DACCOTA CORES THAT CAN ASSIST WITH THIS COMPONENT: N/A, CONTACT INSTITUTIONAL GRANTS OFFICE

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)*
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

DACCOTA CORES THAT CAN ASSIST WITH THIS COMPONENT: BERDC

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

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:

DACCOTA CORES THAT CAN ASSIST WITH THIS COMPONENT: N/A, CONTACT INSTITUTIONAL GRANTS OFFICE

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. *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

DACCOTA CORES THAT CAN ASSIST WITH THIS COMPONENT: CRRFC (SANFORD ONLY), CONTACT INSTITUTIONAL GRANTS OFFICE

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
								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

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

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.

DACCOTA CORES THAT CAN ASSIST WITH THIS COMPONENT: CRRFC, BERDC

OMB No. 0925-0001 and 0925-0002 (Rev. 10/2021 Approved Through 09/30/2024)

BIOGRAPHICAL SKETCH

Provide the following information for the Senior/key personnel and other significant contributors.
Follow this format for each person. **DO NOT EXCEED FIVE 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. Add/delete rows as necessary.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	Completion Date MM/YYYY	FIELD OF STUDY

A. Personal Statement

B. Positions, Scientific Appointments, and Honors

C. Contributions to Science

Name of Applicant (Last, First, Middle):

RESEARCH PLAN

RESPONSE TO REVIEWER (if resubmission) (0.5 page)

SPECIFIC AIMS (1 page)

SIGNIFICANCE (0.5 page)

INNOVATION (0.5 page)

RESEARCH STRATEGY (maximum 2 pages for Introduction to Research awards, 6 pages for all others)

BIBLIOGRAPHY AND REFERENCES CITED

DACCOTA CORES THAT CAN ASSIST WITH THIS COMPONENT: BERDC

Name of Applicant (Last, First, Middle):

VERTEBRATE ANIMALS SECTION

DACCOTA CORES THAT CAN ASSIST WITH THIS COMPONENT: N/A, CONTACT INSTITUTIONAL GRANTS OFFICE

CONSORTIUM/CONTRACTUAL ARRANGEMENTS

LETTER OF SUPPORT

- from Department Head and/or Clinical Unit Chief and any letters necessary to demonstrate the support of consortium participants and collaborators such as Senior/Key Personnel and Other Significant Contributors included in the application
- from each DaCCoTA Core following core meetings

DACCOTA CORES THAT CAN ASSIST WITH THIS COMPONENT: N/A, CONTACT INSTITUTIONAL GRANTS OFFICE

RESOURCE SHARING PLAN

AUTHENTICATION OF KEY BIOLOGICAL AND/OR CHEMICAL RESOURCES

DACCOTA CORES THAT CAN ASSIST WITH THIS COMPONENT: CRRFC

DaCCoTA Grant Application
Human Subjects Overview

Investigator(s)/Co-Investigator(s)

Role	Name	Affiliation
Clinical Investigator	Click or tap here to enter text.	Click or tap here to enter text.
Non-Clinical Investigator	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Project Title: Click or tap here to enter text.

IRB Approval or Human Subjects Determination Status

☐ Approved
☐ Pending Approval/Submitted
☐ Not Submitted
☐ Not Required (project does not involve human subjects research) **FORM COMPLETE, Do Not Proceed**

IRB of Record (If multiple IRBs of record, please justify.)**:** Click or tap here to enter text.

IRB Application Type

☐ Determination of Human Subjects
☐ Record Review of Existing Specimens, Retrospective
☐ Investigator Initiated, Prospective

IRB Deadline(s) (Include pre-review deadlines, if available): Click or tap here to enter text.

Specimen Required (select all that apply)

☐ Serum
☐ Plasma
☐ DNA
☐ Tissue
☐ Archival
☐ Fresh
☐ None
☐ Other, please describe: Click or tap here to enter text.

Subject Characteristics (Describe the characteristics of the subjects. Criteria might include disease status, gender, age, race, ethnicity, comorbidities, treatments, date ranges, survival status, etc. Be as specific as possible.)
Click or tap here to enter text.

Number of Subjects: Click or tap here to enter text.

Do you require serial specimen?

☐ Yes, please describe: Click or tap here to enter text.
☐ No

Community Engagement Relevance Survey for DaCCoTA Applications

Directions: The Community Engagement Relevance Survey is required for all DaCCoTA applications. The purpose of this survey is to identify relevant community engagement in prospective applications.

Applicant Name:
Core and Grant Funding Mechanism:
Project Name:

This identification is required for all DaCCoTA (AICoRN, BERDC, PDC, PPP) applications:

As part of your application, please identify which of the following communities is most relevant to your Community Engagement Scholars application (select all that apply):

☐American Indian (both rural and urban) communities

☐Rural communities

☐New American, Foreign-born, and Immigrant (NFI) communities

☐Lesbian, Gay, Bisexual, Transgender, & Queer + (LGBTQ+) communities

For PDC Community Engagement Scholars Applications Only!

As part of your application, please identify which of the following research priorities is most relevant to your Community Engagement Scholars application (select all that apply):

☐Behavioral health (including substance use disorder, mental health, suicidality, and overall wellness)

☐Food insecurity, nutrition, and food deserts

☐Chronic disease (including diabetes, cancer, hypertension, obesity, and pain)

☐Culturally-safe and trauma-informed healthcare and research (including integrative therapies such as traditional healing, and innovative prenatal and natal, and postnatal care)

☐Unresolved trauma (including health impacts of trauma and toxic stress, adverse childhood experiences, and disproportionate foster care experiences)

DACCOTA CORES THAT CAN ASSIST WITH THIS COMPONENT: N/A, CONTACT INSTITUTIONAL GRANTS OFFICE

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 0.00%	% = F&A costs	$ 0.00
b. 02 year	Amount of base $ ________	x Rate applied 0.00%	% = F&A costs	$ 0.00
c. 03 year	Amount of base $ ________	x Rate applied 0.00%	% = F&A costs	$ 0.00
d. 04 year	Amount of base $ ________	x Rate applied 0.00%	% = F&A costs	$ 0.00
e. 05 year	Amount of base $ ________	x Rate applied 0.00%	% = F&A costs	$ 0.00

Enter Rate above as a decimal (e.g., 0.25 for 25%, 0.495 for 49.5%) TOTAL F&A Costs $ 0.00

*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.)*: