OMB Number: 4040-0001
Expiration Date: 11/30/2025

APPLICATION FOR FEDERAL ASSISTANCE
SF 424 (R&R)

3. DATE RECEIVED BY STATE | **State Application Identifier**

1. TYPE OF SUBMISSION*

○ Pre-application ● Application ○ Changed/Corrected Application

4.a. Federal Identifier

b. Agency Routing Number
ADD NOST if applicable

2. DATE SUBMITTED

Application Identifier
PD: Include KR PD #

c. Previous Grants.gov Tracking Number

5. APPLICANT INFORMATION **UEI*:** UYTTZT6G9DT1

Legal Name*:	The Regents of the Univ. of Calif., U.C. San Diego
Department:	Health Sciences SPO
Division:	School of Medicine
Street1*:	9500 Gilman Drive MC 0041
Street2:	
City*:	LA JOLLA
County:	San Diego
State*:	CA: California
Province:	
Country*:	USA: UNITED STATES
ZIP / Postal Code*:	92093-0041

Person to be contacted on matters involving this application

Prefix: First Name*: Nicole Middle Name: Last Name*: Ketchum Suffix:

Position/Title:	Grant Analyst
Street1*:	9500 Gilman Drive #0041
Street2:	
City*:	La Jolla
County:	San Diego
State*:	CA: California
Province:	
Country*:	USA: UNITED STATES
ZIP / Postal Code*:	92093-0041

Phone Number*: (858) 534-7631 Fax Number: Email: nketchum@health.ucsd.edu

6. EMPLOYER IDENTIFICATION NUMBER ***(EIN) or (TIN)**** 1956006144A1

7. TYPE OF APPLICANT* H: Public/State Controlled Institution of Higher Education

Other (Specify):

Small Business Organization Type ○ Women Owned ○ Socially and Economically Disadvantaged

8. TYPE OF APPLICATION*

● New ○ Resubmission
○ Renewal ○ Continuation ○ Revision

New or resubmission, select appropriate choice

If Revision, mark appropriate box(es).
○ A. Increase Award ○ B. Decrease Award ○ C. Increase Duration
○ D. Decrease Duration ○ E. Other *(specify)* :

Is this application being submitted to other agencies?* ○Yes ●No What other Agencies?

9. NAME OF FEDERAL AGENCY*
National Institutes of Health

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER
TITLE:

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT*
The Role of Trisomy 21 in Human Microglia and Neurodevelopment

12. PROPOSED PROJECT
Start Date* Ending Date*
ENTER PROPOSED START ENTER PROPOSED END

13. CONGRESSIONAL DISTRICTS OF APPLICANT
CA-050

SF 424 (R&R) APPLICATION FOR FEDERAL ASSISTANCE

14. PROJECT DIRECTOR/PRINCIPAL INVESTIGATOR CONTACT INFORMATION

Prefix: First Name*: FIRST NAME OF PI Middle Name: Add if applicable Last Name*: LAST NAME OF PI Suffix:

Position/Title: Predoctoral Fellow
Organization Name*: The Regents of the Univ. of Calif., U.C. San Diego
Department: Pediatrics
Division: School of Medicine, SKAGGS or HW - add
Street1*: appropriate
Street2: 9500 Gilman Drive Include PI Mail Code #
City*: La Jolla
County:
State*: CA: California
Province:
Country*: USA: UNITED STATES
ZIP / Postal Code*: 92093-INCLUDE PI MC
Phone Number*: PI PHONE Fax Number: Email*: PI EMAIL@health.ucsd.edu

15. ESTIMATED PROJECT FUNDING

a. Total Federal Funds Requested*	ADD TC $$
b. Total Non-Federal Funds*	$0.00
c. Total Federal & Non-Federal Funds*	ADD TC $$
d. Estimated Program Income*	$0.00

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 or OTHER EXPLANATORY DOCUMENTATION File Name:

19. AUTHORIZED REPRESENTATIVE

Prefix: First Name*: Nicole Middle Name: Last Name*: Ketchum Suffix:

Position/Title*: Grant Analyst
Organization Name*: The Regents of the Univ. of Calif., U.C. San Diego
Department: Health Sciences SPO
Division: School of Medicine
Street1*: 9500 Gilman Drive, MC:0041
Street2:
City*: La Jolla
County: San Diego
State*: CA: California
Province:
Country*: USA: UNITED STATES
ZIP / Postal Code*: 92093-0041
Phone Number*: 858-534-7631 Fax Number: Email*: nketchum@health.ucsd.edu

Signature of Authorized Representative* Nicole Ketchum

Date Signed* THIS WILL AUTO FILL WHEN SUBMITTED

20. PRE-APPLICATION File Name:

21. COVER LETTER ATTACHMENT File Name:Cover_Letter_F30_final.pdf