P.O. Box 8242
Christiansted, VI 00823
www.ribbonsforacure.net
ribbonsforacure@outlook.com

RIBBONS FOR A CURE, INC.
2021 FINANCIAL ASSISTANCE PROGRAM

Ribbons for a Cure, Inc., offers a Financial Assistance Program (FAP) for cancer patients and survivors who are experiencing financial challenges for cancer treatment or testing. A twelve-month reimbursement not to exceed $250 will be awarded to approved recipients.

A. General Information

1. Financial Assistance Program will be limited to cancer patients and survivors who are permanent residents of the U.S. Virgin Islands.
2. Ribbons for a Cure, Inc. will consider all applications without regard to race, color, religion, sex, national origin, disability, veteran status, sexual orientation or any other characteristic protected by law.
3. Financial Assistance Program award is a fixed amount determined by availability of funds.
4. Financial Assistance Program may be used to fully or partially cover payment(s) for cancer related prescription medication, diagnostic testing or CT scans.
5. Financial Assistance Program can NOT be used to cover any other costs.
6. Only completed applications will be considered for the Financial Assistance Program.

B. Required Steps

1. You MUST complete and submit the official Financial Assistance Program application.
2. You MUST submit proof of residence with your completed application.
3. You MUST submit an official receipt from a licensed pharmacy or diagnostic testing facility for reimbursement after application is approved. Your name must be included on all receipts.
4. Submitted applications will be reviewed and processed in 2 to 4 weeks.
5. If your application is approved, you will be notified by email and/or phone.
6. Applications for patients under 18 must be submitted by the legal parent or guardian.
7. Upon approval of the application, funds will be issued payable to the cancer patient or legal parent or guardian.
8. Beneficiaries may continuously submit receipts within a 12-month period, from the date of approval, for reimbursement of expenses. No receipts for expenses prior to the approval date of the application will be honored.
9. Beneficiaries who have not utilized the total amount of funds approved for reimbursement may not apply for additional funding in the next calendar year.

C. Important Details

1. Only one application may be submitted per person per calendar year.
2. Ribbons for a Cure, Inc. will not use the first name, last name or other identifying information of any recipient without explicit permission.
3. Financial Assistance Program recipients agree to provide Ribbons for a Cure, Inc. with a quote or short testimonial regarding their experience, for use in reports and future promotional materials.
4. Financial Assistance Program recipients agree to participate in follow-up surveys.

D. Ribbons for a Cure, Inc. reserves the right to:

1. Request proof of identity and/or any other documents necessary to verify the details provided in your application before releasing funds.
2. Reverse decisions for any reason, including if any information provided is found to be untruthful or false.

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E. Required Documents:

1. A completed Financial Assistance Program APPLICATION (attached).
2. Valid proof of identification (Driver's License, Passport, Passport Card, Voter's Registration Card, State ID).
3. Proof of U.S. Virgin Islands residency (WAPA, internet, telephone or cable bill).
4. Official receipt from a licensed pharmacy or diagnostic testing facility for reimbursement after application is approved. Your name, service date, payment amount, prescription name, or type of testing must be included on all receipts.

Required documents must be submitted via email or postal mail to:

RIBBONS FOR A CURE, INC.
Financial Assistance Program Committee
P.O. Box 8242
Christiansted, VI 00823

or email to:
ribbonsforacure@outlook.com

NOTE: ONLY COMPLETED AND SIGNED APPLICATIONS WITH REQUIRED SUPPORTING DOCUMENTS WILL BE CONSIDERED.

THE DECISIONS OF THE FINANCIAL ASSISTANCE PROGRAM COMMITTEE WILL BE FINAL.

Ribbons for a Cure, Inc.

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2021 APPLICATION FOR FINANCIAL ASSISTANCE PROGRAM (Page 1 of 2)

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____

U.S. Virgin Islands Resident: Yes _____ No _____ USVI Resident Since: _____

Physical Address: _____

Mailing Address: _____

Home Telephone Number: _____ Cellular Number: _____

Email address: _____

Name of Parent (s) or Guardian (s) if under age 18: _____

Employer: _____ Position: _____

Employer Address: _____ Employer Telephone: _____

Insurance: Yes _____ No _____

Primary Insurance: _____

Secondary Insurance: _____

Are you currently on medical leave: Yes _____ No _____

DIAGNOSTIC INFORMATION

Type of Cancer: _____

Date of Diagnosis: _____

Physician: _____ Telephone Number: _____

Physician Address: _____

Financial Assistance Requested (Check all that apply):

☐ Prescription Medication ☐ Diagnostic Testing ☐ Other: _____

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2021 APPLICATION FOR FINANCIAL ASSISTANCE PROGRAM (Cont.) Page 2 of 2

COMMENTS

Please provide any additional information or special facts that you would like the Financial Assistance Program Committee to consider with your application.

_____

_____

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CERTIFICATION

I affirm that the information reported on this application is true, correct, and complete. I understand fully that any misrepresentation or incorrect information can lead to disqualification or forfeiture of financial assistance.

I understand that if approved, my reimbursement benefits will not exceed $250.00 within a 12-month period, from the date of approval of the application.

I understand that I will not be eligible to apply for additional financial assistance in the next calendar year until I have utilized the total amount of funds approved for reimbursement.

_____ _____

Applicant's Signature Date

FOR OFFICIAL USE ONLY

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