Department of Health and Human Services
Public Health Services

# Grant Application

*Do not exceed character length restrictions indicated.*

**LEAVE BLANK—FOR PHS USE ONLY.**

| Type | Activity | Number |
|---|---|---|
| Review Group | | Formerly |
| Council/Board (Month, Year) | | Date Received |

1. TITLE OF PROJECT *(Do not exceed 81 characters, including spaces and punctuation.)*

2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT OR SOLICITATION ☐ NO ☐ YES
*(If "Yes," state number and title)*
Number: Title:

**3. PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR**

| | | |
|---|---|---|
| 3a. NAME (Last, first, middle) | 3b. DEGREE(S) | 3h. eRA Commons User Name |
| 3c. POSITION TITLE | 3d. MAILING ADDRESS *(Street, city, state, zip code)* | |
| 3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT | | |
| 3f. MAJOR SUBDIVISION | | |
| 3g. TELEPHONE AND FAX *(Area code, number and extension)*<br>TEL: FAX: | E-MAIL ADDRESS: | |

| | | |
|---|---|---|
| 4. HUMAN SUBJECTS RESEARCH<br>☐ No ☐ Yes | 4a. Research Exempt<br>☐ No ☐ Yes | If "Yes," Exemption No. |
| 4b. Federal-Wide Assurance No. | 4c. Clinical Trial<br>☐ No ☐ Yes | 4d. NIH-defined Phase III Clinical Trial<br>☐ No ☐ Yes |

| | |
|---|---|
| 5. VERTEBRATE ANIMALS ☐ No ☐ Yes | 5a. Animal Welfare Assurance No |

| 6. DATES OF PROPOSED PERIOD OF SUPPORT *(month, day, year—MM/DD/YY)* | | 7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD | | 8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT | |
|---|---|---|---|---|---|
| From | Through | 7a. Direct Costs ($) | 7b. Total Costs ($) | 8a. Direct Costs ($) | 8b. Total Costs ($) |
| | | | | | |

9. APPLICANT ORGANIZATION
Name
Address

10. TYPE OF ORGANIZATION
Public: → ☐ Federal ☐ State ☐ Local
Private: → ☐ Private Nonprofit
For-profit: → ☐ General ☐ Small Business
☐ Woman-owned ☐ Socially and Economically Disadvantaged

11. ENTITY IDENTIFICATION NUMBER
DUNS NO. Cong. District

| 12. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE | 13. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION |
|---|---|
| Name | Name |
| Title | Title |
| Address | Address |
| Tel: FAX: | Tel: FAX: |
| E-Mail: | E-Mail: |

| | | |
|---|---|---|
| 14. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Services terms and conditions if a grant is awarded as a result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. | SIGNATURE OF OFFICIAL NAMED IN 13.<br>*(In ink. "Per" signature not acceptable.)* | DATE |

**Use only if preparing an application with Multiple PDs/PIs. See http://grants.nih.gov/grants/multi_pi/index.htm for details.**

| **Contact Program Director/Principal Investigator (Last, First, Middle):** | | |
|---|---|---|
| **3. PROGRAM DIRECTOR / PRINCIPAL INVESTIGATOR** | | |
| 3a. NAME (Last, first, middle) | 3b. DEGREE(S) | 3h. NIH Commons User Name |
| 3c. POSITION TITLE | 3d. MAILING ADDRESS *(Street, city, state, zip code)* | |
| 3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT | | |
| 3f. MAJOR SUBDIVISION | | |
| 3g. TELEPHONE AND FAX *(Area code, number and extension)*<br>TEL: FAX: | E-MAIL ADDRESS: | |
| **3. PROGRAM DIRECTOR / PRINCIPAL INVESTIGATOR** | | |
| 3a. NAME (Last, first, middle) | 3b. DEGREE(S) | 3h. NIH Commons User Name |
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| 3f. MAJOR SUBDIVISION | | |
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| **3. PROGRAM DIRECTOR / PRINCIPAL INVESTIGATOR** | | |
| 3a. NAME (Last, first, middle) | 3b. DEGREE(S) | 3h. NIH Commons User Name |
| 3c. POSITION TITLE | 3d. MAILING ADDRESS *(Street, city, state, zip code)* | |
| 3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT | | |
| 3f. MAJOR SUBDIVISION | | |
| 3g. TELEPHONE AND FAX *(Area code, number and extension)*<br>TEL: FAX: | E-MAIL ADDRESS: | |
| **3. PROGRAM DIRECTOR / PRINCIPAL INVESTIGATOR** | | |
| 3a. NAME (Last, first, middle) | 3b. DEGREE(S) | 3h. NIH Commons User Name |
| 3c. POSITION TITLE | 3d. MAILING ADDRESS *(Street, city, state, zip code)* | |
| 3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT | | |
| 3f. MAJOR SUBDIVISION | | |
| 3g. TELEPHONE AND FAX *(Area code, number and extension)*<br>TEL: FAX: | E-MAIL ADDRESS: | |

