



Beyond the Ribbon Foundation - Cancer Gift Application

Welcome

Beyond the Ribbon Foundation was founded by breast cancer survivors Stacey Atkinson and Brenda Nelson of Powell, Wyoming. Having walked through cancer ourselves, we understand that a cancer diagnosis affects so much more than finances. It can be an overwhelming and uncertain journey for both the person facing cancer and the people who love them.

Beyond the Ribbon originally began with a mission to support individuals going through breast cancer. As our foundation has grown, so has our mission. Today, we are honored to come alongside Big Horn Basin residents facing many different types of cancer.

Our mission is about more than financial assistance. Sometimes what someone needs most is encouragement, prayer, a listening ear, or simply to know they are not walking this road alone. We want to come alongside individuals and families during their cancer journey, offering hope, prayer, support, and practical help wherever we can.

The generosity that makes this possible comes from our local communities, and the money raised by Beyond the Ribbon stays right here in the Big Horn Basin, helping Big Horn Basin residents. Neighbors helping neighbors is at the heart of what we do.

If you or someone you love is facing any type of cancer, we encourage you to complete the enclosed application. Please share not only your financial or practical needs, but also how we can support and pray for you. All information provided is kept strictly confidential and shared only with the Beyond the Ribbon Foundation board.

Hope and Healing in the Big Horn Basin

How to Submit

Mail: Beyond the Ribbon Foundation, P.O. Box 12, Powell, WY 82435

Hand-deliver: Stacey Atkinson @ Eternal Light Creations, 121 N. Bent Street, Powell, WY 82435

If you need help completing this form, contact us and we'll assist you.

Eligibility

- Must be currently diagnosed, going through treatments and/or surgeries
- Must live in the Big Horn Basin, Wyoming

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Section A - Applicant Information

Full name: _____

Date of birth: ____ / ____ / ____

Preferred name (optional): _____

Home address: _____

P.O. Box (if applicable): _____

City: _____ State: _____ ZIP: _____

Phone: _____ OK to text? ☐ Yes ☐ No

Email: _____

Best time to reach you: _____

Primary language: _____ Interpreter needed? ☐ Yes ☐ No

How did you hear about Beyond the Ribbon Foundation? _____

Section B - Your Story & Specific Needs

Please share a brief summary about you/your family, your diagnosis, and what support would help most right now.

This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

You may attach additional pages if needed.

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Section C - (Optional) Prayer Requests

Do you have any specific prayer requests?

Sharing prayer requests is optional and will not affect your eligibility.

Section D - Additional Information

Describe any other details or support that would be helpful to share:

Section E - Consent & Privacy

Consent & privacy: I understand my information will be used only to evaluate my request and administer the gift. It will be kept confidential and not shared outside the organizers except as authorized.

Signature: _____ Date: ____ / ____ / ____



To be completed by your medical provider

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Section F - Medical Information

Date of diagnosis: ____ / ____ / ____

Primary cancer type: _____

Stage (if known): _____

Is patient in active treatment? ☐ Yes ☐ No

Treatments in the last 12 months (check all that apply):

☐ Chemotherapy ☐ Radiation ☐ Surgery ☐ Hormonal ☐ Other: _____

Treating facility/clinic: _____

City, State: _____ Phone: _____

Section G - Authorization to Verify Information

I authorize Beyond the Ribbon Foundation and its partners to contact my healthcare provider(s) listed below to verify my diagnosis and treatment status for the sole purpose of determining eligibility for the gift.

Signature: _____ Date: ____ / ____ / ____

Printed name: _____

Section H - Healthcare Provider Verification

Provider name & title: _____

Hospital/clinic: _____

Clinic address: _____

City, State, ZIP: _____

Phone: _____ Email: _____

Patient name: _____ DOB: ____ / ____ / ____

Diagnosis: _____ Stage: _____

Current treatment status: ☐ Active ☐ Surveillance / Follow-up ☐ Palliative / Hospice

Recent treatments (past 12 months): ☐ Chemo ☐ Radiation ☐ Surgery ☐ Hormonal ☐ Other: _____

I attest that the information above is accurate to the best of my knowledge and may be used to verify eligibility for the gift.

Signature: _____ Date: ____ / ____ / ____