

CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

APPLICATION FORM HRSA 99

Public Burden Statement

Public Burden Statement: The purpose of this information collection is to obtain performance data for the following: HRSA Grantees and cooperative agreement recipients, public health, and applications. In addition, these data will facilitate the ability to demonstrate alignment between BHW programs and CHGME Payment Program's participating children's hospitals. 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 information collection is 0915-0247 and it is valid until 12/31/2025. Public reporting burden for this collection of information is estimated to average 3.7 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 Information Collection Clearance Officer, 5600 Fishers Lane, Room 14NWH04, Rockville, Maryland, 20857.

**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:	

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City, State:

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

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: _____