NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Request for Applications

RFA# 2026-NCROOTS

North Carolina Rural Health Transformation Program

North Carolina Rural Organizations Orchestrating Transformation for Sustainability ("NC ROOTS") Hubs

Applicants are applying to serve as the NC ROOTS Hub Lead for One of Six Regions in North Carolina.

FUNDING AGENCY: North Carolina Department of Health and Human Services (NCDHHS), Office of Rural Health

ISSUE DATE: February 27, 2026

DEADLINE DATE: April 2, 2026

INQUIRIES and DELIVERY INFORMATION:
Direct all inquiries concerning this RFA via email to: dhhs-ncroots.rfa@dhhs.nc.gov

Applications will be received until 5:00 p.m. Eastern US on April 2, 2026
Electronic copies of the application are available at https://www.ncdhhs.gov/divisions/office-rural-health/rural-health-transformation-program

Email applications to: dhhs-ncroots.rfa@dhhs.nc.gov and include RFA 2026-NCROOTS and your entity's name in the Subject line of the email.

Stevens Amendment Disclosure: $213,008,356.47 or 100% of the total costs of the North Carolina Rural Health Transformation Program in budget period 1 are funded with Federal funds, including awards anticipated under this RFA; $0 or 0% of the total cost of this program is funded non-governmental sources. This disclosure is provided in accordance with the Stevens Amendment (Section 505, Division H of Consolidated Appropriations Act, 2021, Public Law 116-260).

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I. About the NCROOTS Hubs RFA

The Rural Health Transformation (RHT) Program was authorized by the H.R. 1 (Section 71401 of Public Law 119-21) and established through Centers for Medicaid and Medicare Services (CMS) to help State governments support rural communities across America in improving health care access, quality, and outcomes by transforming the health care delivery ecosystem. North Carolina has the second-largest rural population in the U.S., with nearly 3 million residents living in rural areas. This plan reflects NCDHHS's commitment to ensuring that every North Carolinian, no matter where they live, has access to high-quality health care. The North Carolina Rural Health Transformation Program (NCRHTP) emerged from extensive engagement with more than 420 stakeholders across the state, including rural hospitals, community health centers, local health departments, faith-based organizations, Tribal communities and community members. The plan is designed so that every North Carolinian can see the benefit of this work —from farmers in Robeson County to teachers in Madison County, small business owners in Bertie County, and parents in Dare County. It aims to strengthen the health care infrastructure that supports individuals, families, and communities across the entire state. The NCRHTP focuses on key initiatives including promoting innovation, strategic partnerships, infrastructure development, and workforce investment. It advances community-designed, community-led solutions to address the unique needs of rural North Carolina and improve the health and well-being of its residents. To support this approach, NCRHTP will establish North Carolina Rural Organizations Orchestrating Transformation for Sustainability (NC ROOTS) Hubs.

An NC ROOTS Hub is a regional lead organization responsible for coordinating rural health transformation efforts within a defined region of North Carolina. Each Hub Lead manages program funding, convenes and aligns partners, and oversees initiatives designed to improve health outcomes, access to care, and system sustainability for rural communities within its respective Medicaid region. Hubs are expected to tailor NCRHTP initiatives and activities to reflect local priorities and regional context, ensuring maximum, locally driven impact.

Each NC ROOTS Hub will establish and coordinate a regional network of experts and partners to advance program initiatives. This network may include hospitals, local health departments, community-based organizations, providers, and other stakeholders working collaboratively to design and implement rural health improvement projects that respond to the needs of rural residents. (For a breakdown of initiatives, see Section II, Background, Figure 1.) There are six (6) NC ROOTS Hub regions in NC, aligning with the Medicaid Standard Plan regions. (For a breakdown of regions, see Section II, Background, Figure 2.)

Each Hub will be responsible for implementing, through a locally informed approach, a set of mandatory projects associated with NCRHTP Initiatives, defined by NCDHHS, and will have the opportunity to implement additional projects suited to the needs of its region.

Each NC ROOTS Hub region will consist of the Hub Lead and the Hub Network. Each Hub Lead will identify and oversee the ROOTS, providing centralized management, coordination, and support for the Hub Network. The Hub Network is a key set of partners uniquely qualified to implement the regional approach, such as rural hospitals, local health departments, community-based organizations, managed care entities, businesses, academic organizations, and others (See Figure 3, Section II Background for more detail*)*. The Hub Lead will establish the Hub Network to implement the NCRHTP initiatives and ensure a locally-led approach is achieved. (Detailed roles and responsibilities for Lead entities and network partners are described in Table 1, Section III.A.1. Scope of Services.)

NCDHHS expects to award $235,513,062 in grant funding, distributed across up to six (6) NC ROOTS Hub Leads for the first grantee award period with additional funding amounts in future years (*see Funding section for more details*). The intended outcome of this RFA is to award one Hub Lead per Region however, NCDHHS may determine that it is in the State's best interest to award more than one Region to a Hub Lead. The funding for each Hub will be determined by the number of rural residents in the region, the specific issues to be addressed, and other factors as determined by the NCRHTP leadership team at NCDHHS.

Successful applicants will receive grant funding to serve as an NC ROOTS Hub Lead for a North Carolina region or regions.

ELIGIBILITY

Public and private entities, including Tribal organizations, are eligible to apply to this RFA if they meet the following criteria:

- Entities must have a Unique Entity Identifier (UEI) issued by SAM.gov.
- Entities must have at least three (3) years of office presence located in and experience delivering programs in North Carolina.
- Entities must have sufficient capital and the fiduciary capacity to cover program costs before receiving the grant funds. This grant operates on a reimbursement basis. This requires the awarded entity to pay for program expenses upfront using their own funds and subsequently request payment from NCDHHS for approved costs.

SUBAWARDS

NCDHHS has determined that successful applicants to this RFA will meet the criteria of Subrecipient as defined in 2 CFR 200.331. Typical characteristics of a Subrecipient include, but are not limited to, that the entity will:

- Have its performance measured in relation to whether the objectives of a federal program were met;
- Have responsibility for programmatic decision-making;
- Be responsible for adherence to applicable federal program requirements specified in the federal grant award; and
- Implement a program for a public purpose.

In accordance with federal guidance, a Subaward may be provided through any form of legal agreement consistent with criteria in with 2 CFR §200.331, including an agreement the Pass-through Entity considers a contract. Successful applicants will receive a Subaward issued by NCDHHS in the form of a negotiated, financial assistance contract.

Per 09 NCAC 03M .0801, NCDHHS cannot disburse any state financial assistance Subaward to an entity that is on the North Carolina Suspension of Funding List. Nor can NCDHHS contract with entities on the North Carolina Debarred Vendors List (01 NCAC 05B .1520) or the Federal Exclusions List (Sections 1128 and 1156 of the Social Security Act (Act).

Awarded Subrecipients must adhere to all required terms and conditions of the Subaward, (see Appendix A for financial assistance terms and conditions) including terms and conditions regarding access to persons and records resulting from all contracts or grants.

FUNDING

Contracts resulting from this RFA shall be funded with pass-through funds from a Cooperative Agreement from the Centers for Medicare & Medicaid Services (CMS) Rural Health Transformation Program, federal Assistance Listing Number 93.978.

Number of awards

Up to six (6) entities will be awarded grant funding through this RFA to serve as NC ROOTS Hubs (*see Figure 2 for NCRHTP ROOTS Hub Regions)*

Funding Periods

There will be four (4) Grantee Award Periods (GAP) lasting until October 30, 2030. Initial contracts will be awarded based on the federal RHTP Notice of Award for Federal Budget Period (FBP) 1, aligning with Grantee Award Period 1, and renewed on an annual basis through the total project period. The following table outlines the anticipated Grantee Award Periods, and projected funding available, which Applicants may consider as they build their budgets.

Funding Periods					
Federal Budget Period (FBP)	FBP 1: 03/01/2026 (anticipated) – 10/30/2026	FBP 2: 10/31/2026 – 10/30/2027*	FBP 3: 10/31/2027 – 10/30/2028*	FBP 4: 10/31/2028 – 10/30/2029*	FBP 5: 10/31/2029 – 10/30/2030*
Grantee Award Period (GAP)	GAP 1: 06/01/2026** – 10/30/27		GAP 2: 10/31/2027 – 10/30/2028	GAP 3: 10/31/2028 – 10/30/2029	GAP 4: 10/31/2029 – 10/30/2030
*FBPs 2, 3, 4, and 5 funding is contingent on performance and funding availability.					
** Contract start date is estimated.					

Performance-Based Continuation

The continuation of federal NCRHTP funding is based on performance. If the State does not meet its intended metrics for FBP1, it may not receive additional funding for FBP2 or it may receive less.

Therefore, NC ROOTS Hub awards and funding for subsequent Award Periods are contingent upon the availability of funding at the State level, NC ROOTS Hub annual performance, and NC ROOTS Hub grant and contract compliance.

The first contracted project period year is expected to begin June 1, 2026, and last until October 30, 2027. Project periods are estimated.

Award Amounts and Budget Guidance

Funding amounts are **estimated** and subject to final federal awards and approved budgets. Allocations are structured by initiative and region to support comprehensive implementation of NC ROOTS Hub activities. Applicants should:

- Align budgets with initiatives and activities outlined in the tables below and detailed in **Chapter III: Scope of Services**.
- Use the **Section 4: Budget** and the **Budget and Justification Form** for guidance on allowable costs, cost categories, and documentation requirements

Illustrative Funding Tables

The following tables provide an illustrative breakdown of anticipated funding allocations by initiative and activity as well as by region for each Grantee Award Period. Applicants should use these figures as a planning guide and ensure their proposed budgets reflect the activities described in *Chapter III: Scope of Services.*

Hub Lead GAP 1 (June. 1, 2026 - Oct. 30, 2027)**		
Initiative/Activity Breakdown	**Budget ($)**	**Per Region ($)**
ROOTS Hub Lead Entity Core Funding	131,000,000	21,833,333
ROOTS Hub Regional Rural Needs Assessment	3,000,000	500,000
Subtotal: Initiative 1 – Build "ROOTS Hub"	**134,000,000**	**22,333,333**
ROOTS Driven Chronic Disease	12,000,000	2,000,000
ROOTS Driven Nutrition Access	8,400,000	1,400,000
ROOTS Driven Perinatal Health Access Expansion	12,000,000	2,000,000
Subtotal: Initiative 2 - Primary Care, Prevention, & Chronic Disease	**32,400,000**	**5,400,000**
ROOTS Driven Workforce Support	17,613,064	2,935,511
ROOTS Driven Workforce Training	36,000,000	6,000,000
Subtotal: Initiative 4 - Build a Robust & Resilient Workforce	**53,613,064**	**8,935,511**
ROOTS Driven Hospital Feasibility & Redesign	7,999,998	1,333,333
ROOTS Driven Primary Care Capitation Model	7,500,000	1,250,000
Subtotal: Initiative 5 - Fiscal Sustainability of Rural Health Providers	**15,499,998**	**2,583,333**
Grand Total GAP 1	**Total per Region**	
$ 235,513,062	**$39,252,177**	
Administrative Expenses may not exceed 10% of total.		

***Illustrative* GAP Budget in Future Years (Oct. 31, 202X - Oct. 30, 203X)**		
Initiative	**Budget ($)**	**Per Region ($)**
Initiative 1	55,000,000	9,166,667
Initiative 2	25,200,000	4,200,000
Initiative 4	18,818,614	3,136,436
Initiative 5	11,000,000	1,833,333
Overall Total	**Total per Region**	
$110,018,614	**$18,336,436**	

DEFINITIONS

Below is a list of definitions for programmatic words or phrases used specifically in this RFA.

Cooperative Agreement: A funding mechanism used by the federal government. It differs from a traditional grant in that a Cooperative Agreement includes substantial programmatic involvement from the federal granting agency.

Deliverable: A concrete document, artifact, product, or evidence produced during program implementation, used to demonstrate progress, compliance, or achievement of required outputs.

Disproportionately burdened communities: Communities that experience greater health, social, or economic challenges compared to others, often due to systemic inequities, environmental exposures, and limited access to resources. These communities typically face higher rates of chronic disease, poverty, and barriers to care.

Evaluation: The systematic process of collecting, analyzing, and reporting data to assess the effectiveness and efficiency of one or more programs, policies, and organizations. Evaluation is used to determine the impact of an intervention and to make decisions about how to improve it. It ensures accountability and supports continuous improvement.

Federal Budget Period (FBP): A specific period of time into which the federal grant award is divided for funding, budgeting, and reporting purposes.

Grantee (also "Subrecipient"): An entity that receives a subaward from a pass-through entity to carry out part of a federal award. Successful applicants to this RFA will be Grantees of the State.

Grantee Award Period (GAP): The period of time for which the State's subaward contracts to its Grantees are funded.

Historically underrepresented communities: Communities that have been excluded or marginalized in decision-making processes, resource allocation, and access to services over time. This includes racial and ethnic minorities, rural populations, and groups that have faced persistent structural barriers.

Key Performance Indicator (KPI): A specific, high-priority metric selected to evaluate success in achieving a key program objective. KPIs are used for ongoing monitoring and reporting at both the initiative and program levels and may be adapted over time in partnership with NCDHHS.

Metric: A quantifiable indicator used to track progress toward a specific goal or objective. Metrics measure inputs, activities, outputs, or outcomes and must be clearly defined, with baseline values and targets established for each initiative.

NCDHHS: North Carolina Department of Health and Human Services.

NCRHTP: North Carolina Rural Health Transformation Program. NCRHTP refers to North Carolina's implementation of the federal program.

Outcome: A measurable change or impact resulting from an initiative, program, or intervention. Outcomes reflect the intended effects on individuals, organizations, or communities and must include both baseline and target values.

Output: A tangible product, service, or deliverable produced as a result of program activities. Outputs are typically counted or described and may include reports, trainings, events, or other concrete deliverables.

Pass-through Entity: A Grantee that provides a subaward to a Subrecipient (including lower-tier subrecipients) to carry out part of a federal program. In subawarding these funds, NCDHHS is a Pass-through Entity.

Performance Measurement & Monitoring: The ongoing process of collecting, reviewing, and reporting data to track progress toward objectives, outcomes, and KPIs of a project. The data can be used to identify increasing or decreasing performance that may warrant further investigation.

Performance Objective: An overarching, measurable achievement expected by the end of the funding period. Performance objectives are state-specific, time-bound, and aligned with federal and programmatic goals.

Prime Recipient: An entity that receives funding directly from a federal awarding agency.

RHTP: Rural Health Transformation Program. RHTP refers specifically to the federal program.

Subaward: An award provided by a Pass-through Entity to a Subrecipient for the Subrecipient to contribute to the goals and objectives of the Project by carrying out part of the federal program awarded to the Pass-through Entity. NCDHHS provides its Subawards by executing a financial assistance contract with the awarded Subrecipient.

Suspension of Funding List: a database maintained and distributed by the North Carolina Office of State Budget and Management in consultation with State agencies designating grantees or subgrantees in a state of non-compliance with grant agreement requirements in accordance with 09 NCAC 03M .0801.

Sustainability Plan: A strategic approach outlining how a program or initiative will maintain its operations, outcomes, and impact beyond the initial funding period. It typically includes plans for securing future funding, building organizational capacity, and embedding practices into long-term systems.

Underserved: Populations or communities that lack adequate access to health care services, including primary care, pediatric care, specialty care, and preventive services. These areas often face shortages of providers, transportation barriers, and socioeconomic challenges that limit health care utilization.

II. BACKGROUND

Rural communities in NC experience high rates of chronic disease and adverse maternal and child health outcomes. These disparities are driven by root causes of disease, such as limited access to preventive, maternal, and chronic disease care, food insecurity, and environmental exposures that increase the risk of disease and poor health outcomes. Barriers to care in rural areas, such as long travel distances, further complicated by geographic features such as mountain regions and coastal barriers, provider shortages, and lack of transportation contribute to delayed diagnoses and reduced access to timely treatment, increasing the risk of preventable complications and hospitalizations. Access to virtual care is also compromised by lack of access to broadband, equipment, and digital literacy.

NC's rural communities each have distinct characterizations. The NCRHTP has been designed to be responsive to these unique needs and pursues a vision to advance regionally contextualized, innovative solutions that strengthen community resilience, improve health, and promote well-being for rural North Carolinians. Anchored in this vision, North Carolina will achieve three goals for rural communities:

1) Catalyze Innovative Care Models, changing the way providers work together to care for patients in rural NC;
2) Transform the Rural Care Experience, building improved systems of community-based medical, behavioral, and social supports close to home; and
3) Create a Sustainable Rural Delivery System through underlying systems change in rural workforce pipelines and care team models, and rural provider financial models.

Defining "Rural"

The program is designed to serve all rural North Carolinians who face fragmented health care and have unmet needs. Rural communities and residents face common characteristics such as:

- **Higher rates of chronic disease** such as diabetes, heart disease, and hypertension
- **Limited access to healthcare**, including fewer providers and longer travel distances
- **Lower population density** with more dispersed communities and greater travel demands
- **Greater economic vulnerability**, including lower incomes, higher poverty, and fewer large employers

Applicants are expected to demonstrate their ability to serve rural residents and their ability to address the unique challenges faced by rural populations such as gaps in care. NC ROOTS Lead Entities will further refine and validate local needs through assessment data and community-based outreach, then build Hub Networks and partnerships accordingly (e.g., identifying and responding to a regional maternity care desert through targeted network development and resource alignment). *Entities located anywhere in the state, serving rural residents wherever they receive care, are eligible to apply.*

NC ROOTS Hubs will be responsible for tailoring NCRHTP initiatives and activities to meet the specific rural needs and geography in a region, ensuring maximum impact. *Figure 1* below shows the initiatives. There are six (6) NC ROOTS Hub regions in NC, aligning with the Medicaid Standard Plan regions. *Figure 2* below shows the six regions.

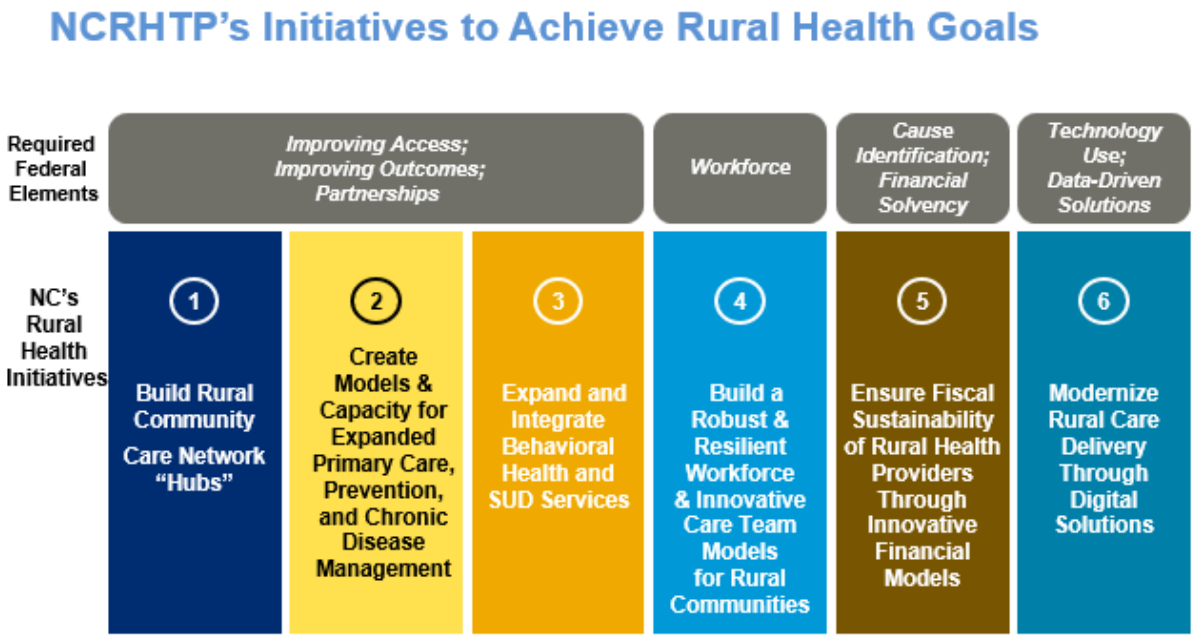
NCRHTP Initiatives

The NC ROOTS Hub Lead entity will serve as the anchor organization for a designated rural region, responsible for establishing, governing, and coordinating a cross-sector network ("Hub Network") to implement the NCRHTP initiatives. The Hub Lead will ensure that all activities are tailored to local needs, advance access to care, and coordinate sustainable improvements in rural health outcomes.

For each of the following NCRHTP Initiatives[1], the Hub Lead will develop a Hub Action Plan to implement the projects most aligned with the target outcomes, as determined in consultation with the Hub Network partners.

[1] NC ROOTS Hub Lead Entities will have either direct responsibility to carry out the initiative or a role in coordination. These are further detailed by initiative sections below.

Figure 1: NCRHTP Initiatives to Achieve NCRHTP Goals



NC ROOTS Hubs will be responsible for tailoring NCRHTP initiatives and activities to meet the specific rural needs and geography in a region and supporting North Carolina's achievement of NCRHTP performance objectives.

