Project Profile

Organization

If the organization information is not complete, please click on the My Organization tab on the upper right hand side of the page (you must save the page before clicking on my organization or none of your information will be saved). Complete all fields within the organization section.

Federal Tax ID Number
Legal Name
Organization Name
Street Address
City
State
Zip Code (9 digit)
Organization Website
Organization Type

Department/Unit/Area

Project Director
Project Director Phone #
Project Director Email
Preferred Contact Method

Primary Contact
Primary Contact Phone #
Primary Contact Email

Community Contact
Community Contact Phone #
Community Contact Email

Financial Contact
Financial Contact Phone #
Financial Contact Email

Project Overview

Title of Project (100 Characters or Less)

Requested Amount

Indicate any accreditations your organization has earned. Check all that apply.*

American College of Radiology - Breast Imaging Center of Excellence (BICOE)

Project Profile

American College of Surgeons - Commission on Cancer (CoC)
American College of Surgeons - National Accreditation Program for Breast Centers (NAPBC)
National Cancer Institute - Designated Cancer Center (NCI)
None of the above

How is the organization involved with National Breast and Cervical Cancer Early Detection Program? *

Not involved with my state BCCEDP program
CDC NBCCEDP Grantee
State BCCEDP Health Care Provider
State BCCEDP Contractor
Refer individuals to BCCEDP
Other (please specify):

Project Partners:

Include all project partners assisting with the proposed project. All supporting documentation must be current, signed and relevant specifically to the proposed project.

Organization	Services Provided	Partner # Years	Attach letters of support, letter of collaboration, MOU, etc.

Previous Support From This Affiliate Of Susan G. Komen® (last 5 Years):

If there is an error in the previous support section, please contact your Affiliate Grant Representative.

Date	Title of Project	Affiliate	Amount
From:To:			
From:To:			
From:To:			
From:To:			
From:To:			

Organization Summary

Provide a brief description of the organization's history and mission.

Describe current programs and accomplishments.

State of Incorporation
 # Paid Full-Time Staff
 # Paid Part-Time Staff
 # Volunteers
Organization Total Annual Budget

Provide Facebook and Twitter accounts in the textbox, if utilized.
Official Facebook Page
Official Twitter Account

Project Priorities and Abstract

Select one or more of the below funding priorities from the RFA that will be addressed:

Programs that provide no cost or low cost clinical breast cancer services and/or financial assistance with diagnostic and treatment copays/deductibles. See RFA for more information.

Abstract (limit 1,000 characters)

Provide a brief description of the project including the following:

- **·The need to be addressed by the project**
- **·List target population(s) served**
- **·List description of key activities**
- **·The expected number of individuals served**
- **·The expected or resulting change(s) your project will likely bring in your community (outcomes) and how you will measure them (what metrics will be used)**

Project Narrative

Enter up to 10 keywords, separated by commas, that describe your project.

Statement of Need
• Describe evidence of the risk/need within the identified population.
• Describe the target population to be served with Komen funding (e.g., Black/African American, low-income, rural) using race, ethnicity, socioeconomic and breast cancer mortality statistics.
• Describe how this project aligns with Komen target communities and/or RFA funding priorities.

Program Design
• Describe how the project will increase the percentage of people who enter, stay in or progress through the continuum of care and thereby reduce breast cancer mortality.
• Explain what specifically will be accomplished using Komen funding and how the project's goal and objectives align with the selected funding priorities.
• Explain how the project is designed to meet the needs of specific communities and reflects the cultural and societal beliefs, values and priorities of each community.
• Explain how the project incorporates an evidence-based intervention (please cite references).
• Explain how collaboration strengthens the project, including roles and responsibilities of all organizations and why partnering organizations are qualified to assist in accomplishing the goal and objectives. Organizations mentioned here should correspond with those providing letters of support/collaboration or MOUs on Project Profile page.

Organization Capacity
• Explain why the applicant organization and associated project staff are suited to lead the project and accomplish the goal and objectives. Include appropriate organization or staff licenses, certifications and/or accreditations.
• Describe evidence of success in delivering breast cancer services to the proposed population. If the breast cancer project is new, describe relevant success with other projects.
• Describe the equipment, resources, tools, space, etc., that the applicant organization possesses or will utilize to implement all aspects of the project.
• Describe the organization's current financial state and fiscal capability to manage all aspects of the project to ensure adequate measures for internal control of grant dollars. If the organizational budget has changed over the last three years, explain the reason for the change.

