

**2010 REQUEST FOR APPLICATION (RFA)**



**GRANT APPLICATION**

**FOR**

**BREAST HEALTH CARE AND EDUCATION PROJECTS**

**FROM**

**THE PEORIA MEMORIAL AFFILIATE OF SUSAN G. KOMEN FOR THE CURE®**

The Peoria Memorial Affiliate of Susan G. Komen for the Cure® offers grants in Central Illinois for innovative projects in the following areas:

- raise awareness and change people's beliefs and attitudes about breast cancer;
- to increase the regular use of mammography by women over forty;
- to improve access to quality care for women in need of diagnostic and treatment services;
- to enhance the quality of life of persons with breast cancer;
- \*\*to improve enrollment in clinical trials of women with breast cancer, especially minority women with breast cancer.

Applications should be sent to:

Helene M. Peterson, Grants Chairperson  
The Peoria Memorial Affiliate of Susan G. Komen for the Cure®  
4700 N. University Street, Suite 92  
Peoria, IL 61614  
(309) 691-6906  
FAX: (309) 691-7259  
E-Mail: [lkellogg@komenpeoria.org](mailto:lkellogg@komenpeoria.org) or [hmpeterson1@comcast.net](mailto:hmpeterson1@comcast.net)

**APPLICATIONS MUST BE RECEIVED BY 4:00 P.M.,**  
**WEDNESDAY, SEPTEMBER 30, 2009**

GRANT RECIPIENTS WILL BE NOTIFIED IN THE 1<sup>ST</sup> QUARTER OF 2010.



## Request for Applications

The Peoria Memorial Affiliate of Susan G. Komen for the Cure®—along with those who generously support us with their talent, time and resources—is working to better the lives of those facing breast cancer in our community. We join more than 100,000 breast cancer survivors and activists around the globe as part of the world’s largest and most progressive grassroots network fighting breast cancer. Through events like the Komen Peoria Memorial Race for the Cure, we have invested over \$6 million in local breast health and breast cancer awareness projects in our 10 county service area. Up to 75 percent of net proceeds generated by the Komen Peoria Memorial Affiliate stay in the 10 county geographic area. The remaining income goes to the national Susan G. Komen for the Cure Grants Program for energizing science to find the cures.

### **About Susan G. Komen for the Cure**

For more information about Susan G. Komen for the Cure, breast health or breast cancer, visit [www.komen.org](http://www.komen.org) or call 1-877 GO KOMEN.

### **Funding Opportunities**

**1. Community Grants:** The Komen Peoria Memorial Affiliate (KPMA) is currently offering grants for innovative programs that reduce breast cancer mortality and morbidity, especially among those who are disproportionately affected by this disease. The Peoria Affiliate supports the common goals of Susan G. Komen for the Cure® to:

- A.) raise awareness and change people’s beliefs and attitudes about breast cancer;
- B.) to increase the regular use of mammography by women over forty;
- C.) to improve access to quality care for women in need of diagnostic and treatment services;
- D.) to enhance the quality of life of persons with breast cancer.

In addition to supporting ongoing Affiliate efforts to achieve the common goals stated above, through a community needs assessment (available at [www.komenpeoria.org](http://www.komenpeoria.org)) we have identified the following funding priority areas for 2010:

1. To increase awareness about breast cancer among women in the Komen Peoria Affiliate Service Area (KPMASA), especially women living in rural areas and black women in Peoria County
2. To overcome barriers of access, cost, transportation, knowledge deficits and/or making breast health a priority to increase regular mammography in (low income) women 40 years and older in KPMASA, and particularly among women in rural areas and black women in Peoria County

3. To overcome barriers of access, cost, transportation, and/or making breast health a priority to improve quality care for low income women 40 years and older in KPMASA, and particularly among women in rural areas and black women in Peoria County in need of diagnostic and treatment services
4. \*\*To improve enrollment in clinical trials of women with breast cancer, especially minority women with breast cancer

**2. \*\*Community Grants for Clinical Trials:** The Peoria Memorial Affiliate of Susan G. Komen for the Cure fulfills its promise, in part, by offering grants to enhance the capacity of breast cancer clinical research conducted in the Komen 10 county service area to increase the number of women enrolled in breast cancer clinical research studies.