Each NC ROOTS Hub will consist of the Hub Lead and the Hub Network. Each Hub will be responsible for implementing a set of mandatory projects associated with NCRHTP Initiatives defined by NCDHHS and will have the option to implement additional projects suited to the needs of the region. The Hub Lead will establish and oversee the ROOTS Hub, providing centralized management, coordination, and support for the Hub Network. The Hub Network is a unique set of partners from across sectors that influence health and are invested in making rural North Carolina healthy. Each Hub will coordinate a cross-sector network to implement NCRHTP initiatives, ensuring governance structures and strategies reflect authentic community engagement, including mandatory Tribal Partnership requirements in regions with Tribal populations. The Hub Network is administered by the Hub Lead to implement the NCRHTP initiatives through a series of Hub-defined projects. Figure 3 below summarizes the Hubs and their networks, as well as the role they will have in implementation of NCRHTP.

Figure 2: NCRHTP ROOTS Hub Regions by County

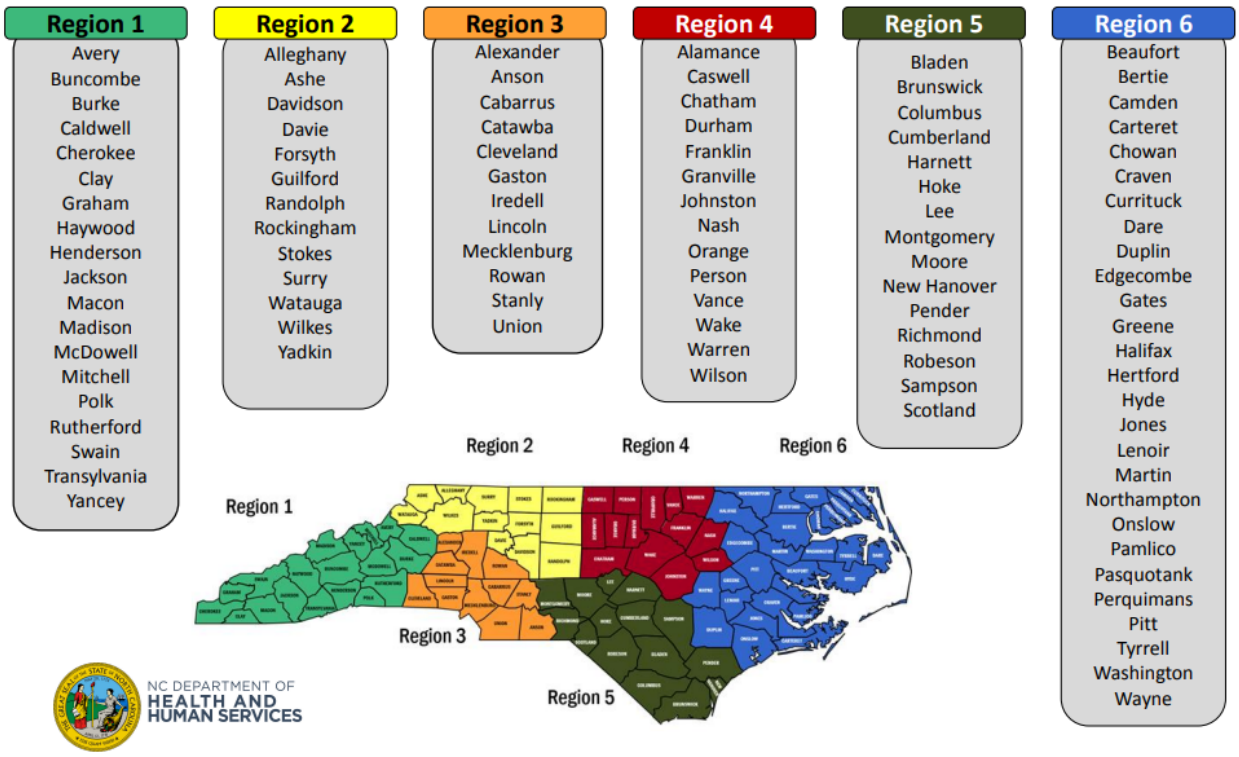
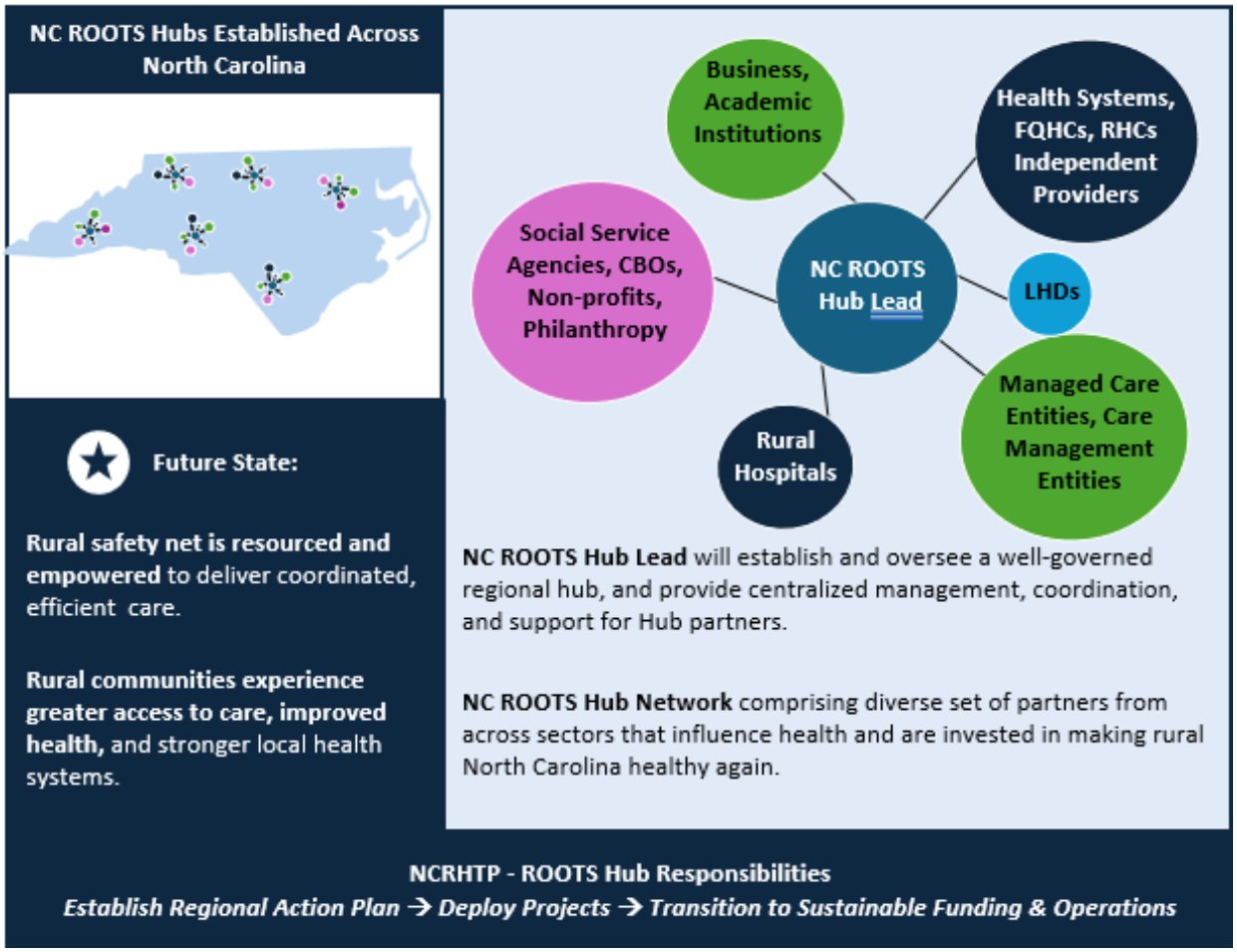


Figure 3: NCRHTP ROOTS Hub Structure



For each NCRHTP initiative, the Hub Lead will develop a Hub Action Plan to implement the projects most aligned with community needs, as determined through the community needs assessment and in coordination with the Hub Network, to ensure that the NC ROOTS Hub can meet the corresponding key performance objectives for the initiatives and NCRHTP outcomes. NCDHHS will require Hubs to coordinate closely with other community partners identified in each Initiative Key Stakeholder list.

NCRHTP Success Measures

At a program level, the NCRHTP uses a structured performance framework that links initiatives to measurable outcomes and metrics, supported by baselines, targets, and timelines. Each initiative includes specific indicators that demonstrate progress toward statewide goals such as improved access, quality, workforce stability, and financial sustainability. ROOTS Hub Leads will align their regional strategies with these program-level measures by reporting on required metrics based on the initiatives and activities carried out, establishing regional baselines, and contributing to statewide targets. Data sources include state dashboards, electronic medical records (EMR) systems, referral platforms, and self-reported hub data, ensuring consistency and accountability across all hubs. This alignment guarantees that local activities roll up to the NCRHTP's overarching objectives and performance

benchmarks. See *Appendix B* for NCRHTP's full list of programmatic indicators[2]. For the purposes of this RFA and applicant's consideration, there are also illustrative metrics at activity level.

III. SCOPE OF SERVICES

Applicants through this request for applications (RFA) must demonstrate the infrastructure, knowledge, experience, and capacity to serve as a regional NC ROOTS Hub Lead ("Hub Lead"). Applicants will serve as the programmatic and fiduciary lead for their selected region and build a ROOTS Hub Network to successfully implement the NCRHTP initiatives outlined below in Section III.A.

The NC ROOTS Hub Lead entity will serve as the anchor organization for a designated rural region, responsible for establishing, governing, and coordinating a cross-sector network ("Hub Network") to implement the NCRHTP initiatives. The Hub Lead will ensure that all activities are tailored to local needs, advance access to care, and coordinate sustainable improvements in rural health outcomes.

Initiative 1, in which the Hub Lead establishes the ROOTS Hub, is the foundation upon which all other NCRHTP work is built.

At a high level, the primary responsibilities of the Hub Lead include:

- Build and manage a regional network of partners, Hub Network, to carry out NCRHTP initiatives in support of North Carolina meeting its key performance objectives at the regional level.
- Coordinate the region's strategy, governance, and day-to-day operations, in line with guidance from NCDHHS.
- Establish the NCROOTS Hub governing body, ensuring community and stakeholder voices are represented, including those from disproportionately burdened and historically underrepresented communities.
    - Create and implement a regional Hub Action Plan, which outlines regional needs, informed by and reflecting input from community stakeholders, including those entities identified as key stakeholders in each of the NCRHTP initiatives.
    - The Hub Action Plan will detail how the Hub will implement the NCRHTP Initiatives and achieve NCRHTP key performance objectives to meet local needs and address barriers to accessing care, including preventive services.
- Leverage grantmaking and reimbursement infrastructure to distribute and track funding across the Hub Network.
- Provide technical assistance (TA) and training to support the Hub Network in implementing the Hub Action Plan. Areas of TA may include, but are not limited to, managing strategy, data, and communications; distributing funding; and providing practice and technical support.
    - TA is defined as providing targeted support to an organization to build capacity. TA involves communication with the organization and should be delivered over the course of the project period.
    - TA should be collaborative to identify underlying needs, targeted to determine needs, flexible, responsive to the unique needs of the organization and demonstrate improvement. TA can be one-on-one or in small group settings. TA can be provided in person or by phone, email, or other online methods such as web-conferencing.
- Track Hub Action Plan progress, collaborate on a routine cadence with NCDHHS to problem-solve and ensure progress, and ensure program integrity and compliance with NCRHTP requirements.

[2] NCDHHS has proposed 31 program-level measures to CMS. These may continue to evolve in discussions with CMS and other stakeholders.

- Overseeing routine monitoring and oversight of the Network to ensure adherence to all requirements.
- Convene community stakeholders to share progress, challenges, and lessons learned.
- Collaborate with other Hub Leads and establish best practices that promote long-term sustainability.
- Develop a sustainability plan for maintaining improved health and access beyond the five-year project period.
- The following table is a list of illustrative deliverables that will be expected from the successful applicant(s) in the first three months of implementation.

1st Quarter Anticipated NC ROOTS Lead Entity Deliverables

Deliverable	Expanded Definition
Needs Assessment	Comprehensive, data-driven analysis of regional health infrastructure, workforce, and service gaps. Includes quantitative metrics (e.g., provider-to-population ratios, travel times) and qualitative stakeholder input. Outcome: prioritized list of needs and barriers to guide the Hub Action Plan.
Hub Action Plan	Strategic roadmap detailing implementation of NCRHTP initiatives. Must outline goals, timelines, responsible parties, measurable outcomes, and integrate stakeholder feedback. Aligns with state guidance.
Agreement / Contracts	Agreements and/or contracts issued to community members, providers, community-based organizations, academic/training institutions, certified community behavioral health clinics, and behavioral health providers for the provision of services to or on behalf of the Hub Lead.
Governing Body Composition	Documented governance structure with representation from disproportionately burdened communities. Includes a clause requiring **30-day prior notification** for any changes. Specifies decision-making processes and stakeholder engagement mechanisms.
Draft Grants Manual	Detailed guide for grantmaking and reimbursement processes. Includes assessment criteria, operating procedures for network partners, compliance requirements, and reporting protocols.
Engagement Plan	Structured approach for ongoing stakeholder engagement. Defines frequency and format (e.g., town halls, surveys), feedback incorporation processes, and communication strategies for transparency.
Data Management & Network Monitoring Plan	**Data Management:** Standards for data collection, storage, sharing, privacy, and security. **Network Monitoring:** Metrics for tracking Hub performance and partner compliance, reporting cadence to NCDHHS, and corrective action procedures. Applicants must clearly describe how they will maintain transparent communication about data use, ensure meaningful benefit to communities, and uphold accountability mechanisms that foster a collaborative and consultative partnership.
Sustainability Plan	Outlines strategies for maintaining Hub operations beyond the five-year project period, including funding diversification and long-term governance.
Technical Assistance Framework	Specifies training and resource support for network partners to implement the Hub Action Plan effectively. Includes an Attestation from the Hub Lead documenting agreement to engage with and participate in technical assistance provided by NCDHHS.
Risk Management Plan	Identifies potential risks (e.g., funding shortfalls, partner attrition) and mitigation strategies to ensure continuity of program progress.
Care Pathway Standards & Referral System	Evidence-based protocols for clinical, behavioral, and social care integration. Includes design for cross-sector referral capabilities and technology requirements.

Community Partnerships and Cultural Responsiveness

North Carolina is home to diverse communities, including eight (8) state-recognized Tribes, two (2) of which are federally recognized; the Eastern Band of Cherokee Indians (EBCI) and Lumbee Tribe of North Carolina; as well as other communities that have historically experienced health disparities and barriers to care. Many of these communities face disproportionate health burdens and unique challenges related to access, trust, workforce challenges, and longstanding systemic factors that have shaped health outcomes over time.

NCDHHS is committed to meaningful partnership with Tribal nations and with communities across

North Carolina that have experienced persistent health gaps. Sustainable improvements in rural health outcomes require authentic collaboration, shared decision-making, and leadership from the communities most affected.

ROOTS Hub Leads must demonstrate the ability to build and sustain strong partnerships with Tribal governments, community-based organizations, local leaders, and other trusted entities within historically underserved communities. In regions that include Tribal populations or other communities with distinct cultural identities and needs, Hub Leads are expected to show capacity for culturally responsive programming, inclusive governance structures, and community-informed implementation strategies that respect Tribal sovereignty, local leadership, and over-all community voice.

These requirements are woven throughout the RFA to ensure that partnership, cultural responsiveness, and community-driven approaches are reflected in governance, planning, workforce development, data practices, and service delivery. Hub Leads must demonstrate how they will foster trust, strengthen collaboration, and tailor initiatives to improve health outcomes for all rural communities they serve.

A. NCRHTP Initiatives

For each initiative where the Hub Lead is directly responsible for implementation and oversight, the Hub Lead will develop a Hub Action Plan establishing a regionally tailored approach to support North Carolina's achievement of NCRHTP performance objectives. The Hub Action Plan is expected to reflect both initiatives required by NCDHHS and those most aligned with addressing the needs of the region, as determined with the Hub Network partners that are jointly accountable for achieving the key performance objectives of each initiative. NCDHHS will require Hubs to coordinate closely with other community partners such as regional Certified Community Behavioral Health Clinics (CCBHCs) for the provision of mental health and substance use services, for which CCBHCs are anchors in the community.

1. NCRHTP Initiative 1: Build Rural Community Care Network "ROOTS Hub"

Initiative 1 establishes the six (6) North Carolina Rural Organizations Orchestrating Transformation for Sustainability ("NC ROOTS") Hubs across the state.

1a. **Operationalize ROOTS Hub Lead**: Hub Leads must stand up their governance structure and begin recruiting network members. The governance structure must be representative of the regional infrastructure supporting the totality of the NCRHTP initiatives. This diverse mix of organizations, providers, and community partners should reflect the geographic, demographic, and service landscape of the region. The network should encompass key stakeholders from across sectors, such as healthcare, behavioral health, social services, community-based organizations, and others, ensuring that the perspectives and needs of the region's varied communities are meaningfully included in planning and implementation. The intent is for the Hub Network to mirror the unique characteristics and priorities of the region, fostering equitable and locally responsive solutions. All applicants must identify whether their proposed ROOTS Hub region includes: (1) federally recognized Tribal lands, (2) state-recognized Tribal communities (Coharie, Haliwa-Saponi, Lumbee Tribe of North Carolina, Meherrin, Occaneechi Band of the Saponi Nation, Sappony, Waccamaw Siouan, Eastern Band of Cherokee Indians - state recognition), (3) Urban Indian populations who maintain cultural and community connections.

Key operational and governance activities include:

1a.i. Develop and oversee a governance structure that includes representation from disproportionately burdened communities including representation from Tribal communities, where applicable, and incorporates ongoing stakeholder feedback.

1a.ii. Incorporate government-to-government collaboration protocols for federally recognized Tribes and formal engagement processes for state-recognized Tribes.

1a.iii. Facilitate regular (at least quarterly) engagement with stakeholders to inform Hub strategy and operations.

1b. **Conduct Needs Assessment and Develop Hub Action Plan**: Within the first three months of implementation, Hubs must conduct a Regional Needs Assessment that maps existing clinical, behavioral health, social support, and digital infrastructure, identifies service gaps, and quantifies access barriers such as travel time, workforce shortages, and unmet demand. The Hub Lead is encouraged to leverage existing assessments (i.e. Community Heath Assessments, the North Carolina Data Portal and Community Health Improvement Plans) and must validate that the assessments are current and address all identified areas of need. Hub leads should engage their stakeholders to ensure the assessment reflects lived experience and local priorities. Each proposed project must be supported by data from this assessment. *Appendix B highlights potential data sources and existing resources to support this assessment.*

1b.i Within the first three months of implementation, produce a data-driven, region-specific priority Hub Action Plan, which is a living document that guides which services and providers need to be strengthened, expanded, or newly developed to meet community needs and provide adequate access to services. Where applicable, explicitly identify Tribal populations and health disparities.

1b.ii. Identify community-based initiatives to close gaps in services and improve outcomes.

1.b.iii. Develop a Tribal Engagement Plan if Tribal communities are present, detailing:

- Initial and ongoing consultation timelines.
- Decision-making protocols ensuring Tribal input influences Hub strategy including defining selection process (e.g., Tribal council appointment).
- Documentation and transparency measures.
    - Require dedicated governance seats for Tribal representatives, proportional to Tribal population in the region.
- Establish conflict resolution processes respecting Tribal sovereignty if disagreements arise between Hub and Tribal partners.

Outcome: Data-driven prioritization of rural health interventions within region; Evidence-based proposals that align with NCDHHS outcome measures and local needs; Improved targeting of funds to high-impact projects, reducing duplication and increasing ROI.

Metrics:

- Completion of regional needs assessment reports.
- Number of data sources analyzed (claims, workforce data, social determinants, provider capacity).
- Number of stakeholder engagement sessions conducted per region.
- Number of individuals and types of entities engaged in sessions.
- Identification of priority gaps aligned with NCDHHS outcome measures (e.g., access, quality, equity).
- Where applicable, governance representation must be proportional to Tribal population in region and sufficient to ensure genuine Tribal voice in Hub decision-making. Tokenistic representation (e.g., one Tribal seat on 20-person board in region where 30% of population is AI/AN) is inadequate.

1c. **Develop the Hub Network**: Hub Leads will ensure that there is regional access to essential infrastructure that promotes rural health, in alignment with target outcomes for NCRHTP. This will be done by identifying gaps, opportunities for capacity building, and leveraging contracting authority to maintain and monitor the network. The high-quality network of rural health care entities and community partners, includes but is not limited to safety net providers (hospitals, FQHCs, LHDs, RHCs), behavioral health providers, community-based organizations (CBOs), academic institutions, and community members. *See Table 1 below for detailed expectations for Hub Network responsibilities.*

1c.i. Based on regional needs assessment, define a regional service model for the continuum of care (primary care, pediatric care, maternity, behavioral health, chronic disease, SUD Treatment, mobile services, etc.)

