U.S. Department of Health and Human Services

HRSA
Health Resources & Services Administration

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2023
Federal Office of Rural Health Policy
Community-Based Division

Rural Health Care Coordination Program

Funding Opportunity Number: HRSA-23-125

Funding Opportunity Type: New

Assistance Listings Number: 93.912

Application Due Date: May 26, 2023

MODIFIED on April 5, 2023:

Revision: Extended the Application Due Date.

Ensure your SAM.gov and Grants.gov registrations and passwords are current immediately!

HRSA will not approve deadline extensions for lack of registration.

Registration in all systems may take up to 1 month to complete.

Issuance Date: March 23, 2023

Amber Berrian
Public Health Analyst
Federal Office of Rural Health Policy
Telephone: (301) 443-0845
Email: forhprhccp@hrsa.gov

See Section VII for a complete list of agency contacts.

Authority: 42 U.S.C. 254c(e) (Section 330A(e) of the Public Health Service Act)

508 COMPLIANCE DISCLAIMER

Note: Persons using assistive technology may not be able to fully access the information in this file. For assistance, email or call one of the HRSA staff listed in Section VII. Agency Contacts.

EXECUTIVE SUMMARY

Funding Opportunity Title:	Rural Health Care Coordination Program
Funding Opportunity Number:	HRSA-23-125
Assistance Listing Number:	93.912
Due Date for Applications:	May 26, 2023
Purpose:	The purpose of this program is to promote rural health care services outreach by improving and expanding delivery of health care services through the application of care coordination strategies in rural areas.
Program Goal(s):	The goals of the Rural Health Care Coordination Program are to: 1. Expand access to and quality of equitable health care services through care coordination strategies exclusively in rural areas; 2. Utilize an innovative evidence-based, promising practice, and/or value-based care model(s) known or demonstrate strong evidence to improve patient health outcomes, and the planning and delivery of patient-centered health care services; 3. Increase collaboration among multi-sector and multidisciplinary network partnerships to address the underlying factors related to social determinants of health; and 4. Develop deliberate and sustainable strategies of care coordination into policies, procedures, staffing, services, and communication systems.
Eligible Applicants:	To be eligible to receive a grant under this program, an entity shall: (A) Be an entity with demonstrated experience serving, or the capacity to serve, rural underserved populations; (B) Represent a consortium (see Appendix B) composed of members that include 3 or more

	health care providers and may be nonprofit or for-profit entities, including tribes and tribal organizations; and (C) Not previously received a grant under 42 U.S.C. 254c(e) for the same or similar project unless the entity is proposing to expand the scope of the project or the area that will be served through the project. See Section III.1 of this notice of funding opportunity (NOFO) for complete eligibility information.
Anticipated Total Annual Available FY 2023 Funding:	$3,000,000
Estimated Number and Type of Award(s):	Up to 10 grants
Estimated Annual Award Amount:	Up to $300,000 per award
Cost Sharing/Match Required:	No
Estimated Notice of Award Date:	September 1, 2023
Period of Performance:	September 1, 2023, through August 31, 2027 (4 years)
Who to contact for questions:	*For overall Program questions/technical assistance:* Amber Berrian Public Health Analyst Community Based Division Federal Office of Rural Health Policy Email: aberrian@hrsa.gov Telephone: 301-443-0845 *For information regarding business, administrative or fiscal issues:* *Eric Brown* Grants Management Specialist Division of Grants Management Operations Office of Federal Assistance Management Email: ebrown@hrsa.gov Phone: 301-945-9844

Application Guide

You (the applicant organization/agency) are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide*, available online, except where instructed in this NOFO to do otherwise. Visit HRSA's How to Prepare Your Application page at https://www.hrsa.gov/grants/apply-for-a-grant/prepare-your- application for more information.

Technical Assistance

HRSA has scheduled a pre-application technical assistance webinar:

April 6, 2023
Time: 3 – 4 p.m. ET
Weblink:
https://hrsa-gov.zoomgov.com/j/1610629141?pwd=TGtJVGNZVjB6T1RTZlB5U0dTRWltUT09

Attendees without computer access or computer audio can use the dial-in information below:

Call-In Number: 1-833-568-8864
Participant Code: 32032979

The webinar will provide an overview of the NOFO and an opportunity for you to ask questions.

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I. Program Description

1. Purpose

This notice announces the opportunity to apply for funding under the Rural Health Care Coordination Program. The purpose of this program is to promote rural health care services outreach by improving and expanding delivery of health care services through comprehensive care coordination strategies in rural areas. This award is intended to serve as initial seed funding to implement creative community-based health solutions in rural communities to expand access to and coordination of care with the expectation that awardees will then be able to sustain the program after the federal funding ends.

The goals for the Rural Health Care Coordination Program are to:

1. Expand access to and quality of equitable health care services through care coordination strategies exclusively in rural areas;
2. Utilize an innovative evidence-based, promising practice, and/or value-based care model(s) that is known to, or demonstrates strong evidence to, improve patient health outcomes and the planning and delivery of patient-centered health care services;
3. Increase collaboration among multi-sector and multidisciplinary network partnerships to address the underlying factors related to social determinants of health; and
4. Develop and implement deliberate and sustainable strategies of care coordination into policies, procedures, staffing, services, and communication systems.

The Rural Health Care Coordination Program is a four-year program with year one (September 1, 2023 – August 31, 2024) being a planning year and years two – four (September 1, 2024 – August 31, 2027) focused on program implementation. Applicants are required to select one primary focus area from the following: 1) heart disease; 2) cancer; 3) chronic lower respiratory disease; 4) stroke; or 5) maternal health. Applicants are to propose innovative approaches to achieve the program goals, address local health challenges including the underlying risk factors that contribute to the selected primary focus area, and improve population health outcomes through coordinated, community-wide programs that link health and human services within an established or formal network (for the purposes of this program the terms “consortium” and “network” are used interchangeably). Although it is required to select one primary focus area, applicants may include underlying risk factors that contribute to the selected primary focus area understanding care coordination includes the provision of care for individuals with chronic and/or medically complex diseases.

At the end of the four years, applicants should be able to contribute to the following outcomes:

1. Expanded access to and affordability of quality comprehensive care coordination leading to cost savings and overall health improvement status;

2. Improved patient health outcomes through the utilization of chronic care management, and/or preventive and wellness services;
3. Institutionalized care coordination strategies within their policies, procedures, staffing, services, and communication systems;
4. Implemented a multidisciplinary and multi-sector referral system; and
5. Identified a variety of funding and financing mechanisms to continue comprehensive care coordination strategies beyond the initial FORHP grant funding.

For more details, see Program-Specific Instructions.

2. Background

The Rural Health Care Coordination Program is authorized by 42 U.S.C. 254c(e) (Section 330A(e) of the Public Health Service Act) to promote rural health care services outreach by improving and expanding delivery of health care services through comprehensive care coordination strategies addressing a primary focus area: 1) heart disease; 2) cancer; 3) chronic lower respiratory disease; 4) stroke; or 5) maternal health.

Care coordination is a vital aspect of health and healthcare services particularly for individuals with chronic or medically complex conditions. For this program, care coordination is "the deliberate organization of a patient's care to facilitate the appropriate delivery of health care services".[1] Care coordination connects primary care physicians, specialists, hospitals, behavioral health providers, other health care organizations, and non-health social service organizations, including but not limited to schools, housing agencies, correctional facilities, and transportation organizations. When care is poorly coordinated in addition to inappropriate follow-up care, patients who see multiple physicians and care providers can face medication errors, hospital readmissions, and avoidable emergency department visits.[2] The effects of poorly coordinated care are particularly evident for people with chronic conditions, such as hypertension, chronic lower respiratory disease and those at high risk for multiple illnesses such as cancer or perinatal related complications. As a result, patients are often expected to navigate a complex healthcare system. Chronic disease is a contributing factor to the five leading causes of death nationally.[3] Therefore, when a network of health care and non-health social services organizations work together to plan, deliver, communicate information, and organize a patient's care to ensure safe, appropriate, and effective care, it creates smooth transitions allowing for holistic patient care and patient engagement in care management.[4]

Rural communities face unique circumstances that pose increased challenges to patient care and well-being. Rural residents tend to be older, in poorer health, and more likely to smoke, be obese, sedentary, and tend to be poorer and have less formal

[1] https://www.ahrq.gov/ncepcr/care/coordination.html
[2] RWJF_SHVS_Realizing-Rural-Care-Coordination.pdf
[3] Potentially Excess Deaths from the Five Leading Causes of Death in Metropolitan and Nonmetropolitan Counties — United States, 2010–2017 | MMWR (cdc.gov)
[4] RWJF_SHVS_Realizing-Rural-Care-Coordination.pdf

education than their urban counterparts.[5] Rural infrastructure such as access to transportation can be limited and pose challenges. The clinical infrastructure in many rural areas is limited, with a focus on primary care and chronic disease management and less access to specialty care. Care coordination is a deliberate and planned approach, providing opportunities to facilitate patient-centered care integration, effectively utilize scarce rural resources, and improve clinical quality through a community-based network approach.

Implementing the provision of equitable care coordination strategies is particularly important to address geographic, gender, and race-based disparities within rural communities. The National Heart, Lung, and Blood Institute (NHLBI) recently published a study demonstrating that rural populations experience an increased burden of heart failure mortality compared with urban populations, and Black men living in rural areas have an especially higher risk.[6] Heart failure is a chronic and progressive condition that develops when the heart does not pump enough blood for the body's needs and can lead to multiple chronic and complex conditions for individuals. Heart failure, like most other cardiovascular diseases (CVD), can be prevented by following a heart-healthy lifestyle or seeking treatment to manage CVD. The study underscores the importance of developing customized approaches to heart failure prevention and other cardiovascular diseases among rural residents, particularly Black men. Additionally, rural populations persistently experience cancer disparities compared with urban populations particularly in cancers that can be prevented or detected early through screening and vaccination.[7]

The Cancer Moonshot Initiative calls on a multi-sector and multi-disciplinary collaboration of private and non-profit sectors, academic institutions and health care providers to close cancer screening gaps, tackle environmental exposures, decrease preventable cancers, and promote advanced research, all while supporting patients and caregivers.

Care coordination is crucial across all aspects of health and health care. An emergent priority addressed through care coordination is the improvement of maternal health outcomes, especially in rural areas. National trends in maternal health have worsened over time, distinctly noting the rural and urban differences for maternal morbidity and mortality rates show rural residents have a 9 percent greater chance of experiencing severe maternal morbidity and mortality compared with urban residents.[8]

Applicants should consider throughout implementation how they can leverage expanded Medicare codes that support integration of behavioral health and primary care, chronic care management, and other care management strategies that could be a key part of sustaining this program.[9] [10] Similarly, applicants may want to consider participation in the Medicare Shared Savings Program (MSSP) as another potential sustainability strategy. The purpose of the MSSP is to support the formation of Accountable Care Organizations (ACOs) and pay these groups of doctors, hospitals,

[5] "Overview of Rural Health" by Vincent Francisco, Craig Ravesloot Ph.D. et al. (umt.edu)
[6] Risk of developing heart failure much higher in U.S. adults living in rural areas vs urban | NHLBI, NIH
[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8997116/
[8] https://www.commonwealthfund.org/publications/2021/sep/restoring-access-maternity-care-rural-america
[9] MLN909188 – Chronic Care Management (cms.gov)
[10] Care Management Medicare Reimbursement Strategies for Rural Providers (ruralhealthinfo.org)

and other health care providers to furnish coordinated, high-quality care to people with Medicare.[11] Applicants may also consider if their approach aligns with new flexibilities under the MSSP designed to support greater participation of ACOs serving rural and underserved Medicare beneficiaries. These new flexibilities include opportunities for upfront payments and a smoother transition to performance-based risk in the MSSP. The new upfront payments in the MSSP may make it easier to form new ACOs, and ACOs may use these funds for a number of purposes including increasing staffing and addressing the social determinants of health (e.g., hiring community health workers, partnering with community-based organizations to address SDOH needs, implementing systems to provide and track patient referrals to available community-based social services).[12][13] Applicants should consider other state-based, national, and private sector value-based efforts that also could be leveraged for sustainability of care coordination efforts beyond this grant. Care coordination initiatives made possible by this grant can be an opportunity not only to improve health outcomes, but also generate cost-savings for both public and private payers.

