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**APPLICATION FOR SKELETAL HUMAN REMAINS ASSISTANCE ACCOUNT FUNDS**

**Name of Applicant(s):**

**Address**:

**City:**  **State:**  **Zip:**

**Email:**  **Phone:**  **Fax:**

**DAHP Human Remains Case Number:**

**Date:**

**Project Title:**

**Grant Type (check which applies):**

Matching

If yes, which party(ies) is/are providing match?

⁯Non-Matching

**Proposed Activities (check all that apply):**

⁯Burial Recovery Costs (Archaeological work)

⁯Reburial Costs

⁯Other (Please list)

**Please note that any archaeological work must be carried out by a professional archaeologist who meets the definition in RCW 27.50.030(8).**

**Project Summary:** Summarize your project in the space provided in an abstract (no more than 500 words). What do you expect to achieve with this grant?

**Archaeological Partners:** All burial recovery projects and some reburials (on-site reburials) will require a professional archaeologist and a valid archaeological permit in good standing, issued by the Department of Archaeology and Historic Preservation. List all of the responsible archaeological personnel involved with the project.

**Schedule of Completion.** Work funded by grants must be completed in a timely manner. Using a table or outline format, list each objective, the major activities needed to complete the objective, and key dates associated with each activity.

**Objective Major Activity(ies) Dates**

**Anticipated Costs (check which applies):**

<$1,000

$1,000-$5,000

$5,000-$10,000

>$10,000 (Estimated amount: )

**Total Budget:**

**Matching Funds:**

**Requested Grant Amount:**

**Activity Costs**

**Activity Description: Costs:**

**Total:**

**Please attach any additional activities, cost estimates, quotes, or rates to the completed form.**

**By signing below, the applicant and concerned parties understand that grant funds must be used only for eligible expenses and are disbursed in accordance with Washington State Law and that all funds will be distributed on a cost-reimbursement basis. Evidence of qualified expenditures, satisfactory to the Department, must be submitted to the Department for reimbursement.**

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**(Signature) (Date)**

**FOR DAHP USE ONLY:**

Eligibility:

⁯ □Eligible

⁯ □Not Eligible

Explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Printed Name Signature Date