

Department of Health and Human Services Public Health Services Grant Application <i>Do not exceed character length restrictions indicated.</i>		LEAVE BLANK—FOR PHS USE ONLY.			
		Type	Activity	Number	
		Review Group		Formerly	
		Council/Board (Month, Year)		Date Received	
1. TITLE OF PROJECT (<i>Do not exceed 81 characters, including spaces and punctuation.</i>)					
2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT OR SOLICITATION <input type="checkbox"/> NO <input type="checkbox"/> YES (<i>If "Yes," state number and title</i>) Number: _____ Title: _____					
3. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR			New Investigator <input type="checkbox"/> No <input type="checkbox"/> Yes		
3a. NAME (Last, first, middle)		3b. DEGREE(S)		3h. eRA Commons User Name	
3c. POSITION TITLE		3d. MAILING ADDRESS (<i>Street, city, state, zip code</i>) E-MAIL ADDRESS:			
3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT					
3f. MAJOR SUBDIVISION					
3g. TELEPHONE AND FAX (<i>Area code, number and extension</i>) TEL: _____ FAX: _____					
4. HUMAN SUBJECTS RESEARCH <input type="checkbox"/> No <input type="checkbox"/> Yes		4b. Human Subjects Assurance No.		5. VERTEBRATE ANIMALS <input type="checkbox"/> No <input type="checkbox"/> Yes	
4a. Research Exempt <input type="checkbox"/> No <input type="checkbox"/> Yes		4c. Clinical Trial <input type="checkbox"/> No <input type="checkbox"/> Yes		4d. NIH-defined Phase III Clinical Trial <input type="checkbox"/> No <input type="checkbox"/> Yes	
If "Yes," Exemption No. _____		5a. If "Yes," IACUC approval Date		5b. Animal welfare assurance no.	
6. DATES OF PROPOSED PERIOD OF SUPPORT (<i>month, day, year—MM/DD/YY</i>) From 7/1/07 Through 6/30/09		7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD 7a. Direct Costs (\$) \$125,000		8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT 7b. Total Costs (\$) \$184,850 8a. Direct Costs (\$) \$225,000 8b. Total Costs (\$) 341,850	
9. APPLICANT ORGANIZATION Name Board of Trustess of the University of Illinois Address MB 502, M/C 551 809 Marshfield Avenue Chicago, IL 60607			10. TYPE OF ORGANIZATION Public: → <input type="checkbox"/> Federal <input checked="" type="checkbox"/> State <input type="checkbox"/> Local Private: → <input type="checkbox"/> Private Nonprofit For-profit: → <input type="checkbox"/> General <input type="checkbox"/> Small Business <input type="checkbox"/> Woman-owned <input type="checkbox"/> Socially and Economically Disadvantaged		
			11. ENTITY IDENTIFICATION NUMBER 37-6000511-A5 DUNS NO. 098987217 Cong. District 7		
12. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE Name Luis Vargas Title Executive Director Address Office of Research Services 304 AOB, M/C 672, 1737 West Polk Street Chicago, IL 60612-7227 Tel: 312-996-9406 FAX: 312-996-9005 E-Mail: awards@uic.edu			13. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION Name Dr. Larry H. Danziger Title Interim Vice Chancellor for Research Address 310 AOB, M/C 672 1737 West Polk Street Chicago, IL 60612-7227 Tel: 312-996-4993 FAX: 312-996-9005 E-Mail: awards@uic.edu		
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. (<i>In ink. "Per" signature not acceptable.</i>)		DATE

DETAILED BUDGET FOR INITIAL BUDGET PERIOD DIRECT COSTS ONLY					FROM 7/01/07	THROUGH 6/30/09	
PERSONNEL <i>(Applicant organization only)</i>		TYPE APPT. <i>(months)</i>	% EFFORT ON PROJ.	INST. BASE SALARY	DOLLAR AMOUNT REQUESTED <i>(omit cents)</i>		
NAME	ROLE ON PROJECT				SALARY REQUESTED	FRINGE BENEFITS	TOTAL
Amy Burton	Principal Investigator	12	15	125,000	18,750	6,411	25,161
Brian Miller	Co-PI	12	10	100,000	10,000	3,419	13,419
Janet Hill	Res. Nurse	12	40	60,000	24,000	8,206	32,206
SUBTOTALS →					52,750	18,036	70,786
CONSULTANT COSTS							
EQUIPMENT <i>(Itemize)</i>							
X-ray Machine \$20,000							
20,000							
SUPPLIES <i>(Itemize by category)</i>							
Lab Supplies \$24,214							
24,214							
TRAVEL							
Travel for PI and Co PI to attend one national conference a year							
3,000							
PATIENT CARE COSTS		INPATIENT None					
		OUTPATIENT None					
ALTERATIONS AND RENOVATIONS <i>(Itemize by category)</i>							
OTHER EXPENSES <i>(Itemize by category)</i>							
DNA Sequencing \$4,800							
Publication Costs \$1,000							
Equipment Maintenance Contracts \$1,200							
7,000							
CONSORTIUM/CONTRACTUAL COSTS				DIRECT COSTS			
SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD <i>(Item 7a, Face Page)</i>							\$ 125,000
CONSORTIUM/CONTRACTUAL COSTS				FACILITIES AND ADMINISTRATIVE COSTS			
TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD							\$ 125,000

