

APPLICATION FOR FEDERAL ASSISTANCE SF-424 - MANDATORY			
1.a. Type of Submission: <input checked="" type="checkbox"/> Application <input type="checkbox"/> Plan <input type="checkbox"/> Funding Request <input type="checkbox"/> Other Other (specify): <input style="width:100%; height: 20px;" type="text"/>	1.b. Frequency: <input checked="" type="checkbox"/> Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Other Other (specify): <input style="width:100%; height: 20px;" type="text"/>	1.d. Version: <input checked="" type="checkbox"/> Initial <input type="checkbox"/> Resubmission <input type="checkbox"/> Revision <input type="checkbox"/> Update <hr/> 2. Date Received: <input style="width:100%; height: 20px;" type="text"/> STATE USE ONLY: <hr/> 3. Applicant Identifier: <input style="width:100%; height: 20px;" type="text"/> 5. Date Received by State: <input style="width:100%; height: 20px;" type="text"/> <hr/> 4a. Federal Entity Identifier: <input style="width:100%; height: 20px;" type="text"/> 6. State Application Identifier: <input style="width:100%; height: 20px;" type="text"/> <hr/> 4b. Federal Award Identifier: <input style="width:100%; height: 20px;" type="text"/>	
1.c. Consolidated Application/Plan/Funding Request? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <input style="width: 50px; height: 15px;" type="text" value="Explanation"/>			
7. APPLICANT INFORMATION:			
a. Legal Name: <input style="width:100%; height: 20px;" type="text"/>			
b. Employer/Taxpayer Identification Number (EIN/TIN): <input style="width:100%; height: 20px;" type="text"/>		c. Organizational DUNS: <input style="width:100%; height: 20px;" type="text"/>	
d. Address:			
Street1: <input style="width:100%; height: 20px;" type="text"/>		Street2: <input style="width:100%; height: 20px;" type="text"/>	
City: <input style="width:100%; height: 20px;" type="text"/>		County / Parish: <input style="width:100%; height: 20px;" type="text"/>	
State: <input style="width:100%; height: 20px;" type="text"/>		Province: <input style="width:100%; height: 20px;" type="text"/>	
Country: <input style="width:100%; height: 20px;" type="text" value="USA: UNITED STATES"/>		Zip / Postal Code: <input style="width:100%; height: 20px;" type="text"/>	
e. Organizational Unit:			
Department Name: <input style="width:100%; height: 20px;" type="text"/>		Division Name: <input style="width:100%; height: 20px;" type="text"/>	
f. Name and contact information of person to be contacted on matters involving this submission:			
Prefix: <input style="width:100%; height: 20px;" type="text"/>	First Name: <input style="width:100%; height: 20px;" type="text"/>	Middle Name: <input style="width:100%; height: 20px;" type="text"/>	
Last Name: <input style="width:100%; height: 20px;" type="text"/>		Suffix: <input style="width:100%; height: 20px;" type="text"/>	
Title: <input style="width:100%; height: 20px;" type="text"/>			
Organizational Affiliation: <input style="width:100%; height: 20px;" type="text"/>			
Telephone Number: <input style="width:100%; height: 20px;" type="text"/>		Fax Number: <input style="width:100%; height: 20px;" type="text"/>	
Email: <input style="width:100%; height: 20px;" 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-xxxx. 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: US Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave SW, Suite 336 E, Washington DC, 20201, Attention: PRA Reports Clearance Officer

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8a. TYPE OF APPLICANT:

Other (specify):

b. Additional Description:

9. Name of Federal Agency:

10. Catalog of Federal Domestic Assistance Number:

CFDA Title:

11. Descriptive Title of Applicant's Project:

12. Areas Affected by Funding:

13. CONGRESSIONAL DISTRICTS OF:

a. Applicant:

b. Program/Project:

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment

Delete Attachment

View Attachment

14. FUNDING PERIOD:

a. Start Date:

b. End Date:

15. ESTIMATED FUNDING:

a. Federal (\$):

b. Match (\$):

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

- a. This submission was made available to the State under the Executive Order 12372 Process for review on:
- b. Program is subject to E.O. 12372 but has not been selected by State for review.
- c. Program is not covered by E.O. 12372.

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17. Is The Applicant Delinquent On Any Federal Debt?

Yes No

Explanation

18. 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

** This 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:

Organizational Affiliation:

Telephone Number:

Fax Number:

Email:

Signature of Authorized Representative:

Date Signed:

Attach supporting documents as specified in agency instructions.

Add Attachments

Delete Attachments

View Attachments

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Consolidated Application/Plan/Funding Request Explanation:

[Empty text area for explanation]

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Applicant Federal Debt Delinquency Explanation:

[Empty text box for explanation]