

| | |
|--------------------------------|--|
| Opportunity Title: | Research Project Grant (Parent R01) |
| Offering Agency: | National Institutes of Health |
| CFDA Number: | |
| CFDA Description: | |
| Opportunity Number: | PA-10-067 |
| Competition ID: | ADOBE-FORMS-B1 |
| Opportunity Open Date: | 10/15/2010 |
| Opportunity Close Date: | 01/07/2013 |
| Agency Contact: | Grants Info Grants Information E-mail: GrantsInfo@nih.gov Phone: 301-435-0714 |

This electronic grants application is intended to be used to apply for the specific Federal funding opportunity referenced here.

If the Federal funding opportunity listed is not the opportunity for which you want to apply, close this application package by clicking on the "Cancel" button at the top of this screen. You will then need to locate the correct Federal funding opportunity, download its application and then apply.

This opportunity is only open to organizations, applicants who are submitting grant applications on behalf of a company, state, local or tribal government, academia, or other type of organization.

* Application Filing Name:

Mandatory Documents

Move Form to Complete

Move Form to Delete

Mandatory Documents for Submission

SF424 (R & R)

Research And Related Other Project Information

Research And Related Senior/Key Person Profile

Project/Performance Site Location(s)

PHS 398 Research Plan

PHS 398 Cover Page Supplement

PHS 398 Checklist

Optional Documents

Move Form to Submission List

Move Form to Delete

Optional Documents for Submission

Research & Related Budget

R & R Subaward Budget Attachment(s) Form

PHS Cover Letter

PHS 398 Modular Budget

Instructions

- 1
Enter a name for the application in the Application Filing Name field.
 - This application can be completed in its entirety offline; however, you will need to login to the Grants.gov website during the submission process.
 - You can save your application at any time by clicking the "Save" button at the top of your screen.
 - The "Save & Submit" button will not be functional until all required data fields in the application are completed and you clicked on the "Check Package for Errors" button and confirmed all data required data fields are completed.

- 2
Open and complete all of the documents listed in the "Mandatory Documents" box. Complete the SF-424 form first.
 - It is recommended that the SF-424 form be the first form completed for the application package. Data entered on the SF-424 will populate data fields in other mandatory and optional forms and the user cannot enter data in these fields.
 - The forms listed in the "Mandatory Documents" box and "Optional Documents" may be predefined forms, such as SF-424, forms where a document needs to be attached, such as the Project Narrative or a combination of both. "Mandatory Documents" are required for this application. "Optional Documents" can be used to provide additional support for this application or may be required for specific types of grant activity. Reference the application package instructions for more information regarding "Optional Documents".
 - To open and complete a form, simply click on the form's name to select the item and then click on the => button. This will move the document to the appropriate "Documents for Submission" box and the form will be automatically added to your application package. To view the form, scroll down the screen or select the form name and click on the "Open Form" button to begin completing the required data fields. To remove a form/document from the "Documents for Submission" box, click the document name to select it, and then click the <= button. This will return the form/document to the "Mandatory Documents" or "Optional Documents" box.
 - All documents listed in the "Mandatory Documents" box must be moved to the "Mandatory Documents for Submission" box. When you open a required form, the fields which must be completed are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message.

- 3
Click the "Save & Submit" button to submit your application to Grants.gov.
 - Once you have properly completed all required documents and attached any required or optional documentation, save the completed application by clicking on the "Save" button.
 - Click on the "Check Package for Errors" button to ensure that you have completed all required data fields. Correct any errors or if none are found, save the application package.
 - The "Save & Submit" button will become active; click on the "Save & Submit" button to begin the application submission process.
 - You will be taken to the applicant login page to enter your Grants.gov username and password. Follow all onscreen instructions for submission.

