

Children’s Hospitals Graduate Medical Education Payment Program

Annual Report Checklist

ANNUAL REPORT FORM HRSA 100-5

Name of Children’s Hospital: _____ **Address:** _____
City: _____ **State:** _____
Zip Code: _____ **Date of Report:** _____
Medicare Provider Number: _____
Federal fiscal year for application: _____
Year the hospital first received CHGME funding: _____

Annual Report Forms	This Column to be Completed by the Applicant Hospital	This Column to be Completed by the CHGME PP
	Is the Listed Item Completed and Attached?	
HRSA 100-1	Yes No	Yes No
HRSA 100-2	Yes No	Yes No
HRSA 100-3	Yes No	Yes No
HRSA 100-4	Yes No	Yes No
HRSA 100-5	Yes No	Yes No
Computer Disk with Zip Code Data	Yes No	Yes No
One (1) hard copy and (1) electronic copy of the completed Annual Report including relevant forms and the zip code file.	Yes No	Yes No