**PINK AID CONNECTICUT**
**GRANT APPLICATION 2025**
**Deadline: November 15, 2024**
**Grant Year: March 1, 2025 - Feb. 28, 2026**

**Applications will be considered for programs and services that serve uninsured and underinsured residents of Connecticut with breast cancer-related needs and their families only. To apply for a 2025 grant (for the grant period March 1, 2025 to February 28, 2026), 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, 2024 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, 2024, to be considered.**

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

Fill in your answer here.

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

Fill in your answer here.

**What is the amount requested for your program? Please provide a detailed, itemized budget of how you propose to use the funds.**

Fill in your answer here.

**How many people will be served by the grant and how do you define “underserved”?**

Fill in your answer here.

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

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

Fill in your answer here.

**The geographic area to be served;**

Fill in your answer here.

**Please indicate the percentage your request represents to the overall budget for this/these program(s).**

Fill in your answer here.

**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.

**Please provide your current operating budget.**

Fill in your answer here.

**If only a portion of your request is granted, how, if at all, would the program(s) operate? [Ex. If $10,000 is requested for an outreach social worker’s salary for 10 hours a week, if only $5,000 is granted, would the social worker then work 5 hours a week?].**

Fill in your answer here.

**If you are requesting grant money for more than one program, please list your programs in order of priority, starting with the most important.**

Fill in your answer here.

**If you have received funding for the program(s) in the past (i) from Pink Aid, please state the amounts and (ii) from other organizations, please state the sources and amounts.**

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.

**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.

**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.

**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