APPLICATION FOR FEDERAL ASSISTANCE SF 424 (R&R)

| | |
|----------------------------------|-------------------------------------|
| 3. DATE RECEIVED BY STATE | State Application Identifier |
| <input type="text"/> | <input type="text"/> |

1. * TYPE OF SUBMISSION

Pre-application Application Changed/Corrected Application

4. a. Federal Identifier

b. Agency Routing Identifier

2. DATE SUBMITTED

Applicant Identifier

5. APPLICANT INFORMATION * Organizational DUNS:

* Legal Name:

Department: Division:

* Street1:

Street2:

* City: County / Parish:

* State: Province:

* Country: * ZIP / Postal Code:

Person to be contacted on matters involving this application

Prefix: * First Name: Middle Name: * Last Name: Suffix:

* Phone Number: Fax Number:

Email:

6. * EMPLOYER IDENTIFICATION (EIN) or (TIN):

7. * TYPE OF APPLICANT:

Other (Specify):

Small Business Organization Type Women Owned Socially and Economically Disadvantaged

8. * TYPE OF APPLICATION:

New Resubmission Renewal Continuation Revision

If Revision, mark appropriate box(es).
 A. Increase Award B. Decrease Award C. Increase Duration D. Decrease Duration
 E. Other (specify):

* Is this application being submitted to other agencies? Yes No What other Agencies?

9. * NAME OF FEDERAL AGENCY:

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:

TITLE:

11. * DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:

12. PROPOSED PROJECT:

* Start Date * Ending Date

*** 13. CONGRESSIONAL DISTRICT OF APPLICANT**

14. PROJECT DIRECTOR/PRINCIPAL INVESTIGATOR CONTACT INFORMATION

Prefix: * First Name: Middle Name: * Last Name: Suffix:

Position/Title:

* Organization Name:

Department: Division:

* Street1:

Street2:

* City: County / Parish:

* State: Province:

* Country: * ZIP / Postal Code:

* Phone Number: Fax Number:

* Email:

| | |
|--|---|
| <p>15. ESTIMATED PROJECT FUNDING</p> <p>a. Total Federal Funds Requested <input style="width:150px; height:15px;" type="text"/></p> <p>b. Total Non-Federal Funds <input style="width:150px; height:15px;" type="text"/></p> <p>c. Total Federal & Non-Federal Funds <input style="width:150px; height:15px;" type="text"/></p> <p>d. Estimated Program Income <input style="width:150px; height:15px;" type="text"/></p> | <p>16. * IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?</p> <p>a. YES <input type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON: DATE: <input style="width:100px;" type="text"/></p> <p>b. NO <input checked="" type="checkbox"/> PROGRAM IS NOT COVERED BY E.O. 12372; OR <input type="checkbox"/> PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW</p> |
|--|---|

17. By signing this application, I certify (1) to the statements contained in the list of certifications* and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances * and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)

* I agree

* The list of certifications and assurances, or an Internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

18. SFLLL or other Explanatory Documentation

19. Authorized Representative

Prefix: Ms. * First Name: Michelle Middle Name: A.

* Last Name: Lewis Suffix:

* Position/Title: Director, Research & Sponsored Programs

* Organization: Joan & Sanford I. Weill Medical College of Cornell University

Department: Research & Sponsored Programs Division: Grants & Contracts

* Street1: 1300 York Avenue

Street2: Box 89

* City: New York County / Parish: New York

* State: NY: New York Province:

* Country: USA: UNITED STATES * ZIP / Postal Code: 10065-4805

* Phone Number: 646-962-8290 Fax Number: 646-962-0531

* Email: grantsandcontracts@med.cornell.edu

*** Signature of Authorized Representative**

Completed on submission to Grants.gov

*** Date Signed**

Completed on submission to Grants.gov

20. Pre-application

RESEARCH & RELATED Other Project Information

1. * Are Human Subjects Involved? Yes No

1.a If YES to Human Subjects

Is the Project Exempt from Federal regulations? Yes No

If yes, check appropriate exemption number. 1 2 3 4 5 6

If no, is the IRB review Pending? Yes No

IRB Approval Date:

Human Subject Assurance Number:

If YES to Human Subjects, please enter 00000093 as the Human Subject Assurance Number.

2. * Are Vertebrate Animals Used? Yes No

2.a. If YES to Vertebrate Animals

Is the IACUC review Pending? Yes No

IACUC Approval Date:

Animal Welfare Assurance Number

If YES to Vertebrate Animals, please enter A3290-01 as the Animal Welfare Assurance Number.