Program Director/Principal Investigator (Last, First, Middle):

PROJECT SUMMARY (See instructions):

RELEVANCE (See instructions):

PROJECT/PERFORMANCE SITE(S) (if additional space is needed, use Project/Performance Site Format Page)

| **Project/Performance Site Primary Location** | | |
|---|---|---|
| Organizational Name: | | |
| DUNS: | | |
| Street 1: | Street 2: | |
| City: | County: | State: |
| Province: | Country: | Zip/Postal Code: |
| Project/Performance Site Congressional Districts: | | |

| **Additional Project/Performance Site Location** | | |
|---|---|---|
| Organizational Name: | | |
| DUNS: | | |
| Street 1: | Street 2: | |
| City: | County: | State: |
| Province: | Country: | Zip/Postal Code: |
| Project/Performance Site Congressional Districts: | | |

SCIENTIFIC/KEY PERSONNEL. See instructions. *Use continuation pages as needed* to provide the required information in the format shown below. Start with Program Director(s)/Principal Investigator(s). List all other key personnel in alphabetical order, last name first.

| Name | eRA Commons User Name | Organization | Role on Project |
|---|---|---|---|

OTHER SIGNIFICANT CONTRIBUTORS

| Name | Organization | Role on Project |
|---|---|---|

**Human Embryonic Stem Cells** ☐ **No** ☐ **Yes**

**If the proposed project involves human embryonic stem cells, list below the registration number of the specific cell line(s) from the following list:** http://stemcells.nih.gov/research/registry/eligibilityCriteria.asp. *Use continuation pages as needed.*

If a specific line cannot be referenced at this time, include a statement that one from the Registry will be used.

**Cell Line**

The name of the program director/principal investigator must be provided at the top of each printed page and each continuation page.

# RESEARCH GRANT
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**Appendix** *(Five identical CDs.)* ☐ Check if Appendix is Included

* Follow the page limits for these sections indicated in the application instructions, unless the Funding Opportunity Announcement specifies otherwise.

Program Director/Principal Investigator (Last, First, Middle):

| DETAILED BUDGET FOR INITIAL BUDGET PERIOD<br>DIRECT COSTS ONLY | FROM | THROUGH |
|---|---|---|

List PERSONNEL *(Applicant organization only)*
Use Cal, Acad, or Summer to Enter Months Devoted to Project
Enter Dollar Amounts Requested *(omit cents)* for Salary Requested and Fringe Benefits

| NAME | ROLE ON PROJECT | Cal. Mnths | Acad. Mnths | Summer Mnths | INST.BASE SALARY | SALARY REQUESTED | FRINGE BENEFITS | TOTAL |
|---|---|---|---|---|---|---|---|---|
| | PD/PI | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| **SUBTOTALS** → | | | | | | | | |

| | |
|---|---|
| CONSULTANT COSTS | |
| EQUIPMENT *(Itemize)* | |
| SUPPLIES *(Itemize by category)* | |
| TRAVEL | |
| INPATIENT CARE COSTS | |
| OUTPATIENT CARE COSTS | |
| ALTERATIONS AND RENOVATIONS *(Itemize by category)* | |
| OTHER EXPENSES *(Itemize by category)* | |

| | | |
|---|---|---|
| CONSORTIUM/CONTRACTUAL COSTS | DIRECT COSTS | |
| **SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD** *(Item 7a, Face Page)* | | $ |
| CONSORTIUM/CONTRACTUAL COSTS | FACILITIES AND ADMINISTRATIVE COSTS | |
| **TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD** | | $ |