Although there have been major advances in cancer prevention, treatment and diagnosis, according to the National Cancer Institute (NCI), less than 5 percent of adults diagnosed with cancer each year will get treatment through enrollment in a clinical trial. In addition to the broad gap in overall enrollment, there is further concern that enrolled individuals should be representative of the broader population. Several sub-populations including women, low income individuals, the elderly, and racial and ethnic minorities are not adequately represented in cancer clinical trials.

The Komen Peoria Memorial Affiliate further seeks to fund projects that employ effective strategies to overcome barriers to enrollment and retention in breast cancer clinical research. Collaborative projects between institutions and community-based organizations are encouraged.

Komen Affiliates may not fund research. Grants for clinical trial enrollment must be exclusively for activities to increase enrollment and not for the research itself. Allowable costs would include transportation assistance, outreach and education to potential patients and health care providers, salaries for staff dedicated to recruitment and retention of clinical trial participants.

**Note:** Organizations seeking grants for breast cancer research should apply directly to Komen for the Cure's Headquarters. For more information, please contact Komen Headquarters at 1-877-GO-KOMEN or visit its web site at [www.komen.org/grants](http://www.komen.org/grants).

**Important Dates**

Grant writing Workshop	August 19, 2009
Application Deadline	September 30, 2009
Award Notification	March, 2010
Award Period	April 1, 2010-March 31, 2011

## Eligibility

Applicants and institutions must conform to the following eligibility criteria to be considered for funding:

- Applicants must ensure that all past and current Komen-funded grants or awards are up-to-date and in compliance with Komen requirements.
- Institutions must be non-profit organizations located in or providing services to one or more of the following locations:  
**Fulton, Hancock, Knox, Marshall, Mason, McDonough, Peoria, Stark, Tazewell, and Woodford Counties.**
- Project must be specific to breast health and/or breast cancer
- \*\*Conducting National Cancer Institute (NCI) or Department of Defense (DOD) approved breast cancer clinical research. This includes studies through the Clinical Trials Cooperative Group Program including but not limited to ACOSOG, ECOG, SWOG, NSABP, ACRIN, and RTOG.

## Allowable Expenses

Funds may be used for the following types of program expenses:

- Salaries and fringe benefits for program staff
- Consultant fees
- Clinical services or patient care costs
- Meeting Costs
- Supplies
- Travel
- Other direct program expenses
- Equipment, \$5,000 maximum
- Indirect costs, not to exceed 15% of direct costs

Funds may **not** be used for the following purposes:

- Medical or scientific research
- Scholarships or fellowships
- Construction or renovation of facilities
- Political campaigns or lobbying
- Endowments
- Debt Reduction

## Educational Materials and Messages

Susan G. Komen for the Cure<sup>®</sup> is a source of information about breast cancer for people all over the world. To reduce confusion and reinforce learning, we require that grantees provide educational messages and materials that are consistent with those promoted by Komen for the Cure. Please visit the following website before completing your application and be sure that your organization can agree to promote these messages: [www5.komen.org/BreastCancer/BreastSelfAwareness.html](http://www5.komen.org/BreastCancer/BreastSelfAwareness.html)

Komen for the Cure grantees are eligible to receive preferred pricing for Komen educational materials. Komen for the Cure materials should be used and displayed whenever possible. To view our educational materials, visit [www.shopkomen.org](http://www.shopkomen.org).

**Contracts:** A grant contract will be the legal mechanism for funding.

**Grant Period:** Grant period begins April 1, 2010 and will conclude on March 31, 2011.

**Payment and Reporting:** Payments will be made quarterly. The first and third quarterly progress reports are due July 31, 2010 and January 31, 2011, respectively. The Mid-year progress report is due October 31, 2010. The Final report is due April 30, 2011.

**Letters of support and additional materials:** Please do **NOT** send additional materials (i.e. reprints, complete curriculum vitae or letters of support). These will not be reviewed.

**Confirmation of receipt of application:** Confirmation of receipt of application will be forwarded to the project director following review for compliance guidelines. Please do not contact the Peoria Memorial Affiliate of Susan G. Komen regarding the status of the application during the review period.

