West Virginia Health Care Authority
Hospital Assistance Grant Application

Date of Application: ____________

Applicant Information

Name of Organization (legal name)		Legal Status of Applicant (ex. Govt, Nonprofit, etc)	
Address	City, State, Zip		Employer Identification Number (FEIN)
Phone	Fax	Phone	Website
Application Contact Person	Title	E-mail	Fiscal Year End:

Current Type of Audit ____________________

Proposal Information

Please give a 2-3 sentence summary of request and attach addition information if needed:

Project Period: ____________________

Payment Methodology ____________________
(monthly, quarterly or schedule of payments)

Plan for Sustainability:

Budget

Personnel Services	____________________
Fringe Benefits	____________________
Equipment and other Capital Expenditures	____________________
Materials and Supplies	____________________
Contractual Costs	____________________
Other	____________________
(ATTACH BUDGET DETAIL IF NECESSARY) **Total Grant Request**	____________________

Authorization

I certify that all representations in this application are true and correct to the best of my knowledge. In the event that I later learn that any representation made in this application is false or incorrect, I will inform the West Virginia Health Care Authority, in writing, of such falsehood and incorrect information.

Applicant Signature	Printed Name	Title	Date
____________________	____________________	____________________	____________________

FOR INTERNAL USE ONLY:

Board Approval	Denial
____________________	____________________