Helping with the day-to-day challenges of living while being treated for breast cancer

Your support provides emergency funds for those fighting breast cancer who need help with housing, food, medical co-pays, and more

Grant Application

Grant Period: January – December 2024
Deadline: November 1, 2023
Report Due: December 31, 2024

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 1 – Organizational Information					
Applicant Organization (Full Legal Name)					
Doing Business As					
Previous Name, if changed					
Organizational Affiliation (if applicable)					
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	
Phone			Fax		
IRS Letter date			Tax Exempt ID# (EIN)		
Mission Statement					
Executive Director			Direct Phone		
Email Address			Web site		

Section 2 - Program Information

Title of Program that Provides Emergency Funds for Breast Cancer Patients			
Program Manager		Direct phone	
Email		Fax	
Date Program Established			
Brief Demographic Description of Population Served			

Counties You Will Serve (Check all that apply) Note: When you apply for funds for specific counties, you agree to help patients undergoing breast cancer treatment currently living in the counties you receive funding for, regardless of where those patients are being treated (for example, if you are a health provider, you cannot deny a breast cancer patient emergency funds if that patient is not being treated at your facility).								
	☐ Adams ☐ Allen ☐ Ashland ☐ Ashtabula ☐ Athens ☐ Auglaize ☐ Belmont ☐ Brown ☐ Butler ☐ Carroll ☐ Champaign	☐ Clark ☐ Clermont ☐ Clinton ☐ Columbiana ☐ Coshocton ☐ Crawford ☐ Cuyahoga ☐ Darke ☐ Defiance ☐ Delaware ☐ Erie	☐ Fairfield ☐ Fayette ☐ Franklin ☐ Fulton ☐ Gallia ☐ Geauga ☐ Greene ☐ Guernsey ☐ Hamilton ☐ Hancock ☐ Hardin	☐ Harrison ☐ Henry ☐ Highland ☐ Hocking ☐ Holmes ☐ Huron ☐ Jackson ☐ Jefferson ☐ Knox ☐ Lake ☐ Lawrence	☐ Licking ☐ Logan ☐ Lorain ☐ Lucas ☐ Madison ☐ Mahoning ☐ Marion ☐ Medina ☐ Meigs ☐ Mercer ☐ Miami	☐ Monroe ☐ Montgomery ☐ Morgan ☐ Morrow ☐ Muskingum ☐ Noble ☐ Ottawa ☐ Paulding ☐ Perry ☐ Pickaway ☐ Pike	☐ Portage ☐ Preble ☐ Putnam ☐ Richland ☐ Ross ☐ Sandusky ☐ Scioto ☐ Seneca ☐ Shelby ☐ Stark ☐ Summit	☐ Trumbull ☐ Tuscarawas ☐ Union ☐ Van Wert ☐ Vinton ☐ Warren ☐ Washington ☐ Wayne ☐ Williams ☐ Wood ☐ Wyandot

Section 3 - Breast Cancer Patients Served

Item	Response
Total Number of Breast Cancer Patients Served in Past Calendar Year	
Number of Breast Cancer Patients Provided Emergency Funds in Past Calendar Year	
Amount of Emergency Funds Distributed to Breast Cancer Patients in Past Calendar Year	$
Other Sources of Emergency Funds	
Projected Number of Breast Cancer Patients Served This Calendar Year	
Grant Period	
Projected Number of Breast Cancer Patients Needing Emergency Funds This Grant Period	
Projected Amount of Funds Needed for Distribution to Breast Cancer Patients this Grant Period	
Amount of Funds You Are Requesting from the Breast Cancer Fund of Ohio this Grant Period	

Section 4 - Attachments

Please attach the following to your proposal:

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

Section 5 - Signatures

We the undersigned agree that our organization is eligible for funding from the Breast Cancer Fund and 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/grantmaking.htm). We also agree that we will promote the Breast Cancer Awareness License Plate in our area; this will include, but not be limited to, a link to www.BCFOhio.org on our website and literature as well as distribution of BCFOhio materials at special events.

Place a checkmark in the boxes to indicate you can provide documentation for the following upon request:

- ☐ Our organization is a designated 501(c)(3) or 501(c)(4) non-profit organization by the IRS
- ☐ We filed a Form 990 (short or long form) in the past year
- ☐ We are physically located and incorporated in, and serving breast cancer patients in, the state of Ohio
- ☐ We have an office and staff of at least one individual
- ☐ We participate in ongoing education programs related to cancer treatment and support
- ☐ We have a written non-discrimination policy and follow practice guidelines based on evidence-based medicine
- ☐ We provide education and application assistance to breast cancer patients regarding availability of existing services
- ☐We provide financial counseling to clients who receive the benefits of this emergency funds and/or or we provide them with information about financial counseling websites such as http://www.cancerfac.org/
- ☐ All options for reimbursement of these expenses or eligibility for existing programs are explored and exhausted prior to use of BCFO funds
- ☐ Patient requests for emergency funding are evaluated/responded to at least once a month.
- ☐ We agree to help patients undergoing breast cancer treatment currently living in the counties indicated in the application above, regardless of where those patients are being treated
- ☐ We record and will report to the BCFOhio the following demographics, and our application form clearly states that these questions are asked solely for statistical purposes and do not affect the patients' chances of receiving funds. All answers will remain confidential and will be reported only in aggregate data
  - # of patients per county
  - # of insured vs uninsured clients
  - # of patients employed, unemployed before diagnosis, unemployed after diagnosis
  - # of males vs females
  - # of patients in age ranges (0-19, 20-39, 40-59, 60 and over)
  - # of patients in income ranges (poverty, low income, mid income, high income - as determined by patient)
  - # of patients in ethnicity categories (White, Black, Hispanic, Asian, Multi-Racial, Other - as determined by patient)

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

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