II. Award Information

1. Type of Application and Award

Type(s) of applications sought: New

HRSA will provide funding in the form of a grant.

2. Summary of Funding

HRSA estimates approximately $3,000,000 to be available annually to fund 10 recipients. You may apply for a ceiling amount of up to $300,000 annually (reflecting direct and indirect costs) per year.

The period of performance is September 1, 2023, through August 31, 2027 (4 years). Funding beyond the first year is subject to the availability of appropriated funds for the Rural Health Care Coordination Program in subsequent fiscal years, satisfactory progress, and a decision that continued funding is in the best interest of the Federal Government.

All HRSA awards are subject to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements at 45 CFR part 75.

[11] Medicare Shared Savings Program Saves Medicare More Than $1.6 Billion in 2021 and Continues to Deliver High-quality Care | HHS.gov

[12] https://www.federalregister.gov/documents/2022/07/29/2022-14562/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other

[13] Federal Register :: Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs To Provide Refunds With Respect to Discarded Amounts; and COVID-19 Interim Final Rules

III. Eligibility Information

1. Eligible Applicants

Eligible applicants include domestic public or private, non-profit or for-profit entities, including faith-based, community-based, tribes, and tribal organizations. The applicant organization may be located in a rural or urban area, but must have demonstrated experience serving, or the capacity to serve, rural underserved populations. The applicant organization should describe in detail their experience and/or capacity to serve rural populations in the **Project Abstract** section of the application.

The applicant organization must represent a network composed of members that include three or more health care providers. For the purposes of this funding opportunity, the terms "consortium" and "network" are used interchangeably. The applicant organization may not previously have received an award under 42 U.S.C. 254c(e) from the HRSA Federal Office of Rural Health Policy for the same or a similar project unless the applicant is proposing to expand the scope of the project or the area that will be served through the project.

For more details, see **Program Requirements and Expectations.**

2. Cost-Sharing/Matching

Cost-sharing/matching is not required for this program.

3. Other

HRSA may not consider an application for funding if it contains any of the non-responsive criteria below:

- Exceeds the ceiling amount
- Fails to satisfy the deadline requirements referenced in Section IV.4

Multiple Applications

Multiple applications from an organization with the same Unique Entity Identifier (UEI) are not allowable.

NOTE: Applications associated with the same DUNS number or EIN should be independently developed and written. HRSA reserves the right to deem applications that provide insufficient information in **Attachment 5** or are nearly identical in content, to be ineligible. In this instance, assuming all other eligibility criteria are met, HRSA will only accept your last validated electronic submission, under the correct funding opportunity number, prior to the Grants.gov application due date as the final and only acceptable application.

HRSA will only accept your last validated electronic submission before the Grants.gov application due date as the final and only acceptable application.

Requesting Exceptions

Tribal exception: HRSA is aware that tribes and tribal governments may have an established infrastructure without separation of services recognized by filing for EINs. In case of tribes and tribal governments, only a single EIN located in a HRSA-designated rural area is necessary to meet the network requirements. Tribes and tribal entities under the same tribal governance must still meet the network criteria of three or more entities committed to the proposed approach, as evidenced by a signed letter of commitment that delineates the expertise, roles and responsibilities in the project, and commitments of each network member. Please submit this information, as **Attachment 5**.

Multiple EIN exception: In general, multiple applications associated with the same DUNS number and/or EIN are not allowable. However, HRSA recognizes a growing trend towards greater consolidation within the health care industry and the possibility that health care organizations may share the same EIN as its parent organization. As a result, at HRSA's discretion, multiple health care organizations that share the same EIN as its parent organization or, organizations within the same network who are proposing different projects are eligible to apply by requesting an exception. Please submit this information, as **Attachment 5**.

To request for a Tribal Exception and/or Multiple EIN Exception, the following **must** be included in **Attachment 5**:

- Names, titles, email addresses, and phone numbers for points of contact at each of the applicant organizations and the parent organization;
- Proposed project focus and service area for each applicant organization with the same EIN (these should not overlap);
- Justification for why each applicant organization must apply to this funding opportunity separately as the applicant organization, as opposed to serving as network member organizations on other applications;
- Assurance that the applicant organizations will each be responsible for the planning, program management, financial management, and decision making of their respective projects, independent of each other and/or the parent organization; and
- Signatures from the points of contact at each applicant organization and the parent organization.

Consulting your State Office of Rural Health

By statute, all applicants are required to consult their State Office of Rural Health (SORH) or equivalent (appropriate state entity) regarding their intent to apply to this program.

HRSA strongly recommends applicants contact their SORH before applying. The SORHs have expertise in FORHP programs specifically as well as rural health generally, and there may be opportunities to utilize SORH expertise in ways to that enhances applications. For example, the SORH may be able to provide information regarding model programs, data resources, and technical assistance for networks, evaluation, partner organizations, or support of information dissemination activities. For this program especially, the SORH can play a vital role as a network partner in both the application phase and if awarded, the planning and implementation phases of this program. If you do not receive a response, please include the original letter of intent requesting the consultation.

SORHs responding to this notice as the applicant organization must provide an attestation in **Attachment 1** that there is no conflict of interest and other non-SORH applicants were not prejudiced. This attestation must clearly show that the SORH application was independently developed and written and that they have not knowingly duplicated efforts or project ideas of non-SORH applicants within their state.

Each state has a SORH, and a list of the SORHs can be accessed at: https://nosorh.org/nosorhmembers/nosorh-members-browse-bystate/. All applicants must include in **Attachment 1** a copy of the letter or email sent to the SORH, and any response received to the letter, which was submitted to the SORH describing their project.

Applicants located in Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau that do not have the functional equivalent of a SORH are nevertheless eligible to apply.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA requires you to apply electronically. HRSA encourages you to apply through Grants.gov using the SF-424 workspace application package associated with this notice of funding opportunity (NOFO) following the directions provided at Grants.gov: HOW TO APPLY FOR GRANTS. If you use an alternative electronic submission, see Grants.gov: APPLICANT SYSTEM-TO-SYSTEM.

The NOFO is also known as “Instructions” on Grants.gov. You must select “Subscribe” and provide your email address for HRSA-23-125 in order to receive notifications including modifications, clarifications, and/or republications of the

NOFO on Grants.gov. You will also receive notifications of documents placed in the RELATED DOCUMENTS tab on Grants.gov that may affect the NOFO and your application. *You are ultimately responsible for reviewing the For Applicants page for all information relevant to this NOFO.*

2. Content and Form of Application Submission

Application Format Requirements

Section 4 of HRSA's *SF-424 Application Guide* provides general instructions for the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, etc. You must submit the information outlined in HRSA *SF-424 Application Guide* in addition to the VAP-specific information below. You are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide* except where instructed in the NOFO to do otherwise. You must submit the application in the English language and budget figures expressed in U.S. dollars (45 CFR § 75.111(a)).

See Section 8.5 of the HRSA *SF-424 Application Guide* for the Application Completeness Checklist.

Application Page Limit

The total number of pages that count toward the page limit shall be no more than **60 pages** when we print them. HRSA will not review any pages that exceed the page limit. Using the pages within the page limit, HRSA will determine eligibility using Section III. Eligibility Information of the NOFO.

These items don't count toward the page limit:

- Standard OMB-approved forms you find in the NOFO's workspace application package
- Abstract (standard form (SF) "Project_Abstract Summary")
- Indirect Cost Rate Agreement
- Proof of non-profit status (if it applies)

If there are other items that don't count toward the page limit, we'll make this clear in Section IV.2.vi Attachments.

If you use an OMB-approved form that isn't in the HRSA-23-125 workspace application package, it may count toward the page limit. We recommend you only use Grants.gov workspace forms related with this NOFO to avoid going over the page limit.

Applications must be complete and validated by Grants.gov under HRSA-23-125 before the deadline.

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

1) You certify on behalf of the applicant organization, by submission of your proposal, that neither you nor your principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.

2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. § 3354).

3) If you are unable to attest to the statements in this certification, you must include an explanation in *Attachments 10-15: Other Relevant Documents*.

See Section 4.1 viii of HRSA's *SF-424 Application Guide* for additional information on all certifications.

Temporary Reassignment of State and Local Personnel during a Public Health Emergency

Section 319(e) of the Public Health Service (PHS) Act provides the Secretary of the Department of Health and Human Services (HHS) with discretion upon request by a state or tribal organization to authorize the temporary reassignment of state, tribal, and local personnel during a declared federal public health emergency. The temporary reassignment provision is applicable to state, tribal, and local public health department or agency personnel whose positions are funded, in full or part, under PHS programs and allows such personnel to immediately respond to the public health emergency in the affected jurisdiction. Funds provided under the award may be used to support personnel who are temporarily reassigned in accordance with § 319(e), which sunsets / terminates on September 30, 2023. Please reference detailed information available on the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) website.

Program Requirements and Expectations

Service Area Requirements

A. All services of the project must be provided in a fully rural county or rural census tract. Funding provided through this program must be used for programs that target populations residing in HRSA-designated rural areas. To determine the rural eligibility, please refer to Rural Health Grants Eligibility Analyzer (hrsa.gov). Applicants must list the rural counties that will be served in their proposed project. Proposed counties should be fully rural, but if counties are partially rural counties, please include the rural census tract(s) in the **Project Abstract**.

B. The applicant organization and/or network members may be located in an urban or rural area in the 50 U.S. states or in the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, the Federated State of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

Applicant Organizational Requirements

A. The applicant organization must:

   a. be an entity with demonstrated experience serving, or the capacity to serve, rural underserved populations;

   b. represent a network composed of members that include three or more health care providers and payers, and may be nonprofit or for-profit entities including tribes and tribal organizations; and

   c. not previously received a grant under this program for the same or similar project unless the entity is proposing to expand the scope of the project or the area that will be served through the project.

B. The applicant organization must be in an established or formal network of multi-sector and multi-disciplinary partnerships, please see the definition of health care provider organizations, in **Appendix B**, for examples of types of partnership organizations.

C. The applicant organization will serve as the lead organization for the proposed network. The applicant must have the staffing and infrastructure necessary to oversee program activities and financial management for the award and ensure that the rural underserved populations and/or organizations in the local community or region to be served will be involved in the development and ongoing operations of the project. HRSA requires that all applicants describe the geographic relationship to the proposed rural service population as well as the plans to ensure that rural populations are served. The applicant must have demonstrated experience serving, or the capacity to serve, rural underserved populations, and describe the experience and/or capacity in the **Project Abstract.**

D. If the applicant organization shares the same EIN as its parent organization or organizations within the same network are proposing different projects, and the applicant is eligible, then the applicant may request an exception in **Attachment 5**. Please see section 7 below (Multiple EIN exception) for additional details

Network Requirements

A. Applicants must represent a network composed of three or more health care provider organizations and payers, including the applicant organization. All applicants should ensure a collaborative network that is representative of the rural underserved populations and/or organizations in the local community or region to be served. HRSA requires **at least sixty-six percent (66%), or two-thirds of the network composition involved in the proposed project be located in a HRSA-designated rural area**, as defined by the Rural Health Grants Eligibility Analyzer.

