STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
RURAL HEALTH TRANSFORMATION PROGRAM

REQUEST FOR APPLICATIONS (RFA)
INITIATIVE GUIDANCE DOCUMENT (BUNDLE ONE)
PREVENTIVE CARE & CARE-AT-HOME

Initiatives 2, 3, 10, 12, and 13 — All Five Required

RFA Number:	033-25/26
Release Date:	April 21, 2026
Applications Due:	June 10, 2026
Agency Sole Point of Contact:	Trey Collins, Bureau of Purchasing and Contract Administration
Federal Funding Source:	Centers for Medicare & Medicaid Services (CMS)
Cooperative Agreement:	No. 1RHTSSCMS332067-01-00
Period of Performance:	December 29, 2025 – October 30, 2030
Year 1 Period of Performance:	August 1, 2026 (or date of execution) - July 30, 2027
Total Bundle Funding (Yr 1):	$60,500,000 statewide (all five initiatives combined)
Strategic Domain:	Sustainable Access | Tech Innovation
Issuing Agency:	Florida Agency for Health Care Administration (Agency)

List of Attachments

The following Attachments are hereby incorporated into this RFA and will be utilized during the application process as specified in this RFA.

Attachment I – RHTP Standard Terms and Administrative Requirements
Attachment II – Required Applicant Response Documents (Sections A – M Response Forms)
Attachment III – Notice of Award
Attachment IV – Agency Standard Grant Agreement
Attachment V – Reviewer Evaluation Rubric

⚠ HOW TO USE THIS DOCUMENT
This document is the complete Request for Applications (RFA) for the Preventive Care and Care-at-Home Bundle under the Florida Rural Health Transformation Program (RHTP). It consolidates the bundle-level requirements and all five initiative-specific requirements into a single document. Applicants should read this document in its entirety. Sections 1–4 establish bundle-wide rules. Sections 5–9 contain the program-specific requirements for each of the five bundle initiatives. Section 4 contains the evaluation information. This document must be read in conjunction with Attachment I, RHTP Standard Terms and Administrative Requirements, which governs federal compliance, rural eligibility definitions, super region structures, subrecipient monitoring, reporting requirements, and standard administrative conditions. References to that document appear throughout.

Applicant Questions and Agency Guidance

Questions regarding this RFA must be submitted in writing to RHTPApplications@ahca.myflorida.com by the deadline specified in the RFA timeline. Only written responses officially posted to the MyFloridaMarketPlace (MFMP) Vendor Information Portal (VIP) constitute binding Agency guidance.

SECTION 1: BUNDLE OVERVIEW AND STRUCTURE

1.1 Purpose and Bundle Composition

The Preventive Care and Care-at-Home Bundle is a collection of multiple initiatives under Florida's Rural Health Transformation Program (RHTP), administered by the Florida Agency for Health Care Administration (Agency) under Centers for Medicare and Medicaid Services (CMS) Cooperative Agreement No. 1RHTSSCMS332067-01-00. All five initiatives within this bundle are required and must be delivered together as an integrated program. An applicant may not apply for a subset of the bundle.

The bundle is designed to create a coordinated continuum of rural preventive care and care-at-home services: mobile health units identify patients in community settings; community paramedicine extends clinical follow-up into rural homes; remote patient telemonitoring provides ongoing chronic disease oversight; retail pharmacy clinics serve as accessible non-emergency care sites; and HIE/ENS onboarding provides the shared data infrastructure that connects all four clinical programs.

Initiative #	Role	Initiative Name	Yr 1 Funding	Lead Eligible?
#2	Lead	Mobile Health	$20,000,000	Yes
#3	Lead	Community Paramedicine / Mobile Integrated Health (MIH)	$18,000,000	Yes

Initiative #	Role	Initiative Name	Yr 1 Funding	Lead Eligible?
#10	Service Component	Remote Patient Telemonitoring (RPTM)	$14,000,000	No
#12	Lead	On-Site Pharmacy / Retail Clinic Services	$6,000,000	Yes
#13	Service Component	Florida HIE Infrastructure / Event Notification System (ENS) Onboarding	$2,500,000	No
BUNDLE TOTAL			**$60,500,000**	

Note on Initiative 13 Funding: The total RHTP HIE/ENS Onboarding statewide allocation of $5,000,000 is split equally between this bundle (Preventive Care and Care-at-Home) and Bundle 2 (Hospital-Enabled Specialty and Acute Care). The share available under this RFA is $2,500,000.

⚠ How the Bundle Works Together
Mobile Health (Initiative 2) serves as the upstream entry point, reaching patients in the community before they reach a care crisis. Mobile health units identify patients with unmet chronic disease, post-discharge, and care coordination needs and refer them into the Community Paramedicine (Initiative 3) care pathway for in-home follow-up. Remote Patient Telemonitoring (Initiative 10) devices are deployed during Community Paramedicine home visits to enable ongoing chronic disease monitoring; alert data drives prioritized follow-up. Retail Clinic Services (Initiative 12) serve as a non-emergency referral destination for step-down care from mobile and CP encounters. All five initiatives share data infrastructure through Florida HIE/ENS Onboarding (Initiative 13), which provides the real-time event notification backbone for post-discharge follow-up, care coordination, and outcome documentation across the full program.

1.2 Lead Initiative and Service Component Designations

The bundle requires that the lead applicant establish primary program identity through one of three qualifying lead initiatives: Initiative 2 (Mobile Health), Initiative 3 (Community Paramedicine / MIH), or Initiative 12 (Retail Clinic Services). These three initiatives may serve as the basis for the lead applicant's primary programmatic identity and organizational qualification.

Initiatives 10 (RPTM) and 13 (HIE/ENS Onboarding) are required service components. An entity may not apply as a bundle lead with Initiative 10 or Initiative 13 as the primary lead initiative. All five bundle initiatives — including RPTM and HIE/ENS — must be fully incorporated in the bundle application and program model regardless of which initiative establishes lead identity.

⚠ Critical Bundle Requirement
A bundle application that does not include dedicated program narrative, budget content, and implementation plan for all five initiatives will be deemed non-responsive and will not proceed

to scored review. Lead initiative identity (Initiative 2, 3, or 12) determines the qualifying program identity of the lead applicant. It does not make the remaining four initiatives optional.

1.3 Statewide and Super Region Funding

The table below summarizes Year 1 funding available for the Preventive Care and Care-at-Home Bundle statewide and by Super Region. Lead applicants must identify the Super Region(s) in which they propose to operate and must not exceed the funding ceiling for any Super Region in which they apply.

Super Region	Initiative 2	Initiative 3	Initiative 10	Initiative 12	Initiative 13	Regional Total
Northwest (NW)	$4,507,879	$4,057,879	$3,155,516	$1,352,364	$563,485	**$13,637,123**
Northeast (NE)	$8,795,507	$7,915,957	$6,156,855	$2,638,652	$1,099,438	**$26,606,409**
Southwest (SW)	$5,157,141	$4,641,427	$3,609,999	$1,547,142	$644,643	**$15,600,352**
Southeast (SE)	$1,539,472	$1,385,525	$1,077,631	$461,842	$192,434	**$4,656,904**
STATEWIDE TOTAL	**$20,000,000**	**$18,000,000**	**$14,000,000**	**$6,000,000**	**$2,500,000**	**$60,500,000**

📋 *See Attachment I, RHTP Standard Terms and Administrative Requirements, Section 3 (Super Regions) for county lists and Super Region boundary definitions. Applicants must read this RFA in conjunction with that document, which governs all cross-initiative federal compliance provisions, subrecipient requirements, public records, and Standard Grant Agreement terms.*

1.4 Award Structure

📋 *See Attachment I, RHTP Standard Terms and Administrative Requirements, Sections 1.3 (Period of Performance and Budget Period Structure) and 12 (Award Administration) — Award structure, budget period schedule, Non-Competing Continuation (NCC) requirements, payment structure, and continuation contingencies are governed by those sections. Applicants must read this RFA in conjunction with that document, which governs all cross-initiative federal compliance provisions, subrecipient requirements, public records, and Standard Grant Agreement terms.*

1.5 Statewide Outcome Measures

The following outcome metrics and targets are drawn directly from the RHTP Project Narrative submitted to and approved by CMS under Cooperative Agreement No. 1RHTSSCMS332067-01-00. These are the statewide measures the Agency is required to report to CMS. Awardees funded under bundle initiatives are required to collect and submit data that feeds into these statewide measures. The Agency will aggregate awardee data to report against these targets; individual awardees are not expected to achieve these outcomes in isolation.

Statewide Outcome Metric (from CMS-Approved Project Narrative)	Statewide Target
Ambulatory Care-Sensitive Hospitalization (ACSH) rate per 100,000	838.2 (baseline) → 754.4 by FFY 2031
Rural residents with a usual source of care	71% (baseline) → 80% by FFY 2030
Mobile health units deployed serving all rural counties	25 units serving all 31 rural counties by FFY 2030
Preventive screening rates for diabetes and hypertension (rural Florida)	55% (baseline) → 66% by FFY 2030 (approx. 5% annual increase from FFY 2027)
Missed appointment rate in rural service areas	18% (baseline) → 16.2% by FFY 2030
Preterm birth rate	10.7% (baseline) → 9.0% by FFY 2030
Infant mortality rate per 1,000 live births	6.0 (baseline) → 5.0 by FFY 2030
Rural pharmacies enrolled in on-site care program	0 (baseline) → 50 by FFY 2030 (FFY 2027: 10; FFY 2028: 15; FFY 2029: 25)

Note: Year 1 establishes county-level and site-level baseline data for metrics where no pre-program baseline exists. Program-specific targets for Years 2–5 will be confirmed following Year 1 baseline collection and communicated through the RHTP data dictionary and performance reporting templates issued post-award.

SECTION 2: ACRONYMS AND DEFINITIONS

2.1 Acronyms

The following table consolidates acronyms used across all bundle initiative documents. Each acronym is spelled out on first use in the body of this document. This list is in addition to the list in Section 2 of Attachment I, RHTP Standard Terms and Administrative Requirements.

Acronym	Definition
510(k)	FDA premarket notification clearance pathway
ACSH	Ambulatory Care-Sensitive Hospitalization
ADT	Admission, Discharge, and Transfer
ALS	Advanced Life Support
API	Application Programming Interface
APRN	Advanced Practice Registered Nurse
ARNP	Advanced Registered Nurse Practitioner

Acronym	Definition
BAA	Business Associate Agreement
BLS	Basic Life Support
BRFSS	Behavioral Risk Factor Surveillance System
CAH	Critical Access Hospital
CCD	Continuity of Care Document
CHD	County Health Department
CHF	Congestive Heart Failure
CHW	Community Health Worker
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
COPD	Chronic Obstructive Pulmonary Disease
CP	Community Paramedicine
CPT	Current Procedural Terminology (billing codes)
EHR	Electronic Health Record
EMR	Electronic Medical Record
EMS	Emergency Medical Services
ENS	Event Notification System
ePCR	Electronic Patient Care Record
FDA	U.S. Food and Drug Administration
FFATA	Federal Funding Accountability and Transparency Act
FFY	Federal Fiscal Year
FHIR	Fast Healthcare Interoperability Resources (HL7 standard)
FQHC	Federally Qualified Health Center
HbA1c	Glycated Hemoglobin (diabetes control measure)
HIE	Health Information Exchange (Florida HIE Infrastructure)
HIPAA	Health Insurance Portability and Accountability Act

Acronym	Definition
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HL7	Health Level Seven International (health data interoperability standard)
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IBSC	International Board of Specialty Certification
IGD	Initiative Guidance Document
MCO	Managed Care Organization
MIH	Mobile Integrated Health
MOU	Memorandum of Understanding
MTM	Medication Therapy Management
NOA	Notice of Award
OB/GYN	Obstetrics / Gynecology
PA	Physician Assistant
PDSA	Plan-Do-Study-Act
PHI	Protected Health Information
PMA	Premarket Approval (FDA device approval pathway)
POCT	Point-of-Care Testing
REDI	Rural Economic Development Initiative (Florida Commerce)
RFA	Request for Applications
RHC	Rural Health Clinic
RHTP	Rural Health Transformation Program
RPTM	Remote Patient Telemonitoring
RUCA	Rural-Urban Commuting Area (codes 4–10 indicate rural areas)
SAM.gov	System for Award Management
UEI	Unique Entity Identifier
USPSTF	U.S. Preventive Services Task Force

Acronym	Definition
VBP	Value-Based Payment
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

2.2 Key Terms and Definitions

Term	Definition
ADT Notifications	Admission, Discharge, and Transfer — real or near real-time HL7 notifications generated by hospital and other provider electronic record systems and transmitted through the Florida Health Information Exchange ENS to authorized recipients to support care coordination.
Alert Threshold	A clinically defined parameter value or range, established under medical direction, that triggers a notification to the supervising clinician or care team for assessment and care coordination response.
Alternative Destination Protocol	A medically directed protocol that authorizes EMS personnel to transport or refer a patient to a destination other than an emergency department when clinically appropriate, including primary care providers, urgent care, or pharmacy-based clinic sites.
Clinical Response Protocol	A documented, medically directed process defining the required care coordination response action, responsible clinician or care team role, and maximum response timeline for each category of alert generated by an RPTM monitoring platform.
Community Paramedicine (CP)	A model of care in which licensed EMS personnel are trained under medical direction to provide non-emergency preventive, chronic disease, and post-discharge follow-up services in community and home settings beyond the scope of traditional emergency response.
Diagnostic Telehealth Kiosk	A self-contained technology station within a pharmacy that enables patients to connect with remote licensed clinicians for real-time assessment, diagnosis, and treatment recommendations for low-acuity conditions, using FDA-cleared diagnostic peripherals.
Event Notification System (ENS)	The Florida solution provided by the Florida HIE program that transmits admission, discharge, and transfer notifications to authorized recipients to support care coordination and continuity of care.
FDA-Cleared Device	A monitoring device that has received 510(k) clearance or Premarket Approval (PMA) from the U.S. Food and Drug Administration for the intended clinical use.
Florida HIE Infrastructure	The statewide health information exchange based on the connectivity of health care entities through national exchange platforms enabling secure electronic sharing of clinical information across participating provider organizations and authorized users.

Term	Definition
Medical Director Prescribed Training	Training content, competency standards, and clinical protocols for community paramedicine services established by the program Medical Director. IBSC CP-C certification is not required in Florida; there is no state-approved CP training curriculum.
Mobile Health Unit	A vehicle-based clinical service delivery platform equipped to deliver preventive, diagnostic, prenatal, and patient education services at scheduled community route stops. Units must be leased or operated under contract; vehicle purchase is not an allowable program cost.
Monitoring Platform	A HIPAA-compliant software system that receives, stores, displays, and transmits patient-generated health data from connected devices to authorized clinical users.
Onboarding (HIE/ENS)	The full set of activities required to move a provider site from non-participation to active operational participation in the Florida HIE infrastructure and/or ENS environment, including assessment, technical connection, testing, workflow design, training, and go-live support.
Operational Use (HIE/ENS)	Routine use of HIE and/or ENS information in clinical, care management, discharge planning, quality, or transitional care workflows, as evidenced by policies, logs, staffing assignments, and reporting.
Point-of-Care Testing (POCT)	Diagnostic testing performed at or near the patient's location, including blood pressure monitoring, blood glucose, rapid antigen testing (strep, influenza, COVID-19), lipid screening, and other tests authorized under applicable scope of practice.
Post-Discharge Monitoring	Remote monitoring services initiated within a defined period following a patient's discharge from an inpatient or emergency care setting, intended to support care transitions and reduce readmissions.
Remote Patient Telemonitoring (RPTM)	The use of digital technologies to collect physiological and clinical data from a patient in one location and transmit it electronically to a clinician or care team in a different location for assessment and care coordination management.
Retail Clinic / On-Site Pharmacy Clinic	A private, protocol-based clinical service area established within an existing rural pharmacy where licensed providers deliver non-emergency health services, point-of-care diagnostics, and preventive care within their scope of practice under Florida law.
Scheduled Route	A documented, recurring mobile health service schedule identifying specific community stop locations, service dates, times, and services offered. Routes must serve multiple rural communities within a Super Region.
Scope of Practice	The range of services a licensed provider is currently authorized to perform under applicable Florida statutes, rules, and Board regulations — without any expansion, modification, or addition of authority.

Term	Definition
Super Region	One of four RHTP-defined geographic service areas (Northwest, Northeast, Southwest, Southeast Florida). Funding allocations, award structures, and program service areas are organized by Super Region. See Attachment I, RHTP Standard Terms and Administrative Requirements, Section 3.

SECTION 3: BUNDLE-LEVEL REQUIREMENTS

3.1 Lead Applicant Eligibility

To submit a bundle application, the lead applicant must meet all baseline eligibility requirements in Attachment I, RHTP Standard Terms and Administrative Requirements, establish primary program identity through Initiative 2, 3, or 12, and demonstrate organizational capacity to deliver — directly or through formal partners — all five required bundle initiative components.

📋 *See Attachment I, RHTP Standard Terms and Administrative Requirements, Section 5 (General Eligibility Requirements) — SAM.gov registration, UEI, debarment certification, entity authorization, and financial solvency documentation requirements are established there. Applicants must read this RFA in conjunction with that document, which governs all cross-initiative federal compliance provisions, subrecipient requirements, public records, and Standard Grant Agreement terms.*

3.2 Required Bundle Partnership Structures

Because the bundle requires five distinct program components, lead applicants are expected to establish formal partnerships with organizations that can deliver components not directly operated by the lead applicant. At minimum, the bundle application must document:

- A clinical oversight structure covering all five initiative service areas, including a named or recruited Medical Director or supervising licensed clinician for the RPTM service component.
- At least one executed MOU or Letter of Intent with a primary care provider, FQHC, RHC, or hospital for clinical supervision of monitoring patients and care coordination.
- A documented plan for HIE/ENS onboarding coordination with the Florida HIE infrastructure and ENS for all participating provider sites across all bundle initiatives.
- Where the lead initiative is Initiative 2 (Mobile Health) or Initiative 12 (Retail Clinic Services), a documented partnership or organizational capacity to deliver Community Paramedicine services as a required bundle component.

📋 *See Attachment I, RHTP Standard Terms and Administrative Requirements, Section 1.7 (Formal Partnerships and Collaboration). Applicants must read this RFA in conjunction with that document, which governs all cross-initiative federal compliance provisions, subrecipient requirements, public records, and Standard Grant Agreement terms.*

3.3 General Allowable and Unallowable Uses of Funds

The following restrictions apply to all five bundle initiatives. Initiative-specific allowable and unallowable uses are described in Sections 5–9 of this document.

- **Clinician salaries for direct clinical care services are not allowable** under any bundle initiative. Grant funds may not be used to pay licensed providers for delivering clinical services to patients. Program coordination staffing, care coordination staffing, training, and administrative support are allowable where directly attributable to the funded program.
- Capital construction or major building renovations are not allowable.
- Administrative costs are limited to 3% of the total award amount.
- Funds may not be used to replace or supplant existing funding for services already funded by Medicaid, HRSA, Title X, WIC, or other federal or state programs.

📋 *See Attachment I, RHTP Standard Terms and Administrative Requirements, Section 14 (Standard Cost Restrictions Reference Table) for the complete list. Applicants must read this RFA in conjunction with that document, which governs all cross-initiative federal compliance provisions, subrecipient requirements, public records, and Standard Grant Agreement terms.*

3.4 Rural Eligibility and Service Areas

📋 *See Attachment I, RHTP Standard Terms and Administrative Requirements, Section 4 (Rural Eligibility Definitions — Four-Pathway Framework) and Section 3 (Super Region Structure) — All RHTP-funded activities must be delivered in and directly serve eligible rural communities. Four recognized pathways establish rural eligibility: CMS Goldsmith Modification, Florida Statute §288.0656, Florida Commerce REDI designation, and HRSA RUCA codes 4–10 / rural census tract ZIP codes. Applications must document rural eligibility for each proposed service location. Applicants must read this RFA in conjunction with that document, which governs all cross-initiative federal compliance provisions, subrecipient requirements, public records, and Standard Grant Agreement terms.*

3.5 Award Considerations — Geographic Need and Regional Coverage

📋 *The Agency reserves the right to make bundle awards based on geographic need and regional coverage. The Agency may decline to fund programs proposing to serve geographic areas already covered by an awarded program under the same initiatives when the Agency determines that additional funding would result in duplicative services or regional saturation. Award recommendations will consider the distribution of funded programs across Super Regions and rural counties. These determinations are committed to Agency discretion.*

RFA Continued on Next Page.

SECTION 4: APPLICATION SUBMISSION REQUIREMENTS AND EVALUATION

4.1 Application Documents and Submission Requirements

4.1.1 Application Structure and Submission

All bundle applications must be submitted as a single, unified application package by the deadline specified in this RFA. The application package must include program narrative and budget content for all five required bundle initiatives organized as integrated sections within the single submission. Applications that address only the lead initiative without full integration of all five required components will be deemed non-responsive.

📋 *See Attachment I, RHTP Standard Terms and Administrative Requirements, Section 6 (Standard RFA Procedures) — submission system, format requirements, late application policy, and disqualification criteria. Applicants must read this RFA in conjunction with that document, which governs all cross-initiative federal compliance provisions, subrecipient requirements, public records, and Standard Grant Agreement terms.*

4.1.2 Application Sections and Page Limits

The following Agency-provided documents and required applicant documents must be submitted with the application in order to be eligible for award. Each section must not exceed the page limits identified in the below table.

Application Section	Maximum Page Limit	Requirements
Section A – Cover Page and Applicant Information	3 pages	Must include Attachment II, Section A Form.
Section B – Executive Summary	5 pages	Must include Attachment II, Section B Form. Executive summary as a one-page abstract. Must provide: Program goals; target population or workforce; proposed model; anticipated rural impact; and alignment with RHTP strategic goals.
Section C – Organizational Capacity and Eligibility	10 pages	Must include Attachment II, Section C Form. Five-year operational history; governance structure; key personnel. *Financial solvency documentation: see* Attachment I, RHTP Standard Terms and Administrative Requirements, Section 7.I.

Application Section	Maximum Page Limit	Requirements
Section D – Project Narrative (Maximum: 50 pages)		
Initiative 2 – Mobile Health Project Narrative	10 pages	Service model; route design; target population; CHW integration; clinical protocols for preventive screening and prenatal services; coordination with all co-bundle initiatives.
Initiative 3 – Community Paramedicine / MIH) Project Narrative	10 pages	Care pathway model; response zone coverage; staffing and clinical oversight; integration with hospital systems and EMS; coordination with all co-bundle initiatives.
Initiative 12 – On-Site Pharmacy / Retail Clinic Services Project Narrative	10 pages	Pharmacy-based clinical service model; scope of practice compliance; provider credentialing; integration with fixed-site and mobile providers; coordination with all co-bundle initiatives.
Initiative 10 – Remote Patient Telemonitoring (RPTM) Service Component Project Narrative	5 pages	Patient enrollment criteria; device specifications and FDA clearance; monitoring platform and HIPAA compliance; alert protocols; care coordination response model; coordination with CP and HIE/ENS.
Initiative 13 – Florida HIE/ENS Onboarding Service Component Project Narrative	5 pages	Provider onboarding strategy; HIE/ENS connectivity plan; workflow redesign; training approach; interoperability standards compliance; operational use documentation plan.
All Initiatives – Bundle Integration and Coordination Plan Project Narrative	10 pages	How all five initiatives function as an integrated program; referral workflows across initiatives; data sharing among all five components; regional coordination governance.
Section E – Partnership Agreements	No limit	Executed MOUs, LOIs, and partnership agreements for all formal partners; clinical supervision agreements. *MOU*

Application Section	Maximum Page Limit	Requirements
		requirements: see Attachment I, RHTP Standard Terms and Administrative Requirements, *Section 1.7.*
Section F – Implementation Work Plan and Milestones (all 5 initiatives)	10 pages	Timeline with initiative-specific milestones; FFY-specific output targets; risk identification and mitigation for each bundle component.
Section G – Data Collection, Reporting, and Continuous Quality Improvement (CQI) Plan	5 pages	Must include Attachment II, Section G Form. Systems, workflows, and named responsible roles for all required metrics across all five bundle initiatives; data quality assurance procedures. Quality management framework using PDSA cycles or equivalent methodology; methods for identifying performance challenges; use of data for program improvement; internal review schedule; commitment to participate in Agency-convened RHTP learning collaboratives and external evaluation activities. *See* Attachment I, RHTP Standard Terms and Administrative Requirements, *Section 7 (Application Section G — CQI Plan) and Section 13.3 (Continuous Quality Improvement) for full requirements.*
Section H – Sustainability Plan	7 pages	Must include Attachment II, Section H Form. Payer reimbursement strategy for each initiative; RPTM billing codes (CPT 99453, 99454, 99457, 99458); HIE/ENS operational continuity; value-based payment integration where applicable.
Section I – Financial Solvency	3 pages	Must include Attachment II, Section I Form. *See* Attachment I, RHTP Standard Terms and Administrative Requirements, *Section 7.I.*

Application Section	Maximum Page Limit	Requirements
Section J and K – Budget and Budget Narrative (all 5 initiative components)	10 pages	Must include Attachment II, Section J and K Forms. Agency-provided budget template must be completed separately for each initiative. Budget amounts must not exceed Super Region ceilings. Administrative costs limited to 3%. *Allowable cost standards: see* Attachment I, RHTP Standard Terms and Administrative Requirements*, Section 14.*
Sections L and M – Required Certifications and Protective Clauses Certification	No limit	Must include Attachment II, Section L and M Forms. RPTM: FDA device clearance, monitoring platform BAA or LOI, Medical Director attestation or recruitment plan. *All required certifications: see* Attachment I, RHTP Standard Terms and Administrative Requirements*, Sections 7.L and 7.M.*

4.2 Evaluation Overview

Bundle applications are evaluated in two sequential stages. Stage 1 is a Pass/Fail compliance review conducted by the Agency. Applications that receive a Fail determination on any single Stage 1 item will be deemed ineligible and will not proceed to Stage 2 technical evaluation. Stage 2 evaluates based on specific, verifiable indicators. Applications are ranked within each Super Region by total Stage 2 score against available funding.

4.2.1 Stage 1: Bundle Mandatory Criteria Review (Pass/Fail)

Submission of all items in Sections 4.1.2 are mandatory, and the Agency will conduct a Pass/Fail review of these items. A finding of “Fail” on any single item renders the bundle application ineligible. Pass/Fail determinations are not subject to partial credit.

Additionally, all submission requirements in Attachment I, RHTP Standard Terms and Administrative Requirements, must be included in the application in order to receive a “Pass” determination by the Agency.

4.2.2 Stage 2: Bundle Technical Evaluation

Applications will be evaluated by an independent review panel. Because all five bundle initiatives are required, each initiative component is evaluated. Failure to adequately address any bundle component may render an application ineligible for award.

Application Section	Evaluation Criteria (Applications will be evaluated based on the extent to which the application meets or exceeds the following criteria)
Application Section C – Organizational Capacity and Eligibility	Five-year organizational history documented with verifiable evidence; governance structure names a Clinical Lead or Program Director with FTE commitment ≥25%; two most recent audited or CPA-reviewed financial statements show positive net assets or document a corrective plan; all five bundle initiatives identified with lead initiative established as Initiative 2, 3, or 12; lead applicant demonstrates documented operational presence in eligible rural service area.
Application Section D – Initiative 2: Mobile Health Program Narrative	All required Mobile Health program components addressed: service model describes mobile unit operations with specific rural service areas, counties, and ZIP codes documented; scheduled route design identifies stop locations with rural eligibility documented; CHW certification plan with timeline documented; EHR or ePCR system identified with documented plan to connect to Florida HIE/ENS within 90 days of award; prenatal service model addresses first-trimester risk assessment, obstetric referral pathway; referral tracking workflow described; coordination mechanisms with all four co-bundle initiatives described operationally.
Application Section D – Initiative 3: Community Paramedicine / MIH Program Narrative	Regional service model covers multiple rural counties within the proposed Super Region with response zone coverage documented; all three required service pathways addressed with patient eligibility criteria and clinical protocols: post-discharge follow-up; chronic disease monitoring (diabetes, COPD, CHF, hypertension all addressed); non-emergent EMS diversion / alternative destination with Year 1 alternative destination protocol and Year 2 on-scene protocol phasing described; EMS licensure and medical direction documented or recruitment plan with timeline included; ePCR connectivity to Florida HIE/ENS documented; alert-to-response workflow from RPTM monitoring data to CP care coordination described; coordination with all four co-bundle initiatives described operationally.
Application Section D – Initiative 12: Retail Clinic Services Program Narrative	Each proposed pharmacy site confirmed as currently operating in an eligible rural area with active Florida pharmacy permit documented; scope of practice compliance notice acknowledged and clinical service model consistent with licensed provider types; on-site clinic area or telehealth kiosk model described with patient flow and service delivery protocols; clinical supervision structure documented with licensed prescriber identified or recruitment plan with timeline; HIE/ENS

Application Section	Evaluation Criteria (Applications will be evaluated based on the extent to which the application meets or exceeds the following criteria)
	connectivity plan documented for each proposed site; referral pathway to Mobile Health and Community Paramedicine described; coordination with all four co-bundle initiatives described operationally.
Application Section D – Initiative 10: Remote Patient Telemonitoring (RPTM) Service Component	RPTM subsection addresses all required components: enrollment criteria for at least three qualifying populations (chronic disease, post-discharge, high-risk maternal); each proposed device type named with FDA clearance documented; monitoring platform named with HIPAA BAA documented or committed; alert threshold protocols described with care coordination response timeframes; HIE/ENS integration plan with 90-day go-live timeline; RPTM budget separately itemized; rural service area co-extensive with lead initiative service area.
Application Section D – Initiative 13: HIE/ENS Onboarding Service Component	HIE/ENS subsection addresses all required components: specific provider sites proposed for onboarding identified by name, type, county, and rural eligibility; onboarding approach includes technical assessment, connectivity, workflow redesign, training, and go-live support with first site operational within first program year; operational use of ENS alerts in care coordination workflows documented for at least one site; data exchange standards (HL7, FHIR, ADT) addressed; training plan described; sustainability of HIE/ENS participation addressed; integration with all five bundle initiatives described.
Application Section D – All Initiatives: Bundle Integration and Coordination Plan	Cross-initiative coordination plan demonstrates: documented referral pathways connecting all five initiatives with named responsible parties and handoff protocols; shared data exchange architecture connecting EHR/ePCR systems across all five initiatives to Florida HIE/ENS; governance structure for bundle-level oversight; patient flow narrative demonstrating how a patient moves across two or more initiatives; CP alert-triggered response to RPTM monitoring data described with specific workflow; Mobile Health and Retail Clinic cross-referral pathways documented with referral tracking; HIE/ENS integration plan ties all five clinical programs to a common data exchange infrastructure.
Application Section F – Implementation Work Plan	Initiative-specific milestones for all five bundle components with specific target dates; FFY-level output targets for Years 1–5; at least two identified implementation risks per initiative with specific mitigations; key milestones include: lead initiative service launch within 180 days; RPTM first patient enrollment

Application Section	Evaluation Criteria (Applications will be evaluated based on the extent to which the application meets or exceeds the following criteria)
	within 120 days; HIE/ENS first site onboarding within 90 days; EHR/HIE connectivity within 90 days of program launch.
Application Section G – Data Collection, Reporting, and CQI Plan	Data collection plan identifies specific data systems and named staff roles for all required metrics across all five bundle initiatives; data submission workflows described for monthly, quarterly, and annual reporting cadences; at least three pre-submission data quality validation steps described; CQI framework uses Plan-Do-Study-Act (PDSA) cycles or equivalent methodology applied across all five initiatives; internal performance review schedule documented with named responsible parties and review frequency; at least one illustrative improvement cycle tied to a bundle-level or initiative-specific program metric; commitment to participate in Agency-convened RHTP learning collaboratives and cooperate with the External Evaluator documented.
Application Section H – Sustainability Plan	Sustainability plan addresses all five initiatives: RPTM billing codes identified (CPT 99453, 99454, 99457, 99458 or equivalent) with evidence of payer coverage; Mobile Health reimbursement pathway identified; Retail Clinic billing pathways for on-site and telehealth services identified; HIE/ENS operational continuity funded through participating provider agreements or state-level infrastructure commitment post-grant; Community Paramedicine reimbursement pathways (Medicaid, insurance, VBP) identified; value-based payment integration strategy described for at least one initiative.
Application Sections J and K – Budget and Cost Reasonableness	Budget itemized by initiative and cost category for all five bundle components; RPTM budget separately identified with device, platform, care coordination staffing, patient education, and reporting costs; administrative costs at or below 3%; all initiative budget amounts within Super Region funding ceilings; budget narrative provides rationale for unit costs; no unallowable costs identified.

📋 *See Attachment I, RHTP Standard Terms and Administrative Requirements, Section 6 governs all RFA procedures, pre-application conference, questions and official guidance, application submission requirements, standard format requirements, disqualification criteria, conflict of interest requirements, and administrative proceedings under Chapter 120, Florida Statutes. Applicants must read this RFA in conjunction with that document, which governs all*

cross-initiative federal compliance provisions, subrecipient requirements, public records, and Standard Grant Agreement terms.

The Agency reserves the right to amend this RFA, issue addenda, reject any or all applications, request clarifications, make multiple awards within and across Super Regions, make no award, or cancel this RFA if the Agency determines such action is in the best interest of the State. See Section 3.5 of this document for geographic coverage and regional saturation considerations.

📋 *Attachment I, RHTP Standard Terms and Administrative Requirements, Sections 8 (Standard Reporting Requirements), 9 (Sustainability Plan Requirements), 10 (Subrecipient Monitoring and Compliance), 11 (Federal Terms and Conditions), 12 (Award Administration), and 13 (Program Evaluation Framework) govern all cross-initiative obligations, federal compliance provisions, reporting cadences, subrecipient monitoring, and administrative requirements. These requirements are not repeated in this document.*

SECTION 5: INITIATIVE 2 — MOBILE HEALTH

Initiative Type:	Lead Initiative
Estimated Funding (Yr 1):	$20,000,000 statewide
Super Region Allocations:	NW $4,507,879 | NE $8,795,507 | SW $5,157,141 | SE $1,539,472

5.1 Overview and Purpose

The Mobile Health Initiative deploys mobile health units on scheduled routes across rural Florida, bringing preventive, diagnostic, prenatal, and chronic disease management services directly to rural communities. Initiative 2 is designed to eliminate geographic and transportation barriers to care by reaching patients at community locations — worksites, faith-based organizations, community centers — rather than requiring patients to travel to fixed-site facilities. Rural preventive screening rates for diabetes and hypertension stand at 55% statewide (Florida BRFSS, 2023); missed appointments occur at an 18% baseline rate in rural service areas (Agency Access Data, 2023). This initiative directly addresses both.

5.2 Eligible Applicants

The following entity types are eligible to serve as lead applicants under Initiative 2:

- Federally Qualified Health Centers (FQHCs).
- Rural Health Clinics (RHCs).
- Critical Access Hospitals (CAHs) with outpatient or community health capacity.
- County Health Departments (CHDs).
- Licensed primary care physician and advanced practice provider-led practices serving rural areas.

- Community-Based Organizations (CBOs) with documented mobile or community health outreach experience and a formal written clinical oversight arrangement with a licensed Florida healthcare provider.
- Area Agencies on Aging.
- Federally recognized tribal organizations.
- Regional healthcare collaboratives and consortia — a single lead entity must be identified and independently meet eligible applicant criteria.

Technology and vehicle vendors may participate only as subcontractors.

5.3 Key Program Components

5.3.1 Preventive Screening and Chronic Disease Services (Required)

- All mobile health programs must deliver standardized preventive screening for diabetes and hypertension at every scheduled route stop. Additional screenings (cancer, COPD, cardiovascular risk) are strongly encouraged.
- Screening protocols must align with USPSTF Grade A and B recommendations and must be documented using an EHR or ePCR system with Florida HIE/ENS connectivity.
- All positive screening results must trigger a documented referral to a fixed-site provider within one business day, with follow-up status tracked and reported.

5.3.2 Prenatal and Maternal Health Services (Required)

- All programs must include prenatal visit services focusing on first-trimester prenatal care initiation rates. Services must include at minimum: first-trimester risk assessment, blood pressure monitoring, gestational diabetes screening, nutritional counseling referral, and WIC enrollment assistance.
- Programs must document a formal clinical oversight relationship with an OB/GYN, CNM, or APRN credentialed in maternal care, either directly or through a formal written agreement with a fixed-site obstetric provider.
- All prenatal encounters must be documented in an EHR or ePCR system connected to the Florida HIE infrastructure.

5.3.3 Patient Education, CHW Navigation, and Rehabilitation Support (Required)

- At least one Florida-certified CHW, or a CHW actively pursuing Florida CHW certification under Section 381.0101, F.S., must be integrated into every mobile unit team. CHWs must achieve Florida certification within 6 months of award.
- CHWs are responsible for care navigation, health needs screening, and connecting patients to local health and human services resources. All CHW activities must be documented and generate reportable data.

5.3.4 Health Information Technology and EHR Connectivity (Required)

- Programs must deploy a mobile-compatible EHR or ePCR system capable of same-day documentation at all route stops, including in areas with limited broadband. EHR/ePCR must connect to the Florida HIE infrastructure and ENS within 90 days of award.
- Route scheduling, appointment management, and missed appointment tracking tools are required to support the statewide missed appointment reduction target.

5.3.5 Route Design, Scheduling, and Community Access Strategy (Required)

- Programs must operate on defined, documented scheduled routes serving multiple rural communities within a Super Region. Ad hoc deployments do not satisfy this requirement.
- Route coverage maps must document communities, ZIP codes, and counties served, with rural eligibility documented for each stop location.

5.3.6 Bundle Integration (Required)

- Mobile Health programs must establish documented referral pathways into the Community Paramedicine care pathway (Initiative 3) for patients needing in-home follow-up; coordinate RPTM device enrollment (Initiative 10) for chronic disease and high-risk maternal patients; coordinate with Retail Clinic Services (Initiative 12) as a step-down referral destination; and connect EHR/ePCR to Florida HIE/ENS (Initiative 13).

5.4 Allowable and Unallowable Uses (Mobile Health-Specific)

Allowable: Mobile unit leasing and outfitting ; mobile-compatible EHR or ePCR systems; Florida HIE/ENS connectivity integration; point-of-care diagnostic equipment (non-capital); CHW certification training and continuing education; clinical staffing costs attributable to mobile program services (program-level caps apply); patient education materials; mobile medical supplies and consumables; fuel and routine maintenance for leased units; program administration (3% cap).

Not Allowable: Vehicle purchase; capital construction or major renovations; food or direct participant incentive payments; clinician salaries for direct clinical care services; funds to supplant existing Medicaid, HRSA, Title X, WIC, or other federal/state program funding.

5.5 Program Specifications and Requirements

5.5.1 Service Delivery

- Routes must serve at least two distinct rural-eligible communities per route cycle. Screening for diabetes and hypertension is required at every stop.
- All positive screening results must trigger a documented referral to a fixed-site provider within one business day.

5.5.2 Staffing

- All clinical services must be delivered by appropriately licensed Florida healthcare providers within their Florida-authorized scope of practice under Chapters 458, 464, and 468, F.S.
- CBOs applying as lead must document a formal written clinical oversight arrangement with a named licensed clinical supervisor.

5.5.3 Technology

- Mobile-compatible EHR or ePCR with point-of-care documentation capability required within 90 days of award. System must connect to the Florida HIE infrastructure and ENS within the same timeframe.

5.6 Initiative-Specific Partnership Requirements

- At least one executed MOU or Letter of Intent with a fixed-site primary care provider, FQHC, RHC, or CHD in the service area to receive referrals from mobile encounters.
- Where a Community Paramedicine program operates in the proposed service area, applicants must describe how mobile encounter data will trigger Community Paramedicine in-home follow-up, including data-sharing protocols and referral workflow.
- Documentation of coordination with the HIE/ENS Onboarding component (Initiative 13) for mobile EHR/ePCR connectivity and ENS alerts.

5.7 Mobile Health-Specific Application Items

The following supplemental items should be addressed in the applicable bundle-level items of Section 4.1.2.

#	Item (Mobile Health-Specific)	Documentation
1	Application includes a dedicated Mobile Health program narrative describing the route design strategy, scheduled service areas, and rural eligibility documentation for proposed route stops.	Mobile Health program narrative section present; route coverage map included or described.
2	Applicant identifies at least one existing or contracted mobile health unit with documented operational capacity or a credible, time-bound procurement or leasing plan.	Fleet documentation, lease agreement, or vendor letter of intent with timeline.
3	Application includes at least one Florida-certified CHW or a documented CHW certification timeline for each identified CHW, with full certification required within 6 months of award.	CHW certification status or documented certification program and completion timeline.
4	Application includes an executed MOU or Letter of Intent with at least one fixed-site primary care provider, FQHC, RHC, or CHD for referral management.	MOU or LOI included in partnership documentation.

5.8 Performance Metrics (Illustrative)

The following metrics are illustrative and representative of the types of measures the Agency may require during the term of the Grant Agreement. Final specifications will be published through the RHTP data dictionary and reporting templates issued post-award.

- Mobile health unit route stops completed per quarter, by county and Super Region, with rural eligibility documentation.
- Unduplicated patients served per quarter, by service type and payer mix.
- Preventive screenings completed (diabetes, hypertension, cancer, COPD) per quarter, with positive screening rates.
- Referrals initiated per quarter, by referral type and receiving provider, with tracked follow-up status.
- Prenatal service encounters per quarter; first-trimester initiation rate by county; high-risk obstetric referrals initiated.
- CHW navigation contacts per quarter; health needs screenings and community referrals initiated.
- Missed appointment rate per quarter, by route and county.
- EHR/ePCR and Florida HIE/ENS connectivity status and go-live date.
- Number of patients referred to Community Paramedicine (Initiative 3) following mobile encounter.

SECTION 6: INITIATIVE 3 — COMMUNITY PARAMEDICINE / MOBILE INTEGRATED HEALTH (MIH)

Initiative Type:	Lead Initiative
Estimated Funding (Yr 1):	$18,000,000 statewide
Super Region Allocations:	NW $4,057,879 | NE $7,915,957 | SW $4,641,427 | SE $1,385,525

6.1 Overview and Purpose

The Community Paramedicine (CP) / Mobile Integrated Health (MIH) Initiative expands the traditional role of Emergency Medical Services (EMS) personnel beyond emergency transport to provide non-emergency, community-based healthcare services in homes and community settings. This initiative addresses rural access barriers including workforce shortages, limited primary care availability, geographic isolation, transportation barriers, and gaps in care transitions following hospital discharge. Community Paramedicine serves as the in-home care delivery engine of the bundle, responding to RPTM alerts, mobile health referrals, and ENS post-discharge notifications with direct in-person patient engagement.

6.2 Eligible Applicants

- Licensed Florida EMS agencies (County EMS agencies; Fire-based EMS agencies; Private EMS agencies with demonstrated community paramedicine capacity)
- Emergency Medical Services districts or special districts
- Regional EMS authorities or collaboratives — a single lead entity must be identified and independently meet eligible applicant criteria
- Critical Access Hospitals (CAHs) with affiliated EMS services providing community paramedicine programming
- Multi-agency EMS consortia where a lead agency is clearly identified

- Florida Department of Health County Health Departments (CHDs) with documented EMS partnerships or integrated community health programs

6.3 Key Program Components

6.3.1 Regional Service Delivery Model (Required)

- Programs must operate as regional service models covering multiple rural communities and counties within a defined service area.

6.3.2 Care Transitions and Post-Discharge Follow-Up (Required)

- Programs must support timely post-discharge follow-up including in-home assessment, medication reconciliation support, and care coordination to reduce avoidable readmissions. Follow-up must be initiated within clinical protocol-specified timeframes following discharge, triggered by ENS alerts where available.

6.3.3 Chronic Disease Monitoring and Support (Required)

- Programs must provide monitoring and education services for rural residents managing chronic conditions. The following are required disease focus areas: diabetes, hypertension, Congestive Heart Failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD). Programs must address all four conditions as part of their chronic disease service pathway.
- RPTM devices and AI-assisted decision support tools must be used to support patient follow-up and chronic disease management as part of the bundle integration requirement.

6.3.4 Non-Emergent EMS Diversion and Alternative Destination (Required)

- Programs must support clinically appropriate non-emergency navigation and care coordination for low-acuity calls within EMS scope of training and medical direction.
- **Year 1 requirement:** Programs must have an alternative destination protocol in place within the first program year. **Year 2 requirement:** On-scene treatment protocols are a Year 2 requirement, recognizing that developing comprehensive on-scene clinical protocols requires time to build operational and clinical governance infrastructure. This phased approach must be reflected in the implementation work plan.

6.3.5 Telehealth and RPTM Integration (Required)

- CP teams must be equipped and trained to deploy and support RPTM devices (Initiative 10) during home visits. RPTM alert data must be integrated into CP clinical workflows so that out-of-range monitoring alerts trigger prioritized CP in-home care coordination response.

6.3.6 Health Information Technology and Data Exchange (Required)

- Programs must implement HIT interoperability between ePCR and EHR systems through the Florida HIE infrastructure and ENS alerts. ENS alert integration is required for

triggering post-discharge CP follow-up visits; programs must document their ENS connectivity approach and go-live timeline.

6.3.7 Workforce Training and Development

- Community paramedicine training must be prescribed by and conducted under the authority of the program Medical Director.

