TATA SISTERHOOD

Support for Triple Negative Breast Cancer Patients

Application for Assistance

Please complete the information below so that we may determine the best way to assist you. We are obliged to maintain the confidentiality of your information and will use it solely for our internal processes and documentation. We are committed to providing a response to applicants within one week of receipt of the application. If for any reason you wish to reach us while you await a decision, please feel free to contact us by email at contact@tatasisterhood.org.

Today's Date: _____

Relationship to Applicant:

□ **Self** □ **Medical Professional** □ **Spouse/partner/parent/family member** □ **Friend**

How did you hear about the TaTa Sisterhood Foundation?

_____

Name: _____

E-mail: _____

Phone Number(s): _____

Street Address: _____

City, State, Zip: _____

Month and Year of TNBC Diagnosis: _____

Oncologist Name: _____ **Oncologist Phone**: _____

Oncologist Fax: _____

Please either provide a letter from your oncologist or a lab or other report confirming your diagnosis or sign the Disclosure Authorization attached hereto so that we may contact your oncologist to confirm. You only need to sign the Disclosure Authorization if you do not include your own confirmation documentation.

Please tell us about your cancer journey and why you are reaching out to the TaTa Sisterhood Foundation:

_____

_____

Would you be willing to share your story on our website or with others, if asked in the future?

_____

_____ _____

Date **Signature**

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The TaTa Sisterhood Foundation is a tax-exempt 501(c)(3) organization.

DISCLOSURE AUTHORIZATION

I authorize all health care providers, including physicians, nurses, and all other persons (including entities) who may have provided, or be providing, me with any type of health care, to disclose my diagnosis of Triple Negative Breast Cancer, which I understand is protected health information, to a representative of the TaTa Sisterhood Foundation for the purposes of determining my eligibility to receive benefits from the Foundation.

This authorization may be revoked by a writing signed by me or by my personal representative. This authorization shall expire six months after the date hereof unless validly revoked prior to that date.

_____ _____

Date **Signature**

_____

Date of Birth