**ANNOUNCEMENT:** Announcement of grants awarded will be made in the first quarter of 2010 to Project Directors.

### **Submission Requirements**

All proposals must be type-written on plain, white, single-sided 8 ½ x 11 paper using 12-point font. **14 copies (one original and thirteen duplicates)** should be submitted. The pages should be numbered and each copy stapled in the top left corner. No special packaging (binders, plastic covers, etc.) or additional material (videotapes, annual reports, brochures, etc.) should be included. **[In addition, please email the proposal and all attachments, as a word document, to the following email address: [lkelloqq@komenpeoria.org](mailto:lkelloqq@komenpeoria.org)]**

Applications must be received on or before 4:00 PM **Wednesday, September 30, 2009** at 4700 N. University, Suite 92, Peoria, IL 61614. No late submissions will be accepted.

*(Monies are not available for projects funded by federal or state dollars appropriated through the CDC according to age and economic factors.)*

**NO FAX COPIES WILL BE ACCEPTED!**

**Failure to adhere to these guidelines will result in delayed processing or refusal of the application.**

## **Review Process**

Each grant application will be reviewed by at least three independent reviewers. They will consider each of the following selection criteria:

**Impact:** Will the program have a substantial positive impact on breast cancer disparities and the priority area selected?

**Feasibility:** How likely is it that the objectives and activities will be achieved within the scope of the funded program?

**Capacity:** Does the organization, Program Director and his/her team have the expertise to effectively implement all aspects of the program? Is the organization respected and valued by the target population?

**Collaboration:** Does this program enhance collaboration among organizations with similar or complementary goals?

**Sustainability:** Is the program likely to be sustained? Is the impact likely to be long-term?

The grant application process is competitive, whether or not an organization has received a grant in the past. Funding in subsequent years is never guaranteed.

**Customer Support:** Questions should be directed to

Helene M. Peterson,  
Grants Chairperson  
309-453-7022  
[hmpeterson1@comcast.net](mailto:hmpeterson1@comcast.net)

Gayle Young,  
Mission Director  
309-691-6906  
[gyoung@komenpeoria.org](mailto:gyoung@komenpeoria.org)



## Application Instructions

### **APPLICATIONS SHOULD INCLUDE AND BE ORDERED AS FOLLOWS:**

**ONE HARD COPY OF THE FOLLOWING:**

- One list of names and Affiliations of members of the Board of Directors for the organization
- One copy of the most recent financial statement, audited if available, showing actual expenses. This information should include a balance sheet, a statement of activities (or statement of income and expenses) and functional expenses.
- One copy of the organizational budget for current year, including income and expenses.
- One copy of Information regarding Key Personnel – For key personnel that are currently employed by the applicant, provide a resume or curriculum vitae. For new or vacant positions, provide job descriptions (*Two page limit per individual*).
- One proof of non-profit status for applicant institution. To document your federal tax-exempt status, attach your determination letter from the Internal Revenue Service. Evidence of state or local exemption will not be accepted. Please do not attach your Federal tax return.
- Additional funders. List names of corporations and foundations from which you are requesting funds, with dollar amounts, indicating which sources are committed or pending.

**AN ORIGINAL (*MARKED ORIGINAL*), AND 13-STAPLED COPIES OF THE APPLICATION, THAT SHOULD INCLUDE AND BE ORDERED AS FOLLOWS: (E-MAIL AN ELECTRONIC WORD COPY TO THE OFFICE)**

### **Grant Application Cover Page**

Complete the attached cover page including an abstract (project summary). The abstract should be limited to 1,200 characters, including spaces and punctuation (approximately 225 words). The abstract should provide a brief description of the proposal including the following:

- a. the purpose of the program;
- b. a description of key activities;
- c. a summary of evaluation methods;
- d. the likely impact of the program.

The **signature of approving institutional personnel**, other than the project director, is required.

\*\*Community Grant for Clinical Trial enrollment go to page 9.

