OMB No. 0915-0247
Expiration Date:

Children's Hospitals Graduate Medical Education Payment Program
Demographic and Contact Information

Name of Applicant:
City, State:
Medicare Provider Number:
FFY in which Applying for CHGME PP Funding: **FFY**
Type of Application (check box to the left): **Initial Application** **Reconciliation Application**

1. Contact and business information for the applicant hospital:

Official Name of the Hospital: ____________________

Physical Address of the Hospital: ____________________

Tax ID: __________ County where hospital is physically located: __________

Medicare Provider Number: __________ D&B D-U-N-S Number: __________

Hospital Website: ____________________

2. Contact information for the individual to be notified if the application is funded.

Name: ____________________

Title: ____________________

Mailing Address: ____________________

Telephone Number: ____________________

Email Address: ____________________

3. Contact information for the individual authorized to sign for the applicant institution. (This individual should be the same person who signs as the authorizing individual on HRSA 99-3.)

Name: ____________________

Title: ____________________

Mailing Address: ____________________

Telephone Number: ____________________

Email Address: ____________________

Signature and Date: ____________________

4. Contact information for the Director of Graduate Medical Education.

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City, State:
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FFY in which Applying for CHGME PP Funding: **FFY**
Type of Application (check box to the left): **Initial Application** **Reconciliation Application**

Name: ______________________________

Title: ______________________________

Mailing Address: ______________________________

Telephone Number: ______________________________

Email Address: ______________________________

Signature and Date: ______________________________

5. Contact information for the individual who can provide the documentation for the information submitted since, like all Federal programs, this proposal is subject to audit.

Name: ______________________________

Title: ______________________________

Mailing Address: ______________________________

Telephone Number: ______________________________

Email Address: ______________________________

6. Contact information for the individual who prepared and/or completed this application package for the applicant hospital and can answer questions related to the information submitted.

Name: ______________________________

Title: ______________________________

Mailing Address: ______________________________

Telephone Number: ______________________________

Email Address: ______________________________