Monitoring and Evaluation
• Describe how the organization(s) will measure progress against the stated project goal and objectives, including the specific evaluation tools that will be used to measure progress. These tools

Project Narrative

can include client satisfaction surveys, pre- and post-tests, client tracking forms, etc. Please include any templates, logic models or surveys as attachments in the Project Work Plan page(s).
• Describe the specific outcomes that will be measured as a result of proposed project activities. Outcomes reported can include number of days to diagnostic resolution after an abnormal imaging test, number of days from diagnosis to first day of treatment, etc.
• Describe the resources and expertise available for M&E during the project period. Specify if the expertise and resources are requested as part of this project, or if they are existing organizational resources.

Please upload references/citations for evidence-based interventions below.

Target Area Addressed:
Applicants must include specific details on how the project intends to target individuals in Adair (IA), Bremer (IA), Buena Vista (IA), Calhoun (IA), Cass (IA), Decatur (IA), Lyon (IA), Ida (IA), Keokuk (IA), Madison (IA), O'Brien (IA), Wright (IA), Muscatine (IA), Clinton (IA), Thurston (NE), Mercer (IL), or Union Counties (SD). These details must be integrated into the project plan and not an "add-on" to the project.

Project Target Demographics

Please select up to 6 target populations from the categories of Race, Ethnicity, Age and Named Groups below. Please also select the counties/parishes your program intends to target from the Target Locations category. Please note that you are selecting populations your program intends to focus on by conducting targeted efforts to reach and serve these individuals.

Race

American Indian and Alaska Native
Asian
Black, African American or African Descent
Middle Eastern or North African
Native Hawaiian and Other Pacific Islander
White
Other race (please specify)

Hispanic, Latino or Spanish origin

Columbian
Cuban
Dominican
Mexican, Mexican American, Chicano
Puerto Rican
Salvadoran
Hispanic, Latino (no specific origin)
Other Hispanic, Latino or Spanish origin (please specify)

Age

39 Years and under
40-49 Years
50-64 Years
65 + Years

Special Populations

Amish, Mennonite
Breast cancer survivors
Healthcare Providers
Homeless, Individuals residing in temporary housing (i.e. shelter)
Immigrants, Newcomers, Refugees, Migrants
Individuals living with metastatic breast cancer
Individuals with disabilities
Individuals who identify as LGBTQ
Males
Rural residents (including Appalachian and Frontier)
Other
Other

Project Target Demographics

Target Locations

Please select the counties that your project will target. You may select as many as you like.Choose Counties

*

You must input at least one individual in the key personnel section. If your project is new and you have not hired someone for the project, place unknown in the name field.
If you have more than five individuals to place on the list, complete the first five rows and then click save. After you save the information more rows for you to complete will be under the original five rows. Repeat as many times as necessary.
To attach your documentation, click on the browse button and find the appropriate document within your files. Double click on the document and the name of the document should appear in the box. When you save the page, the document will attach to the page. Your attachment should not exceed 2 pages.

Please list each person associated with the project. Both personnel included in the budget request and those contributing to the project as in kind. Attach a copy of their resume / Curriculum Vitae (CV), not to exceed 2 pages, or job description ONLY if the position will be added for the funded project.

Name	Job Title	Role on Project	Attach Resume / Job Description

Project Work Plan - Goal

All applications must include one program goal. Fill in both the goal name and the goal description and click the save button to complete the goal.

Goal Name

Goal Description

Project Work Plan - Goal and Objectives

Project Goal

Reduce breast cancer mortality by addressing disparities, increasing access to quality and timely care, and/or improve outcomes through patient navigation.

Objective Name

Enter a SMART Objective that you will meet in order to deliver the Goal. For a guide to crafting SMART objectives, Click Here

Select one service that best represents this objective. For the full list of definitions Click Here.

Where in the Continuum of Care the service is taking place (select all that apply)

Education	**Diagnosis**
Screening	**Treament**

What is the planned timeline for completing that objective?
Start - End

Anticipated number of individuals to be served?

Attach sample evaluation forms, surveys, etc., that will be used to assess the progress and/or impact of these objectives.

Name	Job Title	Role on Project	Total Salary	Benefits	% of Salary on Project	Total
					%	
		Totals:				

If funds have been requested for salaries, a justification must be provided to include a brief description of each individual's role as it relates to the proposed project with an explanation covering why the requested salaries are necessary to achieve proposed objectives.

