TO CELEBRATE LIFE
BREAST CANCER FOUNDATION

GRANT APPLICATION

Please refer to the current **Guidelines and Instructions for Grant Applicants** for application deadline and include **required documents** from the Grants Application Checklist.

Application Date _____

Organization _____

Address _____

City _____ State _____ Zip _____

County _____ Year Founded _____

Executive Director _____

Title _____

Phone _____ Fax _____

Email _____

Project Director _____

Phone _____ Fax _____

Email _____

Name of Project _____

Amount Requested _____

PROJECT INFORMATION

1. Please give a short description of the project and who will be served.

2. Number of people who will be served with the funding amount requested _____

3. This request is for ☐ New project/program ☐ Support for ongoing project

4. Services to be provided (Check all that apply)

☐ Emergency Services (Rent, utilities, co-pays) ☐ Diagnostic Testing ☐ Navigational Services

☐ Complementary Therapies (Holistic modalities – therapeutic massage, recovery fitness training, Jin Shin Jyutsu, acupuncture, manual lymph drainage, guided imagery, nutrition consultation)

☐ Direct Support Services (Food, transportation, support groups, other non-salary costs)

5. Please check the county or counties in which your project will provide services.

☐ Alameda ☐ Contra Costa ☐ Marin ☐ Napa ☐ San Francisco ☐ San Mateo

☐ Santa Clara ☐ Solano ☐ Sonoma

6. Have we previously funded this project? ☐ Yes ☐ No

7. To Celebrate Life deems it increasingly important that our grantees have multiple sources of funding. Will your organization obtain support from other funding sources for this project?

☐ Yes ☐ No If yes, please list ALL sources of current and requested/pending funds for this project.

8. Previous, if any, requests and grants for funding from To Celebrate Life Breast Cancer Foundation.

Year(s) _____

Amount(s) _____

Project Title(s) _____

_____

9. Provide a brief summary of the proposed project to be funded by To Celebrate Life, describing the constituency to be served and the unmet need(s) to be addressed.

10. Total number of unduplicated people who will be served with requested funds _____

11. Provide the location of the constituency served _____

12. State the proposed project's goal and how it relates to the **mission** of To Celebrate LIfe.

13. Please list up to 3 key measurable objectives for Grant fund. (ie: By March 31, 20XX, the Support Group Facilitator will have provided XX support group sessions for women or men who are newly diagnosed with breast cancer and receiving services in XYZ County).

14. Briefly describe the methods you will use to accomplish each of your objectives.

15. How will you evaluate each of the objectives to ensure the objectives are met?

16. Provide a brief timetable or deadline for accomplishing the project objectives.

17. If applicable, describe how you will collaborate and coordinate with other organizations to accomplish your project objectives. Please list examples and the organizations.

18. If applicable, briefly describe how you will ensure that the project is culturally/linguistically appropriate for the constituency you will be serving.

19. Briefly describe the unique aspects of your project (Ie: community served, geographic coverage, services provided, etc.)

20. Please explain why your group or organization is well-suited to carry out this project.

FINANCIAL INFORMATION

21. Please complete the **Budget Form** showing detailed breakdown of the funds requested from To Celebrate Life. (Not your entire budget).

Budget Form

Budget of Funds Requested	**From** (Date) _____	**Through** (Date) _____

Personnel (Specific to Project)				**Total Funds Requested**
Name	Project Role	Base Salary	Percent on Project	Salary Dollar Total
			SUBTOTAL	

Emergency Services (Rent, utilities, co-pays, prescriptions, dental)	**Total Funds Requested**

Direct Services (Food, transportation, support groups, prosthetics, post-surgical lymphedema garments, clinical breast exam and other non-salary costs)	**Total Funds Requested**

Navigational Services (Translation, traversing the medical system, follow-up)	**Total Funds Requested**

Complementary Therapies (Holistic modalities – therapeutic massage, recovery fitness training, guided imagery, Jin Shin Jyutsu, nutrition consultation, acupuncture)	**Total Funds Requested**
TOTAL FUNDING REQUEST	

22. Please provide a justification for funding requested for the budgeted items.

23. Please print, sign and date application below.

Executive Director, Title _____

Signature _____

Date _____

Project Director, Title _____

Signature _____

Date _____

☐ Electronic copy of the application sent per **Guidelines and Instructions**

24. Please remember to include required documents from the **Grants Application Checklist**.

Mail applications (15 copies) to:

To Celebrate Life Breast Cancer Foundation
Atten: Grants Review Board
PO Box 367
Kentfield, CA 94914