B. Each network member must demonstrate substantial involvement in the project and contribute significantly to the goals of the project, including how members will share information across the network and plans for shared governance (see Appendix B). At a minimum, Letters of Support from all network members must be submitted as **Attachment 4.** If

awarded, the roles and responsibilities, member engagement, communication processes details of each network member must be clearly defined in a Memorandum of Understanding/Agreement (MOU/A). The MOU/A must be signed by all network members. *MOU/As for each network member will be required within six (6) months from the program start date if not submitted at the time of application.*

- **Formal Network:** A network organization is considered formal if the network has a signed Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or other formal collaborative agreements, including signed and dated bylaws. The network has a governing body that includes representation from all network member organizations and ensures that the governing body, rather than an individual network member, will make financial and programmatic decisions. The award recipient will remain responsible for complying with all financial and program requirements of the grant award.

  An advisory board that merely provides advice is not considered a governing body. An already existing non-profit board of individuals convened for providing oversight to a single organization is not an appropriate board structure.

  The network ensures a joint decision-making model that ensures an equal voice for all network members and includes ongoing transparency related to network decisions, information and data sharing, and budget allocation decisions.

- **Established Network:** Meets the above definition of a formal network in addition to having a history of working together.

C. The network must have a permanent network director (i.e., network executive director) or have established an interim network director capable of overseeing the network's administrative, fiscal, and business operations at the time an award is made. HRSA strongly recommends the network director role be 1.0 FTE and that the project director role is at least 0.5 FTE. HRSA prefers that the network director role is different from the project director.

Program-Specific Instructions

In addition to application requirements and instructions in Section 4 of HRSA's *SF-424 Application Guide* (including the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract), include the following:

i. Project Abstract

Use the Standard OMB-approved Project Abstract Summary Form that is included in the workspace application package. Do not upload the abstract as an attachment or it may count toward the page limit. For information required in the Project Abstract Summary Form, see Section 4.1.ix of HRSA's *SF-424 Application Guide.*

ABSTRACT HEADING CONTENT
Applicant Organization Information Organization Name, Address (street, city, state, zip code), Facility/Entity Type (FHQC, RHC, public health department, etc.) and Website Address (if applicable)
Designated Project Director & Network Director Information - Project Director Name & Title, Contact Phone Number(s), and E-Mail Address - Network Director Name & Title, Contact Phone Number(s), and E-mail Address - Key Staff Names & Titles, Contact Phone Number(s), and E-mail Address
Rural Health Care Coordination Project: Project Title and Goal
Primary Focus Area: Select one primary focus area from the following: 1) heart disease, 2) cancer, 3) chronic lower respiratory disease, 4) stroke or 5) maternal health)
Proposed Service Area(s): (e.g., states, cities, counties (required)) • NOTE: Proposed rural counties should be fully rural. For partially rural counties, include rural census tract(s).
ABSTRACT BODY CONTENT
Target Patient Population Brief description of the target population group(s) to be served (2-3 sentences max)
Network Members - Network Name, network members' names, addresses, and EINs - Total number of member organizations and facility/entity type of organizations; HRSA requires an attestation that at least sixty-six percent (66%), or two-thirds of the network composition involved in the proposed project be located in a HRSA-designated rural area, as defined by the Rural Health Grants Eligibility Analyzer
Network Project Activities/Services Brief description of the proposed project activities and/or services provided through the network collaboration
Expected Outcomes Brief description of the proposed project expected outcomes. Clearly label and organize these expected outcomes by the goals for the Rural Health Care Coordination Program.
Evidence-based, Promising Practice, and/or Value-Based Care Models The title/name of the evidence-based, promising practice, and/or value-based care model(s) that you will be adopting and/or adapting. If the model was tailored for the proposed project, please briefly describe how it was modified.
Capacity to Serve Rural Underserved Populations Applicants must demonstrate their experience serving or the capacity to serve, rural underserved populations. Please describe your capacity to serve rural underserved populations. Examples to show this capacity may include a history or ability to: - Identify activities that build, strengthen, and maintain the necessary skills and resources needed to sustain or improve health services delivery in rural populations - Discuss organizational expertise and capacity as it relates to the scope of work proposed. Include a brief overview of the organization's assets, skills and qualifications to carry on the project - Describe current experience, including partnerships, activities, program implementation and previous work of a similar nature

- Discuss the effectiveness of methods and/or activities employed to improve health care services in rural communities HRSA requires that all applicants describe the geographic relationship to the proposed rural service population as well as the plans to ensure that rural populations are served.
Funding Opportunity Notification Briefly describe how the applicant organization learned about this funding opportunity. (Select one: State Office of Rural Health, HRSA News Release, Grants.gov, HRSA Project Officer, HRSA Website, Technical Assistance Provider, State/Local Health Department, Other (please explain)
Funding Preference Applicants must explicitly document a qualifying funding preference and cite the qualification that is being met (see 42 U.S.C. 254c(h)(3)) to receive a funding preference. HRSA highly recommends you include concise language making it clear to HRSA which funding preference you qualify for. If you do not qualify for a funding preference, please state that you do not qualify. If applicable, you need to provide supporting documentation in **Attachment 6**. Please refer to Section V.2 for further information.

NARRATIVE GUIDANCE

To ensure that you fully address the review criteria, the table below provides a crosswalk between the narrative language and where each section falls within the review criteria. Any forms or attachments referenced in a narrative section may be considered during the objective review.

Narrative Section	Review Criteria
Introduction	(1) Need
Needs Assessment	(1) Need
Methodology	(2) Response (3) Evaluative Measures (4) Impact
Work Plan	(2) Response and (4) Impact
Resolution of Challenges	(2) Response
Evaluation and Technical Support Capacity	(3) Evaluative Measures (4) Impact (5) Resources/Capabilities
Organizational Information	(5) Resources/Capabilities
Budget and Budget Narrative	(6) Support Requested

ii. Project Narrative

This section provides a comprehensive description of all aspects of the proposed project. It should be succinct, self-explanatory, consistent with forms and attachments and organized in alignment with the sections and format below so that reviewers can understand the proposed project.

Successful applications will contain the information below. Please use the following section headers for the narrative:

- INTRODUCTION -- Corresponds to Section IV's Review Criterion_1_Need

Briefly describe the purpose of the proposed project. Briefly summarize the project's goals and expected outcomes as well as explicitly state the evidence-based, promising practice, systems of care, and/or value-based care model(s) the proposed project will adopt and/or adapt to meet your community's need. Briefly describe the modification or innovation from the actual model(s), if applicable, in making it suitable and appropriate for the proposed project.

Utilize evidence-based practices or models to promote successful program implementation. Models can be found at https://www.ruralhealthinfo.org/project-examples/evidence-levels/evidence-based.

- NEED ASSESSMENTS -- Corresponds to Section V's Review Criterion_1_Need

Provide an overview of the service area and target population to be served. Outline the needs of the local community or region. Describe the target population and its unmet health needs. Cite demographic data whenever possible to support the information provided.

Use the following sub-headings for this section: Target Population, Disease Burden, Geographic Details of Service Area, Barriers/Challenges, and Health Care Availability in Service Area

1. **Target Population -** Describe the target population of the proposed project and the associated unmet health needs. The population description may include information about the incidence and prevalence of specific conditions, such as chronic diseases, or regarding age and socioeconomic status of the target population. Additionally, the applicant should demonstrate that the population it proposes to serve includes subpopulations (rural ethnic and racial minorities and/or other vulnerable populations) that have historically suffered from poorer health outcomes, health disparities, and other inequities compared to the rest of the target population. Compare local data to state and federal data where possible.

2. **Disease Burden -** Select a primary focus area for the proposed project: 1) heart disease; 2) cancer; 3) chronic lower respiratory disease; 4) stroke; or 5) maternal health. Describe the burden of disease and/or condition among the target population to be served. Refer to the **Purpose** for more information on the focus areas and goals of the Rural Health Care Coordination Program. The applicant may include underlying risk factors that contribute to the selected primary focus area understanding care coordination includes the provision of care for individuals with chronic and/or medically complex diseases. The applicant should describe the quality of life for those affected by the disease and/ condition. Data should be used and cited wherever possible to support the information provided.

3. **Geographic Details of Service Area –** Identify the target service area(s) for the proposed project, using a map. Describe any relevant geographical features of the service area that impact access to health care services.

4. **Barriers/Challenges -** Identify any relevant key challenges and barriers to the service area, such as geographic, socioeconomic, linguistic, cultural, racial, ethnic, or other barriers, and discuss how the project plans to overcome identified barriers.

5. **Health Care Availability in Service Area -** Describe the health care services available in or near your target service area, such as the number and types of relevant health and non-health social service organizations, such as housing or transportation agencies and correctional facilities, to address the underlying factors related to social determinants of health. Describe how the local community or region to be served will benefit from the network.

- METHODOLOGY -- Corresponds to Section IV's Review Criterion 2: Response, Review Criterion 3: Evaluative Measures and Review Criterion 4: Impact

Define the specific goals and objectives of your proposed project. Propose methods that you will use to address the needs and meet each of your proposed project, aligning with **the goals for the Rural Health Care Coordination Program.**

These goals and objectives should directly relate to the information presented in the **NEEDS ASSESSMENT** section, including a selection of a primary focus area. The stated goals and objectives should be specific, measurable, realistic, and achievable in a specific timeframe.

Briefly illustrate the level of collaboration of members in the network. Describe each network members' contribution to accomplish set program goals and how the network plans to implement shared governance. Describe the communication plan that will be used within the network and how frequently network meetings will be held. Explain the network's strategy for accomplishing the stated goals and objectives and align with the goals of for the Rural Health Care Coordination Program.

Outline the specifics of the evidence-based, promising practice, and/or value-based care models for your care coordination strategies. Describe any anticipated challenges to the strategies and suggest solutions to the challenges. Explain how you plan on overcoming geographic barriers and addressing transportation and any other relevant social determinants of health barriers.

- WORK PLAN -- Corresponds to Section V's Review Criterion 2: Response and Review Criterion 4: Impact

  Describe the process to achieve each of the activities proposed in **METHODOLOGY** section. Create a work plan with timeline of completion dates for each activity and identifies responsible staff. This section should clearly demonstrate that the completion of work plan activities utilizes a collaborative approach with all network members. This section should also provide clear evidence that the network has the capacity to begin the rollout and implementation of the proposed activities immediately.

  Use the following sub-headings in responding to this section: Work Plan, Impact, Replicability, and Dissemination Plan.

  1. **Work Plan –** Create your work plan narrative description and/or table that discusses proposed action strategies for year one (September 1, 2023 – August 31, 2024) being a planning year and years two – four (September 1, 2024 – August 31, 2027) focused on program implementation, timeframes for the four-year period of performance, key personnel and/or network members responsible, performance and outcome benchmarks, and outputs. Clearly align with the proposed project goals and objectives. You must submit this work plan as **Attachment 8**.
  2. **Impact –** Include a description of the short-term and anticipated long-term impacts from the project implementation (i.e., expected impacts from the target population, service area health access, delivery, and quality). **Throughout the four years of this grant, successful award recipients should be able to contribute to the program outcomes.**
  3. **Replicability -** Describe how the proposed project and its intended impacts may serve as a model for use in similar communities with comparable needs. Include any project results that may have any national, local, state, and or/ regional implications regarding replicability.
  4. **Dissemination Plan –** Describe the methods for disseminating project results and strategies to varying audiences, including information on the types of platforms, mediums, or conferences that will be utilized to share information so that other rural and non-rural communities may benefit from the project.

- RESOLUTION OF CHALLENGES -- Corresponds to Section IV's Review Criterion 2: Response

  1. Describe the process (including staffing and workflow) for how you will track, collect, aggregate, and report data and information from all consortium members to fulfill HRSA reporting requirements. (NOTE:

Applicants must designate at least one individual in the staffing plan to serve as a "Data Coordinator." The Data Coordinator is responsible for tracking, collecting, aggregating, and reporting quantitative and qualitative data and information to fulfill HRSA's reporting requirements. See "Organizational Information" for additional details.)

