Form Approved Through 8/31/2015 OMB No. 0925-0001

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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)*  E-MAIL ADDRESS: | | | | | | | |
| 3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT | | | |
| 3f. MAJOR SUBDIVISION | | | |
| 3g. TELEPHONE AND FAX *(Area code, number and extension)*  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 *(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

04/01/2017 11/30/2017

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 |
|  |  |  |  |  | |  |  |  | |  |
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| **SUBTOTALS** | | | | | | |  |  | |  |
| CONSULTANT COSTS | | | | | | | | | |  |
| EQUIPME46NT *(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)* | | | | | | | | | **$** | |
| CONSORTIUM/CONTRACTUAL COSTS | | | | | FACILITIES AND ADMINISTRATIVE COSTS | | | |  | |
| **TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD** | | | | | | | | | **$** | |

**DETAILED BUDGET FOR SECOND BUDGET PERIOD DIRECT COSTS ONLY**

FROM THROUGH

12/1/17 09/30/18

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 |
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| **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** | | | | | | | | |  | |

PHS 398 (Rev. 08/12 Approved Through 8/31/2015) OMB No. 0925-0001

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

**BUDGET JUSTIFICATION**

**PERSONNEL**

**HPTN Scholar Salary Supplement:**

The HPTN Scholar salary supplement requests funding to cover

**We request Salary Supplement for 18 months: $**

**TRAVEL**

**Travel Expenses:** We are requesting travel funds for travels to HPTN Scholars related meetings, conferences,

and visiting mentorship with (*Your HPTN Mentor*) at \_ (Institution)

. Travel funds requested

as outlined below include round trip airfare, hotel, meals, ground transportation, and travel-related incidentals.

**We request a total travel budget for attendance of the meetings as outlined below: $**

**HPTN ANNUAL MEETINGS (2 MEETINGS, 4 DAYS EACH): $ .**

Attendance of these annual HPTN meetings are requirement of the HPTN Scholars Program. Estimates are based on travel to Washington, DC which was the previous location of this meeting.

Travel from to Washington DC (RT): $ / trip x 2 trips = $ Hotel: $ / day x 4 days x 2 trips= $

Meals: $ /day x 4 days x 2 trips = $

Ground transportation: $ / trip x 2 trip = $ Travel costs incidentals: $ / trip x 2 trip =$

**HPTN SCHOLARS RETREAT (1 MEETING, 3 DAYS): $ .**

Attendance of this HPTN Mid-year meeting is a requirement of the HPTN Scholars Program. Estimates are based on travel to Seattle, WA which was the previous location of this meeting.

Travel from to (RT): $ x1trip = $ Hotel: $ / day x 3 days = $

Meals: $ /day x 3 days = $

Ground transportation: $ /trip = $ Travel costs incidentals: $ /trip =$

**Any other relevant conference during the program (IAS, USCA, etc.): $**

Attendance to the conference will be based on invitation to present on HPTN- related analysis he/she submits as part of the HPTN Scholars Program.

Travel from to (RT): $ x1trip = $ Hotel: $ / day x 3 days = $

Meals: $ /day x 3 days = $

Ground transportation: $ /trip = $ Travel costs incidentals: $ /trip =$

OMB No. 0925-0001/0002 (Rev. 08/12 Approved Through 8/31/2015) Page **Continuation Format Page**

**BIOGRAPHICAL SKETCH**

Provide the following information for the Senior/key personnel and other significant contributors in the order listed on Form Page 2.

Follow this format for each person. **DO NOT EXCEED FOUR PAGES.**

NAME

eRA COMMONS USER NAME (credential, e.g., agency login)

POSITION TITLE

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable.)*

|  |  |  |  |
| --- | --- | --- | --- |
| INSTITUTION AND LOCATION | DEGREE  *(if applicable)* | MM/YY | FIELD OF STUDY |
|  |  |  |  |

**A. Personal Statement**

**B. Positions and Honors**

**Positions and Employment**

OMB No. 0925-0001/0002 (Rev. 8/12 Approved Through 8/31/2015) Page 5 **Biographical Sketch Format Page**

**Other Experience and Professional Memberships**

**Honors**

**C. Selected Peer-reviewed Publications** (Selected from XX peer-reviewed publications)

**Most relevant to the current application**

**Additional recent publications of importance to the field (in chronological order)**

**D. Research Support**

**Ongoing Research Support**

**Completed Research Support**

**For New and Renewal Applications (PHS 398) – DO NOT SUBMIT UNLESS REQUESTED**

**PHS 398 OTHER SUPPORT**

Provide active and pending support for all senior/key personnel. **Other Support includes all financial resources, whether Federal, non-Federal, commercial or institutional, available in direct support of an individual's research endeavors, including but not limited to research grants, cooperative agreements, contracts, and/or institutional awards.** Training awards, prizes, or gifts do not need to be included.

There is no "form page" for other support. Information on other support should be provided in the *format* shown below, using continuation pages as necessary. ***Include the principal investigator's name at the top and number consecutively with the rest of the application.*** The sample below is intended to provide guidance regarding the type and extent of information requested.

For instructions and information pertaining to the use of and policy for other support, see Other Support in the Supplemental Instructions, Part III,

Policies, Assurances, Definitions, and Other Information.

Effort devoted to projects must be measured using person months. Indicate calendar, academic, and/or summer months associated with each project.

**NAME OF INDIVIDUAL**

ACTIVE/PENDING

Project Number (Principal Investigator) Source

Title of Project *(or Subproject)*

The major goals of this project are… OVERLAP *(summarized for each individual)*

**Format**

Dates of Approved/Proposed Project

Annual Direct Costs

**Samples**

Person Months (Cal/Academic/ Summer)

**NAME OF INESTIGATOR**

ACTIVE

PENDING

OVERLAP

**NAME OF INESTIGATOR**

NONE

**NAME OF INESTIGATOR**

ACTIVE

OVERLAP

**NAME OF INESTIGATOR**

ACTIVE

OVERLAP:

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: xx/xx/20xx 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 |  |  | % = 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 | $ |

\*Check appropriate box(es):

TOTAL F&A Costs $

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

PHS 398 (Rev. 08/12 Approved Through 8/31/2015) OMB No. 0925-0001

Page **Checklist Form Page**

**Attachment 1: Detailed Budget Assumptions for Illustrative Purposes for New Scholars**

|  |  |
| --- | --- |
| **Salary** | 01 April – 30 01 Dec 2017 – 30 **Total** |
| November 2017 Sept 2018 (10 **April 2017-Sept** |
| (8 months) months) **2018** |

Name TBD Scholar in

Role

training

Inst. Base Salary $



Salary Request % x mos $ $ $

Fringe % $ $ $

Total $ $ $

**Travel**

**HPTN Meetings (2) at Start and at 12 months (4 days to include 1 day mentor program retreat)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Airfare: New York--DC | $ / RT | $ | $ | $ |
| Per Diem: DC | $ / Day | $ | $ | $ |
| Incidental travel costs |  | $ | $ |  |
| (communications, etc.) | $ / trip |  |  | $ |
| Airport Transfers | $ / trip | $ | $ | $ |

**HIV/AIDS National Meeting (N=1; 3 days)**

|  |  |  |  |
| --- | --- | --- | --- |
| Airfare: New York--Atlanta | $ / RT | $ | $ |
| Per Diem: Atlanta Incidental travel costs (communications, etc.) | $ / day  $ / trip | $  $ | $  $ |
| Airport Transfers | $ / trip | $ | $ |

**HPTN Scholar Mid-Year Meeting (N=1; 3 days)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Airfare: New York—Seattle | $ / RT |  | $ | $ |
| Per Diem: Seattle Incidental travel costs (communications, etc.) | $ / day  $ / trip |  | $  $ | $  $ |
| Airport Transfers | $ / trip |  | $ | $ |
| **Meetings with out of town mentor (4 trips of 5 days each) – if applicable** | | | | |
| Airfare: New York--DC $ / RT | | $ | $ | $ |
| Per Diem: DC $ / day | | $ | $ | $ |
| Incidental travel costs  (communications, etc.) $ / trip | | $ | $ | $ |
| Airport Transfers $ / trip | | $ | $ | $ |
| **Other Direct Costs – if applicable**  Telecommunication costs for monthly calls | | $ | $ | $ |
| Photocopying of key prevention articles, manuals, etc | | $ | $ | $ |
| General office supplies: books; software | | $ | $ | $ |
| **Total Direct Costs** | | $ | $ | $ |
| **Indirect Costs (avg. 30%)** | | $ | $ | $ |
| **TOTAL COSTS** | | $ | $ | $ |

Notes: The mid-year meeting takes place in Seattle and the Annual Meeting in DC each year.