1c.ii. Evaluate the existing network of rural health facilities, local providers, CBOs to determine how well they align with the regional service model. Include Tribal health departments, Indian Health Service facilities, and urban Indian programs where applicable.

1c.iii. Identify community-based initiatives and funding opportunities to close gaps in the Hub Network.

1c.iv. Coordinate with NCDHHS and other stakeholders (e.g., Managed Care Organizations (MCOs)) to close gaps in the network.

1c.v. Consult with stakeholders and governance board to ensure the Hub network reflects community needs. Programming and implementation must be culturally responsive and tailored to populations experiencing health disparities and barriers to care. For example, this may include adapting evidence-based interventions to align with community values and lived experiences; and ensuring services are accessible to individuals with language barriers, including those for whom English is a second language or who use American Sign Language (ASL), through appropriate interpretation, translation, and communication supports.

1c.vi Use the Regional Needs Assessment and Hub Action Plan to inform required and additional projects in Initiatives 2-6.

1d. **Develop Care Pathways and Connections**: Hub Leads will work with stakeholders and network to develop or adopt standardized evidence-based care pathways across the region. The goal is to create integrated systems of care and communication that support seamless coordination among medical, behavioral health, and social service providers.

1d.i Support usage, adoption or implementation of consistent standards for clinical, behavioral health and social care protocols and pathways.

1d.ii Promote integrated care delivery by fostering collaboration and information-sharing among providers, moving beyond referrals to coordinated care planning and joint problem-solving. This includes supporting primary care practices in implementing collaborative care models for managing common mental health conditions (e.g., depression, anxiety, ADHD), in partnership with NCDHHS and technical assistance providers.

1d.iii Develop strategies for ensuring care pathways and referral systems are accessible and effective for providers with less mature system capabilities, offering targeted support and capacity-building, as needed.

Initiative 1 Key Stakeholders:

- NCDHHS
- Community members
- Rural hospitals
- Local Health Departments (LHDs)
- Federally Qualified Healthcare Centers (FQHCs)
- Rural Health Centers (RHCs)
- Private physician practices
- Certified Community Behavioral Health Clinics (CCBHCs)
- Care management entities
- Medicaid Managed Care Organizations (MCOs)
- Commercial Payors
- Licensing Boards
- Provider Associations
- Health & hospital systems
- Community-based organizations (CBOs)
- Social service agencies
- Community Health Workers (CHWs)
- Philanthropic organizations
- Tribal communities (including, but not limited to, Federally Recognized Tribes)
- Academic institutions
- Local businesses
- Other private sector entities

Initiative 1 Outcomes: The proposed activities under Initiative 1 are designed to strengthen the infrastructure, partnerships, and operational capacity needed to transform rural health delivery. The selected metrics below track the sequential and reinforcing steps of this transformation. Together, they measure how well the Hubs are being stood up, how representative their networks are, how effectively they are deploying community-specific solutions, and whether those solutions are improving care coordination and access for patients. The ROOTS Hubs established under Initiative 1 will serve as regional anchors for the expanded primary care (including pediatrics), prevention, and chronic disease management efforts described in Initiative 2, as well as additional activities under other initiatives. *See Appendix B for NCRHTP-level outcomes and metrics for Initiative 1.*

Table 1: Detailed Summary of ROOTS Hub Lead and Network/Participant Expectations

ROOTS Hub Lead	**ROOTS Hub Network**
Description	
The Hub Lead will establish and oversee the ROOTS Hub, providing centralized management, coordination, and support for the Hub Network to promote preventive health, address chronic disease and root causes of disease.	The Hub Network is a unique set of partners* from across sectors that influence health and are invested in making rural North Carolina healthy. The Hub Network is administered by the Hub Lead to implement the NCRHTP initiatives through a series of Hub-defined projects.
Responsibilities	
Hub Leads' responsibilities include: • Building its Hub Network, a high-quality network of rural health care entities and other community partners in its region, that have the capacity and expertise to implement NCRHTP Initiatives at the regional level.	Hub Network partner responsibilities include: • Agree to participate in the Hub Network and bring expertise to bear in implementing the NCRHTP Initiatives within the region

• Acting as a coordinating entity to unify and align the Network by establishing the Hub's governance structure, guiding the Hub's regional strategy, and overseeing Hub operational roles and responsibilities in a manner consistent with state guidance. • Including representation from disproportionately burdened communities within the governing body. • Incorporating stakeholder feedback into the governance structure. • Soliciting ongoing (at least quarterly) stakeholder feedback on Hub Network composition, channels for engagement, effectiveness of engagement, etc. • Including Stakeholders such as: community members, providers, CBOs, academic and training institutions, CCBHCs and behavioral health providers. • Collaborating with its Network to develop a Hub Action Plan, outlining how the Hub will implement the NCRHTP Initiatives based on local needs and barriers to accessing care, including preventive services. • Developing a grantmaking and reimbursement infrastructure, outlining payment protocols and procedures, and tracking funds for its Network. • Providing technical assistance and training to support the Network in implementing the Hub Action Plan. Areas of technical assistance may include, but are not limited to, managing strategy, data, and communications; distributing funding; and providing practice and technical support. • Measuring the Hub's progress on the Hub Action Plan using a set of shared measures • Submitting required reports within specified timelines to NCDHHS. • Overseeing routine monitoring and oversight of the Network to ensure adherence to all requirements. • Sharing progress and learning with other Hub Leads and adopting best practices throughout the duration of the five-year program period, and beyond.	• While remaining independent, support the Hub's regional strategy and adhere to any governance requirements as defined by the Hub Lead. • Contribute to the development of the Hub Action Plan for implementing the NCRHTP Initiatives • Implement the Hub Action Plan within the partner's area of expertise • Adhere to any payment protocols and procedures as defined by the Hub and maintain accurate accounting of used funds • Assess internal capacity to provide accessible services to people with disabilities, including physical, communication, and digital access • Participate in Hub-related training and technical assistance efforts • Use information systems as needed to support implementation of the Hub Action Plan • Track and report data to Hub Lead on shared measures assessing the Hub's progress on the Hub Action Plan • Comply with routine monitoring and oversight requirements as defined by the Hub
* While the composition of each Hub Network may vary based on the Hub Action Plan, it must include rural safety net providers, such as rural hospitals, LHDs, FQHCs, RHCs, independent practitioners, providers, care management entities, and Medicaid managed care organizations. Additional partners include, but are not limited to, community partners that have deep knowledge of the issues affecting the community and that can support the Hub, such as CBOs, social service agencies, CHWs, philanthropic organizations, local businesses, and community members.	

2. NCRHTP Initiative 2: Create Models & Capacity for Expanded Primary Care, Prevention, and Chronic Disease Management

Initiative 2 creates programs and supports for rural communities to address priority public health issues in three areas: 1) Perinatal Health, 2) Chronic Disease, Prevention, Cancer and Physical Fitness, and 3) Food is Medicine. NC ROOTS Hubs will each pursue projects which closely align with the needs of their community and address three (3) focus areas: Perinatal Health, Chronic Disease, and Food Is Medicine.

2a. Perinatal Health:

The ROOTS Driven Perinatal Health Access Expansion initiative aims to build a coordinated perinatal care system and expand access in maternity-care deserts by strengthening consultation and transfer systems. ROOTS Hub Leads will identify regional partners best positioned to improve perinatal health

access in underserved areas, with a focus on populations who experience disparate maternal health outcomes and addressing service gaps.

There are three (3) required components to the Perinatal Health Access Expansion workstream which all ROOTS Hubs must implement. In addition, ROOTS Hubs may choose one to two (1-2) additional components from a list of six electives to implement in their Region, based on their needs assessment. See Table 2 for a list of required and optional Perinatal Health Components. More detail for each component follows Table 2.

Table 2: Initially Planned Perinatal Health Components
Components are denoted as required or elective

Project	Purpose / Key Activities
Required Component: LOCATe Analysis	Partner with Hub Network to use the Level of Care Assessment Tool (LOCATe), a web-based instrument developed by the Centers for Disease Control & Prevention (CDC) to assist states and entities in evaluating and standardizing levels of care for maternal and neonatal outcomes. to determine the capacity of network partners, identify gaps, and opportunities for improvement.
Required Component: Expand Access in Maternity Care Deserts	Strengthen consultation and transfer systems and work with a consortia of academic and AHEC partners (ECU, UNC, MAHEC, etc.) to customize regional approaches that scale AI-enabled ultrasound technology, simulation-based emergency obstetric training, and emergency medical services obstetric training. Conduct environmental scan of maternity services within the region and determine gaps in service provision.
Required Component: Plan and Implement "I Gave Birth" Initiative – Hospital level	The "I Gave Birth" Initiative focuses on increasing access to resources and support needed to navigate the early postpartum period. The general public and medical personnel who do not routinely see postpartum women lack knowledge of complications that can occur following delivery. Access to such knowledge is key to reducing maternal mortality and morbidity. Birth hospitals participating in the "I Gave Birth" initiative provide education and a bracelet to postpartum women before discharge from hospital. The bracelet serves as a visual reminder to the postpartum woman of the potential complications during the postpartum period, while also alerting medical personnel of the unique care needs of the postpartum patient. The "I Gave Birth" initiative provides standardized education to health care professionals to enhance the care that women of childbearing age receive. The aim of the initiative is to increase awareness of the warning signs of postpartum risks and to facilitate a prompt recognition of post-birth complications. This also includes follow up with pregnant and/or postpartum women to determine program impressions.
Elective Component: Perinatal Project ECHO	Virtual mentoring network linking rural obstetrical and postpartum care providers with academic specialists to improve screening, trauma-informed care, and coordination. Also, supports patients receiving care with providers in their own rural communities to assist with reduced travel and trust building. Participation in this program would involve partnership with an entity trained in the ECHO model.
Elective Component: Academic Regional Obstetrical Collaborative (AROC)	Places academic obstetricians in community hospitals while maintaining university affiliation to expand local maternity capacity, for example as currently implemented at East Carolina University.

Elective Component: Implement Community Health Worker (CHW) – Doula Model	The CHW-Doula Program offers extended, intensive peer support to women and families throughout pregnancy, during labor and birth, and in the immediate postpartum period. The CHW will: • Be trained to provide educational information to pregnant women on childbirth preparation, lactation, and postpartum care. • Provide referrals and connect women and families with local health and human services, child care, and prenatal and postnatal care providers. • Facilitate the connection between the pregnant women to the doula. The Birth Doula will: • Facilitate up to two (2) prenatal contacts with the pregnant woman to discuss birth preferences and desires before birth. • Facilitate the pregnant woman and her family to develop rapport with the birth team when admitted to the hospital. • Provide continuous labor support during the birth to include culturally competent information, emotional and physical support. • Complete at least one postnatal contact to debrief and assess the mother's level of satisfaction with the birth experience.
Elective Component: Breastfeeding education and support	Breastfeeding is the best source of nutrition for most infants and can reduce the risk of certain health conditions for both infants and moms. This strategy would establish a current Community Health Worker (CHW) breastfeeding effort or enhance an existing CHW effort to include breastfeeding, to provide additional support and education for breastfeeding women.
Elective Component: Group Prenatal Care	Group prenatal care, currently reimbursable by Medicaid (Centering Pregnancy, Supportive Pregnancy Care, etc.) is an approach where eight to ten (8–10) pregnant women meet with their provider and other pregnant women for ten (10) group sessions over the course of their pregnancy. Group sessions are 90 minutes – two (2) hours in length and consist of health assessments, facilitated group discussion and interactive activities and education on timely health topics. Data supports those women have experienced positive birth outcomes by participating in the group prenatal care model.
Elective Component: Postpartum Patient Navigation	Support patient navigation programs that include postpartum visit appointment scheduling and patient reminders. Patient navigation provides personalized support to help individuals overcome barriers, like transportation, cost, or complex information, to access timely and quality health care acting as a bridge between patients and the system to improve outcomes and access to health services. Navigators offer non-clinical guidance, connecting patients to resources, explaining diagnoses, and advocating for their needs across the entire care journey. The Postpartum Patient Navigation programs should include, but are not limited to, appointment scheduling and patient reminders, whether via telephone, text-messaging, or email. (patient preference), to increase postpartum visit attendance rates.

Required Perinatal Health Components

LOCATe Analysis

Strategy: Plan and Implement the CDC's Maternal and Neonatal Levels of Care Assessment Tool (LOCATe) with local birthing hospitals.

Outcome: Establish a team of representatives from birthing hospitals in the region to propose a set of recommended criteria for maternal and/or neonatal levels of care for facilities in their respective region, inclusive of collaboration with other regions/hubs.

Metrics:

- Number of people trained in the respective region/hub/on LOCATe.
- Number of birthing hospitals that complete the updated LOCATe survey.
- Percent of level of care verification process/review that included representations from community partners.

Expand Access in Maternity Care Deserts

Strategy: Conduct an environmental scan of maternity care deserts and maternity service challenges, strengthen consultation and transfer systems and work with a consortia of academic and AHEC partners to customize and scale technologies.

Outcome: Improved access to maternity care services in rural communities.

Metrics:

- Number of pregnant and postpartum women who participated in the environmental scan.
- Number of AI-enabled ultrasound examinations performed in rural primary care and pediatric care settings.
- Percent clinician confidence scores in managing obstetric emergencies assessed pre- and post-simulation training.
- Number of EMS personnel trained in emergency obstetrical care across rural counties.

"I Gave Birth" Hospital-Level Initiative

Strategy: Hubs work with birthing hospitals in region to plan and implement "I Gave Birth" Initiative. The "I Gave Birth" initiative focuses on increasing access to resources and support, increase awareness and prompt recognition of post birth complications.

Outcome: Established procedures or workflows in Emergency Department that include identifying patients who have been pregnant or given birth within the past year.

Metrics:

- Number of birthing hospitals that implement the initiative within the region.
- Number of hospital staff trained on Post Birth Warning Signs.
- Number of first responders trained on Post Birth Warning Signs.

Elective Perinatal Health Components

Perinatal ECHO Project

Strategy: Implement a Perinatal ECHO (Extension for Community Healthcare Outcomes) project.

Outcome: Survey participating providers to assess overall impact of ECHO sessions to provider practice and/or referral patterns.

Metrics:

- Number of individuals trained using the ECHO model. (There is separate training for being a facilitator in Project Echo)
- Number of ECHO sessions conducted with local perinatal providers.
- Number of providers attending each ECHO session.

Academic Regional Obstetrical Collaborative (AROC)

Strategy: Implement an Academic Regional Obstetrical Collaborative (AROC) as a means of addressing perinatal provider shortages.

Outcome: Reduce distance for travel by pregnant and postpartum women to care.
Metrics:

- Number of obstetricians deployed to community hospitals
- Number of hospitals participating in AROC program

Community Health Worker (CHW) – Doula Model
Strategy: Implement Community Health Worker (CHW) – Doula Model.
Outcome: Percent of participants who report increased support and satisfaction with their perinatal experiences due to education provided and doula support.
Metrics:

- Number of pregnant participants recruited and enrolled in the program.
- Number of participants who receive continuous labor support by a doula.
- Number of pregnant participants who complete a perinatal education course, inclusive of birth preparation, postpartum care and post birth warning signs education by the CHW.

Breastfeeding Education & Support
Strategy: Implement Community Health Worker (CHW) breastfeeding effort to include breastfeeding, in order to provide additional support and education for breastfeeding women.
Outcome: Percent increase in breastfeeding initiation.
Metrics:

- Number of CHWs trained to provide breastfeeding education and support.
- Number of parents who receive CHW education and report improved partner support for breastfeeding.
- Number of new breastfeeding friendly community spaces or workplaces/employers established.

Group Prenatal Care
Strategy: Implement group prenatal care to support positive birth outcomes.
Outcome: Percent of participants who report increased satisfaction with their prenatal care experience.
Metrics:

- Number of pregnant women participating in group prenatal care.
- Number of provider sites that offer group prenatal care.
- Number of pregnant women who attend at least 80% of the group prenatal care sessions.

Postpartum Patient Navigation
Strategy: Support postpartum patient navigation programs.
Outcome: Percent of health care systems and payers that report improved postpartum care quality, outcomes, and patient experience through the integration of patient navigation programs.
Metrics:

- Number of health care systems, clinics, and practices that implement patient navigation programs for postpartum visit appointment scheduling and reminders.
- Number of patient navigators trained and deployed to provide appropriate support for postpartum visit scheduling, reminders, and care coordination.
- Number of partnerships and referral pathways established between patient navigation programs, health care providers, payers, and community-based organizations to support seamless postpartum care coordination.

2b. Chronic Disease, Prevention, Cancer and Physical Fitness:

NC ROOTS Hubs will undertake projects to increase access, patient education, and care coordination infrastructure to reduce health disparities and strengthen rural provider capacity. To ensure a consistent, evidence-based approach to chronic disease prevention across all ROOTS Hub regions, each Hub Lead will be required to increase access to, and utilization of, evidence-based chronic disease prevention and self-management programs.

There are four (4) required components to the Chronic Disease, Prevention, Cancer and Physical Fitness activity which all ROOTS Hubs must implement. In addition, ROOTS Hubs may choose one to two (1-2) additional components from a list of six electives to implement in their Region, based on the regional needs assessment. See Table 3 for a detailed list of required and optional Chronic Disease, Prevention, Cancer and Physical Fitness Components.

As detailed in Section III.A.1b., each NC ROOTS Hub lead will conduct a structured gap assessment to evaluate disease burden, and the availability, accessibility, and utilization of evidence-based programs for the prevention and management of chronic conditions and related risk factors, including diabetes, hypertension, cancer, tobacco/nicotine use, and physical inactivity based upon regional data.

Each region should use existing data sources, such as Community Heath Assessments, the North Carolina Data Portal and Community Health Improvement Plans. Based on the findings, regions will identify priority areas for strengthening program delivery and outreach and detail in their Hub Action Plans. Each region's approach must include a provider education and engagement strategy designed to:

- Increase awareness of available programs
- Improve referral workflows through electronic health record (EHR) integration
- Offer training on eligibility criteria and referral processes
- Promote culturally and linguistically appropriate outreach materials
- Expand health care team for chronic disease management (i.e. pharmacists, CHWs, EMTs)

Funding for Initiative 2.b. Chronic Disease, Prevention, Cancer and Physical Fitness is anticipated to be awarded as follows:

Table 3: Chronic Care/Prevention Initially Planned Components
Components are denoted as required or elective

Project	Purpose / Key Activities
Required Component: Risk Factor Gap Assessment	Conduct a structured gap assessment to evaluate disease burden, and the availability, accessibility, and utilization of evidence-based programs for the prevention and management of chronic conditions, including diabetes, hypertension, tobacco/nicotine use, and cancer based upon regional data. Based on the findings, regions will identify priority areas for strengthening program delivery and outreach.
Required Component: Provider Education and Engagement Strategy for Chronic Disease Prevention & Management	Design and implement a program to increase awareness of available programs, improve referral workflows such as through EHR integration; Train and equip rural providers to identify Medicare patients and provide supports to connect patients to resources and services that will help to age in place and prevent clinical events that lead to disability and/or situations where spend down into Medicaid is needed. For residents that do qualify, services to connect into dual-eligible plans will be provided. NCDHHS will provide technical assistance for linkages to existing services and networks for training.
Required Component: Expand Health Care Team for Chronic Disease Prevention & Management	Conduct training and outreach with providers to expand services, such as tobacco/nicotine treatment program specialists, integrating nutrition support, and enhancing cancer screening outreach and follow-up within primary care and community settings.

Elective Component: Diabetes Services Expansion	Train and equip rural providers and FQHCs to deliver Diabetes Self-Management Education and Support (DSMES), Diabetes Prevention Program (DPP), and Family Healthy Weight Programs (FHWP) across the lifespan. This includes deployment of Facilitated Remote DSMES in rural areas lacking internal capacity, and integration with the FHWP through electronic referral systems to increase the enrollment of children and families.
Elective Component: Hypertension Reduction Initiative	Scale self-measured blood-pressure (SMBP) programs and embed into clinical workflows, embed evidence-based workflows in rural practices, train CHWs and community pharmacists in the Healthy Heart Ambassador Program-Blood Pressure Self-Monitoring model.
Elective Component: Rural Tobacco-Free Futures	Partner with existing LHD-based tobacco collaboratives to identify and respond to gaps in tobacco/nicotine use and vaping cessation efforts, including QuitlineNC referrals, and training rural providers in tobacco-treatment protocols.
Elective Component: Sickle Cell Extension for Community Healthcare Outcomes (ECHO) Network	Tele-mentoring that links rural providers with hematology specialists to deliver evidence-based care for individuals living with sickle cell disease (SCD) in rural communities. This will connect community-based providers with interdisciplinary expert teams through regular virtual clinics. Collaborative arrangements should be made with at least one of the six (6) comprehensive sickle cell medical centers in the state. These subject matter experts will lead bi-monthly ECHO sessions focused on evidence-based standards of care, hydroxyurea therapy, pain management, stroke prevention, mental health, and transition to adult care. Each session will feature case-based learning, concise didactic presentations, and peer-to-peer dialogue, fostering a dynamic environment that builds clinical confidence and promotes consistency in care. Partnerships with community-based organizations and stakeholders will ensure that regional needs and patient perspectives are integrated throughout the program. By expanding access to expertise and strengthening local provider capacity, this model offers a scalable, cost-effective solution for chronic disease management in rural North Carolina
Elective Component: Cancer Prevention and Care Coordination	Coordinate with existing mobile units to deliver high priority (based on regional data) cancer and chronic disease screenings, embed CHW-led outreach and navigation, provide telehealth consultations with specialists, and establish formal referral agreements among FQHCs, CAHs, and diagnostic centers. These integrated efforts will expand access to care and ensure timely follow-up.
Elective Component: Physical Activity Access & Integration	Implement evidence-based physical activity programs in rural communities. Train CHWs and local partners to deliver or refer to these programs. Embed physical activity referrals into EHR workflows. Partner with schools, YMCAs, and senior centers to expand reach.