2. You must clearly demonstrate how the applicant organization will support and enable network members to collect accurate data in response to HRSA reporting requirements. Examples include, but are not limited to, allocating a portion of award funding to each consortium member to support data collection, and/or designating an individual at each member organization who will be responsible for collecting and reporting the HRSA-required data to the applicant organization.

- EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criterion 3: Evaluative Measures, Review Criterion 4: Impact, and Review Criterion 5: Resources/Capabilities

1. **Data Approach** - Include an approach for assessing the network's progress towards achieving the desired outcomes. Describe how to track, measure, evaluate, and communicate progress toward meeting award-funded goals, and the process you will use to create a robust self-evaluation plan if awarded. Please note that a robust evaluation plan is not required to apply for this funding opportunity. A preliminary evaluation plan should be included in **Attachment 8**.
2. **Use of Data** - Describe the process and frequency of evaluation data collection, analysis, and communication. Both outcome and process measures may be used to assess the progress of efforts. The intent of developing a data approach as a network is to track progress, self-evaluate, and collectively utilize the data collected for coordinating patient care, process improvement, and ultimately achieve the desired outcomes as a network.
3. **Baseline Measures** - Using the Care Coordination Program Measures and the overarching FORHP Performance Metric Framework (see Appendix A) to organize, identify and track baseline measures associated with the selected activity(s) in the evaluation plan throughout the duration of the award. The baseline measures must align with the goals and objectives of the proposed project.
4. **Resources/Capabilities**
    a. Identify a Network Director and Project Director, as well as key personnel on the award in the **Project Abstract** and **Attachment 2**. The Network Director will be responsible for overall network monitoring. The Project Director will be responsible for project/program monitoring and carrying out the award activities. The applicant should identify a permanent network and project director prior to receiving award funds. If the applicant organization has an interim network director or project director or has not yet hired a person to serve as the network director or project director, discuss the process and timeline for hiring a permanent individual for these positions.

b. HRSA strongly recommends the Network Director and the project director allot adequate time (at least 1 FTE for the Network Director and at least 0.50 FTE for the Project Director is recommended).

c. A staffing plan is required and should be included in **Attachment 2**. Specifically, the following should be addressed:
   - The job descriptions for key personnel listed in the application.
   - The number and types of staff, qualification levels, and FTE equivalents.
   - The information necessary to illustrate both the capabilities (current experience, skills, knowledge, and experience with previous work of a similar nature) of key staff already identified and the requirements that the applicant has established to fill other key positions if the award is received. Resumes/biographical sketches of key personnel should be included in **Attachment 2**.
   - Staffing needs should have a direct link to the activities proposed in the project narrative and budget portion of the application.

- ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion Criterion_4_Resources_Capabilities

1. Succinctly describe your applicant organization's current mission, structure, and scope of current activities, and how these elements all contribute to your ability to implement the Rural Health Care Coordination Program Requirements and Expectations.
2. Discuss how the applicant organization will properly account for the federal funds and document all costs to avoid audit findings.
3. Briefly describe existing and/or planned policies, procedures, and practices that support and improve equity for all rural populations, including those who suffer from poorer health outcomes, health disparities and other inequalities. These populations include but are not limited to: Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other person of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; and persons otherwise adversely affected by persistent poverty or inequality.
4. A staffing plan and job descriptions for key staff must be included in **Attachment 2.**
5. Provide Letters of Commitment from each network member, in **Attachment 4**, delineating their expertise, roles and responsibilities, and commitments in the project.
6. Include the applicant organization's organizational chart **and** the network's organizational chart and list in **Attachment 3**. The network member list must contain the following information for each network member; it is recommended that this information is provided in a table format:
   a. Network member organization name
   b. Network member organization street address and county
   c. Network member primary point of contact at organization (name, title, email)

d. Network member organization EIN and DUNS. The network must consist of at least three separately owned (i.e., different EINs) entities, including the applicant organization. Tribal entities may be exempt from this requirement;

e. 5) Network member organization sector (e.g., health care, public health, education, law enforcement, tribal entity, etc.). Network partnership should be diverse and encompass more than one sector;

f. Specify the network member organizations' roles, responsibilities, and contributions to the project

g. Specify (yes/no) whether network member is a National Health Service Corps (NHSC) site or NHSC–eligible site (see https://nhsc.hrsa.gov/sites/eligibility-requirements.html for more details)

h. Specify (yes/no) whether the network member is located in a HRSA-designated rural county or rural census tract of an urban county, as defined by the Rural Health Grants Eligibility Analyzer. As a reminder, at least 66 percent of network partners must be located in a HRSA-designated rural areas.

7. Provide a Network Governance Plan, in **Attachment 9**, outlining the goals, governance structure, and roles of each network member. This provides a reporting structure, voting capacity, and shows evidence of effective personnel, adequate FTEs, and financial policies and procedures in place to run the network and program operations, including a description of the income sources to finance the operations of the network (i.e., member dues, sales of network services etc.). For this program, the Network Governance Plan must clearly delineate a commitment to rural health, shared control of rural healthcare facilities, and a shared governance structure.

iii. Budget

The directions offered in the *SF-424 Application Guide* may differ from those offered by Grants.gov. Follow the instructions in Section 4.1.iv of HRSA's *SF-424 Application Guide* and the additional budget instructions provided below. A budget that follows the *Application Guide* will ensure that, if HRSA selects your application for funding, you will have a well-organized plan and, by carefully following the approved plan, may avoid audit issues during the implementation phase.

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) you incur to carry out a HRSA-supported project or activity. Total project or program costs include costs charged to the award and costs borne by you to satisfy a matching or cost-sharing requirement, as applicable.

As required by the Consolidated Appropriations Act, 2023 (P.L. 117-328), Division H, § 202, "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II." Effective January 2023, the salary rate limitation is **$212,100.**

Note that these or other salary rate limitations may apply in the following fiscal years, as required by law.

In addition, the Rural Health Care Coordination Program requires the following:

Travel: Please allocate travel funds for up to two (2) program staff to attend an annual 2.5-day technical assistance workshop in Washington, DC and include the cost in this budget line item. To determine estimated travel costs to Washington, D.C., rates should refer to the U.S. General Services Administration (GSA) per diem rates for FY 2023. Per diem rates can be found on the GSA's website: https://www.gsa.gov/travel-resources. This technical assistance workshop may be transitioned to a virtual meeting. If awarded, additional information will be provided on re-allocating travel funds. Please still include travel costs in the budget.

Subawards/contracts: You are responsible for ensuring that your organization or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Consistent with 45 CFR 75, you must provide a clear explanation of the purpose of each contract, how the costs were estimated, and the specific contract deliverables. A detailed line-item budget form is required for each subaward and should be uploaded to the Subaward Budget Attachment(s) Form. NOTE: These additional line-item budget forms for subawards will not count against the page limit. However, any additional budget justifications ARE included in the page limit.

iv. Budget Narrative

See Section 4.1.v. of HRSA's *SF-424 Application Guide*.

The budget narrative must describe all line-item federal funds (including subawards) proposed for this project. The budget justification narrative should:

- Clearly justify how you will use the Rural Health Care Coordination Program funds requested over the 4-year period of performance to improve access, delivery, and quality of equitable care through comprehensive care coordination strategies in rural communities. The funding request should align with your line-item budget which supports the needs and activities you identified in the project narrative portion of your application.
- Clearly indicate how funds will be distributed across partner organizations (subawards), if proposed.
- Budget for Multi-Year Award: This notice is inviting applications for performance periods up to 4 years. HRSA will make the awards on a competitive basis for 1-year budget periods. Submission and HRSA approval of Progress Report(s) and any other required submission or reports is the basis for the budget period renewal and release of subsequent years' funds. Funding beyond the 1-year budget period is subject to availability of funds, satisfactory progress of the awardee, and a determination that continued funding would be in the best interest of the Federal Government. However, four separate and complete budgets must be submitted with this application.

v. Attachments

Provide the following items in the order specified below to complete the content of the application. **Unless otherwise noted, attachments count toward the application page limit.** Your exception request and proof of funding preferences (if applicable) will not count toward the page limit. **Clearly label each attachment**. You must upload attachments into the application. HRSA and the objective review committee will not open/review any *hyperlinked* attachments.

- **Attachment 1: State Office of Rural Health Letter** (Required)
  Refer to **Consulting your State Office of Rural Health** for the content requirements. This attachment **will not count** towards the 60-page limit.

- **Attachment 2: Staffing Plan and Job Descriptions for Key Personnel** (Required)
  Include the role, responsibilities, and qualifications of proposed project staff to run the network, and specifically to accomplish the proposed network planning grant project. Staffing needs should be explained and should have a direct link to activities proposed in the Project Narrative and budget sections of the application. Staffing plan should include in-kind personnel to the program. Your staffing plan should demonstrate supporting and key personnel that total at least one full-time FTE at the time of application. For the purposes of this application, key personnel are individuals who are funded by this award or person(s) conducting activities central to this program. Refer to **Evaluation and Technical Support Capacity** under **Resources/Capabilities** for more information. This attachment **will not count** towards the 60-page limit.

- **Attachment 3: The Applicant Organization's Organizational Chart AND the Network's Organizational Chart and List** (Required)
  The network organizational chart should depict the structure of the network for the project and should describe how authority will flow from the applicant organization receiving the federal funds to the network partners. The network member list must contain the following information for each network member; it is recommended that this information is provided in a table format:
    - Network member organization name;
    - Network member organization street address and county;
    - Network member primary point of contact at organization (name, title, email);
    - Network member organization EIN and DUNS. The network must consist of at least three separately owned (i.e., different EINs) entities, including the applicant organization. Tribal entities may be exempt from this requirement. Refer to **Eligibility Information under Exceptions** on how to request a tribal and/or multiple EIN exception request, if applicable;
    - Network member organization sector (e.g., health care, public health, education, law enforcement, tribal entity, etc.). Network partnership should be multi-sector and multi-disciplinary partnerships, please see the definition of

health care provider organizations, in **Appendix B**, for examples of types of partnership organizations.
- Specify the network member organizations' roles, responsibilities, and contributions to the project;
- Specify (yes/no) whether the network member is located in a HRSA-designated rural county or rural census tract of an urban county, as defined by the Rural Health Grants Eligibility Analyzer. As a reminder, at least 66 percent of network partners must be located in a HRSA-designated rural areas.

This attachment **will not count** towards the 60-page limit.

- **Attachment 4: Signed Letters of Commitment from all Network Members** (Required)
  Provide a scanned, signed copy of a letter of commitment from each of the network members. Letters of commitment must be submitted with the application and must clearly identify the organizations' roles and responsibilities in the network and project, the activities they will be included in, and how that organization's expertise is pertinent to the grant project. The letter must also include a statement indicating that the proposed partner understands that the award funds be used for the promotion of rural health care services outreach, network/consortium operations and are not to be used for the exclusive benefit of any one (1) network partner and/or to provide clinical services. Refer to **Program Requirements and Expectations** under **Network Requirements** for more information. **This attachment will not count towards the 60-page limit.**

- **Attachment 5: Exceptions Request** (If Applicable)
  Refer to **Eligibility Information under Exceptions** on how to submit the request.
  This attachment **will not count** towards the 60-page limit.

- **Attachment 6: Proof of Funding Preference Designation/Eligibility** (If Applicable)
  Refer to **Funding Preferences** and **Project Abstract** for the content requirements.
  This attachment **will not count** towards the 60-page limit.

- **Attachment 7: HRSA Federal Office of Rural Health Policy Funding History** (If Applicable)
  Current and former HRSA/FORHP award recipients must include the following information for awards received within the last 5 years:
  - Dates of prior award(s) received;
  - Grant number assigned to the previous project(s);
  - A copy of the abstract that was submitted with the previously awarded grant application(s); and
  - A description of the roles of your organization and network members in the previous award.

  This attachment **will count** towards the 60-page limit.

- **Attachment 8: Work Plan** (Required)
  Refer to **Work Plan** under Project Narrative for the content requirements. This attachment **will count** towards the 60-page limit.

