Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0247
Expiration Date: 06/30/2013

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 62.16 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.

OMB No. 0915-0247
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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: _____

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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: _____