OFFICE OF MINORITY HEALTH
FY 2004 COMMUNITY PROGRAMS TO IMPROVE MINORITY HEALTH

PROJECT PROFILE

1. APPLICANT ORGANIZATION:
2. PROJECT DIRECTOR:
3. ADDRESS:
4. PHONE: **FAX:**
5. E-Mail/Internet:
6. PROJECT TITLE:

7. Type of Organization: _____Public (Specify _____)
_____Non-Profit (Specify _____)

8. Community-based Organization
_____Representative of communities or significant segments of communities (Page_____)
_____Control and decision making powers are located at the community level (Page_____)

9. Minority-serving Organization with history of service to racial/ethnic populations (Page_____)

7. Health Area(s) addressed in project. (Identify at least 1, but not more than 3 areas):

_____Adult Immunizations
_____Asthma
_____Cancer
_____Diabetes
_____Heart Disease and Stroke
_____HIV/AIDS
_____Infant Mortality
_____Obesity and Overweight

Check all that apply for the proposed project. Projected numbers are to be inserted in the corresponding columns provided.	**Projected Number of individuals to receive services, by year.**			**Projected Number of Service Providers to be trained, if applicable, by year.**		
	YR 01	**YR 02**	**YR 03**	**YR 01**	**YR 02**	**YR 03**
Racial/Ethnic Groups ____American Indian/Alaska Native ____Asian ____Black/African American ____Hispanic/Latino ____Native Hawaiian or Other Pacific Islander ____Other (specify):_____ Identify Subpopulation(s) (e.g., Samoan): _____						
Gender ____Male ____Female						
Age Group (Complete age range) ***Age Range*** ____Prenatal ____Infants (____to____) ____Children (____to____) ____Adolescents (____to____) ____Adults (____to____) ____Elderly (____to____)						