**RFA #18406**

**Statewide Health Care Facility Transformation Program III (Phase 3)**

**Application Cover Sheet**

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| **Applicant Legal Corporate Name:** Click here to enter text.  **Applicant’s Primary Address** (include County): Click here to enter text.  **Federal ID #:** Click here to enter text.  **NYS Charities Registration #:** Click here to enter text.  **Vendor Identification #:** Click here to enter text.  **Applicant is:**  Municipality  Not For Profit  For Profit  **Prequalified in Grants Gateway?**   Yes  No  Not Applicable  ***(REQUIRED for Not for Profit Applicants)***  **Applicant Type:**  Article 28 General Hospital  Article 28 Hospital designated as a Regional Perinatal Center or other health providers  Article 28 Residential health care facility  Article 28 Diagnostic and treatment center  Article 31 Mental health clinic  Article 31 Children’s residential treatment facility  Article 32 Alcohol and substance abuse treatment clinic  Article 36 Home care provider  Article 40 Hospice provider  Article 7 Adult care facility  Article 16 Clinic  Primary care provider  Assisted living program approved by New York State Department of Health pursuant to  section 461-l of the Social Security Law  **Project Name:** Click here to enter text.  **Amount of SHCFTP Funds Requested** $Click here to enter text.  **Amount of Other Funds** $Click here to enter text.  **Total Project Cost** $Click here to enter text.    **Applicant Contact Information**  Name: Click here to enter text. Title: Click here to enter text.  Phone: Click here to enter text. E-mail: Click here to enter text.  **Signature of an individual who is authorized to bind the Eligible Applicant to any MGC resulting from this application.**  Name: Click here to enter text.  Applicant Authorized Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_ |