Required Chronic Disease, Prevention, Cancer and Physical Fitness Components

Risk Factor Gap Assessment

Strategy: Conduct and maintain a comprehensive regional assessment to guide initiative implementation including:

- Chronic disease burden and risk factors to include cancer, diabetes, hypertension, tobacco use, physical inactivity, and sickle cell disease prevalence
- Availability and utilization of screening and diagnostic services
- Availability and utilization of community resources and chronic disease management programs including Diabetes Self-Management Education and Support (DSMES), Diabetes Prevention Program (DPP), and Family Healthy Weight Programs (FHWP) Healthy Heart Ambassador

Program-Blood Pressure Self-Monitoring, referrals for tobacco/nicotine cessation (i.e. Quitline).
- Availability of nutrition supports, including coverage of food banks, food pantries, etc.
- Workforce capacity to support chronic disease management and referral infrastructure
- Social and geographic barriers to care
- Identification of priority population and geographic service area based on assessment results

Outcome: Plan developed to address chronic disease condition(s) and priority population(s) is created based on assessment.

Metrics:
- Number of completed assessments or pre-existing assessments referenced.
- [Reduction in] the % of adults in the target rural population reporting three or more chronic health conditions.
- [% increase in] # of patients who are offered/received SMBP out of those eligible.

Provider Education & Engagement Strategy for Chronic Disease Prevention & Management

Strategy: Develop and execute a plan to engage providers in implementing strategies to improve referral processes, care coordination, and workforce capacity including:
- Providing education, training, and technical assistance to health care providers on:
  - Evidence-based prevention, screening and treatment guidelines
  - Available chronic disease prevention and management resources within region
  - Referral eligibility and workflows, including, for those near Dual-Eligibles
  - Culturally and linguistically appropriate care
- Support implementation of EHR-based referral and tracking systems
- Identifying Medicare patients and provide support to connect patients to resources and services that will help to age in place and prevent clinical events that lead to disability.

Outcome: Increase in health care providers following evidence-based guidelines and referring patients to culturally and linguistically appropriate resources within the region.

Metrics:
- Number of health care providers trained on evidence-based guidelines, referral eligibility and workflows, and culturally appropriate care.
- Number of sites implementing standardized referral workflows.

Expand Health Care Team for Chronic Disease Prevention & Management

Strategy: Conduct training and outreach with providers to expand services for chronic disease management and follow-up within primary care and community settings.
- Chronic disease areas include but are not limited to diabetes, tobacco management, cancer screenings, nutrition support integration, heart disease & stroke prevention.
- Promote team-based care models for chronic disease management.
- Recruit, train, and support:
  - Community Health Workers (CHW)
  - Patient Navigators
  - Pharmacists and Allied Health Professionals
  - Community Members

Outcome: Increase in health care providers who are implementing team-based care for chronic disease management.

Metrics:
- Number of provider staff recruited and trained.

Elective Chronic Disease, Prevention, Cancer and Physical Fitness Components

Diabetes Services Expansion:

Strategy: Implement and expand pre-diabetes/diabetes education and prevention programs by equipping organizations with training, technical assistance, and recognition support; increase access through remote Diabetes Self-Management Education and Support (DSMES) services and electronic referrals; collaborate with Federally Qualified Health Centers (FQHCs) to implement Family Healthy Weight Programs.

Outcome: Remote DSMES is launched in region and organizations are implementing onsite diabetes education and prevention programming.

Metrics:

- Number of organizations trained to implement Facilitated Remote Diabetes Self -Management Education Support Services (FRDSMES)

Hypertension Reduction Initiative:

Strategy: Partner with rural health care providers to design and implement standardized Self-Measured Blood Pressure (SMBP) workflows for identifying and managing hypertension in adults and integrate evidence-based programs and digital tools to improve patient education, care coordination, and health outcomes.

Outcome: Rural health care providers establish standardized SMBP workflows and patients are referred to evidenced-based programs.

Metrics:

- Number of health care providers trained on SMBP workflows.
- Number of allied professionals trained on evidence-based blood pressure management programs, such as Health Heart Blood Pressure Self- Monitoring initiative.

Rural Tobacco Free Futures:

Strategy: Partner with existing tobacco collaboratives to identify and respond to gaps in tobacco/nicotine use cessation efforts, implement evidence-based media campaigns, and build public-private partnerships to expand tobacco/nicotine cessation access for rural residents. Collaborate with rural health systems and community partners (e.g., schools) to integrate best-practice cessation protocols.

Outcome: Increased number of clinical and community that are implementing evidenced-based protocols to tobacco cessation.

Metrics:

- Number of providers trained on evidence-based tobacco treatment Programs.
- Number of evidence-based media programs implemented within the Region.
- Number of established public-private partnerships to expand tobacco/nicotine cessation access for rural residents.

Sickle Cell Extension for Community Healthcare Outcomes (ECHO) Network:

Strategy: Implement a Perinatal ECHO program to link rural providers with hematology specialists to deliver evidence-based care for individuals living with sickle cell disease.

Outcome: Reduction in emergency department visits for preventable complications for people living with sickle cell disease.

Metrics:

- Number of individuals living with sickle cell disease served.
- Number of rural health providers participating in the ECHO.

- Number of sickle cell comprehensive medical centers participating in the ECHO.

Cancer Prevention and Care Coordination:

Strategy: Establish and manage a regional cancer prevention and early detection network, increase access to mobile, virtual and telehealth services, address non-medical barriers such as transportation and insurance navigation.

Outcome: Patients are aware of and have access to cancer management and support services.

Metrics:

- Number of partner organizations participating in regional cancer prevention and early detection network.
- Number of health care systems implementing strategies to increase access to cancer management and support services (i.e., mobile health clinics, telehealth and virtual visits) in high-need rural areas.

Physical Activity Access & Integration:

Strategy: Collaborate with local organizations to expand access while engaging communities to identify priorities and barriers. Implement media campaigns, educate health care teams on physical activity benefits, and train volunteers to lead community-based programs promoting chronic disease management and overall well-being.

Outcome: Increase awareness and access to physical activity opportunities.

Metrics:

- Number of physical activity programs, opportunities, and resources in high need areas.
- Number of public awareness/education messages disseminated.

2c. Food is Medicine:

NC ROOTS Hubs will lead and coordinate a comprehensive "Food is Medicine" strategy. The strategy is expected to consider the coordination of nutrition supports with other non-medical drivers of health needs in each region, e.g. transportation access and housing insecurity. *NCRHTP funds may not be used to pay for meals or food as it is considered an unallowable cost to CMS. Hub Leads may use funds to support infrastructure and capacity-building efforts that enable nutrition access in rural communities*. As such, all activities associated with this initiative should be designed to build sustainable infrastructure and capacity for rural North Carolinians to experience healthier lives. By creating strategies that focus investments on nutrition access and education infrastructure development, coordination, training, and systems – NC ROOTS Hubs will ensure these efforts are sustainable and locally responsive. Key approaches may include:

2c.i. Build infrastructure to support expansion of healthy grocery box and meal initiatives.

Strategy: Build partnerships, establish contracts, and develop grants that support infrastructure needed to connect patients and families to nutrition supports, including connecting to organizations that distribute healthy food boxes and nutrition education through CBOs (e.g., food pantries, food banks, and clinics).

Outcome: Increase in food services provided from baseline, which support whole-person health by investing in more robust food and nutrition infrastructure that is intentionally connected to the traditional health care sector (i.e. physical and behavioral health).

Metrics:

- Number of established agreements with local entities which support the sustainable enhancement of nutrition infrastructure in all covered counties.
- Number of eligible organizations receiving grants.

- Number of individuals accessing nutrition supports, as a result of the infrastructure.

2c.ii. Strengthen NC Regional Food Hubs and facilitate farm-to-hospital, mobile food markets, and community-based food access.

Strategy: Invest in locally based entities that enable food infrastructure, farmers, community food pantries, technology, and logistics to more effectively coordinate whole-person health by addressing non-medical drivers of health, including delivering fresh, local, and culturally relevant foods. Possible strategies include, but are not limited to, establishing infrastructure for mobile food markets, farmers market SNAP/WIC-match voucher access (e.g., Double Bucks programs), and farm-to-hospital programs.

Outcome: Increase in the capacity of NC Regional Food Hubs to provide services due to infrastructure improvement.

Metrics:

- Number of investments made to strengthen local food infrastructure.
- Number of eligible organizations receiving grants to strengthen and sustain their infrastructure.
- Increase in the capacity of NC Regional Food Hubs.
- Number of individuals accessing nutrition supports, as a result of the infrastructure.

2ciii. Build local capacity.

Strategy: Expand CBO and CHW capacity to provide supports that address non-medical drivers of health, like evidence-based nutrition education curricula, empowering families with practical knowledge such as food preparation, budgeting, and making healthy choices regardless of budget or location.

Outcome: Build locally based infrastructure which leverages North Carolina based providers that have operated in the state for at least two years prior to onboarding.

Metrics:

- Number and percentage of eligible organizations receiving grants.
- Number of people served, as a result of the infrastructure.

2c.vi. Leverage electronic referral and tracking systems.

Strategy: Connect individuals experiencing non-medical drivers of health like food insecurity, housing insecurity, and transportation insecurity to resources using a closed-loop referral infrastructure. Monitor usage of resources and ensure efficient program evaluation.

Outcome: Connect patients to supports for non-medical drivers of health.

Metrics:

- Number of technical assistance opportunities made available to providers (in-person, virtually, etc.).
- Number of providers meaningfully using referral system as part of their routine workflow (including referrals to SNAP and WIC programs).
- Increased number of unique referrals to address non-medical drivers of health.

Initiative 2. Key Stakeholders:

- Health Care Providers:
  - Rural primary care, pediatric, and specialty care providers,
  - Rural hospitals,

    - Local Health Departments (LHD)s,
    - Federally Qualified Health Centers (FQHCs),
    - Community Health Centers (CHCs),
    - Emergency Departments (EDs),
    - Emergency Medical Services (EMS),
    - Community Health Workers (CHWs).
    - Program of All-inclusive Care for the Elderly (PACE)
- Community & Support Organizations:
    - Tribal communities
    - Local community collaboratives,
    - Community Based Organizations (CBOs),
    - Faith-based organizations,
    - Local farmers,
    - Food banks,
    - Community organizations.
    - Personal Care Services (PCS)

Initiative 2 NCRHTP-level Outcomes: Proposed metrics for Initiative 2 capture how expanded access to perinatal care, strengthened chronic disease management, increased tobacco cessation, and improved nutrition infrastructure work synergistically to prevent avoidable hospitalizations and promote whole-person health for rural North Carolinians. *See Appendix B for NCRHTP-level outcomes and metrics for Initiative 2.*

3. NCRHTP Initiative 3: Expand and Integrate Behavioral Health and Substance Use Disorder Services

Initiative 3 aims to expand access to high-quality, community-based behavioral health services in rural communities through a coordinated set of regional initiatives anchored in the Certified Community Behavioral Health Clinic (CCBHC) model. CCBHCs provide a comprehensive range of mental health and substance use services including therapy, psychiatric care, peer support, crisis services, and care coordination. These entities are designed to address the full spectrum of behavioral health needs. Through the NCRHTP, the State will expand CCBHC reach into rural areas in close coordination with regional ROOTS Hubs, strengthening behavioral health infrastructure and tailoring services to meet unique rural needs.

The initiative will expand and enhance access to critical assessment, treatment, and crisis response services through multiple evidence-based models. This includes creating new rural CCBHCs, launching statewide quality improvement efforts, expanding First Episode Psychosis programs, integrating rural crisis centers, scaling Mobile Outreach Response Engagement and Stabilization (MORES) teams who serve children experiencing behavioral health crisis, expanding school-based health centers, and increasing access to medications for opioid use disorder through mobile and co-located opioid treatment programs. Together, these efforts will reduce reliance on emergency departments, improve continuity of care, and address severe behavioral health provider shortages in rural communities.

In addition, North Carolina will leverage innovative and non-traditional workforce models to connect residents to care, including expanding the NC MATTERS perinatal mental health program and paramedic-initiated medication-assisted treatment following overdose. By integrating technology, mobile care, and community-based partnerships, this initiative positions North Carolina to set a national

standard for integrated, fair, and sustainable rural behavioral health care.

While the ROOTS Hub Lead is NOT directly responsible for the implementation or management of Initiative 3, its role is to coordinate, communicate, and align efforts to maximize impact and ensure seamless access to behavioral health care for rural residents.

- The Hub Lead shall serve as a coordinating entity, working collaboratively with the North Carolina Department of Health and Human Services (NCDHHS), Local Management Entities-Managed Care Organizations (LME-MCOs), Certified Community Behavioral Health Clinics (CCBHCs), and other relevant partners.
- The Hub Lead will be responsible for ensuring that network partners, such as LME-MCOs, and community members have awareness of and access to appropriate behavioral health services, including referral pathways, and will support integration of these services into the broader regional strategy.

4. NCRHTP Initiative 4: Build a Robust & Resilient Workforce & Innovative Care Team Models for Rural Communities

Under Initiative 4 of the NCRHTP, ROOTS Hub Leads will serve as regional coordinators for workforce development activities designed to build a robust, resilient, and sustainable rural health workforce. Hub Leads will work in partnership with universities, community colleges, rural hospitals, career and technical education programs, and community-based organizations to establish and support Regional Rural Training Hubs that organize and deliver comprehensive workforce development support across their regions.

The Initiative 4 workforce activities are critical to address North Carolina's persistent rural health workforce shortages, which are driven by uncoordinated and fragmented programming, limited training sites and faculty shortages, and placement and retention challenges. Through coordinated regional action, Hub Leads will:

- Expand existing programs to support education, training, and placement into rural communities for more high-need provider types.
- Ensure sufficient staff/faculty to educate (precept, train, etc.) students.
- Translate “train” into “retain.” Keeping people in rural health positions where turnover is currently high, including high school outreach programs such as the NC Chamber High School to Healthcare program; and
- Leverage data and community insight to tailor solutions to regional specific needs and ensure culturally-responsive approaches.

4a. Establish Regional Rural Training Hubs.

Hub Leads will establish Regional Rural Training Hubs that organize and deliver a broad menu of technical support, training, and administrative services to bolster the rural health care workforce across their region. Training Hubs will be coordinated via the ROOTS Hubs, with programs led by regional partners including rural hospitals, universities, community colleges, K-12 career and technical education departments, and other rural community-based groups. Key activities include:

4a.i. The selected NC ROOTS Hub Lead will coordinate efforts to establish or expand rural residency and fellowship programs in high-need medical specialties across the region. This includes partnering with rural hospitals, academic medical centers, and training institutions; such as UNC System universities, North Carolina AHEC, and regional universities and HBCUs (e.g.,

Elizabeth City State University, Western Carolina University, Appalachian State University, and UNC Pembroke); to identify gaps in Graduate Medical Education (GME) capacity and develop a pipeline to address those workforce shortages. The Hub Lead will also support rural hospitals and health systems in building the infrastructure, faculty supports, and administrative capacity required to host accredited residency and fellowship programs, with a specific focus on specialties identified as high need (*See Table 4*). As part of this effort, programs supported through NCRHTP are expected to incorporate a service commitment requiring participating residents and fellows to practice in rural North Carolina communities for up to five (5) years following completion of training, consistent with program design and applicable requirements.

4a.ii. The NC ROOTS Hub Lead will coordinate the provision of simulation-based training opportunities for medical trainees and practicing clinicians to prepare for high-acuity, low-occurrence clinical events, including obstetric emergencies and trauma. The Hub Lead will organize interprofessional training experiences that foster collaborative, team-based care among physicians, nurses, pharmacists, social workers, paramedics, and other health professionals. This work will support regional access to high-quality simulation training across the continuum of care, ensuring that rural providers are able to maintain competency in critical clinical skills despite geographic and resource constraints. In addition, the Hub Lead will promote community-based, interprofessional training models that support innovative approaches to care delivery, including shared maternity care models, community paramedicine, and care models anchored by Community Health Workers (CHWs).

4a.iii. The NC ROOTS Hub Lead will support efforts to increase the number of qualified training sites and clinical teaching faculty/preceptors across the region by providing technical assistance, training supports, and start-up and operating funding to expand training capacity. This includes supporting the recruitment and retention of clinical teaching faculty and preceptors in rural settings where shortages limit the ability to train and develop the future workforce. The Hub Lead will work in partnership with rural practices, hospitals, and Federally Qualified Health Centers (FQHCs) to build readiness and achieve accreditation as training sites for students in medicine, nursing, behavioral health, and allied health professions. In addition, the Hub Lead will address barriers to clinical training in rural communities by supporting infrastructure improvements, faculty development, and the administrative capacity needed to sustain clinical education programs.

4a.iv. The NC ROOTS Hub Lead will build and coordinate outreach, education, and clinical practice pipelines that guide students from high school and community college through health career pathways and into rural clinical practice, with an emphasis on long-term retention. The Hub Lead will partner with regional K–12 career and technical education departments to develop and strengthen health career pathway programs, including collaboration with established models such as the NC Chamber High School to Healthcare program. In addition, the Hub Lead will work closely with North Carolina Community Colleges System (NCCCS) campuses within the region and engage NCWorks Career Centers to connect jobseekers with education, training, and career services, including access to braided funding for tuition and work-based learning opportunities. The Hub Lead will support the development of culturally responsive health workforce pipelines, including those serving Tribal communities, in collaboration with local high schools and community colleges, and will prioritize “grow your own” strategies that recruit students from rural communities who are more likely to remain and practice in those communities.

4a.v. The NC ROOTS Hub Lead will coordinate the development of workforce pipeline programs that prepare individuals for careers in high-need professions, including six priority provider

categories identified as critical shortage areas. This work will include supporting certification and training programs aligned to regional workforce needs and creating career ladder opportunities within professions, including advancement pathways for key administrative roles such as practice managers. The Hub Lead will also coordinate strategies such as paid internships, tuition-free certification opportunities, and employment incentives and placement services to strengthen recruitment and retention. Where applicable, these pipeline supports will be structured to encourage long-term rural workforce stability, including incentives tied to a five-year rural service commitment.

Table 4. Initiative 4 Initial Focus Areas for High Needs

Primary Care Providers	Specialists	Oral Health	Nurses, Caregivers & Allied Health Professionals	Mental Health & Substance Use Professionals	Emergency Medical Services
Physician Assistants (PAs), Nurse Practitioners (NPs) Medical Doctors (MD and DOs)	Psychiatry, Maternal Health (OB/GYN, Midwives, Doulas from Initiative 2a.)	Dentists; Dental Hygienists	Licensed Practical Nurses (LPNs), Registered Nurses (RNs), Nurse Anesthetists (CRNA), Direct Care Workers, Pharmacists, Pharmacy Technicians, Surgical, Radiology, Lab Technicians CHWs	Social Workers, Peer Support Specialists	Paramedics, Emergency Medical Technicians (EMTs)

Rural Clinical Workforce Incentive Package

Strategy: Implement a Rural Clinical Workforce Incentive Package with a 5-year service commitment.

Outcome: Reduced rural vacancy and turnover; Improved continuity of care; Expanded access to primary and specialty services.

Metrics:

- Number of clinicians recruited to rural sites using program signing 5-year commitment for funds.
- Time-to-fill for rural vacancies; vacancy rate by region/provider type.
- 12-, 36-, and 60-month retention rates; utilization of incentives by type.
- Provider-to-population ratios in target areas.

Child Care Subsidies for Rural Clinicians

Strategy: Establish and implement Child Care Subsidies for Rural Clinicians.

Outcome: Higher retention and improved work-life stability for rural clinicians; Increased clinic capacity and reliability of scheduled services; Enhanced attractiveness of rural posts for family-based recruits.

Metrics:

- Number of clinicians receiving child care support.
- Retention differential between clinicians who receive subsidized child care vs. clinicians who do not receive subsidized child care.

