**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:\_\_\_\_\_\_\_\_\_ |