

[APPLICATION COVER PAGE]

Submit your complete application by visiting:
www.aha.org/submitfosterapp

Applications must be received online before midnight Central Time on April 1, 2016.

Questions?

Please contact AHA Member Relations at 800/424-4301, or visit the web site at www.aha.org/foster.

Name of Health Delivery Organization

Mailing Address

City, State, Zip Code

Name of Contact (Mr. Ms. Mrs.)

Title

Phone

Fax

E-mail

My health delivery organization is a (check one):

Hospital Health System Integrated Network Community Partnership Other

Primary type of community:

Urban Rural Suburban Mix

References

Please list three (3) individuals who can be contacted to provide reference information about:

(a) the commitment of the health delivery organization to community service and (b) the impact of the applicant's community service initiatives.

Name of Reference

Title

Organization

City, State, Phone

Relationship to Health Care Organization

Name of Reference

Title

Organization

City, State, Phone

Relationship to Health Care Organization

Name of Reference

Title

Organization

City, State, Phone

Relationship to Health Care Organization

Signatures

In submitting this application, we give the American Hospital Association permission to use and disseminate the information contained herein except the audited financial statements.

Chief Executive Officer

Type or Print Name

Board of Trustees Chair

Type or Print Name

Chief Medical Officer

Type or Print Name

Application Contact Person

Type or Print Name

Checklist

Be sure to include:

- ✓ 1 copy of complete application (including cover page)
- ✓ 1 copy of audited financial statement
- ✓ 1 copy of most recent annual report and/or community benefit report
- ✓ 1 copy of list of current board of directors/trustees