6.4 Allowable and Unallowable Uses (Community Paramedicine-Specific)

Allowable: EMS personnel training under Medical Director prescribed training programs; telehealth platforms for EMS clinical consultation; remote patient monitoring devices and related software (coordinated with Initiative 10); mobile documentation tools; ePCR connectivity to Florida HIE/ENS; AI-assisted decision support tools; care coordination staffing and tools directly supporting program services; medical supplies for in-home assessments within scope and protocol (non-capital); program administration (3% cap).

Not Allowable: Capital construction or major renovations; clinician salaries for direct clinical care services; purchase of emergency transport vehicles; activities outside EMS scope of training.

6.5 Program Specifications and Requirements

6.5.1 Service Delivery

- Services must be delivered across three required pathways: (1) post-hospital discharge follow-up; (2) chronic disease monitoring and support — diabetes, COPD, CHF, and hypertension as required disease focus areas; and (3) non-emergent EMS diversion and alternative destination.
- All services must be delivered within EMS scope of training under medical direction.

6.5.2 Staffing and Medical Direction

- All EMS clinical services must be delivered by appropriately licensed Florida EMS personnel under medical direction. Programs must operate under documented medical direction with a named Medical Director and written clinical protocols for all service pathways.

6.5.3 Technology

- ePCR systems must be interoperable with the Florida HIE infrastructure and ENS — connectivity plan and executed participation agreement required within 90 days of the executed subaward agreement.

6.6 Initiative-Specific Partnership Requirements

- Executed MOUs or LOIs with at least one primary care provider, FQHC, RHC, or CHD for clinical consultation, referral management, and data-sharing.
- Documented coordination with hospitals for ENS-triggered post-discharge follow-up.

- Description of how RPTM alert data (Initiative 10) will trigger CP in-home care coordination response.
- Coordination with Mobile Health (Initiative 2) for referral intake and with Retail Clinic Services (Initiative 12) as a step-down referral destination.

6.7 Community Paramedicine-Specific Application Items

The following supplemental items should be addressed in the applicable bundle-level items of Section 4.1.2.

#	Item (CP-Specific)	Documentation
1	EMS clinical services are licensed under Florida law; application documents EMS service authority in the proposed rural service area.	Florida EMS licensure documentation; service area documentation.
2	Program operates under documented medical direction with a named Medical Director or documented recruitment plan with specific timeline.	Medical Director attestation or documented recruitment plan.
3	Application describes all three required service pathways: post-discharge follow-up; chronic disease monitoring (diabetes, COPD, CHF, hypertension); and non-emergent EMS diversion / alternative destination.	All three pathways present in program narrative with required disease focus areas identified.
4	Application includes a plan for ePCR connectivity to the Florida HIE infrastructure and ENS.	HIE/ENS connectivity plan described in program narrative or technology section.

6.8 Performance Metrics (Illustrative)

The following metrics are illustrative and representative of the types of measures the Agency may require. Final specifications will be published through the RHTP data dictionary and reporting templates issued post-award.

- CP encounters per quarter, by service pathway (post-discharge, chronic disease, EMS diversion) and Super Region.
- Unduplicated patients served by pathway and payer mix.
- Post-discharge home visits completed, by timeframe (within 24, 48, 72 hours of discharge).
- 30-day hospital readmission rate for CP-enrolled post-discharge patients.
- EMS non-transport and alternative destination rate by call type and county.
- RPTM alerts responded to by CP in-home care coordination visit (Initiative 10 coordination metric).
- Chronic disease engagement metrics: blood pressure control, HbA1c control, CHF and COPD exacerbation rates for CP-enrolled patients.
- ENS connectivity go-live date and percentage of post-discharge follow-ups triggered by ENS alert.

SECTION 7: INITIATIVE 10 — REMOTE PATIENT TELEMONITORING (RPTM)

⚠ Service Component — Cannot Establish Lead Status
RPTM is a required service component of this bundle. An entity may not apply as a bundle lead solely to deliver RPTM services. All five bundle initiatives — including RPTM — must be incorporated in the full bundle application regardless of which initiative (2, 3, or 12) establishes lead identity.

Initiative Type:	Required Service Component
Estimated Funding (Yr 1):	$14,000,000 statewide (flows through the lead entity's bundle award)
Super Region Allocations:	NW $3,155,516 | NE $6,156,855 | SW $3,609,999 | SE $1,077,631

7.1 Overview and Purpose

The Remote Patient Telemonitoring (RPTM) service component deploys technology-enabled chronic disease monitoring and post-discharge care oversight into rural Floridians' homes. RPTM extends clinical reach by enabling continuous or periodic measurement and transmission of physiological data from patient homes to supervising clinicians, enabling timely care coordination intervention before conditions escalate to emergency department visits or avoidable hospitalizations. RPTM funding flows through the lead entity's bundle award; there is no separate RPTM application submission.

7.2 Target Population

Priority enrollment should target rural Floridians with chronic conditions (hypertension, diabetes, CHF, COPD, and related conditions); post-discharge patients requiring clinical follow-up; high-risk maternal patients (gestational hypertension, preeclampsia risk factors, gestational diabetes); and high-risk individuals identified by participating providers. Maternal health RPTM is a priority population given rural Florida's elevated preterm birth and infant mortality rates.

7.3 Key Program Components

- Patient enrollment and eligibility determination: identification, enrollment, and consent of eligible rural patients with chronic conditions or post-discharge care needs.
- Device procurement and distribution: FDA-cleared remote monitoring devices appropriate to enrolled patient conditions (blood pressure cuffs, pulse oximeters, weight scales, glucometers, multi-parameter devices).
- HIPAA-compliant monitoring platform that receives, stores, and transmits patient-generated health data to supervising clinicians.
- Clinical alert protocols and care coordination response: evidence-based alert thresholds and documented care coordination response protocols — the primary response mechanism is care coordination (connecting patients to appropriate care), not direct clinical services delivered with grant funds.

- Patient education and onboarding: structured onboarding covering device use, data transmission, and alert and follow-up processes.
- Integration with CP teams (Initiative 3) and Florida HIE/ENS (Initiative 13) to ensure monitoring data informs care planning and triggers appropriate follow-up.

7.4 Allowable and Unallowable Uses (RPTM-Specific)

Allowable: FDA-cleared monitoring devices (initial procurement and patient distribution); HIPAA-compliant monitoring platform licensing and maintenance; cybersecurity controls; care coordination staffing directly attributable to RPTM program oversight, alert triage, and patient care coordination — not for direct clinical care or clinician compensation for clinical encounters (program-level caps apply); patient education and device onboarding; health IT integration with EHR/EMR and Florida HIE/ENS; workforce training on device management, alert protocols, and HIPAA compliance; data collection, reporting, and program evaluation support; program administration (3% cap).

Not Allowable: Devices or equipment not FDA-cleared for the proposed clinical use; consumer-grade or non-medical-grade monitoring devices; platforms that do not meet HIPAA security requirements; prohibited telecommunications equipment under 2 CFR 200.216; major construction or capital improvements; vehicle purchases.

7.5 Program Specifications and Requirements

7.5.1 Service Delivery

- Enroll rural patients qualifying under the RHTP rural eligibility framework. Obtain informed consent from all enrolled patients prior to initiating monitoring.
- Maintain documented, medically directed alert threshold protocols and care coordination response timelines for each monitoring parameter.
- Coordinate with CP teams (Initiative 3) and the Florida HIE/ENS (Initiative 13) to ensure monitoring data triggers appropriate follow-up.

7.5.2 Equipment and Technology

- All monitoring devices must hold FDA clearance (510(k)) or FDA approval (PMA). Devices must function reliably in rural low-bandwidth environments.
- The monitoring platform must be HIPAA-compliant with documented BAA; must support real-time alert generation; and must integrate with EHR/EMR and the Florida HIE/ENS within 90 days of program launch.

7.5.3 Clinical Oversight

- A designated Medical Director or supervising licensed clinician responsible for clinical governance, alert thresholds, and response protocol development.

7.6 Initiative-Specific Partnership Requirements

- Executed MOUs or LOIs with at least one primary care provider, RHC, FQHC, or hospital that will supervise enrolled patients and receive monitoring alerts, describing clinical supervision structure, alert response responsibilities, and data-sharing expectations.

- Community Paramedicine Coordination: Describe how RPTM alert data will trigger care coordination response from CP teams, including protocols for in-home follow-up visits prompted by monitoring alerts.
- HIE/ENS Integration Coordination: Describe the approach to integrating monitoring program data with the Florida HIE/ENS, including planned timeline and responsible parties.

7.7 Performance Metrics (Illustrative)

The following metrics are illustrative and representative of the types of measures the Agency may require. Final specifications will be published through the RHTP data dictionary and reporting templates issued post-award.

- Patients enrolled in remote monitoring per quarter (new enrollees; cumulative total), by population type: chronic disease, post-discharge, and maternal health.
- Monitoring devices deployed and active by device type.
- Alerts generated per quarter, by severity classification (urgent, non-urgent, trending).
- Percentage of urgent alerts with documented care coordination response within protocol-specified timeframe.
- Care coordination follow-up actions triggered by monitoring alerts, by action type (CP home visit, primary care referral, telehealth consultation).
- Avoidable emergency department visits and hospital readmissions for enrolled patients compared to pre-enrollment baseline.
- Chronic disease outcomes: blood pressure control, HbA1c control, CHF and COPD exacerbation rates for enrolled patients.
- High-risk maternal patients enrolled; adverse maternal events for enrolled patients.
- EHR/EMR and Florida HIE/ENS integration status and go-live date.

SECTION 8: INITIATIVE 12 — RETAIL CLINIC SERVICES (ON-SITE PHARMACY CLINIC SERVICES)

⚠ Scope of Practice Compliance Notice
No funds awarded under this initiative may be used to expand, alter, or create new scope of practice authority for any licensed clinician. All clinical services funded under this initiative must fall strictly within the current, legally authorized scope of practice for each provider type under applicable Florida statutes and rules, including Chapter 465, F.S. (pharmacy), Chapter 458/459, F.S. (medicine and osteopathic medicine), and Chapter 464, F.S. (nursing and advanced practice). The grant may not substitute for, conflict with, or circumvent Florida licensure law or applicable Board rules.

Initiative Type:	Lead Initiative
Estimated Funding (Yr 1):	$6,000,000 statewide
Super Region Allocations:	NW $1,352,364 | NE $2,638,652 | SW $1,547,142 | SE $461,842

8.1 Overview and Purpose

The Retail Clinic Services component enables rural pharmacies to host on-site clinical services delivered by licensed providers practicing strictly within their current, legally authorized scope of practice under Florida law. Lead applicants must be pharmacies already established and operating in eligible rural areas. Eligible pharmacy organizations may add on-site clinical services within existing pharmacy space, install diagnostic telehealth kiosks within their pharmacies, or both. Telehealth kiosk vendors may not serve as lead applicants; they may participate as subcontractors only.

8.2 Eligible Applicants

The following entity types are eligible to serve as lead applicants under Initiative 12:

- Licensed community or retail pharmacies currently operating in eligible rural areas proposing to add on-site clinical service space, POCT, and/or licensed provider integration within their existing pharmacy location.
- Licensed community or retail pharmacies proposing to install one or more diagnostic telehealth kiosks within their existing rural pharmacy location.
- Rural pharmacy organizations proposing a combination of on-site clinical services and telehealth kiosk deployment across one or more existing eligible rural pharmacy sites.
- Multi-site rural pharmacy organizations proposing coordinated implementation across multiple existing eligible rural pharmacy locations within one or more Super Regions.

The following are NOT eligible to serve as lead applicants: telehealth kiosk vendors; pharmacy chains without a currently operating pharmacy in an eligible rural area at the time of application; entities proposing to establish a new pharmacy; non-pharmacy organizations that do not own or operate a currently licensed rural pharmacy.

8.3 Key Program Components

- Setup of private, protocol-based clinical service areas within existing rural pharmacy locations for non-emergency health assessments and preventive care visits.
- Program coordination and operations staffing to support clinical services — direct clinical service compensation from grant funds is not allowable; licensed provider clinical salaries must be supported through billing and reimbursement revenue.
- On-site POCT within scope of practice (blood pressure, blood glucose, rapid antigen testing, lipid screening, and other CLIA-waived tests).
- Chronic disease monitoring visits and medication counseling for patients managing hypertension, diabetes, COPD, and related conditions.
- Diagnostic telehealth kiosk deployment within pharmacy locations to connect rural patients with remote licensed clinicians for same-day assessment.
- HIT connections between pharmacy clinic systems and local EHR systems to support referrals, encounter documentation, and care continuity through the Florida HIE/ENS.

8.4 Allowable and Unallowable Uses (Retail Clinic-Specific)

Allowable: Setup of private clinical service areas within pharmacy locations (partitions, privacy screens, examination furniture); POCT equipment within scope of practice; diagnostic telehealth kiosk hardware, software, and connectivity; program coordination and administrative support

staffing directly attributable to pharmacy clinic operations — NOT direct clinical service compensation; HIT connections and Florida HIE/ENS integration; cybersecurity infrastructure and HIPAA safeguards; workforce training on clinical documentation and telehealth integration; program administration (3% cap).

Not Allowable: Drug product costs (prescription medication acquisition costs); services or activities outside the legally authorized scope of practice; establishment of a new pharmacy as part of this award; telehealth kiosk vendors as lead applicants; capital construction or major renovations; clinician salaries for direct clinical care services.

8.5 Program Specifications and Requirements

8.5.1 Service Delivery

- On-site clinical services must be delivered by licensed providers within their current, legally authorized scope of practice under applicable Florida statutes. Acute and preventive care visits must be delivered by a physician, ARNP, or PA licensed under Florida law.
- Pharmacists may provide services within their licensed scope under Chapter 465, F.S. (dispensing, MTM, immunization administration under authorized protocols, CLIA-waived POCT).
- All pharmacy sites must maintain a valid Florida pharmacy permit in active good standing throughout the award period.

8.5.2 Physical Plant

- Clinic service areas must provide adequate privacy for clinical consultations consistent with applicable Florida pharmacy and healthcare facility requirements. Telehealth kiosk stations must provide audio and video privacy consistent with HIPAA requirements.

8.5.3 Technology

- HIT connections between pharmacy clinic systems and local EHR systems are required. Integration with the Florida HIE and ENS required for care coordination and discharge follow-up — connectivity plan and go-live timeline required. Telehealth platforms must be HIPAA-compliant.

8.5.4 Bundle Integration

- Coordinate with Mobile Health (Initiative 2) as a referral destination for patients from mobile encounters. Coordinate with Community Paramedicine (Initiative 3) for referral of patients requiring in-home follow-up. Support RPTM patient enrollment (Initiative 10) at the point of dispensing. Onboard to Florida HIE/ENS (Initiative 13).

8.6 Initiative-Specific Partnership Requirements

- Documented coordination with Mobile Health and Community Paramedicine co-bundle partners for patient referral and follow-up workflows.
- Telehealth kiosk vendor partnership agreement (where proposed) identifying vendor role, HIPAA compliance, and performance expectations.

- HIE/ENS onboarding coordination with the Florida HIE infrastructure and ENS, consistent with Initiative 13 requirements.

8.7 Retail Clinic-Specific Application Items

The following supplemental items should be addressed in the applicable bundle-level items of Section 4.1.2.

#	Item (Retail Clinic-Specific)	Documentation
1	Applicant documents at least five (5) years of continuous operation as a licensed pharmacy in Florida with at least one currently active pharmacy location in an eligible rural area.	Organizational history narrative; Florida pharmacy permit history; documentation of active rural operation.
2	Each proposed site is an existing, currently operating rural pharmacy owned or operated by the applicant. Current Florida pharmacy permit submitted for each proposed site.	Florida pharmacy permit copies for each proposed site confirming currently operating status.
3	All proposed clinical services are matched to a provider type currently authorized to deliver them under Florida statutes and rules. No scope of practice expansion implied.	Program narrative and staffing plan reviewed; each service matched to authorized Florida provider type.
4	Application does not propose telehealth kiosk vendors as lead applicants.	Program narrative reviewed; lead applicant confirmed as a licensed pharmacy.

8.8 Performance Metrics (Illustrative)

The following metrics are illustrative and representative of the types of measures the Agency may require. Final specifications will be published through the RHTP data dictionary and reporting templates issued post-award.

- Rural pharmacy sites with on-site clinical services or diagnostic telehealth kiosks operational, by site and Super Region
- Patient visits by service type (acute care, chronic disease monitoring, POCT, telehealth kiosk consultation, MTM) per quarter and per site
- Unduplicated patients served by payer mix and county
- POCT volumes by test type and results per quarter
- Referrals initiated to fixed-site primary care, specialty, or hospital providers; referral tracking and follow-up status
- RPTM patients enrolled at pharmacy sites (Initiative 10 coordination metric)
- HIE/ENS integration status and go-live date per site
- Non-urgent emergency department visit rates in service areas compared to pre-program baseline

SECTION 9: INITIATIVE 13 — FLORIDA HIE INFRASTRUCTURE / EVENT NOTIFICATION SYSTEM (ENS) ONBOARDING

⚠ Service Component — Cannot Establish Lead Status
HIE/ENS Onboarding is a required service component of this bundle. An entity may not apply as a bundle lead solely to deliver HIE/ENS onboarding services. All five bundle initiatives — including HIE/ENS Onboarding — must be incorporated in the full bundle application. HIE/ENS funding flows through the lead entity's bundle award; there is no separate HIE/ENS application submission.

Initiative Type:	Required Service Component
Estimated Funding (Yr 1):	$2,500,000 statewide — this bundle's share (total HIE/ENS allocation of $5,000,000 split equally with Bundle 2)
Super Region Allocations:	NW $563,485 | NE $1,099,438 | SW $644,643 | SE $192,434

9.1 Overview and Purpose

The Florida HIE/ENS Onboarding Initiative is the foundational interoperability component of the bundle. Its core purpose is to connect rural hospitals, primary care clinics, RHCs, FQHCs, EMS agencies, and other approved providers to the Florida HIE infrastructure and/or ENS so that participating organizations may receive, exchange, and operationally use real-time information needed to coordinate care across settings. This initiative is not limited to technical connection alone — it requires operational adoption: ENS alerts must be embedded into clinical workflows, staff must be trained, and participating sites must demonstrate active use of event notification data in care coordination practice.

9.2 Program Objectives

- Onboard eligible rural provider sites — hospitals, RHCs, FQHCs, EMS agencies, and primary care practices — to the Florida HIE infrastructure and ENS.
- Achieve operational go-live (active use of ENS alerts in care coordination workflows) for at least one provider site within the first program year.
- Train clinical and care management staff at participating organizations on the use of HIE/ENS data in their workflows.
- Redesign care coordination workflows at participating sites to operationally embed ENS alert responses into discharge planning, post-discharge follow-up, and care transition processes.
- Sustain participating provider sites' HIE/ENS connectivity and operational use beyond the grant period.

9.3 Allowable and Unallowable Uses (HIE/ENS-Specific)

Allowable: Technical assessment of provider site HIE/ENS readiness; technical connectivity implementation (interface development, testing, go-live support); software licensing for HIE participation and ENS alert delivery; workflow redesign consulting and facilitation at participating provider sites; staff training on HIE/ENS data use in care coordination workflows; data quality

testing and conformance validation; care coordination staffing attributable to implementing ENS alert workflows at participating sites (3% administrative cost cap applies).

Not Allowable: Capital construction or major renovations; equipment not directly required for HIE/ENS connectivity; clinical care services or clinician salaries.

9.4 Program Specifications and Requirements

9.4.1 Onboarding Process

- For each proposed provider site, conduct and document a readiness assessment identifying current connectivity status, system infrastructure, and gaps prior to technical implementation.
- Technical connection must be tested and validated prior to go-live declaration. At minimum, one defined ENS-triggered workflow must be operational at each onboarded site within the first program year.

9.4.2 Data Exchange Standards

- All onboarding must achieve compliance with applicable interoperability standards including HL7 2.x ADT message formats and FHIR where supported. ADT notifications must include complete and accurate patient identifying information (name, date of birth, MRN, insurance).

9.4.3 Operational Use Requirements

- Technical connection is necessary but not sufficient. Lead applicants must document how staff at each participating site receive alerts, review them, and take a defined care coordination action in response.

9.5 Initiative-Specific Partnership Requirements

- Describe coordination with the Florida HIE program for provider onboarding support, interface development resources, and ENS alert configuration.
- For each co-bundle clinical initiative (Mobile Health, Community Paramedicine, RPTM, Retail Clinic Services), describe how HIE/ENS connectivity will support data exchange and care coordination between that initiative and onboarded provider sites.

9.6 Performance Metrics (Illustrative)

The following metrics are illustrative and representative of the types of measures the Agency may require. Final specifications will be published through the RHTP data dictionary and reporting templates issued post-award.

- Rural provider sites assessed for HIE/ENS readiness per quarter, by site type and Super Region.
- Provider sites achieving technical connection to the Florida HIE infrastructure and/or ENS, by quarter and site type.
- Provider sites at confirmed operational go-live status (actively using HIE/ENS data in clinical workflows), by quarter.

- ADT notifications received and actioned per quarter per operational site.
- Percentage of post-discharge patients for whom ENS alert triggered a documented care coordination follow-up action.
- Average time from provider site assessment to technical go-live, by site type.
- Data quality: percentage of ADT notifications with complete and accurate patient identifying information.

Remainder of Page Intentionally Left Blank.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

ATTACHMENT I
RURAL HEALTH TRANSFORMATION PROGRAM
STANDARD TERMS AND ADMINISTRATIVE REQUIREMENTS

APPLICABLE TO 14 OF THE 15 RHTP INITIATIVES

CMS Cooperative Agreement No. 1RHTSSCMS332067-01-00

Period of Performance: December 29, 2025 – October 30, 2030

Florida Agency for Health Care Administration (Agency)

HOW TO USE THIS DOCUMENT

This document establishes the standard administrative requirements, federal terms and conditions, rural eligibility definitions, application procedures, reporting standards, and compliance obligations that apply equally to the 14 RHTP initiatives administered through the Request for Application (RFA) process. See Section 1.4 for the complete initiative list. Individual Initiative Guidance Documents (IGDs) reference this document for standard requirements and address only program-specific content.

This document should be read in conjunction with:

- The applicable Initiative Guidance Document for the specific initiative for which you are applying;
- 2 CFR Part 200 (Uniform Guidance) and HHS-specific requirements at 2 CFR Part 300;
- The Agency's RHTP website, where all official guidance is published; and
- The Agency's Standard Grant Agreement and its incorporated attachments and exhibits, which serves as the contractual document executed by the Agency with awarded applicants.

NOTE: The Agency is not seeking to procure a contract for the provision of services or commodities through this RFA. The provisions of Section 120.57(3), providing for procedures to protest a contract award are not applicable to any award issued based on a reply to this Request for Application. The Agency reserves the right to make multiple awards depending on the availability of funds for each grant bundle.

SECTION 1: PROGRAM BACKGROUND AND LEGAL AUTHORITY

1.1 Florida Rural Health Transformation Program (RHTP)

Florida's Rural Health Transformation Program (RHTP) is a five-year, federally funded initiative administered by the Florida Agency for Health Care Administration (Agency) under Centers for Medicare and Medicaid Services (CMS) Cooperative Agreement No. 1RHTSSCMS332067-01-00 (the "cooperative agreement"). The RHTP was developed pursuant to Florida's approved RHTP application and the Medicaid and Children's Health Insurance Program (CHIP) funding authorities under Title XIX and Title XXI of the Social Security Act.

The RHTP is organized around five strategic goals — **Make Rural America Healthy Again, Sustainable Access, Workforce Development, Innovative Care,** and **Tech Innovation** — and is implemented through 15 distinct initiatives described in Section 1.4. Organizations awarded funding under any RFA-based RHTP initiative are designated as "subrecipients" under Uniform Guidance (2 CFR Part 200) and receive a formal subaward from the Agency.

1.2 Federal Authority and Funding Source

Federal Awarding Agency	Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS)
Cooperative Agreement Type	Cooperative Agreement
Award Number	1RHTSSCMS332067-01-00
CFDA Number	93.798
Funding Source	100% federal; no state or subrecipient match required
Applicable Federal Regulations	2 CFR Part 200 (Uniform Guidance); 2 CFR Part 300 (HHS-specific requirements); 48 CFR 31.2 (for-profit cost principles); CMS Standard Terms and Conditions; CMS Program Terms and Conditions; CMS Recipient-Specific Terms

1.3 Period of Performance and Budget Period Structure

The full period of performance for the CMS Cooperative Agreement is December 29, 2025, through October 30, 2030. All subawards issued under this agreement must be fully performed within this overall period of performance.

Recipients will operate under a programmatic budget period of August 1, 2026 (the anticipated agreement execution date), through July 30, 2027, for Year 1. Each subsequent program year will follow this same structure, with the specific budget period dates outlined in the subaward agreements issued after each annual award.

⚠ CRITICAL: Continuation Funding Is Not Automatic
Funding for Budget Periods 2 through 5 is contingent on: (1) the Agency's submission and CMS approval of a Non-Competing Continuation (NCC) application for each budget period; (2) satisfactory subrecipient performance; (3) timely reporting compliance; and (4) continued availability of federal funds.

Unexpended and unobligated funds at the close of each budget period are subject to CMS recoupment. Applicants must plan for timely obligation of all awarded funds within each budget period.

1.4 RHTP Initiatives and Scope of This Document

The RHTP is implemented through 15 distinct initiatives. This document governs the **14 initiatives** administered through a competitive Request for Applications (RFA) process, listed in the table below. One initiative — **Initiative 15: Integrated Medicare-Medicaid Plan Outreach (Dually Eligible Special Needs Plans / D-SNPs)** — is procured through a separate Request for Quotes (RFQ) process and is not subject to this Standard Terms document.

#	Initiative Name	Strategic Goal
1	Rural & Satellite Clinics	Sustainable Access
2	Mobile Health	Sustainable Access
3	Community Paramedicine / Mobile Integrated Health	Sustainable Access
4	Behavioral Health Telehealth & Telehub Psychiatry	Sustainable Access; Quality and Outcomes
5	Tele-Specialties & Imaging	Sustainable Access; Tech Innovation
6	Tele-Intensive Care Unit (eICU)	Sustainable Access; Tech Innovation
7	Hub-and-Spoke Telestroke with Transfer	Sustainable Access; Quality and Outcomes
8	Workforce Development	Workforce and Capacity
9	Health & Lifestyle	Quality and Outcomes
10	Remote Patient Telemonitoring	Technology and System Integration
11	Value-Based Purchasing	Quality and Outcomes
12	On-Site Pharmacy / Retail Clinic Services	Sustainable Access
13	Florida HIE / ENS Onboarding	Technology and System Integration
14	Diagnostic Technology Support	Technology and System Integration

1.5 Initiative Groupings

The 14 RFA-based RHTP initiatives are organized into two (2) groupings: Bundled Initiatives and Standalone Initiatives. The grouping determines how an application must be structured and submitted. Each grouping is described below.

Bundled Initiatives

Bundled initiatives require one (1) comprehensive application that incorporates all component initiatives within the bundle. Bundles are built on required partnerships among providers. An entity applying for a bundle must serve as lead applicant and demonstrate capacity to deliver all required initiative components, either directly or through formal partner organizations, as described in Section 1.7. The two bundles are:

Preventive Care & Care-at-Home Bundle

- Mobile Health (Initiative 2)
- Community Paramedicine / Mobile Integrated Health (Initiative 3)
- Remote Patient Telemonitoring (Initiative 10)
- On-Site Pharmacy / Retail Clinic Services (Initiative 12)
- Florida HIE / ENS Onboarding (Initiative 13)

Specialty & Acute Care Bundle

- Florida HIE / ENS Onboarding (Initiative 13)
- Diagnostic Technology Support (Initiative 14)
- Telehealth Initiatives — Applicants must incorporate at least **one** of the following four telehealth initiatives within their bundle: Behavioral Health Telehealth & Telehub Psychiatry (Initiative 4); Tele-Specialties & Imaging (Initiative 5); Tele-Intensive Care Unit / eICU (Initiative 6); or Hub-and-Spoke Telestroke with Transfer (Initiative 7).

> **⚠ Bundle Applications**
> Applicants may not apply for individual components of a bundle on a standalone basis. Each bundle's Initiative Guidance Document (defined in Section 1.6) specifies required partner types, program design requirements, and evaluation criteria applicable to all component initiatives.

Standalone Initiatives

The following initiatives are each procured through a separate, individual RFA. Each requires its own application, submitted independently from any bundle application:

- Value-Based Purchasing (Initiative 11)
- Rural & Satellite Clinics (Behavioral, Dental and Medical) | (Initiative 1)
- Workforce Development (Behavioral, Dental and Medical) | (Initiative 8)
- Health & Lifestyle (Initiative 9)

Please note that the Agency reserves the discretion to re-advertise any RFA if initiative funds remain available.

1.6 Entity Eligibility

Entity eligibility to apply for any RHTP initiative is initiative-specific and is defined in each Initiative Guidance Document (IGD). Not all entity types are eligible for all initiatives. Eligibility criteria vary based on the nature of services delivered, required licensure, applicable federal and state program requirements, and the specific program design of each initiative or bundle.

All applicants must meet the baseline organizational eligibility requirements set forth in Section 5 of this document regardless of initiative. Meeting baseline eligibility does not guarantee that an entity qualifies for a specific initiative. Applicants must review the applicable IGD to confirm that their organization type and service delivery model meet the initiative-specific eligibility requirements before submitting an application.

> **⚠ Review Your Initiative Guidance Document for Eligibility**
> Entity eligibility is determined initiative by initiative. An application from an entity that is not identified as eligible for the applicable initiative will be denied as ineligible.

1.7 Formal Partnerships and Collaboration

The RHTP is built on a model of coordinated rural health transformation that depends on meaningful engagement among providers, institutions, and community-based organizations. This Section defines the distinction between a formal partnership and a collaboration and establishes the documentation and compliance requirements applicable to each.

A. Formal Partnerships

A formal partnership (also considered as a subcontractor) is a legally documented relationship between the lead applicant and one or more partner organizations in which the partner organization has a defined, committed role in delivering or supporting RHTP-funded program activities. Formal partnerships are required when a partner organization will:

- Deliver any portion of program services or activities funded under the subaward;
- Receive any portion of subaward funds directly or as a pass-through from the lead applicant;
- Serve as a rural delivery site or provide rural access points for the program;
- Employ or contract personnel whose time is charged to the subaward;
- Maintain, share, or exchange data or health information as part of program operations; or
- Fulfill a required component of a bundled initiative application.

Formal partnerships must be documented with a fully executed agreement prior to award. Acceptable documentation includes:

Document Type	Description and Requirements
Memorandum of Understanding (MOU)	A signed agreement between the lead applicant and partner organization specifying: each party's roles and responsibilities; the scope and geographic area of services to be delivered; the allocation of funds (if any) to be passed to the partner; data-sharing protocols; compliance obligations; and the term of the agreement. Must be signed by an authorized representative of each party.
Formal Partnership Agreement	A more detailed contractual agreement used where a partner organization will receive subaward funds as a subrecipient. Must include all MOU elements plus: specific deliverables and performance expectations; subrecipient compliance requirements per 2 CFR 200 Subpart D; reporting obligations; and provisions for monitoring, corrective action, and termination.
Letter of Intent (LOI)	Acceptable at the application stage only for partners that have committed to participate but have not yet executed a full MOU or Partnership Agreement. LOIs must identify the partner organization, describe the intended role, confirm intent to execute a formal agreement prior to award, and be signed by an authorized representative. A fully executed MOU or Partnership Agreement must be in place before funds are disbursed to any partner.

All formal partnership documents must include at minimum:

- Legal names of all parties and authorized representative signatures
- A clear description of each partner's role in program delivery
- The rural service area, counties, or sites covered by the partnership
- The amount or percentage of subaward funds to be allocated to each partner, if any
- Data-sharing expectations and applicable privacy and security requirements
- Each partner's compliance obligations under the subaward and applicable federal requirements
- The term of the agreement and provisions for amendment or termination

⚠ Formal Partnerships Carry Compliance Obligations
Partner organizations that receive subaward funds are designated as subrecipients under 2 CFR 200.93 and are subject to all applicable subrecipient monitoring, reporting, audit, and compliance requirements. The lead applicant, as the primary subrecipient, remains legally and financially responsible to the Agency for all activities and funds regardless of what is delegated to partners. Failure

of a partner to perform or comply does not relieve the lead applicant of its obligations under the subaward agreement.

B. Collaborations

A collaboration is a less formal, non-binding working relationship between the lead applicant and another organization that supports but does not directly deliver or fund RHTP program activities. Collaborating organizations do not receive subaward funds and do not have defined programmatic responsibilities under the subaward. Collaborations may include:

- Community organizations, faith-based organizations, or local governments that provide referrals, outreach, or community connections;
- Health systems, payers, or employers that provide letters of support, access to facilities, or in-kind contributions not charged to the award;
- Academic or research institutions participating in learning collaboratives or knowledge-sharing activities; or
- Peer organizations engaged in coordination, shared planning, or regional alignment activities with no exchange of subaward funds.

Collaborations do not require MOUs or formal agreements, though letters of support or informal MOUs are encouraged where they demonstrate community engagement and programmatic credibility.

SECTION 2: GLOSSARY OF STANDARD TERMS

The following definitions apply across all 14 RFA-based RHTP initiatives. Initiative-specific terms are defined in individual Initiative Guidance Documents.

Term	Definition
Agency	Florida Agency for Health Care Administration — the State agency administering the RHTP cooperative agreement as prime recipient.
AOR	Authorized Organizational Representative — the official authorized to legally bind the applicant organization to the obligations of a subaward.
Budget Period (BP)	A discrete funding interval within the period of performance; RHTP has 5 budget periods (see Section 1.3).
CAH	Critical Access Hospital — a rural hospital Medicare-certified under 42 USC §1395i-4.
CMS	Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.
De Minimis Rate	A flat 3% indirect cost rate available to sub-awardee organizations without a negotiated rate agreement, per 2 CFR 200.414(f).
FERPA	Family Educational Rights and Privacy Act — federal law protecting privacy of student education records (20 USC §1232g).
FFATA	Federal Funding Accountability and Transparency Act — requires reporting of subawards ≥$40,000 to USASpending.gov.
FQHC	Federally Qualified Health Center — a community-based provider receiving cost-based Medicare/Medicaid reimbursement.
HIPAA	Health Insurance Portability and Accountability Act (45 CFR Parts 160 and 164) — governs the privacy and security of protected health information (PHI).

Term	Definition
HPSA	Health Professional Shortage Area — a HRSA-designated area with a shortage of primary care, dental, or mental health providers.
IGD	Initiative Guidance Document — the initiative-specific RFA document that supplements this Standard Terms document for a given RHTP initiative.
Key Personnel	Individuals identified in the approved application as critical to program implementation; changes require Agency prior approval.
Lead Applicant	The eligible organization submitting the application; serves as fiscal agent and primary accountability point for the subaward.
NCC	Non-Competing Continuation — the annual application the Agency submits to CMS to continue funding for each budget period.
NICRA	Negotiated Indirect Cost Rate Agreement — a formal agreement with a cognizant federal agency establishing an indirect cost rate.
NOA	Notice of Award — the official CMS document establishing the cooperative agreement terms for the Florida RHTP.
PDSA	Plan-Do-Study-Act — a quality improvement cycle methodology used to test and implement program changes iteratively.
Period of Performance	December 29, 2025 – October 30, 2030 — the full duration of the RHTP cooperative agreement.
PI/PD	Principal Investigator/Project Director — lead individual responsible for program implementation; minimum 25% effort required.
PMS	HHS Payment Management System — the federal system used to draw down and report expenditures.
Pass-Through Entity (PTE)	Agency — the prime recipient that passes through federal funds to subrecipients and is responsible for subrecipient monitoring.
RACEC	Rural Area of Critical Economic Concern — a community designated by Florida Commerce under the REDI program.
REDI	Rural Economic Development Initiative — Florida Commerce's program designating rural communities for economic development support.
RHTP	Rural Health Transformation Program — Florida's five-year CMS-funded initiative to transform rural health care.
RHC	Rural Health Clinic — a clinic certified under 42 USC §1395x(aa) for cost-based Medicare/Medicaid reimbursement.
RUCA	Rural-Urban Commuting Area code — HRSA geographic classification (codes 4–10 indicate rural areas).
SAM.gov	System for Award Management — the federal registration system; all subrecipients must maintain active registration with a valid UEI.
Stevens Amendment	Section 9136 of the FY 1987 DoD Appropriations Act — requires public communications to disclose federal funding percentage and dollar amount.
Subrecipient	An entity receiving a subaward from the Agency to carry out part of the RHTP program. Subject to 2 CFR 200 Subparts D and F.
Subaward	A formal award from the Agency to a subrecipient; not a contract or agreement. Governs use of RHTP funds.

Term	Definition
Super Region	One of four geographic service areas for RHTP (Northwest, Northeast, Southwest, Southeast); see Section 3.
UEI	Unique Entity Identifier — the 12-character alphanumeric identifier issued by SAM.gov, replacing the legacy DUNS number.
Uniform Guidance	2 CFR Part 200 — the federal regulation governing administrative requirements, cost principles, and audit requirements for federal awards.

SECTION 3: SUPER REGIONS

Florida's RHTP initiatives are organized and funded across four (4) Super Regions covering designated rural counties and communities. Unless otherwise specified in an individual Initiative Guidance Document, applicants must identify the Super Region(s) in which proposed activities will occur and demonstrate rural eligibility per Section 4.

Super Region	Counties
Northwest (NW)	Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla, Walton, Washington
Northeast (NE)	Alachua, Baker, Bradford, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Madison, Nassau, Putnam, St. Johns, Suwannee, Taylor, Union, Volusia
Southwest (SW)	Charlotte, Collier, DeSoto, Glades, Hardee, Hendry, Highlands, Lee, Manatee, Okeechobee, Sarasota
Southeast (SE)	Broward, Indian River, Martin, Miami-Dade, Monroe, Palm Beach, St. Lucie

*Funding allocations by Super Region are initiative specific. Refer to the applicable Initiative Guidance Document for regional and initiative-specific funding amounts.

SECTION 4: RURAL ELIGIBILITY DEFINITIONS

All RHTP-funded activities must be delivered in and directly serve eligible rural communities. This Section defines the four (4) recognized pathways through which geographic areas and organizations establish rural eligibility. All 14 RFA-based RHTP initiatives apply this standard definition. Individual Initiative Guidance Documents may specify additional documentation requirements particular to that initiative.

The four (4) pathways are summarized in the table below, followed by detailed descriptions and documentation requirements for each.

Pathway	Authority	Who Qualifies	Documentation Required
A	Florida Statute §288.0656	Counties ≤75,000 pop.; counties ≤125,000 contiguous to a ≤75,000 county; municipalities therein; qualifying unincorporated federal enterprise communities	State designation documentation or population data from Florida Commerce

Pathway	Authority	Who Qualifies	Documentation Required
B	Florida REDI Designation	Communities designated as Rural Areas of Critical Economic Concern (RACEC) or recognized under the Florida Rural Economic Development Initiative (REDI) by Florida Commerce	Official REDI/RACEC designation from Florida Commerce
C	CMS Goldsmith Modification (Hospitals Only)	1) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 FR 6725); or 2) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital); or 3) The hospital would qualify as a rural, regional or national referral center, or as a sole community hospital if the hospital were located in a rural area.	CMS or State rural designation documentation (hospital applicants only)
D	HRSA RUCA Codes / Rural Census Tracts	Areas with RUCA codes 4–10; rural census tract ZIP codes; Goldsmith ZIP code crosswalk listings	ZIP code(s) with applicable RUCA designation, rural census tract classification, or Goldsmith crosswalk listing

4.1 Pathway A — Florida Statute §288.0656

Any county or municipality designated as rural under Florida Statute §288.0656 qualifies as an eligible rural area. Qualifying areas include:

- A county with a population of 75,000 or fewer.
- A county with a population of 125,000 or fewer which is contiguous to a county with a population of 75,000 or fewer.
- A municipality within a county described above.
- An unincorporated federal enterprise community or an incorporated rural city with a population of 25,000 or fewer, and an employment base focused on traditional agricultural or resource-based industries, located in a county not defined as rural, and meeting at least three economic distress factors (e.g., low income, high unemployment, low housing values) verified by the Florida Department of Commerce.

4.2 Pathway B — Florida Commerce REDI Designation

Communities designated as Rural Areas of Critical Economic Concern (RACEC) or otherwise recognized under the Florida Rural Economic Development Initiative (REDI) through Florida Commerce qualify as eligible rural areas. Applicants must document REDI designation through official Florida Commerce listings as part of their application. Current REDI and RACEC listings are available at Florida Commerce Office of Rural Initiatives.

4.3 Pathway C — CMS Goldsmith Modification (Hospitals Only)

The CMS Goldsmith Modification (originally published in the Federal Register on February 27, 1992, 57 FR 6725) provides an additional rural eligibility pathway. A hospital qualifies under this pathway if: (1) the hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA), as determined under the most recent

modification of the Goldsmith Modification; (2) the hospital is located in an area designated by any law or regulation of the State as a rural area, or is designated by the State as a rural hospital; or (3) the hospital would qualify as a rural referral center, a regional referral center, or a sole community hospital if the hospital were located in a rural area. Applicants relying on this pathway must provide documentation from CMS or the applicable State rural designation authority confirming eligibility at the time of application.

4.4 Pathway D — HRSA RUCA Codes and Rural Census Tracts

Geographic areas assigned Rural-Urban Commuting Area (RUCA) codes 4 through 10 by the Health Resources and Services Administration (HRSA), rural census tract ZIP codes, or areas included in the Goldsmith ZIP code crosswalk qualify as eligible rural areas. This pathway captures rural pockets within otherwise metropolitan counties. Applicants must provide documentation identifying their ZIP code(s) and applicable RUCA designation, rural census tract classification, or Goldsmith crosswalk listing.

✓ CRITICAL: 100% Rural Delivery Requirement
100% of all program activities funded under any RHTP initiative must occur within and directly serve eligible rural communities as defined above.

The Agency will verify rural eligibility documentation during application review, post-award monitoring, and audit activities. Failure to maintain and document ongoing rural delivery may result in disallowance of costs.

SECTION 5: GENERAL ELIGIBILITY REQUIREMENTS

The following baseline requirements apply to all applicants for any RHTP initiative. Individual Initiative Guidance Documents may specify additional eligibility requirements unique to that initiative.

5.1 Baseline Organizational Eligibility

All applicants must:

- Be authorized to do business in the State of Florida, as applicable to the services or programs proposed, and remain in good standing with all state and federal oversight bodies.
- Be located in, or actively serving patients, clients, or trainees in, one or more eligible rural communities as defined in Section 4.
- Have been in continuous operation for a minimum of five (5) years as of the application deadline.
- Demonstrate financial stability through submission of audited financial statements for the two most recent completed fiscal years (federal fiscal years, state fiscal years, or the applicant's organizational fiscal years, as applicable to the entity type).
- Have no formal adverse findings, active corrective action orders, or current exclusions from federal or state health care programs (Medicaid, Medicare, state licensure) as of the application deadline. Pending investigations or unresolved administrative remediation plans must be disclosed in the application; the Agency will evaluate disclosed issues on a case-by-case basis.
- Demonstrate organizational readiness, governance structure, and internal controls sufficient to manage federal subrecipient funds under 2 CFR Part 200. Demonstration must include: an organizational chart; board or governing body composition; written financial management and internal control policies; and evidence of prior federal award management experience (if any).
- Agree that all program activities will occur in eligible rural communities consistent with this document.

5.2 Non-Compete Prohibition

RHTP funds may not be used to fund any personnel position at organizations that maintain non-compete agreements binding to any clinician or provider employed or contracted in a role funded by this award. This prohibition applies to any position for which any portion of compensation is paid with RHTP funds.

5.3 SAM.gov Registration

All subrecipients must maintain an active SAM.gov registration with a valid Unique Entity Identifier (UEI) throughout the entire period of performance. Registration must be renewed annually. This requirement flows down to all sub-subrecipients and contractors receiving $25,000 or more. Failure to maintain active registration may result in withholding of payments.

5.4 Non-Rural Headquartered Organizations

Organizations headquartered outside Florida's designated rural areas may apply if they can demonstrate capacity to deliver all funded activities within eligible rural communities. Such applicants must provide:

1. Signed Memoranda of Understanding (MOUs) or Letters of Intent (LOIs) with eligible rural partner organizations;
2. A rural service area plan identifying specific rural counties and training or service delivery sites;
3. A rural needs assessment documenting verified rural gaps; and
4. A compliance attestation that 100% of activities will occur in eligible rural communities.

Refer to the applicable Initiative Guidance Document for additional requirements applicable to non-rural-headquartered applicants.

SECTION 6: STANDARD RFA PROCEDURES

6.1 Application Process

All RHTP initiative awards are made through an application process in accordance with applicable Florida statutes, rules and Agency policies, and 2 CFR 200.317–200.327. RFAs will be posted on the MyFloridaMarketPlace (MFMP) Vendor Information Portal (VIP). The Agency will also provide a link to each RFA posted in VIP on the Agency's RHTP website for easy reference. Awards will be made based on the evaluation criteria and scoring rubric published in each Initiative Guidance Document.

6.2 RFA Timeline

The following timeline is applicable to each RFA. Specific dates may be published in each Initiative Guidance Document. All deadlines are subject to change at Agency discretion. Any changes to the RFA timeline will be posted as an addendum to the MFMP Vendor Information Portal.

