**Indiana CTSI Community Health Partnerships – Trailblazer Planning Grant**

**APPLICATION COVER PAGE**

**COMMUNITY LEAD NAME**:

RANK / TITLE:

ORGANIZATION:

ADDRESS:

EMAIL:       PHONE NUMBER:

FISCAL AGENT (FA) NAME:

FA EMAIL: FA PHONE NUMBER:

**UNIVERSITY/RESEARCH INSTITUTE LEAD NAME**:

RANK / TITLE:

DEPARTMENT and SCHOOL:

INSTITUTION / AFFILIATION: PU  IUB  IUPUI  UND  OTHER:

CAMPUS ADDRESS:

EMAIL:       eRA COMMONS USERID:

PHONE NUMBER:

FISCAL AGENT (FA) NAME:

FA EMAIL: FA PHONE NUMBER:

**TITLE OF PROPOSAL**:

**BUDGET:**

AMOUNT REQUESTED:

University Partner $ Community Partner $ TOTAL $

*(maximum $5,000)*

**HUMAN SUBJECTS / IRB APPROVAL** APPROVAL

YES NO PROTOCOL # DATE

HUMAN SUBJECTS?

*(If you need but have not received IRB approval, please check ‘YES’ and under Approval Date type ‘PENDING’)*

**REQUIRED APPLICANT AND INSTITUTIONAL SIGNATURES\*** .

The undersigned agree to accept responsibility for the scientific and technical conduct of the research project and for provision of required progress reports if a grant is awarded as the result of this application. Appropriate signatures (at least 4 total) must be obtained for both the University lead and the Community lead.

1. University Lead Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **University Lead Applicant** | **Signature** | | **Date** |
| Applicant | |  |  |

2. University Institutional Signatures

|  |  |
| --- | --- |
| **IUSM Signature and Date** | |
| Department Head / Chair |  |

Departments of Medicine and Pediatric: Division Chief Signature is requested in lieu of the Department Chair. Institutional Official Signature is not required.

|  |  |
| --- | --- |
| **IUB, IUPUI Signature and Date** | |
| Department Head / Chair |  |

|  |  |
| --- | --- |
| **IBRI** | **Signature and Date** |
| Chief of Staff/ Executive Vice President |  |

|  |  |
| --- | --- |
| **Purdue University Signature and Date** | |
| Department Head / Chair |  |
| Institutional Official(1) |  |

Signature approval by any Sponsored Program Services (SPS) Pre-Award Center Manager is required by Purdue University applicants.

|  |  |  |
| --- | --- | --- |
| **University of Notre Dame** | **Signature and Date** | |
| Department Head / Chair | |  |
| Indicate intent to submit to Melanie DeFord via email ([mdeford@nd.edu](mailto:mdeford@nd.edu)).  Must work with your pre-award research administrator.  Institutional routing is not required; however investigators must answer the compliance questions in Cayuse.  If you have any questions, contact David Ross ([dross5@nd.edu](mailto:dross5@nd.edu)) or Melanie DeFord ([mdeford@nd.edu](mailto:mdeford@nd.edu)). | | |
|  |  |  |

|  |  |
| --- | --- |
| **Other Institution Signature and Date** | |
| Institutional Official |  |

3. Community Lead Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **Community Lead** | **Signature** | | **Date** |
| Applicant | |  |  |

4. Community Institutional Signatures

|  |  |
| --- | --- |
| **Institutional Signature Signature and Date** | |
| Institutional Official |  |

*\*As submission will be electronic, a facsimile of the signed page is appropriate.*

COMMUNITY PARTNER (Last, first, middle):   
UNIVERSITY PARTNER (Last, first, middle):

**PARTNERSHIP DESCRIPTION** (Up to 2 pages, single-spaced, Arial 11-point font, 1-in margins, see Section VI. of the Request for Applications for description requirements):

COMMUNITY PARTNER (Last, first, middle):   
UNIVERSITY PARTNER (Last, first, middle):

**DETAILED BUDGET & BUDGET JUSTIFICATION***Please use the spreadsheet format below to indicate the proposed expenditures for 1) the community partner and 2) the university partner.* *For each budget, please provide a Budget Justification that explains and justifies planned expenditures listed in the budget spreadsheet. An estimated effort is expected in the budget for faculty time and effort committed cannot be covered by other federal support.*