3. * Is proprietary/privileged information included in the application? Yes No

4.a. * Does this project have an actual or potential impact on the environment? Yes No

4.b. If yes, please explain:

4.c. If this project has an actual or potential impact on the environment, has an exemption been authorized or an environmental assessment (EA) or environmental impact statement (EIS) been performed? Yes No

4.d. If yes, please explain:

5. * Is the research performance site designated, or eligible to be designated, as a historic place? Yes No

5.a. If yes, please explain:

6. * Does this project involve activities outside of the United States or partnerships with international collaborators? Yes No

6.a. If yes, identify countries:

6.b. Optional Explanation:

7. * Project Summary/Abstract

8. * Project Narrative

9. Bibliography & References Cited

10. Facilities & Other Resources

11. Equipment

12. Other Attachments

RESEARCH & RELATED Senior/Key Person Profile (Expanded)

| PROFILE - Project Director/Principal Investigator | | | | |
|---|--|---|--|--|
| Prefix: | <input type="text"/> | * First Name: | <input type="text"/> | |
| Middle Name: | <input type="text"/> | | | |
| * Last Name: | <input type="text"/> | Suffix: | <input type="text"/> | |
| Position/Title: | <input type="text"/> | Department: | <input type="text"/> | |
| Organization Name: | <input type="text" value="Joan & Sanford I. Weill Medical College of Cornell University"/> | | Division: | <input type="text"/> |
| * Street1: | <input type="text"/> | | | |
| Street2: | <input type="text"/> | | | |
| * City: | <input type="text"/> | County/ Parish: | <input type="text"/> | |
| * State: | <input type="text"/> | Province: | <input type="text"/> | |
| * Country: | <input type="text" value="USA: UNITED STATES"/> | * Zip / Postal Code: | <input type="text"/> | |
| * Phone Number: | <input type="text"/> | Fax Number: | <input type="text"/> | |
| * E-Mail: | <input type="text"/> | | | |
| Credential, e.g., agency login: | <input type="text"/> | | | |
| * Project Role: | <input type="text" value="PD/PI"/> | Other Project Role Category: | <input type="text"/> | |
| Degree Type: | <input type="text"/> | | | |
| Degree Year: | <input type="text"/> | | | |
| *Attach Biographical Sketch | <input type="text"/> | <input type="button" value="Add Attachment"/> | <input type="button" value="Delete Attachment"/> | <input type="button" value="View Attachment"/> |
| Attach Current & Pending Support | <input type="text"/> | <input type="button" value="Add Attachment"/> | <input type="button" value="Delete Attachment"/> | <input type="button" value="View Attachment"/> |

| PROFILE - Senior/Key Person 1 | | | | |
|----------------------------------|---|---|--|--|
| Prefix: | <input type="text"/> | * First Name: | <input type="text"/> | |
| Middle Name: | <input type="text"/> | | | |
| * Last Name: | <input type="text"/> | Suffix: | <input type="text"/> | |
| Position/Title: | <input type="text"/> | Department: | <input type="text"/> | |
| Organization Name: | <input type="text"/> | | Division: | <input type="text"/> |
| * Street1: | <input type="text"/> | | | |
| Street2: | <input type="text"/> | | | |
| * City: | <input type="text"/> | County/ Parish: | <input type="text"/> | |
| * State: | <input type="text"/> | Province: | <input type="text"/> | |
| * Country: | <input type="text" value="USA: UNITED STATES"/> | * Zip / Postal Code: | <input type="text"/> | |
| * Phone Number: | <input type="text"/> | Fax Number: | <input type="text"/> | |
| * E-Mail: | <input type="text"/> | | | |
| Credential, e.g., agency login: | <input type="text"/> | | | |
| * Project Role: | <input type="text"/> | Other Project Role Category: | <input type="text"/> | |
| Degree Type: | <input type="text"/> | | | |
| Degree Year: | <input type="text"/> | | | |
| *Attach Biographical Sketch | <input type="text"/> | <input type="button" value="Add Attachment"/> | <input type="button" value="Delete Attachment"/> | <input type="button" value="View Attachment"/> |
| Attach Current & Pending Support | <input type="text"/> | <input type="button" value="Add Attachment"/> | <input type="button" value="Delete Attachment"/> | <input type="button" value="View Attachment"/> |

To ensure proper performance of this form; after adding 20 additional Senior/ Key Persons; please save your application, close the Adobe Reader, and reopen it.

