

REQUEST FOR PROPOSAL (RFP)



THE MONTANA AFFILIATE OF SUSAN G. KOMEN FOR THE CURE

The mission of Susan G. Komen for the Cure is to eradicate breast cancer as a life-threatening disease by advancing research, education, screening, and treatment. Komen affiliates represent one of the nation's largest private funding sources for breast health and breast cancer screening, education, and treatment support programs.

The Montana Affiliate of Susan G. Komen for the Cure is currently accepting innovative projects in the areas of breast health and breast cancer education, outreach, screening, and treatment support targeting services not otherwise available to the medically underserved populations of Montana.

The Community Profile available at www.komenmontana.org identifies the following funding priorities in the state of Montana:

- Projects focusing on breast screening services for under-insured and un-insured women ages 40-49;
- Projects focusing on breast cancer screening and services for Native American women of all ages ; and
- Projects focused on providing first time screening for rural women.

Important Dates:

Application deadline: January 29, 2010
Award notification: April 9, 2010
Award period: Signed contract date through March 31, 2011

Inquiries regarding this RFP should be directed to Wendy Nicolai at (406)495-9337 or wnicolai@komenmontana.org. Please allow adequate time before the deadline for response to any inquiry.

Submit application packet to:

Montana Affiliate of Susan G. Komen for the Cure®
Attention: Wendy Nicolai
825 Helena Avenue
Helena, MT 59601

GUIDELINES AND INSTRUCTIONS FOR APPLICANTS

The purpose of this program is to address the breast health and breast cancer screening, treatment, and education needs within the state of Montana.

QUALIFICATIONS: Applicants must be a US nonprofit (federally tax-exempt) organization, e.g. nonprofit organizations, educational institutions, government agencies, and Indian tribes are eligible. Proof of nonprofit status must be provided with the application organizations must be providing services in Montana.

GUIDELINES:

- Project must be specific to breast health and/or breast cancer; e.g. if a project is a combined breast and cervical cancer project, funding may only be requested for the breast cancer portion.
- The maximum amount for a single grant this year is \$25,000.
- A dollar for dollar match is required, ie. if your organization is applying for \$25,000, documentation of matching funds in the amount of \$25,000 to support the goals in your proposal must be provided with your application. Match can be cash or in-kind. The goal of this requirement is to increase the level of services provided through our grants.
- All clients must be screened by the Montana Breast and Cervical Health Program (MBCHP) and if found eligible, directed to those services first and prior to use of the Komen grant funds.
- No indirect costs may be charged to the grant.
- Equipment costs, if applicable, may not exceed 10% of direct service 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 employee. It is assumed that technical fees for reading the mammogram are included in the cost of a mammogram.
- The following table shows the maximum cost per mammogram allowed under this grant and is based upon the current negotiated Medicare rate for these services. All figures are for “global” screening, meaning the cost of reading the mammogram is included.

	Digital		Analog	
Screening, bilateral	\$133.21	G0202	\$72.27	77057
Diagnostic, bilateral	\$133.33	G0204	\$95.14	77056
Diagnostic, unilateral	\$105.94	G0206	\$75.09	77055

REVIEW: Qualified applications will be reviewed by a panel established through the Montana Affiliate Grants Committee.

EDUCATION MATERIALS: If your organization plans to distribute educational materials, please include a line item for these materials in your budget, under “supplies”. A variety of educational materials are available from Komen Headquarters. Some items are targeted to special populations. **Before requesting funds to purchase items from other sources or create new materials, please contact the Montana Affiliate for instructions on ordering Komen materials from our Headquarters.** Komen materials should be used in the project whenever possible.

CONTRACTS: The grant contract will be the legal mechanism for funding.

PAYMENT AND REPORTING: The first payment will be made no later than thirty (30) days after receipt of the fully executed contract. The first six month progress report is due by October 31, 2010. A final report is due within forty-five (45) days of completion of the grant period. Failure to submit reports by deadline may result in cancellation of grant.

LETTERS OF SUPPORT AND ADDITIONAL MATERIALS: Please send a letter of support from any organization listed as a partner. Please do not send other materials.

CONFIRMATION OF RECEIPT OF APPLICATION: If immediate confirmation of receipt is requested, please include a self-addressed, stamped postcard that will be returned to you immediately upon receipt of the application. Please do not contact the Montana Affiliate regarding the status of the application during the review period.

ANNOUNCEMENT: Announcement of grants awarded will be made by April 9, 2010. Project Directors will be notified of the outcome of the review in writing.

REQUIRED APPLICATION CONTENT AND FORMAT FOR SUBMITTAL:

A. Cover Page (Form attached)

Note: Signature of approving institutional personnel, other than Project Director, required. Generally, this would be the Chief Executive Officer of the organization.

B. Abstract Page (Form attached)

Note: Provide a short abstract not to exceed 200 words, written in lay terms. Include signature.

