# PHS 2590 Form Completion Instructions:

## Overview:

The attached forms are to be used when we are a sub-award to an agency who will be submitting a continuation proposal to the NIH. HS SPPO needs to review these applications before they are sent to the agency. The following forms are required for all sub-award proposals:

- Face Page
- Budget
- Budget Justification
- Active Support
- Progress Report Summary
- Checklist
- All Personnel Report

Please see the attached documents with highlights and notes with instructions on how to fill in the forms. The Face Page, Detailed Budget, Justification, Progress Report Summary, Checklist, and All Personnel Report are attached. The documents should be on PHS 398 Continuation format pages if there are no specific forms for them.

The above forms are the minimum requirements for all NIH sub-award continuations. In addition to these, the agency may ask for additional forms such as Facilities & Resources documents, Equipment information, and a Bio Sketch. These additional forms should be on PHS 2590 form pages found here:
http://grants.nih.gov/grants/funding/2590/2590.htm
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ePD # 

Form Approved Through 10/31/2018                                    OMB No. 0925-0002

Department of Health and Human Services
Public Health Services

# Grant Progress Report

| Review Group | Type | Activity | Grant Number |
|---|---|---|---|

Total Project Period

From:                                          Through:

Requested Budget Period

From:                                          Through:

1.  TITLE OF PROJECT

2a. PROGRAM DIRECTOR / PRINCIPAL INVESTIGATOR
    (Name and address, street, city, state, zip code)

2b. E-MAIL ADDRESS

2c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT

2d. MAJOR SUBDIVISION

2e. Tel:                              Fax:

3a. APPLICANT ORGANIZATION
    (Name and address, street, city, state, zip code)

3b.  Tel:          **This should be the OCGA analyst's phone & fax numbers**

3c.  DUNS:

4.  ENTITY IDENTIFICATION NUMBER

6.  HUMAN SUBJECTS          No          Yes

| 6a. Research Exempt | If Exempt ("Yes" in 6a): | If Not Exempt ("No" in 6a): |
|---|---|---|
| No     Yes | Exemption No. | IRB approval date |

6b.  Federal Wide Assurance No.

6c. NIH-Defined Phase III

Clinical Trial          No          Yes

7.  VERTEBRATE ANIMALS          No          Yes

7a. If "Yes," IACUC  approval Date

7b. Animal Welfare Assurance No.

8.  COSTS REQUESTED FOR NEXT BUDGET PERIOD

8a. DIRECT $                    8b. TOTAL $

9.  INVENTIONS AND PATENTS          No          Yes

 If "Yes,          Previously Reported
                   Not Previously Reported

5.  NAME, TITLE AND ADDRESS OF ADMINISTRATIVE OFFICIAL

Tel:                              Fax:

E-MAIL:

10. PROJECT/PERFORMANCE SITE(S)

Organizational Name:

DUNS:

Street 1:

Street 2:

| City: | County: |
|---|---|
| State: | Province: |
| Country: | Zip/Postal Code: |

Congressional Districts:

11.  NAME AND TITLE OF OFFICIAL SIGNING FOR APPLICANT ORGANIZATION  *(Item 13)*

TEL:                    FAX:                              E-MAIL:

12. Corrections to Page 1 Face Page

13. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Services terms and conditions if a grant is awarded as a result of this application.  I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.

SIGNATURE OF OFFICIAL NAMED IN 11.  *(In ink)*          DATE

# DETAILED BUDGET FOR NEXT BUDGET PERIOD – DIRECT COSTS ONLY

| | FROM | THROUGH | GRANT NUMBER |
|---|---|---|---|

List PERSONNEL *(Applicant organization only)*
Use Cal, Acad, or Summer to Enter Months Devoted to Project
Enter Dollar Amounts Requested *(omit cents)* for Salary Requested and Fringe Benefits

| NAME | ROLE ON PROJECT | Cal. Mnths | Acad. Mnths | Summer Mnths | SALARY REQUESTED | FRINGE BENEFITS | TOTALS |
|---|---|---|---|---|---|---|---|
| | PD/PI | | | | | | |
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| **SUBTOTALS** ⟶ | | | | | | | |

CONSULTANT COSTS

EQUIPMENT *(Itemize)*

SUPPLIES *(Itemize by category)*

> **Make sure any items that need to be excluded from IDC have been excluded and all items are allowable**

TRAVEL

INPATIENT CARE COSTS

OUTPATIENT CARE COSTS

ALTERATIONS AND RENOVATIONS *(Itemize by category)*

OTHER EXPENSES *(Itemize by category)*

**SUBTOTAL DIRECT COSTS FOR NEXT BUDGET PERIOD** | $ |

| CONSORTIUM/CONTRACTUAL COSTS | DIRECT COSTS |
| CONSORTIUM/CONTRACTUAL COSTS | FACILITIES AND ADMINISTRATIVE COSTS |

**TOTAL DIRECT COSTS FOR NEXT BUDGET PERIOD** *(Item 8a, Face Page)* | $ |

## BUDGET JUSTIFICATION

GRANT NUMBER

Provide a detailed budget justification for those line items and amounts that represent a significant change from that previously recommended. Use continuation pages if necessary.

