

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

### **ANNUAL REPORT FORM HRSA 100-5**

#### **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 0915-0313. Public reporting burden for the applicant for this collection of information is estimated to average 1 hour 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 10-33, Rockville, Maryland, 20857.

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

<b>Annual Report Forms</b>	<b>This Column to be Completed by the Applicant Hospital</b>	<b>This Column to be Completed by the CHGME PP</b>
	<b>Is the Listed Item Completed and Attached?</b>	
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