Activity	Date/Time	Notes
RFA Posted / Open for Applications	April 21, 2026	Posted on MFMP Vendor Information Portal; link provided on RHTP website
Technical Assistance Webinar Series Begins	April 28, 2026	Attendance strongly encouraged; recorded and posted

Activity	Date/Time	Notes
Deadline for Written Questions	May 6, 2026	All questions must be submitted in writing
Anticipated Agency Responses to Questions Posted	May 20, 2026	Posted on MFMP Vendor Information Portal; link provided on RHTP website
Application Submission Deadline	June 10, 2026 2:00 p.m. ET	Applications submitted via email to RHTPApplications@ahca.myflorida.com
Anticipated Technical Review / Scoring	June 17 – July 10, 2026	Performed by an Agency-appointed review panel
Anticipated Notice of Award (NOA) Issued	July 20, 2026	Posted on MFMP Vendor Information Portal; link provided on RHTP website
Anticipated Subaward Execution	August 1, 2026	Subaward agreement signed; performance period begins

6.3 Technical Assistance Webinar Series

The Agency will conduct a series of technical assistance webinars. This three-part series will cover the fundamentals of federal grants, how to develop a strong program narrative, and how to build a compliant and realistic budget.

Attendance is strongly encouraged. A recording, transcript, and FAQ document will be made available on the RHTP website following the conference.

6.4 Questions and Official Guidance

All questions must be submitted in writing to RHTPApplications@ahca.myflorida.com by the deadline specified in the applicable Initiative Guidance Document. For each question, applicants should provide a reference to the RFA document number and/or title, section number, and subsection number that pertains to the item for which the applicant is submitting the question.

Only written responses officially posted to the Vendor Information Portal constitute binding Agency guidance. Verbal communications from Agency staff are not binding and may not be relied upon by applicants.

6.5 Application Submission

- Applications must be submitted electronically via email to RHTPApplications@ahca.myflorida.com by the stated deadline in the RFA Timeline.
  - The subject line of the email must identify the RFA number for which the applicant is applying, as well as the applicant's legal name.
  - Example: "AHCA RFA 033-25/26 – Applicant Name"
- All required application documents must be attached to the email.
- The electronic file name for each application document attached must be clearly labeled and listed in the body of the email for ease of identification and organization.
- Late applications will not be accepted. Applicants are solely responsible for ensuring all materials are complete and successfully uploaded prior to the stated deadline.
- Force majeure exception: The Agency may, at its sole and exclusive discretion, grant an extension of the application deadline in the event of a declared state or federal disaster or emergency that materially impairs an applicant's ability to submit on time. Any such extension will be posted to the RHTP website and will apply equally to all applicants. Rural communities disproportionately affected by disasters are encouraged to contact the Agency promptly to document any impacts.

6.6 Standard Format Requirements

Documents submitted with your application should conform to the following requirements:

- Single-spaced, 12-point Arial or Times New Roman font
- 1-inch margins on all sides
- Section page limits as specified in the applicable Initiative Guidance Document
- Required attachments do not count toward narrative page limits unless specified
- Applications not adhering to the standard formatting requirements may be deemed not eligible for award at the Agency's discretion

6.7 Standard Disqualification Criteria

Applications will be deemed not eligible for award and will not be evaluated if they:

- Are submitted after the deadline
- Are submitted by an ineligible entity
- Are missing a signed Cover Sheet or required certifications
- Modify the content and requirements of Attachment II, Required Applicant Response Documents, unless the document instructions permit specific modifications to be made by the applicant
- Propose activities exclusively in non-rural locations
- Are missing required audited financial statements
- Lack an active SAM.gov/UEI registration as of the application deadline
- Propose primarily unallowable uses of funds as defined in the applicable Initiative Guidance Document

The Agency reserves the right to request clarification or correction of minor technical deficiencies (such as typographical errors, missing page numbers, or minor formatting issues that do not affect content or evaluation). This is solely at the Agency's discretion.

6.8 Conflict of Interest

Pursuant to 2 CFR 200.112, applicants must disclose any actual or potential conflict of interest. No employee, officer, or agent may participate in the selection, award, or administration of a contract supported by federal funds where that person has a real or apparent conflict of interest. Failure to disclose known conflicts may result in disqualification.

The applicant must provide: 1) an attestation signed by an authorized representative that addresses any actual or potential conflict of interest and measures taken to mitigate such conflicts; OR 2) provide an attestation signed by an authorized representative stating that no actual or potential conflict exists.

6.9 Geographic Need and Regional Coverage

The Agency reserves the right to make bundle awards based on geographic need and regional coverage. The Agency may decline to fund programs proposing to serve geographic areas already covered by an awarded program under the same initiatives when the Agency determines that additional funding would result in duplicative services or regional saturation. Award recommendations will consider the distribution of funded programs across Super Regions and rural counties. These determinations will be made at the Agency's discretion.

6.10 Additional Reservation of Rights

The Agency reserves the right to make a contingent award in which it may request additional information or commitments from the Applicant based on the information contained in the application.

The Agency reserves the right not to award the full amount of funds requested in the application and to make a partial award in which it will fund separate components of the application based upon the description of then intended use of the requested funds in the application based on the amounts contained in the Cost Proposal submitted with the Application.

6.11 Electronic Redacted Copies

The applicant shall submit an electronic redacted copy of the application suitable for release to the public in one (1) PDF document; the file shall be identified as "Redacted Version Suitable for Public Release" and contain a transmittal letter authorizing release of the redacted version of the application in the event the Agency receives a public records request, pursuant to Chapter 119, Florida Statutes.

The PDF document must be searchable, allow printing, and must not be password protected (unlocked).

Any confidential or trade secret information covered under Section 812.081, Florida Statutes, should be redacted as described below. The redacted application submission must be marked as the "redacted" copy.

6.12 Confidential or Exempt Information

All applications received by the date and time specified in the RFA Timeline become the property of the State of Florida and are public records subject to the provisions of Chapter 119, Florida Statutes. The State of Florida shall have the right to use all ideas, or adaptations of the ideas, contained in any application received in relation to this RFA. Selection or decline of the application shall not affect this right.

An applicant that asserts that any portion of the application is confidential or exempt from disclosure under Chapter 119, Florida Statutes, shall clearly mark each page of such portion as follows:

1) Pages containing trade secret shall be marked "Trade secret as defined in Section 812.081, Florida Statutes". Applicants who fail to identify trade secret as directed herein acknowledge and agree that they waive any right or cause of action, civil or criminal, against the Agency, its employees, and its representatives, for the release or disclosure of trade secret information not so identified. Applicants shall not mark their entire application as trade secret. The Agency may reject an application that is so marked.

2) Pages that do not contain trade secret but are otherwise exempt or confidential shall be marked "exempt" or "confidential," followed by the statutory basis for such claim. For example: *"The information on this page is exempt from disclosure pursuant to Section 119.071(_)(_), Florida Statutes."*

3) Failure to identify and mark such portions as directed above shall constitute a waiver of any claimed exemption and the Agency will provide any unmarked records in response to public records requests for those records without notifying the applicant. Designating material simply as "proprietary" will not necessarily protect it from disclosure under Chapter 119, Florida Statutes.

All information included in the application and any resulting Grant Agreement that incorporates the successful application (fully, in part, or by reference) shall be a matter of public record regardless of copyright status. Submission of an application to this RFA that contains material for which the applicant holds a copyright shall constitute permission for the Agency to reproduce and disclose such material for the Agency's internal use, and to make such material available for inspection pursuant to a public records request.

If a public records request is submitted to the Agency for applications submitted to this RFA, the applicant agrees that the Agency may release the redacted application without conducting any pre-release review of the redacted application.

Unless otherwise prohibited by law, the Agency will notify the applicant if a requestor contests the applicant's determination that information is confidential or exempt and asserts a right to the information under Chapter

119, Florida Statutes, or other law. The applicant bears sole responsibility for supporting and defending its determination. If an action is brought against the Agency in any appropriate judicial forum contesting the applicant's determination of confidentiality or the redactions made by the applicant to its application, the applicant agrees that the Agency has no duty to defend against such claims and may elect not to do so, and may elect to release an un-redacted version of the application. By submitting an application, the applicant agrees to protect, defend, hold harmless and indemnify the Agency for any and all claims arising from or relating to the applicant's determinations of confidentiality or redaction, including the payment of any attorneys' fees or costs assessed against the Agency.

6.13 Venue

By responding to this RFA, in the event of any legal challenges to this RFA, applicants agree and will consent that hearings and depositions for any administrative or other litigation related to this RFA shall be held in Leon County, Florida. The Agency, in its sole discretion, may waive this venue for depositions.

Applicants (and their successors, including but not limited to their parent(s), affiliates, subsidiaries, subcontractors, assigns, heirs, administrators, representatives and trustees) acknowledge that this RFA (including but not limited to the resulting Grant Agreement, exhibits, attachments, or amendments) is not a rule nor subject to rulemaking under Chapter 120 (or its successor) of the Florida Statutes and is not subject to challenge as a rule or non-rule policy under any provision of Chapter 120, Florida Statutes.

The exclusive venue and jurisdiction for any action in law or in equity to adjudicate rights or obligations arising pursuant to or out of this RFA for which there is no administrative remedy shall be the Second Judicial Circuit Court in and for Leon County, Florida, or, on appeal, the First District Court of Appeal (and, if applicable, the Florida Supreme Court). Any administrative hearings hereon or in connection herewith shall be held in Leon County, Florida.

6.14 Attorney's Fees

In the event of a dispute, each party to the Grant Agreement resulting from this RFA shall be responsible for its own attorneys' fees, except as otherwise provided by Florida law.

SECTION 7: STANDARD APPLICATION REQUIREMENTS

The following Sections (labeled Section A through Section M) are required components of every RHTP Request for Application. Proposal sections are labeled using letters in lieu of numbers to avoid confusion with section numbers in this document and in resulting subaward agreements. Page limits are set in the applicable Initiative Guidance Document. Format standards are specified in Section 6.6 above.

⚠ Certification Template
A standardized certification form covering the required certifications in Section L will be provided as an attachment to each Initiative Guidance Document. Applicants must use the Agency-provided form; substitute certification language will not be accepted.

Section A — Cover Sheet and Applicant Information

Application must include:

- Organization legal name and information;
- Primary contacts (including Authorized Organizational Representative [AOR]);
- Rural pathway eligibility selection;
- Super Region(s) served;

- Initiative the Applicant is applying for;
- Funding amount requested;
- List of collaborators and partners to be detailed in Section D;
- Brief scope summary; and
- Standard application checklist.

Required Attachment: Completed Agency-provided Attachment II, Section A Form.

Section B — Executive Summary

Application must provide:

- Program goals;
- Target population or workforce;
- Proposed model;
- Anticipated rural impact; and
- Alignment with RHTP strategic goals.

Required Attachment: Completed Agency-provided Attachment II, Section B Form.

Section C — Organizational Capacity and Eligibility

Application must demonstrate: Eligibility per Section 5 of this document.

Required Attachment: Completed Agency-provided Attachment II, Section C Form with all required documents.

Section D - Project Narrative

Applicants must submit a Project Narrative that explains how their proposed program design aligns with the purpose, goals, and required activities of their selected initiative(s). The narrative should clearly describe how the applicant will implement their program in accordance with the expectations outlined in the initiative-specific guidance document. Page length requirements and all program specifications can be found in the initiative-specific guidance documents.

Section E — Partnership Agreements

All applications must identify formal partnerships supporting rural program delivery where applicable. Partnerships must be documented with executed MOUs, LOIs, or Partnership Agreements that includes but is not limited to:

- Partner roles and responsibilities;
- Rural site or service delivery commitments;
- Supervisory or instructional responsibilities (where applicable);
- Data-sharing expectations;
- Work share distribution showing the amount of funds each partner organization will receive; and
- Shared compliance obligations.

Refer to the applicable Initiative Guidance Document for initiative-specific partnership requirements.

Required Attachment: MOUs, LOIs and partnership agreements for all entities listed in Attachment II, Section A Form.

Section F — Implementation Work Plan and Milestones

Application must include:

- Timeline from award through the final budget period (Years 1—5) with major milestones and deliverables by year;
- Staffing plan and hiring timeline;
- Technology implementation steps;
- Risk mitigation actions; and
- A Gantt chart or equivalent visual timeline.

Section G — Data Collection, Reporting, and Continuous Quality Improvement Plan

Application must describe:

- Quality management framework using Plan-Do-Study-Act (PDSA) cycles or equivalent methodology;
- Methods for identifying performance challenges;
- Feedback processes;
- Corrective action procedures;
- Use of data for program improvement;
- Internal review schedule; and
- A commitment to participate in external evaluation activities (defined in Section 13.2) and RHTP learning collaboratives.

Required Attachment: Completed Agency-provided Attachment II, Section G Form.

Section H — Sustainability Plan

All applicants must submit a Sustainability Plan demonstrating how program services, infrastructure, and technology will be maintained beyond the five-year RHTP funding window. The plan must include all components specified in Section 9 of this document. Refer to the applicable Initiative Guidance Document for any initiative-specific sustainability requirements.

Required Attachment: Completed Agency-provided Attachment II, Section H Form with all required documents.

Section I — Financial Solvency

Application must:

- Demonstrate the organization’s financial stability and capacity to manage federal subaward;
- Describe financial controls and internal audit processes;
- Identify any concern issues with mitigation strategies; and
- Detail current insurance coverage and fiscal policies.

Required Attachments: Completed Agency-provided Attachment II, Section I Form.

Section J — Budget

Application must include:

- Proposed budget by cost category aligned with allowable uses defined in the Initiative Guidance Document;
- Line-item justification demonstrating cost reasonableness and necessity;
- 3% Administrative Costs Detailed

- A non-supplanting statement confirming that RHTP funds supplement, and do not replace, existing funding sources.

Required Attachment: Completed Agency-provided Attachment II, Section J Form.

J.1 Budget Design Requirements

All RHTP applicants must submit a complete budget for Year 1. The budget must reflect a deliberate, phased spending approach in which Year 1 represents the highest level of investment and each subsequent year tapers to reflect the program's transition from startup and launch into implementation, data reporting, and maintenance. This structure reflects the program's design intent: federally funded startup costs are front-loaded, and by Year 3, programs are expected to be fully operational and managing primarily maintenance and reporting activities. Applicants are strongly encouraged to develop budgets that are as comprehensive, forward-thinking, and strategically justified as possible. Budget changes after award — including waivers — require Agency and CMS approval, and retroactive approval will not be granted. Applicants who build imprecise or insufficiently justified budgets assume the full risk of funding gaps in later years.

J.2 Budget Period Structure and Spending Benchmarks

The five budget periods are divided into two phases. Budget Periods 1 and 2 ("Startup Years") are the primary investment period, during which applicants are expected to complete all procurement, infrastructure buildout, technology implementation, staffing, and program launch. Full program startup must be completed no later than the end of Budget Period 2. Budget Periods 3, 4, and 5 ("Maintenance Years") are limited to implementation continuation, data collection and reporting, performance monitoring, and maintenance of established infrastructure. New capital acquisitions, new leases, and new large-scale technology procurements are not allowable in Maintenance Years except with prior CMS approval. The Agency will not approve Maintenance Year budget requests that include costs more appropriately incurred during Startup Years.

Annual Budget Benchmarks — The following benchmarks govern the maximum allowable funding request for each budget period relative to the Year 1 approved budget:

- **Budget Period 1 (Year 1):** Full approved budget. Year 1 represents the highest allowable funding level and must include all major procurement, capital acquisitions, infrastructure buildout, and program launch costs. Year 1 is the baseline against which all subsequent years are measured.

- **Budget Period 2 (Year 2):** Not to exceed 75% of the Year 1 approved budget. Year 2 is the final Startup Year. Remaining procurement, phased technology rollouts, and continued onboarding activities are allowable, but must have been identified and justified in the original application. No new large-scale capital items may be introduced in Year 2 that were not included in the Year 1 approved budget.

- **Budget Period 3 (Year 3):** Not to exceed 40% of the Year 1 approved budget. Allowable costs are limited to maintenance of existing infrastructure, software licensing renewals, personnel supporting ongoing service delivery and data reporting, and required compliance and reporting activities.

- **Budget Period 4 (Year 4):** Not to exceed 35% of the Year 1 approved budget. Allowable costs are limited to the same categories as Year 3. Continuation of any Year 3 waiver requires a new, separately justified waiver request reviewed against Year 4 performance data.

- **Budget Period 5 (Year 5):** Not to exceed 30% of the Year 1 approved budget. Year 5 is the final program year and must reflect the program's transition toward financial self-sufficiency. By Year 5, programs should be primarily funded through third party payer billing (i.e., Medicaid, Medicare, Tricare, Commercial, etc.), value-based arrangements, or other sustainable revenue sources. Year 5 budgets must demonstrate a credible path to post-grant operational continuity consistent with Section H (Sustainability Plan).

⚠ CRITICAL: Budget Changes Require CMS Approval — Retroactive Approval Will Not Be Granted
Any budget modification that exceeds the annual benchmarks set forth in Section J.2 — including any request to carry a Maintenance Year budget above the applicable percentage cap — constitutes a material budget change requiring (1) prior written approval from the Agency and (2) submission to CMS for review and approval before the expenditure is incurred. This requirement applies regardless of whether the modification is framed as a budget revision, a line-item reallocation, or a waiver request. Costs incurred prior to obtaining written Agency and CMS approval are unallowable and will not be reimbursed. Applicants are therefore strongly encouraged to invest significant effort in developing a comprehensive, accurate, and forward-looking five-year budget at the time of application.

J.3 Large Purchase and Capital Expense Caps

All large purchases — defined as any single acquisition with a unit cost of $10,000 or more, or any lease, contract, or technology procurement with a total value of $50,000 or more — must be identified and justified in the approved Year 1 budget. Large purchases that were not included and approved in the Year 1 budget require a formal budget modification with prior Agency and CMS written approval before the expenditure is incurred. The following category-specific caps apply to all RHTP initiatives and are in addition to any initiative-specific restrictions defined in the applicable Initiative Guidance Document.

- **Facility Leases:** RHTP funds may support facility leases directly required for program service delivery. Lease terms funded with RHTP dollars may not exceed 36 months in total duration, regardless of the program's period of performance. The maximum monthly lease cost allowable without prior Agency written approval is $8,000 per facility per month. Leases exceeding this threshold require prior Agency approval and must be submitted to CMS before execution. Lease agreements must include a termination-for-convenience clause allowing the subrecipient to exit the lease if RHTP funding is discontinued. New facility leases entered in Years 3, 4, or 5 are not allowable, unless approved by the Agency. Applicants must document a post-lease transition plan — demonstrating how the facility cost will be absorbed, transitioned to a partner, or wound down — as part of the Sustainability Plan (Section H).

- **Renovations:** All renovations must be submitted to the Agency for approval from CMS. CMS approval can take up to 30 days.

- **Mobile Health Unit Leases:** Vehicle purchase is prohibited under all RHTP initiatives. Mobile health units must be leased or operated under contract. Mobile unit lease terms funded with RHTP dollars may not exceed 36 months in total duration. The maximum monthly lease cost per unit is $12,000. New mobile unit leases may not be initiated in Years 3, 4, or 5. Continuation of an existing Year 1 or Year 2 lease into Maintenance Years is allowable only if the lease term was disclosed and approved in the original application budget and does not exceed the 36-month cap. Applicants must include a post-grant mobile unit transition plan in their Sustainability Plan (Section H).

- **Clinical and Telehealth Equipment (Unit Cost ≥$10,000):** Equipment purchases with a unit cost of $10,000 or more — including telehealth carts, imaging systems, remote patient monitoring kits, eICU hardware, and point-of-care diagnostic devices — are limited to Startup Years only. Total equipment expenditures in this category may not exceed 25% of the Year 1 approved annual budget in Year 1, and 15% of the approved annual budget in Year 2. Equipment purchases are not allowable in Years 3, 4, or 5, except for documented replacement of a failed or end-of-life device that is critical to continued program operation. Replacement purchases in Maintenance Years require prior Agency written approval and must be submitted to CMS before the expenditure is incurred. All equipment acquired with RHTP funds must be dedicated exclusively to program use and tagged for federal inventory tracking.

- **Health IT and EHR Platform Implementation:** Large-scale technology implementations — including EHR onboarding, HIE connectivity buildout, telehealth platform implementation, and any single-vendor

technology contract with a total value exceeding $100,000 — must be identified, scoped, and fully budgeted in Year 1. Any single-vendor technology contract or platform implementation exceeding $100,000 requires prior Agency written approval before execution. In Maintenance Years (3–5), allowable technology costs are limited to software licensing renewals, platform subscription fees, and cybersecurity maintenance directly tied to systems implemented during Startup Years. New platform implementations or vendor contracts are not allowable in Maintenance Years without prior CMS approval. EHR replacement is subject to the 5% cap defined in Section 11.16.

J.4 Maintenance Year Budget Benchmark Waiver Process

The Agency recognizes that certain programs may face structurally higher maintenance costs due to program complexity, geographic scope, or contractual obligations outside the subrecipient's control. A subrecipient may request a waiver permitting a Maintenance Year budget to exceed the applicable benchmark, subject to the conditions below. Because waivers require CMS review and approval, they are not guaranteed and may not be approved in time to avoid funding gaps. Applicants who anticipate elevated maintenance costs should account for this in their original five-year budget wherever possible rather than relying on the waiver process. Waiver process and criteria will be shared upon program implementation.

⚠ Annual Performance Reevaluation and Continuation Funding
The Agency will conduct an annual performance re-evaluation of each subrecipient prior to the start of each subsequent budget period. Continuation funding for Budget Periods 2 through 5 is contingent on satisfactory performance in this reevaluation. The reevaluation will assess: (1) progress against approved milestones and deliverables; (2) timeliness and completeness of all required reporting; (3) compliance with all budget design requirements and spending benchmarks in this Section; and (4) the subrecipient's demonstrated trajectory toward financial sustainability. Subrecipients that do not meet the performance threshold for continuation may have their award reduced, placed under enhanced monitoring, or terminated consistent with Section 12.4 and Section 13. Waiver requests, if any, are reviewed as part of this annual reevaluation cycle and are subject to CMS approval before taking effect. See Section 12.3 for prior approval requirements applicable to budget modifications.

Section K- Budget Narrative

All applications must include a written budget narrative accompanying the budget template that covers all five years of the grant period. The narrative is the primary justification for all proposed costs and will be evaluated accordingly. Budgets will be reviewed annually. The Agency will meet with each awardee at the midpoint of each budget period to review prior year expenditures and approve and or adjust the upcoming year budget based on project progress. The narrative submitted with the application establishes the foundation for that process.

Level of Detail

Years 1 and 2 require specific, line-item level justification. Years 3 through 5 should reflect the applicant's vision for program evolution, anticipated cost reductions, and path to sustainability. All five years must be addressed and align with expenditures provided in the budget template.

Required Elements

- Phased Cost Plan — Describe how costs will change across five years. Explain which costs are associated with launch and implementation versus ongoing operations. Justify any costs that do not decrease in later years. Budgets should reflect reduced reliance on grant funding as the program matures.

- Personnel and Fringe — Identify each position, FTE percentage, annual salary, grant-funded portion, and relevance to the initiative. State the fringe rate used. Explain any costs shared across initiatives or funding sources.

- Contractual Costs and Subcontractors — Identify each partner (as defined in Section 1.7) individually. Describe scope of work, estimated cost, and procurement method. Unjustified contractual costs will be considered unsupported and may be disallowed.

- Administrative and Indirect Costs — Detail all administrative costs within the 3% cap. Justify any administrative costs claimed as direct costs.

- Costs Spanning Multiple Initiatives — For any cost shared across initiatives within a bundle, explain the allocation methodology and confirm costs are not double-counted.

- Year-by-Year Summary — Provide a brief summary for each year describing primary activities, major cost drivers, and changes from the prior year. For years with decreased budgets, explain what is concluding and how continuity will be maintained.

Required Attachment: Completed Agency-provided Attachment II, Section K Form.

Section L — Required Certifications

All applications must include signed certifications using Attachment II, Section L Form. Additional initiative-specific certifications may be required; refer to the applicable Initiative Guidance Document.

Section M — Protective Clauses Certification

All applications must include signed certifications using the Agency-provided Attachment II, Section M Form covering:

- Exculpatory Protection;
- Safeguarding of Enrollee Information;
- Indemnification;
- Insurance Requirements;
- Flow-Down Requirements;
- Contractual Compliance and Enforcement;
- Utilization Management Safeguards;
- Subcontractor Solvency;
- Fraud, Waste, and Abuse Compliance;
- Cooperation With Recovery and Oversight;
- Termination and Notification Requirements; and
- Encounter Data Requirements.

Remainder of Page Intentionally Left Blank.

SECTION 8: STANDARD REPORTING REQUIREMENTS

The following reporting schedule applies to all RHTP initiative subrecipients unless modified by a specific Initiative Guidance Document. All report submissions must be made through the Agency-designated reporting portal, which will be specified in the subaward agreement.

⚠ Reporting Date Notice
Subrecipient due dates below are set in advance of the Agency's own CMS reporting deadlines to allow the Agency sufficient time to review, roll up, and submit consolidated data to CMS. Subrecipients that miss these deadlines jeopardize the Agency's compliance with federal reporting obligations. Late submissions may trigger corrective action.

Report Type	Reporting Period	Due Date
Quarterly Progress Report — Q1	August – October	November 10
Quarterly Progress Report — Q2	November – January	February 10
Quarterly Progress Report — Q3	February – April	May 10
Annual Progress Report (replaces Q4)	August – July (full program year)	August 15
Sustainability Plan Update	Annual	With Annual Progress Report (August 15)
Final Progress Report	Full performance period	November 27, 2030

Ad Hoc Reporting Compliance

The Subrecipient shall comply with all ad hoc reporting requirements as may be issued by the Agency or the Centers for Medicare & Medicaid Services (CMS). The Agency reserves the right to request additional reports, data, documentation, or information at any time during the Period of Performance or Budget Period. The Subrecipient shall submit all such reports in the format and within the timeframe prescribed by the Agency. Failure to comply with ad hoc reporting requirements may result in corrective action, payment withholding, or other remedies available under the terms of the subaward.

Financial Report Adjustments

The Subrecipient shall have **forty-five (45) calendar days** following the end of each annual Budget Period to submit any revisions, corrections, or amendments to its previously submitted Financial Report (or equivalent financial documentation required by the Agency). This adjustment period is provided solely to ensure the financial report accurately reflects **all allowable expenditures incurred on or before October 30**, including expenditures that occurred prior to that date but were recorded or posted afterward.

8.1 Report Content Requirements

The content requirements below represent the minimum reporting standards applicable to all RHTP subrecipients. The Agency reserves the right to modify reporting content requirements post-award, including

adding, removing, or adjusting required report elements, to reflect program needs, federal guidance, or CMS directives. Subrecipients will be notified in writing of any changes to reporting requirements.

Monthly Data Extracts

Subrecipients must submit monthly data extracts containing program-level indicators as specified in the RHTP data dictionary issued post-award. These extracts support continuous monitoring by the Agency and CMS. Specific data elements vary by initiative and will be defined in the post-award data dictionary.

Quarterly Progress Reports (Q1–Q3)

Quarterly reports must include: (1) narrative progress against milestones and deliverables; (2) performance metric updates; (3) identification of barriers and corrective actions; (4) financial expenditure summary; and (5) any significant changes to the program since the last report.

Annual Progress Report (replaces Q4 Report)

The Annual Progress Report replaces the standalone fourth quarterly report. Annual reports must include: (1) year-over-year progress against all outcome metrics; (2) analysis of program implementation fidelity; (3) sustainability updates; (4) lessons learned; (5) quality improvement activities; (6) full-year financial reconciliation; and (7) plan for the upcoming year.

8.2 Data Quality Standards

All subrecipients must implement pre-submission data quality controls including checks for: completeness, accuracy, timeliness, consistency, and reconciliation against source systems. The Agency may reject, return, or require resubmission of data that does not meet minimum quality standards. Subrecipients must cooperate with Agency verification procedures and cross-checks to statewide data assets.

8.3 Privacy and Security Requirements

- Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164: Required for all subrecipients handling protected health information (PHI). Subrecipients must maintain written HIPAA policies, train staff, and document breach response procedures.
- Family Educational Rights and Privacy Act (FERPA), 20 USC §1232g: Required for subrecipients handling student education records. Policies must meet or exceed federal minimum standards.
- State cybersecurity standards: All data systems must enforce access controls, encryption, audit trails, and breach notification procedures consistent with Florida Department of Management Services cybersecurity standards.
- Subrecipients handling HHS personally identifiable information (PII) or PHI must maintain a written cybersecurity plan and provide a copy to the Agency upon request.

8.4 Data Retention

All financial records, supporting documents, statistical records, and other program records must be retained for a minimum of ten (10) t) years from the date of submission of the final expenditure report, unless a longer period is required by applicable law or is in litigation, claim, or audit status. Records must be available for inspection by the Agency, CMS, HHS Office of Inspector General (HHS OIG), and Government Accountability Office (GAO) upon request.

CONSEQUENCES OF UNTIMELY OR INCOMPLETE REPORTING
Untimely reporting, incomplete data submissions, materially inaccurate data, or failure to implement required data validation processes may result in contractual remedies including withholding of payments, cure notices, corrective action plans, and/or assessment of liquidated damages as specified in the subaward agreement. Liquidated damages represent a reasonable estimate of the State's damages for non-performance — not a penalty.

SECTION 9: SUSTAINABILITY PLAN REQUIREMENTS

All RHTP subrecipients must demonstrate a credible path from grant-supported startup to self-sustaining operations. The following minimum requirements apply to all initiatives. Individual Initiative Guidance Documents specify additional program-specific sustainability components.

9.1 Mandatory Components (All Initiatives)

- Service Continuation Strategy: A detailed description of how funded services, programs, and infrastructure will continue operating after grant funding ends, including staffing, facilities, technology, and operational costs.
- Revenue Strategy and Braided Funding: A clear plan combining payer reimbursement (Medicaid, Medicare, commercial), value-based arrangements, grants, and local funding sources to replace grant startup funding by no later than November 1, 2031 (one year after the program ends). Plans demonstrating financial self-sufficiency prior to that date are viewed favorably.
- Technology Lifecycle Plan: Plans for ongoing licensing, refresh, cybersecurity, and maintenance of technology assets after the grant period, funded from non-grant operating sources.
- Financial Solvency and Risk Controls: Evidence of financial solvency, diversified revenue, adequate reserves, and governance oversight sufficient to support post-award operations.
- Compliance Continuity: Attestation of ongoing compliance with RHTP restrictions (including those on unallowable costs) during and after the grant period.

9.2 Required Documentation

- Financial Pro Forma (Grant Years 1–5 plus one post-award year, i.e., through October 31, 2031): Revenue projections, operating expense projections, margin and cash-flow projections, break-even timeline, and sensitivity analysis. The pro forma should reflect realistic assumptions based on documented payer mix and reimbursement rates. Organizations not yet operational in the proposed service area should clearly note assumptions used.
- Payer Mix Analysis: Current and projected payer mix, reimbursement rates, and strategies to increase insured patient or participant percentage.
- Sustainability Narrative: Written explanation of how services will be sustained, identification of risks and mitigation strategies, and timeline for financial self-sufficiency.
- Leadership Commitment Letter: From organizational leadership committing to sustain services beyond the grant period.
- Partner Commitment Letters (optional but strongly encouraged): From payers, employer partners, or community stakeholders supporting the sustainability plan.

SECTION 10: SUBRECIPIENT MONITORING AND COMPLIANCE

10.1 Subrecipient Designation

Organizations awarded funding under any RHTP initiative are designated as subrecipients under 2 CFR 200.93. As subrecipients, awardees are subject to all applicable requirements of 2 CFR Part 200 Subparts D (Post-Award Requirements) and F (Audit Requirements). The Agency serves as the Pass-Through Entity (PTE).

10.2 Agency Pass-Through Entity Responsibilities

As the Pass-Through Entity, the Agency will:

- Evaluate each applicant's risk posture pre-award and apply specific award conditions if warranted;
- Monitor subrecipients annually through site visits and programmatic and financial report review;
- Verify Single Audit filings and review findings where applicable;
- Check SAM.gov status for debarment and suspension at award and periodically during performance;
- Provide technical assistance to support compliance and program success; and
- Notify CMS of any subrecipient non-compliance per CMS Standard Terms §17.

10.3 Subrecipient Obligations

If awarded, all subrecipients must:

- Maintain active SAM.gov registration with annual renewal;
- Maintain financial management systems meeting 2 CFR 200.302 standards (budgetary controls, accounting records, source documentation, cash management);
- Submit all required reports on time, completely, and accurately, per Section 8;
- Provide access to the Agency, CMS, HHS OIG, and GAO for monitoring and audit activities;
- Retain all records, per Section 8.4;
- Promptly disclose credible evidence of fraud, bribery, or gratuity violations to the Agency and HHS OIG per 2 CFR 200.113 (see Section 11.10);
- Notify the Agency immediately of significant problems, risks, adverse findings, or events affecting performance or compliance;
- Notify the Agency within five (5) business days of any bankruptcy filing, receivership, or insolvency proceedings; and
- Inform all employees in writing of whistleblower rights in their predominant native language per 41 USC §4712.

10.4 Procurement by Subrecipients

All subrecipient procurement must comply with 2 CFR 200.317–200.327; all applicable Florida statutes, rules and Agency policies; cost and price analysis requirements (2 CFR 200.324); required federal contract provisions; and prohibition on contracting with debarred or suspended parties. Subrecipients should consult AHCA's Technical Assistance provider for guidance on applicable Florida state procurement standards.

10.5 Single Audit Requirements

Subrecipients that expend $1,000,000 or more in federal awards in a fiscal year must conduct a Single Audit in accordance with 2 CFR Part 200, Subpart F. Single Audit findings must be disclosed to the Agency, and a corrective action plan submitted within 90 days of the audit report. Subrecipients expending less than $1,000,000 are subject to the Agency's internal monitoring program.

10.6 Corrective Action and Remedies

In the event of non-compliance, the Agency may take the following escalation actions:

- Issue a Notice of Non-Compliance requiring correction within 30–90 days;
- Require a Corrective Action Plan with enhanced monitoring;
- Withhold or suspend payments pending resolution;
- Reduce the award amount;
- Terminate the award for cause under 2 CFR 200.340; and
- Require repayment of disallowed costs.

SECTION 11: FEDERAL TERMS AND CONDITIONS

All subawards under the RHTP flow through from CMS Cooperative Agreement No. 1RHTSSCMS332067-01-00. The following terms are binding on all subrecipients for the 14 RFA-based RHTP initiatives. This Section summarizes key requirements; the full terms are contained in the Notice of Award, available in this RFA as Attachment III.

11.1 Uniform Guidance

All subawards are governed by 2 CFR Part 200 (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards) and HHS-specific modifications at 2 CFR Part 300. For-profit entities are subject to 48 CFR 31.2 for cost principles and 2 CFR 300.218 for audit requirements.

11.2 Salary Limitations

Pursuant to the HHS Appropriations Act and as specified in Attachment III, Notice of Award, none of the funds appropriated under this award 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**. This salary cap applies to direct salaries only. Subrecipients may pay salaries at a rate higher than Executive Level II provided the amount in excess of the cap is paid with non-federal funds.

Since the Executive Level II rate changes each year, subrecipients must consult the current rate posted by the U.S. Office of Personnel Management (OPM) at opm.gov — Salaries and Wages. The applicable cap is the rate in effect during the period in which the work is performed. Subrecipients must update their budgets annually to reflect the current cap.

The Principal Investigator/Project Director (PI/PD) must maintain a minimum of 25% effort on the funded program. This position must be funded with federal funds or documented as a cost-share (in-kind) contribution by the subrecipient.

11.3 Key Personnel

Any changes to key personnel must be reported to the Agency in writing within ten (10) business days. Prior written approval from the Agency is required before implementing key personnel changes. This requirement applies at the subrecipient level; personnel identified in the approved application as critical to program implementation are considered Key Personnel for purposes of this requirement. The Agency will clarify in each subaward agreement which positions constitute Key Personnel for that award.

11.4 SAM.gov Registration

All subrecipients must maintain an active SAM.gov registration with a valid Unique Entity Identifier (UEI) throughout the entire period of performance. Registration must be renewed at least annually. This requirement flows to all sub-subrecipients and contractors receiving $25,000 or more. Failure to maintain active registration may result in withholding of payments and notification to CMS.

11.5 FFATA Subaward Reporting

Pursuant to the Federal Funding Accountability and Transparency Act (FFATA) and 2 CFR Part 170, the Agency is required to report first-tier subawards of $40,000 or more to USASpending.gov within 30 days of the subaward date. Subrecipients whose total senior executive compensation exceeds $300,000 per year may be required to disclose executive compensation data. The Agency will notify subrecipients of specific reporting obligations upon award.

11.6 Stevens Amendment — Public Communications

This language must appear on all public communications, publications, press releases, presentations, and outreach materials related to any RHTP-funded activity.

REQUIRED STEVENS AMENDMENT LANGUAGE (All RHTP Initiatives)
"This program is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $[AMOUNT] with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, CMS/HHS, or the U.S. Government."

All public communications must also state: (1) the percentage and dollar amount of federal funding, and (2) the percentage and dollar amount of non-governmental funding (if any). Subrecipients must submit all publications, presentations, and external communications to the Agency for review at least 30 days prior to release per CMS Standard Terms §29(F).

11.7 Privacy, Security, and HIPAA

Subrecipients must comply with the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164 (HIPAA Privacy and Security Rules), for all programs handling protected health information (PHI). Privacy and security policies must be at least as protective as HIPAA requirements. A cybersecurity plan is required for subrecipients that maintain ongoing HHS system access or that collect, store, or transmit personally identifiable information (PII) or PHI. Breach notification procedures must be documented and implemented. Subrecipients operating educational programs that maintain student education records must additionally comply with the Family Educational Rights and Privacy Act (FERPA), 20 USC §1232g and 34 CFR Part 99.

11.8 Whistleblower Protections

Pursuant to 41 USC §4712, all subrecipients must inform all employees in writing of their whistleblower rights and remedies in their predominant native language. This notice must be provided at hiring or at the time of subaward. Non-federal employers receiving federal funds may not discharge, demote, or otherwise discriminate against employees who report fraud, waste, or abuse.

11.9 Anti-Kickback Statute

42 USC §1320a-7b (the Federal Anti-Kickback Statute) is incorporated by reference into all RHTP subawards. Subrecipients may not solicit, receive, offer, or pay any remuneration (including kickbacks, bribes, or rebates) in connection with any item or service covered by a federal health care program. Violations may result in criminal penalties, civil monetary penalties, and exclusion from federal health care programs.

11.10 Mandatory Disclosures

Pursuant to 2 CFR 200.113, subrecipients must promptly disclose to the Agency and to the HHS Office of Inspector General (HHS OIG) in writing any credible evidence of a violation of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures to HHS OIG must be made to:

- Email: MandatoryGranteeDisclosures@oig.hhs.gov
- Mail: Office of Inspector General, U.S. Department of Health and Human Services, 330 Independence Avenue SW, Room 5527, Washington, DC 20201
-

Failure to make required disclosures may result in suspension, debarment, or other enforcement action.

11.11 Fraud, Waste, and Abuse

Subrecipients must maintain robust internal controls to prevent fraud, waste, and abuse of federal funds. Suspected fraud or abuse may be reported to the HHS OIG Hotline at 1-800-HHS-TIPS (1-800-447-8477) or at oig.hhs.gov/fraud/report-fraud/.

11.12 Civil Rights and Non-Discrimination

All subrecipients must comply with:

- Title VI of the Civil Rights Act of 1964 (45 CFR Part 80) — prohibits discrimination based on race, color, or national origin;
- Section 604 of the Rehabilitation Act of 1973 (45 CFR Part 84) — prohibits discrimination based on disability;
- Title IX of the Education Amendments of 1972 (45 CFR Part 86) — prohibits sex discrimination in education programs;
- Age Discrimination Act of 1975 (45 CFR Part 91) — prohibits age discrimination; and
- Section 1557 of the Affordable Care Act (45 CFR Part 92) — prohibits discrimination in covered health programs on the basis of race, color, national origin, sex, age, or disability.

These requirements flow down to all contractors, subcontractors, and partners receiving RHTP funds.

11.13 Program Income

Program income — defined as gross income earned by a subrecipient that is directly generated by a supported activity or earned as a result of the subaward (2 CFR 200.80) — earned during the period of performance must be handled per 2 CFR 200.307.

11.14 Intellectual Property and Inventions

Per 2 CFR 200.448 and 37 CFR Part 401, CMS retains a royalty-free, nonexclusive, and irrevocable license for federal government purposes with respect to any invention or intellectual property developed under this award. Subrecipients must report inventions annually. A Final Invention Statement (HHS Form 568) must be submitted within 120 days of award expiration or termination.

11.15 Court Orders

Any terms of a subaward that have been enjoined or otherwise prohibited by court order will not be applied or enforced against affected subrecipients while such order remains in effect. The Agency will provide written notice to affected subrecipients regarding applicable court orders as they become known.

11.16 Unallowable Costs (All Initiatives)

The following cost categories are unallowable under all RHTP initiatives regardless of the specific initiative's allowable use provisions. These prohibitions are drawn directly from Attachment III, Notice of Award (RHTCMS332067-01-00), which includes the CMS Program Terms and Conditions; and the CMS Standard Terms and Conditions (ver. 13.14.2025).

Universal Prohibitions (All CMS Awards — Standard Terms §27 and Program Terms §14)

- Pre-award costs.
- Meeting match requirements for any other federal funds or local entities.
- Services, equipment, or supports that are the legal responsibility of another party under federal, State, or tribal law (including vocational rehabilitation, education services, or reasonable workplace accommodations that are a specific obligation of the employer).
- Services, equipment, or supports that are the legal responsibility of another party under any civil rights law.
- Goods or services not allocable to the approved project.
- Supplanting existing State, local, tribal, or private funding of infrastructure or services, such as staff salaries. RHTP funds must supplement — not replace — existing funding.
- Construction or building expansion, purchasing or significant retrofitting of buildings, cosmetic upgrades, or any other cost that materially increases the value of the capital or useful life of a facility as a direct cost.
- The cost of independent research and development, including the proportionate share of indirect costs. See 2 CFR 300.477.
- Profit to any recipient, including for-profit organizations. Profit is any amount in excess of allowable direct and indirect costs. See 2 CFR 200.400(g).
- Funds related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before Congress or any State or local government body. See 2 CFR 200.450 and 45 CFR Part 93. Recipients may lobby at their own expense if federal funds are fully segregated from other financial resources used for lobbying.
- Purchase of covered telecommunications and video surveillance services or equipment prohibited under 2 CFR 200.216, as well as financial assistance to households for installation and monthly broadband internet costs.
- Costs of promotional items and memorabilia, including models, gifts, and souvenirs.
- Costs of advertising and public relations designed solely to promote the non-federal entity.
- Meals, unless in limited circumstances: (1) subjects and patients under study; (2) where specifically approved as part of the project or program activity (not recipient-specific), such as programs providing children's services; or (3) as part of a per diem or subsistence allowance in conjunction with allowable travel.

Program-Specific Prohibitions (RHTP NOFO and Program Terms §14)

- New construction. Funds may not be used for new construction or to supplant funding for in-process or planned construction projects. Minor renovations or alterations are allowable only if clearly linked to program goals, receive prior CMS approval, and do not exceed 20% of the total funding awarded to the subrecipient in a given budget period.
- Duplicate payments. Funds may not replace payment for clinical services reimbursable by insurance, duplicate billable services, or attempt to change existing fee schedules. Provider payments (payments to health care providers for items or services) may not exceed 15% of total funding awarded in a given budget period. Subrecipients proposing to fund direct health care services must justify why services are not already reimbursable and how payment fills a documented gap in care coverage. CMS has final approval of whether proposed services are allowable.
- Sex-trait modification procedures, as defined at 45 CFR 156.400. Funding cannot be used for cosmetic or experimental procedures that fall within this definition.

- Electronic Medical Record (EMR) replacement: No more than 5% of total funding awarded in a given budget period may support replacement of an EMR system where a previous HITECH-certified EMR system was already in place as of September 1, 2025. Replacement systems must be HITECH-certified.
- Rural Tech Catalyst Fund-type initiatives: Funding for initiatives similar to the "Rural Tech Catalyst Fund Initiative" (as described in the NOFO Appendix, pages 115–118) cannot exceed the lesser of (1) 10% of total funding awarded in a given budget period or (2) $20 million. Funding is subject to all restrictions and requirements described in the example initiative.
- Clinician salaries. Funds may not be used for clinician salaries or wage supports for facilities that subject clinicians to non-compete contractual limitations. This applies only to salaries and wages funded through the cooperative agreement via an approved initiative in the approved application.
- Intergovernmental transfers, certified public expenditures, or any other expenditure attributable to financing the non-Federal share of expenditures required under any provision of law.
- SSA §2105(c), paragraphs (1), (7), and (9): These limitations apply as funding restrictions and relate to general limitations, limitations on payment for abortions, and citizenship documentation requirements for payments made with respect to an individual.
- International recruitment or overseas travel not directly related to approved program activities.

Additional unallowable costs specific to individual initiatives are defined in the applicable Initiative Guidance Document. Subrecipients should also consult 2 CFR Part 200 Subpart E (General Provisions for Selected Items of Cost) and HHS-specific modifications in 2 CFR Part 300 for further guidance.