4b. Support expansion of the Rural Behavioral Health Workforce Development Certification:

This statewide program expands the Qualified Professional (QP) Certification Program in partnership with the North Carolina Community College System (NCCCS) to strengthen the behavioral health workforce in rural and underserved counties. While the ROOTS Hub Lead is NOT responsible for the direct implementation, the Hub Lead will coordinate regional implementation of the Behavioral Health Workforce Development Certification Program within its region, including partnership with NCCCS community college campuses to deliver paid work-based learning experiences and tuition-free certification opportunities. The Hub Lead will connect participants with regional behavioral health

employers to support employment placement and will provide ongoing support to program graduates serving in designated rural communities. The Hub Lead will ensure training emphasizes rural practice competencies, integrated care delivery models, telehealth and tele-behavioral health, and trauma-informed approaches. In addition, the Hub Lead will track placement and retention of graduates in rural behavioral health and substance use treatment roles and will coordinate employment placement support and tuition reimbursement for participants who commit to serve in designated rural communities.

4c. Expand Social Work Rural Scholars Program:

This statewide initiative will support the expansion of the Social Work Rural Scholars Program, which is designed to train and retain a new generation of social workers to serve rural and frontier communities across North Carolina. The program will leverage paid field placements and tuition reimbursement for undergraduate and graduate students who commit to careers supporting rural behavioral health, substance use, and aging services. While the ROOTS Hub Lead is NOT responsible for the direct implementation, the NC ROOTS Hub Lead will coordinate regional partnerships with universities offering Bachelor of Social Work (BSW) and Master of Social Work (MSW) programs to place students in rural field placements within the region. The Hub Lead will identify and support field placement sites including behavioral health providers, substance use treatment programs, aging services organizations, integrated care practices, and other eligible community-based settings; and connect participants with mentors and supervisors in rural practice environments. The Hub Lead will also ensure program participants receive specialized training in rural practice competencies, tele-behavioral health delivery, and workforce resiliency and burnout prevention. In addition, the Hub Lead will support program graduates who commit to five (5) years of rural service post-graduation within the region and will track placement and retention of licensed social workers in high-need rural counties.

4d. Coordinate Community Doula and Community Health Worker Program

This program will develop and coordinate a Community Doula and Community Health Worker (CHW) model to expand appropriate perinatal support in rural communities. While the ROOTS Hub Lead is NOT responsible for the direct implementation, the NC ROOTS Hub Lead will recruit, support, and coordinate CHWs who will serve as frontline outreach staff to raise awareness of maternal health programs and recruit pregnant women as early as possible through social media, community events, and presentations to trusted community settings such as churches, schools, and provider organizations. The Hub Lead will support CHWs in facilitating opportunities for social support among pregnant, postpartum, and interconception women and will connect CHWs with doulas to ensure coordinated, team-based perinatal support. In addition, the Hub Lead will coordinate doula training and certification for rural deployment, assign doulas to provide primary perinatal support within the region, and ensure doulas operate collaboratively to provide continuous labor support with backup coverage as needed. The Hub Lead will support doulas and CHWs in maintaining consistent contact with participants from the prenatal period through postpartum and will integrate doula and CHW services with clinical prenatal and postpartum care providers. The Hub Lead will also ensure services are culturally responsive and appropriate for the diverse populations served including communities of color, Tribal communities, and non-English speaking populations – by building sustained community presence, trust, and authentic engagement.

4e. Support Expansion of Emergency Medical Services (EMS) Professionals

This program will support the expansion of Emergency Medical Services (EMS) professionals to address significant and worsening workforce shortages in rural communities. While the ROOTS Hub Lead is NOT responsible for the direct implementation, the NC ROOTS Hub Lead will coordinate regional training programs for Emergency Medical Technicians (EMTs) and paramedics, partnering with community colleges within the region that offer EMS education and certification pathways. The Hub

Lead will support targeted recruitment of individuals from rural communities into EMS training programs and will coordinate employment placement with rural EMS agencies, fire departments, and local health care systems. To promote long-term workforce stability, the Hub Lead will provide retention supports such as mentorship, continuing education, and career advancement opportunities, and will track placement of newly trained EMS professionals serving rural communities within the region.

Initiative 4. Hub Leads **will** coordinate workforce development activities in partnership with diverse regional stakeholders. **Key stakeholders for engagement include:**

- NC Department of Commerce & NCWorks Commission
- The NC Community College System (NCCCS)
- The University of North Carolina System (including ApprenticeshipNC)
- NC AHEC
- NC's extensive network of rural hospitals including those in the HRSA FLEX and SHIP Programs
- NC Healthcare Association
- North Carolina Department of Public Instruction
- North Carolina Independent Colleges & Universities (NCICU)
- Community-based organizations

Initiative 4 NCRHTP-level Outcomes: The outcomes and metrics for Initiative 4 are designed to measure progress toward building a sustainable rural health workforce and care team infrastructure across North Carolina. By tracking the launch of new rural residency and fellowship programs, the placement of CHWs and EMS professionals, reductions in clinician vacancy rates, and improvements in primary care clinician ratios, these metrics ensure that each activity contributes to long-term workforce stability and capacity. Hub Leads will be responsible for tracking and reporting on Initiative 4 outcomes and metrics at the regional level. *See Appendix B for NCRHTP-level outcomes and metrics for Initiative 4.*

Additional Process Metrics Hub Leads Must Track:

- Number of individuals enrolled in each workforce development program (by profession/program type)
- Number of individuals completing training/certification programs
- Number of individuals placed in rural employment
- Retention rates of providers at 1 year, 3 years, 5 years post-placement
- Number of qualified training sites established or enhanced
- Number of clinical faculty/preceptors recruited
- Demographic characteristics of workforce program participants (race/ethnicity, gender, rural origin, etc.) to assess diversity and health equity impact

Note-Reporting Frequency: Hub Leads will submit required reports to NCDHHS within specified timelines (to be detailed in Hub Lead contract).

5. **NCRHTP Initiative 5: Ensure Fiscal Sustainability of Rural Health Providers Through Innovative Financial Models**

Initiative 5 will provide technical assistance, infrastructure funding, and capacity building to ensure the long-term sustainability of rural health providers and hospitals, including building the foundation for

future value-based payment (VBP) opportunities to build capacity for rural primary care and pediatric care providers and hospitals to participate in VBP. VBP shifts health care payments from volume to value – rewarding providers for delivering high-quality, coordinated care rather than the number of services rendered. This approach is especially beneficial in rural settings, where providers often face financial instability and fragmented care systems.

NCRHTP will launch complementary programs to support the long-term sustainability of North Carolina's rural hospitals and primary care and pediatric care providers:

- Funding for hospital feasibility studies and hospital redesigns to best position hospitals supporting rural communities for long-term sustainability.
- Capacity building for rural health care providers and hospital networks – including Critical Access Hospitals (CAH), regional partner hospitals, and primary care providers – to successfully participate in VBP.
- A Medicaid primary care/pediatrics capitation pilot to provide an opportunity for rural primary care providers to test an advanced value-based payment program.

NC ROOTS Hub Leads will leverage their core capabilities of stakeholder engagement, grant making and reimbursement infrastructure, and technical assistance in support of the activities in Initiative 5. This will include administering VBP capacity building funds, facilitating stakeholder engagement and communication, and overseeing and promoting shared learning across regions to accelerate best practice adoption.

5a. Hospital Financial Sustainability and VBP

Under initiative 5, Hub Leads will support hospital-focused activities related to understanding the opportunity for capacity building within rural health care providers and hospital networks to plan for long-term financial sustainability and/or successfully participate in VBP. Initially this will include funding for hospital feasibility studies followed by additional VBP investments in future years.

5a.i Hospital Feasibility and TA

Starting in budget period 1, ROOTs Hub Leads will play a critical role in sustaining rural health access by conducting and/or funding hospital feasibility assessments and, where appropriate, guiding facility redesign. Applicants must demonstrate the capacity to perform or organize the following activities in alignment with industry standards and program goals.

Identify Eligible Hospitals - Feasibility studies will apply to hospitals which demonstrate they serve rural communities (*see II. Background, Defining "Rural")*

1. Hospitals must also be designated as Critical Access Hospitals (CAHs) or Prospective Payment System (PPS) hospitals. Hub Leads will be responsible for engaging with these hospitals to understand opportunities for feasibility studies. The rural hospital or CAH must attest to their ability and plans to implement the recommendations from the study.
2. **Prioritize Hospitals for Funding -** ROOTs Hub Leads must establish a transparent process to determine which hospitals in their region should be prioritized. This process must include:
    a. Population Need Analysis: Evaluate demographic, health, and access indicators.
    b. Operational and Financial Feasibility: Assess likelihood of continued viability.
    c. Collaborative Prioritization: Convene hospitals and stakeholders to align on priorities.
    d. Justification: Provide clear rationale for ranking.
3. **Submit Prioritized Hospitals and Approach –** Based on the above process, ROOTs Hub Leads will submit the following to NCDHHS prior to receiving funding for feasibility studies:
    a. A prioritized list of hospitals.

b. A detailed approach, partnerships, and budget for feasibility studies for each identified hospital. The approach should align to industry standards to include but not limited to:
    i. Market & Community Needs Assessment
    ii. Operational and Financial Feasibility
    iii. Service Line Assessment
    iv. Recommendations & Implementation Roadmap
4. **Execute Approved Approach –** Upon NCDHHS approval, Hub Leads will receive funding to implement the feasibility study using the approved approach and partnerships.
5. **Facility Redesign Planning -** Based on feasibility study findings, Hub Leads will work with partners and hospitals to determine if facility redesign is necessary. A redesign proposal, including scope, partnerships, and budget, must be submitted to NCDHHS for approval prior to implementation. The hospital much attest to its ability to implement the recommendations from the study. The approach should align to industry standards including but not limited to:
    a. Facility Condition Assessment
    b. Space Utilization & Right Sizing- Analysis
    c. Clinical Workflow & Patient Flow Redesign
    d. Programmatic / Service Line Architecture
    e. Technology, Infrastructure & Equipment Modernization
    f. Cost Estimation & Capital Planning
    g. Debt financing capacity
    h. Implementation Roadmap

5a.ii Rural Hospital Financial Sustainability and VBP Capacity Building:

In addition to hospital feasibility studies in Award Period 1, Hub Leads will also be expected to assess the opportunity for future investment in hospital VBP models. This should include engaging with hospitals, the Hub Network and NCDHHS on provider and market readiness for value-based models.

Through stakeholder and hospital engagement in Award Period 1, ROOTs Hub Leads will be expected to submit proposals to NCDHHS on how future VBP investment can improve outcomes and long-term term sustainability of the hospitals in the region. These proposals should include but are not limited to the following information:

- Readiness of existing hospitals to support VBP arrangements
- Needed investments in technology, staff or financial tools to support VBP
- Opportunities to partner with payers to support VBP
- Outlook for VBP to improve outcomes and long-term sustainability of hospitals in the region

While no funding is available for hospital VBP capacity building in Award Period 1 at this time, inputs from Hub Leads during Award Period 1 will inform future funding to cover anticipated VBP activities for future RHTP grant awards from CMS.

5b. Primary Care Capitation Pilot:

NC ROOTS Hubs will leverage their core capabilities of stakeholder engagement, grantmaking and reimbursement infrastructure, and technical assistance in support of the primary care capitation pilot in Initiative 5b. This pilot is intended to improve the value of rural health care services, including improving quality of care and supporting the sustainability of rural primary care/pediatric practices. Hub activities will include administering VBP capacity building funds to participating providers, facilitating stakeholder engagement and communication, and overseeing and promoting shared learning across regions to accelerate best practice adoption.

NCDHHS, via NC Medicaid, aims to launch a primary care capitation pilot for rural providers beginning in 2028.

NC Medicaid will implement this pilot through its contracted managed care organizations. ROOTS Hubs will support technical assistance, disbursement of infrastructure funding, and facilitating stakeholder engagement for successful primary care participation. The Hubs will:

- Support stakeholder convenings to gather feedback on VBP model design and ensure regional input informs program development, in partnership with the Department and other vendors.
- Assist with communications to regional stakeholders related to VBP activities and updates, including supporting recruitment of practices for participation in the pilot.
- Manage disbursement of infrastructure funds to primary care practices to support readiness for participation in primary care capitation model. Responsibilities include:
    - Establishing criteria for fund eligibility in coordination with the Department and in accordance with CMS criteria.
    - Developing an application and assessment process for potential recipients.
    - Determining fund recipients and allocation amounts in collaboration with the Department and practice support vendor.
    - Disbursing funds to approved recipients.
    - Monitoring appropriate use of funds and conducting a final accounting.
- Collaborate with practice support vendor to facilitate successful engagement of participating practices in the primary care capitation pilot, including quality improvement.
- Coordinate activities with other regional ROOTS Hubs to ensure the consistent application of Medicaid requirements statewide and implement a streamlined processes for Hub VBP activities that align across all hubs. This includes aligning workflows, documentation, and reporting practices to maintain uniformity and reduce variation in program execution.
- Facilitate collaboration between primary care capitation pilot activities and future rural hospital VBP capacity-building efforts within the hub's region.
- Assist in developing and implementing long-term strategies for sustaining and expanding advanced VBP initiatives beyond NCRHTP funding.

Impact/Outcome Measure for 5b Primary Care Capitation Pilot: Facilitate primary care participation in the capitation model in each Hub region, in collaboration with other regions/hubs, primary care providers, NC Medicaid and its contracted health plans, the NC Office of Rural Health, and other partners supporting VBP advancement. Each Hub will work with the practice support vendor and participating practices to help Department achieve Initiative 5b CMS key performance objectives.

Metrics for 5b Primary Care Capitation Pilot:

- Establish criteria and process for disbursing value-based payment infrastructure funds by October 30, 2026.
- Support one stakeholder convening to gather feedback on VBP model design and ensure regional input informs program development, in partnership with the Department and other vendors by October 30, 2026.
- Number of providers receiving value-based payment infrastructure funds by October 30, 2027.

Year 1 funding to support the Hub work for this initiative (including application development, practice review and selection, administration of provider funding and oversight, convenings, communication and coordination with other hubs, vendors and stakeholders), are included in foundational Hub funding under Initiative 1, as these activities leverage core Hub capabilities of stakeholder engagement, grantmaking and reimbursement infrastructure, and technical assistance.

Initiative 5. Key Stakeholders:

- NC ORH
- NC Medicaid
- NC County EMS Systems
- NC AHEC
- Rural health care providers (including primary/pediatric care) and their representatives
- Support entities (Accountable Care Organizations, Clinically Integrated Networks)
- UNC Sheps Center – Rural Health Research Program
- Managed care entities (MCOs)

Hospitals

Initiative 5 NCRHTP-level Outcomes: The activities under Initiative 5 are designed to pilot and implement innovative financial models that support the fiscal sustainability of rural health providers. By introducing new payment approaches – such as primary care capitation – and building hospital and primary care provider capacity, these efforts aim to create a more stable financial environment for rural hospitals and clinics and higher quality care for rural patients. The outcomes measured in this table, including increased access to preventive and ambulatory care for adults, improved rates of well-child visits, greater participation in value-based payment models, and reduced transfers to urban hospitals, represent the intended results of these approaches. Together, these activities demonstrate how targeted financial innovation can help rural providers maintain essential services, improve community health, and achieve long-term sustainability. *See Appendix B for NCRHTP-level outcomes and metrics for Initiative 5.*

6. **NCRHTP Initiative 6: Modernize Rural Care Delivery Through Digital Forward Solutions**

The ROOTS Hub Lead is <u>NOT</u> responsible for the direct implementation or oversight of digital health infrastructure, technology procurement, or statewide digital health initiatives under Initiative 6.

However, the Hub Lead is expected to coordinate with the NCRHTP and designated state partners to support the adoption and effective use of digital health solutions within the region. This includes facilitating communication between local providers and state-led digital health programs, promoting awareness of available digital tools and resources, and supporting referral pathways that leverage digital solutions to improve care coordination and access.

The Hub Lead should work to ensure that regional partners are informed about and able to participate in statewide digital health initiatives, but the responsibility for technology implementation, maintenance, and evaluation remains with the NCRHTP and its designated partners.

B. Funding Restrictions

The following is a mandated list of funding restrictions, reflecting requirements imposed by the federal funder and state statutes.

1. Funding may only be used for the permissible uses and purposes of the NCRHTP.
2. Funding cannot be used to supplant programs funded by non-federal sources.
3. Applicants must ensure that administrative costs **do not** exceed 10% of the total awarded budget. The 10% administrative cost cap includes all administrative expenses, whether charged as direct or indirect costs. All administrative costs must be included in this calculation and may not exceed the 10% limit.
4. State Salary Cap for Nonprofits: Per NC Session Law 2023-259, Section 5.4., no more than one hundred forty thousand dollars ($140,000) in State funds, including any interest earnings accruing from those funds, may be used for the annual salary of any individual employee of a nonprofit organization. If for any reason the individual working on this program makes over the salary cap amount, the remaining would need to be covered by other funding sources.
5. Federal Salary Limit: The salary of an individual who is doing any work directly related to the RHT Program is subject to the salary rate limit of $225,700. This includes funding going toward paying the salary of individuals of Subrecipients and contractors. This is the maximum amount that can be billed to this program for an individual's salary. If for any reason the individual working on this program makes over the salary cap amount, the remaining would need to be covered by other funding sources.
6. Funding meals, including food costs for community meetings, is not an allowable use of funds.
7. New construction is unallowable. Supplanting funding for in-process or planned construction projects or directing funding toward new construction builds is unallowable.
    a. Creation of bike paths and walking trails are unallowable expenses as they are considered new construction.
8. Minor renovations or alterations and equipment upgrades to existing rural health care facility buildings and infrastructure to ensure long-term overhead and upkeep costs are commensurate with patient volume are allowable but are subject to the restriction listed above in B.1. and subject to State approval.
    a. Total budgeted for minor renovations or alterations may not exceed 20% of the total budget in a given award year.
    b. Prior approval from NCDHHS is required.
9. Funding cannot be used to replace payment for clinical services that could be reimbursed by insurance. If the ROOTS Hub Lead plans to fund direct health care services, they must justify why the payment is 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. Subject to State approval.
    a. Total budgeted for payments for clinical services may not exceed 15% of the total budget in a given award year.

10. Funding cannot be used for broadband infrastructure.
11. No more than 5% of total funding CMS awards to a State in a given budget period can support funding the replacement of an EMR system if a previous HITECH certified EMR system is already in place as of September 1, 2025.
    a. Upgrades, enhancements, and added modules, interfaces, or functionality to existing EMR/EHR systems are allowable uses of funds and are not subject to the 5% limitation.
12. Funding cannot be used for clinician salaries or wage supports for facilities that subject clinicians to non-compete contractual limitations.
13. Workforce Development: Funds used for workforce development must be used to "recruit and retain clinical workforce talent to rural areas for a minimum of 5 years." Therefore, any clinicians recruited or retained under this use of funds must be physically located in rural areas.
14. Funding cannot be used to issue direct student loans or fund student loan repayment programs.
15. General limitations – Funds shall only be used to carry out the purposes of this award (as described in Social Security Administration (SSA) Section 2101 and may not include coverage of a nonpregnant childless adult), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. For purposes of the preceding sentence, a caretaker relative (as such term is defined for purposes of carrying out SSA Section 1931) shall not be considered a childless adult.
16. Funding shall not be used to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion. Exception: This provision shall not apply to an abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
17. Funding shall not be used to make clinical payments for an individual who has, or is, declared to be a citizen or national of the United States for purposes of establishing eligibility under this title unless the State meets the requirements of SSA Section 1902(a)(46)(B) with respect to the individual.

C. Federal Terms and Conditions

These terms and conditions will apply to financial assistance contracts awarded under this federal grant and their subawards or subcontracts.

1. Awards are subject to any applicable provisions of the Code of Federal Regulations, including and 2 CFR 200.332, Requirements for Pass-Through Entities [Recipients/Grantees and Subrecipients/Subgrantees]. Subpart E is excluded. 2 CFR 200.320, Procurement Methods and 2 CFR 200.332, Requirements for Pass-Through Entities [Recipients/Grantees and Subrecipients/Subgrantees]. Subpart E is excluded.
2. Procurements are subject to the "Most Restrictive Rule," wherein if the entity is a public or governmental entity that has more restrictive procurement rules than those in 2 CFR 200.320, the entity must follow the most restrictive procurement rule.
3. See Appendix A, Section 4 for the federal Cooperative Agreement for Rural Health Transformation (RHT) Program Centers for Medicare & Medicaid Services (CMS) Program Terms and Conditions. Per 2 CFR 200.332(b)(2), "All requirements of the subaward, including requirements imposed by Federal statutes, regulations, and the terms and conditions of the Federal award."
4. See Appendix A, Section 5 for Centers for Medicare & Medicaid Services Standard Grant and Cooperative Agreement Terms and Conditions.

D. NCDHHS Terms and Conditions

These terms and conditions will apply to financial assistance contracts awarded by NCDHHS and to any subgrantees or subcontractors.

Note: these terms and conditions do not reflect prescribed differences in clauses specifically for local governments, state agencies, private universities, and the UNC System.

