INDIANA BREAST CANCER AWARENESS TRUST

GRANT WRITING MANUAL

TIPS AND PROCESSES

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Sample Invitation & Guidelines

INDIANA BREAST CANCER AWARENESS TRUST, INC.
Now Open: Breast Cancer Screening & Diagnostic Grant

About the Grant
The Indiana Breast Cancer Awareness Trust, Inc. (IBCAT) works to increase awareness and expand access to breast cancer screening, diagnostic, and support services across Indiana.

Funding for this work comes from sales of the Indiana Breast Cancer Awareness specialty license plate. Since the plate launched in 2002, over $7.5 million has been awarded in grants and scholarships to help Hoosiers in need. Each plate sold generates a $25 donation, directly supporting breast health programs across the state. IBCAT is a 501(c)(3) nonprofit organization incorporated in the State of Indiana.

Eligibility & Guidelines
- Projects must provide **screening or diagnostic services** to uninsured or underinsured women or men in financial need
- Services must occur within the **State of Indiana**, for **Indiana residents only**
- Applicants must be a **U.S. nonprofit (federally tax-exempt)** organization
- Organizations may submit **one application per grant type** per facility
- Funding limits apply. Reimbursement is based on **current Medicare rates** — see the application for details
- Funded projects require a **signed grant contract** and submission of:
  - Quarterly financial reports
  - 6-month progress report
  - Final year-end report

Important Dates
- **Grant Application Due:** Delivered by mail no later than _____.
- **Electronic Copy Due:** No later than _____. Email to info@breastcancerplate.org
- **Award Announcements:** By December 15, 20__.
- **Grant Period:** January 1-December 31, 20__.

Apply Today
We invite you to consider becoming a part of our mission: Applications are now being accepted.
1. **Download the application** at BreastCancerPlate.org/programsgrants/grant-programs
2. **Get guidance and tips** in our Grant Writing Manual

Questions? Contact our office: 866.724.2228 or info@breastcancerplate.org

Sample Information Page

NOTE: THIS SHEET IS INFORMATIONAL ONLY.
DO NOT INCLUDE AS PART OF GRANT APPLICATION.

Step 1: Complete the Application

Each response should appear under the question, not on a separate sheet, in the order provided. Incomplete, out of order and/or late applications submittals may be rejected.
Additional information: 2026 Breast Health Services Program Guidelines

Step 2: Include Required Attachments

1. **Sample of Patient Application/In-Take Form** – All grant programs must have a process for qualifying IBCAT patients (age, income, etc.) into their screening/diagnostic program.
2. **Letter(s) of Agreement** (if your facility is not the mammography/radiology provider) clearly stating the other party's acceptance of IBCAT reimbursement rates must be provided.
3. **IRS Determination Letter** showing proof of Non-Profit Status. (State Sales Tax Exemption Certificate is not applicable.)

Step 3: Submit Hard Copies of Application by Mail

Ten (10) copies of the application and all attachments must be **RECEIVED by Thursday, October 9, 2025.** Each copy of the application/attachments should be individually stapled packets. No paperclips or binders. Double-sided printing is acceptable. These should be the only submitted documents. Do not include a cover letter or letters of collaboration, or this Informational page.

No Certified Mail. No Signature Required for Release. We suggest Priority Mail with tracking or Overnight w/o signature. Mail USPS standard or Priority Mail to:

Indiana Breast Cancer Awareness Trust
P.O. Box 8212
Evansville, IN 47716

Step 4: Submit Electronic Copy of Application by Email

One PDF copy of your application should be emailed to info@breastcancerplate.org **by 6:00 pm on Wednesday, October 8, 2025.**

