DEPARTMENT OF HEALTH
OFFICE OF RURAL HEALTH AND PRIMARY CARE

FQHC Subsidy Program
GRANT APPLICATION FACE SHEET

Minnesota Department of Health, Office of Rural Health and Primary Care

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1. Applicant Organization (with which grant agreement is to be executed)

Legal Name _____

Address _____

Phone _____

SWIFT Vendor ID _____ **SWIFT Location Code** _____

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2. Director of Applicant Organization

Name/Title _____

Email Address _____

Phone _____

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3. Contact Person for Grant Project (if different from number 2)

Name/Title _____

Email Address _____

Phone _____

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4. UDS Data from Calendar Year 2019

Sliding Fee Discounts for CY2019 _____
(Enter the amount reported in Table 9D, Line 14(e) unless the Health Center provides services in other states. If so, enter the adjusted amount of sliding fee discounts provided in Minnesota facilities only.)

Unduplicated Patient Total for CY2019 _____

Total Patient Encounters for CY2019 _____

I certify that the information contained herein is true and accurate to the best of my knowledge and that I submit this application on behalf of the applicant organization.

Signature	Title	Date