New York State Department of Health
Solicitation of Interest for
TELEHEALTH CAPITAL PROGRAM
Application Cover Sheet
Attachment 4

Applicant Legal Corporate Name: Click here to enter text.

Applicant's New York State DOS ID: Click here to enter text.

Applicant's Primary/Clinic Address: Click here to enter text.

County of Applicant's Primary/Clinic Address: Click here to enter text.

Medicaid Number/ID: Click here to enter text.

NPI Number: Click here to enter text.

Federal ID Number: Click here to enter text.

NYS Charities Registration Number: Click here to enter text.

Vendor Identification #: Click here to enter text.

Applicant is: ☐ Municipality ☐ Not For Profit ☐ For Profit

Prequalified in Grants Gateway? ☐ Yes ☐ No ☐ Not Applicable
(REQUIRED for Not for Profit Applicants)

Applicant Type:

- ☐ Article 28 Diagnostic and treatment center
- ☐ Article 31 Mental health clinic
- ☐ Article 32 Alcohol and substance abuse treatment clinic
- ☐ Article 16 Clinic
- ☐ Article 29-I Voluntary Foster Care Agency

Total Grant Funds Requested $Click here to enter text.

Estimated Total Project Cost $Click here to enter text.

Applicant Contact Information

Name: Click here to enter text. Title: Click here to enter text.

Phone: Click here to enter text. E-mail: Click here to enter text.

Would you like to opt out of sharing your contact information with Rockefeller Philanthropy Advisors and additional $1.5 million in funding? ☐ Yes ☐ No

Signature of an individual who is authorized to bind the Eligible Applicant to any MGC

resulting from this application.

Name: Click here to enter text.

Applicant Authorized Signature: _____Date:_____