- **Attachment 9: Network Governance Plan** (Required)
  Refer to **Appendix B** the definition of "Network Governance Plan" for more information. This attachment **will count** towards the 60-page limit.

- **Attachments 10–15: Other Relevant Documents** (If Applicable)
  This attachment **will count** towards the 60-page limit.

3. Unique Entity Identifier (UEI) and System for Award Management (SAM)

Effective April 4, 2022:

- The UEI assigned by SAM has replaced the Data Universal Numbering System (DUNS) number.
- Register at SAM.gov and you will be assigned a UEI.

You must register with SAM and continue to maintain active SAM registration with current information at all times during which you have an active federal award or an application or plan under consideration by an agency (unless you are an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110(b) or (c), or you have an exception approved by the agency under 2 CFR § 25.110(d)). For your SAM.gov registration, you must submit a notarized letter appointing the authorized Entity Administrator.

If you are chosen as a recipient, HRSA will not make an award until you have complied with all applicable SAM requirements. If you have not fully complied with the requirements by the time HRSA is ready to make an award, you may be deemed not qualified to receive an award, and HRSA may use that determination as the basis for making an award to another applicant.

If you have already completed Grants.gov registration for HRSA or another federal agency, confirm that the registration is still active and that the Authorized Organization Representative (AOR) has been approved.

The Grants.gov registration process requires information in two separate systems:

- System for Award Management (SAM) (https://sam.gov/content/home | SAM.gov Knowledge Base)
- Grants.gov (https://www.grants.gov/)

Effective March 3, 2023, individuals assigned a SAM.gov Entity Administrator role must be an employee, officer, or board member, and cannot be a non-employee. This change is to ensure entities are in control of who has permission to control roles within their entity.

Here's what this means:

- Entity Administrators assigning roles to non-employees will only be able to assign a Data Entry role or lower.
- Any entities assigning Entity Administrator roles using an Entity Administrator Role Request Letter (formerly called "notarized letter") will no longer be able to assign the Entity Administrator role to a non-employee.
- Entity Administrator roles assigned to non-employees will be converted to Data Entry roles. With a Data Entry role, non-employees can still create and manage entity registration data entry but cannot manage roles.

If you are an entity using a non-employee or if you are a non-employee working with an entity to manage registrations, please read (and share) more about this change on the BUY.GSA.gov blog to know what to expect.

For more details, see Section 3.1 of HRSA's *SF-424 Application Guide*.

If you fail to allow ample time to complete registration with SAM or Grants.gov, you will not be eligible for a deadline extension or waiver of the electronic submission requirement.

4. Submission Dates and Times

Application Due Date

The due date for applications under this NOFO is ***May 26, 2023, at 11:59 p.m. ET***. HRSA suggests submitting applications to Grants.gov at least **3 calendar days before the deadline** to allow for any unforeseen circumstances. See Section 8.2.5 – Summary of emails from Grants.gov of HRSA's *SF-424 Application Guide* for additional information.

5. Intergovernmental Review

The Rural Health Care Coordination Program is subject to the provisions of Executive Order 12372, as implemented by 45 CFR part 100.

See Section 4.1 ii of HRSA's SF-424 Application Guide for additional information.

6. Funding Restrictions

You may request funding for a period of performance of up to 4 years, at no more than $300,000 per year (inclusive of direct **and** indirect costs). Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

The General Provisions in Division H of the Consolidated Appropriations Act, 2023 (P.L. 117-328) apply to this program. See Section 4.1 of HRSA's SF-424 Application Guide for additional information. Note that these or other restrictions will apply in following fiscal years, as required by law.

You cannot use funds under this notice to build or acquire real property, for construction, or to pay for equipment costs not directly related to the purposes of this award.

You are required to have the necessary policies, procedures, and financial controls in place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding including statutory restrictions on specific uses of funding. It is imperative that you review and adhere to the list of statutory restrictions on the use of funds detailed in Section 4.1 of HRSA's *SF-424 Application Guide*. Like all other applicable grants requirements, the effectiveness of these policies, procedures, and controls is subject to audit

Be aware of the requirements for HRSA recipients and subrecipients at 2 CFR §200.216 regarding prohibition on certain telecommunications and video surveillance services or equipment. For details, see the HRSA Grants Policy Bulletin Number: 2021- 01E.

All program income generated as a result of awarded funds must be used for approved project-related activities. Any program income earned by the recipient must be used under the addition/additive alternative. You can find post-award requirements for program income at 45 CFR § 75.307.

V. Application Review Information

1. Review Criteria

HRSA has procedures for assessing the technical merit of applications to provide for an objective review and to assist you in understanding the standards against which your application will be reviewed. HRSA has indicators for each review criterion to assist you in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation.

Reviewers will evaluate and score the merit of your application based upon these criteria.

Six review criteria are used to review and rank Rural Health Care Coordination Program applications. Below are descriptions of the review criteria and their scoring points.

CRITERION	NUMBER OF POINTS
1. Need	20
2. Response	25
3. Evaluative Measures	10
4. Impact	10
5. Resources/Capabilities	25
6. Support Requested	10
TOTAL POINTS	100

Criterion 1: NEED (20 points) – Corresponds to Section IV's Introduction and Needs Assessment

The extent to which the application:

- Describes the purpose of the proposed project, how it promotes rural health care services outreach by improving and expanding the delivery of health care services, and how the project will meet the health care needs of the proposed rural underserved population. Clearly and succinctly submits information on the activities/types of services provided, collaborating network members, and expected program outcomes and community impact.

- Indicates the need for the identified care coordination activities providing information on the target population, disease burden, geographic details of service area, barriers/challenges, and health care availability in service area.

- Demonstrates that the population it proposes to serve includes subpopulations (rural ethnic and racial minorities and/or other vulnerable populations) that have historically suffered from poorer health outcomes, health disparities, and other inequities compared to the rest of the target population.

- Identifies a primary focus (heart disease, cancer, chronic lower respiratory disease, stroke, or maternal health) for the proposed project such as reducing the burden of disease and/or condition or implementing evidence-based treatments and disease management strategies that may improve the quality of life among the target population.

- Demonstrates an appropriate use of data sources (i.e., national, local, regional, state) in their analysis of the health care and network needs and the environment in which the network is functioning and the degree to which this evidence substantiates the need for the network and proposed activities.

- Provides quantifiable information on existing services available in the applicant's service area and the gaps in care/ lack of existing services and/or programs related to the identified health care need of the community/region.

- Identifies the key challenges and barriers to network functions and implementation of the care coordination activities in the service area and discusses a plan to overcome the identified challenges and barriers.

- Provides a clear explanation of how this effort does not duplicate any other federal funding members of the network may have been awarded, as indicated in **Attachment 7**.

Criterion 2: RESPONSE (25 points) – Corresponds to Section IV's Methodology, Work Plan and Resolution of Challenges

Developing Strategies to Accomplish Goals (*10 Points)*

The extent to which the application:

- Describes the goals and objectives of the proposed project in a clear, concise, and appropriate manner. These goals and objectives directly relate to the information presented in the **NEEDS ASSESSMENT** section. These activities flow logically from the goals and objectives and aligns with **the goals for the Rural Health Care Coordination Program.**

- Describes the network's strategy for accomplishing the goals and objectives.

- Addresses potential challenges in providing coordinated quality and equitable care and a strategy to address challenges.

- Presents a clear plan for communicating network activities and how the plan is integrated into each network members' organizational activities. Appropriateness of the approach and frequency for network meetings.

Demonstrating Collaboration and Using Evidence-Based, Promising Practice, and/or Value-Based Care Model(s) to Improve Outcomes (10 Points)

The extent to which the application:

- Describes the network's level of collaboration and whether the collaboration level is appropriate to achieve the proposed project activities.

- Describes each network members' contribution to accomplish set project goals.

- Describes how the network of multi-sector and multi-disciplinary partnerships previously collaborated or plans to partner with any community, county, regional, and/or state-level organizations. Refer to the definitions of health care provider organizations and payers, in **Appendix B**, for examples of types of partnership organizations.

- Describes an evidence-based, promising practice care, and/or value-based care model(s) and activities and how they will be used to meet the health care needs of the target population.

- Describes collaboration with payers and participation in value-based care programs such as the Medicare Shared Savings Program (MSSP), CMS Innovation Models, and/or other programs sponsored by public and private payers.

- Demonstrates a comprehensive understanding of potential challenges likely to be encountered in planning and implementing the activities described in the **WORK PLAN** section, in **Attachment 8**. Appropriateness of proposed approaches to resolve the identified potential challenges.

- Describes the approach to overcoming any geographical barriers and addressing any other barriers related to the target population's social determinants of health.

Demonstrating an Appropriate Work Plan and Sustainability Plan (5 Points)

The extent to which the application:

- Includes a clear and coherent Work Plan, as **Attachment 8**, aligned with the network's goals and objectives. Appropriateness of the Work Plan in identifying responsible individual(s) and organization(s) and a timeline for each activity for all four years. Appropriateness of associated process, outcome, and patient and provider satisfaction measures and their benchmarks for each activity and respective goal.

- Aligns the Work Plan with the planning and implementation timeline and deliverables.

- Describes a feasible mechanism for assessing continued need for programs and services provided to the network and community.

- Describes a plan on how to document and disseminate the value of its services, whether though return on investment (ROI), improvement in patients' health outcomes through the clinical quality measures, or other benefits to stakeholders.

- Demonstrates a cohesive sustainability plan, which positions the network to sustain the care coordination activities into policies, procedures, staffing, services, and communication systems.

- Describes plans for engaging public and private payers to enhance sustainability efforts and align payment towards care coordination activities.

Criterion 3: EVALUATIVE MEASURES (10 points) - Corresponds to Section IV's Evaluation and Technical Support Capacity

The extent to which the application:

- Demonstrates the strength of evidence that progress towards meeting goals will be tracked, measured, and assessed. Feasibility and effectiveness of the identified outcome, process, and patient and provider satisfaction measures for assessing the progress of efforts.

- Demonstrates the effectiveness of the process for collecting and analyzing data/information for program assessment measures and the approach for assessing the consortium's progress in relation to proposed outputs and outcomes.

- Demonstrates the effectiveness of the proposed method to create a strong program assessment. The strength of the assessment plan accounts for the needs assessment, program goals, work plan, and sustainability.

- Identifies and incorporates measures that are aligned with the goals and objectives of the program and the supporting work plan activities.

- Explains the feasibility of collecting data and how the data will be used to inform program development and service delivery.

- Demonstrates how the network will monitor the project. Presence and appropriateness of specific measures to use for assuring effective performance of the proposed grant-funded activities and on-going quality assurance/quality improvement strategies that will assist in the early identification and modification of ineffective efforts.

Criterion 4: IMPACT (10 points) – Corresponds to Section IV's Methodology, Work Plan, and Evaluation and Technical Support Capacity

The extent to which the application:

- Demonstrates how the proposed project activities (as discussed in the applicant's **WORK PLAN** in **Attachment 8**) will positively impact the patients, providers, network members, and community and the extent to which the project may be replicable in other communities with similar needs.

- Describes how the applicant plans to contribute to the following outcomes at the end of the four-year period of performance:

    1. Expanded access to and affordability of quality comprehensive care coordination leading to cost savings and overall health improvement status;
    2. Improved patient health outcomes through the utilization of chronic care management, and/or preventive and wellness services;
    3. Institutionalized care coordination strategies within their policies, procedures, staffing, services, and communication systems;
    4. Implemented a multidisciplinary and multi-sector referral system;
    5. Identified a variety of funding and financing mechanisms to continue comprehensive care coordination strategies.

- Describes the anticipated impacts of the selected evidence-based, promising practice, and/or value-based care model(s) that was used in the design and development of the proposed project.