SECTION 12: AWARD ADMINISTRATION

12.1 Subaward Agreement

Selected applicants will enter into a formal subaward agreement with the Agency, using Attachment IV, Agency Standard Grant Agreement. The agreement incorporates by reference: the Notice of Award (NOA) and all attachments; 2 CFR Part 200 and Part 300; this Standard Terms document; the applicable Initiative Guidance Document; and the approved application. It specifies scope of work, budget, reporting requirements, performance metrics, and compliance obligations.

12.2 Payment Structure

All RHTP subaward payments are made on a milestone- and performance-based schedule. No payment will be issued absent the submission of the required deliverable or report for that payment tier. Payments are processed through the CMS Payment Management System (PMS) and are subject to CMS drawdown timing requirements. Subrecipients must maintain financial management systems meeting 2 CFR 200.302 standards, and all payment requests must be supported by adequate source documentation as specified in the subaward agreement. The Agency retains sole authority for contract interpretation and contract clarification under this payment structure.

12.2.1 Budget Period 1 — Milestone Payments and Quarterly Payments

Budget Period 1 of the cooperative agreement runs from December 29, 2025, through October 30, 2026 (approximately 10 months). Subrecipient subawards are projected to execute approximately July 2026, giving subrecipients approximately 4 months within Budget Period 1 to begin activities and obligate startup funds.

- **Milestone Payment 1 — Revised Implementation Plan and Budget (10% of Year 1 approved budget).** Due within 30 days of subaward execution.* The subrecipient must submit a revised implementation plan and budget that incorporates the Agency-approved award amount and any scope revisions or negotiated adjustments identified by the Agency during the award process. The revised

plan must be accepted in writing by the Agency before payment is released. This payment is not automatic upon submission; Agency acceptance is required.

- **Milestone Payment 2 — Baseline Data Submission (15% of Year 1 approved budget).** Due within 60 days of subaward execution.* The subrecipient must submit a complete baseline data report using the Agency-provided template. The Agency will provide the baseline data template and technical assistance on submission requirements post-award. Payment is released upon Agency confirmation that the baseline data submission is complete and meets minimum data quality standards per Section 8.2.

** Milestone payment due dates are calculated from the date of subaward execution and are contingent upon the actual award date and agreement execution. Estimated months shown in the payment schedule table below are illustrative based on a projected July 2026 award date.*

Following the two milestone payments, the remaining 75% of the Year 1 approved budget is divided evenly into four equal quarterly payments of 18.75% each, paid upon submission and Agency acceptance of the applicable Quarterly Progress Report. Quarterly payments are tied directly to the reporting schedule in Section 8 and the CMS reporting calendar. Subrecipients have 30 days from the end of each quarter to submit their Quarterly Progress Report. The Agency has 30 days from receipt of a complete, accepted submission to process payment, which is calibrated to align with the Agency's own CMS reporting obligations. A late or incomplete submission reduces the Agency's processing window and may delay payment; the Agency bears no obligation to expedite payment for late submissions.

Table 12.2 — Year 1 Payment Schedule (Estimated; based on projected July 2026 award date)*

Payment Event	Deliverable Deadline	Y1 Payment	Cumulative Y1
Milestone 1 — Revised Implementation Plan & Budget	~September 1, 2026*	**10%**	10%
Milestone 2 — Baseline Data Submission	~October 1, 2026*	**15%**	25%
Q1 Progress Report (Aug – Oct 2026)	November 1,2026	**18.75%**	43.75%
Q2 Progress Report (Nov 2026 – Jan 2027)	February 15, 2027	**18.75%**	62.5%
Q3 Progress Report (Feb – Apr 2027)	April 15, 2027	**18.75%**	81.25%
Annual Report / Q4 (May – Jul 2027)	August 1, 2027	**18.75%**	**100%**

** Milestone payment dates for the Revised Implementation Plan and Baseline Data Submission are contingent upon the actual award date and agreement execution date. Months shown are estimated based on a projected July 2026 award date and will be adjusted in each subaward agreement to reflect actual execution.*

12.2.2 Budget Periods 2 Through 5 — Quarterly Payment Structure

For Budget Periods 2 through 5, payments are made quarterly, tied to the submission and Agency acceptance of the applicable Quarterly Progress Report or Annual Progress Report as defined in Section 8. Each quarterly payment equals 25% of that budget period's approved annual budget. Subrecipients must submit the Quarterly Progress Report, including all required data submissions, within 30 days of the end of each quarter. The Agency will process and issue payment within 30 days of receiving a complete, accepted submission, calibrated to meet

the Agency's own CMS reporting deadlines. Annual reconciliation occurs at the close of each budget period; unexpended funds are subject to recoupment, per Section 1.3. Continuation funding for each subsequent budget period is subject to the conditions in Section 13.4 and the annual performance reevaluation process described in Section 7.J.4.

12.2.3 Late Submission Consequences

Because the Agency's payment processing window simultaneously satisfies its CMS reporting obligations, late subrecipient submissions directly jeopardize AHCA's compliance with federal deadlines. Accordingly: a quarterly payment will not be issued until the corresponding report is received and accepted as complete. A late submission does not extend the Agency's payment deadline — the clock begins upon Agency receipt of a complete, accepted report. Payments for late submissions will be processed in the next available payment cycle. Repeated late submissions may constitute non-compliance and trigger corrective action under Section 10.6. The Agency bears no obligation to expedite payment or request extensions from CMS due to a subrecipient's failure to submit timely reports.

12.2.4 Invoice Requirements

Payment will be made upon the receipt, review, and approval of deliverables and properly completed invoices. Invoices shall be received by the deadline indicated in the executed Grant Agreement contract following the end of the month or period for which payment is being requested. Invoices must be supported with appropriate documentation and reports.

The Recipient shall submit invoices and all supporting documents on the Recipient's letterhead to the Agency's designated Agreement Manager h following the reporting period. The invoice shall include at a minimum:

a. Documentation detailing deliverables completed and/or services rendered covered by the invoice;

b. The time period in which deliverables were completed and/or services were rendered;

c. The subrecipient's unique identifying invoice number;

d. Invoice date;

e. The subrecipient's payment remittance address;

f. The Agency's Grant Agreement number (GFA###);

g. The subrecipient's Federal employer Identification (FEID) Number;

h. Copies of all receipts and invoices from suppliers showing proof of purchase. Items related to this project must be clearly noted and identifiable on the receipt or invoice;

i. Details of all payroll and travel conducted

j. Other supporting documentation as requested by the Agency.

Payments will be authorized only for services that are in accordance with the terms and conditions of this Agreement.

Invoices shall not be approved for payment by the Agency until reports and deliverables from the subrecipient are received as specified in the Grant Agreement.

12.3 Amendments and Prior Approvals

Prior written approval from the Agency is required before implementing scope changes; key personnel changes; budget reallocations exceeding 10% within a budget period; changes to the geographic service area; and significant operational changes affecting program design. The Agency will seek CMS prior approval as required for changes affecting the prime cooperative agreement. Only written amendments signed by the Agency's authorized official constitute valid approvals.

CMS prior approval is additionally required for: minor renovations exceeding 20% of a budget period's total award (where applicable); and activities not reflected in the approved RHTP application submitted to CMS.

12.4 Continuation Funding

Each budget period beyond Budget Period 1 requires the Agency to submit a Non-Competing Continuation (NCC) application to CMS. An NCC application is a non-competitive financial assistance request the Agency submits annually to receive the next 12-month increment of federal funding. CMS reviews and approves the NCC before issuing a new Notice of Award for that budget period. NCC applications are not reviewed by a merit panel; they are reviewed by CMS staff and must reflect satisfactory progress and updated budget and workplan information.

Continuation funding to subrecipients is conditioned on satisfactory subrecipient performance; timely reporting compliance; Agency approval of the continuation plan and budget; CMS approval of the Agency's NCC application; and continued availability of federal funds. The Agency may reduce, withhold, or decline to renew continuation funding for non-compliance or performance failure.

12.5 Termination

Awards may be terminated for cause (material non-compliance) or for convenience (where continuation is no longer in the public interest or if CMS terminates the cooperative agreement) per 2 CFR 200.340. Costs incurred after termination are generally unallowable. The Agency will provide notice of non-compliance risk and opportunity for corrective action prior to termination for cause where feasible.

SECTION 13: PROGRAM EVALUATION FRAMEWORK

During the term of the Grant Agreement, all RHTP initiatives are subject to a common evaluation framework. Individual Initiative Guidance Documents specify initiative-level outcome metrics, program-specific performance indicators, and additional evaluation requirements. Cadence and reporting templates will be provided upon agreement execution.

13.1 Program Evaluation Components (All Initiatives)

Throughout the term of the Grant Agreement, the Agency will annually evaluate subrecipient performance, using the components listed below, at a minimum. If the subrecipient fails to meet the evaluation components during any year of the Grant Agreement, the Agency reserves the right to a) Issue a corrective action plan; or b) to cancel the Grant Agreement by giving the subrecipient thirty (30) days' written notice, during which time the subrecipient shall only complete program work that the Agency has approved in writing to be completed during the 30-day notice of agreement cancellation period. Additional closeout requirements may be given to the subrecipient by the Agency to ensure all Agency-specified work, reporting, and program requirements are completed by the subrecipient.

A. Implementation Evaluation

Assesses program startup fidelity, site readiness, staffing, partnership execution, and adherence to program design and facility and location requirements.

B. Process and Output Evaluation

Measures program operations and outputs (e.g., patients served, training placements, credentials attained, site activations). Specific metrics are defined in each Initiative Guidance Document.

C. Outcome Evaluation

Assesses progress toward RHTP strategic goal metrics as documented in Florida's approved CMS application. Specific statewide outcome targets are defined in each Initiative Guidance Document.

D. Impact Evaluation

Evaluates long-term population health improvements, workforce changes, and access to care outcomes attributable to RHTP investments.

E. Fiscal and Compliance Evaluation

Assesses allowable use of funds, timeliness and completeness of data submissions, adherence to 2 CFR 200 requirements, and compliance with all programmatic restrictions.

13.2 External Evaluation

The Agency will engage an independent external evaluator to conduct comprehensive evaluations of all RHTP initiatives. All subrecipients must:

- Cooperate fully with external evaluation activities;
- Provide access to program data, documentation, and staff for evaluation purposes;
- Participate in evaluation interviews, surveys, and site visits as requested; and
- Implement quality improvement recommendations arising from evaluation findings.

13.3 Continuous Quality Improvement

All subrecipients must demonstrate commitment to continuous quality improvement by:

- Establishing internal quality improvement processes using Plan-Do-Study-Act (PDSA) cycles or equivalent methodology;
- Regularly reviewing performance data and identifying improvement opportunities;
- Participating in statewide RHTP learning collaboratives as convened by the Agency;
- Sharing lessons learned and best practices with other RHTP subrecipients; and
- Adjusting program implementation based on performance data and evaluation findings.

SECTION 14: STANDARD COST RESTRICTIONS REFERENCE TABLE

The following table summarizes cost restrictions universal to all 14 RFA-based RHTP initiatives. Additional initiative-specific restrictions are defined in each Initiative Guidance Document.

Cost Category	Status	Authority / Notes
Administrative costs	**≤3 of total award (all initiatives)**	2 CFR 200.414; direct grant administration only. Must be expended by October 30 of each grant year.
Major construction / structural expansion	**PROHIBITED**	CMS Award Terms
Supplanting existing funds	**PROHIBITED**	2 CFR 200.306; funds must supplement only
Lobbying	**PROHIBITED**	2 CFR 200.450; 31 USC §1352
Promotional items / gifts / trinkets	**PROHIBITED**	2 CFR 200
Prohibited telecommunications equipment	**PROHIBITED**	2 CFR 200.216
Pre-award costs (without written approval)	**PROHIBITED**	2 CFR 200.458
Sex-trait modification procedures	**PROHIBITED**	45 CFR 156.400
Intergovernmental transfers	**PROHIBITED**	CMS Program Terms
Non-compete restrictions on RHTP-funded roles	**PROHIBITED**	CMS Standard Terms
International recruitment (without approval)	**PROHIBITED**	CMS Award Terms
Profit on cost-reimbursement awards	**PROHIBITED**	2 CFR 200.400(g)
Minor renovations (where applicable)	**≤20% per budget period; CMS prior approval required**	CMS Award Terms; initiative-specific
EHR/EMR replacement (where applicable)	**≤5% per budget period; HITECH-certified systems only**	CMS Program Terms; initiative-specific
Clinician salaries (general direct patient care)	**PROHIBITED**	Agency prohibition; CMS Standard Terms; NOA Program Terms §14
Payment for direct care services	**PROHIBITED**	Agency prohibition; NOA Program Terms §14
Provider payment arrangements	**PROHIBITED**	Agency prohibition; NOA Program Terms §14

Remainder of Page Intentionally Left Blank.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

ATTACHMENT II
RURAL HEALTH TRANSFORMATION PROGRAM
REQUIRED APPLICANT RESPONSE DOCUMENTS

SECTIONS A – M
RESPONSE FORMS

APPLICABLE TO 14 OF THE 15 RHTP INITIATIVES

CMS Cooperative Agreement No. 1RHTSSCMS332067-01-00

Period of Performance: December 29, 2025 – October 30, 2030

Florida Agency for Health Care Administration (Agency)

List of Forms

Section A Form – Cover Page and Applicant Information

Section B Form – Executive Summary

Section C Form – Organizational Capacity and Eligibility

Section G Form – Continuous Quality Improvement Plan

Section H Form – Sustainability Plan

Section I Form – Financial Solvency

Section J Form – Budget

Section K Form – Budget Narrative

Section L Form – Required Certifications

Section M Form – Protective Clauses Certification

RURAL HEALTH TRANSFORMATION PROGRAM (RHTP)
SECTION A
COVER PAGE AND APPLICANT INFORMATION

Instructions:

- The lead applicant must submit one cover page for each application bundle.
- Only one Super Region may be selected per application.
- If an organization is applying for more than one bundle or proposing activities in multiple Super Regions, a separate cover page is required for each unique bundle–region combination.
- Follow the page limits in the RHTP Initiative Guidance.

A. Applicant Organization Information

Legal Organization Name:	Click or tap here to enter text.
FEIN:	Click or tap here to enter text.
UEI (SAM.gov):	Click or tap here to enter text.
SAM.gov Status:	☐ Active ☐ Inactive/Expired
SAM.gov Expiration Date (MM/DD/YYYY):	Click or tap here to enter text.
Organization Type (check one):	☐ Rural Hospital / CAH ☐ FQHC ☐ RHC ☐ EMS / Community Paramedicine ☐ Behavioral Health Provider ☐ Local Government / County Health Department ☐ Nonprofit Organization ☐ Educational Institution ☐ Other
If Other, please specify:	Click or tap here to enter text.

B. Primary Contacts

Authorized Organizational Representative (AOR) Name: Click or tap here to enter text.

Title: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Email: Click or tap here to enter text.

Program Director or Project Lead (if different) Name: Click or tap here to enter text.

Title: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Email: Click or tap here to enter text.

C. Rural Service Area/Rural Counties/Census Tracts Served (Select One)

Rural Eligibility Pathway:

☐ Pathway A – Florida Statute §288.0656
☐ Pathway B – Florida Rural Economic Development Initiative (REDI) or Rural Areas of Critical Economic Concern (RACEC)
☐ Pathway C – CMS Goldsmith (Hospitals only)
☐ Pathway D – HRSA RUCA Codes / Rural Census Tracts
☐ The applicant organization is headquartered outside of Florida's designated rural areas (required documentation is provided in application Section C)

D. Super Region Served (Select One Per Application)

☐ **Northwest** (Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla, Walton, Washington)
☐ **Northeast** (Alachua, Baker, Bradford, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Madison, Nassau, Putnam, St. Johns, Suwannee, Taylor, Union, Volusia)
☐ **Southwest** (Charlotte, Collier, DeSoto, Glades, Hardee, Hendry, Highlands, Lee, Manatee, Okeechobee, Sarasota)
☐ **Southeast** (Broward, Indian River, Martin, Miami-Dade, Monroe, Palm Beach, St. Lucie)

E. Initiative the Applicant Is Currently Applying For (Select One Per Application)

☐ Preventive Care & Care-at-Home Bundle (Bundle 1; Initiatives 2, 3, 10, 12, & 13)
☐ Specialty & Acute Care Bundle (Bundle 2; Initiatives 13, 14, & at least one from 4, 5, 6, 7)
Select which telehealth initiative is included with Bundle 2 (Must select at least one)
☐ Initiative 4 – Behavioral Health Telehealth & Telehub Psychiatry
☐ Initiative 5 – Tele-Specialties & Imaging
☐ Initiative 6 – Tele-Intensive Care Unit / eICU
☐ Initiative 7 – Hub-and-Spoke Telestroke with Transfer
☐ Initiative 1 – Rural & Satellite Clinics
☐ Initiative 8 – Workforce Development
☐ Initiative 9 – Health & Lifestyle
☐ Initiative 11 – Value-Based Purchasing

If you have or will be submitting an application for any other initiatives, please select them below:

☐ Preventive Care & Care-at-Home Bundle (Bundle 1; Initiatives 2, 3, 10, 12, & 13)
☐ Specialty & Acute Care Bundle (Bundle 2; Initiatives 13, 14, & at least one from 4, 5, 6, 7)
☐ Initiative 1 – Rural & Satellite Clinics
☐ Initiative 8 – Workforce Development
☐ Initiative 9 – Health & Lifestyle
☐ Initiative 11 – Value-Based Purchasing

F. Funding Amount Requested $Click or tap here to enter text.

G. Collaborators and Partners (List All Below and Provide Additional Documents Requested in Section E of the Application)

Brief Scope Summary (150 Words Max)

I. Standard Application Section Checklist

☐ Section A — Cover Sheet and Applicant Information (Current Document)
☐ Section B — Executive Summary (See Agency-provided Form)
☐ Section C — Organizational Capacity and Eligibility (One PDF Submission; See Agency-provided Form)
☐ Section D — Project Narrative
☐ Section E — Partnership Agreements
☐ Section F — Implementation Work Plan and Milestones
☐ Section G — Data Collection, Reporting, and Continuous Quality Improvement Plan (See Agency-provided Form)
☐ Section H — Sustainability Plan (See Agency-provided Form)
☐ Section I — Financial Solvency (See Agency-provided Form)
☐ Sections J and K — Budget and Budget Narrative (See Agency-provided Forms)
☐ Sections L and M — Required Certifications (See Agency-provided Forms)

J. AOR Certification

AOR Signature: _____ **Printed Name:** Click or tap here to enter text.

Date (MM/DD/YYY): Click or tap here to enter text.

RURAL HEALTH TRANSFORMATION PROGRAM (RHTP)

SECTION B – EXECUTIVE SUMMARY

Instructions:

- Include all required sections below.
- Use data-driven statements whenever possible.
- Use bullet points and short paragraphs to keep it easy to read.
- Follow the page limits in the RHTP Initiative Guidance.

Legal Organization Name: Click or tap here to enter text.

Initiative the Applicant Is Currently Applying For (Select One Per Application)

☐ Preventive Care & Care-at-Home Bundle (Bundle 1; Initiatives 2, 3, 10, 12, & 13)
☐ Specialty & Acute Care Bundle (Bundle 2; Initiatives 13, 14, & at least one from 4, 5, 6, 7)
Select which telehealth initiative is included with Bundle 2 (Must select at least one)
☐ Initiative 4 – Behavioral Health Telehealth & Telehub Psychiatry
☐ Initiative 5 – Tele-Specialties & Imaging
☐ Initiative 6 – Tele-Intensive Care Unit / eICU
☐ Initiative 7 – Hub-and-Spoke Telestroke with Transfer
☐ Initiative 1 – Rural & Satellite Clinics
☐ Initiative 8 – Workforce Development
☐ Initiative 9 – Health & Lifestyle
☐ Initiative 11 – Value-Based Purchasing

A. Program Title & Summary: Provide a concise, compelling overview of the program's purpose and scope.
Click or tap here to enter text.

B. Program Goals (Add More if Needed):

1. Goal 1: [E.g., "Enhance chronic disease management among rural residents."] Click or tap here to enter text.
2. Goal 2: [E.g., "Expand behavioral health services via community-based care."] Click or tap here to enter text.
3. Goal 3: [E.g., "Strengthen rural healthcare workforce capacity."] Click or tap here to enter text.

C. Target Population or Workforce:

1. Geographic Focus: [List counties/regions in rural Florida or specific communities.] Click or tap here to enter text.
2. Demographics: [E.g., "Adults 18+, low-income, high chronic disease prevalence."] Click or tap here to enter text.
3. Workforce Targeted (If Applicable): [E.g., "Community Health Workers, rural nurses, behavioral health specialists."] Click or tap here to enter text.

D. Proposed Model & Key Components:

1. Program Model (Provide narrative and insert images as needed): Click or tap here to enter text.
2. Structure: [E.g., "Integrate CHWs into primary care teams."]: Click or tap here to enter text.
3. Core Activities (Add as needed):
    a. Click or tap here to enter text.
    b. Click or tap here to enter text.
    c. Click or tap here to enter text.

E. Anticipated Rural Impact:

1. Access: Click or tap here to enter text.
2. Health Outcomes: Click or tap here to enter text.
3. Workforce Stability: Click or tap here to enter text.
4. Economic & System Benefits: Click or tap here to enter text.

F. Alignment with RHTP Strategic Goals – List how your program will address each CMS RHTP goal.

RHTP Strategic Goal	Program Alignment
Make rural America healthy again	Click or tap here to enter text.
Sustainable access	Click or tap here to enter text.
Workforce development	Click or tap here to enter text.
Innovative care	Click or tap here to enter text.
Tech innovation	Click or tap here to enter text.

G. AOR Certification

AOR Signature: _____ **Printed Name:** Click or tap here to enter text.

Date (MM/DD/YYY): Click or tap here to enter text.

RURAL HEALTH TRANSFORMATION PROGRAM (RHTP)

SECTION C — ORGANIZATIONAL CAPACITY AND ELIGIBILITY

Instructions: Applicants must upload Section C Form as a single consolidated PDF. The PDF must contain all required documentation in the exact order listed in this section, including any checklists, attachments, and supporting evidence.

Formatting Requirements:

- All documents must be combined into one (1) PDF.
- Documents must be organized in the order they appear in Section C below (C.A1 through C.A6.4).
- Each subsection must begin on a separate page and be clearly labeled.
- Do not submit ZIP files, multiple uploads, or hyperlinks to external storage.
- Illegible, out-of-order, or incomplete document packages may be deemed non-responsive.
- Follow the page limits in the RHTP Initiative Guidance

Legal Organization Name: Click or tap here to enter text.

A. Baseline Organizational Eligibility Checklist – Documentation Required

☐ **C.A1** Proof of Florida licensure or educational accreditation

☐ **C.A2** Active SAM.gov registration as of the application deadline

☐ **C.A3** Proof of location in, or actively serving patients, clients, or trainees in, one or more eligible rural communities (Select pathway below)

- ☐ Pathway A – Florida Statute §288.0656
- ☐ Pathway B – Florida Rural Economic Development Initiative (REDI) or Rural Areas of Critical Economic Concern (RACEC)
- ☐ Pathway C – CMS Goldsmith (Hospitals only)
- ☐ Pathway D – HRSA RUCA Codes / Rural Census Tracts

Applicants headquartered outside of Florida's designated rural areas, or otherwise ineligible for one of the established RHTP pathways, must provide all items below:

- ☐ Signed Memoranda of Understanding (MOUs) or Letters of Intent (LOIs) with eligible rural partner organizations (these should be included in Section C **and** Section D, as applicable for non-rural headquartered organizations)
- ☐ A rural service area plan that identifies specific rural counties and training or service delivery sites
- ☐ A rural needs assessment documenting verified rural gaps
- ☐ A compliance attestation that 100% of activities will occur in eligible rural communities (included in application Section J)

☐ **C.A4** 5+ years of continuous operation as of the application deadline

Applicants must provide <u>one</u> of the following:

- ☐ State registration showing an establishment date at least five (5) years prior to the application deadline
- ☐ Articles of Incorporation/Organization
- ☐ IRS determination letter (nonprofits only)

☐ Provider enrollment documentation (if applicable)

☐ Any other verifiable document demonstrating five years of continuous operation

☐ **C.A5** Two most recently completed fiscal years of audited financial statements (federal fiscal years, state fiscal years, or the applicant's organizational fiscal years, as applicable to the entity type)

☐ **C.A6** Demonstrate organizational readiness, governance structure, and internal controls sufficient to manage federal subrecipient funds under 2 CFR Part 200

For single applicant organizations, only submit the following items:

☐ **C.A6.1** Organizational chart

☐ **C.A6.2** Board or governing body composition

☐ **C.A6.3** Written financial management and internal control policies

☐ **C.A6.4** Evidence of prior federal award management experience (if any). Organizations without prior federal award experience must describe internal controls and may be subject to enhanced monitoring conditions.

AOR Certification

Signature: _____

Printed Name: Click or tap here to enter text.

Date: Click or tap to enter a date.

RURAL HEALTH TRANSFORMATION PROGRAM (RHTP)

Section G — Continuous Quality Improvement (CQI) Plan

Instructions: The CQI Plan should include all required components, including the quality management framework using the PDSA cycle (or an equivalent method), how performance challenges will be identified, the program's feedback processes, corrective action procedures, how data will be used to guide improvements, the internal review schedule, and a commitment to participate in external evaluation activities and RHTP learning collaboratives. Keep the plan brief – using clear language, bullet points, and short paragraphs where helpful, and ensure it stays within the page limits outlined in the RHTP Initiative Guidance.

Section A – Program Overview

A1. Legal Organization Name: Click or tap here to enter text.

A2. Initiative Included in This Application

☐ **Preventive Care & Care-at-Home Bundle (Bundle 1; Initiatives 2, 3, 10, 12, & 13)**
☐ **Specialty & Acute Care Bundle (Bundle 2; Initiatives 13, 14, & at least one from 4, 5, 6, 7)**
- **Select which telehealth initiative is included with Bundle 2 (Must select at least one)**
  - ☐ **Initiative 4 – Behavioral Health Telehealth & Telehub Psychiatry**
  - ☐ **Initiative 5 – Tele-Specialties & Imaging**
  - ☐ **Initiative 6 – Tele-Intensive Care Unit / eICU**
  - ☐ **Initiative 7 – Hub-and-Spoke Telestroke with Transfer**

☐ **Initiative 1 – Rural & Satellite Clinics**
☐ **Initiative 8 – Workforce Development**
☐ **Initiative 9 – Health & Lifestyle**
☐ **Initiative 11 – Value-Based Purchasing**

Section B – CQI Plan

B1. Quality Management Framework: The applicant should describe the program's quality management approach, including how the Plan-Do-Study-Act (PDSA) cycle will be used to identify issues, test changes, review results, and determine whether changes should be adopted or modified. Click or tap here to enter text.
B2. Identifying Performance Challenges: The applicant should describe the methods that will be used to identify performance challenges, including routine data review, staff reporting, participant feedback, and comparison to program benchmarks. Click or tap here to enter text.
B3. Feedback Processes: The applicant should explain the feedback processes in place, including how regular team meetings will be used to review findings and how staff, partners, and participants will be able to report concerns or suggestions. Click or tap here to enter text.
B4. Corrective Action Procedures: The applicant should describe the procedures for corrective action, including how problems will be defined, how root causes will be assessed, how targeted

changes will be implemented using a PDSA cycle, and how results will be monitored and documented. Click or tap here to enter text.
B5. Use of Data for Improvement: The applicant should explain how program data will be reviewed and used to guide decision-making, track performance, and assess the impact of improvement efforts. Click or tap here to enter text.
B6. Internal Review Schedule: The applicant should identify the program's internal review schedule, including monthly or quarterly CQI reviews, semi-annual performance reviews, and an annual overall program assessment. Click or tap here to enter text.
B7. External Evaluation & Learning Collaboratives: The applicant should describe their plan for ensuring participation in required external evaluation activities (Section 13.2) and to fully engage in RHTP learning collaboratives. Click or tap here to enter text.

AOR Signature: _____

Printed Name: Click or tap here to enter text.

Date: Click or tap to enter a date.

RURAL HEALTH TRANSFORMATION PROGRAM (RHTP)

SECTION H — SUSTAINABILITY PLAN

Instructions: All Applicants must submit a Sustainability Plan that describes how program services, infrastructure, technology, staffing, and operational gains funded by the RHTP will be maintained beyond the five-year funding period. The Sustainability Plan must address all required components outlined in Section 9 of the RHTP Standard Terms and any additional initiative-specific sustainability requirements contained in the applicable Initiative Guidance Document. There should be **one** Section H per bundle.

Formatting and Submission Requirements

1. **Attachment Rules:**
    - Financial Pro Forma, letters of support, and commitment letters do not count towards the page limit defined in the Standard Terms.
    - All attachments must be placed in the order referenced in Section H below and included at the end of the submission with identifiable headers.
    - Do **not** submit the cover page (current page)
2. **Submission Format:**
    - The Sustainability Plan must be submitted as one (1) combined PDF.
    - The PDF must include, in this order:
      (1) Sustainability Plan narrative (beginning with page 2), followed by
      (2) all required attachments described in Section H below.
    - Multiple uploads, ZIP files, or links to external documents are **not** permitted.
    - Follow the page limits in the RHTP Initiative Guidance
3. **Document Integrity:**
    - Applicants must ensure all pages are clearly labeled, legible, and sequentially ordered.
    - Illegible, incomplete, or out of order submissions may be deemed nonresponsive.
4. **Consistency:** The plan must align with:
    - The applicant's Work Plan,
    - Budget and budget narrative,
    - Staffing plan, and
    - Proposed model of care or service delivery.

RURAL HEALTH TRANSFORMATION PROGRAM (RHTP)

SECTION H — SUSTAINABILITY PLAN

Section A – Program Overview

A1. Legal Organization Name: Click or tap here to enter text.

A2. Initiative Included in This Application

☐ **Preventive Care & Care-at-Home Bundle (Bundle 1; Initiatives 2, 3, 10, 12, & 13)**
☐ **Specialty & Acute Care Bundle (Bundle 2; Initiatives 13, 14, & at least one from 4, 5, 6, 7)**
Select which telehealth initiative is included with Bundle 2 (Must select at least one)
☐ **Initiative 4 – Behavioral Health Telehealth & Telehub Psychiatry**
☐ **Initiative 5 – Tele-Specialties & Imaging**
☐ **Initiative 6 – Tele-Intensive Care Unit / eICU**
☐ **Initiative 7 – Hub-and-Spoke Telestroke with Transfer**
☐ **Initiative 1 – Rural & Satellite Clinics**
☐ **Initiative 8 – Workforce Development**
☐ **Initiative 9 – Health & Lifestyle**
☐ **Initiative 11 – Value-Based Purchasing**

Section B – Service Continuation Strategy

B1. Description of How Funded Services Will Continue Post-RHTP Funding Click or tap here to enter text.
B2. Sustainment of Program Operations & Workflows Click or tap here to enter text.
B3. Staffing Plan for Long-Term Continuity Click or tap here to enter text.
B4. Facilities & Physical Infrastructure (Including Leased Spaces/Vehicles) Click or tap here to enter text.
B5. Ongoing Operational Costs & Funding Sources Click or tap here to enter text.
B6. Partnerships Supporting Continuation of Services Click or tap here to enter text.

Section C – Technology Lifecycle Plan

C1. Overview of Technology Assets Supported by RHTP Funding Click or tap here to enter text.
C2. Licensing & Subscription Continuity Click or tap here to enter text.
C3. Technology Refresh & Replacement Schedule Click or tap here to enter text.
C4. Cybersecurity & Data Protection Plan Click or tap here to enter text.
C5. Maintenance & Technical Support Strategy

Click or tap here to enter text.
C6. Post-Grant Funding Sources for Technology Costs Click or tap here to enter text.
C7. Long-Term Integration with Organizational IT Infrastructure Click or tap here to enter text.

Section D – Plan for Sustaining Revenue & Braided Funding

D1. Overview of Long-Term Revenue Strategy Click or tap here to enter text.
D2. Sustaining Payer Reimbursement Streams ☐ Medicaid ☐ Managed Care ☐ Medicare ☐ Commercial ☐ Other (Provide Details): Click or tap here to enter text.
D2.1. Combining Payer Reimbursements Click or tap here to enter text.
D3. Sustaining Value-Based Payment Arrangements Click or tap here to enter text.
D4. Additional Funding Sources to Replace Grant Startup Funding Click or tap here to enter text.

Section E – Payer Mix Analysis

E1. Current Payer Mix (%): Click or tap here to enter text.
E2. Projected Payer Mix (%) Post-Grant: Click or tap here to enter text.
E3. Reimbursement Rates & Expected Revenue Contribution Click or tap here to enter text.
E3. Strategies to Increase Insured Patient/Participant Percentage Click or tap here to enter text.
E4. Risks & Mitigation Related to Payer Composition Click or tap here to enter text.

Section F – Financial Sustainability

F1. Explanation of Diversified Revenue Sources Click or tap here to enter text.
F2. Description of Adequate Reserves & Long-Term Financial Stability Click or tap here to enter text.
F3. Plan for Governance & Financial Oversight Click or tap here to enter text.
F4. Post-Award Financial Monitoring & Adjustment Strategy Click or tap here to enter text.

Section G – Timeline for Financial Self-sufficiency

G1. Target Date for Full Financial Self-Sufficiency (No Later Than Nov 1, 2031): Click or tap here to enter text.
G2. Key Milestones Toward Sustainability Click or tap here to enter text.
G3. Transition Plan for All Grant-Funded Expenses

Click or tap here to enter text.
G4. Risks to Achieving the Timeline & Mitigation Measures Click or tap here to enter text.

Section H – Required Attachments:

☐ Financial Pro Forma (Grant Years 1–5 plus one post-award year, i.e., through October 31, 2031)
☐ Leadership Commitment Letter(s)
☐ Partner Commitment Letter(s) *Optional, but Strongly Encouraged*

Compliance Continuity Attestation

The Applicant hereby attests that the organization, including all participating partners and subcontractors, will maintain full and continuous compliance with all requirements, restrictions, and conditions of the RHTP throughout the entire funding period and for all required post-award reporting and monitoring periods.

AOR Signature: _____

Printed Name: Click or tap here to enter text.

Date: Click or tap to enter a date.

RURAL HEALTH TRANSFORMATION PROGRAM (RHTP)

Section I — Financial Solvency

Instructions: The applicant should provide a concise Financial Solvency section that clearly demonstrates the organization's financial stability and capacity to manage a federal subaward. The applicant should describe their financial controls and internal audit processes, identify any financial concerns along with mitigation strategies, and detail current insurance coverage and fiscal policies. Applicants should follow page-limit requirements outlined in the RHTP Initiative Guidance.

Section A – Program Overview

A1. Legal Organization Name: Click or tap here to enter text.

A2. Initiative Included in This Application

☐ **Preventive Care & Care-at-Home Bundle (Bundle 1; Initiatives 2, 3, 10, 12, & 13)**
☐ **Specialty & Acute Care Bundle (Bundle 2; Initiatives 13, 14, & at least one from 4, 5, 6, 7)**
- **Select which telehealth initiative is included with Bundle 2 (Must select at least one)**
  - ☐ **Initiative 4 – Behavioral Health Telehealth & Telehub Psychiatry**
  - ☐ **Initiative 5 – Tele-Specialties & Imaging**
  - ☐ **Initiative 6 – Tele-Intensive Care Unit / eICU**
  - ☐ **Initiative 7 – Hub-and-Spoke Telestroke with Transfer**

☐ **Initiative 1 – Rural & Satellite Clinics**
☐ **Initiative 8 – Workforce Development**
☐ **Initiative 9 – Health & Lifestyle**
☐ **Initiative 11 – Value-Based Purchasing**

Section B – Financial Solvency

B1. Organizational Financial Stability: The applicant should describe the organization's overall financial stability and capacity to manage a federal subaward, including evidence of sound fiscal management, sufficient cash flow, and the ability to meet federal financial requirements. Click or tap here to enter text.
B2. Financial Controls and Internal Audit Processes: The applicant should describe the financial controls in place, including accounting systems, segregation of duties, approval procedures, and internal audit or monitoring processes that ensure compliance, accuracy, and prevention of misuse of funds. Click or tap here to enter text.
B3. Financial Concerns and Mitigation Strategies: The applicant should identify any known or potential financial concerns (such as prior audit findings, budget constraints, cash-flow risks, or system limitations) and describe the mitigation strategies that will be implemented to address them. Click or tap here to enter text.
B4. Insurance Coverage and Fiscal Policies: The applicant should detail the organization's current insurance coverage (e.g., general liability, professional liability, workers' compensation) and summarize key fiscal policies that guide financial management, compliance, and risk reduction.

Click or tap here to enter text.

AOR Signature: _____

Printed Name: Click or tap here to enter text.

Date: Click or tap to enter a date.

Section J - RHTP Budget Proposal Template for Bundle 1: Preventive Care & Care-at-Home Bundle

General Instructions: The proposed detailed budget shall include costs required for providing the services specified in this RFA. Please refer to Attachment I, RHTP Standard Terms and Administrative Requirements, for allowable vs. unallowable expenses.

1	Yellow highlighted cells required direct data entry. All other cells should auto populate or auto-calculate as necessary. Begin by inputting the Lead Applicant Organization's legal name at the top of the "Total Estimates" tab and selecting the region(s) for which you are applying. Your legal name will auto-populate across all tabs.	**Example:**	Modify	Do not modify
2	Input the total amount needed for the full Year 1 for each line item.			
3	For each initiative in this bundle, enter the detailed costs in every cost category provided in the budget template on the appropriate tab. List the specific items, quantities, and costs that make up your request for that category. Each tab must be completed. As you fill in the category level details for each initiative, the totals for Years 1 through 5 will calculate automatically on the "Total Estimates" tab. You do not need to enter totals manually—only the detailed line items for each initiative.			
4	**Personnel:** For each proposed grant-funded position, enter the position title (not an individual's name), the annual salary amount, the proposed number of FTEs for the position, and the average level of effort for all FTEs rounded to the nearest 10th. Include partner personnel and add rows as necessary. Fringe benefits are input at a standard 27%. If your organization has a different percentage, please change the highlighted field. Please note that personnel does not include subcontractors.			
5	**Equipment:** Equipment is defined in the U.S Office of Management and Budget's Uniform Guidance, 2 CFR 200.33, as: 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 $10,000. In the Uniform Guidance, two main categories of equipment are classified as General Purpose Equipment and Special Purpose Equipment. Examples of General Purpose Equipment include office equipment and furnishings, modular offices, telephone networks, information technology equipment and systems, air conditioning equipment, reproduction and printing equipment, and motor vehicles. Special Purpose Equipment are used only for research, medical, scientific or other technical activities. Examples of special purpose equipment include microscopes, x-ray machines, surgical instruments and spectrometers.. For all purchases meeting the OMB definition of equipment, enter unique line items, including the unit rate and number of units proposed for the program. Do not bundle multiple types of equipment in one line, unless they are expressly marketed and invoiced as a package at a combined unit rate for the entirety. Add rows as necessary.			
6	**Supplies:** Supplies are items that cost less than $10,000 per unit and are expected to be used up, worn out, or fully depreciated within one year. These items are not treated as capital assets; instead, they are considered consumable materials that support day to day program activities. Supplies typically include smaller technology items, basic office furnishings, and materials needed to deliver services or run program operations. Examples of supplies include laptops, tablets, desktop computers, printers, projectors, office furniture, program materials, phones, and software subscriptions. Because these items do not meet the federal threshold for equipment, they should be budgeted as supplies even if they are essential technology for the project. When entering supplies in the budget, create a separate line for each type of supply, and include both the unit cost and the number of units needed. Avoid grouping unrelated items together so reviewers can clearly understand what is being purchased and why. Add additional rows whenever necessary to give a full and accurate picture of the supply costs proposed for the program. Add rows as necessary.			
7	**Travel:** All travel must be budgeted in accordance with State of Florida Division of Financial Services standards. Please consult Florida Statute 112.061 for details. Mileage for local, in area travel should be calculated at the approved vicinity mileage rate of $0.445 per mile and is already included in each initiative worksheet. Enter descriptions for any care rentals, overnight travel, air travel, etc. as necessary.			

Other Direct Costs: For all other allowable and necessary operational program costs, excluding subcontractor costs for required bundled initiatives, enter a description and rate information as necessary.

8 This section may be used for items such as training, recruitment costs, marketing, legal services, occupancy costs, minor remodeling, etc., depending on the specific needs of the program. Please consult the standard terms and conditions for general considerations of allowable / unallowable costs and the specific initiative guidance documents for initiative-specific budget details.

Sub contractual Costs: Enter each subcontractor expense as its own line item in the Sub contractual Costs section. Include the unit rate, number of units, and the amount requested for each **9** subcontracted service. Only list costs for work that a subcontractor—not the lead applicant—will perform. Do not combine different subcontractor activities into a single line. Add additional rows as needed to fully describe all subcontractor costs for this initiative.

10 **Administrative Costs:** Allowable indirect Administrative Costs may not exceed 3% of the Applicant's Total Operational Cost. Must be spent by 10/30 of **each budget year**.

The Agency reserves the right to request the return of any hardware, software, equipment and **11** furniture purchased by the successful Applicant using funds from the resulting Agreement. In the event the Agency does not desire to have the hardware, software, equipment and furniture returned, the successful Applicant may retain said ownership.

Section J - RHTP Budget Proposal Template for Bundle 1: Preventive Care & Care-at-Home Bundle

Applicant Organization Legal Name	Type Legal Name Here				
Region Applied for (Select 1 Region per Submission):	☐	Northwest	☐	Southwest	
	☐	Northeast	☐	Southeast	

Cost Category	Year 1	Year 2	Year 3	Year 4	Year 5	Total Program Lifetime
Subtotal Salaries & Wages	$2,500.00	$1,875.00	$1,000.00	$875.00	$750.00	$7,000.00
Subtotal Fringe Benefits	$675.00	$506.25	$270.00	$236.25	$202.50	$1,890.00
TOTAL PERSONNEL	$3,175.00	$2,381.25	$1,270.00	$1,111.25	$952.50	$8,890.00
TOTAL EQUIPMENT	$5,000.00	$3,750.00	$2,000.00	$1,750.00	$1,500.00	$14,000.00
TOTAL SUPPLIES	$5,000.00	$3,750.00	$2,000.00	$1,750.00	$1,500.00	$14,000.00
TOTAL TRAVEL	$4.45	$3.34	$1.78	$1.56	$1.34	$12.46
TOTAL OTHER DIRECT COSTS	$5,000.00	$3,750.00	$2,000.00	$1,750.00	$1,500.00	$14,000.00
TOTAL SUBCONTRACTUAL COSTS	$5,000.00	$3,750.00	$2,000.00	$1,750.00	$1,500.00	$14,000.00
TOTAL OPERATIONAL COSTS	**$23,179.45**	$17,384.59	$9,271.78	$8,112.81	$6,953.84	$64,902.46
Administrative Costs	$695.38	$521.54	$278.15	$243.38	$208.62	$1,947.07
TOTAL PROJECTED PROJECT COSTS	**$23,874.83**	**$17,906.13**	**$9,549.93**	**$8,356.19**	**$7,162.45**	**$66,849.53**

Budget Period 1 (Year 1): ***Full approved budget.*** *Year 1 represents the highest allowable funding level and must include all major procurement, capital acquisitions, infrastructure buildout, and program launch costs. Year 1 is the baseline against which all subsequent years are measured.*

Budget Period 2 (Year 2): ***Not to exceed 75% of the Year 1 approved budget.*** *. Remaining procurement, phased technology rollouts, and continued onboarding activities are allowable, but must have been identified and justified in the original application. No new large-scale capital items may be introduced in Year 2 that were not included in the Year 1 approved budget unless approved by the Agency.*

Budget Period 3 (Year 3): ***Not to exceed 40% of the Year 1 approved budget.*** *Allowable costs are limited to maintenance of existing infrastructure, software licensing renewals, personnel supporting ongoing service delivery and data reporting, and required compliance and reporting activities.*

Budget Period 4 (Year 4): ***Not to exceed 35% of the Year 1 approved budget.*** *Allowable costs are limited to the same categories as Year 3. Continuation of any Year 3 waiver requires a new, separately justified waiver request reviewed against Year 4 performance data.*

Budget Period 5 (Year 5): ***Not to exceed 30% of the Year 1 approved budget.*** *Year 5 is the final program year and must reflect the program's transition toward financial self-sufficiency. By Year 5, programs should be primarily funded through third party payer billing (i.e., Medicaid, Medicare, Tricare, Commercial, etc.), value-based arrangements, or other sustainable revenue sources. Year 5 budgets must demonstrate a credible path to post-grant operational continuity consistent with Section G (Sustainability Plan).*

Applicant Organization Name

AOR Signature **Date**

AOR Printed Name

AOR Title

Failure to submit a Detailed Budget, signed by an authorized official representative (AOR) may result in the rejection of response.

