

**Community Based
FOBT Screening Plan**

Name of Coalition:		Name of Local Health Department/Existing cancer coalition with a 501c3 Non-profit status:	
Contact Name:		Contact Name:	
Address:		Address:	
Phone:		Phone:	
E-mail:		E-mail:	
Fax:		Fax:	
Type and Brand of FOBT Kit:		FOBT Kits Provided By:	
Projected Number of Kits that will be distributed:			
Description of Coalition's Distribution Process:			
Description of Coalition's Process for Follow Up of Non-Returned FOBT Kits:			
Please provide a copy of Enrollment/Intake/Demographic Form Collected from FOBT Recipients Provided			
Description of Coalition's Coordination with Processing Lab:			
Name of Lab or Labs processing FOBTs:			

Description of Coalition's Follow up for Positive FOBT:		
Process for referring potential eligible Nebraska clients to NCP for colonoscopy:		
Designated Person for FOBT Registry Data Entry:	Address:	Phone:
		Fax:
		E-mail
Plan Feedback:		Date:
Response:		Date:
Plan Approval / Signatures:		
American Cancer Society Representative:		
Nebraska Colon Cancer Representative:		
Nebraska Comprehensive Cancer Control Program Representative:		

List of In Kind Activities/Services and Estimated Value