

West Virginia Health Care Authority

Early Adopter Grant Program for Health Information Exchange

Application

Date of application: _____

Hospital Information

Name of Hospital (legal name)

Address *City, State, Zip* *Employer Identification Number (EIN)*

Phone *Fax* *Website*

Name of contact person regarding application *Title* *Phone* *E-mail*

Proposal Information

Please give a 2-3 sentence summary of request:

Population served: _____ Geographic area served: _____

Project dates: _____ Fiscal year end: _____

Budget (from page 2)

Consulting Services/Implementation and Upgrade Fees _____

Hardware/Software _____

Training _____

Total Grant Request

Cost Share (Matching) Funds (20% required) _____

Additional Forms Required

	Included with application	Previously submitted to the WVHIN
WVHIN Provider Connectivity Readiness Assessment		
WVHIN Participation Agreement		

Authorization

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

Signature *Print Name* *Title* *Date*