Initiative 2 - Mobile Health

Applicant Organization Legal Name	Type Legal Name Here

Budget Category				Year 1 Total
PERSONNEL				
Salaries & Wages Grant Funded Positions Only	**Annual Amount/Salary**	**# FTE**	**Level of Effort**	**Amount Requested**
	$1,000.00	1.00	0.50	$500.00
			Subtotal Salaries & Wages	**$500.00**
Fringe Benefits	% Estimate		27%	$135.00
			TOTAL PERSONNEL:	**$635.00**
EQUIPMENT	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00
			TOTAL EQUIPMENT:	**$1,000.00**
SUPPLIES	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00
			TOTAL SUPPLIES:	**$1,000.00**
TRAVEL	**Unit Rate**		**# Units**	**Amount Requested**
Vicinity Mileage	$0.445		2.00	$0.89
			TOTAL TRAVEL:	**$0.89**
OTHER DIRECT COSTS	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00

		TOTAL OTHER DIRECT:	$1,000.00
		TOTAL DIRECT COSTS:	$3,635.89
SUBCONTRACTUAL COSTS	**Unit Rate**	**# Units**	**Amount Requested**
	$1,000.00	1.00	$1,000.00
		TOTAL SUBCONTRACTUAL COSTS:	$1,000.00
		TOTAL OPERATIONAL COSTS:	$4,635.89
Administrative Costs		*3.00%*	$139.08
		TOTAL ANNUAL AMOUNT REQUESTED:	$8,410.86

Initiative 3 - Community Paramedicine/Mobile Integrated Health

Applicant Organization Legal Name	Type Legal Name Here

Budget Category				Year 1 Total
PERSONNEL				
Salaries & Wages Grant Funded Positions Only	**Annual Amount/Salary**	**# FTE**	**Level of Effort**	**Amount Requested**
	$1,000.00	1.00	0.50	$500.00
			Subtotal Salaries & Wages	**$500.00**
Fringe Benefits	% Estimate		27%	$135.00
			TOTAL PERSONNEL:	**$635.00**
EQUIPMENT	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00
			TOTAL EQUIPMENT:	**$1,000.00**
SUPPLIES	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00
			TOTAL SUPPLIES:	**$1,000.00**
TRAVEL	**Unit Rate**		**# Units**	**Amount Requested**
Vicinity Mileage	$0.445		2.00	$0.89
			TOTAL TRAVEL:	**$0.89**
OTHER DIRECT COSTS	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00

		TOTAL OTHER DIRECT:	$1,000.00
		TOTAL DIRECT COSTS:	$3,635.89
SUBCONTRACTUAL COSTS	**Unit Rate**	**# Units**	**Amount Requested**
	$1,000.00	1.00	$1,000.00
		TOTAL SUBCONTRACTUAL COSTS:	$1,000.00
		TOTAL OPERATIONAL COSTS:	$4,635.89
Administrative Costs		*3.00%*	$139.08
		TOTAL ANNUAL AMOUNT REQUESTED:	$8,410.86

Initiative 10 - Remote Patient Telemonitoring

Applicant Organization Legal Name	Type Legal Name Here

Budget Category				Year 1 Total
PERSONNEL				
Salaries & Wages Grant Funded Positions Only	**Annual Amount/Salary**	**# FTE**	**Level of Effort**	**Amount Requested**
	$1,000.00	1.00	0.50	$500.00
			Subtotal Salaries & Wages	**$500.00**
Fringe Benefits	% Estimate		27%	$135.00
			TOTAL PERSONNEL:	**$635.00**
EQUIPMENT	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00
			TOTAL EQUIPMENT:	**$1,000.00**
SUPPLIES	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00
			TOTAL SUPPLIES:	**$1,000.00**
TRAVEL	**Unit Rate**		**# Units**	**Amount Requested**
Vicinity Mileage	$0.445		2.00	$0.89
			TOTAL TRAVEL:	**$0.89**
OTHER DIRECT COSTS	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00

		TOTAL OTHER DIRECT:	$1,000.00
		TOTAL DIRECT COSTS:	$3,635.89
SUBCONTRACTUAL COSTS	**Unit Rate**	**# Units**	**Amount Requested**
	$1,000.00	1.00	$1,000.00
		TOTAL SUBCONTRACTUAL COSTS:	$1,000.00
		TOTAL OPERATIONAL COSTS:	$4,635.89
Administrative Costs	*3.00%*		$139.08
		TOTAL ANNUAL AMOUNT REQUESTED:	$8,410.86

Initiative 12 - On-Site Pharmacy / Retail Clinic Services

Applicant Organization Legal Name	Type Legal Name Here

Budget Category				Year 1 Total
PERSONNEL				
Salaries & Wages Grant Funded Positions Only	**Annual Amount/Salary**	**# FTE**	**Level of Effort**	**Amount Requested**
	$1,000.00	1.00	0.50	$500.00
			Subtotal Salaries & Wages	**$500.00**
Fringe Benefits	% Estimate		27%	$135.00
			TOTAL PERSONNEL:	**$635.00**
EQUIPMENT	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00
			TOTAL EQUIPMENT:	**$1,000.00**
SUPPLIES	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00
			TOTAL SUPPLIES:	**$1,000.00**
TRAVEL	**Unit Rate**		**# Units**	**Amount Requested**
Vicinity Mileage	$0.445		2.00	$0.89
			TOTAL TRAVEL:	**$0.89**
OTHER DIRECT COSTS	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00

		TOTAL OTHER DIRECT:	$1,000.00
		TOTAL DIRECT COSTS:	$3,635.89
SUBCONTRACTUAL COSTS	Unit Rate	# Units	Amount Requested
	$1,000.00	1.00	$1,000.00
		TOTAL SUBCONTRACTUAL COSTS:	$1,000.00
		TOTAL OPERATIONAL COSTS:	$4,635.89
Administrative Costs	*3.00%*		$139.08
		TOTAL ANNUAL AMOUNT REQUESTED:	$8,410.86

Initiative 13 - Florida HIE / ENS Onboarding

Applicant Organization Legal Name	Type Legal Name Here

Budget Category				Year 1 Total
PERSONNEL				
Salaries & Wages Grant Funded Positions Only	**Annual Amount/Salary**	**# FTE**	**Level of Effort**	**Amount Requested**
	$1,000.00	1.00	0.50	$500.00
			Subtotal Salaries & Wages	**$500.00**
Fringe Benefits	% Estimate		27%	$135.00
			TOTAL PERSONNEL:	**$635.00**
EQUIPMENT	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00
			TOTAL EQUIPMENT:	**$1,000.00**
SUPPLIES	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00
			TOTAL SUPPLIES:	**$1,000.00**
TRAVEL	**Unit Rate**		**# Units**	**Amount Requested**
Vicinity Mileage	$0.445		2.00	$0.89
			TOTAL TRAVEL:	**$0.89**
OTHER DIRECT COSTS	**Unit Rate**		**# Units**	**Amount Requested**
	$1,000.00		1.00	$1,000.00

		TOTAL OTHER DIRECT:	$1,000.00
		TOTAL DIRECT COSTS:	$3,635.89
SUBCONTRACTUAL COSTS	**Unit Rate**	**# Units**	**Amount Requested**
	$1,000.00	1.00	$1,000.00
		TOTAL SUBCONTRACTUAL COSTS:	$1,000.00
		TOTAL OPERATIONAL COSTS:	$4,635.89
Administrative Costs		*3.00%*	$139.08
		TOTAL ANNUAL AMOUNT REQUESTED:	$8,410.86

RURAL HEALTH TRANSFORMATION PROGRAM (RHTP)

SECTION K – BUDGET NARRATIVE

Instructions: Applicants must submit a budget narrative that clearly explains how each cost was developed, why it is necessary, and how the program will remain sustainable as federal funding decreases over the five-year period. Use the template below to structure your narrative. Do not submit the cover page (current page). Follow the page limits in the RHTP Initiative Guidance.

Section A – Organization Information: Follow prompts in Section A below.

Section B – Overview of Budget Approach: Follow prompts in Section B below.

Section C – Cost Category Justifications

- **C.1 Personnel:** Identify positions (titles only) and summarize their role in the bundle (e.g., detail their efforts across initiatives, if applicable). If your fringe rate is not 27%, please explain your organization's accepted fringe rate. Explain how staffing levels change over time as federal funding tapers. Finally, if positions scale down in Years 3–5, describe how duties shift to permanent staff or partner resources.
- **C.2 Equipment:** Explain any equipment purchases in Year 1 and why they occur during the startup period.
- **C.3 Supplies:** Summarize consumable materials needed and how annual amounts were estimated.
- **C.4. Travel:** Describe required travel (e.g., training, supervision, outreach), ensuring that all rates are in alignment with Florida Statute 112.061.
- **C.5 Other Direct Costs:** Explain all operational costs requested.
- **C.6 Sub contractual Costs:** Describe subcontracted services, why they are needed, and how costs were determined, and explain any changes in subcontractor involvement over the five-year performance period.

Section D – Sustainability and Tapered Funding Strategy: Explain how your program will maintain operations as federal funding decreases across the five-year program period (from 100% in Year 1 down to 30% in Year 5).

- **D.1 Operational Tapering Plan:** Describe how your program will transition from Year 1 startup activities into a stable operating model by Year 3. Identify which costs decline naturally (e.g., reduced equipment purchases, lower training needs). Describe efficiencies gained over time (technology adoption, revised staffing patterns, integration with existing workflows).
- **D.2 Long-Term Financial Plan:** Which budget categories will transition to non-federal funding sources? How will your organization absorb or sustain key personnel? What permanent infrastructure (equipment, technology, workflows) installed in Year 1 will support long-term operations?
- **D.3 Risk Mitigation:** Identify any financial risks related to tapering and your strategies to address them (e.g., delayed reimbursements, slower-than-expected revenue growth, turnover in partner organizations).

Section A – Organization Information

A1. Legal Organization Name: Click or tap here to enter text.

A2. Initiative Included in This Application

☐ **Preventive Care & Care-at-Home Bundle (Bundle 1; Initiatives 2, 3, 10, 12, & 13)**
☐ **Specialty & Acute Care Bundle (Bundle 2; Initiatives 13, 14, & at least one from 4, 5, 6, 7)**
Select which telehealth initiative is included with Bundle 2 (Must select at least one)
☐ **Initiative 4 – Behavioral Health Telehealth & Telehub Psychiatry**
☐ **Initiative 5 – Tele-Specialties & Imaging**
☐ **Initiative 6 – Tele-Intensive Care Unit / eICU**
☐ **Initiative 7 – Hub-and-Spoke Telestroke with Transfer**
☐ **Initiative 1 – Rural & Satellite Clinics**
☐ **Initiative 8 – Workforce Development**
☐ **Initiative 9 – Health & Lifestyle**
☐ **Initiative 11 – Value-Based Purchasing**

A3. Super Region Served (Select One Per Application)
☐ **Northwest** ☐ **Northeast** ☐ **Southwest**☐ **Southeast**

Section B – Overview of Budget Approach

B1. Describe how Years 1 and 2 represent the "startup years," including major purchases or investments. Click or tap here to enter text.
B2. Explain how the budget transitions from start-up activities to stable operations after Year 2. Click or tap here to enter text.
B3. Discuss how you ensured alignment with the Year 2–5 spending caps. Click or tap here to enter text.
B4. Identify the indirect cost rate, the base, and the source — NICRA or 10% de minimis per 2 CFR 200.414(F). Justify any administrative costs claimed as direct costs. Click or tap here to enter text.

Section C – Cost Category Justifications

C1. Personnel Click or tap here to enter text.
C2. Equipment Click or tap here to enter text.
C3. Supplies Click or tap here to enter text.
C4. Travel Click or tap here to enter text.
C5. Other Direct Costs Click or tap here to enter text.
C6. Subcontractual Costs Click or tap here to enter text.

Section D – Sustainability and Tapered Funding Strategy

D1. Operational Tapering Plan Click or tap here to enter text.

D2. Long-term Financial Plan Click or tap here to enter text.
D3. Risk Mitigation Click or tap here to enter text.

Budget Attestations

The applicant also confirms that equipment will not be purchased in Years 3–5 unless allowed under program rules. The applicant also attests that all initiative budgets align with the following budget constraints:

- Year 1: Full baseline budget
- Year 2: ≤ 75% of Year 1
- Year 3: ≤ 40% of Year 1
- Year 4: ≤ 35% of Year 1
- Year 5: ≤ 30% of Year 1

By signing below, the Authorized Organizational Representative affirms that all information, explanations, and budget details provided in this narrative are true, complete, and accurate to the best of their knowledge.

AOR Signature: _____

Printed Name: Click or tap here to enter text.

Date: Click or tap to enter a date.

RURAL HEALTH TRANSFORMATION PROGRAM (RHTP)

SECTION L – REQUIRED CERTIFICATIONS

By initialing each certification listed in this Section L, the Authorized Organizational Representative (AOR) affirms, represents, and certifies that the Applicant understands, accepts, and agrees to comply with all applicable federal, state, and programmatic requirements described herein. The AOR's initials constitute a binding acknowledgment on behalf of the Applicant that each certification is accurate, complete, and enforceable as a condition of eligibility for funding under the RHTP. The AOR further attests that the initials affixed to each certification are made knowingly and voluntarily, with full authority to legally bind the Applicant organization.

		AOR Initials
A.	**Debarment and suspension:** The Applicant agrees to comply with the terms of 2 CFR 200.214 and 2 CFR Part 180 in the delivery of services funded under this application.	
B.	**Lobbying:** The Applicant is prohibited by 2 CFR 200.450 and Title 31 USC, §1352, from using Federal funds for lobbying the Executive or Legislative Branches of the federal government in connection with this grant or cooperative agreement. The applicant shall also disclose lobbying undertaken with non-Federal funds if grants and/or cooperative agreements exceed $100,000 in total costs (45 CFR Part 93).	
C.	**Anti-kickback statute:** The Applicant agrees to comply with the terms of 42 USC §1320a-7b in the delivery of services funded under this application.	
D.	**Civil Rights compliance:** The Applicant agrees that no person will, on the basis of race, color, national origin, creed or religion be excluded from participation in, be refused the benefits of, or be otherwise subjected to discrimination pursuant to the Act governing these funds or any project, program, activity or sub-grant supported by the requirements of, (a) Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended which prohibits discrimination the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended which prohibits discrimination in employment or any program or activity that receives or benefits from federal financial assistance on the basis of handicaps; (d) Title II of the American with Disabilities Act of 1990 (e) Age Discrimination Act 1975, as amended which prohibits discrimination on the basis of age, (f) Equal Employment Opportunity Program (EEOP) must meets the requirements of 28 CFR 42.301.	
E.	**HIPAA compliance:** The Applicant agrees to comply with all applicable requirements of the HIPAA Privacy and Security Rules, as set forth in 45 CFR Parts 160 and 164, in the delivery of any services funded under this application.	
F.	**Non-compete prohibition**: The Applicant agrees to comply with the Non-Compete Prohibition requirements set forth in Section 4.2 of the RHTP Standard Terms, ensuring that no RHTP-funded personnel are subject to non-compete restrictions in the delivery of services funded under this application.	

G.	**SSA compliance:** The Applicant agrees to comply with the terms of SSA §2105(c) in the delivery of services funded under this application.	
H.	**Stevens Amendment Acknowledgment:** The Applicant agrees to comply with the terms of Section 8136 of the FY 1987 DoD Appropriations Act in the delivery of services funded under this application.	
I.	**Conflict of interest disclosure:** The Applicant agrees to disclose any conflicts of interest in compliance with the terms of 2 CFR 200.112 arising from the delivery of services funded under this application.	
J.	**SAM.gov active registration confirmation:** The Applicant attests that it currently has an active registration within the SAM.gov system and agrees to maintain registration for the duration of services funded under this application.	
K.	**Certification of Non-supplanting:** The Applicant certifies that funds awarded under this solicitation will not be used for programs currently being paid for by other funds or programs where the funding has been committed.	
L.	**Drug-Free Workplace Requirements:** The Applicant agrees that it will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76.	
M.	**Smoke-Free Workplace Requirements:** Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library projects to children under the age of 18, if the projects are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's projects provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for Inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.	
N.	**Compliance and Performance:** The Applicant understands that grant funds in subsequent program years are contingent upon compliance with the requirements of this grant program and demonstration of performance towards completing the grant key activities and meeting the grant objectives, as well as availability of funds.	
O.	**Submission of Data:** The Applicant agrees to provide data and other information requested by parties under contract with the Agency for evaluation and technical assistance services funded by the RHTP.	
P.	**Location of Programming:** The Applicant affirms and agrees that 100% of all program activities funded under any RHTP initiative will occur within, and directly serve, eligible rural communities, in full compliance with the RHTP Standard Terms.	
Q.	**Exclusions from Federal or State Health Care Programs:** The Applicant certifies that their organization and collaborative partners have no active exclusions, formal adverse findings, or unresolved corrective action orders from federal or state health care programs.	

RURAL HEALTH TRANSFORMATION PROGRAM (RHTP)

SECTION M – PROTECTIVE CLAUSES CERTIFICATION

By initialing each certification listed in this Section L, the Applicant's Authorized Organizational Representative (AOR) certifies that all provider agreements, subcontracts, and related amendments executed under this application shall include the following protective provisions and that these provisions shall survive termination, including termination due to insolvency:

		AOR Initials
A.	**Exculpatory Protection:** The Applicant agrees to include an exculpatory clause ensuring that neither Medicaid enrollees nor the Agency are liable for any debts, obligations, or financial liabilities of the provider or any subcontractor.	
B.	**Safeguarding of Enrollee Information:** The Applicant agrees to safeguard all enrollee information in accordance with all applicable federal requirements, including 42 CFR 438.224.	
C.	**Indemnification:** The Applicant agrees to indemnify, defend, and hold harmless the Agency, its designees, and Medicaid enrollees from all claims, damages, costs, and reasonable attorney fees proximately caused by negligent or wrongful acts arising from the provider's or subcontractor's performance. This obligation shall survive termination, including termination for insolvency.	
D.	**Insurance requirements:** The Applicant agrees to require subcontractors to maintain workers' compensation coverage for all employees connected with work performed under this agreement, consistent with Florida law.	
E.	**Flow-Down Requirements:** The Applicant agrees that any delegated or subcontracted functions shall include all protective, operational, and compliance requirements contained in the governing agreement, unless expressly exempted.	
F.	**Contractual Compliance and Enforcement:** The Applicant agrees to include provisions allowing for revocation of delegation or other sanctions if subcontractor performance is inadequate.	
G.	**Utilization Management Safeguards:** The Applicant agrees that compensation for individuals or entities performing utilization management shall not be structured to incentivize denial, reduction, or discontinuation of medically necessary services, consistent with 42 CFR 438.210(e).	
H.	**Subcontractor Solvency:** The Applicant agrees to establish, enforce, and monitor solvency requirements to ensure subcontractors are able to meet their obligations.	
I.	**Fraud, Waste, and Abuse Compliance:** The Applicant agrees to include all requirements of Section 6032 of the Deficit Reduction Act of 2005 in its subcontracts, including False Claims Act notices, whistleblower protections, and staff responsibilities for identifying and preventing fraud, waste, and abuse.	

J.	**Cooperation With Recovery and Oversight:** The Applicant agrees that providers and subcontractors shall cooperate with audits, recovery activities, and repayment of overpayments, and shall co-brand communications with enrollees and providers as required.	
K.	**Termination and Notification Requirements:** The Applicant agrees that all contactors, subcontracts, and partners shall contain termination procedures consistent with Agency requirements and require a provision of least 90 days' notice prior to withdrawal.	
L.	**Encounter Data Requirements:** The Applicant agrees that subcontractors shall submit timely, complete, and accurate encounter data in accordance with Agency specifications.	

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Notice of Award

Award# RHTCMS332067-01-00
FAIN# RHTCMS332067
Federal Award Date: 12/29/2025

Recipient Information

1. Recipient Name
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
2727 Mahan Dr
Ms # 16
Florida Center for Health
Tallahassee, FL 32308-5407

2. Congressional District of Recipient
02

3. Payment System Identifier (ID)
1593452939A1

4. Employer Identification Number (EIN)
593452939

5. Data Universal Numbering System (DUNS)
135837198

6. Recipient's Unique Entity Identifier (UEI)
ULZMDBF4YKY7

7. Project Director or Principal Investigator
Shevaun Harris
Shevaun.Harris@ahca.myflorida.com
850-412-3613

8. Authorized Official
Kimberly Quinn
Deputy Bureau Chief, Medicaid Policy
kimberly.quinn@ahca.myflorida.com
850-412-4277

Federal Agency Information
Office of Acquisitions and Grants Management

9. Awarding Agency Contact Information
Chris Clark
christopher.clark@cms.hhs.gov
301-492-4319

10.Program Official Contact Information
Katherine Sapra
Acting Deputy Director
katherine.sapra@cms.hhs.gov
410-786-8984

Federal Award Information

11. Award Number
RHTCMS332067-01-00

12. Unique Federal Award Identification Number (FAIN)
RHTCMS332067

13. Statutory Authority
Big Beautiful Bill Act of 2025, Section 71401

14. Federal Award Project Title
The Florida Rural Health Transformation Program (RHTP) modernizes, stabilizes, and sustains rural health systems across 31 counties, serving approximately 1.2 million Floridians.

15. Assistance Listing Number
93.798

16. Assistance Listing Program Title
Rural Health Transformation Program

17. Award Action Type
New

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19.	**Budget Period Start Date** 12/29/2025 **- End Date** 10/30/2026	
20.	**Total Amount of Federal Funds Obligated by this Action**	$209,938,194.50
	20a. Direct Cost Amount	$209,938,194.50
	20b. Indirect Cost Amount	$0.00
21.	Authorized Carryover	$0.00
22.	Offset	$0.00
23.	Total Amount of Federal Funds Obligated this budget period	$0.00
24.	**Total Approved Cost Sharing or Matching, where applicable**	$0.00
25.	**Total Federal and Non-Federal Approved this Budget Period**	$209,938,194.50
26.	**Period of Performance Start Date** 12/29/2025 **- End Date** 10/30/2030	
27.	Total Amount of the Federal Award including Approved Cost Sharing or Matching this Period of Performance	$209,938,194.50

28. Authorized Treatment of Program Income
ADDITIONAL COSTS

29. Grants Management Officer – Signature
Ms. Shamia Cunningham
Grants Management Officer

30. Remarks

Please see the attached Recipient Specific, Program, and Standard Terms and Conditions.

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Notice of Award

Award# RHTCMS332067-01-00
FAIN# RHTCMS332067
Federal Award Date: 12/29/2025

Recipient Information

Recipient Name
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
2727 Mahan Dr
Ms # 16
Florida Center for Health
Tallahassee, FL 32308-5407

Congressional District of Recipient
02

Payment Account Number and Type
1593452939A1

Employer Identification Number (EIN) Data
593452939

Universal Numbering System (DUNS)
135837198

Recipient's Unique Entity Identifier (UEI)
ULZMDBF4YKY7

31. Assistance Type
Cooperative Agreement

32. Type of Award
Other

33. Approved Budget
(Excludes Direct Assistance)

I. Financial Assistance from the Federal Awarding Agency Only
II. Total project costs including grant funds and all other financial participation

a. Salaries and Wages	$0.00
b. Fringe Benefits	$0.00
c. Total Personnel Costs	$0.00
d. Equipment	$0.00
e. Supplies	$0.00
f. Travel	$0.00
g. Construction	$0.00
h. Other	$209,938,194.50
i. Contractual	$0.00
j. TOTAL DIRECT COSTS	$209,938,194.50
k. INDIRECT COSTS	$0.00
l. TOTAL APPROVED BUDGET	$209,938,194.50
m. Federal Share	$209,938,194.50
n. Non-Federal Share	$0.00

34. Accounting Classification Codes

FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	OBJECT CLASS	ASSISTANCE LISTING	AMT ACTION FINANCIAL ASSISTANCE	APPROPRIATION
6-5992269	RHT332067A	RHT	4158	93.798	$209,938,194.50	75-2632-0515

AWARD ATTACHMENTS

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION RHTCMS332067-01-00

1. Recipient Specific Terms and Conditions
2. Program Terms and Conditions
3. Standard Terms and Conditions

Rural Health Transformation (RHT) Program
Recipient Specific Terms and Conditions – Budget Period 1 (December 29, 2025 – October 30, 2026)

Recipient: Florida Agency for Health Care Administration

1. **General.** In addition to all Standard Terms and Conditions and Program Terms and Conditions, Recipient is subject to the following Recipient Specific Terms and Conditions. The Centers for Medicare and Medicaid Services (CMS) may add or otherwise amend these Recipient Specific Terms and Conditions as necessary at any point during the RHT Program Period of Performance.

2. **Restriction of Funds.** A temporary restriction of funds has been implemented for all Recipients due to final funding adjustments. **Recipient may not draw down funds until Recipient provides information to CMS, and CMS provides prior approval.**

   Recipients must submit a revised budget by COB, January 30, 2026. CMS will review the revised budget and notify applicable Recipients within the following 30 days if additional information is required or unallowable costs are identified during the budget review that must be reallocated to other allowable costs.

   Directions for resubmission:

   All Recipients subject to funding restrictions are required to submit a Revision (Budget) (Type 6) amendment in GrantSolutions in accordance with the directions provided below and any subsequent communications issued by CMS.

   - Recipients must reallocate funding to appropriate budget categories. **All restricted funds awarded were placed in the "other" budget category to facilitate this revision process.**
   - If funding was adjusted from the amount originally requested, please submit a revised budget materials reflecting this new amount.
   - Revised budget narratives must include supporting information for all costs. Each activity/cost must be described and fully itemized. Lump sum totals will not be accepted. The necessity for a particular cost or how a particular cost/activity links to the program must not be assumed. TBD line items will remain restricted until finalized. Funds in the entire amount will only be lifted where all costs are deemed allowable and justified.
   - The total award amount must be accurately reflected across all documents (SF-424, SF-424A (Budget Worksheet), Project Narrative, Budget Narrative, etc.).
     - A revised Project Narrative should be submitted if the revised Budget Narrative will conflict with the Project Narrative submitted with the application.

    - The Project Narrative and Budget Narrative should accurately reflect the activities and project goals that will be pursued with the Budget Period 1 Rural Health Transformation award.
- The amendment submission must be accompanied by a cover letter signed by the Authorized Organizational Representative (AOR) that:
    - Requests the lifting of the restriction on funds.
    - Includes any additional information requested by the program office (if applicable).
    - Seeks review and approval of the information provided.

Recipients may participate in a scheduled conference call to address the terms and conditions. Should you have any questions or require assistance, please contact your assigned Grants Management Specialist.

Cooperative Agreement for Rural Health Transformation (RHT) Program
Centers for Medicare & Medicaid Services (CMS)
Program Terms and Conditions [1]

TERMS AND CONDITIONS

GENERAL

1. **The HHS/CMS Center for Medicaid and CHIP Services (CMCS) Project Officer.** The Project Officer (PO) assigned with responsibility for technical and programmatic questions from the Recipient is identified in field 10 of the Notice of Award (Program Official Contact Information).
2. **The CMS Grants Management Specialist.** The Grants Management Specialist (GMS) assigned with responsibility for the financial, administrative, and cooperative agreement compliance (non-programmatic) questions from the Recipient is identified in field 9 of the Notice of Award (Awarding Agency Contact Information).
3. **Statutory Authority.** This award is issued under the authority of Section 71401 of Public Law 119-21.
4. **Notice of Funding Opportunity (NOFO).** All relevant project requirements and definitions outlined in the NOFO (CMS-RHT-26-001) apply to this award and have been incorporated into the Terms and Conditions of Award by reference.
5. **Period of Performance.** The period of performance for the Rural Health Transformation (RHT) Program cooperative agreement is **December 29, 2025, through October 30, 2030.**[2]
6. **Budget Periods**. CMS will award funding in five budget periods.
    - Budget period 1: December 29, 2025 to October 30, 2026 (10 months)
    - Budget period 2: October 31, 2026 to October 30, 2027
    - Budget period 3: October 31, 2027 to October 30, 2028
    - Budget period 4: October 31, 2028 to October 30, 2029
    - Budget period 5: October 31, 2029 to October 30, 2030

[1] Effective 12/29/2025

[2] If a Recipient receives redistributed funds for FY2031 and/or FY2032, updated Terms and Conditions will be distributed with the Notice of Award reflecting the extended Period of Performance.

7. **Continued Funding.** Continued funding is conditional on the availability of appropriated funds, recipient satisfactory performance, and compliance with the Terms and Conditions.[3] At any time, CMS can decrease funding, recover funding, or terminate an award if a Recipient fails to perform the requirements of the award. The award may also otherwise be terminated to the extent authorized by law, if the agency determines the award no longer effectuates program goals or agency priorities. See Section 19 of these Program Terms and Conditions, Termination.

   For CMS to issue continuation funding for subsequent budget periods, Recipients must also demonstrate satisfactory progress. Satisfactory progress for Recipients includes, but is not limited to:

   - Progress in implementing initiatives approved by CMS in the approved application. Progress will be measured both qualitatively and quantitatively. CMS will use a combination of data submitted in the quarterly and annual progress reports and written and verbal updates from the Recipient to the CMS PO (e.g., during regular check-in calls) to assess progress.
     - CMS will assess the Recipient's adherence to the implementation plan and timeline included in the approved application.
     - CMS will assess the Recipient's progress on self-imposed performance metrics, including milestones and targets.
   - Progress in implementing State policy actions. CMS will assess the Recipient's follow-through on legislative or regulatory commitments made in the approved application. The Recipient must finalize State policy actions proposed in its application, if any, by the end of calendar year 2027. The Recipient has until the end of calendar year 2028 to enact the relevant policies for technical score factors B. 2. "Health and lifestyle" and B. 4. "Nutrition Continuing Medical Education", if any. See NOFO, Appendix, Points scoring details, Table 4, Points scoring methodology, definitions, and data sources for rural facility and population score factors and technical score factors (pages 74-78).
   - Accurate, complete, comprehensive, and timely submission of quarterly and annual progress reports.
   - Quality and timely communication with and responses to the CMS PO and CMS GMS. This includes providing the CMS PO and/or the CMS GMS with any ad-hoc data or information, as requested.

   Additional factors impacting continued funding

[3] Failure to comply with the Terms and Conditions, including statutory and regulatory requirements, may result in notification of potential enforcement action and/or request for Recipient to submit a plan to remedy the non-compliance.

- CMS can take appropriate remedies and enforcement actions, which may impact the total funding available for the next budget period. See Sections 16-19 of these Program Terms and Conditions.
- The Recipient can voluntarily withdraw from the RHT Program cooperative agreement at any time before the end of the period of performance.

Annual Recalculation

- CMS will recalculate the Recipient's technical score and corresponding workload funding amount for subsequent budget periods, based on the information and data the Recipient provides in its annual progress report (e.g., for budget period 2, CMS will recalculate the technical score and corresponding workload funding using the Recipient's annual progress report #1). See Table 1. Annual Progress and Final Report Due Dates.
    - Please note: CMS will **not** recalculate the rural facility and population score annually. The rural facility and population score will only be calculated once during the initial application review.
- For additional information, see NOFO, Funds Distribution (pages 13-15). The definitions and factors used to recalculate the technical score and associated workload funding will stay as described in the NOFO throughout the Period of Performance.

Continuation Applications

- The Recipient must submit a Non-Competing Continuation (NCC) application each budget period to receive funding for each subsequent budget period.
- An NCC application is a non-competitive financial assistance request that the Recipient must submit to receive the next 12-month increment of funding.
- NCC applications are due 60 days **before** the end of the current budget period (e.g., if the budget period ends on October 30, 2026, the NCC application is due by August 30, 2026) and must be submitted to GrantSolutions. Specific NCC requirements will be provided by the CMS GMS.
- CMS will issue the NCC award for each budget period on the start date of that budget period (i.e., October 31 for budget periods 2-5).
- The Recipient may use the NCC to adjust their budget or make other administrative changes. The Recipient may revise their project goals based on any changes in funding in alignment with the requirements detailed in the NOFO and Terms and Conditions, and in collaboration with CMS. Due to their non-competitive nature, NCC applications are not reviewed or scored by a merit review panel. Instead, all NCCs will be reviewed by CMS staff.
    - CMS may request revisions to the NCC application submitted.

- A new Notice of Award is issued to (1) approve the NCC application submitted (or amended NCC application, as requested by CMS) and (2) award additional funding for the applicable budget period.

8. **Management Review/Audit.** The funding authorized by this award is subject to any future financial management review or audit.

9. **Personnel Changes.** The Recipient must notify the CMS PO and the CMS GMS via e-mail prior to any key personnel changes.

   Key Personnel include the Authorized Organizational Representative (AOR), Principal Investigator/Project Director (PI/PD), and anyone else who plays a significant, measurable role in the development or execution of the project, regardless of whether or not they receive salaries or compensation under the award.

   Within 10 business days of the Recipient receiving notification of the key personnel change, the Recipient must submit an amendment in GrantSolutions (i.e., Revision (PI/PD) amendment for PI/PD Changes, and Revision (NoA Other) amendment for AOR and all other key personnel changes besides PI/PD).

10. **Changes in Scope.** The Recipient must consult with the CMS PO and CMS GMS prior to requesting a Change in Scope. If advised the request is permissible, then Recipient must submit an amendment to GrantSolutions, including a detailed explanation for the change to the scope of work as well as a revised timeline, workplan, and budget. An AOR signed cover letter must also be submitted. If approved, CMS will issue a revised Notice of Award indicating approval. See Standard Terms and Conditions, Section 13, Prior Approval Requirements.

11. **Cooperative Agreement Roles and Responsibilities**. All awards under the RHT Program are structured as cooperative agreements.[4] Cooperative agreements are used when there will be substantial CMS project involvement after an award is made. Substantial CMS project involvement relates to programmatic involvement, not administrative oversight.

    Here are the general responsibilities for both the Recipient and CMS.

    Recipient responsibilities:

    - Comply with the Terms and Conditions.
    - Collaborate with CMS staff to implement and monitor the project.
    - Submit the performance measures agreed upon in the Notice of Award and subsequent revisions to workplan as approved by CMS.
    - Submit all required progress and financial reports, including final reports detailed in these Program Terms and Conditions.

[4] See Standard Terms and Conditions, Section 4, Cooperative Agreements.

- Attend at least monthly calls with the CMS PO and/or CMS GMS to discuss progress and challenges. The meetings will include key personnel, including the PI/PD.
- Participate in all virtual meetings, as requested by CMS.
- Participate in annual in-person meeting, as requested by CMS.
- Actively contribute to sharing lessons learned with other Recipients through facilitated learning collaboratives.
- Participate in all monitoring activities requested by CMS and/or its contractor(s).
- Participate in program evaluation activities requested by CMS and/or its contractor(s).
- Participant in program audit activities requested by CMS and/or its contractor(s).

CMS responsibilities:

- Monitor the Recipient's project performance and progress according to the processes outlined in NOFO, Post-Award Requirements and Administration (pages 59-61), and the Terms and Conditions.
- Collaborate with the Recipient and provide substantial project planning and implementation input.
- Provide substantial input in evaluation activities.
- Make recommendations for continuing the project.
- Maintain up-to-date website content to keep Recipient informed.
- Review and approve all key personnel.
- Maintain regular communication with the Recipient through at least monthly conference calls along with technical assistance and consultation.
- Review and provide feedback on all required progress reports.
- Review and approve all required submitted data.
- Provide a structured approach to sharing, integrating, and actively applying improvement concepts, tactics, and lessons learned amongst approved award Recipients.
- Evaluate changes to proposed activities in Recipient workplan in extenuating circumstances. CMS will evaluate Recipient's Rural Health Transformation Plan amendments as needed to approve use of funding for alternative activities not originally agreed upon in your application and annual reporting. The intent is not to change a Recipient's allocated funding amount, but to accommodate funding of

alternative activities not originally envisioned in rare and extenuating circumstances with existing allocated funding. Extenuating circumstances may include:

- Drastic changes in the State health care delivery system that would make the original activities not reasonably practicable to implement or not beneficial.
- Catastrophic events that are not foreseeable when Recipient applied.

12. **Required Cooperative Agreement Programmatic Reporting.** The Recipient must submit quarterly and annual progress reports. All progress reports will be submitted via use of Grant Messages in GrantSolutions for quarterly progress reports and the NCC application in GrantSolutions for annual progress reports. CMS will provide additional information, including a template, on report submission before the first annual or quarterly progress report is due.

- Failure to submit timely, accurate, complete, and comprehensive progress reports may result in CMS withholding, reducing, or recovering award payments.
- See also Standard Terms and Conditions, Section 34, Non-compliance.

Quarterly progress reports

- The quarterly reporting periods are as follows: August 1-October 30, October 31-January 30, and January 31-April 30. To reduce reporting burden with the annual progress reports, there is **no** quarterly progress report submission for May 1-July 31. See Table 2. Quarterly Progress Report Due Dates.
- Only reflective of progress made during the relevant quarter. Includes: spending data broken down by use of funds and initiatives, milestone progress, and technical assistance request(s).
- Due approximately 30 days after the end of the reporting period
- Submit to GrantSolutions via Grant Messages

Annual progress reports

- Annual
- Cumulative of activities completed during the annual reporting period. See Table 1. Annual Progress and Final Progress Report Due Dates. Includes: qualitative progress updates on milestones and implementation, quantitative updates on metrics that Recipient is tracking as a part of their approved workplan, quantitative description of funds expenditure by initiative and use of funds, and any additional information that should be used as part of CMS' annual workload funding recalculation for the subsequent budget period.
- Due 60 days before the end of the budget period

- Please note: The annual progress report is due approximately 60 days before the end of the budget period to allow CMS time to recalculate the technical score and associated workload funding for the subsequent budget period.
- The first annual report is due August 30, 2026 (covers a 7-month reporting period). All other annual reports cover a 12-month reporting period.

- Annual reports must be submitted with the non-competing continuation application in GrantSolutions.

Final progress report

- One-time only
- Cumulative of all activities completed during the entire period of performance
- Due 120 days after the end of the period of performance

  If the Recipient voluntarily withdraws from the RHT Program cooperative agreement prior to the end of the period of performance or is terminated, the final progress report is due 120 days after that date.

Table 1. Annual Progress and Final Report Due Dates

Report	Reporting Period Start Date	Reporting Period End Date	Due Date
Annual Report # 1[5]	December 29, 2025	July 31, 2026	August 30, 2026
Annual Report # 2	August 1, 2026	July 31, 2027	August 30, 2027
Annual Report # 3	August 1, 2027	July 31, 2028	August 30, 2028
Annual Report # 4	August 1, 2028	July 31, 2029	August 30, 2029
Annual Report # 5	August 1, 2029	July 31, 2030	August 30, 2030
Final Report[6]	**December 29, 2025**	**October 30, 2030**	**February 27, 2031**

Table 2. Quarterly Progress Report Due Dates

[5] Due to the timing of awards, Annual Report #1 covers a seven-month period. All subsequent annual progress reports cover a 12-month period.

[6] If a Recipient receives redistributed funds for FY2031 and/or FY2032, updated Terms and Conditions will be distributed with the Notice of Award reflecting the extended Period of Performance. The updated Terms and Conditions will include updated reporting requirements and due dates.

Report	Reporting Period Start Date	Reporting Period End Date	Due Date
Quarterly Report # 1	August 1, 2026	October 30, 2026	November 29, 2026
Quarterly Report # 2	October 31, 2026	January 30, 2027	March 1, 2027
Quarterly Report # 3	January 31, 2027	April 30, 2027	May 30, 2027
Annual report due August 30, 2027 in place of quarterly report			
Quarterly Report # 4	August 1, 2027	October 30, 2027	November 29, 2027
Quarterly Report # 5	October 31, 2027	January 30, 2028	February 29, 2028
Quarterly Report # 6	January 31, 2028	April 30, 2028	May 30, 2028
Annual report due August 30, 2028 in place of quarterly report			
Quarterly Report # 7	August 1, 2028	October 30, 2028	November 29, 2028
Quarterly Report # 8	October 31, 2028	January 30, 2029	March 1, 2029
Quarterly Report # 9	January 31, 2029	April 30, 2029	May 30, 2029
Annual report due August 30, 2029 in place of quarterly report			
Quarterly Report # 10	August 1, 2029	October 30, 2029	November 29, 2029
Quarterly Report # 11	October 31, 2029	January 30, 2030	March 1, 2030
Quarterly Report # 12	January 31, 2030	April 30, 2030	May 30, 2030
Annual report due August 30, 2030 in place of quarterly report			
Quarterly Report # 13	August 1, 2030	October 30, 2030	November 29, 2030

13. Required Financial Reports

Annual Expenditure Federal Financial Report (FFR)

- The Recipient must record recipient expenses in real-time as well as submit an annual Expenditure Federal Financial Report (FFR).
- The Recipient must submit the annual Expenditure Federal Financial Report (SF-425 or FFR) in the Payment Management System (PMS) no later than 90 days following the last day of the budget period (e.g., Budget period 1 ends on October 30, 2026, so the annual Expenditure FFR is due in PMS by January 27, 2027).
- Failure to submit timely reports may result in CMS withholding, reducing, or recovering award payments.
- For specific directions on filing the FFR, see the CMS Standard Terms and Conditions, Section 29(D), Financial Reporting or contact the CMS GMS.

Final Expenditure Federal Financial Report

- The Recipient must also submit a final FFR.
- The Recipient must submit the Final Expenditure Federal Financial Report (SF-425 or FFR) in PMS no later than 120 days following the end of the period of performance.

Payment Management System (PMS) Reporting

- Once CMS issues an award, the funds for each budget period are posted within 24-48 hours of the budget period start date in Recipient's account established in PMS. Recipients can access their funds by using the PMS funds request process. For more information, see the CMS Standard Terms and Conditions, Section 10, Payment.
- Recipients must submit timely FFRs to the PMS to draw down funds.

14. Use of Funds. The Recipient must use funds for the purposes stated in the NOFO and the purposes approved by CMS in the approved application.

Funds **may not** be used for any of the following[7]:

- Pre-award costs.
- Meeting matching requirements for any other federal funds or local entities.
- Services, equipment, or supports that are the legal responsibility of another party under federal, State, or tribal law, such as vocational rehabilitation or education services.
- Services, equipment, or supports that are the legal responsibility of another party under any civil rights law, such as modifying a workplace or providing accommodations that are obligations under law.
- Goods or services not allocable to the project.

[7] For guidance on additional restrictions or unallowable costs, see 2 CFR Part 200 Subpart E - General Provisions for Selected Items of Cost, and HHS-specific modifications as applicable in 2 CFR 300.

- Supplanting existing State, local, tribal, or private funding of infrastructure or services, such as staff salaries.
- Construction or building expansion, purchasing or significant retrofitting of buildings, cosmetic upgrades, or any other cost that materially increases the value of the capital or useful life as a direct cost.
- The cost of independent research and development, including their proportionate share of indirect costs. See 2 CFR 300.477.
- Purchase of covered telecommunications and video surveillance equipment (See 2 CFR 200.216) as well as financial assistance to households for installation and monthly broadband internet costs.
- Meals, unless in limited circumstances such as:
    - Subjects and patients under study.
    - Where specifically approved as part of the project or program activity, such as in programs providing children's services.
    - As part of a per diem or subsistence allowance provided in conjunction with allowable travel.
- Activities prohibited under 2 CFR 200.450 and the HHS Grants Policy Statement, including but not limited to:
    - Payments related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the Congress or any State government, State legislature, local legislature or legislative body, including but not limited to paying the salary or expenses of any grant Recipient or agent acting for such Recipient for such activity.
    - Lobbying, but Recipients can lobby at their own expense if they can segregate federal funds from other financial resources used for lobbying.

Program-specific limitations

In addition, the following program-specific funding limitations also apply:

- Construction. Funds may not be used for new construction. Funds also may not be used for the following:
    - To supplant funding for in process or planned construction projects or directing funding towards new construction builds.
    - Construction or building expansion, purchasing or significant retrofitting of buildings, cosmetic upgrades, or any other cost that materially increases the value of the capital or useful life as a direct cost.

- Minor Renovations or Alterations. Funds may be used for minor renovations or alterations if they are clearly linked to program goals and receive CMS prior approval. See NOFO, Program requirements and expectations, Use of Funds (pages 11-13), and Program-specific limitations, Unallowable Costs (pages 19-20).[8]
    - Funding used for renovation or alterations cannot exceed 20% of the total funding awarded to the Recipient in each budget period.
- Duplicate payments. Funds may not be used to replace payment for clinical services that could be reimbursed by insurance. Funds also may not be used for payments to clinical services if they duplicate billable services and/or attempt to change the payment amounts of existing fee schedules. If the Recipient plans to fund direct health care services, the Recipient must justify why they are not already reimbursable, how the payment will fill a gap in care coverage (such as uncompensated care or services not covered by insurance), and/or how they transform the current care delivery model. CMS will have final approval of whether proposed services are allowable.
    - Funding used for provider payments, defined in the NOFO as providing payments to health care providers for the provision of health care items or services, cannot exceed 15% of the total funding awarded to the Recipient in a given budget period.
    - Funding cannot be used for initiatives that fund certain cosmetic and experimental procedures that fall within the definition of a specified sex-trait modification procedure at 45 CFR 156.400 because that is beyond the scope of this program.
- No more than 5% of total funding awarded to the Recipient in a given budget period can support funding the replacement of an Electronic Medical Record (EMR) system if a previous HITECH certified EMR system is already in place as of September 1, 2025.
- Funding towards initiatives similar to the "Rural Tech Catalyst Fund Initiative", as described in the NOFO Appendix (pages 115-118), cannot exceed the lesser of (1) 10% of total funding awarded to the Recipient in a given budget period or (2) $20M of total funding awarded to the Recipient in a given budget period. Funding is subject to all restrictions and requirements described in the example initiative.
- Funds may not be used for clinician salaries. Funds also may not be used for clinician salaries or wage supports for facilities that subject clinicians to non-compete contractual limitations. This applies only to salaries and wages funded by the

Commented [AJ(1]: Spell out?

[8] Category J funding (Capital Expenditures and infrastructure) is described in the NOFO as investing in existing rural health care facility buildings and infrastructure, including minor building alterations or renovations and equipment upgrades to ensure long-term overhead and upkeep costs are commensurate with patient volume, subject to restrictions in the funding policies and limitations section of the NOFO. Category J funding cannot exceed 20% of the total funding CMS has awarded the Recipient in a given budget period.

cooperative agreement award through an approved initiative described in the approved application.

