OFFICE OF MINORITY HEALTH

FY 2004 Community-Focused Initiative to Reduce the Burden of Stroke

PROJECT PROFILE

1. **APPLICANT ORGANIZATION:**
2. **PROJECT DIRECTOR:**
3. **ADDRESS:**
4. **PHONE: FAX: E-Mail/Internet:**
5. **PROJECT TITLE:**
6. **Type of Organization (select one): ❑ Public ❑ Non-Profit (Specify _____)**
7. **Evidence of Time in the Community (must be at least 5 years). Page(s) _____**
8. **Evidence of organizational linkage between the applicant and community health center(s) and/or health provider(s), system(s) or plan(s) (e.g., MOU/MOA, Letter of Support). Page(s) _____**
9. **Type of Geographic Area to be Served: ❑ Urban (at least 100,000 pop.) ❑ Rural (at least 60,000 pop.)**

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 by year.**			
	YR 01	**YR 02**	**YR 03**	**YR 04**	**YR 01**	**YR 02**	**YR 03**	**YR 04**
Racial/Ethnic Groups ____ Black/African American ____ Hispanic/Latino ____ Asian ____ American Indian/Alaska Native ____ 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____)								