



## Grant Application Cover Page

### Organization Information

Project Title: \_\_\_\_\_

Organization Name: \_\_\_\_\_

Legal Name \_\_\_\_\_

Department: \_\_\_\_\_

Federal Tax ID: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip (include +4): \_\_\_\_\_ - \_\_\_\_\_

County: \_\_\_\_\_ Website: \_\_\_\_\_

Amount Requested: \_\_\_\_\_

Please indicate the type of organization (choose all that apply):

- |                          |   |                          |                          |                           |                          |                          |
|--------------------------|---|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 501(c)(3)                | Federally<br>qualified<br>health clinic | Hospital                 | Government<br>agency     | Religious<br>organization | School                   | University               |

### Project Director Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Degree(s): \_\_\_\_\_

Email: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip (include +4): \_\_\_\_\_ - \_\_\_\_\_

### Community Contact for General Public Resource

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Degree(s): \_\_\_\_\_

Telephone: \_\_\_\_\_

**Abstract: (Please limit your abstract to 1500 characters.)**

Provide a brief description of the proposal, in lay terms, including the following:

1. The purpose of the program
2. A description of key activities
3. A summary of evaluation methods
4. Conclude with likely impact of the program

**Please enter up to 10 keywords that describe your proposed project:**

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**Does this project/program incorporate evidence-based strategies/promising practices? If so, explain/cite:**

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**If evidence-based strategies/promising practices are not appropriate or available, explain why and describe a justified alternative:**

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

	% Education	% Screening	% Diagnosis
	% Treatment	% Treatment Support	
% Survivorship	% Health Care Delivery/Systems Change		

**Which of the priorities from our Community Profile does your project propose to address?**

- Access to breast health and breast cancer services for medically under-served, priority populations including free or low-cost screening, diagnostic, treatment, after-care and transportation services
- Patient navigation programs that remove any physical, cultural and/or linguistic barriers priority populations may face and ensures services and treatment throughout the entire continuum of care
- Community outreach program providing culturally appropriate, targeted education that explains breast cancer risk factors, breast self-awareness, screening guidelines and healthy lifestyle choices for women with a particular emphasis on medically under-served, priority populations

**Target Zip Codes:** \_\_\_\_\_

**If applicable, how long has your organization received funds from Komen for this project :** \_\_\_\_\_

**In what way is your organization involved with the National Breast and Cervical Cancer Early Detection Program (<http://www.cdc.gov/cancer/nbccedp/>) or Breast Cervical Cancer Services Program (<http://www.dshs.state.tx.us/bcccs/default.shtm>)?**

- Not Involved
- CDC Grantee
- Provider
- Contractor
- Other

**Partners** (List partnering organization and the services they will provide; letters of support are not necessary per Request for Applications instructions):

Organization	Services Provided (in-kind or direct)	Partner # Years	Amount/Value

**Target Populations (select up to four primary populations):**

**Ethnic/Racial Groups**

- |  |                                |
|--|--------------------------------|
| <input type="checkbox"/> Unspecified   | <input type="checkbox"/> Other |
| <input type="checkbox"/> African American, African descent<br>(non-Hispanic) | <input type="checkbox"/> Other |
| <input type="checkbox"/> American Indian/Alaskan Native                      | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asian   | <input type="checkbox"/> Other |
| <input type="checkbox"/> Caucasian/Anglo (non-Hispanic)                      |                                |
| <input type="checkbox"/> Hispanic/Latina(o)                                  |                                |
| <input type="checkbox"/> Middle Easterner                                    |                                |
| <input type="checkbox"/> Pacific Islander                                    |                                |

**General Population**

- Unspecified
- Youth 0-19
- Adults 20-39
- Adults 40-49
- Adults 50-64
- Adults 65+

**Gender**

- Unspecified
- Females
- Males

**Named Groups**

- Survivors
- Survivors, living with metastatic disease
- Co-Survivors
- English as a Second Language
- Immigrants, Newcomers, Refugees
- Offenders, Ex-Offenders
- Homeless
- Uninsured, Underinsured
- Healthcare providers
- Lesbian/Gay/Bisexual/Transgender
- Migrant Workers
- Jewish
- Persons with Disabilities

**Required Signatures**

I understand that funding decisions are made at the sole discretion of the Komen San Antonio Affiliate.

Program Director

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Approving Institution Official Signature

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_