The Angela Andrade Foundation

The Angela Andrade Foundation was established to support metastatic breast cancer patients. Angela's family and friends want to enhance and improve the quality of life of metastatic breast cancer patients through financial support.

- **Eligibility:** You are eligible to apply to the Angela Andrade Foundation if:
  - You are a patient with metastatic breast cancer
  - You are a permanent resident of the United States
  - You are receiving treatment within the United States

  - **Application:** Please complete the attached application. **An email address is required**.

- **Grants:** Applicants may be awarded up to $1,800**.**
  - When possible, all grant payments will be made directly to service providers on behalf of the recipient.
  - In some instances, grants may be made directly to the recipient. In these instances, a grant agreement will be made between the recipient and the Foundation.

- **Timeline for Selection:** Recipients will be selected every quarter in 2021.
  - Deadline to receive applications for each quarter are as follows: the 15th of February 2025, the 15th of May 2025, the 15th of August 2025, and the 15th of November 2025. One grant will be awarded in March, June, September, and December in 2025.
  - Applicants must wait one year before reapplying for a grant from The Angela Andrade Foundation.

- **Submission Instructions:** Please email application to angelaandradefoudation@gmail.com:

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED.

To learn more about The Angela Andrade Foundation, please visit: www.angelaandradefoundation.org

Application to The Angela Andrade Foundation

Name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Telephone: _____

Email Address: _____

Please print clearly. We will confirm receipt of your application via email.

I. Provide a brief history of your metastatic breast cancer and the date of diagnosis (month/year):
____breast cancer metastatic to the bones_____date
_____
_____
_____
_____

II. How would a grant from The Angela Andrade Foundation improve your quality of life during your illness?
_____
_____

III. Please include your personal statement. If you need additional space, please use a separate sheet of paper.
_____
_____
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_____

IV. Detail how you would use the funding. If awarded, the grant will be up to $1,800.

Amount	Item

V. How did you hear about The Angela Andrade Foundation? _____

VI. If awarded a grant, may we have your permission to post your comments on our website? We will only use your first

name and last initial. Yes ☐ No ☐

HIPAA FORM

To be filled out by patient and returned with application.

Authorization for Use/Disclosure of Protected Health Information

Physician's Name: _____

Physician's Address: _____

Physician's Phone Number: _____

Patient's Name: _____

Patient's Date of Birth: _____

I authorize the disclosure and use of protected health information about me to The Angela Andrade Foundation as detailed below.

1. **Information that may be disclosed/used**: The patient's diagnosis.

2. **Purpose for which information will be used/disclosed:** To confirm grant eligibility.

3. **Persons authorized to disclose information**: The Physician identified above, as well as his/her authorized representatives.

4. **Persons authorized to receive the information:** Employees or other authorized representatives of:

The Angela Andrade Foundation and
Charitable Ventures

To be filled out by physician ONLY and returned with application.

Physician's Contact Information:

_____

Name of Physician Telephone number Email Address

_____

Applicant's Diagnosis

I certify that I am the treating physician of the applicant.

_____

Signature Title Date