- None of the funding shall be used by the Recipient for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-Federal share of expenditures required under any provision of law.
- SSA 2105(c), paragraphs (1), (7), and (9) apply as funding limitations. These limitations are related to general limitations, limitations on payment for abortions, and citizenship documentation requirements for payments made with respect to an individual.

15. **Funding Redistribution.** CMS will redistribute unexpended or unobligated funds in the nearest following fiscal year using the same structure to recalculate technical score and associated workload funding described in Section 7 of these Program Terms and Conditions, Continued Funding, Annual Recalculation.

    - Unexpended funds include those funds awarded to a Recipient that it does not spend by the end of the subsequent fiscal year with respect to each budget period start date.
    - Unobligated funds include those funds not awarded by CMS from the full $10 billion available in a given budget period.
    - Any funding that is unexpended or unobligated as of October 1, 2032, shall be returned to the Treasury of the United States. [9]

    Refer to the Glossary for more guidance on unexpended and unobligated funds.

16. **Enforcement Actions**. Failure to comply with the Terms and Conditions or statutory or regulatory requirements, may result in placement of the recipient on a non-compliance action plan and/or a notification of potential enforcement action. Recipients placed on a non-compliance action plan and/or that receive notification of potential enforcement action during the period of performance might not receive additional funding for the next 12-month budget period(s), based on their progress in addressing required corrective actions. CMS will also consider if a Recipient is placed on a Corrective Action Plan to address audit findings.

    If CMS determines a Recipient is not using award funds in a manner consistent with the description in the approved application (a "violation of agreement"), CMS may withhold, reduce, or recover award payments. Violations of agreement include, but are not limited to:

    - Using funds in a manner inconsistent with activities described in the approved application, on activities explicitly limited or prohibited in the Terms and Conditions, and/or on activities not approved by CMS.
    - Failure to finalize State policy actions proposed in the approved application by the end of calendar year 2027 (e.g., December 31, 2027). Recipients will have until the end of

[9] In accordance with 42 U.S.C. 1397ee(h)(1)(B).

calendar year 2028 (e.g., December 31, 2028) to enact the B.2. “Health and lifestyle” and B.4. “Nutrition Continuing Medical Education” policies as described in the NOFO (pages 74-78).

- Not investing funds in a way that broadly affects the Recipient’s rural areas and residents in a positive manner.
- Failure to submit required reporting as described in these Program Terms and Conditions.
- Failure to follow through on other actions included in the approved application.
- Violating the Terms and Conditions.
- Improperly managing or using award funds, including fraud, waste, abuse, and criminal activity.

17. **Notification of Risks or Problems**. The Recipient shall immediately upon discovery notify the CMS PO and CMS GMS in writing of any significant problems or risks relating to the administrative, financial, and programmatic aspects of the award.
    - Significant problems include, but are not limited to, adverse findings pursuant to Standard Terms and Conditions, Section 31, Affirmative Duty to Track All Parties to the Award, or issues or barriers that may cause the Recipient to miss milestones described in these Program Terms and Conditions, or failure to implement this program as described in the Notice of Award.
    - CMS may elect to allow the Recipient an opportunity to take appropriate remedies which may include the Recipient accepting specific award conditions, technical assistance, and/or adhering to a non-compliance action plan within a timeframe and manner determined by CMS.
    - If the Recipient fails to meet the terms of any non-compliance action plan within the designated timeframe, CMS may terminate the cooperative agreement.
    - If the Recipient’s actions endanger the public health and welfare, CMS may immediately terminate the cooperative agreement without the opportunity for corrective action.
    - The regulations that pertain to suspension and termination are referenced in the CMS Standard Terms and Conditions, Sections 23, Suspension and Debarment Regulations and 35, Termination. In the event of a conflict between the terms of this section and the regulations, the regulations shall prevail.
18. **Remediation Actions.** The Recipient must remedy noncompliance within 90 days after being notified by CMS. Remediation may include recipient submitting a non-compliance action plan detailing its plan to resolve the non-compliance. If Recipient does not remedy noncompliance, CMS may recover past payments and withhold further payments of both workload and baseline funding. See also Standard Terms and Conditions, 34, Non-compliance. If CMS withholds or recovers funding, CMS may do as follows:

- For violations that affect the Recipient's technical score: Proportional to the incremental award funds granted based on the technical score points Recipient was previously awarded. This means that CMS may recalculate workload funding based on a Recipient's updated technical score and withhold or recover funding accordingly.
- For violations that do not directly affect the Recipient's technical score: Assessed on a case-by-case basis. All prior and future payments may become eligible for withholding and/or recovery.

As required by Public Law 119-21, any amounts withheld or recovered shall be returned to the Treasury of the United States.

19. **Termination.** This award is subject to the termination provisions at 2 C.F.R. 200.340. Pursuant to 2 C.F.R. 200.340, the recipient agrees by accepting this award that continued funding for the award is contingent upon the availability of appropriated funds, program authority, recipient satisfactory performance, compliance with the Terms and Conditions, and a decision by the agency that the award continues to effectuate program goals or agency priorities.
20. **Amendments.** CMS may amend these Program Terms and Conditions without the consent of the Recipient for good cause, or as necessary to comply with applicable federal or State law, regulatory requirements, accreditation standards, or licensing guidelines or rules. CMS will include with any such amendment an explanation of the reasons for the amendment. To the extent practicable, CMS will provide the Recipient with 30 days' advance written notice of any unilateral amendment, which notice must specify the amendment's effective date.

GLOSSARY

Baseline funding means the $25 billion in funding that will be equally distributed to all Recipients. Baseline funding will equal half of the total funding available for each budget period divided by the number of Recipients.

Budget period means the 10-month period beginning on December 29, 2025, and ending on October 30, 2026, for budget period 1, and each 12-month period beginning on October 31 and ending on October 30 for budget periods 2-5, as described in Section 6 of these Program Terms and Conditions, Budget Periods.

Cooperative agreement means a legal instrument of financial assistance between CMS and the Recipient consistent with 31 U.S.C. §§ 6302 & 6305 that:

- Is used to enter into a relationship the principal purpose of which is to transfer anything of value from CMS to the Recipient to carry out a public purpose authorized by a law of the United States (see 31 U.S.C. § 6305(1)); and not to acquire property or services for the federal government or for the federal government's direct benefit or use, and
- Is distinguished from a grant in that it provides for substantial involvement between CMS and the Recipient in carrying out the approved activities under this award (see 31 U.S.C. § 6305(2))

Enforcement action means an action that CMS may take if it finds that the Recipient has not complied with the Terms and Conditions.

Fiscal year means the account period that spans 12 months. For the federal government, it runs from October 1 to September 30. For example, Fiscal Year 2026 (FY 2026) starts October 1, 2025, and ends September 30, 2026.

Non-Competing Continuation (NCC) Application means the non-competitive application that the Recipient must submit during each budget period to receive an award for funding in the subsequent budget period.

Recipient means the lead State agency that submitted the approved application and received the Notice of Award from CMS. This does not include subrecipients.

Remediation means activities and actions required by CMS to correct identified deficiencies and produce improvements that enable the Recipient to meet the requirements of this Notice of Award.

Rural Health Transformation Plan means the detailed plan submitted as part of the NOFO application that describes a Recipient's vision, goals, and strategies to transform rural health care. See NOFO, Rural health transformation plan (pages 29-38).

Subrecipient means a non-federal entity that receives a subaward from the Recipient to carry out activities related to the award.

Technical score means the numerical score used to calculate workload funding based on initiative-based factors, State policy actions, and data-driven metrics. See NOFO Appendix, Points

scoring details, Table 4, Points scoring methodology, definitions, and data sources for rural facility and population score factors and technical score factors (pages 64-97).

Terms and Conditions means, collectively, the following: 1) the Recipient Specific Terms and Conditions, if applicable, 2) these Program Terms and Conditions, and 3) the Standard Terms and Conditions incorporated by reference in, and included as an attachment to, the Notice of Award.

Unexpended funds means the total amount of funds authorized by Congress and obligated by CMS but have not been drawn down by the Recipient. This may refer to funds that the Recipient has included in their Rural Health Transformation plan but have not been paid out on initiatives run at the State-level by the end of the subsequent fiscal year.

Unobligated funds means the portion of budget authority that has not been legally committed by CMS to Recipients in any given year.

Workload funding means the remaining $25 billion available to all Recipients and distributed based on a Recipient's technical score. Workload funding is equal to half of the total funding available for each budget period. Workload Funding will be recalculated every budget period using information submitted by the Recipient as part of their Annual Progress Report. See NOFO Appendix, Points scoring details, Table 4, Points scoring methodology, definitions, and data sources for rural facility and population score factors and technical score factors (pages 64-97).

Centers for Medicare & Medicaid Services
Standard[1] Grant and Cooperative Agreement Terms and Conditions

These terms and conditions apply to all funded award actions issued on or after December 14, 2025

GENERAL

1. **Recipient**. The recipient named on the Notice of Award (NoA) in field #1 is the non-federal entity that receives a federal award directly from CMS to carry out an activity under this Federal program.

   Recipients must comply with all terms and conditions of their NoAs, including:
   (a) These Standard Terms and Conditions
   (b) Recipient Specific Terms and Conditions, if applicable
   (c) Program Terms and Conditions
   (d) requirements of the authorizing statutes and implementing regulations for the program under which the NoA is funded
   (e) applicable requirements or limitations in appropriations acts
   (f) terms and conditions included in the HHS Grants Policy Statement **HHS GPS - effective 10/1/2025** in effect at the time of a new, noncompeting continuation, or renewal, or supplemental awards
   (g) the **HHS Administrative and National Policy Requirements**
   (h) Statutory and national policy requirements in **2 CFR 300.300**
   (i) applicable grant regulations in **2 CFR 200** and **2 CFR 300**
   (j) any policies or requirements specific to the award; and
   (k) any requirements included in the Notice of Funding Opportunity (NOFO).

2. **Acceptance of Application & Terms of Agreement.** By drawing or otherwise obtaining funds from the U.S. Department of Health and Human Services (DHHS) Payment Management System (PMS), the recipient:

   (a) acknowledges and accepts the terms and conditions of the award
   (b) is obligated to perform in accordance with the requirements of the award; and
   (c) certifies that proper financial management controls and accounting systems, to include personnel policies and procedures, have been established to adequately administer Federal awards and the funds drawn down.

   Additionally, by accepting this award, including the obligation, expenditure, or drawdown of award funds, recipient certifies as follows:

[1] Standard Terms and Conditions include all possible grants administrative requirements for CMS awards. All standard terms and conditions apply unless the requirement is not applicable based on the project awarded. Recipients should contact their assigned Grants Management Specialist if they have questions about whether an administrative term and condition applies to the award.

By applying for or accepting federal funds from HHS, recipients certify compliance with all federal antidiscrimination laws and these requirements and that complying with those laws is a material condition of receiving federal funding streams. Recipients are responsible for ensuring subrecipients, contractors, and partners also comply.

The recipient hereby agrees that it will comply with **Title VI of the Civil Rights Act of 1964**, as amended (codified at 42 U.S.C. 2000d et seq.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 80); **Section 504 of the Rehabilitation Act of 1973**, as amended (codified at 29 U.S.C. 794), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 84); **Title IX of the Education Amendments of 1972**, as amended (codified at 20 U.S.C. § 1681 et seq.) and all requirements imposed by or pursuant to the Regulation of the Department of the Health and Human Services (45 CFR Part 86); The **Age Discrimination Act of 1975**, as amended (codified at 42 U.S.C. § 6101 et seq.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 91); and **Section 1557 of the Patient Protection and Affordable Care Act**, as amended (codified at 42 U.S.C. § 18116), and all requirements imposed by or pursuant to the Regulation of the Department of the Health and Human Services (45 CFR Part 92).

For Programs that could implicate **Title IX** (i.e., awards to or for school, colleges, universities, 4-H programs, non-governmental organization (NGO) programs, sports programs, and education-related awards to prisons or other detention facilitates):

- Recipient is compliant with Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. §§ 1681 et seq., including the requirements set forth in Presidential Executive Order 14168 titled Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, and Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d et seq., and recipient will remain compliant for the duration of the NoA.
- The above requirements are conditions of payment that go to the essence of the NoA and are therefore material terms of the NoA.
- Payments under the NoA are predicated on compliance with the above requirements, and therefore recipient is not eligible for funding under the NoA or to retain any funding under the NoA absent compliance with the above requirements.
- Recipient acknowledges that this certification reflects a change in the government's position regarding the materiality of the foregoing requirements and therefore any prior payment of similar claims does not reflect the materiality of the foregoing requirements to this NoA.

Recipient acknowledges that a knowing false statement relating to recipient's compliance with the above requirements and/or eligibility for the NOA may subject recipient to liability under the False Claims Act, **31 U.S.C. § 3729**, and/or criminal liability, including under **18 U.S.C. § 287** and **18 U.S.C. § 1001**.

If the recipient cannot accept the terms and conditions of this NoA, the recipient must notify the Grants Management Officer (GMO), in writing, within thirty (30) days of the issue date of this NoA in accordance with the **HHS Grant Policy Statement (GPS) 2.6.1: Accepting the Award**. Once an award is accepted by a recipient, the contents of the NoA are binding on the recipient unless and until modified by a revised NoA signed by the GMO.

3. **Court Orders**. Any term or condition in this NoA, including those incorporated by reference, that HHS is enjoined by court order from imposing or enforcing shall not apply or be enforced as to any recipient or subrecipient to which that court order applies and while that court order is in effect.

4. **Cooperative Agreements**. A cooperative agreement is an alternative assistance instrument to be used in lieu of a grant whenever substantial Federal involvement with the recipient during performance is anticipated. The difference between grants and cooperative agreements is the degree of Federal programmatic involvement rather than the type of administrative requirements imposed. Therefore, statutes, regulations, policies, and the information contained in these Standard Terms and Conditions that are applicable to grants also apply to cooperative agreements, unless otherwise stated. Your NoA states whether the funding mechanism is a grant or cooperative agreement.

5. **Funding for Recipients.** All funding provided under this award must be used by the Recipient exclusively for the program referenced in the NoA and described in the NOFO and outlined in the recipient's approved application. This includes any approved revisions, as applicable, made subsequent to the recipient's approved application.
    - Funds available to pay allowable costs during the period of performance include both Federal funds awarded and approved carryover balances.
    - Federal award funds must supplement, not replace (supplant) non-federal funds. All recipients who receive awards under programs must ensure that federal funds do not supplant funds that have been budgeted for the same purpose through non-federal sources. Applicants or award recipients may be required to demonstrate and document that a reduction in non-federal resources occurred for reasons other than the receipt of expected receipt of federal funds.

6. **Recipient Roles and Responsibilities.**
    - Principal Investigator/Project Director (PI/PD): The PI/PD is the individual(s) employed and designated by the recipient to direct the project or program being supported by the award. The PI/PD is responsible and accountable to officials of the recipient organization for the proper conduct of the project, program, or activity, whether or not they receive salaries or compensation under the award.

      The recipient Organization must identify a PI/PD who will dedicate sufficient time and effort (minimally 25%) to manage and provide oversight of the grant/cooperative agreement program. Sufficient time and effort are defined as the time and effort required to successfully fulfill all program requirements and expectations as well as meet the project goals. You must justify the time committed as necessary to meet this threshold. CMS reserves the right to require additional time.

NOTE: A PI/PD must be committed financially to this award, i.e., the position must be funded with federal funds or alternatively, can be funded as a cost-share (in-kind) by the recipient (or a combination of the two). A PI/PD cannot dedicate time as a cost share (in-kind) without documenting this commitment on the Notice of Award (as a non-federal share). This is true, even if there is no required cost sharing for the award. The recipient has a choice as to how the PI/PD is funded.

- Authorized Organizational Representative (AOR): The AOR is an employee of the recipient and has authority to act for the organization. The AOR is responsible for meeting award requirements, properly managing the award, and providing oversight. The AOR's signature on a grant application guarantees that the information in the application is correct and the organization is responsible for following all requirements.

  While we do not require a minimum level of effort for the AOR because the necessary time commitment will vary, the AOR (if an award is received) acknowledges and confirms upon recipient's drawdown of funds his/her responsibility to provide oversight of the award and to provide the necessary signature approvals on all documents. Additionally, the AOR must attend meetings with CMS as required by the terms and conditions of award. An AOR must ensure he/she allocates sufficient time for financial oversight, programmatic monitoring, and compliance with CMS grant requirements. CMS reserves the right to require additional effort if the time committed is insufficient.

- Key Personnel:
  The PI/PD and other individuals who contribute to the programmatic development or execution of a project in a substantive, measurable way, whether they receive salaries or compensation under the award.

7. **Uniform Administrative Requirements, Cost Principles, and Audit Requirements.** The NoA issued is subject to the administrative requirements, cost principles, and audit requirements that govern Federal monies associated with this NoA, as applicable, in the Uniform Guidance – **2 CFR 200** and **2 CFR 300**.

   In accordance with **2 CFR 300.106**, the Department of Health and Human Services adopts the Office of Management and Budget (OMB) guidance in 2 CFR part 200, with the additions included in this part (part 300) and **part 376 of this chapter**. Thus, this part gives regulatory effect to the OMB guidance and supplements the guidance as needed for the Department.

8. **Fraud, Waste, and Abuse.** The HHS Office of the Inspector General (OIG) maintains a toll-free number (1-800-HHS-TIPS [1-800-447-8477]) for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements as well as the **HHS OIG website**. Information may also be submitted by **email** or by mail to:

   Office of the Inspector General
   U.S. Department of Health & Human Services

Attn: HOTLINE
330 Independence Ave., SW
Washington, DC 20201

Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous.

9. **Medicare and Medicaid anti-kickback** statute is hereby incorporated by reference: **42 U.S.C. § 1320a-7b**.

10. **Payment.** The Division of Payment Management does not award grants. The issuance of grant awards and other financial assistance is the responsibility of the awarding agencies. Once an award is made, the funds are posted in recipient accounts established in the Payment Management System (PMS). Recipients may then access their funds by using the PMS funds request process.

    Recipients must indicate which approved activity(ies) from the budget category(ies) identified on the SF-424A Form (e.g., personnel, supplies) that the payment request will cover. Also include the amount requested for each budget category. Do not include Personally Identifying Information (PII) in your request.

    The PMS funds request process enables recipients to request funds using a Personal Computer with an Internet connection. The funds are then delivered to the recipient via Electronic Funds Transfer (EFT). If you are a new grant recipient, register in PMS **here**. If you need further help with that process, please contact the One-DHHS Help Desk via email at **PMSSupport@psc.hhs.gov** or call (877) 614-5533 for assistance.

    For Federal Payment requirements, refer to **2 CFR 200.305, Federal Payment** as well as **2 CFR 300.305**.

11. **GrantSolutions and email addresses.** Recipients must maintain an active account with GrantSolutions (GS) to communicate, receive, and obtain documentation from CMS. If the designated recipient Authorized Organizational Representative (AOR) and Project Director (PD) do not already have accounts in GS, they must contact GS immediately upon receipt of award to complete a user account form. Any change in key personnel, must also be communicated to CMS and GS staff so that the key responsible individuals are current and correct within the GS system.

12. **Reservation of Rights.** Nothing contained in this NoA is intended or shall be construed as a waiver by the United States Department of Justice, the Internal Revenue Service, the Federal Trade Commission, HHS OIG, or CMS of any right to institute any proceeding or action against the recipient for violations of any statutes, rules or regulations administered by the Government, or to prevent or limit the rights of the Government to obtain relief under any other federal statutes or regulations, or on account of any violation of this award or any other provision of law. The NoA shall not be construed to bind any Government agency except CMS, and this NoA binds CMS only to the extent provided herein, unless prohibited by law.

The failure by CMS to require performance of any provision shall not affect CMS's right to require performance at any time thereafter, nor shall a waiver of any breach or default result in a waiver of the provision itself.

ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

13. Prior Approval Requirements. CMS anticipates that the recipient may need to modify the recipient's NoA budget or other aspects of its approved application during performance to accomplish the award's programmatic objectives. In general, recipients are permitted to rebudget within and between budget categories to meet unanticipated needs and to make other types of post-award changes, provided that the changes still meet the statutory program requirements and the regulatory requirements under **2 CFR 200** and **2 CFR 300**, as applicable.

Items that require prior approval (i.e. formal written approval) from the GMO, as stated in the Terms and Conditions of the NoA and HHS grant regulations must be submitted in writing. Based on the nature, extent, and timing of the request, the GMO may approve, deny, or request additional material to further document and evaluate your request.

A recipient must request approval of post-award changes to its award through submission of an amendment in GS (based upon the applicable change request). Only an amended NoA signed by the GMO is considered valid approval. Verbal authorization is not approval and is not binding on CMS. Recipients who proceed without prior approval, do so at their own risk.

Amendment Type guidance:

- If a budget revision/change request impacts more than one budget category, utilize Revision (Budget) amendment type.
- If budget revision change request only impacts one budget category, utilize Revision (NoA Other) amendment type.
- If the change requested does not match a possible amendment type from the selection list in GS, utilize Revision (NoA Other) amendment type.

Prior approval is **required** for but is not limited to:

- Changes in Key Personnel and Level of Effort;
- Budget Revisions (see also Standard Term and Condition, 14. *Revision of Budget and Program Plans*);
- Subaward activities not yet proposed or approved;
- Consultant/Contract activities not yet proposed or approved;
- Changes in Scope;
- Carryover Requests;
- No Cost Extensions;
- Lifting of Funding Restrictions;
- Removal of Non-Compliance Plans;
- Equipment and other capital expenditures **2 CFR 200.439**
- Rearrangement and reconversion costs **2 CFR 200.462**

Activities that require prior approval are further detailed in HHS grant **2 CFR 200.407, Prior written approval (prior approval)**, **2 CFR 200.308, Revision of budget and program plans**, and the HHS Grants Policy Statement.

14. **Revision of Budget and Program Plans.** Recipients must consult and comply with requirements outlined under **2 CFR 200.308, Revision of budget and program plans**.

    In accordance with **2 CFR 200.308(i), Transfer of Funds**, CMS requires prior approval for budget revisions where the transfer of funds among direct cost categories or programs, functions and activities in which the Federal share of the project exceeds the Simplified Acquisition Threshold ($350,000) and the **cumulative amount** of such transfers exceeds or is expected **to exceed 10 percent** of the total budget as last approved. CMS cannot permit a transfer that would cause any Federal appropriation to be used for purposes other than those consistent with the appropriation.

15. **Travel Costs.** Recipients must comply with the requirements in **2 CFR 200.475.**

16. **Conflict of Interest Policies.** Recipient must comply with the conflict-of-interest policy requirements outlined **here**. See also **2 CFR 200.112** and **2 CFR 300.112**.

17. **Bankruptcy.** If recipient or one of its subrecipients enters bankruptcy proceedings, whether voluntary or involuntary, the recipient agrees to provide written notice of the bankruptcy to the CMS Grants Management Specialist and CMS Project Officer (PO) within five (5) days of initiation of the proceedings. This notice shall include the date on which the bankruptcy petition was filed, the identity of the court in which the bankruptcy petition was filed, a copy of any and all of the legal pleadings, and a listing of Government grant and cooperative agreement numbers and grant offices for all Government grants and cooperative agreements against which final payment has not been made.

18. **Prohibition on certain telecommunications and video surveillance services or equipment.** **2 CFR 200.216** is incorporated herein by reference.

19. **Human Subjects Protection.** If applicable to recipient's program, the recipient bears ultimate responsibility for protecting human subjects under the award, including human subjects at all sites, and for ensuring that a Federal-wide Assurance (FWA) approved by the Office for Human Research Protections (OHRP) and certification of Institutional Review Board (IRB) review and approval have been obtained before human subjects research can be conducted at each collaborating site. For more information about OHRP, FWA, and IRBs, click **here**.

    Recipients may not draw funds from PMS, request funds from the paying office, or make obligations against Federal funds for research involving human subjects at any site engaged in nonexempt research for any period not covered by both an OHRP-approved assurance and IRB approval consistent with **45 CFR Part 46**. Costs associated with IRB review of human research protocols are not allowable as direct charges under grants and cooperative agreements unless such costs are not covered by the organization's indirect cost rate.

HHS requires recipients and others involved in grant/cooperative agreement-supported research to take appropriate actions to protect the confidentiality of information about and the privacy of individuals participating in the research. Recipients, subrecipients, Investigators, IRBs, and other appropriate entities must ensure that policies and procedures are in place to protect identifying information and must oversee compliance with those policies and procedures.

20. **Privacy and Security of Health Information.** The recipient shall put all appropriate regulatory, administrative, technical, and physical safeguards in place before applicable program activities begin to protect the privacy and security of individually identifiable health information. In doing so, regardless of whether it is a covered entity (CE) or business associate (BA) as those terms are defined under the HIPAA Privacy Rule, the recipient shall ensure its own and its subrecipients' and contractors' policies and procedures are at least as stringent (i.e., protective of privacy) as those governing the use and disclosure of protected health information by HIPAA CEs and their BAs under **45 CFR Part 160** and **45 CFR Part 164**. The recipient and its subrecipients should consult with their own counsel and refer to the **HIPAA guidance materials** for further information about the requirements in 45 CFR Parts 160 and 164.

21. **Employee Whistleblower Protections.** Federal law mandates that all Federal contractors, subcontractors, recipients, subrecipients, or personal services contractors, must inform their employees in writing of the rights and remedies provided under this section, in the predominant native language of the workforce. For more information click **here**.

22. **Mandatory Disclosures.** Consistent with **2 CFR 200.113, Mandatory disclosures**, applicants and recipients must promptly disclose, in writing, to CMS with a copy to the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Additionally, subrecipients must promptly disclose, in a timely manner, in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to CMS and to the HHS OIG at the following addresses:

    U.S. Department of Health & Human Services
    Centers for Medicare & Medicaid Services
    Office of Acquisition and Grants Management
    Attn: Director, Division of Grants Management, Mandatory Grant Disclosures
    7500 Security Blvd, Mail Stop B3-30-03
    Baltimore, MD 21244-1850

    Materials must also be scanned and emailed to your Grants Management Specialist.

    AND

U.S. Department of Health & Human Services
Office of Inspector General
ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW, Cohen Building
Room 5527
Washington, DC 20201
Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or
Email: **MandatoryGranteeDisclosures@oig.hhs.gov**

Failure to make required disclosures can result in any of the remedies described in **2 CFR 200.339, Remedies for noncompliance**, including suspension or debarment (See **2 CFR 200 Part 180** & **2 CFR 200 Part 376** and **31 U.S.C. 3321**).

The recipient must include this mandatory disclosure requirement in all subawards and contracts under this award.

23. **Suspension and Debarment Regulations.** **2 CFR 200.214** is incorporated herein by reference.

24. **Appropriations Provision.** The Department of Health and Human Services (HHS) operates under Appropriations and Extensions Acts, as applicable, each fiscal year. Recipients must review and comply with applicable General Provisions for the Department of Health and Human Services included within the Appropriations Law for the current fiscal year. These provisions may apply to all recipients of HHS federal funding OR may apply directly to recipients of federal funding from one or more HHS agencies.

    Salary Limitations: 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. This salary cap applies to direct salaries. Recipients may pay salaries at a rate higher than the Executive Level II if the amount beyond the HHS salary cap is paid with non-HHS funds. Since the Executive Level II rate and HHS Appropriations Act citation changes each year, HHS refers to the most recent information posted on the Office of Personnel Management (OPM) website at **2025 Executive Level II Pay Scale** (January 1, 2025 – December 31, 2025). Please consult **the OPM website (Salaries and Wages)** in January 2026 for the salary cap for 2026 (January 1, 2026 – December 31, 2026).

25. **Cybersecurity.** You must create a cybersecurity plan if your project involves both of the following conditions:

    - You have ongoing access to HHS information or technology systems.
    - You handle personal identifiable information (PII) or personal health information (PHI) from HHS.

    See the **HHS Administrative and National Policy Requirements** for full information.

26. Health Information Technology (HIT) Interoperability Language. Recipient is subject to the Health Information Technology and Interoperability requirements stated **here**.

COST PRINCIPLES

CMS recipients and subrecipients must comply with the cost principles set forth in HHS regulations at 2 CFR 200, Subpart E. Recipients and subrecipients must also use these principles as a guide in pricing fixed-price contracts and subcontracts when costs are used in determining the appropriate price. Hospitals must follow **Appendix IX to 2 CFR 300**. **Principles for Determining Costs Applicable to Research and Development Under Grants and Contracts with Hospitals.**

For-profit recipients are subject to 48 CFR subpart 31.2[2]. For more detailed information on applicability and exemptions, refer to **2 CFR 200.401**.

Guidelines for determining direct and indirect (F&A) costs charged to Federal awards are provided in **2 CFR 200 Direct and Indirect Costs** and **Special considerations for States, Local Governments, and Indian tribes**. Requirements for development and submission of indirect (F&A) cost rate proposals and cost allocation plans are contained in Appendices III - Appendix IX to Part 200.

For-profit entities which receive the preponderance of their federal awards from HHS may contact the Division of **Financial Advisory Services (DFAS), Indirect Cost Branch**, to negotiate an indirect cost rate. Otherwise, for-profit organizations are limited to the 15% de minimis rate in accordance with 2 CFR **200.414(f)**.

27. Prohibited Uses of Grant or Cooperative Agreement Funds. The following list contains costs that are unallowable for all CMS programs. Recipients must consult the Program Terms and Conditions for other prohibited costs specific to the grant or cooperative agreement program.

- Pre-award costs.
- Meeting matching requirements for any other federal funds or local entities.
- Services, equipment, or supports that are the legal responsibility of another party under federal, state, or tribal law such as vocational rehabilitation or education services. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
- Goods or services not allocable to the approved project.
- Supplanting existing state, local, tribal, or private funding of infrastructure or services, such as staff salaries.
- Construction.

[2] There are no cost principles specifically applicable to grants to for-profit organizations. Therefore, the cost principles set forth in the FAR (48 CFR subpart 31.2) generally are used to determine allowable costs under CMS grants to for-profit organizations. As provided in those cost principles, **allowable travel costs** may not exceed those established by the FTR.

- Capital expenditures for improvements to land, buildings, or equipment that materially increase their value or useful life as a direct cost except with the prior written approval.
- The cost of independent research and development, including their proportionate share of indirect costs in accordance with **2 CFR 300.477**.
- Profit to any recipient even if the recipient is a for-profit organization. Profit is any amount in excess of allowable direct and indirect costs.
- Funds related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the Congress or any state government, state legislature or local legislature or legislative body. See also **45 CFR part 93**, **2 CFR 200.450, Lobbying,** and applicable Appropriations Law**.**

- Other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a state, local, or tribal government in policymaking and administrative processes within the executive branch of that government, funding awarded under this NOFO may not be used for:
    - Paying the salary or expenses of any grant recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the Congress or any state government, state legislature, or local legislature or legislative body.
    - Lobbying, but recipients can lobby at their own expense if they can segregate federal funds from other financial resources used for lobbying.
- Certain telecommunications and video surveillance equipment. See **2 CFR 200.216**.
- Costs of promotional items and memorabilia, including models, gifts, and souvenirs.
- Costs of advertising and public relations designed solely to promote the non-Federal entity.
- Meals unless in limited circumstances such as:
    - Subjects and patients under study;
    - Where specifically approved as part of the project or program activity (not recipient specific), e.g., in programs providing children's services; and
    - As part of a per diem or subsistence allowance provided in conjunction with allowable travel.

For guidance on some types of costs that we restrict or do not allow, see **2 CFR 200, General Provisions for Selected Items of Costs**.

POST AWARD MONITORING AND REPORTING

28. Continued funding is contingent on satisfactory progress, compliance with the terms and conditions, program authority, and the availability of funds. The NoA identifies the period of performance, which may include multiple 12-month budget periods. If a period of performance is comprised of multiple budget periods, the recipient must submit a non-competing continuation application each year as a prerequisite to continued funding.

Recipients must demonstrate satisfactory performance during the previous funding cycle(s) to be issued additional year funding; or, in the case of multi-year awards where all funding is issued in the first year, to ensure continued access to funding. Recipients should refer to the NOFO and Program Terms and Conditions for additional information on satisfactory progress.

Additionally, as is noted in 2 CFR 200, CMS annually conducts a review of risks posed by applicants prior to award (recipients should review the factors in their entirety at **2 CFR 200.206, Federal agency review of risk posed by applicants**). At-risk recipients, including those which do not comply with reporting requirements or have outstanding audit findings, may not receive a non-competing continuation award.

Alternatively, recipients could receive decreased funding, or their award could be terminated subject to the provisions at **2 CFR 200.340, Termination** if they are non-compliant with the terms and conditions of award. See also Standard Term and Condition, 35. *Termination*.

29. **Reporting Requirements.** Recipients must comply with the reporting requirements outlined in the Recipient Specific, Standard **and** Program Terms and Conditions of the NoA. The general information and guidance for financial and programmatic reporting provided below supplements the specifics included in the Program Terms and Conditions.

A. PROJECT AND DATA INTEGRITY

Recipients must protect the confidentiality of all project-related information that includes personally identifying information.

The recipient must assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted. The CMS PO shall not direct the interpretation of the data used in preparing these documents or reports.

At any phase in the project, including the project's conclusion, the recipient, if requested by the CMS PO, must deliver to CMS materials, systems, or other items used, developed, refined or enhanced in the course of, or under the award. The recipient agrees that CMS must have a royalty-free, nonexclusive and irrevocable license to reproduce, publish, or otherwise use and authorize others to use the items for Federal government purposes. See also **200.315(b), Intangible Property**.

B. SYSTEM OF AWARD MANAGEMENT (SAM) AND UNIVERSAL ENTITY IDENTIFIER (UEI) REQUIREMENTS

This NoA is subject to the requirements of **2 CFR part 25, Appendix A** which is specifically incorporated herein by reference. Recipient must maintain current information in SAM, at all times when an award is active or if there is an application pending review. Recipient must review and update the information **at least once a year** after the initial registration to remain active, and more frequently if required by changes

in the information. This requirement flows down to subrecipients and contractors under awards or subawards.

As part of its SAM registration and renewal process, recipient must also complete or update its **Responsibility/Qualification (R/Q)** reporting to reflect information about its civil, criminal, or administrative proceedings. **Applicants/recipients must answer "Yes" to question #1 (shown below) of the Proceedings question in SAM.gov to view and answer all relevant questions**.

- Is your business or organization, as represented by the Unique Entity ID on this entity registration, responding to a Federal procurement opportunity that contains the provision at FAR 52.209-7, subject to the clause in FAR 52.209-9 in a current Federal contract**, or** applying for a Federal grant opportunity which contains the award term and condition described in 2 C.F.R. 200 **Appendix XII to Part 200, Award Term and Condition for Recipient Integrity and Performance Matters**?

C. SUBAWARD REPORTING AND EXECUTIVE COMPENSATION (FFATA)

This NoA is subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (Public Law 109-282), as implemented by **2 CFR Part 170**. Requirements include:

A. First tier subaward reporting of $40,000 or more in federal funds. Due no later than 30 days after issuance of subaward.
B. Executive compensation reporting, if required, as referenced in 2 CFR Part 170. Due no later than 30 days after issuance of subaward.

D. FINANCIAL REPORTING

HHS recipients must record recipient expenses in real-time as well as submit quarterly, semi-annual, or annual expenditure Federal Financial Reports (FFRs) as described below and stipulated in the Program Terms and Conditions of Award. Instructions on how to complete the FFR can be found **here** after logging onto PMS.

- Quarterly and semi-annual expenditure reports are due no later than 30 days following the applicable period.
- Annual expenditure FFRs are due no later than 90 days following the applicable budget period end date or 12-month period for multi-year budget periods.
- Final FFRs are due no later than 120 days following the period of performance end date.
    - The final FFR must show cumulative expenditures under the NoA and any unobligated balance of federal funds and as appropriate, all other parts of the form must be completed.

- Additionally, recipient must liquidate all obligations incurred under the award not later than 120 days after the end of the period of performance. This deadline may be extended with prior written approval from the CMS Grants Management Specialist.

E. PROGRAMMATIC REPORTING

See **2 CFR §200.301**, **Performance Measurement**, and Program Terms and Conditions for specific details on required information.

Submission of Progress Reports to PMS
Recipients must submit progress reports to GrantSolutions via the Performance Progress Report (PPR) module.

Recipients with the following roles can view, edit, and electronically submit the PPR:
- Recipient's Authorized Organizational Representative (AOR)
- Principal Investigator/Program Director (PI/PD) assigned to the Award

The CMS Project Officer will either accept or return the PPR to the recipient for additional information or clarification. The grant or cooperative agreement is not considered complete and in accordance with the applicable terms and conditions of the NoA until all required reports have been accepted by the CMS Project Officer.

F. STEVENS AMENDMENT

When issuing statements, press releases, publications, requests for proposals, bid solicitations, and other documents – such as toolkits, resource guides, websites, and presentations – describing the projects or programs funded in whole or in part with HHS funds, the recipient must clearly state:

(1) the percentage and dollar amount of the total costs of the program or project funded with Federal money; and
(2) the percentage and dollar amount of the total costs of the project or program funded by non-governmental sources.

Acknowledgement of Support
When issuing statements resulting from activities supported by HHS financial assistance, the recipient entity must include an acknowledgement of federal assistance using one of the following or a similar statement (see immediately below).

If the HHS grant or cooperative agreement is NOT funded with other non-governmental sources:

This **[project/publication/program/website, etc.] [is/was]** supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human

Services (HHS) as part of a financial assistance award totaling **$XX** with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

The HHS grant or cooperative agreement IS partially funded with other nongovernmental sources:

This **[project/publication/program/website, etc.] [is/was]** supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling **$XX** with **XX** percentage funded by CMS/HHS and **$XX** amount and **XX** percentage funded by non-government source(s). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

(a) **Review by CMS.** Recipient shall submit the following to the CMS PO for review and comment unless specified otherwise in the Program Terms and Conditions:

(i) At least 30 days prior to its release:

- publications that report results from or describe information obtained through this award.
- any external formal presentation of any report or statistical or analytical material based on information obtained through this award. Formal presentation includes papers, articles, professional publication, speeches, and testimony.
- external presentation-related material, such as abstracts, power point presentations or other slide decks, posters, and videos.
- all public materials specific to the program including but not limited to, brochures, recruitment materials, informational materials, advertisements, website copy, website pages, videos, and op-ed articles.

(ii) At least 7 days prior to release:

- any press release or media advisory concerning the outcome of activities supported through this award.
- all media interviews, media requests, releases of information, filming, and broadcasts.

(b) For 1 year after completion of the project, the recipient shall continue to submit for review and comment all publications, presentations, and communications resulting from this award or based on information obtained through this award, including papers, articles, professional publications, power point presentations, posters, speeches, announcements, and testimony in any format, including digital technology.

(c) It is the policy of the HHS that the recipient must communicate to CMS how the dollar amounts and funding percentages are calculated, including whether or not indirect costs have been incorporated. Recipient must submit this

information to CMS for review and comment for each applicable type of result/accomplishment according to the same timeline schedule outlined in (a).

(d) Specifically excluded from the review and comment process are internal presentations, information discussions, in general, class lectures, and informal meetings and conversations with community leaders. However, if such a presentation or slide deck is later re-purposed for a public event, it will need to be submitted in advance for CMS review.

(e) One copy of each publication resulting from work performed under an HHS grant- supported project must accompany the final progress report.

G. USE OF DATA AND WORK PRODUCTS (REPORTING)

At any phase of the project, including the project's conclusion, the recipient, if so requested by the CMS PO, must submit copies of analytic data file(s) with appropriate documentation, representing the data developed/used in end-product analyses generated under the award.

- The analytic file(s) may include primary data collected, acquired or generated under the award and/or data furnished by CMS.
- The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by the Principal Investigator/Project Director (PI/PD) and the CMS PO.
- The negotiated format(s) could include both file(s) that would be limited to CMS's internal use and file(s) that CMS could make available to the general public.

All data provided by CMS will be used for the research described in this grant/cooperative agreement NoA only and in connection with the Recipient's performance of its obligations and rights under this program. Recipient has an obligation to collect and secure data for future monitoring by CMS. The recipient will return any data provided by CMS or copies of data at the conclusion of the project. All proprietary information and technology of the recipient are and shall remain the sole property of the recipient.

If the PI/PD determines through this research that a significant new finding has been developed, he/she will communicate it to the CMS PO before formal dissemination to the general public. The recipient shall notify CMS of research conducted for publication.

H. ANNUAL PROPERTY REPORTING.

2 CFR 200.312, Federally owned and exempt property, is incorporated herein by reference. Recipient must submit annually an inventory listing of Federally owned property in its custody to CMS.

I. PATENTS AND INVENTIONS

In accordance with **2 CFR 200.448, Intellectual Property**, all recipients are subject to applicable regulations governing patents and inventions, including government-wide regulations issued by the Department of Commerce at **37 CFR Part 401**. If applicable, recipients must report any inventions on an annual basis using the non-competing continuation application or annual progress report for multi-year budget periods.

A Final Invention Statement and Certification (**Form HHS 568**) must be completed and submitted within 120 days following the expiration or termination of a grant or cooperative agreement.

- The Statement must include all inventions which were conceived or first actually reduced to practice under the grant or award, from the original effective date of support through the date of completion or termination.
- The Statement shall include any inventions reported previously for grants and cooperative agreements as part of a non-competing continuation application or annual progress report.
- Recipients must also provide details about all inventions that have been licensed but not patented and include details on income resulting from HHS-funded inventions and patents.

Unpatented research products or resources—research tools—may be made available through licensing to vendors or other investigators. Income earned from any resulting fees must be treated as program income. This reporting requirement is applicable to grants and cooperative agreements issued by the U.S. DHHS in support of research and research-related activities. For further guidance, please see the HHS GPS: *Patents and Inventions* and *Invention Reporting*.

J. AUDIT REPORTING (SEE 2 CFR 200.501, Audit requirements).

A non-Federal entity that expends **$1,000,000** or more during the non-Federal entity's FY in Federal awards must have a single or program-specific audit conducted for that year and submit an audit reporting package to the Federal Audit Clearinghouse (FAC). HHS grant awarding agencies are required to ensure that single or program-specific audits are completed and reported by recipients within nine months after the end of the audit period (recipient FY end date).

For questions and information concerning the FAC submission process, please contact the FAC (entity which assists Federal cognizant and oversight agencies in obtaining audit data and reporting packages) at 888-222-9907 or click **here**.

For-profits including for-profit hospitals should consult **2 CFR 300.218** for limitations on profit and program income.

Audits for for-profit organizations with HHS programs must be sent to:

- the HHS Audit Resolution Division (ARD) via email at **For-Profit_Audit@hhs.gov**
- copy to: CMS KC_OIG_Audit at **KC_OIG_Audit@cms.hhs.gov**

- copy to the Grants Management Specialist identified in Federal Awarding Agency box #9 on the NoA.
- All for-profit organization audit submission questions should be sent to ARD via email at **AuditResolution@hhs.gov**.

Do not send audits for organizations (for-profits) to the FAC.

SUBRECIPIENT PASS-THROUGH REQUIREMENTS

The recipient can provide a portion of the direct award to other organizations, called subrecipients, to accomplish the goals and objectives of the award. In this case, the recipient becomes a pass-through entity and the subrecipient's award is called a subaward. As a recipient, you must ensure the applicable general terms and conditions stated in this document flow down to subrecipients.

The recipient is **completely** legally and financially responsible for **all** aspects of this NoA including funds provided to subrecipients, in accordance with **2 CFR 200, Subpart D, Subrecipient monitoring and management**.

30. Subaward Reporting. Refer to Standard Term and Condition, 29(C) *Subaward Reporting and Executive Compensation (FFATA)*.

31. Affirmative Duty to Track All Parties to the Award. Recipient must at a minimum regularly track all subrecipients, including subrecipient key personnel and subcontractors in SAM.gov.

As provided in **2 CFR Part 180** and implemented in **2 CFR Part 376**, the recipient must check SAM.gov as follows to ensure that it does not make a subaward to an entity that is debarred, suspended, or ineligible:

- For all first-tier subawards regardless of potential value. Agencies must also require first tier- subrecipients and lower-tier subrecipients to check SAM.gov and
- For all first-tier procurement contracts with a value of **$40,000** or more and all lower tiers of subcontracts under covered non-procurement transactions (**2 CFR 376.220**).

The purpose of this affirmative duty is to track all parties that include health care, commercial, non-profit, and other people and entities to report immediately to the CMS PO and Grants Management Specialist those that cannot participate in federal programs or receive federal funds. The recipient cannot have any persons or entities on the NoA that cannot participate in federal programs or receive federal funds. If any of these systems are not publicly available, then the recipient must comply with the purpose and intent of this requirement using a process that meets at least the level of scrutiny provided by these databases.

The recipient shall provide the CMS PO and Grants Management Specialist with the National Provider Identifier (NPI), Tax ID, and EIN, as applicable, of all Key Personnel

and/or entities to the NoA that may include subrecipients. This list shall be provided to CMS as a Grant Note/Message in GS within **thirty (30) days** from the start of the award and must be maintained in real time throughout the NoA.

32. **Pass Through Entities, Subrecipients, and Contractors.** **2 CFR 200.331, Subrecipient and contractor determinations**, and **2 CFR 200.332, Requirements for pass-through entities**, are incorporated herein by reference.