1. See Appendix A, Section 1 for the General Healthcare Terms and Conditions for Nonprofit Entities.
2. See Appendix A, Section 2 for the Privacy & Security Office Terms and Conditions.
3. See Appendix A, Section 3 for the NCDHHS Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement (BAA).

E. Required Reporting

To support overall grant KPIs and measures, along with NCDHHS oversight of the program, NC ROOTs Hub Leads will be responsible for the following reporting activities:

KPIs and Measures Development – The Hub Lead must have the capability to co-develop, refine, and operationalize key performance indicators (KPIs) and measures in partnership with NCDHHS and regional stakeholders. Specific KPIs, benchmarks, and targets will be finalized during the implementation phase and may be modified over the course of the contract. The Hub Lead must demonstrate the ability to operationalize new or revised metrics as directed by NCDHHS.

- Collaborate with NCDHHS to define and adapt KPIs aligned to rural health transformation goals and CMS requirements.
- Modify or expand KPI sets over time to support new initiatives, policy changes, or CMS requirements.
- Document and maintain measure definitions, assumptions, limitations, and data lineage.
- Provide KPI reports and dashboards to NCDHHS.

Program Performance and Oversight - The Hub Lead must maintain the infrastructure and management capacity to monitor, assess, and report on program performance across the ROOTS Hub region and its network partners. Detailed performance measures, reports, review processes, and

oversight protocols will be established during the implementation phase. The Hub Lead must demonstrate the ability to adapt reporting and oversight practices as requirements evolve.

- Collaborate with NCDHHS to establish performance measures and oversight reporting across programs and subrecipients to monitor progress against programmatic goals, milestones, and deliverables.
- Aggregate and synthesize performance information from multiple network partners and data sources to produce performance oversight reports and dashboards.
- Provide program performance and oversight reports to NCDHHS.

Financial and Funds Reporting – The Hub Lead must have the financial systems and controls necessary to ensure transparent, compliant, and adaptable financial reporting for all ROOTS Hub funds. Detailed financial reporting formats, schedules, and compliance requirements will be finalized during the Scope of Work phase and may change over the contract period. The Hub Lead must demonstrate the capacity to respond to updated reporting and oversight requirements.

- Track and report expenditures, budgets, and fund distribution across initiatives and network partners.
- Maintain updated forecasts of budget needs and expenditures over the life of the grant
- Produce regular financial summaries that support fiscal oversight, audit readiness, and performance-based decision-making.
- Monitor subrecipient use of funds and identify material variances, risks, or compliance issues.
- Adjust reporting structures to reflect changes in funding sources, payment models, or program design.
- Provide financial and funds reports to NCDHHS.

For further understanding of KPIs that will be evaluated please refer to NCDHHS' RHTP project narrative.

F. Data and Technology System Capabilities

- Network and Subrecipient Data/Information
    - Subrecipient/Partner registry with canonical record`
    - Contract lifecycle management
    - Standardized onboarding workflows
    - Reporting ingestion, QA and storage

- Funds Distribution and Financial Oversight
    - Grant & sub-award tracking and management (funding source, initiative partner, cost category, etc.)
    - Payment workflows & Cash management
    - Audit trails & document retention
    - Document decision making

- Data Ingestion, Storage and Analytics
    - Data extract ingestion and storage systems and capabilities to analyze program performance, assess opportunities and submit reporting to NCDHHS:
        - Administrative data (EMRs/HIE)
        - Clinical data (EMRs/HIE)
        - Referral data (EMRs/HIE/Social Care Referral Platform)

        - Public health data (TBD)
        - Subrecipient reporting and extracts
    - Analytics and reporting capabilities to support the following:
        - Measurement development
        - Reporting
        - Dashboards and other visualizations
    - Data security and encryption that meets industry encryption standard criteria as defined by NIST and HIPAA Security Standards to encrypt all confidential information including protected health information (PHI) and personally identifiable information (PII) while in transit and at rest to ensure data confidentiality and security.

IV. GENERAL INFORMATION ON SUBMITTING APPLICATIONS

1. **Award or Rejection**
   All qualified applications will be evaluated, and award made to the entity or entities whose combination of budget and service capabilities are deemed to be in the best interest of the funding agency. The funding agency reserves the unqualified right to reject any or all applications if determined to be in its best interest.

2. **Cost of Application Preparation**
   Any cost incurred by an entity in preparing or submitting an application is the entity's sole responsibility; the funding agency will not reimburse any entity for any pre-award costs incurred.

3. **Elaborate Applications**
   Elaborate applications in the form of brochures or other presentations beyond that necessary to present a complete and effective application are not desired.

4. **Oral Explanations**
   The funding agency will not be bound by oral explanations or instructions given at any time during the competitive process or after awarding the grant.

5. **Reference to Other Data**
   Only information that is received in response to this RFA will be evaluated; reference to information previously submitted will not suffice.

6. **Titles**
   Titles and headings in this RFA and any subsequent RFA are for convenience only and shall have no binding force or effect.

7. **Form of Application**
   Each application must be submitted on the form provided by the funding agency. Both the Application Form and Budget and Justification Form may be downloaded in accordance with Sections V.1. and V.2. of this RFA and may be sent to interested entities along with this RFA.

8. **Exceptions**
   All applications are subject to the terms and conditions outlined herein. All responses will be controlled by such terms and conditions. The attachment of other terms and conditions by any entity may be grounds for rejection of that entity's application. Funded entities specifically agree to the conditions set forth in the Subaward (contract).

9. **Advertising**
   In submitting its application, entities agree not to use the results therefrom or as part of any news release or commercial advertising without prior written approval of the funding agency.

10. **Right to Submitted Material**
    All responses, inquiries, or correspondence relating to or in reference to the RFA, and all other reports, charts, displays, schedules, exhibits, and other documentation submitted by the entity will become the property of the funding agency when received.

11. Applying Entity's Representative

Each entity shall submit with its application the name, address, and telephone number of the person(s) with authority to bind the entity and answer questions or provide clarification concerning the application.

12. Subcontracting

Entities may propose to subcontract or subgrant portions of work provided that their applications clearly indicate the scope of the work to be subcontracted or passed through, and to whom.

Subcontractors are vendors hired by the entity via a contract to provide a good or service required by the agency to perform or accomplish specific work outlined in the entity's executed contract with the State.

Subgrantees of the entity are awardees chosen by the agency to receive a portion of the State's pass-through funding to carry out all or a portion of the programmatic responsibilities outlined in the entity's executed contract with the State.

Entities may refer to 2 CFR 200.331 to assist in making the determination.

Each is subject to the State's approval prior to being awarded a contract or agreement from the entity. All Subcontractors and Subgrantees are subject to the funding restrictions and applicable terms and conditions of the Federal award and the State award to the entity. The entity is required to execute written agreements with all Subcontractors and Subgrantees prior to the commencement of any work.

Entities must also ensure that subcontractors are not on the North Carolina Suspension of Funding List, Debarred Vendors List, or Federal Exclusions List.

In accordance with 09 NC Administrative Code 03M.0703 – Required Contract Provisions, information is required for each proposed subgrantee and subcontractor. See Section VII. Application, Attachment L for Subcontractor/Subgrantee Information Form.

13. Proprietary Information

Trade secrets or similar proprietary data which the entity does not wish disclosed to other than personnel involved in the evaluation will be kept confidential to the extent permitted by NCAC TO1: 05B.1501 and G.S. 132-1.3 if identified as follows: Each page shall be identified in boldface at the top and bottom as "CONFIDENTIAL." Any section of the application that is to remain confidential shall also be so marked in boldface on the title page of that section.

14. Contract

NCDHHS will issue a financial assistance contract ("Subaward") to the Subrecipient of the federal funding which will include a negotiated, approved scope of work, performance metrics and milestones, and budget.

Per 09 NCAC 03M .0801, NCDHHS cannot disburse any state financial assistance Subaward to an entity that is on the North Carolina Suspension of Funding List. Nor can NCDHHS contract with entities on the North Caroline Debarred Vendors List (01 NCAC 05B .1520) or the Federal Exclusions List (Sections 1128 and 1156 of the Social Security Act (Act). Entities have the option to request in writing to the Office of State Budget and Management to be removed from the Suspension of Funding List (SOFL) if they believe they have been suspended in error. Once removed from the SOFL, the recipient is eligible for current and future grants.

15. Reimbursement

The NCRHTP operates on a reimbursement basis. This requires the awarded entity to pay for program expenses upfront using their own funds and subsequently request payment from NCDHHS for approved costs. The process is as follows:

- Once a contract is fully executed by both parties, spending may begin.
- The awarded entity ("Grantee") pays for goods, services, or salaries required for the project using its own cash flow.
- The Grantee must meticulously track all expenses, keep receipts, invoices, and payroll records to prove costs are allowable and earned.
- The Grantee submits a reimbursement request to NCDHHS with required documentation of expenses.
- NCDHHS reviews the request and documentation to ensure expenses are allowable and reasonable.
- Once approved, NCDHHS will issue reimbursement payment to the Grantee.

Reimbursement will be made only for costs that are allowable, allocable, and reasonable in accordance with the cost principles set forth in 2 CFR Part 200, Subpart E – Cost Principles, including but not limited to 2 CFR §§ 200.403 (Factors affecting allowability of costs), 200.404 (Reasonable costs), and 200.405 (Allocable costs).

V. APPLICATION PROCESS AND REVIEW

The following is a general description of the process by which applicants will be selected for NCRHTP funding.

1. **Announcement of the Request for Applications (RFA)**
   The announcement of the RFA and instructions for receiving the RFA will be posted at the following NCDHHS website on February 24, 2026: https://www.ncdhhs.gov/about/grant-opportunities/rural-health-grant-opportunities and may be sent to prospective entities via direct mail, email, and/or the Program's website.

2. **Distribution of the RFA**
   RFAs will be posted on NCDHHS website https://www.ncdhhs.gov/divisions/office-rural-health/rural-health-transformation-program and may be sent via email to interested entities beginning February 27, 2026.

3. **Question & Answer Period**
   Written questions concerning the specifications in this Request for Applications will be received until 5:00 p.m. on March 13, 2026. As an addendum to this RFA, a summary of all questions and answers will be placed on the following website: https://www.ncdhhs.gov/divisions/office-rural-health/rural-health-transformation-program by 5:00 p.m. on March 20, 2026. Any questions must be emailed to: dhhs-ncroots.rfa@dhhs.nc.gov.
   Questions directed to any other NCDHHS staff will not be addressed.

4. **Notice of Intent**
   Any entity that plans to submit an application is strongly encouraged to register its intent by 5:00 p.m. on March 6, 2026, by emailing dhhs-ncroots.rfa@dhhs.nc.gov
   Information requested shall include the following:
   - The legal name of the entity.
   - The name, title, phone number, mailing address, and email address of the person who will coordinate the application submission.
   - Briefly describe your entity's mission, history, and core areas of expertise.
   - Briefly describe your entity's experience working in rural North Carolina, particularly with underserved or disproportionately burdened communities.
   - Please include "NC ROOTS Hub RFA Notice of Intent" in the email subject line.

5. **Applications**
   Applicants shall email a PDF version of the full application to dhhs-ncroots.rfa@dhhs.nc.gov. In addition to their application response, applicants should email the excel worksheet of the application budget. Faxed and hand-delivered applications will not be accepted.

6. **Format**
   The application should be single-spaced with 1" margins. Times New Roman, Calibri, or similar font; 12 pt (10 pt for tables/charts).

7. **Space Allowance**
   Page limits are clearly marked in each section of the application.
   Attachments do not count toward page limit. Examples include: Organizational chart, board list, job descriptions, financial statements, letters of commitment.

8. Application Deadline
All applications must be received by 5 p.m. US Eastern Time on April 2, 2026.

9. Receipt of Applications
Applications from each responding entity will be logged with the date and time received. Entities will receive an email that the application has been received.

10. Review of Applications
Applications are reviewed by a multi-disciplinary committee of public and private health and human services subject matter specialists. Staff from applicant entities may not participate as reviewers.

Applications will be evaluated by a committee according to completeness, content, experience with similar projects, ability of the entity's staff, cost, etc. The State reserves the right to conduct site visits as part of the application review and award process. The award of a grant to one entity does not mean that the other applications lacked merit, but that, all facts considered, the selected application was deemed to provide the best service to the State. Entities are cautioned that this is a request for applications, and the funding agency reserves the unqualified right to reject any and all applications when such rejections are deemed to be in the best interest of the funding agency.

11. Request for Additional Information
At their option, the application reviewers may request additional information from any or all applicants for the purpose of clarification or to amplify the materials presented in any part of the application. However, entities are cautioned that the reviewers are not required to request clarification. Therefore, all applications should be complete and reflect the most favorable terms available from the entity.

12. Audit
Please be advised that successful applicants may be required to have an audit in accordance with 09 NCAC 03M .0205. Per 09 NCAC 03M .0205 (amended effective retroactive to July 1, 2024), there are two reporting levels established for recipients and subrecipients receiving grants. Reporting levels are based on the allocated funds from all grants disbursed through the State of North Carolina during the entity's fiscal year. The reporting levels are:

1) Level I – A recipient or subrecipient that receives, holds, uses, or expends grants in an amount less than the dollar amount requiring audit as listed in the Code of Federal Regulations 2 CFR 200.501(a) within its fiscal year.
2) Level II – A recipient or subrecipient that receives, holds, uses, or expends grants in an amount of equal to or greater than the dollar amount requiring audit as listed in 2 CFR 200.501(a) within its fiscal year.

The dollar amount requiring audit listed in 2 CFR 200.501(a) is herein incorporated by reference, including subsequent amendments and editions, and can be accessed free of charge at https://www.ecfr.gov/.

Level II grantees shall have a single or program-specific audit prepared and completed in accordance with Generally Accepted Government Auditing Standards, also known as the Yellow Book G.S. 143C-6-22 and G.S. 143C-6-23 as applicable to the entity's status.

13. Assurances
The contract may include assurances that the successful applicant would be required to execute prior to receiving a contract as well as when signing the contract.

14. Nonprofit IRS Status

Nonprofit agencies applying to this RFA must include a copy of an IRS determination letter regarding the entity's 501(c)(3) tax-exempt status which normally includes the entity's tax identification number, so it would also satisfy that documentation requirement.)

In addition, those private non-profit agencies are to provide a completed and signed page verifying continued existence of the agency's 501(c)(3) status.

15. Federal Certifications

Entities receiving Federal funds are required to execute Federal Certifications regarding Non-discrimination, Drug-Free Workplace, Environmental Tobacco Smoke, Debarment, Lobbying, and Lobbying Activities.

16. Unique Entity Identifier (UEI)

All entities receiving federal funds must have a Unique Entity Identifier (UEI) which is issued by the federal government in SAM.gov.

If your entity does not have a UEI, please use the online registration at SAM.gov to receive one free of charge.

17. Documents Required for Contract Development and Execution

The following documents specific to the applicant entity are required by NCDHHS annually for contract development and must be completed and submitted with the RFA Application. All documents are provided as Attachments in Section VII. of this RFA.

- Documentation of the entity's Tax Identification Number (TIN) or Employer Identification Number (EIN) for all entities.
- Documentation of the entity's Unique Entity Identifier (UEI) for all entities.
- Documentation of the entity's nonprofit status (applies only to nonprofit entities).
- Nonprofit Verification Form (applies only to nonprofit entities).
- Conflict of Interest Policy (applies only to non-governmental entities).
- Conflict of Interest Certification (applies only to non-governmental entities).
- Notarized No Overdue Tax Debts Certification (applies only to non-governmental entities).
- Contractor Certifications required by North Carolina Law for all entities.
- Federal Certifications required by the federal funding agency for all entities.
- Federal Funding Accountability and Transparency Act (FFATA) Data Form for all entities.

Note: At the start of each calendar year, all entities with current NCDHHS contracts are required to update their contract documentation. These entities will be contacted a few weeks prior to the due date and will be provided the necessary forms and instructions.

18. Registration with Secretary of State

Private, non-profit applicants must be registered with the North Carolina Secretary of State to do business in North Carolina. (Refer to: https://www.sosnc.gov/divisions/business_registration)

19. Registration in NC e-Procurement via NC Electronic Vendor Portal (eVP)

Successful applicants (excepting Local Health Departments, which are exempt from this requirement) must be registered in NC eProcurement via the Electronic Vendor Portal (eVP) in order to receive reimbursement payments. This registration does not change your organization's grantee status or how the organization will be treated by NCDHHS.

20. Iran Divestment Act

The Iran Divestment Act of 2015, as amended, prohibits State agencies from investing in or contracting with individuals and companies engaged in certain investment activities in Iran. Any organization identified engaging in investment activities in Iran, as determined by appearing on the Final Divestment List created by the NC Department of the State Treasurer, is ineligible to contract with the State of North Carolina or any political subdivision of the State. Refer to NC General Statutes Chapter 147 Article 6E.

21. Boycott Israel Divestment Policy

The Divestments from Companies Boycotting Israel Act of 2017, as amended, prohibits State agencies from making investments in, and contracts with, companies that are engaged in a boycott of Israel, as defined by this Act. Any organization that boycotts Israel, as determined by appearing on the Final Divestment List created by the NC Department of the State Treasurer, is ineligible to contract with the State of North Carolina or any political subdivision of the State. Refer to NC General Statutes Chapter 147 Article 6G.

22. Application Process Summary Dates

February 27, 2026:	Request for Applications released to eligible applicants.
March 6, 2026:	Notice of Intent due.
March 13, 2026:	End of Q&A period. All questions due by 5pm EST.
March 20, 2026:	Answers to Questions released as an addendum to the RFA.
April 2, 2026:	Applications due by 5pm EST.
May 1, 2026:	Successful applicants will be notified.
June 1, 2026:	Estimated Contract Start Date.

VI. EVALUATION CRITERIA

SCORING OF APPLICATIONS

Applications shall be scored based on the responses to the four (4) application content areas. Maximum score is 510 points.

Content Areas

Section 1: Capacity and Ability - This section is intended to evaluate the applicant's organizational strength and readiness to serve as an NC ROOTS Hub Lead. The purpose is to determine whether the applicant possesses the capacity, systems, and leadership necessary to manage complex initiatives and deliver sustainable outcomes for rural health transformation comprising the following sub-sections:

1-1 Organizational Profile
1-2 Operational Experience
1-3 Data and IT Infrastructure
1-4 Financial practices.
1-5 Quality Improvement
1-6 Key Staff

Total maximum points for Section 1 equals 195.

Section 2: Service Area and Community Context - This section is intended to evaluate the applicant's understanding of the geographic region and community context in which the NC ROOTS Hub will operate. The purpose is to ensure that the applicant can effectively address regional challenges, leverage existing resources, and foster collaborative governance and sustainability for long-term impact. It comprises the following sub-sections:

2-1 Geographic Focus
2-2 Community Needs and Assets
2-3 Network-Building & Collaboration
2-4 Stakeholder Engagement

Total maximum points for Section 2 equals 135.

Section 3: Vision and Approach - This section is intended to evaluate the applicant's strategic vision and preparedness to assume the role of NC ROOTS Hub Lead. The purpose is to ensure that the applicant demonstrates a clear, actionable plan and the capacity to lead regional transformation efforts effectively.

3-1 Proposed Role as Hub Lead
3-2 Challenges & Support Needs
3-3 Governance
3-4 Priority Projects
3-5 Project Workplan (Award Period 1)

Total maximum points for Section 3 equals 120

Budget: This section evaluates the clarity, accuracy, and alignment of the proposed budget with the applicant's planned activities and compliance requirements. Reviewers will assess whether costs are reasonable, justified, and adhere to funding restrictions.

Total maximum points for Budget Section equals 60

Scoring Criteria

Category	Score	Evidence
Excellent	5	Comprehensive, clear, and compelling response. Fully addresses all requirements with strong evidence, examples, data, and alignment. No significant weaknesses.
Strong	4	Thorough response that addresses requirements well. Minor gaps or areas needing clarification but overall strong and credible.
Adequate	3	Meets basic requirements. Some gaps, limited detail, or moderate weaknesses, but generally responsive.
Weak	2	Partially addresses requirements. Significant gaps, unclear plans, or limited evidence of capacity.
Poor	1	Fails to address requirements adequately. Major weaknesses, insufficient detail, or lacks feasibility.

