



**2010-2011  
Grant Application Cover Page**

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

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

Tax ID Number: \_\_\_\_\_

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

\*\*Please indicate how the grant funds will be used by percentage. "Screening" is defined for these purposes as "clinical breast exam (CBE), mammogram, breast ultrasound, breast MRI, and other diagnostic tests to detect breast cancer".

\_\_\_\_\_ % Education    \_\_\_\_\_ % Screening    \_\_\_\_\_ % Treatment

**Project Director Information**

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

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Zip (include +4): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

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

**Priority Area Addressed (select one primary priority area):**

- [Priority 1 from RFA] Specify A, B, C, or D
- [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):**

(\*\*Please note that at several points in the RFA narrative, you will be asked to explain, specifically, how the project intends to reach the selected populations.)

**Ethnic/Racial Groups**

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

**Medically Underserved**

- Uninsured/underinsured/low income
- Immigrants
- In a Shelter
- Homeless
- Migrant Workers
- Refugees
- Rural

**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

**Health Professionals**

- Health Educators
- Healthcare Providers
- Scientists

**Required Signatures**

I understand that funding decisions are made at the sole discretion of the Mid-Michigan Affiliate of Susan G. Komen for the Cure.

Program Director

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Title: \_\_\_\_\_

Approving Institution Official Signature

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Title: \_\_\_\_\_