- Presents clear benchmarks of success for each year. Extent to which the benchmarks to be applied to the project are industry standard from recognized sources, such as the National Quality Foundation (NQF), the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS); or the extent to which the applicant proposes appropriate benchmarks if industry standards are not available.

- Describes clearly how the network will strengthen its relationship with the community/region/county/state it serves. Degree to which, where appropriate, applicant clearly demonstrates the role of lay consumers of care in the network and care coordination planning and functioning.

- Presents a realistic and effective approach for widely disseminating information regarding results of the project.

- Describes a plan to address the focus area(s) through a system of care perspective, outlining the roles of all the network members collaboratively contributing to towards improving rural health outcomes.

Criterion 5: RESOURCES/CAPABILITIES (25 points) – Corresponds to Section IV's Organizational Information and Work Plan

Network Member Roles and Organizational Chart (10 points)

The extent to which the applicant organization:

- Demonstrates the following:
    a. Ability to exercise administrative and programmatic direction over award- funded activities.
    b. Ability to be responsible for hiring and managing the award-funded staff.
    c. Has the administrative and accounting capabilities to manage the award funds.
    d. Have identified a network director at the time an award is made, who has the qualifications to oversee the daily functions of the network, contribute to the success of the network, move the network and member organizations towards value-based care and population health management, encourages collaborative decision making, and promotes program sustainability. Strongly recommend including a Project Director.
- Includes the Applicant Organizational Chart and the Network's Organizational Chart and List in **Attachment 3**, and the extent to which the organizational chart(s) demonstrates clear and distinct organizations among the network; the applicant organization and network member organizations (i.e., network members are not affiliated or acquired by the applicant organization or parent organization of applicant organization).
- Provides evidence that network member organizations are meaningful collaborators to the proposed program, evidenced by the value and expertise they bring to the network and the health needs of the community. This section should demonstrate how the network has thought broadly about the inclusion of non-traditional health care entities in the network to promote population health management.
- The applicant organization must be in an established or formal network of multi-sector and multi-disciplinary partnership. Please refer to the definitions in **Appendix B** for health care provider organizations and payers.
- The extent to which the network's composition includes three or more health care provider organizations.

- The extent to which the network demonstrates at least sixty-six percent (66%), or two-thirds of network member organizations (member organizations in the Network's Organizational Chart and List in **Attachment 3**) of the proposed project be located in a HRSA designated rural area and applicants verify the urban or rural status of each network member organization.
- The extent to which the applicant will ensure that the rural underserved populations in the local community or region to be served will be involved in the development and ongoing operations of the project.

Effective Network Governance (5 Points)

The extent to which the application:

- Describes the effectiveness of your shared governance structure for the network to ensure an equal voice for all members and the presence of an effective, collaborative, and independent network-driven leadership is in place. The applicant demonstrates the strength of the network member's mutual commitment via the Network Governance Plan, as defined in **Appendix B**, **in Attachment 9.**
- Provides evidence of effective personnel, adequate FTEs, and financial policies and procedures in place to run the network and program operations, including a description of the income sources to finance the operations of the network (i.e., member dues, sales of network services etc.) are provided.

Evidence of Effective Network Collaboration and Capacity to carry out the Program (10 Points)

The extent to which the application:

- Provides evidence that the network is highly functional and collaborative, with evidence of the successful prior network collaboration to address the health needs of the community. Evidence that network member organizations will collectively work towards achieving the goals and objectives of the proposed program.
- Provides qualifications of the network director in place or interim director. The application appropriately specifies that:

  a. If the network has an interim network director, the feasibility and timeliness for hiring a full-time director network (i.e., the number of known candidates, the projected starting date for the position of full-time director, etc.).

b. If the network director role historically has not been 1.0 FTE, the applicant effectively explains 1) why 2) if other staff roles are able to fulfill some of the roles and responsibilities of this position and 3) how the director is able to successfully fulfill the network leader responsibilities at a lower FTE without compromising the network.

- Provides qualifications of the project director in place to oversee the daily functions, coordination, and implementation of program activities:

  a. The network should have a project director devoting adequate time (at least 0.5 FTE is recommended) on the program.

  b. If the network has an interim project director, the feasibility and timeliness for hiring a full-time project director (i.e., the number of known candidates, the projected starting date for the position of full-time director, etc.).

  It is recommended that the Network Director is a full-time 1.0 FTE and that the Project Director is at least 0.5 FTE. However, it is acceptable if the Network Director is at least 0.5 FTE, and a Project Director is full-time at 1.0 FTE with provided justification.

Criterion 6: SUPPORT REQUESTED (10 points) – Corresponds to Section IV's Budget and Budget Justification

The SF-424A budget forms, along with the budget justification components of the itemized budget and budget narrative, are to be used in the review of this section. Together, they provide information regarding the reasonableness of the support requested.

A. The budget justification logically documents how and why each line-item request (such as personnel, travel, equipment, supplies, information technology, and contractual services) supports the goals and activities of the proposed award-funded activities over the length of the four-year period of performance.

B. The degree to which the estimated cost to the government for proposed award- funded activities is reasonable.

2. Review and Selection Process

The objective review process provides an objective evaluation of applications to the individuals responsible for making award decisions. The highest ranked applications receive consideration for award within available funding ranges. HRSA may also consider assessment of risk and the other pre-award activities described in Section 3 below. See Section 5.3 of HRSA's *SF-424 Application Guide* for more details. In addition to the ranking based on merit criteria, HRSA approving officials will apply other factors (e.g., geographical distribution) described below in selecting applications for award.

For this program, HRSA will use funding preferences.

Funding Preferences
This program provides a funding preference for some applicants, as authorized by 42 U.S.C. 254c(h)(3). Applicants receiving the preference will be placed in a more competitive position among applications that can be funded. Applications that do not receive a funding preference will receive full and equitable consideration during the review process. HRSA staff will determine the funding factor and will grant it to any qualified applicant that demonstrates they meet the criteria for the preference(s) as follows:

Qualification 1: Health Professional Shortage Area (HPSA)
You can receive this funding preference if: the applicant or the service area of the applicant is in an officially designated health professional shortage area (HPSA). Applicants must include a screenshot or printout from the HRSA Shortage Designation website, which indicates if a particular address is located in a HPSA: https://data.hrsa.gov/tools/shortage-area/by-address.

Qualification 2: Medically Underserved Community/Populations (MUC/MUPs)
You can receive this funding preference if: the applicant or the service area of the applicant is in a medically underserved community (MUC) and/or if the applicant serves medically underserved populations (MUPs). Applicants must include a screenshot or printout from the HRSA Shortage Designation website that indicates if a particular address is located in a MUC or serves an MUP: https://data.hrsa.gov/tools/shortage-area/by-address.

Qualification 3: Focus on Primary Care, and Wellness and Prevention Strategies
You can receive this funding preference if: Your project focuses on primary care and wellness and prevention strategies. You must include a brief justification (no more than three sentences) describing how your project focuses on primary care and wellness and prevention strategies.

If you qualify for a funding preference, please indicate which qualification is being met in the **Project Abstract** and **Attachment 6**. Please label documentation as *Proof of Funding Preference Designation/Eligibility*. If you do not provide appropriate documentation in **Attachment 6**, as described, you will not receive the funding preference.

HRSA highly recommends you include clear concise language making it clear to HRSA which funding preference you qualify for. You only have to meet one of the qualifications stated above to receive the preference. Meeting more than one qualification does not increase an applicant's competitive position. If you do not qualify for a funding preference, please use concise language making it clear to HRSA that you do not qualify.

3. Assessment of Risk

HRSA may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory, or other requirements (45 CFR § 75.205).

HRSA reviews applications receiving a favorable objective review for other considerations that include past performance, as applicable; cost analysis of the project/program budget; assessment of your management systems, ensuring continued applicant eligibility; and compliance with any public policy requirements, including those requiring just-in-time submissions. HRSA may ask you to submit additional programmatic or administrative information (such as an updated budget or "other support" information) or to undertake certain activities (such as negotiation of an indirect cost rate) in anticipation of an award. However, even at this point in the process, such requests do not guarantee that HRSA will make an award. Following review of all applicable information, HRSA's approving and business management officials will determine whether HRSA can make an award, if special conditions are required, and what level of funding is appropriate.

Award decisions are discretionary and are not subject to appeal to any HRSA or HHS official or board.

HRSA is required to review and consider any information about your organization that is in the Federal Awardee Performance and Integrity Information System (FAPIIS). You may review and comment on any information about your organization that a federal awarding agency previously entered. HRSA will consider your comments, in addition to other information in FAPIIS in making a judgment about your organization's integrity, business ethics, and record of performance under federal awards when completing the review of risk as described in 45 CFR § 75.205 HHS Awarding Agency Review of Risk Posed by Applicants.

HRSA will report to FAPIIS a determination that an applicant is not qualified (45 CFR § 75.212).

VI. Award Administration Information

1. Award Notices

HRSA will release the Notice of Award (NOA) on or around the start date of September 1, 2023. See Section 5.4 of HRSA's *SF-424 Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2.1 of HRSA's *SF-424 Application Guide*.

If you are successful and receive an NOA, in accepting the award, you agree that the award and any activities thereunder are subject to:

- all provisions of 45 CFR part 75, currently in effect or implemented during the period of the award,
- other federal regulations and HHS policies in effect at the time of the award or implemented during the period of award, and
- applicable statutory provisions.

Accessibility Provisions and Non-Discrimination Requirements

Should you successfully compete for an award, recipients of federal financial assistance (FFA) from HHS will be required to complete an HHS Assurance of Compliance form (HHS 690) in which you agree, as a condition of receiving the grant, to administer your programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, age, sex and disability, and agreeing to comply with federal conscience laws, where applicable. This includes ensuring that entities take meaningful steps to provide meaningful access to persons with limited English proficiency; and ensuring effective communication with persons with disabilities. Where applicable, Title XI and Section 1557 prohibit discrimination on the basis of sexual orientation, and gender identity. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. See https://www.hhs.gov/civil- rights/for-providers/provider-obligations/index.html and https://www.hhs.gov/civil-rights/for-individuals/nondiscrimination/index.html.

- For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html and https://www.lep.gov.
- For information on your specific legal obligations for serving qualified individuals with disabilities, including providing program access, reasonable modifications, and to provide effective communication, see http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html.

- HHS funded health and education programs must be administered in an environment free of sexual harassment, see https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html.
- For guidance on administering your project in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see https://www.hhs.gov/conscience/conscience- protections/index.html and https://www.hhs.gov/conscience/religious- freedom/index.html.

Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under federal civil rights laws or call 1-800-368-1019 or TDD 1-800- 537-7697.

The HRSA Office of Civil Rights, Diversity, and Inclusion (OCRDI) offers technical assistance, individual consultations, trainings, and plain language materials to supplement OCR guidance and assist HRSA recipients in meeting their civil rights obligations. Visit OCRDI's website to learn more about how federal civil rights laws and accessibility requirements apply to your programs, or contact OCRDI directly at HRSACivilRights@hrsa.gov.

Executive Order on Worker Organizing and Empowerment

Pursuant to the Executive Order on Worker Organizing and Empowerment, HRSA strongly encourages applicants to support worker organizing and collective bargaining and to promote equality of bargaining power between employers and employees. This may include the development of policies and practices that could be used to promote worker power. Applicants can describe their plans and specific activities to promote this activity in the application narrative.

Requirements of Subawards

The terms and conditions in the NOA apply directly to the recipient of HRSA funds. The recipient is accountable for the performance of the project, program, or activity; the appropriate expenditure of funds under the award by all parties; and all other obligations of the recipient, as cited in the NOA. In general, the requirements that apply to the recipient, including public policy requirements, also apply to subrecipients under awards, and it is the recipient's responsibility to monitor the compliance of all funded subrecipients. See 45 CFR § 75.101 Applicability for more details.

