

U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

**MEDICARE WAIVER
DEMONSTRATION
APPLICATION**



DISCLOSURE STATEMENT According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0880. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

**Medicare Waiver Demonstration
Applicant Data Sheet**

	Date Submitted
Applicant Legal Name	Date Received by CMS
Address (city, county, state, zip code)	Name, telephone number and address of person to be contacted on matters involving the application.
Descriptive Title of Applicant's Project Rural Community Hospital Demonstration Program	Project Duration (MM/DD/YYYY) From _____ To _____
Proposed Project	Type of Applicant <input type="checkbox"/> Academic Institution <input type="checkbox"/> Individual <input type="checkbox"/> Profit Organization <input type="checkbox"/> Not for Profit Organization <input type="checkbox"/> Other, please specify
Areas Affected by Project (cities, counties, states)	
Applicant's Medicare Provider Number(s)	Applicant's Employer Identification Number
Is The Applicant a Medicare Provider/Organization in Good Standing? explanation. <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", attach an	
<i>TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE TERMS AND CONDITIONS OF THE AWARD AND APPLICABLE FEDERAL REQUIREMENTS IF AWARDED.</i>	
Type Name and Title of Authorized Representative	Telephone Number
Signature of Authorized Representative	Date Signed