



Grant Application Cover Page

Project Title: _____

Organization: _____

Tax ID Number: _____

Amount Requested: _____

Please indicate how the grant funds will be used by percentage:

_____ % Education _____ % Screening _____ % Treatment

Project Director Information

First Name: _____ Last Name: _____ Degree(s): _____

Email: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip (include +4): _____ -

Abstract: (Please limit your abstract to 1200 characters.):

Priority Area Addressed (select one primary priority area):

- [Priority 1 from RFA]
- [Priority 2 from RFA]
- [Priority 3 from RFA]

Geographical Area Served: _____

Does your agency receive funds from the Breast and Cervical Cancer Early Detection Program (BCCEDP) in your state? [Affiliate may change this question to reflect the name of their state's BCCEDP program]

- Yes
- No

Target Populations (select up to three primary populations):

Ethnic/Racial Groups

- African American
- American Indian/Alaskan Native
- Asian
- Hispanic/Latina(o)
- Middle Eastern
- Pacific Islander
- White/Caucasian

- Migrant Workers
- Refugees
- Rural

Health Professionals

- Health Educators
- Healthcare Providers
- Scientists

Patients

- Breast Cancer Patients
- Breast Cancer Survivors
- Lymphedema Patients
- Recently Diagnosed Patients

Other Groups

- Co-Survivors
- College Students
- Elderly (>65)
- High School Students
- Incarcerated
- Lesbian/Gay/Bisexual/Transgender
- Low-Literacy
- Men
- Persons With Disabilities

Medically Underserved

- Homeless
- Immigrants
- In a Shelter

Required Signatures

I understand that funding decisions are made at the sole discretion of [Affiliate Name].

Program Director

Signature: _____ Date: _____
Name: _____ Title: _____

Approving Institution Official Signature

Signature: _____ Date: _____
Name: _____ Title: _____