*This form requests basic information about the Applicant and the Grant Project. This form must be completed in its entirety by an authorized representative.*

**Hospital Identifiers**

|  |  |
| --- | --- |
| 1. Rural Hospital Name (Complete legal name, including any “DBA”): |  |
| 2.Rural Hospital National Provider Identifier (NPI) (10 digits): |  |
| 3.Rural Hospital License Number (2 to 6 digits): |  |
| 4.Rural Hospital General Email Address: |  |
| 5.Rural Hospital Texas Identification Number (TIN) (Must start with a “1”, Must be 11 digits): |  |
| 6.Federal Employer Identification Number: |  |
| 7.Texas Franchise Number: |  |
| 8.Texas Secretary of State Filing Number: |  |
| 9. Data Universal Numbering System (DUNS) Number |  |
| 10.SAM.gov Unique Entity Identifier: |  |

**Location**

|  |  |
| --- | --- |
| 11.Rural Hospital Physical Address (Not a P.O. Box): |  |
| City: |  |
| State: |  |
| Zip: |  |

**Applicant Contact Information**

|  |  |
| --- | --- |
| 12.Person authorized to sign the Application: |  |
| 13.Title of person authorized to sign the Application: |  |
| 14.Primary contact’s name for questions regarding the application: |  |
| 15.Financial Officer name: |  |
| 16.Accounts Payable name: |  |
| 17.Contract Management name: |  |
| 18.Alternate contact for Contract Management name: |  |

**Applicant Contact Information Continued**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Mailing Address** | **Phone Number** | **E-Mail Address** |
| **19.Financial Officer’s:** |  |  |  |
| **20.Accounts Payable’s:** |  |  |  |
| **21.Primary contact for questions:** |  |  |  |
| **22.Contract Management:** |  |  |  |
| **23.Alternate contact for Contract Management:** |  |  |  |

**Ownership**

**24. At the time of this Application, is this Rural Hospital undergoing a Change of Ownership?**

**Yes**

**No**

**25. Is it anticipated that this Rural Hospital will undergo a Change of Ownership during the Project Period?**

**Yes**

**No**

**26. If “Yes,” what is the effective date of the Change of Ownership for this Rural Hospital?**

**Additional Hospital Information (This information will not be used to determine eligibility)**

**27. At the time of Application, will this Rural Hospital be in compliance with federal transparency laws, including the requirements in 45 Code of Federal Regulations (CFR) Sections 180.10-180.60?**

**Yes**

**No**

**Signature of Authorized Representative**

|  |  |
| --- | --- |
| 28. SIGNATURE OF AUTHORIZED REPRESENTATIVE |  |
| 29. Date |  |