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

RIBBONS FOR A CURE, INC.
2025 FINANCIAL ASSISTANCE PROGRAM

Ribbons for a Cure, Inc., offers a Financial Assistance Program (FAP) for cancer patients and survivors for cancer treatment or testing. A one-time donation not to exceed $500 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 for the past three years.
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, CT scans, or treatment.
5. Only completed applications will be considered for the Financial Assistance Program.
6. Failure to submit required documentation will result in application denial.
7. Financial assistance awards are limited to three consecutive years per applicant.

B. **Required Steps**

1. You MUST complete and submit the official Financial Assistance Program application.
2. You MUST complete all sections of the application.
3. You MUST submit proof of residence with your completed application.
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.

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 current photograph, 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 US Virgin Islands issued identification (VI Driver's License, VI Voter's Registration, VI Identification Card VI Senior Citizen Card).
3. Proof of U.S. Virgin Islands residency (WAPA, internet, telephone or cable bill in your name).
4. A completed and signed Physician Verification Form (attached).
5. A biopsy / pathology report that confirms the cancer diagnosis.

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.

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2025 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 _____

Are you willing to provide a current photograph, quote or short testimonial if requested: 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 ☐ CT Scans ☐ Treatment

☐ Other: _____

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2025 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.

_____

_____

_____

_____

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 benefits will not exceed $500.00.

I understand that I will not be eligible to apply for additional financial assistance after three consecutive years of receiving benefits.

_____	_____	_____
Print Name	Applicant's Signature	Date

FOR OFFICIAL USE ONLY

_____
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RIBBONS FOR A CURE, INC.
FINANCIAL ASSISTANCE PROGRAM

PHYSICIAN VERIFICATION FORM

This is to verify that the following patient is/will be receiving treatment for a diagnosis of cancer:

Patient Name: _____

Type of Cancer: _____ Date of Diagnosis: _____

Treatment Type(s): _____

Physician/Provider Name: _____

Physician/Provider Address: _____

Physician/Provider Phone Number: _____

_____ _____
PHYSICIAN'S SIGNATURE DATE:

Please return completed form to:

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AFFIDAVIT OF RESIDENCE

If proof of U.S. Virgin Islands residency is not available in your name, the below information should be completed by person you live with and submitted along with one address document in that person's name.

Date _____

I, _____, under penalty of perjury state that Mr./Ms._____ currently resides at my premises located at _____. Mr./Ms. has resided at that address continuously since _____.

By: _____
[Signature of Affiant]

_____
[Name of Affiant]

Subscribed and sworn to before me on this _____ day of _____, 20_____.

_____
Notary Public

My Commission Expires: _____

Notary Public Number _____

SEAL