**PINK AID CONNECTICUT
GRANT APPLICATION 2021
Deadline: November 15, 2020
Grant Year: March 1, 2021 - Feb. 28, 2022**

**Applications will be considered for programs and services that serve residents of Connecticut only. To apply for a 2021 grant (for the grant period March 1, 2021 to February 28, 2022), please complete this form in the spaces provided and then email it as an attachment, along with a copy of your organization’s IRS 501(c)(3) determination letter. Your email and all attachments should be directed to pinkaidctgrants@pinkaid.org by November 15, 2020 or if unable to email, please mail all of the above to Pink Aid, P.O. Box 5157, Westport, CT 06881, Attn: Grants Committee**

**Your application must be received by email or postmarked by November 15, 2020, to be considered.**

**What is the name and address of your organization (as reported to the IRS)?**

Fill in your answer here.

**What is the name, title, email address and contact information for the person filling out this application and applying for this grant.**

Fill in your answer here.

**What is the name, title, email address and contact information for the person responsible for the program and any grant awarded?**

Fill in your answer here.

**What is your organization’s mission/purpose?**

Fill in your answer here.

**Please describe the program for which you are seeking a grant, including:**

**Its name and purpose(s);**

Fill in your answer here.

**Its intended beneficiaries and the number of people you expect to reach (please include how you define “underserved”);**

Fill in your answer here.

**The geographic area to be served;**

Fill in your answer here.

**Please be specific when answering the following:**

**a. What is the amount requested for your program? Please provide a detailed , itemized budget of how you propose to use the funds and include your current operating budget. (If more space is needed, please attach your detailed budget)**

Fill in your answer here.

**b. If additional funds will be necessary to implement this program, please state the amount needed and also state the actual and prospective sources of these funds**

Fill in your answer here.

**c. Please indicate the percentage your request represents to the overall budget for this program.**

Fill in your answer here.

**d. If you have received funding for this program in the past, please state the amount(s) and source(s) of these funds.**

Fill in your answer here.

**If you are applying for grant funds for screening/diagnostic testing (including mammograms, ultrasounds and biopsies), please indicate your reimbursement rate for the underserved, underinsured population.  Please explain what this rate is based on and specifically, how it conforms to the guidelines set forth by CT State CEDPP 2016/17. Please also indicate whether this rate includes the radiologist’s reading for such testing.**

Fill in your answer here.

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**Please tell us anything else that you would like for us to know about your organization and/or your program. Please do not copy and paste any existing promotional materials but rather use this space only if there is something relating to your grant and/or beneficiaries that you believe is relevant to our decision and has not otherwise been covered in this application.**

Fill in your answer here.

**By execution of this Grant Application, I hereby certify that any grant received will be used solely for the benefit of underserved Connecticut residents with breast cancer related needs.**

 **By:** Your Name **Title:**  Your Title