- C. Project Description should not exceed five typewritten pages with a font size no smaller than a ten-point typeface.
1. Brief explanation of project.
 2. Statement of need/problem to be addressed. Please describe how the constituency to be served fits within those needs identified in the groups identified in our Community Profile.
 3. Marketing plan which includes how Komen Montana will be publicized.
 4. Description of constituency to be served and how they will benefit from the proposed program. Please indicate number of women and men to be served.
 5. Description of program goals and measurable objectives.
 6. Description of activities planned to accomplish these goals. Is this a new or ongoing activity of your hospital or organization?
 7. Timetable for accomplishing goals (Please note: six month reports are required).
 8. Description of other organizations or entities, if any, participating in the program. If applicable, letters of collaboration should be included from each organization.
 9. Long-term strategies for funding of the program after initial funding ends.
 10. A review of comparable programs offered in this service area and an explanation of how this program is unique.
- D. Financial Information (Not to exceed three typewritten pages).
1. Budget for requested funds (Form attached).
 2. Budget justification
 3. List of other sources of current funding for the project.
- E. Biosketch form for Project Director and attendant personnel listed in budget request (no more than two pages per person). (Form attached)
- F. Proof of non-profit status for applicant institution.
- G. Most recent progress report from previous grantees of the Montana Affiliate of Susan G. Komen for the Cure (six-month or final report for their most recent grant).

Applications must be signed by the director of the project. Excess pages will be removed prior to review. Submit original plus three copies of each application packet. Fax copies will not be accepted. Failure to adhere to these guidelines will result in disqualification of the application.

COVER PAGE FOR GRANT PROPOSAL



**THE MONTANA AFFILIATE OF
SUSAN G. KOMEN FOR THE CURE
2010-2011
REQUEST FOR FUNDING
FOR BREAST HEALTH AND/OR BREAST CANCER PROJECT**

PROJECT DIRECTOR & TITLE _____

INSTITUTE _____

ADDRESS _____

PHONE () _____

FAX () _____

EMAIL _____

TITLE OF PROJECT _____

TOTAL AMOUNT REQUESTED _____

GRANT PERIOD 04/01/2010 to 03/31/2011

SIGNATURE & TITLE OF APPROVING PERSONNEL (OTHER THAN PROGRAM DIRECTOR) _____ DATE _____

NAME & TITLE OF APPROVING INSTITUTIONAL PERSONNEL (TYPED) _____

APPLICATIONS MUST BE POSTMARKED BY JANUARY 29, 2010
(Photocopies of this form are acceptable)

ABSTRACT PAGE

PROJECT DIRECTOR _____

ORGANIZATION/INSTITUTION _____

MBCHP PROVIDER? YES NO

TARGET POPULATION _____

ABSTRACT

In the space below, please provide a short abstract, not to exceed 200 words, written in lay terms for release to the general public should this application be chosen for funding.

Permission to publish:

Permission is hereby granted to Susan G. Komen for the Cure to publish the above abstract should this application be selected for funding.

SIGNATURE _____

DATE _____

NAME (TYPED) _____

PHONE NUMBER _____

BIOSKETCH FORM

PROJECT DIRECTOR *(Last Name, First, Middle)*

 BIOGRAPHICAL INFORMATION 			
Information should be submitted for the project director and other personnel included in budget request. Please use a separate form for each person.			
NAME		TITLE	
EDUCATION <i>(Begin with baccalaureate or initial professional education such as nursing; include postdoctoral training)</i>			
INSTITUTION <i>(Indicate Location)</i>	DEGREE	YEAR CONFERRED	FIELD OF STUDY
PROFESSIONAL EXPERIENCE: Please list, in chronological order, concluding with present position, previous employment, experience and honors. List, in chronological order, the titles, authors and complete references to all publications during the past three years and to representative earlier publications pertinent to this application. DO NOT EXCEED TWO PAGES			

BUDGET FORM

GRANT APPLICATION REQUIRED BUDGET FORM

DETAILED BUDGET FOR ENTIRE BUDGET PERIOD		FROM 04/01/10			THROUGH 03/31/11		
PERSONNEL <i>(MUST BE SPECIFIC TO PROJECT)</i>		TYPE APPT. (MONTHS)	% EFFORT ON PROJECT	BASE SALARY	DOLLAR AMOUNT REQUESTED		
NAME	ROLE ON PROJECT				SALARY REQUESTED		TOTALS
SUBTOTALS							
SUPPLIES (ITEMIZE BY CATEGORY)							
EQUIPMENT (NOT TO EXCEED 10% OF DIRECT SERVICE COSTS)							
MATCHING FUNDS (PLEASE PROVIDE DESCRIPTION AND AMOUNTS)							
TRAVEL							
PATIENT CARE COSTS		INPATIENT					
		OUTPATIENT					
OTHER EXPENSES (ITEMIZE BY CATEGORY)							
SUBTOTAL - DIRECT COSTS							
TOTAL FUNDING REQUEST							

PLEASE ATTACH BUDGET JUSTIFICATION