Project/Performance Site Location(s)

Project/Performance Site Primary Location I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country:

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Project/Performance Site Location 1 I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country:

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s)

PHS 398 Research Plan

1. Application Type:

From SF 424 (R&R) Cover Page. The response provided on that page, regarding the type of application being submitted, is repeated for your reference, as you attach the appropriate sections of the Research Plan.

*Type of Application:

| | | | | |
|------------------------------|---------------------------------------|----------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> New | <input type="checkbox"/> Resubmission | <input type="checkbox"/> Renewal | <input type="checkbox"/> Continuation | <input type="checkbox"/> Revision |
|------------------------------|---------------------------------------|----------------------------------|---------------------------------------|-----------------------------------|

2. Research Plan Attachments:

Please attach applicable sections of the research plan, below.

| | | | | |
|--|----------------------|--------------------------------|-----------------------------------|---------------------------------|
| 1. Introduction to Application <small>(for RESUBMISSION or REVISION only)</small> | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |
| 2. Specific Aims | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |
| 3. *Research Strategy | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |
| 4. Inclusion Enrollment Report | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |
| 5. Progress Report Publication List | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |

Human Subjects Sections

| | | | | |
|--------------------------------------|----------------------|--------------------------------|-----------------------------------|---------------------------------|
| 6. Protection of Human Subjects | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |
| 7. Inclusion of Women and Minorities | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |
| 8. Targeted/Planned Enrollment Table | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |
| 9. Inclusion of Children | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |

Other Research Plan Sections

| | | | | |
|---|----------------------|--------------------------------|-----------------------------------|---------------------------------|
| 10. Vertebrate Animals | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |
| 11. Select Agent Research | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |
| 12. Multiple PD/PI Leadership Plan | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |
| 13. Consortium/Contractual Arrangements | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |
| 14. Letters of Support | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |
| 15. Resource Sharing Plan(s) | <input type="text"/> | Add Attachment | Delete Attachment | View Attachment |

| | | | |
|--------------|---------------------------------|------------------------------------|----------------------------------|
| 16. Appendix | Add Attachments | Remove Attachments | View Attachments |
|--------------|---------------------------------|------------------------------------|----------------------------------|

1. Project Director / Principal Investigator (PD/PI)

Prefix: * First Name:

Middle Name:

* Last Name:

Suffix:

2. Human Subjects

Clinical Trial? No Yes

* Agency-Defined Phase III Clinical Trial? No Yes

3. Applicant Organization Contact

Person to be contacted on matters involving this application

Prefix: * First Name:

Middle Name:

* Last Name:

Suffix:

* Phone Number: Fax Number:

Email:

* Title:

* Street1:

Street2:

* City:

County/Parish:

* State:

Province:

* Country: * Zip / Postal Code:

PHS 398 Checklist

OMB Number: 0925-0001

1. Application Type:

From SF 424 (R&R) Cover Page. The responses provided on the R&R cover page are repeated here for your reference, as you answer the questions that are specific to the PHS398.

* Type of Application:

New Resubmission Renewal Continuation Revision

Federal Identifier:

2. Change of Investigator / Change of Institution Questions

Change of principal investigator / program director

Name of former principal investigator / program director:

Prefix:

* First Name:

Middle Name:

* Last Name:

Suffix:

Change of Grantee Institution

* Name of former institution:

3. Inventions and Patents (For renewal applications only)

* Inventions and Patents: Yes No

If the answer is "Yes" then please answer the following:

* Previously Reported: Yes No

4. * Program Income

Is program income anticipated during the periods for which the grant support is requested?

