establishes a disbursement limit for any individual applicant per treatment year. To be eligible to receive a disbursement from ***Ribbons of Hope***, the following conditions must be met

1. The applicant must be a resident of Carbon County for at least six months; or the applicant's family resides in Carbon County, and the applicant is now living in Carbon County while receiving treatment.
2. The applicant must provide written documentation of a cancer diagnosis by the treating physician.
3. The applicant must be receiving medical treatment for the cancer diagnosis.
4. Upon approval by ***Ribbons of Hope*** each applicant may receive a maximum of Six hundred Dollars ($1,000.00) each calendar year. A recipient may apply for additional funds the calendar year after the original date of approval by Ribbons of Hope as long as cancer treatment is continuing.

PROCEDURE FOR ASSISTANCE

1. Complete and submit an Assistance Application to ***Ribbons of Hope***.
2. Applications must be accompanied by a written letter from the treating physician on the physician's letterhead, stating what type of cancer has been diagnosed, the treatment prescribed.
3. ***Ribbons of Hope*** will review the Assistance Applications. If additional information is required, the applicant will be notified.
4. Applicants meeting eligibility will be notified in writing of the receipt of an award of financial assistance. Please allow 4-6 weeks for processing and disbursement by ***Ribbons of Hope*** volunteers
5. Recipients may use funds from ***Ribbons of Hope*** as the recipient deems appropriate.

REAPPLYING FOR FINANCIAL ASSITANCE

If treatment continues beyond one year from the original date of approval of financial assistance or if cancer treatment becomes necessary at a later date, recipients may reapply for financial assistance one year from the date the application is received by ***Ribbons of Hope***. The application for continued benefits should contain a letter from the treating physician stating that the patient's cancer treatment is continuing.

Ribbons of Hope-Carbon County Cancer Fund

PO Box 613
Rawlins, Wyoming 82301

ELIGIBILITY REQUIREMENTS FOR FINANCIAL ASSISTANCE

1. The applicant must be a resident of Carbon County for at least six months; or the applicant's family resides in Carbon County, and the applicant is now living in Carbon County while receiving treatment.
2. The applicant must provide written documentation of a cancer diagnosis by the treating physician.
3. The applicant must be receiving medical treatment for the cancer diagnosis.
4. Upon approval by ***Ribbons of Hope***, each applicant may receive a gift of up to One Thousand dollars ($1,000.00) each calendar year. A recipient may apply for additional funds the year after the original date of approval by Ribbons of Hope as long as cancer treatment is continuing.

Applicant's Name _____Application Date_____

Mailing Address_____

Street/PO Box City State Zip Code

Home Phone: _____Length of Time You Have Resided in Carbon County_____

Date of Birth____/___/____Employer _____Work Phone_____

Contact Person (other than Applicant):_____Phone_____

Mailing Address_____

Street/PO Box City State Zip Code

Treating Physician:_____Phone_____

Address of Physician_____

Street/PO Box City State Zip Code

I have attached written documentation from my treating physician on the physician's letterhead stating the **type of cancer that has been diagnosed, the treatment prescribed.** I hereby consent that this medical record may be made a part of my application for assistance from ***Ribbons of Hope***. I further consent that my treating physician shall furnish to ***Ribbons of Hope*** any additional information concerning my health or physical condition requested by Ribbons of Hope or its officials.

I understand that my application cannot be processed until I have submitted all required documents to the address shown on top of the application.

By signing below, I certify that this request has been made voluntarily, that I have read and understand this application, and that the information given above is accurate to the best of my knowledge.

Applicant's Signature_____Date_____

Ribbons of Hope Representative_____Date_____

PLEASE ALLOW 4-6 WEEKS FOR PROCESSING AND DISBURSEMENT BY *RIBBONS OF HOPE*. BE SURE TO KEEP A COPY OF YOUR GRANT APPLICATION AND PHYSICIAN'S LETTER.

Contacts:
Copper France 307-321-7605
Lisa Engstrom 307-320-5923
Kelly Bohanan 307-710-1524