

Cost Transfer Explanation & Justification Form

Per NIH Grants Policy Statement 7.5, "Cost transfers to NIH grants... should be accomplished within 90 days of when the error was discovered. The transfers must be supported by documentation that fully explains how the error occurred and a certification of the correctness of the new charge by a responsible organizational official of the recipient, consortium participant, or contractor. An explanation merely stating that the transfer was made "to correct error" or "to transfer to correct project" is not sufficient. Transfers of costs from one project to another or from one competitive segment to the next, solely to cover cost over-runs, are not allowable."

If a transfer is made within 90 days of the original charge, answer questions 1 and 2; if over 90 days, answer all 4 questions.

1. Why was this expense charged to the account originally from which it is now being transferred? Include detailed information (date, account charged, amount, etc.). *For example: 9/01/18 63313-710-100500-00000-123456-GMLOC \$25.26 Life Technologies Inc.*

2. Why should this charge be transferred to the proposed receiving account? Include the account number to charge.

3. Why is this cost transfer being requested more than 90 calendar days after the original charge? Attach any necessary supporting documentation.

4. What action is being taken to eliminate the need for additional cost transfers of this type?

Requestor's signature: _____ (PI or cognizant administrator)

Printed name, title, and phone #: _____

Date: _____

Note: The Cost Transfer Explanation and Justification form should be approved by the Principle Investigator (PI) or their delegate. By signing above, the PI or their delegate certifies that the cost transferred is an appropriate expenditure for the sponsored project or contract charged and that the expenditure complies with the terms and restrictions governing that sponsored project or contract.

If questions 3 & 4 are applicable, the following approvals are required:

Business Administrator or Department Chair

Signature: _____ Date: _____

Printed name, title, and phone #: _____

***Submit form to AskGrantsMgt@wakehealth.edu