

APPLICATION FOR FEDERAL DOMESTIC ASSISTANCE - Short Organizational

Version 01

*** 1. NAME OF FEDERAL AGENCY:**

2. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:

CFDA TITLE:

*** 3. DATE RECEIVED:**

SYSTEM USE ONLY

*** 4. FUNDING OPPORTUNITY NUMBER:**

*** TITLE:**

5. APPLICANT INFORMATION

*** a. Legal Name:**

b. Address:

*** Street1:**

Street2:

*** City:**

County:

*** State:**

Province:

*** Country:**

*** Zip/Postal Code:**

c. Web Address:

http://

*** d. Type of Applicant: Select Applicant Type Code(s):**

Type of Applicant:

Type of Applicant:

*** Other (specify):**

*** e. Employer/Taxpayer Identification Number (EIN/TIN):**

*** f. Organizational DUNS:**

*** g. Congressional District of Applicant:**

6. PROJECT INFORMATION

*** a. Project Title:**

*** b. Project Description:**

c. Proposed Project: * Start Date:

*** End Date:**

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7. PROJECT DIRECTOR

Social Security Number (SSN) - Optional:

Disclosure of SSN is voluntary. Please see the application package instructions for the agency's authority and routine uses of the data.

Prefix: <input type="text"/>	* First Name: <input type="text"/>	Middle Name: <input type="text"/>
* Last Name: <input type="text"/>	Suffix: <input type="text"/>	
* Title: <input type="text"/>	* Email: <input type="text"/>	
* Telephone Number: <input type="text"/>	Fax Number: <input type="text"/>	
* Street1: <input type="text"/>	Street2: <input type="text"/>	
* City: <input type="text"/>	County: <input type="text"/>	
* State: <input type="text"/>	Province: <input type="text"/>	
* Country: <input type="text"/>	* Zip/Postal Code: <input type="text"/>	

8. PRIMARY CONTACT/GRANTS ADMINISTRATOR

<input type="checkbox"/> Same as Project Director (skip to item 9):	Social Security Number (SSN) - Optional: <input type="text"/>	
	Disclosure of SSN is voluntary. Please see the application package instructions for the agency's authority and routine uses of the data.	
Prefix: <input type="text"/>	* First Name: <input type="text"/>	Middle Name: <input type="text"/>
* Last Name: <input type="text"/>	Suffix: <input type="text"/>	
* Title: <input type="text"/>	* Email: <input type="text"/>	
* Telephone Number: <input type="text"/>	Fax Number: <input type="text"/>	
* Street1: <input type="text"/>	Street2: <input type="text"/>	
* City: <input type="text"/>	County: <input type="text"/>	
* State: <input type="text"/>	Province: <input type="text"/>	
* Country: <input type="text"/>	* Zip/Postal Code: <input type="text"/>	

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9. * 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

** 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.

AUTHORIZED REPRESENTATIVE

Prefix: <input type="text"/>	* First Name: <input type="text"/>	Middle Name: <input type="text"/>
* Last Name: <input type="text"/>	Suffix: <input type="text"/>	
* Title: <input type="text"/>	* Email: <input type="text"/>	
* Telephone Number: <input type="text"/>	Fax Number: <input type="text"/>	
* Signature of Authorized Representative: <input type="text"/>	* Date Signed: <input type="text"/>	

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Standard Form 424 Organization Short (04-2005)

Prescribed by OMB Circular A-102