### **Community Grant Program Description (use attached forms):**

1. **Background:** Describe the organization's history, mission, and goals. Describe current programs and recent accomplishments. **(Form: A)**
2. **Statement of Need/Problem:** Describe why the proposed project is needed. Describe the population to be served. Review comparable programs offered in this service area and explain how this program is unique. **(Form: A)**
3. **Goals and Evidence Based Measurable Objectives:** State the program goals and measurable objectives, including the number of people to be served. Explain how the goals and objectives address the selected priority area. **(Form: B)**
4. **Activities / Timeline:** Describe the activities that will be conducted to accomplish the above goals and objectives. Provide a realistic, timeline for implementing the program. **(Form: B)**
5. **Evidence Based Measurable Outcome Plan:** Describe how you will measure that you are achieving the objectives and how you will assess the impact of the program on the priority area selected. **(Form: B)**
6. **Collaboration/Other Sources of Funding:** Describe the other organizations or entities, if any, participating in the Program. Please list any other sources of support for this breast cancer program, i.e., Mammograms Save Lives, Ticket for the Cure, Hospital support, etc. **(Form: C)**
7. **Organizational Capacity:** Describe the organization's experience serving the target population. Describe the other organizations, if any, participating in the program. Explain why your organization is best-suited to carry out the program. Attachment: **(Form: C)**
8. **Sustainability:** Explain how this program and its impact will be sustained long-term. What resources (financial, personnel, partnerships, etc.) will be needed to sustain this effort over time? How will those resources be secured? Applicants should demonstrate that other sources of funding will be sought and used to support this project. **(Form: C)**

### **Budget (Form: D)**

Provide a detailed total program budget. Please note that indirect costs may not exceed 15% of direct costs and equipment costs may not exceed \$5,000.

### **Budget Justification**

For each line item in the budget, provide a brief description of how the funds will be used and why they are programmatically necessary. List all other committed and pending sources of support for the program. **(Form: E)**

## **\*\*Community Grant for Clinical Trial Enrollment:**

### **Basic Study Information (Not to exceed one page)**

Briefly describe, in lay terms, the approved breast cancer clinical research trial(s)/study(ies) which will be the focus of this project. Include the title of the trial/study; phase; type of trial/study; eligible participants; purpose; when the trial/study began; sponsor; and protocol ID.

**Attach an IRB approval letter for Community Grant for Clinical Trial Enrollment.**

### **Program Description (use attached forms):**

1. **Background:** Describe the organization's history, mission, and goals. Describe current programs and recent accomplishments. **(Form: A)**
2. **Statement of Need/Problem:** Describe why the proposed project is needed. Describe the population to be served. Indicate the barriers to enrollment and retention in clinical research studies experienced by the population to be served (e.g. lack of awareness, financial constraints, transportation issues, cultural values, beliefs, preferences and/or practices that affect behaviors) and how the project aims to overcome these barriers. **(Form: A)**
3. **Goals and Evidence Based Measureable Objectives:** State the program goals and measurable objectives, including the number of people to be educated and enrolled in breast cancer clinical research and/or to receive support services that facilitate participation in breast cancer clinical research. **(Form: B)**
4. **Activities and Timeline:** Describe the activities that will be conducted to accomplish the above goals and objectives. Provide a realistic, month-by-month timeline for implementing the program. **(Form: B)**
5. **Evaluation Plan:** Describe how you will measure that you are achieving the objectives and how you will assess the impact of the program on the priority area selected. **(Form: B)**
6. **Collaboration:** Describe the other organizations or entities, if any, participating in the Program. **(Form: C)**
7. **Organizational Capacity:** Describe the organization's experience serving the target population. Describe the other organizations, if any, participating in the program. Explain why your organization is best-suited to carry out the program. **(Form: C)**
8. **Sustainability:** Explain how this program and its impact will be sustained long-term. What resources (financial, personnel, partnerships, etc.) will be needed to sustain this effort over time? How will those resources be secured? Applicants should demonstrate that other sources of funding will be sought and used to support this project. **(Form: C)**

### **Budget (Form: D)**

Provide a detailed total program budget. All funding for this program, including other grants and general funds should be included in the budget. Please note that indirect costs may not exceed 15% of direct costs and equipment costs may not exceed \$5,000.

