Form Approved
OMB No. 0938-0880

MEDICARE WAIVER DEMONSTRATION APPLICANT DATA SHEET

Applicant Legal Name		Date Submitted	
Address		Date Received by CMS	
City	County	State	ZIP Code

Name, telephone number and address of person to be contacted on matters involving the application.

Descriptive Title of Applicant's Project

Project Duration (mm/dd/yyyy)
From __________ To __________

Proposed Project

Type of Applicant

o Academic Institution o Individual o Profit Organization
o Not for Profit Organization o Other, please specify___________________________________

Areas Affected by Project (cities, counties, states)

Applicant's Medicare Provider Number(s)	Applicant's Employer Identification Number

Is The Applicant a Medicare Provider/Organization in Good Standing?
o Yes o No If "No," attach an explanation

To the best of my knowledge and belief, all data in this application are true and correct, the document has been duly authorized by the governing body of the applicant and the applicant will comply with the terms and conditions of the award and applicable Federal requirements if awarded.

Type Name and Title of Authorized Representative	Telephone Number (include area code)
Signature of Authorized Representative	Date Signed (mm/dd/yyyy)