Roots&Ribbons
FOUNDATION

Application for Financial Assistance

Print Name ____ Date ______________

Physical address ____________________________ Zip Code________ Phone __________

Email: ____________________________________ T-shirt size: ____________________

Physician's use only:

I can confirm that ____ is currently in my care for

____ (diagnosis).

Attending Physician Name (Printed): ____

Attending Physician Signature: ____________________________ Date: _______________

Name of Physician's Group/Practice: _________________________ Phone number: _________

Applicant Signature: _______________________________________ Date: _________

Please return application to Roots and Ribbons Foundation, P.O. Box 1487, Morgan City, LA 70381 or scan and email to rootsandribbonsfoundation@gmail.com. Applicant must provide proof of diagnosis when submitting this application. (This is confidential and used for verification purposes only.)

How did you hear about us? (Circle all that apply):

Friend Facebook Event ____________________________ (Please specify)

Digital Billboard Marketing Card Other ______________________________

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Administrative Use Only

Application Approved Application Denied

Signature: ____ Date: ____________

VISA Card Amt. __________ Date ___________ Delivered by _______________________

Recipient Signature ____________________________ Name Printed _________________