### **Budget Justification**

For each line item in the budget, provide a brief description of how the funds will be used and why they are programmatically necessary. List all other committed and pending sources of support for the program. **(Form: E)**

Office Use Only:

Proposal # \_\_\_\_\_



## Grant Application Cover Page

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

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

Federal Tax ID  
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**, including spaces and punctuation):

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

\_\_\_1. To increase awareness about breast cancer among women in Peoria Affiliate, especially women living in rural areas and black women in Peoria County

\_\_\_2. To overcome barriers of access, cost, transportation, knowledge deficits and/or making breast health a priority in increase regular mammography in (low income) women 40 years and older in PMA, and particularly among women in rural areas and black women in Peoria County

\_\_\_3. To overcome barriers of access, cost, transportation, and/or making breast health a priority to improve quality care for (low income) women 40 years and older in Peoria Affiliate, and particularly among women in rural areas and black women in Peoria County in need of diagnostic and treatment services

\_\_\_4. \*\*To improve enrollment in clinical trials of women with breast cancer, especially minority women with breast cancer

Geographical Area Served:

Does your agency receive funds from the Breast and Cervical Cancer Early Detection Program (BCCEDP) in your state?

- Yes
- No

**Target Populations (select only three primary populations):**

**Ethnic/Racial Groups**

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

**Medically Underserved**

- Homeless
- Immigrants
- In a Shelter
- Migrant Workers
- Refugees
- Rural

**Patients**

- Breast Cancer Patients
- Breast Cancer Survivors
- Lymphedema Patients
- Recently Diagnosed Patients

**Health Professionals**

- Health Educators
- Healthcare Providers
- Scientists

**Other Groups**

- Co-Survivors
- College Students
- Elderly (>65)
- High School Students

- Incarcerated
- Lesbian/Gay/Bisexual/Transgender
- Low-Literacy
- Men
- Persons With Disabilities

**Target Population Description (optional)**

Enter specific details for this target population.

**Required Signatures**

I understand that funding decisions are made at the sole discretion of Peoria Memorial Affiliate of Susan G. Komen for the Cure®.

**Program Director**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Approving Institution Official Signature**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

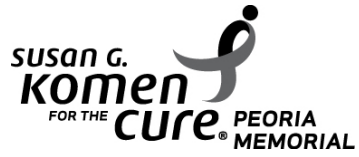
**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_



## Organizational Background

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

<p>Organization's Mission Statement:</p>	
<p>Give a <b>brief</b> summary of the organization's history, programs, and purpose.</p>	



<p>Describe current programs and recent accomplishments</p>	
<p>Statement of need/problem</p>	



(Please use a separate sheet for each goal.)

**Goal & Measurable Objective:**

**Activities/Timeline:**

**Evidence Based Measurable Outcome Plan** (@ 6 and 12 months):

**Evaluation of the Goal and Measurable Outcome Plan:**

(Fill out after project is completed as a part of final report.) Due 30 days following granting period

**(Please use this form or format)**

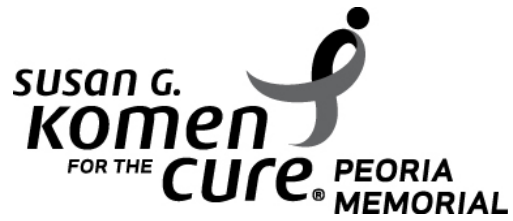
**(Please use a separate sheet for each goal.)**



**Collaboration/Other Sources of Funding:**

**Organizational Capacity:**

**Sustainability:**



**Budget**

Organization:	Requested From Komen
<b>Salaries</b> (List names and amounts in budget justification-FORM E)	
<b>Fringe</b> (Benefits and Payroll Taxes)	
<b>Subtotal - Salaries and Fringe</b>	<b>.00</b>
<b>Consultant Costs</b>	
<b>Supplies</b> (Itemize by Category in Budget Justification-FORM E)	
<b>Equipment</b> (not to exceed \$5,000 maximum)	
<b>Travel</b> (Mileage at IRS rate)	
<b>Patient Care Costs*</b>	
<b>Screening</b>	
<b>Diagnostics</b>	
<b>Treatment</b>	
<b>Sub-Contracts</b>	
<b>Other</b> (itemize in Budget Justification-FORM E)	
<b>Subtotal - Direct Costs</b>	<b>.00</b>
<b>Indirect Costs</b> (not to exceed 15% of direct costs)	<b>.00</b>
<b>Total Funding Request</b>	<b>.00</b>

