

# PRE-APPLICATION FORM

## MINNESOTA ELECTRONIC HEALTH RECORDS (EHR) LOAN PROGRAM OFFICE OF RURAL HEALTH AND PRIMARY CARE



APPLICANT NAME: \_\_\_\_\_

Applicant Type: \_\_\_\_\_ Community clinic \_\_\_\_\_ Rural hospital \_\_\_\_\_ Physician clinic \_\_\_\_\_ Nursing facility  
\_\_\_\_\_ Other provider (describe) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street Address (if different): \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_ State Tax ID Number \_\_\_\_\_

Web Site url (if applicable): \_\_\_\_\_

Year Incorporated: \_\_\_\_\_ State of Incorporation: \_\_\_\_\_

ADMINISTRATOR/CEO: \_\_\_\_\_

Title: \_\_\_\_\_ Direct Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

CONTACT PERSON (if different than above): \_\_\_\_\_

Title: \_\_\_\_\_ Direct Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

SYSTEM AFFILIATION, SUBSIDIARY OR PARENT ORGANIZATION (if any): \_\_\_\_\_

Nature of Affiliation: \_\_\_\_\_

(Managed by, leased to, owned by, etc.)

LOAN AMOUNT REQUESTED: \$ \_\_\_\_\_

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

Signature	Title	Date
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**APPLICANT NAME:** \_\_\_\_\_

**LOAN AMOUNT REQUESTED:** \_\_\_\_\_

**I. PROJECT SUMMARY.** (If 2007 or 2008 e-Health Grant applicant, please reference application here.)

**A.** Brief description

**B.** Name of vendor/product identified: \_\_\_\_\_

CCHIT certified: \_\_\_\_\_ YES \_\_\_\_\_ NO (Explanation) \_\_\_\_\_

**C.** Plans for Interoperability: Clear description of capabilities of system to address interconnection or interoperability with other health care entities located in the same geographic area.

**II. PROJECT BUDGET**

Provide detail on how loan funds would support total project budget.

*Note: Loan funds are primarily intended for EHR software, hardware and vendor support expenses.*

**III. PRELIMINARY FINANCIAL INFORMATION.** Please attach the most recent of the following:

1. Audited Financial Statement
2. Income Statement
3. Cost Report (if available)

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Send this form with request attachments to:

**Minnesota EHR Loan Program**  
Office of Rural Health and Primary Care  
Minnesota Department of Health  
PO Box 64882  
85 E. 7<sup>th</sup> Place, Suite 220  
St. Paul, MN 55164-0882

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Your pre-application will be reviewed by MDH staff. Based upon preliminary review, you may expect the following:

1. Request for more information or clarification.
2. Recommendation to not go forward with full application.
3. Authorization to go forward with full application and pay \$750 application fee.