Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0247
Expiration Date: XX/XX/20XX

CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

APPLICATION FORM HRSA 99

Public Burden Statement

OMB No. 0915-0247
Expiration Date: XX/XX/20XX

Children's Hospitals Graduate Medical Education Payment Program

Demographic and Contact Information

Name of Applicant:
City, State:
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: _____

OMB No. 0915-0247
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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: _____