Form Approved Through 02/28/2023 OMB No. 0925-0001

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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)* | | | | E-MAIL ADDRESS: | |  |  |  |  |  |  |
| TEL: | FAX: |  |  |  | |  |  |  |  |  |  |
| 4. HUMAN SUBJECTS RESEARCH | | 4a. Research Exempt | | If “Yes,” Exemption No. | | | |  |  |  |  |
| No Yes |  |  | No Yes |  | | | |  |  |  |  |
| 4b. Federal-Wide Assurance No. | | 4c. Clinical Trial | |  |  | 4d. NIH-defined Phase III Clinical Trial | | | | | |
|  | No Yes |  |  |  | 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 | |  |  | 10. TYPE OF ORGANIZATION | | | |  |  |  |  |
| Name |  |  |  | Public: **→** Federal State Local | | | | | | | |
| Address |  |  |  | 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.  *(In ink. “Per” signature not acceptable.)* | | | | | | | DATE |

PHS 398 (Rev. 03/2020) Face Page **Form Page 1**

|  |
| --- |
| 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: | | | | | |

PHS 398 (Rev. 03/2020 Approved Through 02/28/2023) 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 |
| 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:** | | | | | |
| <https://grants.nih.gov/stem_cells/registry/current.htm> | | | [.](https://grants.nih.gov/stem_cells/registry/current.htm) *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** |  |  |  |  |  |

PHS 398 (Rev. 03/2020 Approved Through 02/28/2023) OMB No. 0925-0001 **Form Page 2-continued**

|  |  |
| --- | --- |
| Program Director/Principal Investigator (Last, First, Middle): |  |
|  | |
| LAY SUMMARY: | |
|  | |
| RELEVANCE: | |
|  | |

PHS 398 (Rev. 03/2020 Approved Through 02/28/2023) OMB No. 0925-0001 Page **Form Page 3**



|  |  |  |
| --- | --- | --- |
| **DETAILED** **BUDGET FOR INITIAL BUDGET PERIOD** | FROM | THROUGH |
| **DIRECT COSTS ONLY** |

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

PHS 398 (Rev. 03/2020 Approved Through 02/28/2023) OMB No. 0925-0001 **Form Page 4**

Name of Applicant (Last, First, Middle):

**BUDGET JUSTIFICATION**

0925-0001 (Rev. 03/20/20 Approved Through 02/28/2023 **Continuation Format Page**

Name of Applicant (Last, First, Middle):

**RESEARCH PLAN**

0925-0001 (Rev. 03/20/20 Approved Through 02/28/2023 **Continuation Format Page**

Name of Applicant (Last, First, Middle):

**RESEARCH PLAN**

0925-0001 (Rev. 03/20/20 Approved Through 02/28/2023 **Continuation Format Page**

Name of Applicant (Last, First, Middle):

**RESEARCH PLAN**

0925-0001 (Rev. 03/20/20 Approved Through 02/28/2023 **Continuation Format Page**

Name of Applicant (Last, First, Middle):

**REFERENCES**

0925-0001 (Rev. 03/20/20 Approved Through 02/28/2023 **Continuation Format Pag**

Name of Applicant (Last, First, Middle):

**DC CFAR DEVELOPMENTAL AWARD CHECKLIST**

Please check the appropriate responses:

1. Does your proposed study include vulnerable populations?

□ Yes □ No

If yes, please select which vulnerable populations are included:

□ Pregnant women, neonates, or fetuses

□ Prisoners

□ Children (note: the NIH defines children as **birth to 18 years of age**)

□ Refugees

□ Transgender

□ Other vulnerable population

1. Does your proposed study involve procedures or behavioral interventions deemed above minimal risk?

□ Yes □ No

If you answered yes to question 1 or 2, please note that if funded, your study will be required to undergo additional [NIH clinical review](https://www.niaid.nih.gov/research/cfar-research-project-guidelines). **No human subject work may be initiated** **until clinical approval is received.**

1. Will any research (human or non-human) or other work be conducted in a foreign country?

□ Yes □ No

If you answered yes to question 3, please note that if funded, you will be required to complete the [International Studies Checklist](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=2ahUKEwj3_7CovpXfAhXJpFkKHWZgBtgQFjAAegQICRAC&url=https%3A%2F%2Fwww.niaid.nih.gov%2Fsites%2Fdefault%2Ffiles%2Finternationalstudieschecklist.doc&usg=AOvVaw2ZgSrmBhRyeabYE2OuQuPB) and your study will undergo additional NIH review. **No international work may be initiated until approval is received.**

1. Does this study involve animals?

□ Yes □ No