PHS 398 Form Completion Instructions:

Overview:

The attached forms are to be used when we are a sub-award to an agency who will be submitting a proposal to the NIH. HS SPPO needs to review these applications before they are sent to the agency. The following forms are required for all sub-award proposals:

- Face Page
- Statement of Work
- Budget
- Budget Justification
- Checklist

Please see the attached documents with highlights and notes with instructions on how to fill in the forms. The Face Page, Detailed Budget, and Checklist are attached. The statement of work and budget justification should be on PHS 398 Continuation format pages if there is no specific form for them.

The above forms are the minimum requirements for all NIH sub-award. In addition to these, the agency may ask for additional forms such as Facilities & Resources documents, Equipment information, and a Bio Sketch. These additional forms should be on PHS 398 form pages found here: http://grants.nih.gov/grants/funding/phs398/phs398.html

All highlighted fields must be filled in for all proposals and checked for accuracy

Form Approved Through 03/31/2020 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		
Council/Board (Month, Year)		Date Received

Check to make sure these boxes are blank

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

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

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							
	SUBTOTALS							

Calculate the number of months with base salary to make sure the salary requested is correct

PI must always have effort

If no salary is requested for the PI, follow HSSPPO guidelines to determine if this is allowable or if a waiver will be required
http://healthsciences.ucsd.edu/vchs/research-services/hssppo/review/Pages/SalaryEffort-Concerns.aspx

Add Down

Add Across

CONSULTANT COSTS

Look up consultant names in Blink to make sure they are not UCSD employees

EQUIPMENT *(Itemize)*

Make sure any items that need to be excluded from IDC have been excluded and all items are allowable

SUPPLIES *(Itemize by category)*

TRAVEL

INPATIENT CARE COSTS

OUTPATIENT CARE COSTS

ALTERATIONS AND RENOVATIONS *(Itemize by category)*

OTHER EXPENSES *(Itemize by category)*

Make sure NGN and HS-TSC costs are included if effort is involved

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		$

If this is a flow-through application, our F&A costs are listed here and the Total Direct Costs line will include our direct and indirect cost for the 1st year

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	**Make sure all costs listed match with costs in initial budget period and/or budget justifications**				
TRAVEL					
INPATIENT CARE COSTS					
OUTPATIENT CARE COSTS					
ALTERATIONS AND RENOVATIONS					
OTHER EXPENSES					
DIRECT CONSORTIUM/ CONTRACTUAL COSTS					
SUBTOTAL DIRECT COSTS *(Sum = Item 8a, Face Page)*					
F&A CONSORTIUM/ CONTRACTUAL COSTS	If this is a flow-through, our F&A costs are listed here and the Total Direct Cost line will include our direct and indicrect costs for each period				
TOTAL DIRECT COSTS					

TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD **$**

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

Make sure the justification matches the costs in the detailed budget and in the totals above

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.)

Make sure the correct type of application is checked. If it is a Resubmission, Renewal, Revision, or Change of Grantee Institution, make sure the correct previous grant number is listed.

☐ 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)

Check to make sure these boxes are blank

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 ______	% = 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	$

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

*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.)*:

FY 2018 is 56.00%; FY 2019 is 57.00%; FY 2020 is 57.50%; FY 2021 is 57.50%; and FY 2022, until amended, is 58.00%. Contact Janet Turner at DHHS Cost Allocation Services, Western Field Office, 415-437-7859 or CAS-SF@psc.hhs.gov, with questions about UC San Diego's F&A rate.