Questions? Contact our office: 866.724.2228 or info@breastcancerplate.org

IBCAT Grant Application Informational Page

Title Page

INDIANA BREAST CANCER AWARENESS TRUST, INC.
REQUEST FOR GRANT FUNDING: COVER PAGE

Application for Breast Cancer Screening & Diagnostic Programs

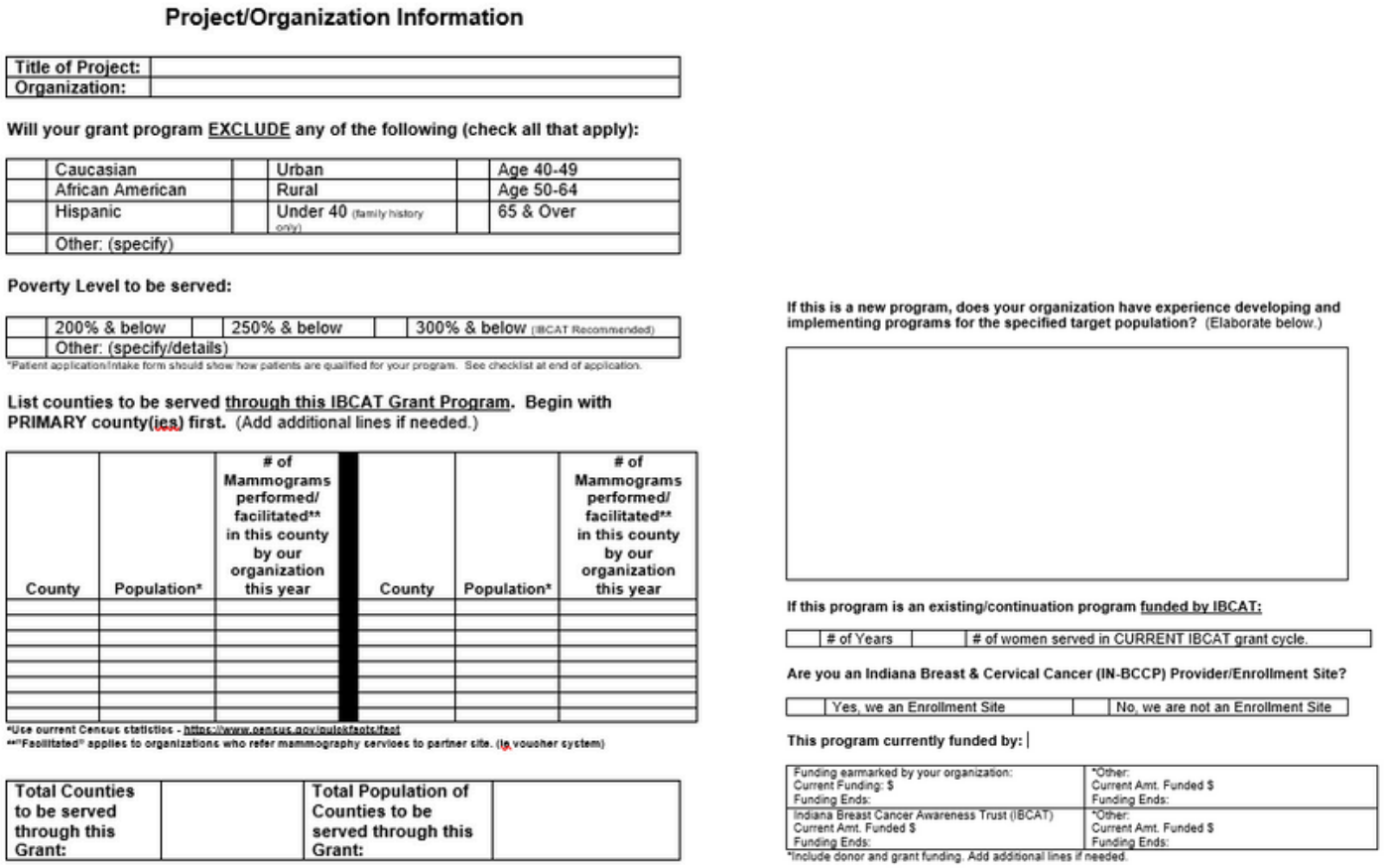
ORGANIZATION NAME	
PROJECT DIRECTOR & TITLE	
STREET ADDRESS	
CITY, STATE, ZIP CODE	
EMAIL	
PHONE NUMBER	
FEDERAL TAX ID #	
GRANT CONTACT & ADDRESS (IF DIFFERENT FROM PROJECT DIRECTOR)	
PHONE NUMBER	
EMAIL	
Patients in Need of Assistance should contact:	Name: Phone:
TITLE OF PROJECT	
THIS PROJECT IS: (CHECK ONE)	☐ New Program for 20-- ☐ Existing/Continuation
TOTAL AMOUNT REQUESTED (MUST BE IN ACCORDANCE WITH GUIDELINES OF SECTION 5 OF APPLICATION). MU ST MATCH BUDGET FORM – NO ROUNDING	
GRANT PERIOD	01/01/20-- to 12/31/20--
NAME & TITLE OF APPROVING ORGANIZATION PERSONNEL (TYPED)	DATE
SIGNATURE OF APPROVING ORGANIZATION PERSONNEL	

By signing this document permission is hereby granted to the Indiana Breast Cancer Awareness Trust to publish this award should your application be selected for funding.

Key Points:

- Federal tax ID number is **important -** please include.
- Grant **contact information** and mailing address if different from project director. **Be sure to include, if applicable.**
- **Title of project** - Can be simple, but have a Title.
- **Patients** in need of assistance need a **contact** number, and so do we.
- Total request **must** match **Budget Form** in Section #5.
- **Signature** - Don't Forget!