**Funds cannot be used to purchase equipment greater than $1,000 per piece. Faculty salary support can be covered up to $1,000 per proposal. Hospitality costs should be a minimal part of the budget and need to be well justified as a required part of meeting the goals. Travel expenses are limited to those that are necessary to achieve the aims of the proposed project. Only in-state travel is allowable, and State of Indiana reimbursement rates apply (**[**http://www.in.gov/idoa/2459.htm**](http://www.in.gov/idoa/2459.htm)**).**

COMMUNITY PARTNER (Last, first, middle): UNIVERSITY PARTNER (Last, first, middle):

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **COMMUNITY PARTNER**  **DETAILED BUDGET FOR INITIAL BUDGET PERIOD**  **DIRECT COSTS ONLY** | | | | | FROM | | THROUGH | |
| PERSONNEL *(Applicant organization only)* | |  | % |  | DOLLAR AMOUNT REQUESTED *(omit cents)* | | | |
| NAME | ROLE ON  PROJECT | TYPE  APPT.  *(months)* | EFFORT  ON  PROJ. | INST.  BASE  SALARY | SALARY REQUESTED | FRINGE  BENEFITS | | TOTAL |
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| **SUBTOTALS** | | | | |  |  | |  |  |  |
| CONSULTANT COSTS | | | | | | | |  |
| SUPPLIES | | | | | | | |  |
| TRAVEL | | | | | | | |  |
| PATIENT CARE COSTS | | | | | | | |  |
| OTHER EXPENSES | | | | | | | |  |
| TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD | | | | | | | |  |

COMMUNITY PARTNER (Last, first, middle): UNIVERSITY PARNTER (Last, first, middle):

**COMMUNITY PARTNER BUDGET JUSTIFICATION** (maximum 1 page):

COMMUNITY PARTNER (Last, first, middle): UNIVERSITY PARTNER (Last, first, middle):

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **UNIVERSITY PARTNER**  **DETAILED BUDGET FOR INITIAL BUDGET PERIOD**  **DIRECT COSTS ONLY** | | | | | FROM | | THROUGH | |
| PERSONNEL *(Applicant organization only)* | |  | % |  | DOLLAR AMOUNT REQUESTED *(omit cents)* | | | |
| NAME | ROLE ON  PROJECT | TYPE  APPT.  *(months)* | EFFORT  ON  PROJ. | INST.  BASE  SALARY | SALARY REQUESTED | FRINGE  BENEFITS | | TOTAL |
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| **SUBTOTALS** | | | | |  |  | |  |  |  |
| CONSULTANT COSTS | | | | | | | |  |
| SUPPLIES | | | | | | | |  |
| TRAVEL | | | | | | | |  |
| PATIENT CARE COSTS | | | | | | | |  |
| OTHER EXPENSES | | | | | | | |  |
| TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD | | | | | | | |  |

COMMUNITY PARTNER (Last, first, middle): UNIVERSITY PARTNER (Last, first, middle):

**UNIVERSITY PARTNER BUDGET JUSTIFICATION** (maximum 1 page):

COMMUNITY PARTNER (Last, first, middle): UNIVERSITY PARTNER (Last, first, middle):

**Resume, NIH Biosketch or CV of 1) Project Lead and 2) Co-Project Lead**  
*Any up-to-date version of a resume, NIH Biosketch or CV is acceptable.*

COMMUNITY PARNTER (Last, first, middle): UNIVERSITY PARTNER (Last, first, middle):

**May we use your application (with names, organizations, and geographic locations removed) for educational purposes?**

Yes

No

**Are you interested in receiving student feedback on your grant?**

Yes

No

**May we send you a follow-up survey regarding your experience in developing and submitting your proposal?**

Yes

No

**YOUR RESPONSE TO THE ABOVE THREE QUESTIONS WILL NOT AFFECT THE REVIEW PROCESS IN ANY WAY**

Community Lead (Last, first, middle): University Lead (Last, first, middle):

**2021 Trailblazer Planning Grant Checklist**

At least 1 Indiana-based community partner and 1 Indiana-based university partner

All individuals listed on application have joined Indiana CTSI CHeP Network

Application includes cover page with signatures and IRB approval designation

Funding requested is specified and does not exceed $5,000

Application has project description (Arial 11pt font, 1 in margins) that is 2 pages or less

Application includes project timeline with proposed project period 12 months or less

Budget and budget justification are provided for each partner

Budget only includes direct costs (facilities, administrative, and indirect costs not allowed, no equipment >$1,000, only in-state travel)

Biosketch, resume, or CV included for each partner

Response to request to use application for educational purposes

Response to request to send follow-up survey