

**APPLICATION FOR FEDERAL ASSISTANCE
 SF 424 (R&R)**

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

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

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:
 Country: ZIP / Postal Code:
 Phone Number: Fax Number:
 Email:

15. ESTIMATED PROJECT FUNDING

a. Total Federal Funds Requested
 b. Total Non-Federal Funds
 c. Total Federal & Non-Federal Funds
 d. Estimated Program Income

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. YES THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON:
 DATE:
 b. NO PROGRAM IS NOT COVERED BY E.O. 12372; OR
 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)

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.

18. SFLLL (Disclosure of Lobbying Activities) or other Explanatory Documentation

19. Authorized Representative

Prefix: First Name: Middle Name:
 Last Name: Suffix:
 Position/Title:
 Organization:
 Department: Division:
 Street1:
 Street2:
 City: County / Parish:
 State: Province:
 Country: ZIP / Postal Code:
 Phone Number: Fax Number:
 Email:

Signature of Authorized Representative

Date Signed

20. Pre-application

21. Cover Letter Attachment