Yes No

If you checked "yes" above (indicating that program income is anticipated), then use the format below to reflect the amount and source(s). Otherwise, leave this section blank.

| *Budget Period | *Anticipated Amount (\$) | *Source(s) |
|----------------------|--------------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

5. * 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

Close Form

RESEARCH & RELATED BUDGET - SECTION C, D, & E, BUDGET PERIOD 1

* ORGANIZATIONAL DUNS: 0602175020000

* Budget Type: Project Subaward/Consortium

Enter name of Organization: Joan & Sanford I. Weill Medical

* Start Date: * End Date: Budget Period 1

C. Equipment Description

List items and dollar amount for each item exceeding \$5,000

| | Equipment item | * Funds Requested (\$) |
|-----|---|------------------------|
| 1. | <input type="text"/> | <input type="text"/> |
| 2. | <input type="text"/> | <input type="text"/> |
| 3. | <input type="text"/> | <input type="text"/> |
| 4. | <input type="text"/> | <input type="text"/> |
| 5. | <input type="text"/> | <input type="text"/> |
| 6. | <input type="text"/> | <input type="text"/> |
| 7. | <input type="text"/> | <input type="text"/> |
| 8. | <input type="text"/> | <input type="text"/> |
| 9. | <input type="text"/> | <input type="text"/> |
| 10. | <input type="text"/> | <input type="text"/> |
| 11. | Total funds requested for all equipment listed in the attached file | <input type="text"/> |
| | Total Equipment | <input type="text"/> |

Additional Equipment:

Add Attachment

Delete Attachment

View Attachment

D. Travel

Funds Requested (\$)

| | | |
|----|--|----------------------|
| 1. | Domestic Travel Costs (Incl. Canada, Mexico and U.S. Possessions) | <input type="text"/> |
| 2. | Foreign Travel Costs | <input type="text"/> |
| | Total Travel Cost | <input type="text"/> |

E. Participant/Trainee Support Costs

Funds Requested (\$)

| | | |
|----------------------|---------------------------------|--|
| 1. | Tuition/Fees/Health Insurance | <input type="text"/> |
| 2. | Stipends | <input type="text"/> |
| 3. | Travel | <input type="text"/> |
| 4. | Subsistence | <input type="text"/> |
| 5. | Other <input type="text"/> | <input type="text"/> |
| <input type="text"/> | Number of Participants/Trainees | Total Participant/Trainee Support Costs <input type="text"/> |

RESEARCH & RELATED Budget {C-E} (Funds Requested)

Close Form

RESEARCH & RELATED BUDGET - SECTION F-K, BUDGET PERIOD 1

* ORGANIZATIONAL DUNS: 0602175020000

* Budget Type: Project Subaward/Consortium

Enter name of Organization: Joan & Sanford I. Weill Medical

* Start Date: * End Date: Budget Period 1

| F. Other Direct Costs | Funds Requested (\$) |
|---|----------------------|
| 1. Materials and Supplies | <input type="text"/> |
| 2. Publication Costs | <input type="text"/> |
| 3. Consultant Services | <input type="text"/> |
| 4. ADP/Computer Services | <input type="text"/> |
| 5. Subawards/Consortium/Contractual Costs | <input type="text"/> |
| 6. Equipment or Facility Rental/User Fees | <input type="text"/> |
| 7. Alterations and Renovations | <input type="text"/> |
| 8. <input type="text"/> | <input type="text"/> |
| 9. <input type="text"/> | <input type="text"/> |
| 10. <input type="text"/> | <input type="text"/> |
| Total Other Direct Costs | <input type="text"/> |

| G. Direct Costs | Funds Requested (\$) |
|--------------------------------------|----------------------|
| Total Direct Costs (A thru F) | <input type="text"/> |

| H. Indirect Costs | Indirect Cost Type | Indirect Cost Rate (%) | Indirect Cost Base (\$) | * Funds Requested (\$) |
|-----------------------------|----------------------|------------------------|-------------------------|------------------------|
| 1. | MTDC | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 2. | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 3. | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 4. | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Total Indirect Costs | | | | <input type="text"/> |

Cognizant Federal Agency: DHHS, Robert I. Aaronson, 212-261-2069
(Agency Name, POC Name, and POC Phone Number)

| I. Total Direct and Indirect Costs | Funds Requested (\$) |
|--|----------------------|
| Total Direct and Indirect Institutional Costs (G + H) | <input type="text"/> |

| J. Fee | Funds Requested (\$) |
|--------|----------------------|
| | <input type="text"/> |

K. * Budget Justification

(Only attach one file.)