VII. APPLICATION

Application Checklist

The following items must be included in the application. Please assemble the application in the following order:

1. __ **Cover Letter**
2. __ **Application Face Sheet**
3. __ **Applicant's Response Addressing all Questions**
   - __ Section 1: Capacity & Ability
   - __ Section 2: Service Area & Community Context
   - __ Section 3: Vision & Readiness
4. __ **Project Budget**
   - __ Budget & Budget Narrative in the format provided
   - __ Indirect Cost Rate Approval Letter (if applicable)
5. __ **Attachment A: Letters of Commitment**
6. __ **Attachment B: Entity Information**
   - __ Documentation of the entity's Tax Identification Number (TIN) or Employer Identification Number (EIN).
   - __ Documentation of the entity's Unique Entity Identifier (UEI).
   - __ Most current 990 or financial statement.
   - __ Organizational chart of the applying entity.
   - __ List of current Board of Directors (or equivalent if a public) of the applying entity.
   - __ Job descriptions for all key staff positions that are necessary to implement and support the project
7. __ **Attachment C: Policy Control Assessment**
8. __ **Attachment D: Financial Internal Control Assessment**
9. __ **Attachment E: IRS Nonprofit Documentation (nonprofits only)**
10. __ **Attachment F: Verification of 501(c)(3) Status Form (nonprofits only)**

11. __ **Attachment G: Conflict of Interest (COI)**

    __ COI Acknowledgment

    __ COI Policy

12. __ **Attachment H: No Overdue Tax Debts**

13. __ **Attachment I: State Certifications**

14. __ **Attachment J: Federal Certifications**

15. __ **Attachment K: FFATA Data Form**

16. __ **Attachment L Subcontractor/Subgrantee Information Form**

17. __ **Attachment M: NC eVP Registration Confirmation**

Cover Letter

The application must include a cover letter, on its letterhead, signed and dated by an individual authorized to legally bind the Applicant. The letter must include:

- Legal name of the Applicant entity
- RFA number (2026-NCROOTS)
- Applicant entity's federal tax identification number (EIN)
- Applicant entity's Unique Entity Identifier (UEI)
- Primary location of the Applicant entity and all additional offices/service locations and date location was established.
- NCRHTP Region for which the Applicant entity is applying to be the ROOTS Hub Lead.
- Confirmation that the entity is not a Medicaid Managed Care Organization.

Please address the following items in the letter:

- entity mission
- brief history
- background
- current (last 3 years) services/programs provided in North Carolina
- how this proposed work fits within your entity mission

There is no page limit for the cover letter.

Application Face Sheet

This form provides basic information about the applicant and the proposed project with *the North Carolina Rural Health Transformation Project*, including the signature of the individual authorized to sign "official documents" for the entity. This form is the application's cover page. Signature affirms that the facts contained in the applicant's response to RFA# 2026-NCROOTS are truthful and that the applicant is in compliance with the assurances and certifications that follow this form and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below.

1. Legal Name of Entity: 2. Name of individual with Signature Authority:	
3. Mailing Address (include zip code+4): 4. Address to which checks will be mailed:	
5. Street Address:	
6. Contract Administrator: Name: Title:	Telephone Number: Fax Number: Email Address
7. Entity Status (check all that apply): ☐ Public ☐ Private Non-Profit ☐ For-Profit ☐ Other. Explain:	
8. Entity Federal Tax ID Number:	9. Entity UEI:
10. URL (website):	
11. Entity's Fiscal Year End:	
12. Current Service Delivery Areas (county(ies) and communities):	
13. Proposed Region(s) To Be Served with Funding:	
14. Amount of Funding Requested:	
15. Projected Expenditures: Does applicant's state and/or federal expenditures exceed $500,000 for applicant's current fiscal year (excluding amount requested in #14) Yes ☐ No ☐	
The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications contained in NCDHHS Assurances Certifications. I understand that the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. The governing body of the applicant has duly authorized this document and I am authorized to represent the applicant.	
16. Signature of Authorized Representative:	17. Date

Section 1: Capacity & Ability

Do not delete the question headers.
Please provide your response to each question under the heading.

Total Value: 195

Page Limit:
15

Section 1

This section is intended to evaluate the applicant's organizational strength and readiness to serve as an NC ROOTS Hub Lead. The purpose is to determine whether the applicant possesses the capacity, systems, and leadership necessary to manage complex initiatives and deliver sustainable outcomes for rural health transformation.

1-1. Organizational Profile

a. Briefly describe your entity's mission, history, and core areas of expertise.
b. Describe how long your entity has operated in North Carolina.
c. Briefly describe recent (in the past 5 years) community projects or programs your entity has implemented, including outcomes. Confirm you have at least three (3) years of office presence located in and experience delivering programs in North Carolina.
d. Describe your entity's experience working in rural North Carolina, particularly with underserved or disproportionately burdened communities.
e. If applicable, describe your organization's experience working with communities that have historically experienced health disparities or barriers to care, including but not limited to Tribal communities, communities of color, rural populations, individuals with limited English proficiency, and individuals who use ASL or other communication supports. Describe your approach to recruiting, training, and retaining staff who demonstrate cultural competency and the ability to work effectively across diverse communities, including strategies to ensure services are accessible, linguistically appropriate, and responsive to community needs.

1-2. Operational Experience

a. Outline your entity's staffing, infrastructure, and systems for managing and monitoring large-scale, multi-partner initiatives.
b. Describe your entity's experience with grantmaking, fund distribution, and financial oversight for subgrantees or partners.
c. Describe your entity's experience as a subrecipient of NCDHHS or another State entity in the last ten (10) years, including the Division/Office or other State entity and the amount of the award(s).

1-3. Data and IT Infrastructure

a. Where will program data be stored (cloud, hybrid) and how will the storage approach support security, scalability, and compliance?
b. Describe how data will be organized to support program operations, performance measurement, and required reporting
c. Describe your entity's experience in analyzing clinical and population health data.
d. List all source systems or software used for collecting, tracking, and analyzing clinical and/or population health data
e. Describe internal data security measures, environmental safeguards, firewalls, access controls, and other industry security best practices utilizing appropriate hardware and software necessary to monitor, maintain, and ensure data integrity in accordance with all applicable federal regulations, state regulations and NCDHHS privacy and security policies.
f. If applicable, what systems and data protocols will you implement to ensure respect for Tribal data sovereignty and community-based participatory research principles?

1-4. Financial practices.

a. NCDHHS issues grants on a reimbursement basis. Grantees must expend funds in accordance with the grant and their approved budget. NCDHHS reimburses allowable expenditures based on a monthly submission of expenses and receipts. Please describe your entity's financial capacity to expend funds monthly on a reimbursement basis, including issuing subgrants and reimbursing your subgrantees before your entity is reimbursed by the State.
b. Describe how your entity manages and tracks distinct funding sources to account for expenditure categories, allowability, and reporting.
c. Describe how your entity conducts financial oversight and/or audits to ensure compliance.
d. Has the entity had an audit finding in the last three (3) years? If yes, please provide the finding, the fiscal year, and the corrective action plan that was implemented to correct it. Provide for each finding if the entity has had more than one.
e. Attach the entity's most recent 990 or financial statement as part of Attachment B.

1-5. Quality Improvement

a. Describe the quality improvement structure your entity has for current programming.
b. How with the entity incorporate quality improvement into its role as the NC ROOTS Hub Lead?

1-6. Key Staff. Using the format of the chart below, list all the current staff positions that are expected to support the implementation of the proposed program. Note: NCRHTP cannot replace local funds allocated to existing staff or programs. You may expand the chart or attach a separate document to your entity's response to this section.

a. Include name, degree, credentials, years of service with the organization, supervision information (if relevant) and full-time equivalency.
b. Provide copies of job descriptions in Attachment B.
c. Any other relevant details may be included in narrative form.
d. What is the current level of staff turnover within your entity?
e. How will you work to minimize the amount of staff turnover over the course of the project?
f. How will you ensure that staff are actively engaged in their work?
g. Attach to Section 1 the organizational chart for your entity.
h. Attach to Section 1 a list of board members or commissioners governing your entity, including number of years served.

Position	Employee Name	Degree/ Credentials	# years in position	Number of staff supervised	Full Time Equivalency (FTE)

Section 2: Service Area

Do not delete the question headers.
Please provide your response to each question under the heading.

Total Value: 135

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Section 2

This section is intended to evaluate the applicant's understanding of the geographic region and community context in which the NC ROOTS Hub will operate. The purpose is to ensure that the applicant can effectively address regional challenges, leverage existing resources, and foster collaborative governance and sustainability for long-term impact.

2-1. Geographic Focus

a. Which Region(s) is your entity applying to serve as NC ROOTS Hub Lead?

☐Region 1 ☐Region 2 ☐Region 3

☐Region 4 ☐Region 5 ☐Region 6

b. Describe your entity's current role in the community, including presence and partnerships in these areas, including relationships relevant to the NCRHTP.

2-2. Community Needs and Assets

a. Provide an assessment of your region's needs and barriers to accessing care, including preventive services, as they relate to the NCRHTP.
b. Identify Tribal populations within your proposed region and describe their health disparities and unique barriers to care. Describe your strategy for engaging Tribal leadership and community members in needs assessments and Hub Action Plan development. How will you incorporate Tribal priorities into decision-making?
c. Based on your knowledge and/or available data, what are the most pressing health and social needs in your region? (e.g., perinatal health, chronic disease, behavioral health, workforce shortages, digital access)
d. What existing assets, programs, or partnerships could be leveraged to address these needs?

2-3. Network-Building & Collaboration

a. Describe your entity's experience building and leading multi-sector networks or coalitions (e.g., health care, behavioral health, social services, CBOs, academic partners).
b. Describe the governance or decision-making structures your entity has used to ensure community voice informs your approaches.
c. Attach Letters of Commitment in Attachment A to this application which document entity support and ability to fulfill the role from community organizations included in the work and supporting the implementation of the plan. Please include evidence of support from Tribal communities, if relevant.

2-4. Stakeholder Engagement

a. Describe how your entity engages community members, providers, and other stakeholders in program design and implementation?
b. Please share examples of how you have incorporated stakeholder feedback into your work.
c. Name and describe the essential community partners in your Region that will be needed to engage and implement the ROOTS Hub work.
d. Describe how your entity will partner with the required members of the ROOTS Hub Network, including the process for recruiting additional members.
e. Describe how your entity will engage disproportionately burdened communities.
f. Describe how your entity will engage and integrate stakeholders in its governance structure.

Section 3: Vision & Approach

Do not delete the question headers.
Please provide your response to each question under the heading.

Total Value: 120

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Section 3

This section is intended to evaluate the applicant's strategic vision and preparedness to assume the role of NC ROOTS Hub Lead. The purpose is to ensure that the applicant demonstrates a clear, actionable plan and the capacity to lead regional transformation efforts effectively.

3-1. Proposed Role as Hub Lead

a. Describe how your entity will approach and fulfill the responsibilities of an NC ROOTS Hub Lead (see Section III, Scope of Services).
b. Describe the unique strengths or innovations your entity will bring to the role of Hub Lead.
c. Describe your entity's qualifications to implement NCRHTP Initiatives at the regional level, including guiding and overseeing the Hub's regional strategy.

3-2. Challenges & Support Needs

a. What barriers or challenges does your entity anticipate in serving as a Hub Lead?
b. Describe the strategies your entity would employ to overcome those barriers or challenges.
c. What types of technical assistance, training, or resources would help your entity succeed?

3-3. Governance

a. Describe how your entity will manage strategy, data, and communications among the Hub Network.
b. Describe how your entity will solicit and incorporate stakeholder feedback into its governance structure and decision making.
c. Describe how your entity will ensure disproportionately burdened communities are represented in the governance structure including tribal communities.
d. Describe the entity's grantmaking structure, including how applications will be solicited, reviewed, and grants awarded.
e. Describe the entity's process for routine program and fiscal monitoring and oversight of its Hub Network and any partners.

3-4. Priority Projects

a. Based on the community's needs, which NCRHTP Initiatives (Initiatives are listed in RFA Section III.A.) are most urgent to implement in your region?
b. Describe the specific projects or models your Hub Network would prioritize as part of the Hub Action Plan.
c. Propose your approach to establish standardized referral pathways and processes for clinical, behavioral, and social referrals via the hub network. Describe any existing systems that can be leveraged.
d. Describe how stakeholder feedback would be incorporated into the prioritization.
e. Describe how your entity and your Hub Network will work toward sustainability and long-term impact for your region and community?
f. Describe any additional funding streams, grants, public-private partnerships, etc. your entity and the Hub Network would seek out to sustain initiatives after the 5-year project period.
g. Provide a Tribal Engagement Plan summary to include proposed consultation timelines outline decision-making protocols, for respecting Tribal sovereignty.
h. Describe how your Hub will integrate culturally responsive workforce development strategies.

3-5. Project Workplan (Award Period 1)

Please provide a project implementation plan for the anticipated first award period of April 1, 2026 – October 30, 2027.

a. The Award Period 1 Project Workplan should include:
   - Goals & SMART Objectives
   - Key Activities needed to meet each objective and their associated outputs and outcomes
   - Timeline and Schedule
   - Roles & Responsibilities
   - Measurement & Evaluation Plan
   - Sustainability Plan: For each activity, briefly explain your plan to sustain these efforts beyond the life of the program or maximize impact for these one-time funds.

b. Entity may choose how their plan is formatted for submission, (e.g., Gantt chart, tables, narrative).

Section 4: Budget

Total Value: 60

Provide a budget and narrative justification for Grantee Award Period (GAP) 1:
June 1, 2026 – October 30, 2027. For the purposes of creating a budget, Applicants may refer to the following Illustrative Funding Table:

Hub Lead GAP 1 (June. 1, 2026 - Oct. 30, 2027)**	
Initiative/Activity Breakdown	**Per Region ($)**
ROOTS Hub Lead Entity Core Funding	21,833,333
ROOTS Hub Regional Rural Needs Assessment	500,000
Subtotal: Initiative 1 – Build "ROOTS Hub"	**22,333,333**
ROOTS Driven Chronic Disease	2,000,000
ROOTS Driven Nutrition Access	1,400,000
ROOTS Driven Perinatal Health Access Expansion	2,000,000
Subtotal: Initiative 2 - Primary Care, Prevention, & Chronic Disease	**5,400,000**
ROOTS Driven Workforce Support	2,935,511
ROOTS Driven Workforce Training	6,000,000
Subtotal: Initiative 4 - Build a Robust & Resilient Workforce	**8,935,511**
ROOTS Driven Hospital Feasibility & Redesign	1,333,333
ROOTS Driven Primary Care Capitation Model	1,250,000
Subtotal: Initiative 5 - Fiscal Sustainability of Rural Health Providers	**2,583,333**
Total per Region	**$39,252,177**
Administrative Expenses may not exceed 10% of total.	

Budget and Justification Form
Applicants must complete the *Budget and Justification Form*, which requires a line-item budget and narrative justification for the first period of funding (June 1, 2026 – October 30, 2027).

Budgets must align clearly with proposed activities and resources.

The form and form instructions will be posted along with this RFA and can be downloaded on February 27, 2026 from the following website: on the following website:
https://www.ncdhhs.gov/divisions/office-rural-health/rural-health-transformation-program

Narrative Justification for Expenses
A narrative justification must be included for *every* expense listed in the GAP 1 budget. Narratives for each line item must first be broken down by NCRHTP Initiative. Then, the justification for item under the Initiative should show how the amount was calculated, and it should be clear how the expense relates to the project. Ensure all subtotals equal the total amount entered on the row for that line item. Reference *How to Fill out the Open Window Budget Form* which can be found on the following website:
https://www.ncdhhs.gov/divisions/office-rural-health/rural-health-transformation-program

Administrative Cost Limit
Administrative costs are limited to 10% of the total amount allotted to a State for a budget period. This 10% limit on administrative costs includes both indirect and direct costs that are considered administrative costs.

Applicants must explicitly demonstrate compliance with the 10% administrative costs limit by identifying which budget line items constitute administrative expenses (such as salaries of executive management or staff who oversee or manage the program rather than directly implementing it). **All administrative expense line items must include the notation "ADMIN" in the budget narrative.** When tabulated, the total of all administrative expenses, together with any indirect costs, must not exceed 10% the total budget for the Grantee Award Period.

Additional Funding Restrictions
Refer to funding restrictions outlined in Section III.B. All project budgets must adhere to these requirements.

Travel Reimbursement Rates
Mileage reimbursement rates must be based on rates determined by the North Carolina Office of State Budget and Management (OSBM). Because mileage rates fluctuate with the price of fuel, the OSBM will release the "Change in IRS Mileage Rate" memorandum to be found on OSBM's website when there is a change in this rate. The current state mileage reimbursement rate is $0.725 per mile.

For other travel-related expenses, please refer to the current rates for travel and lodging reimbursement, presented in the chart below. NCDHHS will only reimburse for rates authorized in North Carolina Department of Health and Human Services Travel Policy. NCDHHS utilizes GSA State/City Standard Travel Per Diems as the maximum allowable statutory rate for meals and lodging (subsistence). The following is the current NCDHHS schedule which shall be used for reporting allowable subsistence expenses incurred while traveling on official state business:

Current Rates for Travel and Lodging

Meals	**In State**	**Out of State**
Breakfast	$16.00	$16.00
Lunch	$19.00	$19.00
Dinner	$28.00	$28.00
Total Meals Per Diem Per Day	*$63.00*	*$63.00*
Lodging *(Maximum rate per person, excludes taxes and fees)*	$110.00 + taxes/fees	$110.00 + taxes fees
Total Travel Allowance Per Day	**$173.00**	**$173.00**
Mileage	$0.725 per mile/regardless of distance	

Staff Development Costs
Applicants should include costs for registration to attend or to host trainings to support staff development in carrying out the services outlined in this RFA. Travel costs associated with attending or hosting trainings should be included under Contract Staff Travel and not exceed the travel reimbursement rates.

Supplies
Materials needed for office work and for trainings, meetings, etc. may be included in the Supply category. Examples of supplies are as follows: paper, ink cartridges, flip chart paper, markers, notebooks, etc.

Justification Example: Initiative 4: 50 Notebooks for a training @ $10.00 each = $500.

Equipment
The maximum that can be expended on an equipment item, without prior approval from NCDHHS, is $4,999. An equipment item that exceeds $4,999 shall be approved by NCDHHS before the purchase can be made. If an equipment item shall be used by multiple programs, you must prorate the cost of that equipment item and the narrative must include a detailed calculation which demonstrates how the entity prorates the equipment.

Justification Example: Initiative 1: 1 shredder @ $1,500 each for office staff to shred confidential information for the entity.

Purchase of equipment should be accompanied by a depreciation schedule. Disposition instructions for equipment which has not fully depreciated at the end of the project period will be provided.

All equipment purchases must comply with 2 CFR 200.216 and Section 889 of Public Law 115-232. Award funds may not be used to procure covered telecommunications equipment or services. Applicants are responsible for ensuring compliance with these requirements.

Personnel Salary and Fringe
Provide position titles, staff FTE amounts, brief description of the positions, and method of calculating each fringe benefit that shall be funded. A description can be used for multiple staff if the duties being performed are similar. *Do **not** prorate the salary and fringe amounts. The spreadsheet will prorate these amounts based on the number of months and percent of time worked.*

Justification Example: Initiative 1: P. Duffy, Hub Network Liaison, 1.0 FTE, Recruits, coordinates, organizes, and communicates with recruited Hub Network partners.

Budget Narrative Justification Example: FICA at 7.65% of budgeted salary; Retirement at 10% of budgeted salary; Unemployment at 2% of budgeted salary; and Other at 3% (includes life insurance, AD&D and liability insurance) of budgeted salary. Health insurance is $6,000 per individual.

Audits
Entity audit costs contribute to the administrative cap on the total award budget.
G.S. 143C-6-23 requires every nongovernmental entity that receives State or Federal pass-through grant funds directly from a State agency to file annual reports on how those grant funds were used. Grantees that receive $1,000,000 or more in financial assistance grants from the State of North Carolina must have an annual independent audit. Only these grantees may include audit expenses in the budget. Audit expenses must be prorated based on the ratio of the grant to the total pass-through funds received by the entity.

Indirect Cost
Indirect cost is the cost incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. Indirect Cost may not exceed restrictions or limits placed on it by the funding source.

Entity with a Federal Negotiated Indirect Cost Rate (FNICR) or Cost Allocation Plan must submit a copy of their most recently approved rate or plan and enter the rate to be used in the line with the appropriate calculation and justification in accordance with the award requirements.

Entity without an FNICR may elect to use the maximum federal de minimis rate per 2 CFR 200.414 as their federally-approved indirect cost rate. Enter the rate to be used in the line with the appropriate calculation and justification in accordance with the award requirements.

Entities that do not wish to claim any indirect cost should enter, $0.00 and "No indirect cost requested" in the line.

IMPORTANT NOTE: Entity indirect costs and allocated administrative costs contribute to the 10% administrative cap on the total award budget.

Applicants must be cognizant that some of the direct costs in their budget may be deemed "administrative" by the requirements of the funding source. Therefore, all administrative costs must be identified prior to requesting additional indirect cost. Please indicate in your budget and narrative how you calculated your administrative costs.

Limits on Administrative Cost

Contracts from this RFA are funded with pass-through funds from the Centers for Medicare & Medicaid Services (CMS) Rural Health Transformation Program (RHTP), federal Assistance Listing Number 93.978.

The RHTP grant limits all administrative expenses to 10 percent (10%) of the total awarded budget.

All administrative costs, including indirect costs and direct costs that are program administrative costs, are included in the RHTP grant's 10% administrative cost limit.

For further information on administrative costs see CMS's Rural Health Transformation Grant FAQs.

