Funding Request Form

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		
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 grant agreement with the Wyoming Department of Health**		
Name and Title of Individual who will sign grant agreement if awarded		
Street Address (City/State/Zip)		
Mailing Address (if different from above)		
Funding Request Information		
Total Funding Request	$	

1. **Overview of organization:** Briefly describe your organization's experience in increasing networks that offer group psychosocial support to help survivors express and manage disease-related emotions, increase social support, enhance relationships with family and physicians, and improve symptom control. Describe the population(s) and/or communities your organization serves (i.e., rural residents, survivors with lower socio-economic status, racial and/or ethnic minorities).

2. **Provide a brief description of the proposed project:**

3. **Describe the goals you would like to achieve during this project:**

4. Provide a summary of activities and timeline:
5. Describe how your proposed project will address health disparities in underserved populations:
6. Describe how your proposed project will address barriers to psychosocial support for cancer survivors:
7. Describe how you will evaluate the proposed project to determine effectiveness: For example, what surveys, scales, or other evidence-based tools will you use? How will you know that you've met your objectives?

Enter amounts requested and briefly describe each item.

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