



Request for Proposal

The Miles of Hope Breast Cancer Foundation is a not for profit organization established in 2003. The Fund provides programs and support services for women and families in the Hudson Valley, New York, affected by breast cancer. All funds raised for the Foundation are used in the Hudson Valley.

Miles of Hope Breast Cancer Foundation Request for Proposal

Guidelines and Instructions

The Miles of Hope Breast Cancer Foundation is currently offering grants for projects in the areas of breast health and breast cancer education, outreach, screening, treatment and support projects in the counties of Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Westchester and Ulster.

Projects Will Be Funded in The Following Areas:

- breast cancer education
- educational outreach to special populations
- support programs
- financial aid for social support and ancillary services

Restrictions:

- Project must be specific to breast health and/or breast cancer.
- Applicants must be a US nonprofit (federally tax-exempt) organization. Nonprofit organizations, known educational institutions (i.e. college or university), government agencies, and Indian tribes are eligible.
- Services must be provided in the eight counties served by the Miles of Hope Breast Cancer Foundation.
- Equipment costs, if applicable, may not exceed 30% of direct costs and should be used exclusively on this project.
- Salaries, if requested, are for personnel related to this project only and not the general work of the employee.
- Funds will not be awarded to capital campaigns.

Application Instructions:

- Type (preferred) or print all requested information in the spaces provided.
- All information must be supplied. If any information is incomplete, the application will be rejected.
- Submit complete applications packets only.

Application forms:

Applications must be submitted on Foundation application forms in the spaces provided. Please submit one (1) copy of the completed application form and one (1) copy of the requested attachment material.

Grant application deadlines: Applications will be considered on a case by case basis as funds are available.

Contact information for submission and inquiries:

Please mail completed application packets to:

Miles of Hope Breast Cancer Foundation
P.O. Box 405
LaGrangeville, NY 12540
Phone: (845) 527-6884
www.milesofhopebcf.org
Email: info@milesofhopebcf.org (inquiries only)

Miles of Hope Breast Cancer Foundation
Grant Application

Please Type

Agency Name: _____ Date: _____

Address: _____
Street City State Zip

Telephone: _____ Fax: _____

Web site address of organization: _____

Name & title of contact person: _____

Telephone for contact person: _____ Email: _____

Amount being requested: _____

Purpose or mission of the agency or organization:

Date of Incorporation: _____ Geographical area served: _____

Number of unduplicated persons served: _____

Please complete pages 2 and 3 of this application, and then attach one (1) copy of the following information:

- Copy of Federal Tax-Exemption letter from the IRS. (This only applies to applicants who have not received prior grants.)
- List of organization's officers and directors or trustees.
- Names, titles and qualifications of personnel responsible for project.
- Copy of last annual report (if the organization publishes an annual report).
- Copy of last annual audit.

Miles of Hope Breast Cancer Foundation
Grant Application

Please Type

Agency Name: _____ Date: _____

Amount of funding requested: _____

PLEASE CHECK TYPE OF APPLICATION: EDUCATION SUPPORT

Describe the proposed use of the funds requested. Please indicate whether this is a new program or support for a pre-existing program.

How will you fund the project if you receive partial funding?

You may attach additional information if relevant to your grant request.

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REQUIRED BUDGET FORM

DETAILED BUDGET FOR ENTIRE BUDGET PERIOD		FROM			THROUGH		
PERSONNEL (MUST BE SPECIFIC TO PROJECT)		TYPE APPT. (MONTHS)	% EFFORT ON PROJECT	BASE SALARY	DOLLAR AMOUNT REQUESTED		
NAME	ROLE ON PROJECT				SALARY REQUESTED	FRINGE BENEFIT	TOTALS
SUBTOTALS							
SUPPLIES (ITEMIZE BY CATEGORY)							
EQUIPMENT (NOT TO EXCEED 30% OF DIRECT COST)							
TRAVEL							
PATIENT CARE COSTS		INPATIENT					
		OUTPATIENT					
OTHER EXPENSES (ITEMIZE BY CATEGORY)							
Total Funding Request							

PLEASE ATTACH BUDGET JUSTIFICATION