**BUDGET FOR ENTIRE PROPOSED PROJECT PERIOD
DIRECT COSTS ONLY**

BUDGET CATEGORY TOTALS		INITIAL BUDGET PERIOD <i>(from Form Page 4)</i>	ADDITIONAL YEARS OF SUPPORT REQUESTED			
			2nd	3rd	4th	5th
PERSONNEL: <i>Salary and fringe benefits. Applicant organization only.</i>		70,786	70,786			
CONSULTANT COSTS						
EQUIPMENT		20,000				
SUPPLIES		24,214	19,214			
TRAVEL		3,000	3,000			
PATIENT CARE COSTS	INPATIENT					
	OUTPATIENT					
ALTERATIONS AND RENOVATIONS						
OTHER EXPENSES		7,000	7,000			
CONSORTIUM/ CONTRACTUAL COSTS	DIRECT					
SUBTOTAL DIRECT COSTS <i>(Sum = Item 8a, Face Page)</i>		125,000	100,000			
CONSORTIUM/ CONTRACTUAL COSTS	F&A					
TOTAL DIRECT COSTS		125,000	100,000			
TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD						\$ 225,000

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

BUDGET JUSTIFICATION PAGE MODULAR RESEARCH GRANT APPLICATION						
	Initial Period	2 nd	3 rd	4 th	5 th	Sum Total (For Entire Project Period)
DC less Consortium F&A	<i>(Item 7a, Face Page)</i>					<i>(Item 8a, Face Page)</i>
Consortium F&A						
Total Direct Costs	125,000	100,000				\$ 225,000

Personnel

Consortium

CHECKLIST

TYPE OF APPLICATION (Check all that apply.)

- NEW application. (This application is being submitted to the PHS for the first time.)
- REVISION/RESUBMISSION of application number: _____
(This application replaces a prior unfunded version of a new, competing continuation/renewal, or supplemental/revision application.)
- COMPETING CONTINUATION/RENEWAL of grant number: _____
(This application is to extend a funded grant beyond its current project period.)
- SUPPLEMENT/REVISION to grant number: _____
(This application is for additional funds to supplement a currently funded grant.)
- CHANGE of principal investigator/program director.
Name of former principal investigator/program director: _____
- CHANGE of Grantee Institution. Name of former institution: _____
- FOREIGN application Domestic Grant with foreign involvement List Country(ies) Involved: _____

INVENTIONS AND PATENTS
(Competing continuation/renewal appl. only)

No Previously reported

Yes. If "Yes," 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 following policies, assurances and/or certifications when applicable. Descriptions of individual assurances/certifications are provided in Part III. If unable to certify compliance, where applicable, provide an explanation and place it after this page.

•Human Subjects Research •Research Using Human Embryonic Stem Cells •Research on Transplantation of Human Fetal Tissue •Women and Minority Inclusion Policy •Inclusion of Children Policy •Vertebrate Animals

•Debarment and Suspension •Drug- Free Workplace (applicable to new [Type 1] or revised/resubmission [Type 1] applications only) •Lobbying •Non-Delinquency on Federal Debt •Research Misconduct •Civil Rights (Form HHS 441 or HHS 690) •Handicapped Individuals (Form HHS 641 or HHS 690) •Sex Discrimination (Form HHS 639-A or HHS 690) •Age Discrimination (Form HHS 680 or HHS 690) •Recombinant DNA Research, Including Human Gene Transfer Research •Financial Conflict of Interest •Smoke Free Workplace •Prohibited Research •Select Agent Research •PI Assurance

3. FACILITIES AND ADMINSTRATIVE COSTS (F&A)/ INDIRECT COSTS. See specific instructions.

- DHHS Agreement dated: _____ No Facilities And Administrative Costs Requested.
- DHHS Agreement being negotiated with _____ Regional Office.
- No DHHS Agreement, but rate established with Office of Naval Research Date 7/1/07

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 \$	<u>105,000</u>	x Rate applied	<u>0.57</u>	% = F&A costs	\$	<u>59,850</u>	
b. 02 year	Amount of base \$	<u>100,000</u>	x Rate applied	<u>0.57</u>	% = F&A costs	\$	<u>57,000</u>	
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							\$	116,850

*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.):