\*Current Medicare Rate

Attach Budget Narrative/Justification



**Budget Justification:** (begin typing here)



**First Quarter Budget Progress Report**

<b>Grant Number:</b>	<b>Original/Revised Approved Budget</b>	<b>Komen Expenses through June 30</b>
<b>Salaries (itemized in Budget Justification)</b>		
<b>Fringe (Benefits and Payroll Taxes)</b>		
<b>Subtotal - Salaries and Fringe</b>	<b>.00</b>	<b>.00</b>
<b>Consultant Costs</b>		
<b>Supplies</b>		
<b>Equipment (not to exceed \$5,000 maximum)</b>		
<b>Travel (Mileage at IRS rate)</b>		
<b>Patient Care Costs*</b>		
<b>Screening</b>		
<b>Diagnostics</b>		
<b>Treatment</b>		
<b>Sub-contracts</b>		
<b>Other (itemized in Budget Justification)</b>		
<b>Subtotal - Direct Costs</b>	<b>.00</b>	<b>.00</b>
<b>Indirect Costs (not to exceed 15% of direct costs)</b>	<b>.00</b>	<b>.00</b>
<b>Total</b>	<b>.00</b>	<b>.00</b>

**Program Director Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Name (Typed):** \_\_\_\_\_ **Title:** \_\_\_\_\_

\*Medicare Rate

ATTACH 1<sup>st</sup> QUARTER DOCUMENTATION

**Due July 31 of Grant Year**



Due Date: October 31, 2010

### Mid-Year Grant Progress Report

**Grant Number and Project Title:** \_\_\_\_\_

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

**Contact Person:** \_\_\_\_\_

**FEIN:** \_\_\_\_\_

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

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

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

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip (include +4):** \_\_\_\_\_

**Period Covered by Progress Report** From: April 1 To: September 30

Specific Aims: (insert objectives from application)	Percent Completed: (This must be an actual percentage)				
	1-25%	26-50%	51-75%	76-100%	N/A
Objective 1:					
Objective 2:					
Objective 3:					
Objective 4:					
Objective 5:					

**Number of People Served**

_____	Breast Cancer Education
_____	Breast Cancers Detected
_____	Clinical Breast Exams
_____	Clinical Trials Education
_____	Clinical Trials Enrollment
_____	Complementary/Alternative Medicine
_____	Diagnostic Services Provided
_____	Educational Materials Provided
_____	Mammogram Performed
_____	Psychosocial Support
_____	Referred for Diagnostic Services
_____	Referred for Mammogram
_____	Treatment Assistance
_____	Other

1. **Project Progress Report:** In this section please provide a short summary describing the outcomes and accomplishments of this project, describe the progress toward meeting the measurable objectives as outlined in the grant application, including number of people served during this period. (1 page)
2. **Other Sources of Support:** In this section, please list any notice or receipt of other sources of support for this project received during the past six months. (1 page, if any)
3. **Project Materials:** In this section, please list and attach all published or produced materials, pictures, etc. for the past six months. (1 page plus attachments)
4. **Accounting of Grant Funds:** Please attach a current accounting of grant funds using the Budget Progress Report (**FORM: H**) and 2<sup>nd</sup> Quarter attach documentation.



**Mid-Year Budget Progress Report**

<b>Grant Number:</b>	<b>Original/Revised Approved Budget</b>	<b>Komen Expenses through September 30</b>
<b>Salaries (itemized in Budget Justification)</b>		
<b>Fringe (Benefits and Payroll Taxes)</b>		
<b>Subtotal - Salaries and Fringe</b>	<b>.00</b>	<b>.00</b>
<b>Consultant Costs</b>		
<b>Supplies</b>		
<b>Equipment (not to exceed \$5,000 maximum)</b>		
<b>Travel (Mileage at IRS rate)</b>		
<b>Patient Care Costs*</b>		
<b>Screening</b>		
<b>Diagnostics</b>		
<b>Treatment</b>		
<b>Sub-contracts</b>		
<b>Other (itemized in Budget Justification)</b>		
<b>Subtotal - Direct Costs</b>	<b>.00</b>	<b>.00</b>
<b>Indirect Costs (not to exceed 15% of direct costs)</b>	<b>.00</b>	<b>.00</b>
<b>Total</b>	<b>.00</b>	<b>.00</b>

**Program Director Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Name (Typed):** \_\_\_\_\_ **Title:** \_\_\_\_\_

**\*Medicare Rate**                      ATTACH 2<sup>ND</sup> QUARTER DOCUMENTATION                      **Due October 31 of Grant Year**



**Third Quarter Budget Progress Report**

<b>Grant Number:</b>	<b>Original/Revised Approved Budget</b>	<b>Komen Expenses through December 31</b>
<b>Salaries (itemized in Budget Justification)</b>		
<b>Fringe (Benefits and Payroll Taxes)</b>		
<b>Subtotal - Salaries and Fringe</b>	<b>.00</b>	<b>.00</b>
<b>Consultant Costs</b>		
<b>Supplies</b>		
<b>Equipment (not to exceed \$5,000 maximum)</b>		
<b>Travel (Mileage at IRS rate)</b>		
<b>Patient Care Costs*</b>		
<b>Screening</b>		
<b>Diagnostics</b>		
<b>Treatment</b>		
<b>Sub-contracts</b>		
<b>Other (itemized in Budget Justification)</b>		
<b>Subtotal - Direct Costs</b>	<b>.00</b>	<b>.00</b>
<b>Indirect Costs (not to exceed 15% of direct costs)</b>	<b>.00</b>	<b>.00</b>
<b>Total</b>	<b>.00</b>	<b>.00</b>

**Program Director Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Name (Typed):** \_\_\_\_\_ **Title:** \_\_\_\_\_

\*Medicare Rate                      ATTACH 3<sup>RD</sup> QUARTER DOCUMENTATION                      Due January 31 of Grant Year



## Request for Grant Change

<b>GRANT #:</b>
<b>ORGANIZATION:</b>
<b>DATE SUBMITTED:</b>

\_\_\_\_\_ No cost extension. Change in ending date only) (Attach explanation)

Request ending date be extended from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Budget change. For reducing the budget or moving funds between categories. This form may not be used to increase the budget. Funds may be reallocated up to 5% of total Grant Funds without a formal request to the Affiliate. (Please attach revised budget change form- Form K and justification.)

\_\_\_\_\_ Personnel change. (Attach explanation and curriculum vitae of proposed new personnel.)

Position to be changed \_\_\_\_\_

Present personnel \_\_\_\_\_

New (proposed) personnel \_\_\_\_\_

\_\_\_\_\_ Other: (Attach Explanation)

**Signatures (required):**

Project Director \_\_\_\_\_

Sponsored Programs Office or Institution Approval \_\_\_\_\_

PMASGKFTC Approval by \_\_\_\_\_ Date: \_\_\_\_\_



## Request for Change of Grant Budget

Grant Number	Original Approved Komen Budget	New Budget (Proposed)
<b>Salaries</b> (itemized in Budget Justification)		
<b>Fringe</b> (Benefits and Payroll Taxes)		
<b>Subtotal - Salaries and Fringe</b>	.00	.00
<b>Consultant Costs</b>		
<b>Supplies</b>		
<b>Equipment</b> (not to exceed \$5,000 maximum)		
<b>Travel</b> (Mileage at IRS rate)		
<b>Patient Care Costs*</b>		
<b>Screening</b>		
<b>Diagnosis</b>		
<b>Treatment</b>		
<b>Sub-contracts</b>		
<b>Other</b> (itemize in budget justification)		
<b>Subtotal – Direct Costs</b>	.00	.00
<b>Indirect Costs</b> (not to exceed 15% of direct costs)	.00	.00
<b>Total</b> <i>The new total may not exceed the total for the original budget. Budget increases are not allowed.</i>	.00	.00

\*Medicare Rate

**NOTE:** Funds may be reallocated, between line items, up to 5% of total Grant Funds without a formal request to the Affiliate.



Due Date: April 30, 2011

## Final Report

Grant Number and  
Project Title: \_\_\_\_\_

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

Contact Person: \_\_\_\_\_

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

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

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

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

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

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

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

Grant Period

From: April 1

To: March 31

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In this section, please provide a short summary (**1200 characters or less**) in lay language describing the outcomes and accomplishments of this project. Include a statement of plans for the future of the program. (Must be **TYPED** on this form; 1200 Characters; including spaces and punctuation, do not add attachments.)