Consultant	**Agency Affiliation**	**Cost per Service or Hour**	**Number of Services or Hours to be Provided**	**Total**	**Where in the Continuum of Care is the service taking place? (select all that apply) Education Diagnosis Screening Treatment**

Consultant Total:

Sub-Contract Name	**Total**	**Where in the Continuum of Care is the service taking place? (select all that apply) Education DiagnosisScreening Treatment**

Sub-Contract Total:

Consultant and Sub-Contract Total:

Provide a brief justification explaining how the funds will be used, why they are necessary to achieve proposed objectives and how costs were estimated.

Supplies

Supplies	Number of Items	Cost per Item	Total
Other			
		Total:	

Provide a brief justification explaining how the funds will be used and why they are necessary to achieve proposed objectives.

Travel

Travel	Total
Lodging	
Air Travel	
Ground Transportation	
Meals	
Mileage	
Other	
Total:	

Provide an estimated expense calculation and a brief justification explaining how the funds will be used (e.g., number of expected trips), why they are necessary to achieve proposed objectives and how costs were estimated.

Additional documentation requested by Affiliate

Screening

Includes clinical screening procedures and barrier reduction services for individuals to detect breast cancer early. This would include genetic testing to assess breast cancer risk.

Screening	Number of Services to be Provided	Cost per Service	Total Costs
		Screening Total:	

Diagnostic

Includes clinical diagnostic services and barrier reduction services for individuals that have symptoms or received an abnormal mammogram. This would include genomic testing (not genetic testing) that is used to guide treatment decisions.

Diagnostic	Number of Services to be Provided	Cost per Service	Total Costs
		Diagnostic Total:	

Treatment

Includes clinical treatment services and barrier reduction services for those diagnosed with breast cancer.

Treatment	Number of Services to be Provided	Cost per Service	Total Costs
		Treatment Total:	

Transportation

Transportation cost for a patient related directly to receiving a patient care service: screening, diagnostic, and/or treatment.

Transportation	Type of Assistance (e.g., gas cards, bus pass)	Number of Services to be Provided	Cost per Service	Total Costs

Transportation Total:

Patient Care Total:

Provide a brief justification explaining how the funds will be used, why they are necessary to achieve proposed objectives and how costs were estimated.

Sub-Contracts

Sub-Contract Name	Total
Total:	

Provide written justification for all items requested in this section of the Budget

This section is required if you have requested funds for sub-contracts.

Other

Description	Total

Total:

Provide an estimated expense calculation and a brief justification explaining how the funds will be used, why they are necessary to achieve proposed objectives and how costs were estimated.

Additional documentation requested by Affiliate

Indirect Cost

Subtotal – Direct Costs	% Indirect Requested	Total
	%	
	Total:	
Maximum Indirect Allowed by RFA	%	

Provide a brief justification explaining how the funds will be used and why they are necessary to achieve proposed objectives.

Additional documentation requested by Affiliate

		From Other Sources		
	Requested from Komen	**Cash**	**In Kind**	**Total Required**
Salaries and Fringe				
Consultants/Subcontracts				
Supplies				
Travel				
Patient Care Costs				
Screening				
Diagnostics				
Treatment				
Transportation				
Other				
Subtotal – Direct Costs				
Indirect Costs				
Total:				

List the source(s) of cash and/or in-kind donation(s) and explain how such donation(s) will support the project.

What percentage of the organization's overall budget is the amount requested from Komen for this project?

%

Upload required proof of tax-exempt status, and other required financial/insurance documentation as outlined in the RFA.

Please indicate the percentage of total funds allocated between categories. The total must equal 100%.

Education (e.g., group or 1-1 education sessions, trainings)	%
Screening (e.g., provision of CBE or mammograms, lay navigation or care coordination of individuals into	%

screening, transportation assistance to access screening services)		
Diagnosis (e.g., provision of diagnostic services, patient navigation or care coordination of individuals into diagnostic services, transportation assistance to access diagnostic services)		%
Treatment (e.g., financial assistance for treatment, patient navigation or care coordination of individuals into treatment)		%
Treatment Support (e.g., financial assistance for daily living expenses, assistance with transportation)		%
Survivorship (e.g., support groups, complementary therapies, exercise/nutrition programs)		%
Healthcare Delivery Improvements (e.g., newly implemented reminder systems, expansion of clinic hours, telemedicine)		%
	Total:	%