



## Small Grant Application

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

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

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.):

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: \_\_\_\_\_