

CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

APPLICATION FORM HRSA 99-5

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 0915-0247. Public reporting burden for this collection of information is estimated to average 0.33 hours per response, including the time for reviewing instructions, searching existing data sources, 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 14N-39, Rockville, Maryland, 20857.

Children’s Hospitals Graduate Medical Education Payment Program Application Checklist

Name of Applicant:

Medicare Provider

Number:

FFY in which Applying for CHGME PP Funding: FFY

Type of Application (check box to the left): Initial Application Reconciliation Application

Application Forms and Supporting Documentation	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?		
Forms and Supporting Documentation Required to be Submitted by All Participating Hospitals <input type="checkbox"/>		
HRSA-99 (2 pages)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
HRSA 99-1 (4 pages)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
HRSA 99-2 (1 page)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
HRSA 99-3 (6 pages)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
HRSA 99-4 (2 pages) – Required at Reconciliation only	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
HRSA 99-5 (1 page)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>
Additional Supporting Documentation		
The forms and supporting documentation listed below may not be applicable to all hospitals. Hospitals should contact their CHGME PP regional manager for assistance and/or clarification.		
Cover letter detailing any issues that may impact the processing or approval of the children’s hospital’s application for CHGME PP funding.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
CMS 2552-96 MCR Worksheet E-3, Part IV(s) Required for each cost reporting period identified in the HRSA 99-1 in which the hospital filed a full MCR.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Affiliation Agreement for an Aggregate Cap Required for each cost reporting period identified in the HRSA 99-1 in which the hospital established a Medicare GME Affiliation Agreement. Please ensure that the most recent version/update is provided (i.e., reflecting any adjustments made to the agreement during the academic year).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
CMS Letter(s) addressing changes to the Hospital’s 1996 Base Year Cap as a result of §422 of the MMA and/or §5503 of the ACA (increases and/or decreases).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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