**Wyoming Cancer Program Mini-Grants**

**Funding Request Form**

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| **Organization Information** |
| **Applicant Name** |       |
| **Name/Title of Primary Contact** |       |
| **E-Mail Address (required)** |       |
| **Street Address** **City/State/Zip** |       |
| **Mailing Address (if different from above)** |       |
| **Phone** |       |
| **Fiscal Agent Information** |
| **Tax ID Number** |       |
| **DUNS Number** |  |
| **Are you registered with SAM.gov?** |     **Yes \*No** |
| **Are you registered with the Wyoming Secretary of State?**  |  **Yes \*No** |
| **\* If no, please begin the process as registration will be a requirement in order to enter into a contract with the Wyoming Department of Health** |
| **Name and Title of Individual who will sign contract if awarded** |  |
| **Street Address (City/State/Zip)** |       |
| **Mailing Address (if different from above)** |       |
| **Funding Request Information** |
| **Total Funding Request** | $ |

**Organization Summary**

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| --- |
| **Overview of Organization** |
| **Overview of Key Project Staff/Personnel** |
|  **Cancer Control Experience** |

**Project Summary**

|  |
| --- |
| **Project Overview:** |
| **Project Goal:** |
| **Evidence-based Intervention Description:** |
| **What will be Measured** |  |
| **Current** |  |
| **Target** |  |
| **Completion Date** |  |
| **Summary of Activities and Timeline:***
 |
| **Evaluation Plan:** |

**Project Budget**

***Enter Budget amounts requested and briefly describe each item.***

|  |  |  |
| --- | --- | --- |
| **Budget Item** | **Budget Amount** | **Justification for Funds** |
|  |
| **Personnel/Salary**  |
|  | $       |       |
|  |  |  |
| **Supplies** |
|  | $       |       |
|  | $      |       |
|  | $       |       |
| **Other**  |
|  | $       |       |
|  | $       |       |
|  | $       |       |
|  | $       |       |
|       | $       |       |
|       | $       |       |
|       | $       |       |
| **BUDGET TOTAL** | **$** |

**Signature Page**

I certify to the best of my knowledge that the information contained in this application is correct. If awarded funding under this program, I certify that this project will be conducted in accordance with funding source requirements and the assurances provided within this application. I have been authorized by the organization's governing body to make this application and enter into a contract with the Wyoming Department of Health.

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Signature of Authorizing Fiscal/Financial Agent Date