    Recipient must monitor the activities of the subrecipient as necessary to ensure that the subaward is used for authorized purposes, in compliance with Federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved.

33. **Equal Treatment.** **45 CFR Part 87** is incorporated herein by reference.

REMEDIES FOR NONCOMPLIANCE

34. **Non-compliance**. **2 CFR 200.208, Specific conditions**, and **2 CFR 200.339, Remedies for noncompliance**, are incorporated herein by reference.

35. **Termination.** This NoA is subject to the termination provisions at **2 CFR 200.340**. Pursuant to 2 CFR 200.340, the recipient agrees by accepting this NoA that continued funding for the award is contingent upon:
    - the availability of appropriated funds,
    - recipient satisfactory performance,
    - compliance with the Terms and Conditions of the award, and
    - to the extent authorized by law, if CMS determines that the award no longer effectuates program goals or agency priorities.

    In accordance with 200.340(c), if CMS terminates the Federal award prior to the end of the period of performance due to the recipient's material failure to comply with the terms and conditions of the Federal award, CMS must report the termination in SAM.gov. Material noncompliance includes, but is not limited to, violation of the terms and conditions of the award; failure to perform award activities in a satisfactory manner; improper management or use of award funds; or fraud, waste, abuse, mismanagement, or criminal activity.

CLOSEOUT

36. **Withdrawal.** If the recipient decides to withdraw from this award prior to the end of the period of performance, it must provide written notification (both hard copy and via email) to the CMS Grants Management Specialist at least fifteen (15) days in advance of the date of official withdrawal and termination of these terms. The letter must be signed by the AOR and other appropriate individuals with authority and submitted as a Revision (NoA Other)

amendment in GrantSolutions. CMS will not be liable for any withdrawal close-out costs that are borne by the recipient. Recipients have three (3) days to return all unused grant funds.

37. **Disposition of Federally Owned Property, Equipment, and Residual Unused Supplies.** Upon completion (or early termination) of a project, the recipient must take appropriate disposition actions.

    Recipient must complete and submit the **SF-428 Cover Letter** and the **SF-428-B Tangible Personal Property Report, Final Report.** The Tangible Personal Property Report (SF-428) is a standard form to be used by awarding agencies to collect information related to tangible personal property when required by a Federal financial assistance award. This form:

    - allows recipients to request specific disposition of federally owned property and acquired equipment.
    - provides a means for calculating and transmitting appropriate compensation to CMS for residual unused supplies.

    As noted in 1.b of this report, if your agency is in possession of Federally-owned property or acquired equipment (defined as nonexpendable personal property with an acquisition cost of $10,000 or more under the award), you must also submit a **SF-428-S, Supplemental Sheet**, that lists and reports on all Federally owned or acquired equipment under the specific grant or cooperative agreement award. If there is no tangible personal property to report, select "d." in section 1 of the SF-428-B and indicate "none of the above."

    Recipient must request specific disposition instructions from CMS if the recipient has federally owned property. Otherwise, disposition instructions are here **§ 200.313 Equipment § 200.314 Supplies.**

38. **Records Retention.** **2 CFR 200.334, Records retention requirements** is incorporated herein by reference.

Agreement No. GFA###

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
GRANT AGREEMENT

THIS AGREEMENT is entered into between the State of Florida, **AGENCY FOR HEALTH CARE ADMINISTRATION**, hereinafter referred to as the "**Agency**," whose address is 2727 Mahan Drive, Tallahassee, Florida 32308, and **SUBRECIPIENT NAME**, hereinafter referred to as the "**Subrecipient**," whose address is **SUBRECIPIENT ADDRESS**, **REASON**.

TABLE OF CONTENTS

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
GRANT AGREEMENT

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
GRANT AGREEMENT

I. THE SUBRECIPIENT HEREBY AGREES:

A. General Provisions

1. To comply with the criteria and final date, as specified herein, by which such criteria must be met for completion of this Agreement. The Subrecipient shall not be eligible for reimbursement for work performed prior to the execution date of this Agreement.

2. To provide services according to the terms and conditions set forth in this Agreement, **Attachment I**, Agency Request for Application, and all other attachments named herein which are attached hereto and incorporated by reference (collectively referred to herein as this "Agreement").

3. To perform as an independent Subrecipient and not as an agent, representative or employee of the Agency.

4. To recognize that the State of Florida, by virtue of its sovereignty, is not required to pay any taxes on the services or goods purchased under the terms of this Agreement.

B. Florida Department of State

To be registered with the Florida Department of State as an entity authorized to transact business in the State of Florida by the effective date of this Agreement.

C. Prohibition of Gratuities

To certify that no elected official or employee of the State of Florida has or shall benefit financially or materially from this Agreement in violation of the provisions of Chapter 112, F.S. This Agreement may be terminated if it is determined that gratuities of any kind were either offered or received by any of the aforementioned parties.

D. Audits and Records

1. To maintain books, records, and documents (including electronic storage media) pertinent to performance under this Agreement in accordance with generally accepted accounting procedures and practices which sufficiently and properly reflect all revenues and expenditures of funds provided by the Agency under this Agreement.

2. In addition to the requirements of the preceding paragraph, the Subrecipient shall comply with the applicable provisions contained in **Attachment II**, Special Audit Requirements, attached hereto and incorporated herein by reference.

3. To assure that these records shall be subject at all reasonable times to inspection, review, or audit by State personnel and other personnel duly authorized by the Agency, as well as by Federal personnel.

4. To maintain and file with the Agency such progress, fiscal and inventory reports as specified in **Attachment I**, Agency Request for Application, and other reports as the Agency may require within the period of this Agreement. In addition, access to relevant computer data and applications which generated such reports should be made available upon request.

5. To comply with public record laws as outlined in Section 119.0701, F.S.

6. To provide a financial and compliance audit to the Agency as specified in **Attachment II**, Special Audit Requirements and to ensure that all related party transactions are disclosed to the Agency Agreement Manager.

7. To include these aforementioned audit and record keeping requirements in all approved sub-agreements and assignments.

E. Inspection of Records and Work Performed

1. The Agency and its authorized representatives shall, at all reasonable times, have the right to enter the successful Subrecipient's premises, or other places where duties under this Agreement are performed. All inspections and evaluations shall be performed in such a manner as not to unduly delay work. Persons duly authorized by the Agency and Federal auditors, pursuant to 45 CFR, Part 74 and/or 45 CFR, Part 92, shall have full access to and the right to examine any of said records and documents.

2. The Subrecipient shall retain all financial records, medical records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to performance under this Agreement for a period of ten (10) years after termination of this Agreement, or if an audit has been initiated and audit findings have not been resolved at the end of ten (10) years, the records shall be retained until resolution of the audit findings.

3. Refusal by the Subrecipient to allow access to all records, documents, papers, letters, other materials or on-site activities related to this Agreement performance shall constitute a breach of this Agreement.

4. The right of the Agency and its authorized representatives to perform inspections shall continue for as long as the Subrecipient is required to maintain records.

5. The Subrecipient shall be responsible for all storage fees associated with all records maintained under this Agreement. The Subrecipient is also responsible for the destruction of all records that meet the retention schedule noted above.

6. Failure to retain all records as required may result in cancellation of this Agreement. The Agency shall give the Subrecipient advance notice of cancellation pursuant to this provision and shall pay the Subrecipient only those amounts that are earned prior to the date of cancellation in accordance with the terms and conditions of this Agreement. Performance by the Agency of any of its obligations under this Agreement shall be subject to the successful Subrecipient's compliance with this provision.

7. In accordance with Section 20.055, F.S., the Subrecipient and its subcontractors shall cooperate with the Office of the Inspector General in any investigation, audit, inspection, review or hearing; and shall grant access to any records, data or other information the Office of the Inspector General deems necessary to carry out its official duties.

8. The rights of access in this Section must not be limited to the required retention period but shall last as long as the records are retained.

F. Accounting

1. To maintain an accounting system and employ accounting procedures and practices that conform to generally accepted accounting principles and standards or other comprehensive basis of accounting principles as acceptable to the Agency. For costs associated with specific agreements under which the Agency must account to the Federal government for actual costs incurred, the costs and charges for that agreement will be determined in accordance with generally accepted accounting principles.

2. To submit annual financial audits (or parent organization's annual financial audits with organizational chart) to the Agency within thirty (30) calendar days of receipt

G. Public Records Requests

1. To comply with Section 119.0701, F.S., if applicable, and all other applicable parts of the Florida Public Records Act.

2. To keep and maintain public records that ordinarily and necessarily would be required in order to perform services under this Agreement.

3. To provide the public with access to public records on the same terms and conditions that the Agency would provide the records and at a cost that does not exceed the cost provided in Section 119.07, F.S., or as otherwise provided by law.

4. To upon request from the appropriate Agency custodian of public records, provide the Agency with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost in Section 119.07, F.S., or as otherwise provided by law.

5. To ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of this Agreement term and following completion of this Agreement if the Subrecipient does not transfer the records to the Agency.

6. To not collect an individual's social security number unless the Subrecipient has stated in writing the purpose for its collection. The Subrecipient collecting an individual's social security number shall provide a copy of the written statement to the Agency and otherwise comply with applicable portions of Section 119.071(5), F.S.

7. To meet all requirements for retaining public records and transfer, at no cost, to the Agency all public records in possession of the Subrecipient upon termination of this Agreement and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. All records stored electronically must be provided to the Agency in a format that is compatible with the information technology systems of the Agency.

8. If the Subrecipient does not comply with a public records request, the Agency shall enforce provisions in accordance with this Agreement.

9. IF THE SUBRECIPIENT HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE SUBRECIPIENT'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS AGREEMENT, CONTACT THE AGENCY CUSTODIAN OF PUBLIC RECORDS FOR THIS AGREEMENT. THE AGENCY CUSTODIAN OF PUBLIC RECORDS FOR THIS AGREEMENT IS THE AGREEMENT MANAGER.

H. Communications

1. Notwithstanding any term or condition of this Agreement to the contrary, the Subrecipient bears sole responsibility for ensuring that its performance of this Agreement fully complies with all State and Federal law governing the monitoring, interception, recording, use or disclosure of wire, oral or electronic communications, including but not limited to the Florida Security of Communications Act, Section 934.01, et seq., F.S.; and the Electronic Communications Privacy Act, 18 U.S.C. Section 2510 et seq. (hereafter, collectively, "Communication Privacy Laws").

2. Prior to intercepting, recording or monitoring any communications which are subject to Communication Privacy Laws, the Subrecipient must:

a. Submit a plan which specifies in detail the manner in which the Subrecipient will ensure that such actions are in full compliance with Communication Privacy Laws (the "Privacy Compliance Plan"); and

b. Obtain written approval, signed and notarized by the Agency Agreement Manager, approving the Privacy Compliance Plan.

3. No modifications to an approved Privacy Compliance Plan may be implemented by the Subrecipient unless an amended Privacy Compliance Plan is submitted to the Agency, and written approval of the amended Privacy Compliance Plan is signed and notarized by the Agency Agreement Manager. Agency approval of the Subrecipient's Privacy Compliance Plan in no way constitutes a representation by the Agency that the Privacy Compliance Plan is in full compliance with applicable Communication Privacy Laws, or otherwise shifts or diminishes the Subrecipient's sole burden to ensure full compliance with applicable Communication Privacy Laws in all aspects of the Subrecipient's performance of this Agreement. Violation of this term may result in sanctions to include termination of this Agreement and/or liquidated damages.

4. The Subrecipient agrees that it is the custodian of any and all recordings for purposes of the Public Records Act, Chapter 119, F.S., and is solely responsible for responding to any public records requests for recordings. This responsibility includes gathering, redaction, duplication and provision of the recordings as well as defense of any actions for enforcement brought pursuant to Section 119.11, F.S.

I. Background Screening

1. To ensure that all Subrecipient employees including managing employees that have direct access to personally identifiable information (PII), protected health information (PHI), or financial information have a County, State, and Federal criminal background screening comparable to a Level 2 background screening as described in Section 435.04, F.S., completed with results prior to employment.

2. Per Section 435.04(1)(a), F.S., Level 2 screening standards include, but need not be limited to, fingerprinting for statewide criminal history records checks through the Department of Law Enforcement, and national criminal history records checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies. If the Subrecipient is not authorized under the law to conduct a

Level 2 background screening, then completion of a Level 1 background screening as defined in Section 435.03, F.S., is acceptable.

3. If the Subrecipient employee or managing employee was employed prior to the execution of this Agreement, the Subrecipient shall ensure that the County, State, and Federal criminal background screening comparable to a Level 2 background screening is completed with results prior to the employee accessing any PII, PHI, or financial information.

4. Any Subrecipient employee or managing employee with background results that are unacceptable to the State as described in Section 435.04, F.S., or related to the criminal use of PII as described in Section 817, F.S., or has been subject to criminal penalties for the misuse of PHI under 42 U.S.C. 1320d-5, or has been subject to criminal penalties for the offenses described in Section 812.0195, F.S., Section 815, F.S., Section 815.04, F.S., or Section 815.06, F.S., shall be denied employment or be immediately dismissed from performing services under this Agreement by the Subrecipient unless an exemption is granted.

5. Direct access is defined as having, or expected to have, duties that involve access to PII, PHI, or financial information by any means including, but not limited to, network shared drives, email, telephone, mail, computer systems, and electronic or printed reports.

6. To ensure that all Subrecipient employees including managing employees that have direct access to any PII, PHI or financial information have a County, State, and Federal criminal background screening comparable to a Level 2 background screening completed with results every five (5) years.

7. To develop and submit policies and procedures related to this criminal background screening requirement to the Agency for review and approval within thirty (30) calendar days of this Agreement execution. The Subrecipient's policies and procedures shall include a procedure to grant an exemption from disqualification for disqualifying offenses revealed by the background screening, as described in Section 435.07, F.S.

8. To keep a record of all background screening records to be available for Agency review upon request.

9. Failure to comply with background screening requirements shall subject the Subrecipient to liquidated damages as described **Attachment I,** Agency Request for Application.

J. Monitoring

1. To provide reports as specified in **Attachment I**, Agency Request for Application. These reports will be used for monitoring progress or performance of the contractual services as specified in **Attachment I**, Agency Request for Application.

2. To permit persons duly authorized by the Agency to inspect any records, papers, documents, facilities, goods and services of the Subrecipient which are relevant to this Agreement.

3. To ensure that each of its employees or subcontractors who perform activities related to the services associated with this Agreement will report to the Agency any health care facility that is the subject of these services that may have violated the law. To report concerns pertaining to a health care facility, the Subrecipient, employee or subcontractor may contact the Agency Complaint Hotline by calling 1-888-419-3456 or by completing the online complaint form found at https://apps.ahca.myflorida.com/hcfc.

4. To ensure that each of its employees or subcontractors who performs activities related to the services associated with this Agreement, will report to the Agency areas of concern relative to the operation of any entity covered by this Agreement. To report concerns, the Subrecipient, employee or subcontractor may contact the Agency Complaint Hotline by calling 1-877-254-1055 or by completing the online complaint form found at https://apps.ahca.myflorida.com/smmc_cirts/.

5. Reports which represent individuals receiving services are at risk for, or have suffered serious harm, impairment, or death shall be reported to the Agency immediately and no later than twenty four (24) clock hours after the observation is made. Reports that reflect noncompliance that does not rise to the level of concern noted above shall be reported to the Agency within ten (10) calendar days of the observation.

K. Indemnification

The Subrecipient agrees to indemnify, defend, and hold harmless the Agency, as provided in this Clause.

1. Scope. The Duty to Indemnify and the Duty to Defend, as described herein (collectively known as the "Duty to Indemnify and Defend"), extend to any completed, actual, pending or threatened action, suit, claim or proceeding, whether civil, criminal, administrative or investigative (including any action by or in the right of the Subrecipient), and whether formal or informal, in which the Agency is, was or becomes involved and which in any way arises from, relates to or concerns the Subrecipient's acts or omissions related to this Agreement (inclusive of all attachments, etc.) (collectively "Proceeding").

a. Duty to Indemnify. The Subrecipient agrees to hold harmless and indemnify the Agency to the full extent permitted by law against any and all liability, claims, actions, suits, judgments, damages and costs of whatsoever name and description, including attorneys' fees, arising from or relating to any Proceeding.

b. Duty to Defend. With respect to any Proceeding, the Subrecipient agrees to fully defend the Agency and shall timely reimburse all of the Agency's legal fees and costs; provided, however, that the amount of such payment for attorneys' fees and costs is reasonable pursuant to rule 4–1.5, Rules Regulating The Florida Bar. The Agency retains the exclusive right to select, retain and direct its defense through defense counsel funded by the Subrecipient pursuant to the Duty to Indemnify and Defend the Agency.

2. Expense Advance. The presumptive right to indemnification of damages shall include the right to have the Subrecipient pay the Agency's expenses in any Proceeding as such expenses are incurred and in advance of the final disposition of such Proceeding.

3. Enforcement Action. In the event that any claim for indemnity, whether an Expense Advance or otherwise, is made hereunder and is not paid in full within sixty (60) calendar days after written notice of such claim is delivered to the Subrecipient, the Agency may, but need not, at any time thereafter, bring suit against the Subrecipient to recover the unpaid amount of the claim (hereinafter "Enforcement Action"). In the event the Agency brings an Enforcement Action, the Subrecipient shall pay all of the Agency's attorneys' fees and expenses incurred in bringing and pursuing the Enforcement Action.

4. Contribution. In any Proceeding in which the Subrecipient is held to be jointly liable with the Agency for payment of any claim of any kind (whether for damages, attorneys' fees, costs or otherwise), if the Duty to Indemnify provision is for any reason deemed to be inapplicable, the Subrecipient shall contribute toward satisfaction of the claim whatever portion is or would be payable by the Agency in addition to that portion which is or would be payable by the Subrecipient, including payment of damages, attorneys' fees and costs, without recourse against the Agency. No provision of this part or of any other section of this Agreement (inclusive of all attachments, etc.), whether read separately or in conjunction with any other provision, shall be construed to: (i) waive the State or the Agency's immunity to suit or limitations on liability; (ii) obligate the State or the Agency to indemnify the Subrecipient for the Subrecipient's own negligence or otherwise assume any liability for the Subrecipient's own negligence; or (iii) create any rights enforceable by third parties, as third party beneficiaries or otherwise, in law or in equity.

L. Insurance

1. To the extent required by law, the Subrecipient shall be self-insured against, or shall secure and maintain during the life of this Agreement, Worker's Compensation Insurance for all its employees connected with the work of this Agreement and, in case any work is subcontracted, the Subrecipient shall require the subcontractor similarly to provide Worker's Compensation Insurance for all of the latter's employees unless such employees engaged in work under this Agreement are covered by the Subrecipient's self-insurance program. Such self-insurance or insurance coverage shall comply with the Florida Worker's Compensation law. In the event hazardous work is being performed by the Subrecipient under this Agreement and any class of employees performing the hazardous work is not protected under Worker's Compensation statutes, the Subrecipient shall provide, and cause each subcontractor to provide, adequate insurance satisfactory to the Agency, for the protection of its employees not otherwise protected.

2. The Subrecipient shall secure and maintain Commercial General Liability insurance including bodily injury, property damage, personal and advertising injury and products and completed operations. This insurance will provide coverage for all claims that may arise from the services and/or operations completed under this Agreement, whether such services and/or operations are by the Subrecipient or anyone directly, or indirectly employed by it. Such insurance shall include a Hold Harmless Agreement in favor of the State of Florida and also include the State of Florida as an Additional Named Insured for the entire length of this Agreement and hold the State of Florida harmless from subrogation. The Subrecipient shall set the limits of liability necessary to provide reasonable financial protections to the Subrecipient and the State of Florida under this Agreement.

3. All insurance policies shall be with insurers licensed or eligible to transact business in the State of Florida. The Subrecipient's current insurance policy(ies) shall contain a provision that the insurance will not be canceled for any reason except after thirty (30) calendar days written notice. The Subrecipient shall provide thirty (30) calendar days written notice of cancellation to the Agency's Agreement Manager.

4. The Subrecipient shall submit insurance certificates evidencing such insurance coverage prior to execution of this Agreement.

M. Assignments and Subcontracts

To neither assign the responsibility of this Agreement to another party nor subcontract for any of the work contemplated under this Agreement without prior written approval of the Agency. No such approval by the Agency of any assignment or subcontract shall be deemed in any event or in any manner to provide for the incurrence of any obligation of the Agency in addition to the total

dollar amount agreed upon in this Agreement. All such assignments or subcontracts shall be subject to the conditions of this Agreement and to any conditions of approval that the Agency shall deem necessary.

N. Subcontracting

1. To not subcontract, assign, or transfer any work identified under this Agreement, without prior written consent of the Agency.

2. To not subcontract with any provider that would be in conflict of interest to the Subrecipient during the term of this Agreement in accordance with applicable Federal and/or State laws.

3. Changes to approved subcontracts and/or subcontractors require approval in writing by the Agency's Agreement Manager prior to the effective date of any subcontract.

4. The Agency encourages Subrecipients to partner with subcontractors who can provide best value and the best in class solutions. However, the Subrecipient is responsible for all work performed under this Agreement. No subcontract that the Subrecipient enters into with respect to performance under this Agreement shall in any way relieve the Subrecipient of any responsibility for performance of its duties. The Subrecipient shall assure that all tasks related to the subcontract are performed in accordance with the terms of this Agreement. If the Agency determines, at any time, that a subcontract is not in compliance with an Agreement requirement, the Subrecipient shall promptly revise the subcontract to bring it into compliance. In addition, the Subrecipient may be subject to sanctions and/or liquidated damages pursuant to this Agreement and Section 409.912(6), F.S. (related to sanctions).

5. All payments to subcontractors will be made by the Subrecipient.

6. To be responsible for monitoring the subcontractor's performance. The results of the monitoring shall be provided to the Agency's Agreement Manager, fourteen (14) business days after the end of each month or as specified by the Agency. If the subcontractor's performance does not meet the Agency's performance standard according to the Agency's monitoring report or the Subrecipient's monitoring report, an improvement plan must be submitted to the Subrecipient and the Agency within fourteen (14) business days of the deficient report.

7. The State supports and encourages supplier diversity and the participation of small and minority business enterprises in State contracting, both as Subrecipients and subcontractors. The Agency supports diversity in its Procurement Program and requests that all subcontracting opportunities afforded by this Agreement enthusiastically embrace diversity. The award of subcontracts should reflect the full diversity of the citizens of the State of

Florida. Subrecipients can contact the Office of Supplier Diversity at (850) 487-0915 or online at http://osd.dms.state.fl.us/ for information on minority Subrecipients who may be considered for subcontracting opportunities.

8. A minority owned business is defined as any business enterprise owned and operated by the following ethnic groups: African American (Certified Minority Code H or Non-Certified Minority Code N); Hispanic American (Certified Minority Code I or Non-Certified Minority O); Asian American (Certified Minority Code J or Non-Certified Minority Code P); Native American (Certified Minority Code K or Non-Certified Minority Code Q); or American Woman (Certified Minority Code M or Non-Certified Minority Code R).

O. Return of Funds

To return to the Agency any overpayments due to unearned funds or funds disallowed pursuant to the terms of this Agreement that were disbursed to the Subrecipient by the Agency. The Subrecipient shall return any overpayment to the Agency within forty (40) calendar days after either discovery by the Subrecipient, its independent auditor, or notification by the Agency, of the overpayment.

P. Procurement of Products or Materials with Recycled Content

It is expressly understood and agreed that any products which are required to carry out this Agreement shall be procured in accordance with the provisions of Section 403.7065, F.S.

Q. Civil Rights Requirements/Subrecipient Assurance

The Subrecipient assures that it will comply with:

1. Title VI of the Civil Rights Act of 1964, as amended, 42 United States Code (U.S.C.) 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin.

2. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap.

3. Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex.

4. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age.

5. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis

of race, creed, color, national origin, sex, handicap, political affiliation or beliefs.

6. The Americans with Disabilities Act of 1990, Public Law (P.L.) 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities.

7. Chapter 409, F.S.

8. Rule 62-730.160, F.A.C. pertaining to standards applicable to generators of hazardous waste.

9. All applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 United States Code (U.S.C.) 7401 et seq.

10. The Medicare-Medicaid Fraud and Abuse Act of 1978.

11. Other Federal omnibus budget reconciliation acts.

12. The Balanced Budget Act of 1997.

13. All regulations, guidelines, and standards as are now or may be lawfully adopted under the above statutes.

The Subrecipient agrees that compliance with this assurance constitutes a condition of continued receipt of or benefit from funds provided through this Agreement, and that it is binding upon the Subrecipient, its successors, transferees, and assignees for the period during which services are provided. The Subrecipient further assures that all contractors, subcontractors, subgrantees, or others with whom it arranges to provide services or benefits to participants or employees in connection with any of its programs and activities are not discriminating against those participants or employees in violation of the above statutes, regulations, guidelines, and standards.

R. Equal Employment Opportunity (EEO) Compliance

To not discriminate in its employment practices with respect to race, color, religion, age, sex, marital status, political affiliation, national origin, or handicap.

S. Patents, Royalties, Copyrights, Right To Data and Sponsorship Statement

1. The Subrecipient, without exception, shall indemnify and hold harmless the Agency and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or unattended invention, process, or article manufactured or supplied by the Subrecipient. The Subrecipient has no liability when such claim is solely and exclusively due to the combination, operation or use of any article supplied hereunder with equipment or data not supplied by the

Subrecipient or is based solely and exclusively upon the Agency's alteration of the article.

2. The Agency will provide prompt written notification of a claim of copyright or patent infringement and shall afford the Subrecipient full opportunity to defend the action and control the defense. Further, if such a claim is made or is pending, the Subrecipient may, at its option and expense procure for the Agency the right to continue the use of, replace or modify the article to render it non-infringing (if none of the alternatives is reasonably available, the Agency agrees to return the article on request to the Subrecipient and receive reimbursement, if any, as may be determined by a court of competent jurisdiction).

3. If the Subrecipient brings to the performance of this Agreement a pre existing patent, patent-pending and/or copyright, the Subrecipient shall retain all rights and entitlements to that pre existing patent, patent-pending and/or copyright, unless this Agreement provides otherwise.

4. If the Subrecipient uses any design, device, or materials covered by letter, patent, or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or cost arising from the use of such design, device, or materials in any way involved in the work. Prior to the initiation of services under this Agreement, the Subrecipient shall disclose, in writing, all intellectual properties relevant to the performance of this Agreement which the Subrecipient knows, or should know, could give rise to a patent or copyright. The Subrecipient shall retain all rights and entitlements to any pre existing intellectual property which is so disclosed. Failure to disclose will indicate that no such property exists. The Agency will then have the right to all patents and copyrights which arise as a result of performance under this Agreement as provided in this section.

5. If any discovery or invention arises or is developed in the course of, or as a result of, work or services performed under this Agreement, or in any way connected herewith, the Subrecipient shall refer the discovery or invention to the Agency for a determination whether patent protection will be sought in the name of the State of Florida. Any and all patent rights accruing under or in connection with the performance of this Agreement are hereby reserved to the State of Florida. All materials to which the Agency is to have patent rights or copyrights shall be marked and dated by the Subrecipient in such a manner as to preserve and protect the legal rights of the Agency.

6. Subrecipients must seek prior approval from the Agency before distributing any form of advertisement/sponsorship materials regarding this Agreement to the public. The Subrecipient shall submit for review and approval to the Agency any written materials, including web-based materials and web site content, through funds from this Agreement at least thirty (30) calendar days, prior to the targeted dissemination date.

7. Where activities supported by this Agreement produce original writing, sound recordings, pictorial reproductions, drawings or other graphic representation and works of any similar nature, the Agency has the right to use, duplicate and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others acting on behalf of the Agency to do so. If the materials so developed are subject to copyright, trademark, or patent, legal title and every right, interest, claim, or demand of any kind in and to any patent, trademark or copyright, or application for the same, shall vest in the State of Florida, Department of State for the exclusive use and benefit of the State. Pursuant to Section 286.021, F.S., no person, firm, corporation, including parties to this Agreement shall be entitled to use the copyright, patent, or trademark without the prior written consent of the Florida Department of State.

8. The Agency will have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Subrecipient.

9. Pursuant to Section 286.25, F.S., all non-governmental Subrecipients must assure that all notices, information pamphlets, press releases, advertisements, descriptions of the sponsorship of the program, research reports, and similar public notices prepared and released by the Subrecipient shall include the statement: **"Sponsored by SUBRECIPIENT NAME and the State of Florida, Agency for Health Care Administration."** If the sponsorship reference is in written material, the words, "State of Florida, Agency for Health Care Administration" shall appear in the same size letters or type as the name of the organization.

10. All rights and title to works for hire under this Agreement, whether patentable or copyrightable or not, shall belong to the Agency and shall be subject to the terms and conditions of this Agreement.

11. The computer programs, materials and other information furnished by the Agency to the Subrecipient hereunder shall be and remain the sole and exclusive property of the Agency, free from any claim or right of retention by or on behalf of the Subrecipient. The services and products listed in this Agreement shall become the property of the Agency upon the successful applicant's performance and delivery thereof. The Subrecipient hereby acknowledges that said computer programs, materials and other information provided by the Agency to the Subrecipient hereunder, together with the products delivered and services performed by the Subrecipient hereunder, shall be and remain confidential and proprietary in nature to the extent provided by Chapter 119, F.S., and that the Subrecipient shall not disclose, publish or use same for any purpose other than the purposes provided in this Agreement; however, upon the Subrecipient first demonstrating to the Agency's satisfaction that such information, in part or in whole, (1) was already known to the Subrecipient

prior to its receipt from the Agency; (2) became known to the Subrecipient from a source other than the Agency; or (3) has been disclosed by the Agency to third parties without restriction, the Subrecipient shall be free to use and disclose same without restriction. Upon completion of the Subrecipient's performance or otherwise cancellation or termination of this Agreement, the Subrecipient shall surrender and deliver to the Agency, freely and voluntarily, all of the above described information remaining in the Subrecipient's possession.

12. The Subrecipient warrants that all materials produced hereunder will be of original development by the Subrecipient and will be specifically developed for the fulfillment of this Agreement and will not knowingly infringe upon or violate any patent, copyright, trade secret or other property right of any third party, and the Subrecipient shall indemnify and hold the Agency harmless from and against any loss, cost, liability or expense arising out of any breach or claimed breach of this warranty.

13. The terms and conditions specified in this section shall also apply to any sub-agreement made under this Agreement. The Subrecipient shall be responsible for informing the Subrecipient of the provisions of this section and obtaining disclosures.

T. Final Invoice

The Subrecipient must submit the final invoice for payment to the Agency no more than sixty (60) calendar days after this Agreement ends or is terminated. If the Subrecipient fails to do so, all right to payment is forfeited and the Agency will not honor any requests submitted after the aforesaid time period. Any payment due under the terms of this Agreement may be withheld until all reports due from the Subrecipient and necessary adjustments thereto have been approved by the Agency.

U. Use of Funds for Lobbying Prohibited

To comply with the provisions of Section 216.347, F.S., which prohibits the expenditure of Agreement funds for the purpose of lobbying the Legislature, the judicial branch or a State agency.

V. Health Insurance Portability and Accountability Act

1. To comply with the Department of Health and Human Services Privacy Regulations in the CFR, Title 45, Sections 160 and 164, regarding disclosure of protected health information as specified in **Attachment III**, Business Associate Agreement.

2. The Subrecipient must ensure it meets all Federal regulations regarding required standard electronic transactions and standards for privacy and

individually identifiable health information as identified in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 and associated regulations.

3. The Subrecipient shall conduct all activities in compliance with 45 CFR 164 Subpart C to ensure data security, including, but not limited to encryption of all information that is confidential under Florida or Federal law, while in transmission and while resident on portable electronic media storage devices. Encryption is required and shall be consistent with Federal Information Processing Standards (FIPS), and/or the National Institute of Standards and Technology (NIST) publications regarding cryptographic standards.

W. Confidentiality of Information

1. The Subrecipient shall not use or disclose any confidential information, including social security numbers that may be supplied under this Agreement pursuant to law, and also including the identity or identifying information concerning a Medicaid sub-recipient or services under this Agreement for any purpose not in conformity with State and Federal laws, except upon written consent of the sub-recipient, or his/her guardian.

2. All personally identifiable information, including Medicaid information, obtained by the Subrecipient shall be treated as privileged and confidential information and shall be used only as authorized for purposes directly related to the administration of this Agreement. The Subrecipient must have a process that specifies that patient-specific information remains confidential, is used solely for the purposes of data analysis or other Subrecipient responsibilities under this Agreement, and is exchanged only for the purpose of conducting a review or other duties outlined in this Agreement.

3. Any patient-specific information received by the Subrecipient can be shared only with those agencies that have legal authority to receive such information and cannot be otherwise transmitted for any purpose other than those for which the Subrecipient is retained by the Agency. The Subrecipient must have in place written confidentiality policies and procedures to ensure confidentiality and to comply with all Federal and State laws (including the HIPAA and HITECH Acts) governing confidentiality, including electronic treatment records, facsimile mail, and electronic mail).

4. The Subrecipient's subcontracts must explicitly state expectations about the confidentiality of information, and the subcontractor is held to the same confidentiality requirements as the Subrecipient. If provider-specific data are released to the public, the Subrecipient shall have policies and

procedures for exercising due care in compiling and releasing such data that address statutory protections of quality assurance and confidentiality while assuring that open records requirements of Chapter 119, F.S., are met.

5. The Subrecipient and its subcontractors shall comply with the requirements of Section 501.171, F.S. and shall, in addition to the reporting requirements therein, report to the Agency any breach of personal information.

6. Any releases of information to the media, the public, or other entities require prior approval from the Agency.

X. Employment

The Subrecipient shall comply with Section 274A of the Immigration and Nationality Act. The Agency will consider the employment by any contractor of unauthorized aliens a violation of this Act. If the Subrecipient knowingly employs unauthorized aliens, such violation shall be cause for unilateral cancellation of this Agreement. The Subrecipient shall be responsible for including this provision in all subcontracts with private organizations issued as a result of this Agreement.

Y. Work Authorization Program

The Immigration Reform and Control Act of 1986 prohibits employers from knowingly hiring illegal workers. The Subrecipient shall only employ individuals who may legally work in the United States (U.S.) – either U.S. citizens or foreign citizens who are authorized to work in the U.S. The Subrecipient shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system, https://e-verify.uscis.gov/emp, to verify the employment eligibility of all new employees hired by the Subrecipient during the term of this Agreement and shall also include a requirement in its subcontracts that the subcontractor utilize the E-Verify system to verify the employment eligibility of all new employees hired by the subcontractor performing work or providing services pursuant to this Agreement.

Z. Equipment and Vehicles

1. Reimbursement for the purchase of any vehicles and/or equipment is subject to specific approval from the Agency. The Agency is not responsible for reimbursement of any equipment and/or vehicle purchases made without prior approval of the Agency under the terms and conditions of this Agreement and **Attachment I**, Agency Request for Application.

2. The Subrecipient affirms its commitment to using any equipment and/or vehicle purchased through this Agreement solely for the purposes of this

Agreement and in accordance with **Attachment I,** Agency Request for Application, throughout the duration of this Agreement.

3. The Subrecipient is responsible for implementation of adequate maintenance procedures to keep the vehicle and/or equipment in good operating condition. Unless otherwise specified, standard maintenance schedules and procedures provided by the manufacturer(s) are to be followed.

4. The Subrecipient is responsible for any loss, damage, or theft of, and any loss, damage, or injury caused by the use of the vehicle and/or equipment purchased through this Agreement and held in the Subrecipient's possession for use in this Agreement with the Agency.

AA. Reporting of Violations

Any determination by the Subrecipient that any aspect of health care practice by any provider that might have short-term or long-term detrimental consequences to the health of the sub-recipients shall be reported in writing to the Agency within twenty-four (24) hours of identification. The Subrecipient shall also immediately report:

1. All instances of suspected physical or mental abuse of either adults or children, to the Agency Agreement Manager and to the Department of Children and Families (DCF) hotline at 1-800-962-2873; and

2. All instances of suspected provider and/or sub-recipient fraud to the Agency Agreement Manager and, if applicable, the Medicaid Program Integrity Unit at https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx or 1-866-966-7226.

BB. Order of Precedence

In the event of conflicts among documents that are part of this Agreement, resolution shall be made as follows:

1. Agency's Grant Agreement (and all incorporated attachments).

2. Agency's Request for Application.

3. Subrecipient's CMS approved application.

4. Subrecipient's Application in Response to the Request for Application.

CC. Performance of Services

The Subrecipient shall ensure all services provided under this Agreement will be performed within the borders of the United States and its territories and protectorates. State-owned Data will be processed and stored in data centers that are located only in the forty-eight (48) contiguous United States.

DD. Venue

1. In the event of any legal challenges to this Agreement, the Subrecipient agrees and will consent that hearings and depositions for any administrative or other litigation related to this Agreement shall be held in Leon County, Florida. The Agency, in its sole discretion, may waive this venue for depositions.

2. The Subrecipient (and its successors, including but not limited to its parent(s), affiliates, subsidiaries, subcontractors, assigns, heirs, administrators, representatives and trustees) acknowledges that this Agreement (including but not limited to exhibits, attachments, or amendments) is not a rule nor subject to rulemaking under Chapter 120 (or its successor) of the F.S. and is not subject to challenge as a rule or non-rule policy under any provision of Chapter 120, F.S.

3. This Agreement shall be delivered in the State of Florida and shall be construed in accordance with the laws of Florida. Wherever possible, each provision of this Agreement shall be interpreted in such a manner as to be effective and valid under applicable law, but if any provision shall be found ineffective, then to the extent of such prohibition or invalidity, that provision shall be severed without invalidating the remainder of such provision or the remaining provisions of this Agreement.

4. The exclusive venue and jurisdiction for any action in law or in equity to adjudicate rights or obligations arising pursuant to or out of this Agreement for which there is no administrative remedy shall be the Second Judicial Circuit Court in and for Leon County, Florida, or, on appeal, the First District Court of Appeal (and, if applicable, the Florida Supreme Court). Any administrative hearings hereon or in connection herewith shall be held in Leon County, Florida.

EE. Federal/State Laws and Regulations

1. If this Agreement contains Federal Funds, the Subrecipient shall comply with the provisions of Federal law and regulations including, but not limited to Chapter 2 of the Code of Federal Regulations (CFR) and any other final or interim rules, and other applicable regulations.

2. No Federal Funds received in connection with this Agreement may be used

by the Subrecipient, or agent acting for the Subrecipient, to influence legislation or appropriations pending before the Congress or any State legislature. If this Agreement contains Federal funding in excess of **$100,000.00**, the Subrecipient must, prior to Agreement execution, complete **Attachment V,** Certification Regarding Lobbying. If a Disclosure of Lobbying Activities Form, Standard form is required, it may be obtained from the Agency's Agreement Manager. All disclosure forms as required by the Certification Regarding Lobbying form must be completed and returned to the Agency's Agreement Manager, prior to payment under this Agreement.

3. Pursuant to 2 CFR, Part 376, the Subrecipient must, upon Agreement execution, complete **Attachment IV,** Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion Agreements/Subcontracts.

4. If this Agreement contains State assistance, the Subrecipient shall comply with the provisions set forth in Section 215.971, F.S., to provide quantifiable units of deliverables, including reports, findings, and drafts, in writing and/or in an electronic format agreeable to both Parties, as specified in **Attachment I**, Agency Request for Application, to be received and accepted by the Agreement Manager prior to payment.

5. The Subrecipient shall comply with the provisions of Sections 11.062 and 216.347, F.S., which prohibit the expenditure of agreement funds for the purpose of lobbying the Legislature, judicial branch, or a State agency.

6. The Subrecipient shall submit bills for any travel expenses in accordance with Section 112.061, F.S. The Agency may establish rates lower than the maximum provided in Section 112.061, F.S.

7. The Subrecipient shall comply with all applicable Federal and State laws and regulations.

FF. IRS Form 990 and Total Executive Compensation Reporting

Attachment VI, IRS Form 990 and Total Executive Compensation Reporting Requirements is hereby incorporated into this Contract. This requirement from Florida Governor's Executive Order 20-44 shall only apply if the Subrecipient is a not for profit organization.

GG. Forced Labor Vendor List

In accordance with section 287.1346, F.S., the Agency may terminate the Agreement if the Subrecipient is placed on the forced labor vendor list.

HH. Use of Funds for Diversity, Equity, and Inclusion Prohibited

No State funding under this Agreement is being provided for, promoting, advocating for, or providing training or education on "Diversity, Equity, and Inclusion" (DEI). DEI is any program, activity, or policy that classifies individuals on the basis of race, color, sex, national origin, gender identity, or sexual orientation and promotes differential or preferential treatment of individuals on the basis of such classification, or promotes the position that a group or an individual's action is inherently, unconsciously, or implicitly biased on the basis of such classification.

I. THE AGENCY HEREBY AGREES:

A. Agreement Amount

To pay for agreement services according to the conditions of **Attachment I**, Agency Request for Application, in an amount not to exceed **$##,###.##**, subject to the availability of funds. The State of Florida's performance and obligation to pay under this Agreement is contingent upon an annual appropriation by the Legislature.

B. Agreement Term

This Agreement shall begin upon execution by both Parties or **START DATE**, (whichever is later) and end on **END DATE**, inclusive.

This Agreement may be renewed for a period that may not exceed three (3) years or the term of the original Agreement, whichever period is longer. Renewal of the Agreement shall be in writing and subject to the same terms and conditions set forth in the initial agreement. A renewal Agreement may not include any compensation for costs associated with the renewal. Renewals are contingent upon satisfactory performance evaluations by the Agency, are subject to the availability of funds, and optional to the Agency.

For Agreements approved through State Legislature and appropriated from the State's General Revenue funds, the availability for Agreement renewal is contingent upon the determination of the Legislature to appropriate and approve these funds for the next fiscal year. The Agency oversees the award, administration and distribution of current funds and is not responsible for determining the amount or availability of future funds.

If funds are appropriated to the Agency for Agreement renewal, the Agency's decision whether to approve or deny renewal will be based upon performance evaluation of the program(s) of the Subrecipient.

C. Agreement Payment

Section 215.422, F.S., provides that agencies have five (5) business days to inspect and approve goods and services, unless bid specifications, Agreement or

Purchase Order specifies otherwise. With the exception of payments to health care providers for hospital, medical, or other health care services, if payment is not available within forty (40) calendar days, measured from the latter of the date the invoice is received or the goods or services are received, inspected and approved, a separate interest penalty set by the Comptroller pursuant to Section 55.03, F.S., will be due and payable in addition to the invoice amount. To obtain the applicable interest rate, please contact the Agency's Fiscal Section at (850) 412-3901, or utilize the Department of Financial Services website at www.myfloridacfo.com/aadir/interest.htm. Payments to health care providers for hospital, medical or other health care services, shall be made not more than thirty-five (35) calendar days from the date eligibility for payment is determined, and the daily interest rate is .0003333%. Invoices returned to a Subrecipient due to preparation errors will result in a payment delay. Invoice payment requirements do not start until a properly completed invoice is provided to the Agency. A Vendor Ombudsman, whose duties include acting as an advocate for Subrecipients who may be experiencing problems in obtaining timely payment(s) from a State agency, may be contacted at (850) 413-5516 or by calling the State Comptroller's Hotline, 1-800-848-3792.

II. THE SUBRECIPIENT AND AGENCY HEREBY MUTUALLY AGREE:

A. Termination

1. Termination at Will

This Agreement may be terminated by the Agency upon no less than thirty (30) calendar days written notice, without cause, unless a lesser time is mutually agreed upon by both Parties. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

2. Termination Due To Lack of Funds

In the event funds to finance this Agreement become unavailable, the Agency may terminate this Agreement upon no less than twenty four (24) clock hours' written notice to the Subrecipient. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. The Agency will be the final authority as to the availability of funds. The Subrecipient shall be compensated for all acceptable work performed up to the time notice of termination is received.

3. Termination for Breach

a. Unless the Subrecipient's breach is waived by the Agency in writing, the Agency may, by written notice to the Subrecipient, terminate this Agreement upon no less than twenty four (24) clock hours' written notice. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. If

applicable, the Agency may employ the default provisions in Rule 60A-1.006(3), F.A.C.

b. Waiver of breach of any provisions of this Agreement shall not be deemed to be a waiver of any other breach and shall not be construed to be a modification of the terms of this Agreement. The provisions herein do not limit the Agency's right to remedies at law or to damages.

B. Agreement Managers

1. The Agency's Agreement Manager's contact information is as follows:

NAME
Agency for Health Care Administration
2727 Mahan Drive MS ###
Tallahassee, Florida 32308
(###) ###-###

2. The Subrecipient's Agreement Manager's contact information is as follows:

NAME
ADDRESS
CITY, STATE, ZIP CODE
PHONE NUMBER

3. The Subrecipient shall notify the Agency Agreement Manager in writing within five (5) business days of an Agreement Manager change. Either party may notify the other by email of a change to a designated Agreement Manager and provide the contact information for the newly designated contact. Such notice is sufficient to effectuate this change without requiring a written amendment to the Agreement.

C. Renegotiation or Modification

1. Modifications of provisions of this Agreement shall only be valid when they have been reduced to writing and duly signed during the term of this Agreement. The Parties agree to renegotiate this Agreement if Federal and/or State revisions of any applicable laws, or regulations make changes in this Agreement necessary.