<b>Specific Aims:</b> (insert objectives from application)	<b>Percent Completed: (This must be an actual percentage)</b>				
	<b>1-25%</b>	<b>26-50%</b>	<b>51-75%</b>	<b>76-100%</b>	<b>N/A</b>
<b>Objective 1:</b>					
<b>Objective 2:</b>					
<b>Objective 3:</b>					
<b>Objective 4:</b>					
<b>Objective 5:</b>					

**Number of People Served**

- \_\_\_\_\_ Breast Cancer Education
- \_\_\_\_\_ Breast Cancers Detected
- \_\_\_\_\_ Clinical Breast Exams
- \_\_\_\_\_ Clinical Trials Education
- \_\_\_\_\_ Clinical Trials Enrollment
- \_\_\_\_\_ Complementary/Alternative Medicine
- \_\_\_\_\_ Diagnostic Services Provided
- \_\_\_\_\_ Educational Materials Provided
- \_\_\_\_\_ Mammogram Performed
- \_\_\_\_\_ Psychosocial Support
- \_\_\_\_\_ Referred for Diagnostic Services
- \_\_\_\_\_ Referred for Mammogram
- \_\_\_\_\_ Treatment Assistance
- \_\_\_\_\_ Other

1. **Project Final Report:** In this section, describe the outcomes toward meeting the objectives as outlined in the grant application, including number of people served during the life of the grant. (1 page)
2. **Other Sources of Support:** In this section, please list any notice or receipt of other sources of support for this project received during the grant period. (1 page, if any)
3. **Project Materials:** In this section, please list and attach all published or produced materials, pictures, etc. during the grant period. (1 page plus attachments)
4. **Accounting of Grant Funds:** Please attach a final accounting of grant funds using the Budget Report (**Form M**) and attach 4<sup>th</sup> Quarter documentation.



**Budget Final Report**

<b>Grant Number:</b>	<b>Approved/Revised Komen Budget</b>	<b>Actual Komen Funds Spent (Should Match Funds Received for Year)</b>
<b>Salaries</b> (itemized in Budget Justification)		
<b>Fringe</b> (Benefits and Payroll Taxes)		
<b>Subtotal Salaries and Fringe</b>	<b>.00</b>	<b>.00</b>
<b>Consultant Costs</b>		
<b>Supplies</b> (Itemize by Category in Budget Justification)		
<b>Equipment</b> (not to exceed \$5000 maximum)		
<b>Travel</b> (Mileage at IRS rate)		
<b>Patient Care Costs*</b>		
<b>Screening</b>		
<b>Diagnostics</b>		
<b>Treatment</b>		
<b>Sub-Contracts</b>		
<b>Other</b> (itemized in Budget Justification)		
<b>Subtotal - Direct Costs</b>	<b>.00</b>	<b>.00</b>
<b>Indirect Costs</b> (not to exceed 15% of direct costs)	<b>.00</b>	<b>.00</b>
<b>Total</b>	<b>.00</b>	<b>.00</b>

**Program Director**  
**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Printed Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

\*Medicare Rate      ATTACH 4<sup>th</sup> QUARTER DOCUMENTATION      Due 30 Days following Grant Period



## Compliance Checklist

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

<i>ONE COPY OF THE FOLLOWING</i>	<i>OK</i>	<i>Deficient</i>	<i>Comments</i>
BOARD LIST (1 COPY)			
FINANCIAL STATEMENT (1 COPY)			
ORGANIZATIONAL BUDGET (1 COPY)			
KEY PERSONNEL (1 COPY/PERSON)			
PROOF NON-PROFIT STATUS (1 COPY)			
ADDITIONAL FUNDERS (1 COPY)			
**IRB APPROVAL LETTER (1 COPY)			

<b><u>GRANT APPLICATION – 1 ORIGINAL AND 13 STAPLED COPIES IN THE FOLLOWING ORDER:</u></b>			
COMPLETE APPLICATION COVER PAGE			
ORGANIZATIONAL BACKGROUND (FORM A)			
GOALS & OBJECTIVES (FORM B)			
COMPLETED FORM C			
COMPLETED BUDGET (FORM D)			
BUDGET JUSTIFICATION (FORM E)			
E-MAIL COMPLETED RFA TO OFFICE(WORD DOCUMENT)			
Additional Comments			

Checked By: \_\_\_\_\_

Status:

- \_\_\_\_\_ Acceptable for Review
- \_\_\_\_\_ Return to Applicant for changes
- \_\_\_\_\_ Decline - Major Compliance Issue(s)