

Application Form

Attachment 1

RFA EBI

Applicants must answer all questions completely.

Legal name of applicant as it appears on the corporate charter

Federal Tax ID number

Organization Street Address

Organization City Org Zip

Organization Type

Primary Contact Person

Name

Title

Email

Phone number Extension

Secondary Contact Person

Name

Title

Email

Phone number Extension

If awarded a grant, who will be the authorized signor of the resulting contract?

Name

Title

Email

Phone number Extension

Is your organization a registered vendor with the State of Tennessee?

Do you propose to use subcontractors for any portions of the scope of service? If yes, please provide the name and address of each subcontractor and what specific services each will perform:

Please select one of the following as it applies to this application:

- We have reviewed the Sample Contract with legal counsel and can identify no issues with executing this contract in its present form.
- We have reviewed the the Sample Contract with legal counsel and will request changes to the Sample Contract. Details are attached. We understand that exceptions to the boilerplate contract language may not be approved and may result in the rejection of the application.

Application Form

1. Describe your patient population, or the population you serve:

2. Describe how your organization currently implements evidence-based activities that increase community knowledge of breast and cervical cancer, promotes screening as early detection in your patient population/population served and/or reduces barriers to screening:

3. Describe the current organization environment:

Number of clinic/service sites

Existing cancer screening policies and procedures, if healthcare:

Workflow approach:

4. Select all barrier reduction activities that your organization has experience implementing:

- Transportation
- Cost of Care/Co-Pay Assistance
- Lack of Insurance
- Extended/Flexible Operating Hours
- Child/Adult Care
- Language and Cultural Barriers
- Additional Access to Breast/Cervical Cancer Screening/Diagnostic Resources
- Client Reminders
- Provider Reminders
- Provider Assessment and Feedback

5. Select all activities that your organization will implement if selected to be funded:

- Transportation
- Cost of Care/Co-Pay Assistance
- Lack of Insurance
- Extended/Flexible Operating Hours
- Child/Adult Care
- Language and Cultural Barriers
- Additional Access to Breast/Cervical Cancer Screening/Diagnostic Resources
- Client Reminders
- Provider Reminders
- Provider Assessment and Feedback

6. Provide a brief description on how your organization will implement the selected activity(ies).

7. Provide a list of resources available, including internal and community resources, to facilitate successful implementation:

8. Organizations will be required to submit baseline data prior to implementation of the contract and on an annual basis. Does your organization have experience in providing data? If so, how is this tracked and delivered?

9. Please specify which county(ies) where services will be delivered:

10. Please specify your target population including demographics:

11. Diverse population(s) targeted, if any (i.e., African American women, Hispanics, rural communities):

12. Provide a list of community partners that will be involved:

13. Provide an estimate of the projected reach from implementation of this contract:

Please complete the attached budget. Include a detailed budget narrative addressing grant funding from other sources, supplemental organization funding, and sustainability beyond the grant period.