Ribbon Riders, Inc.
PO Box 952283
Lake Mary, FL 32795
407.796.7465

Thank you for contacting Ribbon Riders regarding our Breast Cancer Assistance program. Please review the attached information prior to submitting your application.

DO I QUALIFY?

To qualify for assistance from Ribbon Riders, you must meet the following criteria:

- Live in Orange, Osceola, Seminole, Lake or Volusia counties
- **Are currently in ACTIVE TREATMENT for breast cancer.** You have undergone chemotherapy, radiation, Hormone therapy, or surgery related to breast cancer within the past 90 days.

APPLICATION:

- **Fill in all information. DO NOT leave any lines blank.**
- Copy of billing from Hospital and or Treatment Center within the **past 90 days (detailing breast cancer treatment)** are acceptable.
- Billing **must show an outstanding balance that the patient is responsible for**.
- You are required to sign this document as it that allows your doctor's office to release your diagnosis information to us (HIPAA).
- Complete and sign the grant affidavit.
- Provide a legible copy of your FL Driver's License or State issued ID with current address as proof of residence.
- Applicants may apply once every 12 calendar months (must still be in active treatment).

APPROVAL:

- If your application is approved, you will be provided a grant to use toward your critical needs.
- You will be notified once your application has been approved. Grants will be mailed to the address on the application.

SUBMIT YOUR APPLICATION:

- Fax: 321.559.1665
- Email: assistance@ribbonriders.org
- Mail: Ribbon Riders, PO Box 952283, Lake Mary, FL 32795

Ribbon Riders, Inc.
407.796.7465 (PINK)

RIBBON RIDERS
BREAST CANCER ASSISTANCE
FUND APPLICATION

TELL US ABOUT YOURSELF:

First Name:	Last Name:	
Address: (Please do not use Post Office Box)	City:	State: Zip:
County:	Home:	Cell Phone:
Date of Birth:	Email Address:	
Names and Ages of anyone living in your household spouse, children, etc.		
APPLICANT SIGNATURE: (applicant must sign and authorize release of confidential information for HIPAA) I hereby certify that all of the above information is accurate. I authorize the release of my name and proof of treatment from my medical team.		
Signature of Applicant	**Name (Printed)**	**Date**

YOUR MEDICAL SUPPORT TEAM: (this section to be filled out by your doctor, nurse, or case worker)

Doctor Name:	Type/Stage:
Date diagnosed with breast cancer:	Medical Diagnosis:
Where are you being treated? (Name of center/hospital)	
Comments/Additional Information:	

** Billing from Hospital and or Treatment Center **detailing treatment** is acceptable.
** Must be in **active treatment, chemotherapy, radiation, hormone therapy with in the past 90 days**.
** Billing must show an **outstanding balance of detailed treatment that the patient is responsible for**.

I have read and reviewed this completed application can confirm that this applicant is currently in **ACTIVE** treatment for breast cancer. (chemotherapy, radiation, surgery within the past 90 days)

Signature of Medical or Social Services Professional	Phone Number:
Email	

SEND COMPLETED FORMS TO:
www.RibbonRiders.org
Ribbon Riders, Inc.
PO Box 952283
Lake Mary, FL 32795
Fax: 321.559.1665, Phone **407.796.PINK** (7465)
Email: assistance@ribbonriders.org
Phone 407.796.PINK(7465)

RIBBON RIDERS GRANT AFFIDAVIT

The purpose of this affidavit is to certify that I,_____residing at
NAME

_____
ADDRESS **CITY** **STATE** **ZIP**

Please do not use your Post Office Box number.

I certify, that if I am approved for financial assistance from Ribbon Riders, I will utilize the grant to pay for my critical needs only (rent, utilities, gas, groceries, prescriptions, insurance, doctors/ hospital bills or co-pays).

_____ _____
SIGNATURE **DATE**

_____
PRINT NAME

UPDATED July 2018