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| **INSTRUCTIONS:**   * Complete form in its entirety based upon Sponsor solicitation and **ATTACH**: **1)** a copy of the grant solicitation and/or Executive Summary; **2)** draft budget and other documents as needed * Contact the Office of Grant Administration with any questions at 404.616.1828 or email [dnoble@gmh.edu](mailto:ljones2@gmh.edu) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Project Title:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Date:** | | | | | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CONTACT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Proposal Initiator:** | | | | |  | | | | | | | | | | | | | | | | | | **Title:** | | | | | | | | | | | | | | | | |
| **Department:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Telephone:** | | |  | | | | | | | | | | | **Fax:** | | | |  | | | | | | **Email:** | | | | | |  | | | | | | | | | |
| **PROJECT SUMMARY (Include: 1. Benefit to Grady; 2. Project outcomes; 3. Departments involved; 4. Plans to sustain program; 5. Sponsor reporting requirements). *Include attachments as needed.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **APPLICATION INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Funding Sponsor:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Sponsor Deadline** | | | | | |  | | | | | | | | | | | | | **Prelim/Internal Deadline:** | | | | | | | | | | | | | |  | | | | | | |
| **Solicitation Number:** | | | | | |  | | | | | | | | | | | | | **CFDA # (if applicable):** | | | | | | | | | | | | | |  | | | | | | |
| **Sponsor Contact:** | | | | | | Name: | | |  | | | | | | | | | | | | | | | | URL: | | | | | | | |  | | | | | | |
|  | | | | | | Email: | | |  | | | | | | | | | | | | | | | | Phone: | | | | | | | |  | | | | | | |
| **Proposal Type:** | | | | New | | | | | | | Letter of Intent | | | | | | | | | Supplement | | | | | | Renewal | | | | | | | | | | Other: | | | |
| **Sponsor Type:** | | | | Federal | | | | | | | State/Local | | | | | | | | | Foundation | | | | | | Industry | | | | | | | | | | Other: | | | |
| **Activity Type:** | | | | Patient Care | | | | | | | Training | | | | | | | | | Research | | | | | | Equipment | | | | | | | | | | Other: | | | |
| **Submission Method:** | | | | Grants.gov | | | | | | | Other Electronic | | | | | | | | | Paper | | | | | | Other: | | | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **BUDGET INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Period of Performance** | |  | | | | | | | | | | | | |  | |  | | | | | | | | | | | |  | | % | | | | | | | | |
|  | | **Begin** | | | | | | | | | | | | |  | | **End** | | | | | | | | | | | |  | | **F&A/Indirect Rate** | | | | | | | | |
| *(can be estimates)* | | **Year One** | | | | | | **Year Two** | | | | | **Year Three** | | | | | | | | | **Year Four** | | | | | | **Year Five** | | | | | | | | | | **Total** | |
| **Personnel Cost** | | $ | | | | | | $ | | | | | $ | | | | | | | | | $ | | | | | | $ | | | | | | | | | | $ | |
| **Capital Cost** | | $ | | | | | | $ | | | | | $ | | | | | | | | | $ | | | | | | $ | | | | | | | | | | $ | |
| **Misc. Cost** | | $ | | | | | | $ | | | | | $ | | | | | | | | | $ | | | | | | $ | | | | | | | | | | $ | |
| **F&A Cost\*** | | $ | | | | | | $ | | | | | $ | | | | | | | | | $ | | | | | | $ | | | | | | | | | | $ | |
| **Total Costs** | | $ | | | | | | $ | | | | | $ | | | | | | | | | $ | | | | | | $ | | | | | | | | | | $ | |
| \*F&A (overhead) for Federal grant requests should be 38.4% of direct expenses. For private gifts that will be used to incur new salary expense, a minimum of 10% overhead should be applied. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Cost Sharing/ Matching?** | | | | | | | Yes | | | No | | If Yes, Grady source of funding | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| **Sub-awards Required** | | | | | | | Yes | | | No | | If Yes, list entity name | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| **GHS Eligibility:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Is this a Subcontract?** | | | | | | | | | | | Yes | | | | | No | | | | | If yes, sponsor name? | | | | | | | | | | |  | | | | | | | |
| **If existing grant, please provide:** | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | |  | | | |  |
|  | | | | | | | | | | | Agency Award # (if available) | | | | | | | | | | | | | | | DeptID | | | | | | | | | ProjectID | | | |  |
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| **ASSURANCES, REVIEW and APPROVALS** |

***By signing below, Principal Director/Project Manager (PD/PM) certifies that:***

1. The information submitted within the application is true, complete and accurate to the best of the PD/PM’s knowledge;
2. Any false, fictitious or fraudulent statements or claims may subject the PD/PM to criminal, civil or administrative penalties;
3. The PD/PM agrees to accept responsibility for the technical conduct of the project and to provide the required progress reports if a grant is awarded as a result of the application;
4. The proposal complies with federal/state/local regulations, as appropriate, including sponsor guidelines and Grady's Policies and Procedures;
5. The Principal Director/Project Manager, key personnel or anyone involved in the sponsored activity is not presently debarred, proposed for debarment, suspended, declared ineligible, or voluntarily excluded from transactions by the federal department, or agency; and are aware of no circumstance invalidating the legal certifications in the proposal to be made on behalf of the Grady Health System.

Principal Director/Project Manager (Proposal Initiator) Date

***DEPARTMENT/DIVISION:***

Vice President Date

***APPROVALS (signature):***

Finance: Director of Grant Administration Date

Planning Department (if applicable) Date

Chief Nursing Officer (if applicable) Date

Chief Operating Officer (if applicable) Date

Chief Medical Officer (if applicable): Date

Physician Lead (if applicable) Date

Chief Financial Officer (CFO) Date

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| Executive Council Recommendation: | Approved to Proceed/Apply: | Request Denied:  (Rationale Required) |
| Rationale: | |