

Department of Health and Human Services Public Health Services  <b>Grant Application</b>  <i>Do not exceed character length restrictions indicated.</i>		<b>LEAVE BLANK—FOR PHS USE ONLY.</b>	
		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> )    ADDRESS:	
3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT			
3f. MAJOR SUBDIVISION			
3g. TELEPHONE AND FAX ( <i>Area code, number and extension</i> ) E-MAIL TEL: _____ FAX: _____			
4. HUMAN SUBJECTS RESEARCH <input type="checkbox"/> No <input type="checkbox"/> Yes		5. VERTEBRATE ANIMALS <input type="checkbox"/> No <input type="checkbox"/> Yes	
4b. Human Subjects Assurance No.		5a. If "Yes," IACUC approval Date	
4c. Clinical Trial <input type="checkbox"/> No <input type="checkbox"/> Yes		5b. Animal welfare assurance no.	
4d. NIH-defined Phase III Clinical Trial <input type="checkbox"/> No <input type="checkbox"/> Yes			
4a. Research Exempt <input type="checkbox"/> No <input type="checkbox"/> Yes			
If "Yes," Exemption No. _____			
6. DATES OF PROPOSED PERIOD OF SUPPO RT ( <i>month, day, year—MM/DD/YY</i> )		7. COSTS REQUESTED FOR INITIAL BUDG ET PERIOD	
From _____ Through _____		8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT	
7/1/07 6/30/09		7a. Direct Costs (\$) <b>\$125,000</b>	7b. Total Costs (\$) <b>\$202,765</b>
		8a. Direct Costs (\$) <b>\$250,000</b>	8b. Total Costs (\$) <b>\$391,280</b>
9. APPLICANT ORGANIZATION Name <b>Board of Trustess of the University of Illinois</b> Address <b>MB 502, M/C 551 809 Marshfield Avenue Chicago, IL 60607</b>		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 <b>37-6000511-A5</b> DUNS NO. <b>098987217</b> Cong. District <b>7</b>	
12. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE Name <b>Luis Vargas</b> Title <b>Executive Director</b> Address <b>Office of Research Services 304 AOB, M/C 672, 1737 West Polk Street Chicago, IL 60612-7227</b> Tel: <b>312-996-9406</b> FAX: <b>312-996-9005</b> E-Mail: <b>awards@uic.edu</b>		13. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION Name <b>Joe G.N. Garcia, MD</b> Title <b>Vice Chancellor for Research</b> Address <b>310 AOB, M/C 672 1737 West Polk Street Chicago, IL 60612-7227</b> Tel: <b>312-996-4993</b> FAX: <b>312-996-9005</b> E-Mail: <b>awards@uic.edu</b>	
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	

<b>DETAILED BUDGET FOR INITIAL BUDGET PERIOD DIRECT COSTS ONLY</b>					FROM 7/1/07	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	100,000	15,000	5,129	20,129
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
<b>SUBTOTALS</b> →					<b>49,000</b>	<b>16,754</b>	<b>65,754</b>
CONSULTANT COSTS							
EQUIPMENT <i>(Itemize)</i>							
PCR Machine \$7,500							
Computer \$3,000							
10,500							
SUPPLIES <i>(Itemize by category)</i>							
Lab Supplies \$13,746							
13,746							
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 \$4800							
Publication Costs \$1000							
Equipment Maintenance Contracts \$1200							
7,000							
CONSORTIUM/CONTRACTUAL COSTS					DIRECT COSTS		25,000
<b>SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD</b> <i>(Item 7a, Face Page)</i>							<b>\$ 125,000</b>
CONSORTIUM/CONTRACTUAL COSTS					FACILITIES AND ADMINISTRATIVE COSTS		12,500
<b>TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD</b>							<b>\$ 137,500</b>

## F & A Calculation Based on MTDC –Federally Sponsored Research

	<u>Year 01</u>	<u>Year 02</u>
Total Direct Costs from Module*	\$137,500	\$137,500
(includes both consortium direct & indirect costs as well)		
EXCLUSIONS:		
Patient Care Costs	\$0	\$0
Equipment	\$10,500	\$10,500
Subcontracts (1 <sup>st</sup> \$25,000 per subcontract)	\$12,500	\$37,500
Tuition Remission	\$0	\$0
Modified Total Direct Cost Base	\$114,500	\$89,500
F & A @ 57%	\$65,265	\$51,015
Total Costs (Direct + F &A)	\$202,765	\$188,515

**NOTE:** The first \$25,000 of each subcontract is included in the F & A calculations. If year 01 subcontract is < \$25k obtain the remaining F & A in subsequent year(s)

\* For NIH applications using the Module format, the checklist is calculated based upon the Total Direct Costs on the Module Page (this amount includes the consortium F & A)

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

BUDGET CATEGORY TOTALS		INITIAL BUDGET PERIOD (from Form Page 4)	ADDITIONAL YEARS OF SUPPORT REQUESTED			
			2nd	3rd	4th	5th
PERSONNEL: <i>Salary and fringe benefits. Applicant organization only.</i>		65,754	65,754			
CONSULTANT COSTS						
EQUIPMENT		10,500	10,500			
SUPPLIES		13,746	13,746			
TRAVEL		3,000	3,000			
PATIENT CARE COSTS	INPATIENT					
	OUTPATIENT					
ALTERATIONS AND RENOVATIONS						
OTHER EXPENSES		7,000	7,000			
CONSORTIUM/ CONTRACTUAL COSTS	DIRECT	25,000	25,000			
<b>SUBTOTAL DIRECT COSTS</b> (Sum = Item 8a, Face Page)		125,000	125,000			
CONSORTIUM/ CONTRACTUAL COSTS	F&A	12,500	12,500			
<b>TOTAL DIRECT COSTS</b>		137,500	137,500			
<b>TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD</b>						<b>\$ 275,000</b>

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

<b>BUDGET JUSTIFICATION PAGE MODULAR RESEARCH GRANT APPLICATION</b>						
	<b>Initial Period</b>	<b>2<sup>nd</sup></b>	<b>3<sup>rd</sup></b>	<b>4<sup>th</sup></b>	<b>5<sup>th</sup></b>	<b>Sum Total (For Entire Project Period)</b>
<b>DC less Consortium F&amp;A</b>	<i>125,000</i>	125,000				250,000 <i>(Item 8a, Face Page)</i>
<b>Consortium F&amp;A</b>	12,500	12,500				25,000
<b>Total Direct Costs</b>	137,500	137,500				<b>\$ 275,000</b>

**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>114,500</u>	x Rate applied	<u>0.57</u>	% = F&A costs	\$	<u>65,265</u>	
b. 02 year	Amount of base \$	<u>89,500</u>	x Rate applied	<u>0.57</u>	% = F&A costs	\$	<u>51,015</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							\$	<u>116,280</u>

\*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.): \_\_\_\_\_