Project/Organization Information



Project/Organization Information

Title of Project:	
Organization:	

Will your grant program EXCLUDE any of the following (check all that apply):

	Caucasian		Urban		Age 40-49
	African American		Rural		Age 50-64
	Hispanic		Under 40 (family history only)		65 & Over
	Other: (specify)				

Poverty Level to be served:

	200% & below		250% & below		300% & below (IBCAT Recommended)
	Other: (specify/details)				

*Patient application/intake form should show how patients are qualified for your program. See checklist at end of application.

List counties to be served through this IBCAT Grant Program. Begin with PRIMARY county(ies) first. (Add additional lines if needed.)

County	Population*	# of Mammograms performed/ facilitated** in this county by our organization this year	County	Population*	# of Mammograms performed/ facilitated** in this county by our organization this year

*Use current Census statistics - https://www.census.gov/quickfacts/fact
**"Facilitated" applies to organizations who refer mammography services to partner site. (ie voucher system)

Total Counties to be served through this Grant:		Total Population of Counties to be served through this Grant:	

If this is a new program, does your organization have experience developing and implementing programs for the specified target population? (Elaborate below.)

If this program is an existing/continuation program funded by IBCAT:

	# of Years		# of women served in CURRENT IBCAT grant cycle.

Are you an Indiana Breast & Cervical Cancer (IN-BCCP) Provider/Enrollment Site?

	Yes, we an Enrollment Site		No, we are not an Enrollment Site

This program currently funded by:

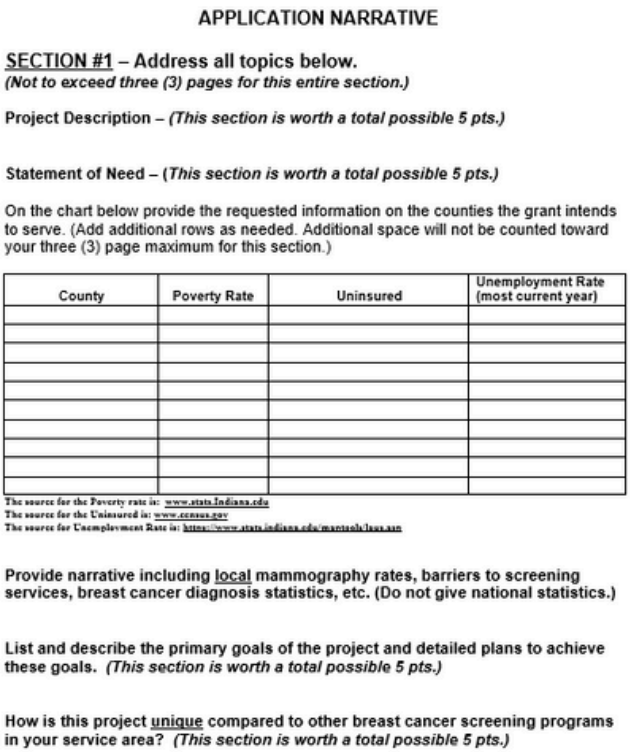
Funding earmarked by your organization: Current Funding: $ Funding Ends:	*Other: Current Amt. Funded $ Funding Ends:
Indiana Breast Cancer Awareness Trust (IBCAT) Current Amt. Funded $ Funding Ends:	*Other: Current Amt. Funded $ Funding Ends:

*Include donor and grant funding. Add additional lines if needed.

Key Points:

- **Title of Project & Organization –** Should be consistent with Title Page.
- **Target Population -** Who will you **NOT** serve? Select all that apply.
- Carefully considering the **poverty level** allows you to serve women who do not qualify for BCCP or other programs, and patients who are insured but need diagnostics, but cannot afford their deductible.
- Use provided resources to complete counties to be served table. Also be sure to include mammogram numbers for **CURRENT** year.
- Remember **total counties and population numbers** tie directly to **allowable funding levels** in Section #5.
- Complete **additional narrative** section if you are a **new program**
- Include BCCP information - If you do not know, find out!

Section #1



APPLICATION NARRATIVE

SECTION #1 – Address all topics below.
(Not to exceed three (3) pages for this entire section.)

Project Description – *(This section is worth a total possible 5 pts.)*

Statement of Need – (*This section is worth a total possible 5 pts.)*

On the chart below provide the requested information on the counties the grant intends to serve. (Add additional rows as needed. Additional space will not be counted toward your three (3) page maximum for this section.)

County	Poverty Rate	Uninsured	Unemployment Rate (most current year)

The source for the Poverty rate is: www.stats.Indiana.edu
The source for the Uninsured is: www.census.gov
The source for Unemployment Rate is: https://www.stats.indiana.edu/maptools/laus.asp

Provide narrative including local mammography rates, barriers to screening services, breast cancer diagnosis statistics, etc. (Do not give national statistics.)

List and describe the primary goals of the project and detailed plans to achieve these goals. *(This section is worth a total possible 5 pts.)*

How is this project unique compared to other breast cancer screening programs in your service area? *(This section is worth a total possible 5 pts.)*

Key Points:

Section #1 – 20 Maximum Points – Not to exceed (3) pages for entire section

Project Description: 5 points
This section requires a **detailed** description: one or two paragraphs. A summary of your project of all the sections. When read, one could accurately describe your project.

Statement of Need: 5 points
Complete required chart - County, poverty rate, uninsured, unemployment rate (for the most current year)
Provide narrative including local mammography rates, barriers to screening services, breast cancer diagnosis statistics, etc. (Do not give national statistics.)

- Describe what is going on in your counties that you will cover in the grant.
- Who do you work with to make this grant happen? Referencing agencies is great but no letters of support please.
- Use American Society: Cancer Facts and Figures 2022, Atlanta, Georgia.
- National Cancer Institute: State Cancer Profiles: accessed online: https://statecancerprofiles.cancer.gov

Primary goals and plans to achieve: 5 points

SMART Goals - **S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**ime-Bound

- Example of poor goal: Decrease breast cancer mortality in XX counties.
- Example of **SMART** Goal: Provide 65 mammograms to the underserved in our service area counties.
- Example of **SMART** Goal: Promote breast health awareness to 500 women through educational presentations and events.

How this project is unique: 5 points
Your project – Briefly describe again.

Unique – How is it unique compared to other breast cancer screening programs in your area? If it is not unique, then say so . . . . "my competitor in town has a similar project." Justify the need for your program in addition to theirs.

Sections #2 thru #4

SECTION #2 – Address all topics below.
(Not to exceed two (2) pages for this entire section.)

What resources does your organization (and your service provider, if applicable) have for this project – facilities, equipment, partnerships? *(This section is worth a total possible 5 pts.)*

How will you recruit patients/participants for your project? (*Note: All applicants are required to submit a patient application/in-take form and/or process for qualifying patients for the screening program. See attachment listing at end of application.) (This section is worth a total possible 5 pts.)*

What potential challenges do you foresee and how will you overcome them? *(This section is worth a total possible 5 pts.)*

Key Points:

Section #2 - 15 Maximum Points - Not to exceed 2 pages

Resources for this project: 5 points

- Who will provide services if you are not a screening/diagnostic facility?
- Organization's other grants (if applicable). Their providers, reimbursement, etc.
- Describe your facility or facilities.
- Name and model numbers of equipment used for mammograms, diagnostic or biopsy equipment.
- Describe your project's partnerships with other facilities or providers.

Patient/Participant Recruitment: 5 points

- Describe organization's recruitment process in detail.
- Describe your process for qualifying patients.
- Copy of Patient Application/In-Take Form is **required**.

Potential challenges and overcoming them: 5 points

- List potential challenges separately and address each one.
- Examples: recruitment; facilities; too many patients; staffing; insurance; patients are fearful of mammograms; transportation needs, etc.

SECTION #3 – Address topic below.
(Not to exceed one (1) page.)

Timeline for Implementing Your Program
(This section is worth a total possible 5 pts.)

Section #3 – 5 Maximum Points – Not to exceed 1 page

Timeline for Implementing Your Program:

- Give detail.
- Be realistic.
- Breakout by month or quarter, or a combination of both.

SECTION #4 – Address topic below.
(Not to exceed one (1) page.)

How Will You Define Program Success?
(This section is worth a total possible 5 pts.)

Section #4 – 5 Maximum Points – Not to exceed 1 page

Evaluation methods to define program success:

- What method will you use?
- Go to Section 1 – Read your goals. Have a plan to evaluate each and describe it here.
- Look at your Detailed Budget sheet in Section 5. Goals should include attaining the number of patients/procedures you asked for IBCAT to fund.
- Will you use patient satisfaction questionnaires?

INDIANA BREAST CANCER AWARENESS TRUST

Section #5

Section #5 – Funding Levels & Project Budget

Grant Funding Levels – In accordance with counties listed in the Project/Organization Information section (page 2) of this application.

# of Counties	Population & Maximum Grant	Population & Maximum Grant	Population & Maximum Grant
1 – 6	<100,000 = $5,000 max.	100,001-299,999 = $10,000 max	>300,000 = $15,000 max
7 – 14	<400,000 = $20,000 max	400,001-599,999 = $25,000 max	>600,000 = $30,000 max
15+	$40,000 max		

Complete the Budget Form shown on following page.
(This section is worth a total possible 5 pts.)

Narrative explanation justifying the proposed budget.
Do not exceed one (1) page. (This section is worth a total possible 5 pts.)

Existing IBCAT grantees should address any sizeable increase over past grant amount(s).

DETAILED BUDGET FOR ENTIRE BUDGET PERIOD
FROM JANUARY 1, 20-- THROUGH DECEMBER 31, 20--

PATIENT CARE COSTS: (BASED ON MEDICARE REIMBURSEMENT RATES)

Code	Service Description	#		Rate		Sub-Total
77067	Screening Mammogram (Digital)		@	$ ---.--	=	$
77063	Tomosynthesis (Screening)		@	$ ---.--	=	$
77065	Diagnostic, Unilateral (Digital)		@	$ ---.--	=	$
77066	Diagnostic, Bilateral (Digital)		@	$ ---.--	=	$
G0279	Tomosynthesis		@	$ ---.--	=	$
76641	Ultrasound breast complete		@	$ ---.--	=	$
76642	Ultrasound breast limited		@	$ ---.--	=	$
19000	Drainage of breast lesion		@	$ ---.--	=	$
19001	Drain breast lesion add-on (used w/19000)		@	$ ---.--	=	$
10021	Fine Needle Asp. w/o guidance		@	$ ---.--	=	$
10005	Fine Needle Asp. w/ultrasound guidance		@	$ ---.--	=	$
88172	Cytopathology, eval. of fine needle aspirate		@	$ ---.--	=	$
19081	Biopsy – Stereotactic		@	$ ---.--	=	$
19083	Biopsy – Ultrasound		@	$ ---.--	=	$
19085	Biopsy – MRI		@	$ ---.--		$
88305	Tissue exam by pathologist		@	$ ---.--	=	$
77046	MRI, Breast w/o contrast, Unilateral		@	$ ---.--	=	$
77047	MRI, Breast w/o contrast, Bilateral		@	$ ---.--	=	$
77048	MRI, w/ & w/o contrast, (w/CAD) Unilateral		@	$ ---.--	=	$
77049	MRI, w/ & w/o contrast, (w/CAD) Bilateral		@	$ ---.--	=	$
	*Other:		@			$
	*Other:		@			$
	*Other:		@			$
	*Other:		@			$
	*Other:		@			$
	*Other:		@			$

*PROCEDURES REQUESTED MUST INCLUDE CPT CODE. REIMBURSEMENT MUST BE AT MEDICARE RATE.

TOTAL FUNDING REQUEST* $

*Lump Sum amounts are not acceptable. Approximation per Service is required. Total Funding Request should match Page 1 of the application.

Key Points:

Section #5 – 10 Maximum Points

Budget Form: 5 points

- Use Budget Form on following page
- The table defines your maximum allowable grant which ties to County/Population define in Program/Organizational Information page.
- All procedures reimbursed at Medicare Reimbursement Rate
- If requesting procedures not included on Budget Form, add and include current Medicare Reimbursement Rate
- Each line item you are requesting must have # and total. *Please check your math*. We do!
- Carry Total Funding Request Amount to Cover Sheet

Budget Narrative: Not to exceed one (1) page - 5 points

- How did you came up with these numbers?
- Do not simply state, “See Project Budget”.

Grant Process Overview

1

Grant reviewers read and score each application.*

2

Scores are submitted to IBCAT office where they are tallied.

3

Grant Review Committee conference is held to discuss and rank each application.

*Deficiencies will be communicated directly with applicant.

4

Slate of Grants is prepared for the Board of Directors.

5

Board of Directors vote on and approve grant funding in late November.

Compliance Review

Application and electronic copy submitted **on time.**

Information only sheets **NOT** included in submittal.

Cover sheet fully completed with **signature.**

One original & nine (9) **copies** submitted and **stapled** neatly in order.

Sample Patient intake form included.

Sections do not exceed **allowable lengths.**

Letter of agreement needed only if the applicant is **not** the service provider.

IRS Determination letter showing Non-Profit status included.

Remember, the **overall impression** of your application is worth up to an additional 5 points.

Thank you for partnering with us to achieve our Mission. We hope you find this a useful tool in preparing your IBCAT Grant Application. Should you have any questions, please reach out to us.

info@breastcancerplate.org

1.866.724.2228