3. Reporting

Award recipients must comply with Section 6 of HRSA's *SF-424 Application Guide* **and** the following reporting and review activities:

1) **Baseline Services Map.** Award recipients are required to submit a baseline services map during the planning year that will include an asset mapping exercise of the relevant health services in the service area and a gap analysis. Additional instructions will be provided upon receipt of the award.

2) **Strategic Work Plan.** Award recipients are required to submit a four-year work plan and logic model during the first year of the period of performance that implements and tests the proposed model in an iterative process using baseline data established in the first year. Elements of strategic planning tied to internal and external analysis and alignment of the model with the network goals should be integrated into the work plan. Additional instructions will be provided upon receipt of the award.
3) **Data Collection Plan.** Award recipients are required to submit a data collection plan during the planning year that details each network site-level data and the network's plan to meet data reporting requirements. Additional instructions will be provided upon receipt of the award.
4) **Performance Measures Reporting.** The recipient must report data selected from the measures in Appendix A: Draft Performance Measures on an annual basis.
5) **Progress Report(s).** The recipient must submit a progress report to HRSA on an annual basis including both quantitative data and brief narratives to capture project progress to date. Submission and HRSA approval of a progress report will trigger the budget period renewal and release of each subsequent year of funding. Further information will be available in the NOA. More information will be available in the NOA.
6) **Integrity and Performance Reporting.** The NOA will contain a provision for integrity and performance reporting in FAPIIS, as required in 45 CFR part 75 Appendix XII.
7) **Final Program Report.** A final report is due within 90 calendar days after the period of performance ends. The Final Report must be submitted online by recipients in the EHBs at https://grants.hrsa.gov/webexternal/home.asp.The Final Report is designed to provide HRSA with information required to close out a grant after completion of project activities. Recipients are required to submit a final report at the end of their project.

Note that the OMB revisions to Guidance for Grants and Agreements termination provisions located at 2 CFR § 200.340 - Termination apply to all federal awards effective August 13, 2020. No additional termination provisions apply unless otherwise noted.

All award recipients will receive technical assistance (TA) during the four-year period of performance. Targeted TA will assist award recipients with achieving desired project outcomes, sustainability, and strategic planning, and will ensure alignment of the awarded project with the goals for the Rural Health Care Coordination Program. TA is provided to award recipients at no additional cost and is an investment made by HRSA/FORHP to contribute to the success of the awarded projects. HRSA/FORHP has found that most award recipients benefit greatly from the support provided through these collaborations. If funded, award recipients will learn more about the targeted technical assistance and evaluation support.

VII. Agency Contacts

You may request additional information and/or technical assistance regarding business, administrative, or fiscal issues related to this NOFO by contacting:

Eric Brown
Grants Management Specialist
Division of Grants Management Operations,
OFAM Health Resources and Services Administration
Telephone: 301-945-9844
Email: ebrown@hrsa.gov

You may request additional information regarding the overall program issues and/or technical assistance related to this NOFO by contacting:

Amber Berrian
Public Health Analyst
Attn: Rural Health Care Coordination Program
Federal Office of Rural Health Policy
Health Resources and Services Administration
Telephone: (301) 443-0845
Email: forhprhccp@hrsa.gov

You may need assistance when working online to submit your application forms electronically. Always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, 7 days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International callers dial 606-545-5035) Email: support@grants.gov
Self-Service Knowledge Base

Successful applicants/recipients may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). Always obtain a case number when calling for support. For assistance with submitting in the EHBs, contact the HRSA Contact Center, Monday–Friday, 7 a.m. to 8 p.m. ET, excluding federal holidays at:

HRSA Contact Center
Telephone: (877) 464-4772 / (877) Go4-HRSA
TTY: (877) 897-9910
Web: http://www.hrsa.gov/about/contact/ehbhelp.aspx

The EHBs login process is changing May 26, 2023 for applicants, recipients, service providers, consultants, and technical analysts. To enhance EHBs' security, the EHBs will use **Login.gov** and **two-factor authentication**. Applicants, recipients, service providers, consultants, and technical analysts must create a Login.gov account by May 25, 2023 to prepare for the new login process. For step-by-step instructions on creating a Login.gov account refer to the EHBs Wiki Help page.

VIII. Other Information

Technical Assistance - See TA details in Executive Summary.

Tips for Writing a Strong Application - See Section 4.7 of HRSA's SF-424 Application Guide.

Resources for your Application - Recommended data sources for identifying your proposed target population(s) and service area(s).

1) Centers for Disease Control and Prevention (CDC) Social Vulnerability Index
2) Reliable, recent County or State data for your proposed area(s) or target population(s), as appropriate.
3) CMS electronic Clinical Quality Measures site and resources for data-sharing and reporting
4) Diabetes Prevention Program Cost Saving Calculator
5) HealthIT.gov (Health Information Exchange resources)
6) Alliance for Innovation on Maternal Health

   Alliance for Innovation on Maternal Health (AIM) works through state teams and health systems to align national, state and hospital level quality improvement efforts to improve overall maternal health outcomes. https://safehealthcareforeverywoman.org/aim-program/
7) Centers for Medicare & Medicaid Services (CMS): Rural Health Clinics
   To determine whether a facility is an RHC, visit https://qcor.cms.gov/main.jsp, select "Basic Search," then under "Advanced Search," select "Rural Health Clinics (RHCs)."
8) Rural Health Information Hub

   The Rural Health Information Hub (RHIhub) is supported by funding from HRSA and helps rural communities and other rural stakeholders access the full range of available programs, funding, and research that can enable them to provide quality health and human services to rural residents. Please visit RHIhub's website at: https://www.ruralhealthinfo.org. RHIhub also provides free customized assistance that can provide support in gathering data, statistics, and general rural health information. To do so, contact RHIhub, and the RHIhub information specialists can provide the information you need in responding to this section. To utilize RHIhub's free customized assistance, please call 1-800-270-1898 or send an email to info@ruralhealthinfo.org.
9) Rural Health Research Gateway

   The Rural Health Research Gateway website provides easy and timely access to all of the research and findings of the HRSA-funded Rural Health Research Centers. You can use the site to find abstracts of both current and completed research projects, publications resulting from those projects, and information about the research centers themselves as well as individual researchers. The

Rural Health Research Gateway website is hosted at the University of North Dakota Center for Rural Health with funding from HRSA. Its intent is to help move new research findings of the Rural Health Research Centers to various end users as quickly and efficiently as possible. Please visit their website at: http://www.ruralhealthresearch.org.

10) Regional Telehealth Resource Centers
Provide technical assistance to organizations and individuals who are actively providing or interested in providing telehealth services to rural and/or underserved communities. https://www.telehealthresourcecenter.org/

11) The Rural Health Care Coordination Program Directory:

https://www.ruralhealthinfo.org/assets/4057-17180/2020-rural-health-care-coordination-grantee-directory.pdf

This directory was developed at the beginning of a period of performance and provides a brief description of each award recipient's project.

Please note that by including a non-federal resource on this list, HRSA is not endorsing the resource or guaranteeing that the information in the resource is accurate.

Appendix A: Draft Performance Measures

Rural Health Care Coordination Program

Proposed Performance Improvement and Measurement System (PIMS)

Please Note: *The following measures are proposed, non- finalized, and are subject to change. They have been included to make applicants aware of the types of data reporting that will be required. HRSA will provide additional information if awarded.*

FORHP PERFORMANCE METRIC FRAMEWORK - IMPROVED ACCESS

GOAL #1: EXPAND ACCESS TO AND QUALITY OF EQUITABLE CARE COORDINATION STRATEGIES EXCLUSIVELY IN RURAL COMMUNITIES

ACCESS TO CARE (applicable to all award recipients):

- Number of unique individuals from target patient population who received direct services
- Type of direct service encounters provided

SOCIAL DETERMINANTS OF HEALTH (applicable to all award recipients):

- Number of patients provided with transportation by type (e.g., car, bus tickets, rideshare, taxi, etc.)
- Ability to access healthy food
- Housing conditions – safe & free of environmental hazards
- Ability to pay for utilities and basic bills

POPULATION DEMOGRAPHICS (applicable to all award recipients):

- Number of people served by ethnicity, race, age group (Children (0-12), Adolescents (13-17), Adults (18-64), Elderly (65 and over))
- Insurance status/coverage
- Gender
- Primary Language Spoken

STAFFING/WORKFORCE COMPOSITION (applicable to all award recipients):

- Types and number of personnel providing care coordination (i.e., CHWs, Care Coordinators, Nurses, PAs, primary care physicians)
- Clinicians: patient panel size
- Support staff: number of patients assigned; total number served per year Number of care coordinators/community health workers/patient navigators/health insurance counselors trained to serve patients using evidence-based curricula

FORHP PERFORMANCE METRIC FRAMEWORK – IMPROVED RURAL HEALTH

GOAL #2: UTILIZE INNOVATIVE EVIDENCE-BASED, PROMISING PRACTICE, AND/OR VALUE-BASED CARE MODELS KNOWN OR DEMONSTRATE STRONG EVIDENCE TO IMPROVE PATIENT HEALTH OUTCOMES, AND THE PLANNING AND DELIVERY OF PATIENT-CENTERED HEALTH CARE SERVICES

CLINICAL MEASURES

(Select based on proposed focus area except for Care Coordination Measures)

- Diabetes Care:
  - NQF 0059 (CMS 122v7 is the 2019 version) Comprehensive Diabetes Care
  - NQF 0729: Optimal Diabetes Care
- Care Coordination (required):
  - CMS50v6: Closing the Loop,
  - NQF 0097: Medication Reconciliation
- Cancer Screening:
  - NQF 0032: Cervical Cancer Screening
  - NQF 0034: Colorectal Cancer Screening
  - NQF 2372: Breast Cancer Screening
  - NQF: 3510 Screening/Surveillance Colonoscopy

- NQF 3575: Total per Capita Cost
- Maternal Health
  - Number of women who receive a prenatal visit
  - Number of women who receive a prenatal visit in the first trimester
  - Number of women who receive a postpartum visit
  - Number of women who receive case management contact
  - Number of live deliveries
  - Number of maternal deaths
  - Number of NICU stays for deliveries that occur within the network, including stays that are transferred outside of the network

CARE COORDINATION (applicable to all award recipients): Care coordination mechanisms/ activities you implemented.

- Patient Follow-Up Rate (%) = (Number of Follow-Ups / Total Patient Population) *100
- Number of people receiving services from a care coordinator
- Number of patients enrolled in a case management program
- Number of case-managed patients who have had [number of] visits with their provider [during a particular time period]
- Number of patients who have a self-management plan
- Patient No-Show Rate (%) = (Number of no-shows per facility/total patients scheduled within patient population) *100
- Case management/care coordination contacts: referrals to non- medical services

UTILIZATION (applicable to all award recipients):

- Emergency department (ED) rate
- 30-day hospital readmission rate
- NQF1789: Hospital-Wide All-cause Unplanned Readmission Measure
- Acute Hospital Utilization
- Hospitalization following discharge from a skilled nursing facility (HFS)
- Revenue and revenue per encounter or visit

TELEHEALTH (applicable to all award recipients): Number of Patient Care Sessions and Total number of miles saved.

ELECTRONIC HEALTH RECORD (optional for award recipients): Summary of Care Record: Use of certified EHR technology (CEHRT) to create a summary of care record and electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.

FORHP PERFORMANCE METRIC FRAMEWORK – EXPANDED RURAL HEALTH CAPACITY

GOAL #3: INCREASE COLLABORATION AMONG MULTI-SECTOR AND MULTIDISCIPLINARY NETWORK PARTNERSHIPS TO ADDRESS THE UNDERLYING FACTORS RELATED TO SOCIAL DETERMINANTS OF HEALTH

NETWORK (applicable to all award recipients):

- Identify types and number of nonprofit and for-profit organizations in the network;
- Assess network's strength across 7 out of 8 characteristics of a sustained network (See RHI's Aim for Sustainability Portal);
- Calculate the Return on Community Investment (ROCI) a methodology for evaluating or assessing the financial and economic impact of a government or nonprofit investment in a community.

