

## 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            \$