| APPLICATION FOR FEDERAL ASSISTANCE | 3. DATE RECEIVED BY STATE State Application Identifier |
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| SF-424 R&R Multi-Project Cover | |
| 1. TYPE OF SUBMISSION | 4. a. Federal Identifier |
| Pre-application Application Changed/Corrected Application | b. Agency Routing Identifier |
| 2. DATE SUBMITTED Applicant Identifier |] . p |
| | c. Previous Grants.gov Tracking ID |
| 5. APPLICANT INFORMATION Organizational DUNS: | |
| Legal Name: | |
| Department: Division: | |
| Street1: | |
| Street2: | |
| City: County / Parish: | |
| State: | Province: |
| Country: | ZIP / Postal Code: |
| Person to be contacted on matters involving this application | |
| Prefix: First Name: | Middle Name: |
| Last Name: | Suffix: |
| Position/Title: | |
| Street1: | |
| Street2: | |
| City: County / Par | rish: |
| State: | Province: |
| Country: | ZIP / Postal Code: |
| Phone Number: Fax Number: | |
| Email: | |
| 6. EMPLOYER IDENTIFICATION (EIN) or (TIN): | |
| 7. TYPE OF APPLICANT: Please select one of the following | |
| Other (Specify): | |
| Small Business Organization Type Women Owned Socially and Economically Disadvantaged | |
| 8. TYPE OF APPLICATION: If Revision, mark | appropriate box(es). |
| New Resubmission A. Increase Award B. Decrease Award C. Increase Duration D. Decrease Duration | |
| Renewal Continuation Revision E. Other (specify): | |
| Is this application being submitted to other agencies? Yes No What other Agencies? | |
| 9. NAME OF FEDERAL AGENCY: 10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: | |
| TITLE: | |
| 11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: | |
| | |
| 12. PROPOSED PROJECT: 13. CONGRESSIONAL DISTRICT OF APPLICANT | |
| Start Date Ending Date | |
| | |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 4040-0001. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

SF-424 R&R Multi-Project Cover APPLICATION FOR FEDERAL ASSISTANCE Page 2 14. PROJECT DIRECTOR/PRINCIPAL INVESTIGATOR CONTACT INFORMATION Prefix: First Name: Middle Name: Last Name: Suffix: Position/Title: Organization Name: Department: Division: Street1: Street2: City: County / Parish: State: Province: ZIP / Postal Code: Country: Phone Number: Fax Number: Email: 15. ESTIMATED PROJECT FUNDING 16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS? a. YES THIS PREAPPLICATION/APPLICATION WAS MADE a. Total Federal Funds Requested AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON: b. Total Non-Federal Funds DATE: c. Total Federal & Non-Federal Funds b. NO PROGRAM IS NOT COVERED BY E.O. 12372; OR d. Estimated Program Income PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW 17. 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 18, Section 1001) Lagree * 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. 18. SFLLL (Disclosure of Lobbying Activities) or other Explanatory Documentation Add Attachment Delete Attachment View Attachment 19. Authorized Representative Prefix: First Name: Middle Name: Suffix: Last Name: Position/Title: Organization Name: Division: Department: Street1: Street2: City: County / Parish: Province: State: ZIP / Postal Code: Country: Phone Number: Fax Number: Email: Signature of Authorized Representative **Date Signed** Add Attachment Delete Attachment View Attachment 20. Pre-application Delete Attachment View Attachment Add Attachment 21. Cover Letter Attachment