

**CDC Capacity-Building Assistance (CBA)  
Notification Form**

---

Today's Date: \_\_\_\_\_

CBA Request # \_\_\_\_\_  
*(To be assigned by CDC)*

CBA Provider Name: \_\_\_\_\_

---

**Requesting Organization Information**

Name of Organization: \_\_\_\_\_

Affiliation:

- |  |  |
|--|--|
| <input type="checkbox"/> CDC Funded CBO<br><i>(Program Announcement # _____)</i> | <input type="checkbox"/> Health Department Funded CBO  |
| <input type="checkbox"/> Health Department                                       | <input type="checkbox"/> Non-Funded CBO or Stakeholder |
|  | <input type="checkbox"/> Other (specify): _____        |
- 

**Contact Information**

Contact Name: \_\_\_\_\_

Title or Position: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

Phone Number: \_\_\_\_\_

State: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Country: \_\_\_\_\_

E-mail: \_\_\_\_\_

Zip Code: \_\_\_\_\_

---

**Racial/Ethnic Group Served**

*Select the primary population*

- |  |  |
|--|--|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Hispanic or Latino                        |
| <input type="checkbox"/> Asian                             | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Black or African American         | <input type="checkbox"/> White                                     |

### **Risk Population Served**

*Check all that apply*

- MSM
  - MSM/IDU
  - IDU
  - Heterosexual
  - Homeless Persons
  - Transgender Persons
  - Incarcerated Persons
  - Mother at Risk for HIV
  - Migrant Populations
  - Youth at Risk for HIV
  - Other (specify): \_\_\_\_\_
- 

### **CBA Focus Area (FA)**

Select only one

- FA 1: Organizational Infrastructure
  - FA 2: Enhancing Interventions
  - FA 3: Community Access/Utilization
  - FA 4: Community Planning
- 

**Describe the Capacity Building Assistance (CBA) Requested:**