FORHP PERFORMANCE METRIC FRAMEWORK – SUSTAINABILITY

GOAL #4: DEVELOP DELIBERATE AND SUSTAINABLE STRATEGIES OF CARE COORDINATION INTO POLICIES, PROCEDURES, STAFFING, SERVICES, AND COMMUNICATION SYSTEMS

SUSTAINABILITY (applicable to all award recipients): Sources of sustainability; List the ratio for economic impact vs. HRSA program funding (use the HRSA's Economic Impact Analysis tool to calculate ratio).

- Revenue and Resources

- Membership dues with a formal structure
- Service reimbursement
- Resource sharing (shared space, staff, etc.)
- Negotiating agreements with payers

- Types of Financing Mechanisms Utilized
  - Per Member per Month (PMPM) fee structure
  - Multi-Payer Payment for Shared Capacity
  - Population-Based Payments
  - Grant Funding
  - Medicare Care Coordination Current Procedural Terminology (CPT) Codes
- Outcomes
  - Payer Mix for patient population = percentage of patients who are insured by insurance type (private health plans, CMS Marketplace, Medicare, Medicaid, uninsured).
  - Health insurance status of patients served during the reporting period
  - Time spent uninsured = Number of months
  - List the ratio for economic impact vs. HRSA program funding (use the HRSA's Economic Impact Analysis tool to calculate ratio).

Appendix B: Definitions

For the purpose of this Notice of Funding Opportunity, the following terms are defined:

Award Recipient – An entity, usually but not limited to non-federal entities, that receives a federal award directly from a federal awarding agency to carry out an activity under a federal program. The term recipient does not include sub recipients.

Budget Period – An interval of time (typically twelve months) into which the period of performance is divided for budgetary and reporting purposes.

Care Coordination – Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

Consortium - See the definition for Network.

Equipment – Tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level established by the non-Federal entity for financial statement purposes, or $5,000.

Evidence-Based – Evidence-based program is defined as the development, implementation, and evaluation of effective programs and policies in public health through application of principles of scientific reasoning, including systematic uses of data and information systems, and appropriate use of behavioral science theory and program planning models. Programs are encouraged to utilize evidence-based practices or models to promote successful program implementation. Models can be found at https://www.ruralhealthinfo.org/project-examples/evidence-levels/evidence-based.

Health Care Provider Organizations – Health care provider organizations are defined as entities including but not limited to hospitals, health systems, rural health clinics (RHCs), federally qualified health centers (FQHCs), primary care providers, specialty care providers, outpatient medical practices, oral health service providers, mental health centers, critical access hospitals (CAH), Certified Community Behavioral Health Clinics (CCBHCs), local public health departments, non-health human and social service organizations, community action agencies, accountable care organizations (ACO), State Home Visit, and Health Start Program organizations.

Health Information Technology – The electronic storage of records, electronic billing, electronic ordering of tests and procedures, and even a shared, interoperable network to allow providers to communicate with one another.

Letter of Commitment– a signed letter including expertise, roles and responsibilities in the project, and commitments of each network member.

Memorandum of Understanding/Agreement – The Memorandum of Understanding/Agreement (MOU/A) is a written document that must be signed by all consortium member CEOs, Board Chairs or tribal authorities to signify their formal commitment as network members. An acceptable MOU/A must describe the network purpose and activities in general; member responsibilities in terms of financial contribution, participation, and voting; and membership benefits.

Network – A formal organizational arrangement among at least three separately owned health care providers or other entities that provide or support the delivery of health care services. The purpose of a network is to foster collaboration and integration of functions among network entities to strengthen the rural health care system. For the purpose of this funding opportunity, the terms “consortium” and “network” are used interchangeably.

Network Director – An individual designated by the award recipient institution to lead the program supported by the award through providing the vision and goals for the network and for guiding all partners towards network-wide goals. The network director is responsible and accountable to the recipient organization officials for the proper conduct of the project or program. The entity (award recipient) is, in turn, legally responsible and accountable to HRSA and HHS for the performance and financial aspects of the award-supported activity. The interim network director may be employed by or under contract to the award recipient organization. The permanent network director may be under contract to the award recipient and the contractual agreement must be explained.

Network Governance Plan – A written summary outlining the goals, governance structure, and roles of each network member. This provides a reporting structure, voting capacity, and shows evidence of effective personnel, adequate FTEs, and financial policies and procedures in place to run the network and program operations, including a description of the income sources to finance the operations of the network (i.e., member dues, sales of network services etc.). For this program, the Network Governance Plan must clearly delineate a commitment of rural health and shared control of rural healthcare facilities.

Project Director – An individual designated by the award recipient institution to direct implementation of the project or program being supported by the award. The Project Director is responsible to the award recipient for organizing and carrying out project-related activities across the network and ensuring compliance with program requirements.

Non-profit – any corporation, trust, association, cooperative, or other organization, not including IHEs [institutions of higher education], that: (1) Is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; (2) Is not organized primarily for profit; and (3) Uses net proceeds to maintain, improve, or expand the operations of the organization.

Notice of Award – The legally binding document that serves as a notification to the recipient and others that funds have been awarded, contains or references all terms of the award and documents the obligation of federal funds in the HHS accounting system.

Payers – any entity responsible for providing coverage to patients and for the payment of healthcare. This includes but is not limited to private health insurance companies, State Medicaid, federal Medicaid, Medicare, Medicare Advantage, and other types of health plans.

Project – All proposed activities specified in an application as approved for funding.

Period of Performance – The total time for which support of a discretionary project has been approved. A period of performance may consist of one or more budget periods.
The total period of performance comprises the original period of performance and any extension periods.

Promising Practice Model – A model with at least preliminary evidence of effectiveness in small-scale interventions or for which there is potential for generating data that will be useful for making decisions about taking the intervention to scale and generalizing the results to diverse populations and settings." An example of a promising practice is a small-scale pilot program that generates positive outcome results and justifies program expansion to new access points and/or service populations.

Rural – All counties that are not designated as parts of Metropolitan Areas (MAs) by the Office of Management and Budget (OMB) are considered rural. To determine the rural eligibility, please refer to the Rural Health Grants Eligibility Analyzer (hrsa.gov).

Rural Hospital – Any short-term, general, acute, non-federal hospital that is not located in a metropolitan county, is located in a RUCA type 4 or higher, or is a Critical Access Hospital.

Shared governance – A collaborative approach where every network member has equal say in the direction and strategy of the network towards common goals. For example, the lead organization incorporates feedback across all network members no matter the size, influence, or revenue for the purposes of improving care coordination for the patient population.

State – any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and any agency or instrumentality thereof exclusive of local governments.

System of Care – A service delivery approach that uses community partnerships to create a coordinated array of broad and flexible services. The network, led by a core set of principles and values, will work together with the community to create or improve upon equitable systems, workflows and strategies to improve health outcomes.

Telehealth – The use of electronic information and telecommunications technologies to support remote clinical services and remote non-clinical services.

1. *Telecommunication technologies* include but are not limited to: mobile health, video conferencing (with or without video), digital photography, store-and forward/asynchronous imaging, streaming media, wireless communication, telephone calls, remote patient monitoring through electronic devices such as wearables, mobile devices, smartphone apps; internet-enabled computers, specialty portals or platforms that enable secure electronic messaging and/or audio or video communication between providers or staff and patients not including EMR/EHR systems;
2. *Remote clinical services* include but are not limited to: telemedicine, physician consulting, screening and intake, diagnosis and monitoring, treatment and prevention, patient and professional health-related education, and other medical decisions or services for a patient;
3. *Remote non-clinical services* include but are not limited to: provider and health professionals training, research and evaluation, the continuation of medical education, online information and education resources, individual mentoring and instruction, health care administration including video conferences for managers of integrated health systems, utilization and quality monitoring;
   NOTE: if a telecommunication technology, remote clinical or remote non-clinical service is missing, please reach out to HRSA for further clarification.

Tribal Government – Includes all federally recognized tribes and state-recognized tribes.

Tribal Organization – Includes an entity authorized by a tribal government or consortia of tribal governments.

Vulnerable Populations – Vulnerable populations are communities that face significant barriers to better health and whose circumstances have made them susceptible to poor health. Vulnerable populations encounter significant disparities in life expectancy, limited access to and use of health care services, and increased morbidity and mortality rates linked to developmental problems, personal incapacities, disadvantaged social status, inadequacy of interpersonal networks and supports, degraded neighborhoods and environments, and the complex interactions of these factors over the life course.

Some characteristics of vulnerable and underserved populations include individuals who share one or more of the following characteristics. They may:

- Have a high risk for multiple health problems and/or pre-existing conditions
- Have limited life options (i.e., financial, educational, housing)
- Display fear and distrust in accessing government programs or disclosing sensitive information about family members

Appendix C: Page Limit Worksheet

The purpose of this worksheet is to give you a tool to ensure the number of pages uploaded into your application is within the specified page limit (do not submit this worksheet as part of your application).

The Standard Forms listed in Column 1 do not count against the page limit; however, attachments to the Standard Forms listed in column 2 do count toward the page limit. For example, the Budget Narrative Attachment Form does not count; however, the attachment uploaded in that form does count against the page limit.

Standard Form Name ***(Forms themselves do not count against the page limit)***	**Attachment File Name** ***(Unless otherwise noted, attachments count against the page limit)***	**# of Pages** ***Applicant Instruction – enter the number of pages of the attachment to the Standard Form***
Application for Federal Assistance (SF-424-Box 14)	Areas Affect by Project (Cities, Counties, States, etc.)	*(Does not count against the page limit)*
Application for Federal Assistance (SF-424-Box 16)	Additional Congressional District	*(Does not count against the page limit)*
Application for Federal Assistance (SF-424 – Box 20)	Is the Applicant Delinquent on Any Federal Debt	*(Does not count against the page limit)*
Attachments Form	Attachment 1: State Office of Rural Health Letter	*(Does not count against the page limit)*
Attachments Form	Attachment 2: Staffing Plan and Job Descriptions for Key Personnel	*(Does not count against the page limit)*
Attachments Form	Attachment 3: Applicant Organization's Organizational Chart AND the Network's Organizational Chart and List	*(Does not count against the page limit)*
Attachments Form	Attachment 4: Signed Letters of Commitment from all Network Members	*(Does not count against the page limit)*
Attachments Form	Attachment 5: Exceptions Request	*(Does not count against the page limit)*
Attachments Form	Attachment 6: Proof of Funding Preference Designation/Eligibility	*(Does not count against the page limit)*
Attachments Form	Attachment 7: HRSA Federal Office of Rural Health Policy Funding History	*My attachment =* _____ *pages*

Attachments Form	Attachment 8: Work Plan	*My attachment =* _____ *pages*
Attachments Form	Attachment 9: Network Governance Plan	*My attachment =* _____ *pages*
Attachments Form	Attachment 10	*My attachment =* _____ *pages*
Attachments Form	Attachment 11	*My attachment =* _____ *pages*
Attachments Form	Attachment 12	*My attachment =* _____ *pages*
Attachments Form	Attachment 13	*My attachment =* _____ *pages*
Attachments Form	Attachment 14	*My attachment =* _____ *pages*
Attachments Form	Attachment 15	*My attachment =* _____ *pages*
Project/Performance Site Location Form	Additional Performance Site Location(s)	*My attachment =* _____ *pages* *(Form does not count, attachment to the form counts)*
Project Narrative Attachment Form	Project Narrative	*My attachment =* _____ *pages* *(Form does not count, attachment to the form counts)*
Budget Narrative Form	Budget Narrative	*My attachment =* _____ *pages* *(Form does not count, attachment to the form counts)*
# of Pages Attached to Standard Forms		Applicant Instruction: Total the number of pages in the boxes above.
Page Limit for HRSA-23-125 is 60 pages		***My total =*** _____ ***pages***