

Department of Health and Human Services Public Health Services Grant Application <i>Do not exceed character length restrictions indicated.</i>		LEAVE BLANK—FOR PHS USE ONLY.	
		Type	Activity
		Review Group	Formerly
		Council/Board (Month, Year)	Date Received
1. TITLE OF PROJECT <i>(Do not exceed 81 characters, including spaces and punctuation.)</i>			
2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT OR SOLICITATION ☐ NO ☐ YES <i>(If "Yes," state number and title)</i> 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 <i>(Street, city, state, zip code)</i> E-MAIL ADDRESS:	
3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT			
3f. MAJOR SUBDIVISION			
3g. TELEPHONE AND FAX <i>(Area code, number and extension)</i> TEL: _____ FAX: _____			
4. HUMAN SUBJECTS RESEARCH ☐ No ☐ Yes		4a. Research Exempt If "Yes," Exemption No. ☐ No ☐ Yes	
4b. Federal-Wide Assurance No.		4c. Clinical Trial ☐ No ☐ Yes	4d. NIH-defined Phase III Clinical Trial ☐ No ☐ Yes
5. VERTEBRATE ANIMALS ☐ No ☐ Yes		5a. Animal Welfare Assurance No.	
6. DATES OF PROPOSED PERIOD OF SUPPORT <i>(month, day, year—MM/DD/YY)</i> From _____ Through _____		7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD 7a. Direct Costs (\$)	8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT 8a. Direct Costs (\$)
		7b. Total 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 Name _____ Title _____ Address _____ Tel: _____ FAX: _____ E-Mail: _____		13. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION Name _____ Title _____ Address _____ Tel: _____ FAX: _____ 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. <i>(In ink. "Per" signature not acceptable.)</i>	
		DATE	

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:			

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OMB No. 0925-0001

Form Page 2

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

SENIOR/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 senior/key personnel in alphabetical order, last name first.

Name	eRA Commons User Name	Organization	Role on Project
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OTHER SIGNIFICANT CONTRIBUTORS

Name	Organization	Role on Project
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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

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

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

RESEARCH GRANT TABLE OF CONTENTS

	<i>Page Numbers</i>
Face Page.....	<u>1</u>
Description, Project/Performance Sites, Senior/Key Personnel, Other Significant Contributors, and Human Embryonic Stem Cells.....	<u>2</u>
Table of Contents.....	_____
Detailed Budget for Initial Budget Period.....	_____
Budget for Entire Proposed Period of Support.....	_____
Budgets Pertaining to Consortium/Contractual Arrangements.....	_____
Biographical Sketch – Program Director/Principal Investigator (<i>Not to exceed five pages each</i>).....	_____
Other Biographical Sketches (<i>Not to exceed five pages each – See instructions</i>).....	_____
Resources.....	_____
Checklist.....	_____
Research Plan.....	_____
1. Introduction to Resubmission Application, if applicable, or Introduction to Revision Application, if applicable *	_____
2. Specific Aims *	_____
3. Research Strategy *	_____
4. Bibliography and References Cited/Progress Report Publication List.....	_____
5. Vertebrate Animals.....	_____
6. Select Agent Research.....	_____
7. Multiple PD/PI Leadership Plan.....	_____
8. Consortium/Contractual Arrangements.....	_____
9. Letters of Support (e.g., Consultants).....	_____
10. Resource Sharing Plan(s).....	_____
11. Authentication of Key Biological and/or Chemical Resources.....	_____
12. PHS Human Subjects and Clinical Trials Information	_____



* 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
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 <i>(from Form Page 4)</i>	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: <i>Salary and fringe benefits. Applicant organization only.</i>					
CONSULTANT COSTS					
EQUIPMENT					
SUPPLIES					
TRAVEL					
INPATIENT CARE COSTS					
OUTPATIENT CARE COSTS					
ALTERATIONS AND RENOVATIONS					
OTHER EXPENSES					
DIRECT CONSORTIUM/ CONTRACTUAL COSTS					
SUBTOTAL DIRECT COSTS <i>(Sum = Item 8a, Face Page)</i>					
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.

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

RESOURCES

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

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 involvementList Country(ies)
Involved: _____INVENTIONS AND PATENTS (Renewal appl. only) ☐ No ☐ YesIf "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 ADMINISTRATIVE COSTS (F&A)/ INDIRECT COSTS. See specific instructions.☐ HHS Agreement dated: _____☐ No Facilities And Administrative Costs Requested.☐ HHS Agreement being negotiated with _____

Regional Office.

☐ No HHS 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	% = F&A costs	\$
b. 02 year	Amount of base \$	x Rate applied	% = F&A costs	\$
c. 03 year	Amount of base \$	x Rate applied	% = F&A costs	\$
d. 04 year	Amount of base \$	x Rate applied	% = F&A costs	\$
e. 05 year	Amount of base \$	x Rate applied	% = F&A costs	\$
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.):

Note: the PHS Human Subjects and Clinical Trials Information form is not included in this combined form. See individual form here: <http://grants.nih.gov/forms/human-subject-study-form.pdf>

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.

[illegible]

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.

A special label for responding to RFAs is not required.