## BUDGET FOR ENTIRE PROPOSED PROJECT PERIOD
## DIRECT COSTS ONLY

| BUDGET CATEGORY TOTALS | INITIAL BUDGET PERIOD *(from Form Page 4)* | 2nd ADDITIONAL YEAR OF SUPPORT REQUESTED | 3rd ADDITIONAL YEAR OF SUPPORT REQUESTED | 4th ADDITIONAL YEAR OF SUPPORT REQUESTED | 5th ADDITIONAL YEAR OF SUPPORT REQUESTED |
|---|---|---|---|---|---|
| PERSONNEL: *Salary and fringe benefits. Applicant organization only*. | | | | | |
| CONSULTANT COSTS | | | | | |
| EQUIPMENT | | | | | |
| SUPPLIES | | | | | |
| TRAVEL | | | | | |
| INPATIENT CARE COSTS | | | | | |
| OUTPATIENT CARE COSTS | | | | | |
| ALTERATIONS AND RENOVATIONS | | | | | |
| OTHER EXPENSES | | | | | |
| DIRECT CONSORTIUM/ CONTRACTUAL COSTS | | | | | |
| **SUBTOTAL DIRECT COSTS** *(Sum = Item 8a, Face Page)* | | | | | |
| F&A CONSORTIUM/ CONTRACTUAL COSTS | | | | | |
| **TOTAL DIRECT COSTS** | | | | | |
| **TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD** | | | | | **$** |

JUSTIFICATION. Follow the budget justification instructions exactly. Use continuation pages as needed.

## RESOURCES

Follow the 398 application instructions in Part I, 4.7 Resources.

Program Director/Principal Investigator (Last, First, Middle):

# CHECKLIST

**TYPE OF APPLICATION** *(Check all that apply.)*

☐ NEW application. *(This application is being submitted to the PHS for the first time.)*

☐ RESUBMISSION of application number: _____
*(This application replaces a prior unfunded version of a new, renewal, or revision application.)*

☐ RENEWAL of grant number: _____
*(This application is to extend a funded grant beyond its current project period.)*

☐ REVISION to grant number: _____
*(This application is for additional funds to supplement a currently funded grant.)*

☐ CHANGE of program director/principal investigator.

Name of former program director/principal investigator: _____

☐ CHANGE of Grantee Institution. Name of former institution: _____

☐ FOREIGN application ☐ Domestic Grant with foreign involvement List Country(ies) Involved:

INVENTIONS AND PATENTS *(Renewal appl. only)* ☐ No ☐ Yes

If "Yes," ☐ Previously reported ☐ Not previously reported

**1. PROGRAM INCOME** ***(See instructions.)***
All applications must indicate whether program income is anticipated during the period(s) for which grant support is request. If program income is anticipated, use the format below to reflect the amount and source(s).

| Budget Period | Anticipated Amount | Source(s) |
|---|---|---|
| | | |

**2. ASSURANCES/CERTIFICATIONS** ***(See instructions.)***
In signing the application Face Page, the authorized organizational representative agrees to comply with the policies, assurances and/or certifications listed in the application instructions when applicable. Descriptions of individual assurances/certifications are provided in Part III and listed in Part I, 4.1 under Item 14. If unable to certify compliance, where applicable, provide an explanation and place it after this page.

**3. FACILITIES AND ADMINSTRATIVE COSTS (F&A)/ INDIRECT COSTS.** See specific instructions.

☐ DHHS Agreement dated: _____ ☐ No Facilities And Administrative Costs Requested.

☐ DHHS Agreement being negotiated with _____ Regional Office.

☐ No DHHS Agreement, but rate established with _____ Date _____

CALCULATION* *(The entire grant application, including the Checklist, will be reproduced and provided to peer reviewers as confidential information.)*

| | | | | | | |
|---|---|---|---|---|---|---|
| a. Initial budget period: | Amount of base $ | _____ | x Rate applied | 0.00% | % = F&A costs | $ _____ |
| b. 02 year | Amount of base $ | _____ | x Rate applied | 0.00% | % = F&A costs | $ _____ |
| c. 03 year | Amount of base $ | _____ | x Rate applied | 0.00% | % = F&A costs | $ _____ |
| d. 04 year | Amount of base $ | _____ | x Rate applied | 0.00% | % = F&A costs | $ _____ |
| e. 05 year | Amount of base $ | _____ | x Rate applied | 0.00% | % = F&A costs | $ |
| | **Enter Rate above as a decimal (e.g., 0.25 for 25%, 0.495 for 49.5%)** | | | | TOTAL F&A Costs | $ |

*Check appropriate box(es):

☐ Salary and wages base ☐ Modified total direct cost base ☐ Other base *(Explain)*

☐ Off-site, other special rate, or more than one rate involved *(Explain)*

Explanation *(Attach separate sheet, if necessary.):*

**4. DISCLOSURE PERMISSION STATEMENT:** If this application does not result in an award, is the Government permitted to disclose the title of your proposed project, and the name, address, telephone number and e-mail address of the official signing for the applicant organization, to organizations that may be interested in contacting you for further information (e.g., possible collaborations, investment)? ☐ Yes ☐ No

# Planned Enrollment Report

**This report format should NOT be used for collecting data from study participants.**

**Study Title:**

**Domestic/Foreign:** Domestic

**Comments:**

| Racial Categories | Ethnic Categories | | | | Total |
|---|---|---|---|---|---|
| | Not Hispanic or Latino | | Hispanic or Latino | | |
| | Female | Male | Female | Male | |
| American Indian/ Alaska Native | | | | | 0 |
| Asian | | | | | 0 |
| Native Hawaiian or Other Pacific Islander | | | | | 0 |
| Black or African American | | | | | 0 |
| White | | | | | 0 |
| More Than One Race | | | | | 0 |
| **Total** | 0 | 0 | 0 | 0 | 0 |

# Cumulative Inclusion Enrollment Report

**This report format should NOT be used for collecting data from study participants.**

**Study Title:**

**Comments:**

| Racial Categories | Ethnic Categories | | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| | Not Hispanic or Latino | | | Hispanic or Latino | | | Unknown/Not Reported Ethnicity | | | |
| | Female | Male | Unknown/ Not Reported | Female | Male | Unknown/ Not Reported | Female | Male | Unknown/ Not Reported | |
| American Indian/ Alaska Native | | | | | | | | | | 0 |
| Asian | | | | | | | | | | 0 |
| Native Hawaiian or Other Pacific Islander | | | | | | | | | | 0 |
| Black or African American | | | | | | | | | | 0 |
| White | | | | | | | | | | 0 |
| More Than One Race | | | | | | | | | | 0 |
| Unknown or Not Reported | | | | | | | | | | 0 |
| **Total** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## DO NOT SUBMIT UNLESS REQUESTED
### Renewal Applications Only
## ALL PERSONNEL REPORT

**Always list the PD/PI(s). In addition, list all other personnel who participated in the project during the current budget period for at least one person month or more, regardless of the source of compensation (a person month equals approximately 160 hours or 8.3% of annualized effort). Use Cal, Acad, or Summer to Enter Months Devoted to Project.**

| Commons ID | Name | Degree(s) | SSN (last 4 digits) | Role on Project (e.g. PD/PI, Res. Assoc.) | DoB (MM /YY) | Cal | Acad | Summer |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

# *Mailing address for application*

*Use this label or a facsimile*

**All applications and other deliveries to the Center for Scientific Review must come either via courier delivery or via the United States Postal Service (USPS.) Applications delivered by individuals to the Center for Scientific Review will not be accepted.**

**Applications sent via the USPS EXPRESS or REGULAR MAIL should be sent to the following address:**

**CENTER FOR SCIENTIFIC REVIEW**
**NATIONAL INSTITUTES OF HEALTH**
**6701 ROCKLEDGE DRIVE**
**ROOM 1040 – MSC 7710**
**BETHESDA, MD 20892-7710**

**NOTE: All applications sent via a courier delivery service (non-USPS) should use this address, but CHANGE THE ZIP CODE TO 20817**

**The telephone number is 301-435-0715. C.O.D. applications will *not* be accepted.**

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**A special label for responding to RFAs is not required.**