

APPLICATION FOR FEDERAL DOMESTIC ASSISTANCE - Short Organizational

* 1. NAME OF FEDERAL AGENCY:

2. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:

CFDA TITLE:

* 3. DATE RECEIVED: SYSTEM USE ONLY

* 4. FUNDING OPPORTUNITY NUMBER:

* TITLE:

5. APPLICANT INFORMATION

* a. Legal Name:

b. Address:

* Street 1: <input type="text"/>	Street 2: <input type="text"/>
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* City: <input type="text"/>	County / Parish: <input type="text"/>
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* State: <input type="text"/>	Province: <input type="text"/>
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* Country: <input type="text"/>	* Zip/Postal Code: <input type="text"/>
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c. Web Address:
http://

* d. Type of Applicant: Select Applicant Type Code(s):

Type of Applicant:

Type of Applicant:

* Other (specify):

* e. Employer/Taxpayer Identification Number (EIN/TIN):

* f. Organizational DUNS:

* g. Congressional District of Applicant:

6. PROJECT INFORMATION

* a. Project Title:

* b. Project Description:

c. Proposed Project: * Start Date	<input type="text"/>	End Date:	<input type="text"/>
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OMB Number: 4040-0003

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7. PROJECT DIRECTOR

Prefix:	<input type="text"/>	First Name:	<input type="text"/>	Middle Name:	<input type="text"/>
* Last Name:	<input type="text"/>			Suffix:	<input type="text"/>
* Title:	<input type="text"/>			* Email:	<input type="text"/>
* Telephone Number:	<input type="text"/>			Fax Number:	<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"/>			* Zip/Postal Code:	<input type="text"/>

8. PRIMARY CONTACT/GRANTS ADMINISTRATOR

<input type="checkbox"/> Same as Project Director (skip to item 9):					
Prefix: *	<input type="text"/>	First Name:	<input type="text"/>	Middle Name:	<input type="text"/>
* Last Name:	<input type="text"/>			Suffix:	<input type="text"/>
* Title:	<input type="text"/>			* Email:	<input type="text"/>
* Telephone Number:	<input type="text"/>			Fax Number:	<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"/>			* Zip/Postal Code:	<input type="text"/>

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9. * 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 218, 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.

AUTHORIZED REPRESENTATIVE

Prefix: *

First Name:

Middle Name:

* Last Name:

Suffix:

* Title:

* Email:

* Telephone Number:

Fax Number:

* Signature of Authorized Representative:

* Date Signed:

MOCK