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 the NIH Grants Policy Statement, Section 4: Public Policy Requirements, Objectives and Other Appropriation Mandates. 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.

☐ 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.):*

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)*
TEL: FAX:

E-MAIL ADDRESS:

4. HUMAN SUBJECTS RESEARCH ☐ No ☐ Yes	4a. Research Exempt ☐ No ☐ Yes	If "Yes," Exemption No.
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 *(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
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. *(In ink. "Per" signature not acceptable.)* DATE

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							0
								0
								0
								0
								0
								0
SUBTOTALS →						0	0	0

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)*	
DIRECT COSTS	
SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD *(Item 7a, Face Page)*	**$** 0
FACILITIES AND ADMINISTRATIVE COSTS	
TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD	**$** 0

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)*	0	0	0	0	0
F&A CONSORTIUM/ CONTRACTUAL COSTS					
TOTAL DIRECT COSTS	0	0	0	0	0

TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD **$** 0

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