



Financial Request Form

The mission of Ribbon of Hope is to be a financial, informational, and emotional resource for individuals with breast cancer in Northeastern Wisconsin. Ribbon of Hope assists breast cancer patients regardless of age, gender, race, or religion.

To be eligible for financial assistance you must be a breast cancer patient currently receiving treatment.

You also need to live or receive your treatment in Brown or Kewaunee County.

Awards range from \$100 to \$1500 for breast cancer patients and up to \$2500 for metastatic breast cancer patients.

No more than one request every thirty days will be processed.

Send your request form, itemized bill and/or receipts to: Ribbon of Hope Foundation, P.O. Box 148, De Pere, WI 54115
Or fax the request form and receipts to 920.339.9300

Applicant's Name: _____ Date of birth: _____

Address: _____ City: _____ County: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Person completing the form: _____ Relationship to Applicant: _____

I authorize a representative from Ribbon of Hope to verify with my physician that I am in treatment for breast cancer.

Applicant's Signature: _____ Date: _____

This Section to be Completed by Oncologist/Surgeon

(Name) _____ is a patient of mine and is currently receiving treatment for breast cancer.

Doctor's Signature: _____ Date: _____

Doctor's name (print): _____ Doctor's phone number: _____

Location of Treatment (Clinic & City) _____

Stage of Breast Cancer: ___ Stage I ___ Stage II ___ Stage III ___ Stage IV ___ Other

Date of Diagnosis and Treatment Type: _____

Other Information (Optional): _____

This Section to be Completed by Breast Cancer Patient

Request
(Minimum Request is \$25 per item)

Amount
Requested

Check Payable to

Rent/Mortgage		
Utilities (gas, electric, water, not phone)		
Transportation/Gas Cards (up to \$500)		
Lodging (during treatment/up to \$75/night; \$500 cap)		
Physician fees (after insurance is cleared)		
Diagnostic tests (after insurance is cleared)		
Hospital expenses (after insurance is cleared)		
Prescription Medications for Breast Cancer		
Prosthesis/Prosthetic Bras		
Wigs, wig care products and head coverings (up to \$500)		

Total Amount Requested _____

Please check here if you have received a grant from ROH in the past ____

Copies of the bills/receipts must be attached to the application to receive payment. Please send copies only and retain the original bills/receipts for your file. If your request is approved, the Ribbon of Hope Foundation will make the check payable to the clinic, hospital, utility, etc. The checks will be mailed to you, and it is your responsibility to distribute the checks to the appropriate places.

Briefly add any other information that you think would be helpful for the committee: _____

I certify that the above information is true and complete to the best of my knowledge.

Signature: _____ Date: _____

If you have questions, please call Ribbon of Hope at 920.676.HOPE (676.4673).

The Ribbon of Hope Foundation will assist individuals who are diagnosed with breast cancer. The decision on the course of treatment is the sole responsibility of the individual with breast cancer. The Ribbon of Hope Foundation bears no responsibility to seek or not to seek any treatment options.