2. The rate of payment and the total dollar amount may be adjusted retroactively to reflect price level increases and changes in the rate of payment when these have been established through the appropriations process and subsequently identified in the Agency's operating budget.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
GRANT AGREEMENT

D. Name, Mailing and Street Address of Payee

1. The name (Subrecipient name as shown on Page 1 of this Agreement) and mailing address of the official payee to whom the payment shall be made:

NAME
ADDRESS
CITY, STATE, ZIP CODE

2. The name of the contact person and street address where financial and administrative records are maintained:

NAME
ADDRESS
CITY, STATE, ZIP CODE

E. All Terms and Conditions

This Agreement and its attachments as referenced herein contain all the terms and conditions agreed upon by the Parties.

This Agreement is and shall be deemed jointly drafted and written by all Parties to it and shall not be construed or interpreted against the Party originating or preparing it. Each Party has the right to consult with counsel and has either consulted with counsel or knowingly and freely entered into this Agreement without exercising its right to counsel.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
GRANT AGREEMENT

IN WITNESS THEREOF, the Parties hereto have caused this #### (##) page Agreement, which includes any referenced attachments, to be executed by their undersigned officials as duly authorized. This Agreement is not valid until signed and dated by both Parties.

SUBRECIPIENT NAME		**STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION**	
SIGNED BY:	_____	**SIGNED BY:**	_____
NAME:	_____	**NAME:**	_____
TITLE:	_____	**TITLE:**	_____
DATE:	_____	**DATE:**	_____

FEDERAL ID NUMBER (or SS Number for an individual): **###**

SUBRECIPIENT FISCAL YEAR ENDING DATE: **###**

List of Attachments/Exhibits included as part of this Amendment:

Specify Type	Number	Description
Attachment	**I**	Agency Request for Application (## Pages)
Attachment	**II**	Special Audit Requirements (8 Pages)
Attachment	**III**	Business Associate Agreement (5 Pages)
Attachment	**IV**	Certification regarding Debarment, Suspension, Ineligibility, and Voluntary exclusion Agreements/Subcontracts (1 Page)
Attachment	**V**	Certification Regarding Lobbying Certification for Contracts, Grants, Loans and Cooperative Agreements (1 Page)
Attachment	**VI**	IRS Form 990 and Total Executive Compensation Reporting Requirements (1 Page)

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

AUDIT REQUIREMENTS FOR AWARDS OF STATE AND FEDERAL FINANCIAL ASSISTANCE

The administration of resources awarded by the Agency for Health Care Administration (hereinafter "AHCA") to the Subrecipient may be subject to audits and/or monitoring by the AHCA, as described in this document. (Note: This document was developed using language recommended by the Florida Department of Financial Services (DFS-A2-CL as Rev. 11/18) and includes additional information requested by the AHCA.)

MONITORING

1. In addition to reviews of audits conducted in accordance with 2 CFR 200, Subpart F - Audit Requirements, and section 215.97, Florida Statutes (F.S.), as revised (see AUDITS below), monitoring procedures may include, but not be limited to, on-site visits by the AHCA staff, limited scope audits as defined by 2 CFR §200.425, or other procedures. By entering into this agreement, the Subrecipient agrees to comply and cooperate with any monitoring procedures or processes deemed appropriate by the AHCA. In the event the AHCA determines that a limited scope audit of the Subrecipient is appropriate, the Subrecipient agrees to comply with any additional instructions provided by the AHCA staff to the Subrecipient regarding such audit. The Subrecipient further agrees to comply and cooperate with any inspections, reviews, investigations, or audits deemed necessary by the Chief Financial Officer (CFO) or Auditor General.

2. The Subrecipient must complete **EXHIBIT 2,** Audit Compliance Certification, of this attachment and submit to the AHCA's Office of Inspector General at IGSingleaudit@ahca.myflorida.com and the AHCA Agreement Manager within sixty (60) calendar days following the end of the Subrecipient's fiscal year.

   Copies of **EXHIBIT 2** shall be submitted by or on behalf of the Subrecipient directly to each of the following:

   a. Send one (1) electronic copy to the Office of Inspector General at IGSingleaudit@ahca.myflorida.com; and

2. Send one (1) electronic copy to the AHCA Agreement Manager at: [Insert AHCA Agreement Manager's Email Address Here] *Note: It is the Subrecipient's responsibility to send the report to the current AHCA Agreement Manager. As all agreements are subject to amendment/modification, Subrecipients are responsible for forwarding this information to the Agreement Manager named in the Agreement at time of completion of the form. Refer to the current version of the Agreement to confirm the Agreement Manager's contact information prior to submission.*

AUDITS

Part I: Federally Funded

This part is applicable if the Subrecipient is a state or local government or a nonprofit organization as defined in 2 CFR §200.1.

3. A Subrecipient that expends $750,000 or more in federal awards in its fiscal year must have a single or program-specific audit conducted in accordance with the provisions of 2 CFR 200, Subpart F - Audit Requirements. **EXHIBIT 1** to this form lists the federal resources awarded through the AHCA by this agreement. In determining the federal awards expended in its fiscal year, the Subrecipient shall consider all sources of federal awards, including federal resources received from the AHCA. The determination of amounts of federal awards expended should be in accordance with the guidelines established in 2 CFR §§200.502-503. An audit of the Subrecipient conducted by the Auditor General in accordance with the provisions of 2 CFR §200.514 will meet the requirements of this Part.

4. For the audit requirements addressed in Part I, paragraph 1, the Subrecipient shall fulfill the requirements relative to auditee responsibilities as provided in 2 CFR §§200.508-512.

5. A Subrecipient that expends less than $750,000 in federal awards in its fiscal year is not required to have an audit conducted in accordance with the provisions of 2 CFR 200, Subpart F - Audit Requirements. If the Subrecipient expends less than $750,000 in federal awards in its fiscal year and elects to have an audit conducted in accordance with the provisions of 2 CFR 200, Subpart F - Audit Requirements, the cost of the audit must be paid from non-federal resources (i.e., the cost of such an audit must be paid from Subrecipient resources obtained from other than federal entities).

6. The Subrecipient may access information regarding the Catalog of Federal Domestic Assistance (CFDA) via the internet at SAM.gov | Assistance Listings. *Note: The content of the CFDA is now available through the Assistance Listings section of the new site – SAM.gov. The acronym "CFDA" as used in this form is hereby understood to refer to the Assistance Listings found at SAM.gov.*

Part II: State Funded

This part is applicable if the Subrecipient is a nonstate entity as defined in section 215.97(2), F.S.

7. In the event that the Subrecipient expends a total amount of state financial assistance equal to or in excess of $750,000 in any fiscal year of such Subrecipient (for fiscal years ending June 30, 2017, and thereafter), the Subrecipient must have a state single or project-specific audit for such fiscal year in accordance with section 215.97, F.S.; applicable rules of the Department of Financial Services; and Chapters 10.550 (local governmental entities) and 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General. **EXHIBIT 1** to this form lists the state financial assistance awarded through the AHCA by this agreement. In determining the state financial assistance expended in its fiscal year, the Subrecipient shall consider all sources of state financial assistance, including state financial assistance received from the AHCA, other state agencies, and other nonstate entities. State financial assistance does not include federal direct or pass-through awards and resources received by a nonstate entity for federal program matching requirements.

8. For the audit requirements addressed in Part II, paragraph 1, the Subrecipient shall ensure that the audit complies with the requirements of section 215.97(8), F.S. This includes submission of a financial reporting package as defined by section 215.97(2), F.S., and Chapters 10.550 (local governmental entities) and 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General.

9. If the Subrecipient expends less than $750,000 in state financial assistance in its fiscal year (for fiscal years ending June 30, 2017, and thereafter), an audit conducted in accordance with the provisions of section 215.97, F.S., is not required. If the Subrecipient expends less than $750,000 in state financial assistance in its fiscal year and elects to have an audit conducted in accordance with the provisions of section 215.97, F.S., the cost of the audit must be paid from the nonstate entity's resources (i.e., the cost of such an audit must be paid from the Subrecipient's resources obtained from other than state entities).

10. For information regarding the Florida Catalog of State Financial Assistance (CSFA), a Subrecipient should access the Florida Single Audit Act website located at https://apps.fldfs.com/fsaa/.

Part III: Other Audit Requirements

Refer to Executed Agreement sections pertaining to Federal Regulations, State Laws and Rules, and Audit and Records.

Part IV: Report Submission

11. Copies of reporting packages for audits conducted in accordance with 2 CFR 200, Subpart F - Audit Requirements, and required by Part I of this form shall be submitted, when required by 2 CFR §200.512, by or on behalf of the Subrecipient directly to the Federal Audit Clearinghouse (FAC) as provided in 2 CFR §200.36 and §200.512.

    The FAC's website provides a data entry system and required forms for submitting the single audit reporting package. Updates to the location of the FAC and data entry system may be found at the OMB website.

12. Copies of financial reporting packages required by Part II of this form shall be submitted by or on behalf of the Subrecipient directly to each of the following:

    a. The AHCA at each of the following addresses:

        1) Send one (1) electronic copy and management letter, if issued, to the Office of Inspector General at IGSingleaudit@ahca.myflorida.com; and

        13. Send one (1) electronic copy and management letter, if issued, to the AHCA Agreement Manager at: [Insert AHCA Agreement Manager's Email Address Here] Note*: It is the Subrecipient's responsibility to send the report to the current AHCA Agreement Manager. As all agreements are subject to amendment/modification, Subrecipients are responsible for forwarding this information to the Agreement Manager named in the Agreement at time of completion of the report. Refer to the current version of the Agreement to confirm the Agreement Manager's contact information prior to submission.*

    a. The Auditor General's Office at the following address:

        Auditor General
        Local Government Audits/342
        Claude Pepper Building, Room 401
        111 West Madison Street
        Tallahassee, Florida 32399-1450

        The Auditor General's website (https://flauditor.gov/) provides instructions for filing an electronic copy of a financial reporting package.

14. Copies of reports or the management letter required by Part III of this form shall be submitted by or on behalf of the Subrecipient directly to:

    a. The AHCA at each of the following addresses:

        1) Send one (1) electronic copy and management letter, if issued, to the Office of Inspector General at IGSingleaudit@ahca.myflorida.com; and

        15. Send one (1) electronic copy and management letter, if issued, to the AHCA Agreement Manager at: [Insert AHCA Agreement Manager's Email Address Here] Note*: It is the Subrecipient's responsibility to send the report to the current AHCA Agreement Manager. As all agreements are subject to amendment/modification, Subrecipients are responsible for forwarding this information to the Agreement Manager named in the Agreement at time of completion of the report. Refer to the current version of the Agreement to confirm the Agreement Manager's contact information prior to submission.*

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

a. The Auditor General's Office at the following address:

Auditor General
Local Government Audits/342
Claude Pepper Building, Room 401
111 West Madison Street
Tallahassee, Florida 32399-1450

The Auditor General's website (https://flauditor.gov/) provides instructions for filing an electronic copy of a financial reporting package.

16. Any reports, management letters, or other information required to be submitted to the AHCA pursuant to this agreement shall be submitted timely in accordance with 2 CFR §200.512, section 215.97, F.S., and Chapters 10.550 (local governmental entities) and 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General, as applicable.

17. Subrecipients, when submitting financial reporting packages to the AHCA for audits done in accordance with 2 CFR 200, Subpart F - Audit Requirements, or Chapters 10.550 (local governmental entities) and 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General, should indicate the date that the reporting package was delivered to the Subrecipient in correspondence accompanying the reporting package.

Part V: Record Retention

The Subrecipient shall retain sufficient records demonstrating its compliance with the terms of the award(s) and this agreement for a period of ten fiscal years (10) from the date the audit report is issued, and shall allow the AHCA, or its designee, the CFO, or Auditor General access to such records upon request. The Subrecipient shall ensure that audit working papers are made available to the AHCA, or its designee, the CFO, or Auditor General upon request for a period of ten (10) years from the date the audit report is issued, unless extended in writing by the AHCA.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

AUDIT REQUIREMENTS FOR AWARDS OF STATE AND FEDERAL FINANCIAL ASSISTANCE

EXHIBIT 1

Federal Funds Awarded to the Subrecipient Pursuant to this Agreement Consist of the Following:
NOTE: If the resources awarded to the Subrecipient represent more than one Federal program, provide the same information shown below for each Federal program and show total Federal resources awarded.

Federal Program Number	Federal Agency	Assistance Listing Number	Assistance Listing Title	Funding Amount	State Appropriation Category
				$	
				$	
				$	

Compliance Requirements Applicable to the Federal Resources Awarded Pursuant to this Agreement are as Follows:

The Subrecipient shall comply with the program requirements described in the Office of Management and Budget (OMB) 2 CFR 200, Subpart F, Appendix XI - Compliance Supplement.

State Funds Awarded to the Subrecipient Pursuant to this Agreement Consist of the Following Matching Funds for Federal Programs:
NOTE: If the resources awarded to the Subrecipient for matching represent more than one Federal program, provide the same information shown below for each Federal program and show total State resources awarded for matching.

Federal Program Number	Federal Agency	Assistance Listing Number	Assistance Listing Title	Funding Amount	State Appropriation Category
				$	
				$	
				$	

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

AUDIT REQUIREMENTS FOR AWARDS OF
STATE AND FEDERAL FINANCIAL ASSISTANCE

State Funds Awarded to the Subrecipient Pursuant to this Agreement Consist of the Following Funds Subject to Section 215.97, F.S.:
NOTE: If the resources awarded to the Subrecipient represent more than one State project, provide the same information shown below for each State project and show total state financial assistance awarded that is subject to Section 215.97, Florida Statutes.

State Program Number	Funding Source	State Fiscal Year	CSFA Number	CSFA Title	Funding Amount	State Appropriation Category
					$	
					$	
					$	

Total Award:	**$**	

Compliance Requirements Applicable to State Resources Awarded Pursuant to this Agreement are as Follows:

The Subrecipient shall comply with the program requirements described in the Catalog of State Financial Assistance (CSFA) located at: https://apps.fldfs.com/fsaa/catalog.aspx and the State Projects Compliance Supplement located at: https://apps.fldfs.com/fsaa/compliance.aspx.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

EXHIBIT 2
AUDIT COMPLIANCE CERTIFICATION

(To be completed and submitted within sixty (60) calendar days following the end of the Subrecipient's fiscal year end date.)

Subrecipient Information

Subrecipient Name: _____

FEID#: _____ Subrecipient Fiscal Year End Date: _____

Contact Information for Authorized Representative

Name: _____

Email Address: _____ Telephone Number: _____

1. Did the Subrecipient expend federal awards, during its fiscal year that it received under any agreement (e.g., agreement, grant, memorandum of agreement, memorandum of understanding, etc.) between Subrecipient and the Agency for Health Care Administration (Agency)? ☐Yes ☐No

   If the above answer is yes, also answer the following before proceeding to item 2:

   Did Subrecipient expend **$750,000.00** or more in federal awards (from the Agency and all other sources of federal awards combined) during its fiscal year? ☐Yes ☐No

   If yes, Subrecipient certifies that it will timely comply with all applicable single or project-specific audit requirements of 2 Code of Federal Regulations (CFR) 200, Subpart F, as revised.

2. Did the Subrecipient expend state financial assistance, during its fiscal year, that it received under any agreement (e.g., agreement, grant, memorandum of agreement, memorandum of understanding, etc.) between Subrecipient and the Agency for Health Care Administration (Agency)? ☐Yes ☐No

   If the above answer is yes, also answer the following before proceeding to item 3:

   Did the Subrecipient expend **$750,000.00** or more of state financial assistance (from the Agency and all other sources of state financial assistance combined) during its fiscal year? ☐Yes ☐No

   If yes, Subrecipient certifies that it will timely comply with all applicable state single or project-specific audit requirements of Section 215.97, Florida Statutes (F.S.), and the applicable rules of the Florida Department of Financial Services and the Auditor General.

3. By signing below, I certify, on behalf of the Subrecipient, that the above representations for items 1 and 2 are true and correct.

_____ _____

Signature of Authorized Representative Date

Printed Name of Authorized Representative	Title

ATTACHMENT III
BUSINESS ASSOCIATE AGREEMENT

The parties to this Attachment agree that the following provisions constitute a business associate agreement for purposes of complying with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Attachment is applicable if the SUBRECIPIENT is a business associate within the meaning of the Privacy and Security Regulations, 45 C.F.R. 160 and 164.

The SUBRECIPIENT certifies and agrees as to abide by the following:

1. Definitions. Unless specifically stated in this Attachment, the definition of the terms contained herein shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164.

    a. Protected Health Information. For purposes of this Attachment, protected health information shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164, limited to the information created, received, maintained or transmitted by the SUBRECIPIENT from, or on behalf of, the Agency.

    b. Electronic Protected Health Information (e-PHI). For purposes of this Attachment, electronic protected health information shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164 (The Security Rule), limited to the electronic information created, received, maintained or transmitted by the SUBRECIPIENT from, or on behalf of, the Agency.

    c. Security Incident. For purposes of this Attachment, security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system and includes any event resulting in computer systems, networks, or data being viewed, manipulated, damaged, destroyed or made inaccessible by an unauthorized activity.

    d. Confidentiality. For the purposes of this Attachment, confidentiality refers to when electronic protected health information is not made available or disclosed to unauthorized persons or processes.

    e. Integrity. For the purposes of this Attachment, integrity means that electronic protected health information has not been altered or destroyed in an unauthorized manner.

    f. Availability. For the purposes of this Attachment, availability refers to electronic health information remaining accessible and usable upon demand by an authorized person.

2. Applicability of HITECH and HIPAA Privacy Rule and Security Rule Provisions. As provided by federal law, Title XIII of the American Recovery and Reinvestment Act of 2009 (ARRA), also known as the Health Information Technology Economic ad Clinical Health (HITECH) Act, requires a Business Associate (SUBRECIPIENT) that contracts with the Agency, a HIPAA covered entity, to comply with the provisions of the HIPAA Privacy and Security Rules (45 C.F.R. 160 and 164) and comply with 45 C.F.R. 162 as applicable.

3. Use and Disclosure of Protected Health Information. The SUBRECIPIENT shall comply with the provisions of 45 CFR 164.504(e)(2)(ii). The SUBRECIPIENT shall not use or disclose protected health information other than as permitted by this Contract or by federal and state law. The sale of protected health information or any components thereof is prohibited except as provided in 45 CFR 164.502(a)(5). The SUBRECIPIENT will use appropriate safeguards to prevent the use or disclosure of protected health information for any purpose not in conformity with this Contract and federal and state law. The SUBRECIPIENT will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information the SUBRECIPIENT creates, receives, maintains, or transmits on behalf of the Agency.

4. Use and Disclosure of Information for Management, Administration, and Legal Responsibilities. The SUBRECIPIENT is permitted to use and disclose protected health information received from the Agency for the proper management and administration of the SUBRECIPIENT or to carry out the legal responsibilities of the SUBRECIPIENT, in accordance with 45 C.F.R. 164.504(e)(4). Such disclosure is only permissible where required by law, or where the SUBRECIPIENT obtains reasonable assurances from the person to whom the protected health information is disclosed that: (1) the protected health information will be held confidentially, (2) the protected health information will be used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and (3) the person notifies the SUBRECIPIENT of any instance of which it is aware in which the confidentiality of the protected health information has been breached.

5. Disclosure to Third Parties. The SUBRECIPIENT will not divulge, disclose, or communicate protected health information to any third party for any purpose not in conformity with this Contract without prior written approval from the Agency. The SUBRECIPIENT shall ensure that any agent, including a subcontractor, to whom it provides protected health information received from, or created or received by the SUBRECIPIENT on behalf of the Agency, agrees to the same terms, conditions, and restrictions that apply to the SUBRECIPIENT with respect to protected health information. The SUBRECIPIENT's subcontracts shall fully comply with the requirements of 45 CFR 164.314(a)(2)(iii).

6. Access to Information. The SUBRECIPIENT shall make protected health information available in accordance with federal and state law, including providing a right of access to persons who are the subjects of the protected health information in accordance with 45 C.F.R.164.524.

7. Amendment and Incorporation of Amendments. The SUBRECIPIENT shall make protected health information available for amendment and to incorporate any amendments to the protected health information in accordance with 45 C.F.R. 164.526.

8. Accounting for Disclosures. The SUBRECIPIENT shall make protected health information available as required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528. The SUBRECIPIENT shall document all disclosures of protected health information as needed for the Agency to respond to a request for an accounting of disclosures in accordance with 45 C.F.R. 164.528.

9. Privacy Protection. The SUBRECIPIENT shall permit an individual to request a restriction on the use and disclosure of protected health information about the individual to carry out treatment, payment, or health care operations; and disclosures permitted under 164.510(b) in accordance with 45 C.F.R. 164.522. The SUBRECIPIENT shall permit an individual to request to receive communications of protected health information from the SUBRECIPIENT by alternative means or at alternative locations in accordance with 45 C.F.R. 164.522.

10. Access to Books and Records. The SUBRECIPIENT shall make its internal practices, books, and records relating to the use and disclosure of protected health information received from, or created or received by the SUBRECIPIENT on behalf of the Agency, available to the Secretary of the Department of Health and Human Services ("HHS") or the Secretary's designee for purposes of determining compliance with the HHS Privacy Regulations.

11. Reporting. The SUBRECIPIENT shall make a good faith effort to identify any use or disclosure, or loss of confidentiality, integrity, or availability, of protected health information, or e-PHI, not provided for in this Contract.

    a. To Agency. The SUBRECIPIENT will report to the Agency in the manner and format obtained from the Contract Manager or Agency contact, within ten (10) business days of discovery, any use or disclosure, or loss of confidentiality, integrity, or availability, of protected health information, or e-PHI, not provided for in this Contract of which the SUBRECIPIENT is aware. The SUBRECIPIENT will report to the Agency in the manner and format obtained from the Contract Manager or Agency contact, within twenty-four (24) hours of discovery, any security incident of which the SUBRECIPIENT is aware. A violation of this paragraph shall be a material violation of this Contract. Such notice shall include the identification of each individual whose unsecured protected health information has been or is reasonably believed by the SUBRECIPIENT to have been, accessed, acquired, used, or disclosed during such breach.

    b. To Individuals. In the case of a breach of protected health information discovered by the SUBRECIPIENT, the SUBRECIPIENT shall first notify the Agency of the pertinent details of the breach and upon prior review by the Agency shall notify each individual whose unsecured protected health information has been or is reasonably believed by the SUBRECIPIENT to have been, accessed, acquired, used or disclosed as a result of such breach. Such notification shall be in writing by first-class mail to the individual (or the next of kin if the individual is deceased) at the last known address of the individual or next of kin, respectively, or, if specified as a preference by the individual, by electronic mail. Where there is insufficient, or out-of-date contact information (including a phone number, email address, or any other form of appropriate communication) that precludes written (or, if specifically requested, electronic) notification to the individual, a substitute form of notice shall be provided, including, in the case that there are 10 or more individuals for which there is insufficient or out-of-date contact information, a conspicuous posting for a period of at least 90 days on the Web site of the covered entity involved or notice in major print or broadcast media, including major media in the geographic areas where the individuals affected by the breach likely reside. In any case deemed by the SUBRECIPIENT to require urgency because of possible imminent misuse of

unsecured protected health information, the SUBRECIPIENT may also provide information to individuals by telephone or other means, as appropriate.

c. To Media. In the case of a breach of protected health information discovered by the SUBRECIPIENT where the unsecured protected health information of more than 500 persons is reasonably believed to have been, accessed, acquired, used, or disclosed, after prior review by the Agency, the SUBRECIPIENT shall provide notice to prominent media outlets serving the State, relevant portion of the State, or jurisdiction involved.

d. To Secretary of Health and Human Services (HHS). The SUBRECIPIENT shall cooperate with the Agency to provide notice to the Secretary of HHS of unsecured protected health information that has been acquired or disclosed in a breach.

i. SUBRECIPIENTs Who Are Covered Entities. In the event of a breach by the SUBRECIPIENT, or a contractor or subcontractor of the SUBRECIPIENT, and the SUBRECIPIENT is a HIPAA covered entity, the SUBRECIPIENT, not the Agency, shall be considered the covered entity for purposes of notification to the Secretary of HHS pursuant to 45 CFR 164.408. The SUBRECIPIENT shall be responsible for filing the notification to the Secretary of HHS and will identify itself as the covered entity in the notice. If the breach was with respect to 500 or more individuals, at least 5 business days prior to filing notice with the Secretary of HHS the SUBRECIPIENT shall provide a copy of the notice and breach risk assessment to the Agency for review. Upon prior review by the Agency of the notice and breach risk assessment, the SUBRECIPIENT shall file the notice with the Secretary of HHS within the notification timeframe imposed by 45 C.F.R. 164.408(b) and contemporaneously submit a copy of said notification to the Agency. If the breach was with respect to less than 500 individuals, the SUBRECIPIENT shall notify the Secretary of HHS within the notification timeframe imposed by 45 C.F.R. 164.408(c) and shall contemporaneously submit a copy of said notification to the Agency.

e. Content of Notices. All notices required under this Attachment shall include the content set forth in 42 U.S.C. 17932(f) and 45 C.F.R. 164 Subpart D, except that references therein to a “covered entity” shall be read as references to the SUBRECIPIENT.

f. Financial Responsibility. The SUBRECIPIENT shall be responsible for all costs related to the notices required under this Attachment.

g. Other Reporting. The SUBRECIPIENT shall comply with any other applicable reporting requirements in conformity with federal and state laws. If notifications are made under any such laws, copies of said notifications shall be provided contemporaneously to the Agency.

12. Mitigation. SUBRECIPIENT shall mitigate, to the extent practicable, any harmful effect that is known to the SUBRECIPIENT of a use or disclosure of protected health information in violation of this Attachment.

13. Termination. Upon the Agency's discovery of a material breach of this Attachment, the Agency shall have the right to assess liquidated damages as specified elsewhere in the contract to which this Attachment is included, and/or to terminate this Contract.

14. Effect of Termination. At the termination of this Contract, the SUBRECIPIENT shall return all protected health information that the SUBRECIPIENT still maintains in any form, including any copies or hybrid or merged databases made by the SUBRECIPIENT; or with prior written approval of the Agency, the protected health information may be destroyed by the SUBRECIPIENT after its use. If the protected health information is destroyed pursuant to the Agency's prior written approval, the SUBRECIPIENT must provide a written confirmation of such destruction to the Agency. If return or destruction of the protected health information is determined not feasible by the Agency, the SUBRECIPIENT agrees to protect the protected health information and treat it as strictly confidential.

The SUBRECIPIENT has caused this Attachment to be signed and delivered by its duly authorized representative, as of the date set forth below.

SUBRECIPIENT NAME

SIGNED BY: _____ **DATE:** _____

NAME: _____ **TITLE:** _____

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

ATTACHMENT IV

CERTIFICATION REGARDING
DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION
CONTRACTS/SUBCONTRACTS

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987, Federal Register (52 Fed. Reg., pages 20360-20369).

INSTRUCTIONS

1. Each Subrecipient whose contract/subcontract equals or exceeds $25,000 in federal monies must sign this certification prior to execution of each contract/subcontract. Additionally, Subrecipients who audit federal programs must also sign, regardless of the contract amount. The Agency for Health Care Administration cannot contract with these types of Subrecipients if they are debarred or suspended by the federal government.
2. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the Federal Government may pursue available remedies, including suspension and/or debarment.
3. The Subrecipient shall provide immediate written notice to the contract manager at any time the Subrecipient learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "debarred," "suspended," "ineligible," "person," "principal," and "voluntarily excluded," as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the contract manager for assistance in obtaining a copy of those regulations.
5. The Subrecipient agrees by submitting this certification that, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the Federal Government.
6. The Subrecipient further agrees by submitting this certification that it will require each subcontractor of this contract/subcontract, whose payment will equal or exceed $25,000 in federal monies, to submit a signed copy of this certification.
7. The Agency for Health Care Administration may rely upon a certification of a Subrecipient that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting/subcontracting unless it knows that the certification is erroneous.
8. This signed certification must be kept in the contract manager's contract file. Subcontractor's certifications must be kept at the contractor's business location.

CERTIFICATION

(1) The prospective Subrecipient certifies, by signing this certification, that neither he nor his principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal department or agency.

(2) Where the prospective Subrecipient is unable to certify to any of the statements in this certification, such prospective Subrecipient shall attach an explanation to this certification.

_____ _____

Signature Date

_____

Name and Title of Authorized Signer

ATTACHMENT V
CERTIFICATION REGARDING LOBBYING
CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure Form to Report Lobbying,” in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____ _____

Signature Date

_____ _____

Name of Authorized Individual Application or Contract Number

_____

Name and Address of Organization

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

ATTACHMENT VI
IRS FORM 990 AND EXECUTIVE COMPENSATION REPORTING REQUIREMENTS

In accordance with Executive Order 20-44, which requires executive agencies to submit a list of entities named in statute with which a State agency must form a sole-source, public-private agreement, or an entity that, through contract or other agreement with the State, annually receives fifty percent (50%) or more of their budget from the State or from a combination of State and Federal funds; any Subrecipient that meets one or both of the criteria listed must submit to the Agency an annual report, including the most recent IRS Form 990, detailing the total compensation for each member of the Subrecipient's executive leadership teams.

Total compensation shall include salary, bonuses, cashed-in leave, cash equivalents, severance pay, retirement benefits, deferred compensation, real-property gifts, and any other payout. In addition, Subrecipient must inform the Agency of any changes in total executive compensation between the annual reports within sixty (60) days of any change taking effect. All compensation reports must indicate what percentage of compensation comes directly from the State and/or Federal allocations to the Subrecipient.

The annual report must be submitted to the Agency's Contract Manager and emailed to CATS.Help@ahca.myflorida.com within one hundred and eighty (180) calendar days after the end of the Subrecipient's tax year. This requirement shall survive the Agreement end date until the final annual report is submitted to the Agency, and the Agency has provided written acceptance of the final annual report. If the Subrecipient fails to submit the annual report, the Agency will impose liquidated damages, as specified below in Table 1, Performance Standard and Liquidated Damage.

TABLE 1
PERFORMANCE STANDARD AND LIQUIDATED DAMAGE

Performance Standard Requirement	Liquidated Damages to be Imposed
The Subrecipient shall submit an annual report that meets the requirements of this Attachment III of the Agreement.	**$100.00** per day for each day past the due date until the annual report is submitted to the Agency.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK.

FLORIDA RURAL HEALTH TRANSFORMATION PROGRAM (RHTP)

Attachment V – Reviewer Evaluation Rubric

Bundle 1 — Preventive Care & Care-at-Home

Initiatives 2 (Mobile Health), 3 (Community Paramedicine/MIH), 10 (RPTM), 12 (Retail Clinic), 13 (HIE/ENS Onboarding)

RFA Number: 033-25/26

This rubric is provided as a transparency tool to help applicants understand how submitted applications will be evaluated. All sections and required components of the RFA will be reviewed in their entirety. Applicants should note that this rubric does not score every RFA section as a separate line item. Instead, related sections are evaluated holistically, for example, themes such as sustainability, workforce capacity, and program integration are considered across multiple application sections and scored together.

Scoring Threshold

Minimum Total Weighted Score required for funding consideration: **65 / 100**

0–5 Scoring Scale

Score	Rating	Definition
5	**Exemplary**	Fully meets the highest verifiable indicator with specific, documented evidence. All required components present, clearly articulated, and directly supported by named personnel, executed agreements, specific systems, documented timelines, and cited documentation.
4	**Strong**	Meets the highest indicator with only minor documentation gaps. Substantially complete with minor clarifications that would not change feasibility or compliance.
3	**Adequate**	Meets the middle-tier (HIGH/mid) indicator. Most required components addressed; some elements lack specificity, evidence, or named detail but core requirements are present.
2	**Partial**	Meets the PARTIAL indicator. Response is present but general; multiple required components are missing, unsupported, or described only conceptually without operational detail.
1	**Minimal**	Below PARTIAL. Topic acknowledged but response fails to address required components meaningfully; little to no documented evidence; heavy reliance on assertion.
0	**Absent**	Required component is absent, not addressed, or meets the NONE/0 pts indicator in the source RFA. No documentation submitted or content fails to address the scored element.

Technical Scoring (0–5 Weighted)

A. Organizational Capacity | Weight: 10%	
Score	**Anchor Description**
5	Five-year organizational history documented with verifiable evidence; governance structure names a Clinical Lead or Program Director with FTE commitment ≥25%; two most recent audited/CPA-reviewed financial statements show positive net assets or document a corrective plan; all five bundle initiatives identified with lead initiative established as Initiative 2, 3, or 12; lead applicant demonstrates documented operational presence in eligible rural service area.
4	All required elements present; minor documentation gap (e.g., single appendix or corrective-plan detail) does not affect capacity determination.
3	Five-year history documented but supporting evidence limited; Clinical Lead named but FTE not specified; financials positive but only one year submitted; lead initiative established but rural presence not fully documented.
2	Organizational history asserted but not supported; governance described without named individuals; one year of financials missing; five-year history unclear.
1	Organizational capacity minimally supported; lead identity partially established; significant evidence gaps.
0	Five-year operational history not demonstrated; financial statements not submitted; unresolved program integrity findings without corrective action; lead initiative identity not established.

B. Initiative 2: Mobile Health Program Narrative | Weight: 14.5%	
Score	**Anchor Description**
5	All required Mobile Health program components addressed: service model with specific rural service areas, counties, and ZIP codes; scheduled route design with stop locations and rural eligibility; CHW certification plan with timeline; EHR/ePCR identified with 90-day HIE/ENS connectivity; prenatal service model addresses first-trimester risk assessment and obstetric referral; referral tracking workflow described; coordination with all four co-bundle initiatives described operationally. Where the Mobile Health service area includes counties with maternal health disparities or prenatal-care shortage, the application includes a dedicated mobile obstetrics service component: OB service delivery on mobile unit(s) (prenatal visits, first-trimester risk assessment, routine prenatal monitoring, postpartum care); licensed OB provider (OB-GYN, CNM, or family medicine with OB) on mobile unity OR documented telehealth OB consultation arrangement with referral protocol; high-risk maternal handoff pathway to hospital-based OB with defined clinical triggers.
4	Mobile Health narrative substantially complete; one element (e.g., one co-bundle integration or CHW timeline specificity) needs minor clarification. Mobile obstetrics component present, if applicable, but one element (OB provider model, high-risk handoff triggers, or postpartum coverage) requires minor clarification.
3	Most required components addressed; route design present but stop locations not fully documented; CHW plan present but timeline not specific; HIT connectivity plan present without confirmed 90-day timeline; coordination described for at least three co-bundle initiatives. Mobile OB capacity referenced, if applicable, but service delivery model or provider arrangement not operationally described.

B. Initiative 2: Mobile Health Program Narrative | Weight: 14.5%

Score	Anchor Description
2	Mobile Health service model described without route specificity; staffing plan general; HIT plan referenced but not developed; coordination mentioned without operational mechanisms. Mobile OB addressed only as a downstream referral without mobile unit service capacity where the service area warrants it.
1	Mobile Health narrative minimal; key components (routes, CHW, HIT, prenatal, coordination) addressed only superficially.
0	Mobile Health narrative absent or does not address required service model, route design, staffing, or clinical protocols.

C. Initiative 3: Community Paramedicine / MIH Program Narrative | Weight: 12.5%

Score	Anchor Description
5	Regional service model covers multiple rural counties with documented response zones; all three service pathways addressed with patient eligibility criteria and clinical protocols (all four chronic disease focus areas); Year 1 alternative destination and Year 2 on-scene protocol phasing described; EMS licensure and medical direction documented (or recruitment plan); ePCR–HIE/ENS connectivity documented; RPTM-to-CP alert workflow described; coordination with all four co-bundle initiatives operational.
4	CP/MIH narrative substantially complete; minor gap (e.g., one chronic disease focus area or phasing detail) requires clarification.
3	Most components addressed; regional coverage documented but county-level completeness limited; at least two of three service pathways fully described with required chronic disease focus; EMS licensure referenced without documentation; coordination described for at least three co-bundle initiatives.
2	CP service model present but limited to one service pathway; staffing and medical direction described generally; no EMS licensure evidence; coordination mentioned without workflows.
1	CP/MIH narrative minimal; service pathways referenced without clinical protocol detail.
0	Community Paramedicine narrative absent or does not describe a functional MIH service model.

D. Initiative 12: Retail Clinic Services Program Narrative | Weight: 12.5%

Score	Anchor Description
5	Each proposed pharmacy site confirmed operating in eligible rural area with active Florida pharmacy permit; scope of practice compliance acknowledged with service model aligned to licensed provider types; on-site clinic area or telehealth kiosk model described with patient flow; clinical supervision structure with licensed prescriber identified (or recruitment plan); HIE/ENS connectivity plan for each site; referral pathways to Mobile Health and CP described; coordination with all four co-bundle initiatives operational.
4	Retail Clinic narrative substantially complete; one element (e.g., prescriber recruitment detail or single co-bundle pathway) needs minor clarification.
3	Most components addressed; at least one pharmacy permit confirmed; scope of practice compliance addressed; clinical supervision identified without full documentation; coordination described for at least three co-bundle initiatives.

D. Initiative 12: Retail Clinic Services Program Narrative | Weight: 12.5%	
Score	**Anchor Description**
2	Retail clinic model described generally; pharmacy sites identified without permit documentation; clinical supervision without named or recruited prescriber; limited co-bundle coordination.
1	Retail clinic narrative minimal; scope-of-practice compliance unclear; supervision not addressed.
0	Retail Clinic narrative absent or does not address a pharmacy-based service model or scope of practice compliance.

E. RPTM Service Component (Initiative 10) | Weight: 7.5%	
Score	**Anchor Description**
5	Enrollment criteria for at least three qualifying populations (chronic disease, post-discharge, high-risk maternal); each proposed device type named with FDA clearance documented; monitoring platform named with HIPAA BAA documented or committed; alert threshold protocols described with response timeframes; HIE/ENS integration with 90-day go-live timeline; RPTM budget separately itemized; rural service area co-extensive with lead initiative.
4	RPTM component substantially complete; minor gap (e.g., response timeframe for one alert tier or one device FDA reference) pending.
3	RPTM subsection present; enrollment criteria identified but fewer than three qualifying populations; FDA clearance for at least one device included; platform named with HIPAA evidence; alert thresholds described but response timeframes incomplete; budget included but not fully itemized.
2	RPTM subsection present but incomplete; device types referenced without FDA clearance; alert protocols present without thresholds or response timeframes.
1	RPTM barely addressed; no FDA devices; no platform BAA; no alert protocols.
0	RPTM subsection absent or does not address monitoring model, devices, or alert protocols.

F. HIE/ENS Onboarding Service Component (Initiative 13) | Weight: 7.5%	
Score	**Anchor Description**
5	All required components: specific provider sites (name, type, county, rural eligibility) for onboarding; onboarding approach addresses technical assessment, connectivity, workflow redesign, training, and go-live support with first site operational within first program year; operational use of ENS alerts in care coordination documented for at least one site; data exchange standards (HL7, FHIR, ADT) addressed; training plan described; sustainability addressed; integration with all five bundle initiatives.
4	HIE/ENS component substantially complete; one element (e.g., single data standard detail or integration with one initiative) needs minor clarification.
3	Provider sites identified without full rural eligibility documentation; onboarding addresses technical connection but operational workflow adoption not fully described; integration with at least three co-bundle initiatives described.
2	Limited to technical connectivity; no operational workflow or training plan; no co-bundle integration described.

F. HIE/ENS Onboarding Service Component (Initiative 13) | Weight: 7.5%	
Score	**Anchor Description**
1	HIE/ENS component minimal; provider sites unspecified; no onboarding phases identified.
0	HIE/ENS subsection absent or does not describe a functional onboarding approach.

G. Bundle Integration and Coordination Plan | Weight: 12.5%	
Score	**Anchor Description**
5	Referral pathways connecting all five initiatives with named responsible parties and handoff protocols; shared data exchange architecture connecting EHR/ePCR across all five initiatives to Florida HIE/ENS; governance structure for bundle-level oversight; patient flow across ≥2 initiatives demonstrated; CP alert-triggered response to RPTM data described with specific workflow; Mobile Health–Retail Clinic cross-referral pathways documented with tracking; HIE/ENS ties all five programs to common data exchange infrastructure.
4	Bundle integration substantially complete; minor gap (e.g., one handoff protocol or one integration workflow) requires clarification.
3	Coordination plan present; referral pathways described for at least four initiatives; data exchange approach described but not fully documented; governance structure identified; patient flow described but handoff protocols not detailed.
2	Coordination plan present but generic; referral pathways described without operational detail; integration described conceptually without workflows.
1	Bundle integration barely addressed; initiatives described independently.
0	No bundle coordination plan; each initiative addressed as independent program with no integration described.

H. Implementation Work Plan | Weight: 7.5%	
Score	**Anchor Description**
5	Initiative-specific milestones for all five bundle components with specific target dates; FFY-level output targets for Years 1–5; at least two implementation risks per initiative with specific mitigations; key milestones met: lead initiative service launch within 180 days; RPTM first patient enrollment within 120 days; HIE/ENS first site onboarding within 90 days; EHR/HIE connectivity within 90 days of program launch.
4	Work plan substantially complete; minor gap in one milestone date or one risk/mitigation pair.
3	Milestones for most bundle components with dates; some FFY-level targets; risks identified for at least three initiatives but mitigations are generic.
2	Work plan present but dates approximate or missing for more than two initiatives; risks listed without mitigations.
1	Work plan minimal; critical launch milestones absent or noncompliant with required timeframes.
0	Work plan absent or does not distinguish activities by bundle initiative.

I. Sustainability Plan | Weight: 7.5%	
Score	**Anchor Description**
5	Sustainability plan addresses all five initiatives: RPTM billing codes identified with payer coverage evidence; Mobile Health reimbursement pathway identified; Retail Clinic on-site and telehealth billing pathways identified; HIE/ENS operational continuity funded post-grant; CP reimbursement pathways (Medicaid, insurance, VBP) identified; VBP integration strategy described for at least one initiative.
4	Sustainability plan substantially complete; one component (e.g., payer coverage evidence or VBP strategy depth) pending.
3	Sustainability plan present for most initiatives; reimbursement strategies identified but payer coverage documentation not included; VBP integration mentioned but not developed.
2	Sustainability plan present but generic; reimbursement referenced without specific billing codes or payer strategies.
1	Sustainability barely addressed; no billing codes; minimal post-grant revenue plan.
0	Sustainability plan absent; or plan relies exclusively on continued grant funding.

J. Data Collection, Reporting, and CQI Plan | Weight: 6.5%	
Score	**Anchor Description**
5	Data collection plan identifies specific data systems and named staff roles for all required metrics across all five bundle initiatives; data submission workflows for monthly, quarterly, and annual reporting; at least three pre-submission data quality validation steps; CQI framework uses PDSA (or equivalent) applied across all five initiatives; internal performance review schedule with named parties and frequency; at least one illustrative improvement cycle tied to a bundle- or initiative-level metric; commitment to RHTP learning collaboratives and External Evaluator cooperation documented.
4	Data and CQI plan substantially complete; minor gap (e.g., single staff role or one QA step) pending.
3	Data collection plan identifies data systems for most initiatives but does not assign named staff roles for all; reporting cadences addressed; fewer than three data quality validation steps; CQI methodology named but no initiative-specific improvement cycle; learning collaborative participation committed to.
2	Data collection plan present but incomplete; reporting cadences addressed at high level without system or role specificity; CQI referenced without framework or internal review schedule.
1	Minimal data/CQI content; no roles, no validation steps, no framework.
0	Data collection and reporting plan absent or does not address required metrics; no CQI framework.

K. Budget and Cost Reasonableness | Weight: 1.5%	
Score	**Anchor Description**
5	Budget itemized by initiative and cost category for all five bundle components; RPTM budget separately itemized (device, platform, care coordination staffing, patient education, reporting); administrative costs at or below 3%; all initiative budget amounts within Super Region funding ceilings; budget narrative provides rationale for unit costs; no unallowable costs identified.
4	Budget substantially complete; one itemization detail pending.
3	Budget covers all five initiatives but RPTM or HIE/ENS component not separately itemized; administrative cost compliance demonstrated; Super Region ceiling confirmed; unit cost narrative present but limited.
2	Budget present for all five initiatives but not disaggregated by initiative; administrative cost cap compliance unclear.
1	Budget incomplete or missing itemization across multiple initiatives.
0	Budget does not cover all five initiatives; administrative costs exceed 3%; or budget proposes categorically unallowable costs.

Total Score Summary

#	Evaluation Section	Score (0–5)	Weight	Weighted Points
A	Organizational Capacity	_____	10%	_____ / 10
B	Initiative 2: Mobile Health Program Narrative	_____	14.5%	_____ / 14.5
C	Initiative 3: Community Paramedicine / MIH Program Narrative	_____	12.5%	_____ / 12.5
D	Initiative 12: Retail Clinic Services Program Narrative	_____	12.5%	_____ / 12.5
E	RPTM Service Component (Initiative 10)	_____	7.5%	_____ / 7.5
F	HIE/ENS Onboarding Service Component (Initiative 13)	_____	7.5%	_____ / 7.5
G	Bundle Integration and Coordination Plan	_____	12.5%	_____ / 12.5
H	Implementation Work Plan	_____	7.5%	_____ / 7.5
I	Sustainability Plan	_____	7.5%	_____ / 7.5
J	Data Collection, Reporting, and CQI Plan	_____	6.5%	_____ / 6.5
K	Budget and Cost Reasonableness	_____	1.5%	_____ / 1.5
TOTAL WEIGHTED SCORE (out of 100)				**_____ / 100**

Minimum score required for funding consideration: 65 / 100

Applications scoring below the minimum threshold will not be recommended for award, regardless of fund availability.