

**CHILDREN'S HOSPITALS GRADUATE MEDICAL  
EDUCATION PAYMENT PROGRAM**

**APPLICATION FORM HRSA 99**

**Public Burden Statement**

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0247. Public reporting burden for the applicant for this collection of information is estimated to average 69 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-33, Rockville, Maryland, 20857.

## 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: \_\_\_\_\_

## **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**

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

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: \_\_\_\_\_