DEPARTMENT OF HEALTH
OFFICE OF RURAL HEALTH AND PRIMARY CARE

Rural Hospital Planning and Transition Grant Program

CONSORTIUM SUMMARY SHEET

For consortium applications, this form should be completed by each hospital in the consortium.

Name of Hospital

Address

City State Zip

Name of Hospital Administrator Phone Number

Signature of Hospital Administrator

Contact Person - if other than Hospital Administrator Phone Number

Title of Project:

Application submitted by:

Individual Hospital

Hospital Consortium

Application for:

Development of Strategic Plan

Implementation of Transition Project

Proposed Project Budget

For a hospital applying as part of a consortium, these figures should reflect the amounts being requested by this hospital only, not for the consortium.

State Funds Requested	$
Matching Funds	$
Total Project Costs	$