**CURRENT BUDGET PERIOD** | FROM | THROUGH

Explain any estimated unobligated balance (including prior year carryover) that is greater than 25% of the current year's total budget.

Program Director/Principal Investigator (Last, First, Middle):

## PROGRESS REPORT SUMMARY

| GRANT NUMBER |
| --- |
| PERIOD COVERED BY THIS REPORT |

**PROGRAM DIRECTOR / PRINCIPAL INVESTIGATOR**

| FROM | THROUGH |
| --- | --- |

APPLICANT ORGANIZATION

TITLE OF PROJECT (Repeat title shown in Item 1 on first page)

A. Human Subjects (Complete Item 6 on the Face Page)

    Involvement of Human Subjects      No Change Since Previous Submission      Change

B. Vertebrate Animals (Complete Item 7 on the Face Page)

    Use of Vertebrate Animals      No Change Since Previous Submission      Change

C. Select Agent Research      No Change Since Previous Submission      Change

D. Multiple PD/PI Leadership Plan      No Change Since Previous Submission      Change

E. Human Embryonic Stem Cell Line(s) Used      No Change Since Previous Submission      Change

SEE PHS 2590 INSTRUCTIONS.

**WOMEN AND MINORITY INCLUSION: See PHS 398 Instructions. Use Inclusion Enrollment Report Format Page.**

GRANT NUMBER

# CHECKLIST

**1. PROGRAM INCOME** *(See instructions.)*
All applications must indicate whether program income is anticipated during the period(s) for which grant support is requested. If program income is anticipated, use the format below to reflect the amount and source(s).

| Budget Period | Anticipated Amount | Source(s) |
|---|---|---|
| | | |

**2. ASSURANCES/CERTIFICATIONS** *(See instructions.)*
In signing the application Face Page, the authorized organizational representative agrees to comply with the policies, assurances and/or certifications listed in the application instuctions when applicable. Descriptions of individual assurances/certifications are provided in Part III of the PHS 398, and listed in Part I, 4.1 under Item 14. If unable to certify compliance, where applicable, provide an explanation and place it after the Progress Report (Form Page 5).

**3. FACILITIES AND ADMINSTRATIVE (F&A) COSTS**
Indicate the applicant organization's most recent F&A cost rate established with the appropriate DHHS Regional Office, or, in the case of for-profit organizations, the rate established with the appropriate PHS Agency Cost Advisory Office.

F&A costs will *not* be paid on construction grants, grants to Federal organizations, grants to individuals, and conference grants. Follow any additional instructions provided for Research Career Awards, Institutional National Research Service Awards, Small Business Innovation Research/Small Business Technology Transfer Grants, foreign grants, and specialized grant applications.

DHHS Agreement dated:     5/23/2018 _____        ☐ No Facilities and Administrative Costs Requested.

☐ No DHHS Agreement, but rate established with _____     Date _____

CALCULATION*

Entire proposed budget period:     Amount of base $ _____   x Rate applied _____   % = F&A costs  $ _____

Add to total direct costs from Form Page 2 and enter new total on Face Page, Item 8b.

*Check appropriate box(es):

☐ Salary and wages base          ☐ Modified total direct cost base          ☐ Other base  *(Explain)*

☐ Off-site, other special rate, or more than one rate involved  *(Explain)*

Explanation  *(Attach separate sheet, if necessary.):*

# ALL PERSONNEL REPORT

Place this form at the end of the signed original copy of the application. Do not duplicate.

**GRANT NUMBER**

**Always list the PD/PI(s). In addition, list all other personnel who participated in the project during the current budget period for at least one person month or more, regardless of the source of compensation (a person month equals approximately 160 hours or 8.3% of annualized effort). Use the following abbreviated categories for describing Role on Project:**

- **PD/PI**
- **Co-Investigator**
- **Faculty**
- **Postdoctoral (scholar, fellow, or other postdoctoral position)**
- **Technician**
- **Staff Scientist (doctoral level)**

- **Statistician**
- **Graduate Student (research assistant)**
- **Non-student Research Assistant**
- **Undergraduate Student**
- **High School Student**
- **Consultant**
- **Other (please specify)**

**If personnel are supported by a Reentry or Diversity Supplement please indicate such after the Role on Project, using the following abbreviations: RS - Reentry Supplement; DS - Diversity Supplement.**

**Use Cal (calendar), Acad, or Summer to enter months devoted to project.**

| Commons ID | Name | Degree(s) | SSN (last 4 digits) | Role on Project | DoB (MM /YY) | Cal | Acad | Summer |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| This information should be filled in for all personnel who worked on the project in the last year | | | | | | | | |
| | | | | | | | | |