Emergency Trauma Fund

TRAUMA CENTER APPLICATION FORM

Emergency Trauma Fund
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Web: EmergencyTraumaFund.com

ETF USE ONLY
DATE RECEIVED STAMP

1. NAME OF HOSPITAL	2. FEDERAL TAX ID NUMBER
3. STREET ADDRESS	4. MAILING ADDRESS (IF DIFFERENT)
CITY, STATE & ZIP CODE	CITY, STATE & ZIP CODE
5. CONTACT NAME & TITLE	6. PHONE NUMBER
7. EMAIL ADDRESS	8. FAX NUMBER

9. DESIGNATE HOSPITAL STATUS (MARK ALL THAT APPLY)

☐ PRIVATE NOT FOR PROFIT ☐ PRIVATE FOR PROFIT ☐ COUNTY / CITY GOVERNMENT
☐ STATE AGENCY ☐ SPECIAL DISTRICT ☐ OTHER:

10. THE JOINT COMMISSION (TJC) ACCREDITED ☐ YES ☐ NO	IF ACCREDITED BY OTHER THAN TJC, PLEASE NOTE ACCREDITING COMPANY:
11. DOES YOUR HOSPITAL RECEIVE DISPROPORTIONATE SHARE HOSPITAL (DSH) FUNDING ☐ YES ☐ NO	12. LICENSED TRAUMA CENTER ☐ YES ☐ NO IF YES, WHAT LEVEL ☐ LEVEL I ☐ LEVEL II ☐ LEVEL III ☐ LEVEL IV

13. NUMBER OF TRAUMA PATIENTS CARED FOR PREVIOUS FISCAL YEAR	14. TOTAL NUMBER OF EMERGENCY PATIENTS CARED FOR PREVIOUS FISCAL YEAR	15. PERCENTAGE THAT WERE MEDICARE PREVIOUS FISCAL YEAR %	16. PERCENTAGE THAT WERE MEDICAID OR MEDI-CAL PREVIOUS FISCAL YEAR %

17. AMOUNT OF CHARITABLE CARE PROVIDED BY HOSPITAL PREVIOUS FISCAL YEAR	18. AMOUNT OF CHARITABLE CARE PROVIDED BY HOSPITAL YEAR TO DATE
$	$

19. STATEMENT OF NEED - IN THE SPACE BELOW, PLEASE WRITE A BRIEF STATEMENT DESCRIBING NEED FOR ADDITIONAL EMS / TRAUMA FUNDING

I, THE UNDERSIGNED, DO HEREBY ATTEST THAT THE INFORMATION CONTAINED WITHIN THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MY APPLICATION WILL BE DISQUALIFIED SHOULD FALSIFIED INFORMATION BE REVEALED.

PRINTED NAME	TITLE
SIGNATURE	DATE

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