



BREAST CANCER FUND OF OHIO

1506 Britain Road Akron OH 44310 | 866-976-BCFO (2236) | www.BCFohio.org

Show your support for breast cancer patients and survivors

Real help beyond medical care ... \$25 from every license plate helps women who are coping with the day-to-day challenges of living while being treated for breast cancer.

Breast Cancer Fund of Ohio Grant Application 2009 - 2010 Grant Cycle

Directions: Save this document to your computer and then tab-and-type to complete the application. Save frequently. If you need additional space for answers to the application questions, put them on an extra sheet of paper at the end of the application. Print when finished, apply appropriate signatures, attached required documents and mail to the Breast Cancer Fund of Ohio.

Section One - Organizational Information					
Applicant Organization (Full Legal Name)					
Doing Business As					
Previous Name, if changed					
IRS Name, as listed on 501 c 3 letter					
Street Address					
City		State		Zip	
Phone		Fax			
Mailing Address (if different than street address)					
City		State		Zip	
Email Address			Web site		
Phone			Fax		
IRS Letter date			Tax Exempt ID# (EIN)		
Executive Director			Direct Phone		
Organizational Affiliation (if applicable)					
Chapter of national or regional organization (specify)					

Section 2 - Program Information			
Program/Project Title			
Program Manager		Direct phone	
Email		Fax	
Date Program Established			
Sources of Program Funding & Amounts			
Previous Year Budgeted Expenses of Program			
Current Year Budgeted Expenses of Program			
Number of Clients Served in Previous Year			
Estimated # of Clients Served in Grant Year			
Program/Project Objectives: <i>(List at least 3 primary objectives of your program)</i>			
1.			
2.			
3.			
Brief Demographic Description of Population Served			
If you receive a grant from BCFO, would you consider utilizing the funds to serve patients in additional counties in your area? If yes, which ones?			
If you receive a grant from BCFO and you are a health care provider, would you consider utilizing the funds to serve patients treated at other health care facilities? If yes, which ones?			

Section 3 - Program Grant Request					
Overall Program Budget		Total Budget Amount			
Grant Request		Other Funding			
Personnel Expenses (if applicable)		Check here if Personnel Expenses are not applicable <input type="checkbox"/>			
Title of Personnel		Expenses		% of time on Project	
Specific Program Expenses					
Patient Assistance	BCFO Grant Request	Other Funding		Total Budget	
Housing					
Utilities					
Transportation					
Medical					
Other					
Total					

Section 4 - Attachments

Please attach the following to your proposal:

1. Copy of Organization's IRS determination letter
2. One page resume for Project Director
3. Current Organization Budget (for health care providers, attach a copy of your Patient Assistance Program budget)

Section 5 - Signatures

We the undersigned agree that any funds provided will be used solely for the purpose listed in the Guidelines for Application to the Breast Cancer Fund of Ohio. (<http://www.BCFOhio.org/guidelines.pdf>)

Signatures (*both are required unless otherwise specified by BCFO*)

Signature of Executive Director	Print Name
Signature of Board President	Print Name