RESEARCH & RELATED BUDGET - Cumulative Budget

| | | Totals (\$) |
|---|----------------------|----------------------|
| Section A, Senior/Key Person | | <input type="text"/> |
| Section B, Other Personnel | | <input type="text"/> |
| Total Number Other Personnel | <input type="text"/> | |
| Total Salary, Wages and Fringe Benefits (A+B) | | <input type="text"/> |
| Section C, Equipment | | <input type="text"/> |
| Section D, Travel | | <input type="text"/> |
| 1. Domestic | <input type="text"/> | |
| 2. Foreign | <input type="text"/> | |
| Section E, Participant/Trainee Support Costs | | <input type="text"/> |
| 1. Tuition/Fees/Health Insurance | <input type="text"/> | |
| 2. Stipends | <input type="text"/> | |
| 3. Travel | <input type="text"/> | |
| 4. Subsistence | <input type="text"/> | |
| 5. Other | <input type="text"/> | |
| 6. Number of Participants/Trainees | <input type="text"/> | |
| Section F, Other Direct Costs | | <input type="text"/> |
| 1. Materials and Supplies | <input type="text"/> | |
| 2. Publication Costs | <input type="text"/> | |
| 3. Consultant Services | <input type="text"/> | |
| 4. ADP/Computer Services | <input type="text"/> | |
| 5. Subawards/Consortium/Contractual Costs | <input type="text"/> | |
| 6. Equipment or Facility Rental/User Fees | <input type="text"/> | |
| 7. Alterations and Renovations | <input type="text"/> | |
| 8. Other 1 | <input type="text"/> | |
| 9. Other 2 | <input type="text"/> | |
| 10. Other 3 | <input type="text"/> | |
| Section G, Direct Costs (A thru F) | | <input type="text"/> |
| Section H, Indirect Costs | | <input type="text"/> |
| Section I, Total Direct and Indirect Costs (G + H) | | <input type="text"/> |
| Section J, Fee | | <input type="text"/> |

R&R SUBAWARD BUDGET ATTACHMENT(S) FORM

Instructions: On this form, you will attach the R&R Subaward Budget files for your grant application. Complete the subawardee budget(s) in accordance with the R&R budget instructions. Please remember that any files you attach must be a PDF document.

[Click here to extract the R&R Subaward Budget Attachment](#)

Important: Please attach your subawardee budget file(s) with the file name of the subawardee organization. Each file name must be unique.

| | | | | |
|---------------------------------|--|----------------|-------------------|-----------------|
| 1) Please attach Attachment 1 | | Add Attachment | Delete Attachment | View Attachment |
| 2) Please attach Attachment 2 | | Add Attachment | Delete Attachment | View Attachment |
| 3) Please attach Attachment 3 | | Add Attachment | Delete Attachment | View Attachment |
| 4) Please attach Attachment 4 | | Add Attachment | Delete Attachment | View Attachment |
| 5) Please attach Attachment 5 | | Add Attachment | Delete Attachment | View Attachment |
| 6) Please attach Attachment 6 | | Add Attachment | Delete Attachment | View Attachment |
| 7) Please attach Attachment 7 | | Add Attachment | Delete Attachment | View Attachment |
| 8) Please attach Attachment 8 | | Add Attachment | Delete Attachment | View Attachment |
| 9) Please attach Attachment 9 | | Add Attachment | Delete Attachment | View Attachment |
| 10) Please attach Attachment 10 | | Add Attachment | Delete Attachment | View Attachment |

PHS Cover Letter

OMB Numbers: 0925-0001
0925-0002

*Mandatory Cover Letter Filename:

Add Cover Letter File

Delete Cover Letter File

View Cover Letter File

PHS 398 Modular Budget, Periods 1 and 2

OMB Number: 0925-0001

| | | |
|-------------------------|--|--|
| Budget Period: 1 | Start Date: <input style="width: 80%;" type="text"/> | End Date: <input style="width: 80%;" type="text"/> |
|-------------------------|--|--|

| | |
|-----------------------------------|---|
| A. Direct Costs | * Funds Requested (\$) |
| * Direct Cost less Consortium F&A | <input style="width: 100%;" type="text"/> |
| Consortium F&A | <input style="width: 100%;" type="text"/> |
| * Total Direct Costs | <input style="width: 100%;" type="text"/> |

| | Indirect Cost Type | Indirect Cost Rate (%) | Indirect Cost Base (\$) | * Funds Requested (\$) |
|----|--|--|--|---|
| 1. | MTDC | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |
| 2. | <input style="width: 90%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |
| 3. | <input style="width: 90%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |
| 4. | <input style="width: 90%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |

| | |
|---|---|
| Cognizant Agency (Agency Name, POC Name and Phone Number) | Robert I. Aaronson Department of Health & Human Services Federal Plaza, Room 41-122 New York, NY 10278 212-261-2069 or 212-264-2088 |
| Indirect Cost Rate Agreement Date <input style="width: 80%;" type="text" value="06/24/2010"/> | Total Indirect Costs <input style="width: 100%;" type="text"/> |

| | |
|---|--|
| C. Total Direct and Indirect Costs (A + B) | Funds Requested (\$) <input style="width: 100%;" type="text"/> |
|---|--|

| | | |
|-------------------------|--|--|
| Budget Period: 2 | Start Date: <input style="width: 80%;" type="text"/> | End Date: <input style="width: 80%;" type="text"/> |
|-------------------------|--|--|

| | |
|-----------------------------------|---|
| A. Direct Costs | * Funds Requested (\$) |
| * Direct Cost less Consortium F&A | <input style="width: 100%;" type="text"/> |
| Consortium F&A | <input style="width: 100%;" type="text"/> |
| * Total Direct Costs | <input style="width: 100%;" type="text"/> |

| | Indirect Cost Type | Indirect Cost Rate (%) | Indirect Cost Base (\$) | * Funds Requested (\$) |
|----|--|--|--|---|
| 1. | MTDC | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |
| 2. | <input style="width: 90%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |
| 3. | <input style="width: 90%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |
| 4. | <input style="width: 90%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |

| | |
|---|---|
| Cognizant Agency (Agency Name, POC Name and Phone Number) | Robert I. Aaronson Department of Health & Human Services Federal Plaza, Room 41-122 New York, NY 10278 212-261-2069 or 212-264-2088 |
| Indirect Cost Rate Agreement Date <input style="width: 80%;" type="text" value="06/24/2010"/> | Total Indirect Costs <input style="width: 100%;" type="text"/> |

| | |
|---|--|
| C. Total Direct and Indirect Costs (A + B) | Funds Requested (\$) <input style="width: 100%;" type="text"/> |
|---|--|

PHS 398 Modular Budget, Periods 3 and 4

| | | |
|-------------------------|--|--|
| Budget Period: 3 | Start Date: <input style="width: 80%;" type="text"/> | End Date: <input style="width: 80%;" type="text"/> |
|-------------------------|--|--|

| | | |
|------------------------|-----------------------------------|---|
| A. Direct Costs | | * Funds Requested (\$) |
| | * Direct Cost less Consortium F&A | <input style="width: 100%;" type="text"/> |
| | Consortium F&A | <input style="width: 100%;" type="text"/> |
| | * Total Direct Costs | <input style="width: 100%;" type="text"/> |

| | Indirect Cost Type | Indirect Cost Rate (%) | Indirect Cost Base (\$) | * Funds Requested (\$) |
|----|--|--|--|---|
| 1. | MTDC | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |
| 2. | <input style="width: 95%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |
| 3. | <input style="width: 95%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |
| 4. | <input style="width: 95%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |

| | |
|---|---|
| Cognizant Agency (Agency Name, POC Name and Phone Number) | Robert I. Aaronson Department of Health & Human Services Federal Plaza, Room 41-122 New York, NY 10278 212-261-2069 or 212-264-2088 |
|---|---|

| | |
|---|--|
| Indirect Cost Rate Agreement Date <input style="width: 80%;" type="text" value="06/24/2010"/> | Total Indirect Costs <input style="width: 100%;" type="text"/> |
|---|--|

| | |
|---|--|
| C. Total Direct and Indirect Costs (A + B) | Funds Requested (\$) <input style="width: 100%;" type="text"/> |
|---|--|

| | | |
|-------------------------|--|--|
| Budget Period: 4 | Start Date: <input style="width: 80%;" type="text"/> | End Date: <input style="width: 80%;" type="text"/> |
|-------------------------|--|--|

| | | |
|------------------------|-----------------------------------|---|
| A. Direct Costs | | * Funds Requested (\$) |
| | * Direct Cost less Consortium F&A | <input style="width: 100%;" type="text"/> |
| | Consortium F&A | <input style="width: 100%;" type="text"/> |
| | * Total Direct Costs | <input style="width: 100%;" type="text"/> |

| | Indirect Cost Type | Indirect Cost Rate (%) | Indirect Cost Base (\$) | * Funds Requested (\$) |
|----|--|--|--|---|
| 1. | MTDC | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |
| 2. | <input style="width: 95%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |
| 3. | <input style="width: 95%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |
| 4. | <input style="width: 95%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 80%;" type="text"/> | <input style="width: 100%;" type="text"/> |

| | |
|---|---|
| Cognizant Agency (Agency Name, POC Name and Phone Number) | Robert I. Aaronson Department of Health & Human Services Federal Plaza, Room 41-122 New York, NY 10278 212-261-2069 or 212-264-2088 |
|---|---|

| | |
|---|--|
| Indirect Cost Rate Agreement Date <input style="width: 80%;" type="text" value="06/24/2010"/> | Total Indirect Costs <input style="width: 100%;" type="text"/> |
|---|--|

| | |
|---|--|
| C. Total Direct and Indirect Costs (A + B) | Funds Requested (\$) <input style="width: 100%;" type="text"/> |
|---|--|

PHS 398 Modular Budget, Periods 5 and Cumulative

Budget Period: 5

Start Date: End Date:

A. Direct Costs

* Funds Requested (\$)

* Direct Cost less Consortium F&A

Consortium F&A

* Total Direct Costs

B. Indirect Costs

| | Indirect Cost Type | Indirect Cost Rate (%) | Indirect Cost Base (\$) | * Funds Requested (\$) |
|----|----------------------|------------------------|-------------------------|---|
| 1. | MTDC | <input type="text"/> | <input type="text"/> | <input style="background-color: yellow; border: 2px solid red;" type="text"/> |
| 2. | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 3. | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 4. | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Cognizant Agency (Agency Name, POC Name and Phone Number)

Indirect Cost Rate Agreement Date Total Indirect Costs

C. Total Direct and Indirect Costs (A + B)

Funds Requested (\$)

Cumulative Budget Information

1. Total Costs, Entire Project Period

*Section A, Total Direct Cost less Consortium F&A for Entire Project Period \$

Section A, Total Consortium F&A for Entire Project Period \$

*Section A, Total Direct Costs for Entire Project Period \$

*Section B, Total Indirect Costs for Entire Project Period \$

*Section C, Total Direct and Indirect Costs (A+B) for Entire Project Period \$

2. Budget Justifications

| | | | | |
|------------------------------------|----------------------|---|--|--|
| Personnel Justification | <input type="text"/> | <input type="button" value="Add Attachment"/> | <input type="button" value="Delete Attachment"/> | <input type="button" value="View Attachment"/> |
| Consortium Justification | <input type="text"/> | <input type="button" value="Add Attachment"/> | <input type="button" value="Delete Attachment"/> | <input type="button" value="View Attachment"/> |
| Additional Narrative Justification | <input type="text"/> | <input type="button" value="Add Attachment"/> | <input type="button" value="Delete Attachment"/> | <input type="button" value="View Attachment"/> |