Tribal Partnership

Applicants must demonstrate that budget allocations reflect proportional investment in Tribal communities relative to population size, health needs, and community-identified priorities. As applicable, budgets should include funding for culturally responsive workforce development, and evidence-based support for Tribal organizations and programs. Where applicable, applicants must clearly identify these allocations in the budget narrative and justify how they advance Tribal health.

Attachment A: Letters of Commitment

Please attach letters of commitment from required NC ROOTS Hub Network Partners and community partners.

Attachment B: Entity Information

Please provide each of the following:

- Documentation of the entity's Tax Identification Number (TIN) or Employer Identification Number (EIN).
- Documentation of the entity's Unique Entity Identifier (UEI).
- Most current 990 or financial statement.
- Organizational chart of the applying entity.
- List of current Board of Directors (or equivalent if a public) of the applying entity.
- Job descriptions for all key staff positions that are necessary to implement and support the project.

Attachment C: Policy Control Assessment

Answer all questions with Yes, No, or N/A.

General Management

1. Are there written policies and internal operating procedures that have been approved by the governing body or senior management? Answer:
2. Does the Entity have a code of ethical conduct that has been made available to all employees? Answer:
3. Are procedures documented, kept current and readily available for daily use by all employees? Answer:
4. Are roles and responsibilities clearly defined in writing and communicated? Answer:
5. Does management understand the knowledge and skills required to accomplish key tasks? Answer:
6. Is management involved in and actively encourage training? Answer:
7. Does management use budgets or spending plans to review the Entity's financial performance? Answer:
8. Are periodic reports on the status of actual performance to budget prepared and reviewed by top management? Answer:
9. Are all accounting activities under the supervision of a knowledgeable accounting supervisor? Answer:
10. Does management actively follow-up on complaints from customers/ clients/consumers? Answer:
11. Has the Entity established performance goals for key areas and programs and does it compare its actual performance with its goals and objectives no less frequently than annually? Answer:
12. Is there an organizational chart that clearly defines the lines of management authority and responsibility? Answer:
13. Has management established a back-up plan for sudden or significant changes in personnel? Answer:
14. Does the Entity have a formal, written record retention schedule that complies with State and federal requirements and timeframes? Answer:
15. If the Entity grants funding to subrecipients, is a formal, written plan in place for contracting with subrecipients? Answer:
16. If the Entity grants funding to subrecipients, is a written plan in place for monitoring subrecipients which includes documenting monitoring activity? Answer:
17. If the Entity will receive federal grant funds from the State, is the Entity familiar with the requirements of Code of Federal Regulations 2 CFR 200, otherwise known as the "Uniform Guidance"? Answer:
18. Are external audits performed on a routine, periodic basis? Answer:

Accounts Payable

19. Is a written policy in place to ensure that the best possible prices are obtained for goods and services purchased? Answer:
20. Are written procedures in place to ensure that all purchases and procurements are in compliance with applicable State and federal policies? Answer:
21. Are controls/procedures in place to identify costs and expenditures disallowed by grant funds prior to purchase? Answer:
22. Are procedures in place to ensure that goods and services have been received in a satisfactory manner prior to payment being issued? Answer:
23. Is there adequate segregation of duties to ensure that different individuals order goods and services, attest to their satisfactory receipt, issue payment, and balance bank statements? Answer:
24. Are bank statements and petty cash accounts balanced monthly? Answer:
25. If subsidiary expenditure journals are maintained, are they reconciled with the general ledger at least monthly? Answer:
26. Are payments made only on the basis of original invoices? Answer:
27. Are controls in place to stop invoices being paid more than once? Answer:
28. Is check signing limited to authorized personnel? Answer:
29. Are unused and voided checks adequately controlled? Answer:

30. Are controls in place to prevent overpayments or unauthorized payments to individuals or third parties? Answer:
31. Do knowledgeable personnel code invoices for payment? Answer:
32. Are there controls in place to prevent obligation or expenditure of grant funds beyond the period of availability? Answer:

Human Resources and Payroll

33. Are there written policies regarding leave, fringe benefits, recruitment, and separation? Answer:
34. Do all supervisors have access to a copy of the personnel policy manual? Answer:
35. Is nepotism or conflict of interest in employment prohibited? Answer:
36. Is information on employment applications verified and references obtained? Answer:
37. Are appropriate time records for leave maintained and are they reconciled at least annually? Answer:
38. Is the performance of all employees formally evaluated on at least an annual basis? Answer:
39. If employees work on more than one program or are paid from more than one funding source, are appropriate time sheets or activity reports maintained and approved by a supervisor? Answer:
40. Is there adequate segregation of duties to ensure that different individuals process personnel action forms, process and distribute the payroll, and record the payroll in the general ledger? Answer:

Accounts Receivable

41. Are procedures in place to ensure timely preparation of reimbursement requests? Answer:
42. Are remittance advices and billings maintained to support accounts receivable entries in the general ledger? Answer:
43. If subsidiary accounts receivable journals are maintained, are they reconciled with the general ledger at least monthly? Answer:
44. Are cash receipts properly and promptly documented, posted to accounts receivable records, and deposited? Answer:
45. Is there adequate segregation of duties to ensure that different individuals prepare billings, collect and deposit cash, and reconcile accounts receivable and cash receipts entries to the general ledger? Answer:
46. Do bank deposits have the official depository bank number preprinted on the document and are checks deposited noted on the deposit slip by maker and amount? Answer:
47. Are prenumbered receipts issued for all cash currency receipts and are all numbered receipts accounted for? Answer:
48. Are all employees handling cash receipts adequately bonded? Answer:
49. If required by the nature of the funding source or the agreement with the State, are receipts that represent Program Income properly identified, reported and used? Answer:

Inventory/Fixed Assets

50. Does the Entity maintain supplies on-hand in excess of the amount needed in a normal month? Answer:
51. Does the Entity have written procedures in place to maintain an accurate inventory of supplies and equipment? Answer:
52. Are receipts to and withdrawals from supply/equipment inventory properly documented? Answer:
53. Is the value of the supply/equipment inventory recorded on the general ledger? Answer:
54. Is a physical count of the inventory taken at least annually and are inventory records updated accordingly? Answer:
55. Does the Entity have an equipment fixed asset capitalization policy requiring, at minimum, assets costing more than $5,000 to be capitalized? Answer:
56. Are fixed assets physically tagged upon receipt? Answer:
57. Is the value of fixed assets recorded in the general ledger? Answer:
58. Is a physical inventory of fixed assets taken at least annually and are fixed asset records updated accordingly? Answer:

Eligibility

59. Does the Entity offer services that are governed by specific eligibility criteria? Answer: (If no, answer N/A to questions 60 – 65)

60. Is there an up-to-date manual available to staff performing eligibility functions? Answer:
61. Are staff performing eligibility functions adequately trained? Answer:
62. Is the information provided by the client verified by an independent third party? Answer:
63. Are client records periodically updated and reviewed to determine continued eligibility? Answer:
64. Is there adequate segregation of duties to ensure that different people determine eligibility and compute benefit payments or authorize services? Answer:
65. Are benefit payments to individuals or payments for services to third parties on behalf of individual clients matched or compared to eligibility systems to ensure eligibility of the client? Answer:

Allowable Costs and Services

66. Does the Entity have a federally approved indirect cost rate or has a formal indirect cost rate been prepared in accordance with applicable OMB Circular and audited by a Certified Public Accountant? Answer:
67. If the Entity performs more than one service, or is funded by more than one funding source, does it have a written plan on how costs are to be allocated between services/funding sources? Answer: Answer: (If No, answer N/A to questions 68 and 69)
68. Does the cost allocation plan appropriately allocate cost to all benefitting programs? Answer:
69. Are the allocation bases current and reasonable? Answer:

Attachment D: Financial Internal Control Assessment

Answer all questions with Yes, No, or N/A..

Receipts

1. Cash receipts are deposited (i.e. does the organization prohibit amounts from either being withheld from the deposit or requesting the bank to deduct cash from the deposit). Answer:
2. Cash receipts are deposited on a daily basis. Answer:
3. The individual(s) who opens the mail logs cash receipts, including notation of any restrictions, before the cash or documentation is routed to others. Answer:
4. A restrictive endorsement ("For Deposit Only") is placed/stamped on all checks when received. Answer:
5. Prenumbered receipt forms, which include acknowledgment of any restrictions, are issued for receipts and donated materials received and the numerical sequence is accounted for. Answer:
6. The entity can receive electronic deposits directly into their bank account. Answer:
7. Lock-box (or cashiering) services are used to control access to cash and cash equivalents (e.g., gift cards). Answer:
8. Receipts on accounts are posted to an accounts receivable subsidiary ledger. Answer:
9. Receipt of payments on receivables are documented, such as by receipt forms or notations on pledge forms. Answer:
10. Receipts from restrictive funding sources, including grants, have unique coding and accounted for separately so funding is not intermingled. Answer:
11. An analysis of aged receivables is reviewed at least monthly by a person independent of the functions of handling and recording of cash receipts. Answer:

Disbursements

12. The governing board authorizes all bank accounts and check signers. Answer:
13. Dual signatures required on all checks. Answer:
14. The bank is immediately notified of all changes of authorized check signers. Answer:
15. Cash disbursements are made by check (except for petty cash and electronic transfer). Answer:
16. Cash disbursements are supported by vendors' invoices or other external documents. Answer:
17. Vendor invoices, or other documents, indicate the date that goods or services were received. Answer:
18. Unpaid vendor invoices are filed separately from paid invoices. Answer:
19. All disbursements are approved for payment by a responsible official(s). Answer:
20. For disbursements that require special approval of the governing board, their approval is adequately documented. Answer:
21. Vendor invoices are recalculated prior to checks being prepared. Answer:
22. All supporting documents are canceled to prevent duplicate payment. Answer:
23. A log or other notation is made of purchases that include a contribution element. Answer:
24. Checks are signed only when supported by approved invoices (not signed in advance). Answer:
25. Check signers compare data on supporting documents to checks presented for their signatures. Answer:
26. Check signers examine appropriate approval on supporting documents before signing checks. Answer:
27. Checks are prenumbered and accounted for. Answer:
28. Voided checks are adequately defaced and are easily accessible for review. Answer:
29. The practice of cashing checks out of cash receipts is prohibited. Answer:
30. Bank transfers are approved, recorded, and verified to ascertain that both sides of the transaction are recorded. Answer:
31. A policy exists which documents the rationale used to allocate expenses among functions, grants, and contracts. Answer:

Human Resources and Payroll

32. A payroll journal is prepared and balanced. Answer:
33. Payroll disbursements are made by check and /or electronic transfer. Answer:
34. Employees' earnings records are maintained. Answer:

35. W-4 forms are maintained. Answer:
36. Employee's earnings records are maintained. Answer:
37. Records of mandated withholding (e.g., FICA, unemployment) are maintained. Answer:
38. Adequate records are maintained to allow allocation of payroll costs to functions (including lobbying activities), specific grants, and contracts. Answer:
39. Written procedures exist for appropriate allocation of personnel expense. Answer:
40. Time sheets or cards are prepared by employees. Answer:
41. Time sheets or cards are approved by a director or manager Payroll checks are prenumbered and accounted for. Answer:
42. Checks are recorded in the payroll journal as prepared. Answer:
43. Payroll journals are posted at least monthly to employee's earnings records. Answer:
44. An imprest payroll bank account is used. Answer:
45. Unclaimed payroll checks are followed up on by the board of directors or their designee. Answer:

Accounting System

46. Bank accounts are reconciled monthly. Answer:
47. A balancing cash receipts journal is maintained and includes notations of any donor-imposed restrictions. Answer:
48. A balancing cash disbursements journal is maintained for each bank account. Answer:
49. A purchases journal is maintained. Answer:
50. The accounting system captures information necessary either to identify the function for which each expense is incurred or to allocate each expense incurred among appropriate functions. Answer:
51. Recorded contributions and grants are compared to approved budgets and significant variances are investigated by a responsible official. Answer:
52. Contributions and grants that can reasonably be estimated are budgeted. Answer:
53. Documentation, including all correspondence, is maintained for each restricted contribution or grant.
54. An imprest petty cash fund is utilized and reconciled periodically. Answer:
55. Prenumbered purchase requisitions and/or purchase orders are prepared as authorization for
56. purchases. Answer:
57. For reimbursement type grants and contracts, reimbursement requested and received are reconciled at least monthly, and a responsible official investigates differences. Answer:

Government Programs

58. Accounting policies and procedures are adequate to maintain separate records of the receipts and expenditures related to each grant or award. Answer:
59. Expenditures for each grant or award are recorded according to each of the organization's budget categories. Answer:
60. Government funds are deposited in separate bank accounts or controlled separately, as required. Answer:

61. Requests for advances and reimbursements from grantor agencies are approved by an appropriate official of the entity. Answer:
62. Procedures have been established to ensure that individuals are not discriminated against on the grounds of race, color, national origin, age, or disability. Answer:
63. A time schedule for financial reports is maintained to ensure timely filing. Answer:
64. Financial reports, before they are filed, are reconciled to accounting records. Answer:
65. Policies that are specific to government programs are communicated to the organization's personnel. Answer:
66. Policies and procedures have been established to obtain prior approval of certain costs from the granting agency, as required by OMB Omni-Circular, 2 CFR, Part 200 Subpart F. Answer:
67. Policies and procedures have been established to ensure that individuals or organizations receiving benefits are eligible under the specific requirements of the programs. Answer:
68. For programs with matching or earmarking requirements, policies and procedures have been established to ensure that the limits have been met in accordance with applicable laws and regulations. Answer:
69. Cash management procedures, such as cash flow projections, are employed to help ensure a minimum time lapse between receipt of funds and the disbursement. Answer:

70. Costs charged directly or indirectly to grants are reviewed by a responsible official for compliance with regulations or agreements (including consideration of whether federal funds are used for partisan political activity). Answer:
71. Policies and procedures have been established to prevent charging grants for non-reimbursable items, such as bad debt expenses, fines and penalties, interest, fund-raising, and financial costs. Answer:

Fixed Assets

72. An annual physical inventory is taken and adequate count records (tags or sheets) are maintained. Answer:
73. Adequate records of fixed assets costs and depreciation records are maintained. Answer:
74. Written capitalization policies have been established by the board of directors. Answer:

General Controls

75. When hiring individuals who will be involved with handling of incoming mail or the handling or recording of cash receipts, a responsible official checks applicants' references and otherwise attempts to evaluate their integrity. Answer:
76. Solicitation material describes solicitor identification and notifies the donor to expect a prenumbered receipt. Answer:
77. The governing board receives frequent reports on the collection status of major pledges and pending grant applications. Answer:
78. The director or manager investigates customer complaints. Answer:
79. Vendors are reviewed by a responsible official to identify potential conflict of interest situations. Answer:
80. The governing board receives frequent reports of purchases from, and distributions to related parties which may constitute a conflict of interest. Answer:

Attachment E: IRS Letter

Public Agencies:
Provide a copy of a letter from the IRS which documents your organization's tax identification number. The organization's name and address on the letter must match your current organization's name and address.

Private Non-profits:
Provide a copy of an IRS determination letter which states that your organization has been granted exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code. The organization's name and address on the letter must match your current organization's name and address.

This IRS determination letter can also satisfy the documentation requirement of your organization's tax identification number.

Attachment F: Verification of 501(c)(3) Status Form

IRS Tax Exemption Verification Form (Annual)

I, _____, hereby state that I am _____ of
(Printed Name) (Title)
_____ ("Organization"), and by that authority duly given
(Legal Name of Organization)
and as the act and deed of the Organization, state that the Organization's status continues to be designated as 501(c)(3) pursuant to U.S. Internal Revenue Code, and the documentation on file with the North Carolina Department of Health and Human Services is current and accurate.

I understand that the penalty for perjury is a Class F Felony in North Carolina pursuant to N.C. Gen. Stat. § 14-209, and that other state laws, including N.C. Gen. Stat. § 143C-10-1, and federal laws may also apply for making perjured and/or false statements or misrepresentations.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this the _____ day of _____, 20_____.

_____

(Signature)

Attachment G: Conflict of Interest Policy

CONFLICT OF INTEREST ACKNOWLEDGEMENT AND POLICY

State of _____

County _____

I, _____ hereby state that I am the _____

(Printed Name) (Title)

of _____ ("Organization"), and by that authority

(Legal Name of Organization)

duly given and as the act and deed of the Organization, state that the following Conflict of Interest Policy was adopted by the Board of Directors/Trustees or other governing body in a meeting held on the _____ day of _____, _____. I understand that the penalty

(Day of Month (Month) (Year)

for perjury is a Class F Felony in North Carolina pursuant to N.C. Gen. Stat. § 14-209, and that other state laws, including N.C. Gen. Stat. § 143C-10-1, and federal laws may also apply for making perjured and/or false statements or misrepresentations.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this the _____ day of _____, 20_____.

(Day of Month) (Month) (Year)

_____

(Signature)

Instruction for Organization:
Sign and attach the entity's current Conflict of Interest Policy adopted by the Board of Directors/Trustees or other governing body.
If the organization does not currently have a Conflict of Interest Policy, it may choose to adopt and sign the following example policy.

_____

Name of Organization

_____

Signature of Organization Official

Entity Conflict of Interest Policy

Replace this example with the entity's signed, adopted policy or adopt and sign this sample policy.

The Board of Directors/Trustees or other governing persons, officers, employees or agents are to avoid any conflict of interest, even the appearance of a conflict of interest. The Organization's Board of Directors, Trustees, or other governing body, officers, staff and agents are obligated to always act in the best interest of the organization. This obligation requires that any Board member or other governing person, officer, employee or agent, in the performance of Organization duties, seek only the furtherance of the Organization mission. At all times, Board members or other governing persons, officers, employees or agents, are prohibited from using their job title, the Organization's name or property, for private profit or benefit.

A. The Board members or other governing persons, officers, employees, or agents of the Organization should neither solicit nor accept gratuities, favors, or anything of monetary value from current or potential contractors/vendors, persons receiving benefits from the Organization or persons who may benefit from the actions of any Board member or other governing person, officer, employee or agent. This is not intended to preclude bona-fide Organization fund raising-activities.

B. A Board or other governing body member may, with the approval of Board or other governing body, receive honoraria for lectures and other such activities while not acting in any official capacity for the Organization. Officers may, with the approval of the Board or other governing body, receive honoraria for lectures and other such activities while on personal days, compensatory time, annual leave, or leave without pay. Employees may, with the prior written approval of their supervisor, receive honoraria for lectures and other such activities while on personal days, compensatory time, annual leave, or leave without pay. If a Board or other governing body member, officer, employee or agent is acting in any official capacity, honoraria received in connection with activities relating to the Organization are to be paid to the Organization.

C. No Board member or other governing person, officer, employee, or agent of the Organization shall participate in the selection, award, or administration of a purchase or contract with a vendor where, to his knowledge, any of the following has a financial interest in that purchase or contract:

1. The Board member or other governing person, officer, employee, or agent;
2. Any member of their family by whole or half blood, step or personal relationship or relative-in-law;
3. An organization in which any of the above is an officer, director, or employee;
4. A person or organization with whom any of the above individuals is negotiating or has any arrangement concerning prospective employment or contracts.

D. **Duty to Disclosure** -- Any conflict of interest, potential conflict of interest, or the appearance of a conflict of interest is to be reported to the Board or other governing body or one's supervisor immediately.

E. **Board Action** -- When a conflict of interest is relevant to a matter requiring action by the Board of Directors/Trustees or other governing body, the Board member or other governing person, officer, employee, or agent (person(s)) must disclose the existence of the conflict of interest and be given the opportunity to disclose all material facts to the Board and members of committees with governing board delegated powers considering the possible conflict of interest. After disclosure of all material facts, and after any discussion with the person, he/she shall leave the governing board or committee meeting while the determination of a conflict of interest is discussed and voted upon. The remaining board or committee members shall decide if a conflict of interest exists.

In addition, the person(s) shall not participate in the final deliberation or decision regarding the matter under consideration and shall leave the meeting during the discussion of and vote of the Board of Directors/Trustees or other governing body.

F. **Violations of the Conflicts of Interest Policy --** If the Board of Directors/Trustees or other governing body has reasonable cause to believe a member, officer, employee or agent has failed to disclose actual or possible conflicts of interest, it shall inform the person of the basis for such belief and afford the person an opportunity to explain the alleged failure to disclose. If, after hearing the person's response and after making further investigation as warranted by the circumstances, the Board of Directors/Trustees or other governing body determines the member, officer, employee or agent has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

G. **Record of Conflict** -- The minutes of the governing board and all committees with board delegated powers shall contain:

1. The names of the persons who disclosed or otherwise were found to have an actual or possible conflict of interest, the nature of the conflict of interest, any action taken to determine whether a conflict of interest was present, and the governing board's or committee's decision as to whether a conflict of interest in fact existed.
2. The names of the persons who were present for discussions and votes relating to the transaction or arrangement that presents a possible conflict of interest, the content of the discussion, including any alternatives to the transaction or arrangement, and a record of any votes taken in connection with the proceedings.

Approved by:

_____
Name of Organization

_____
Signature of Organization Official

_____
Date

Attachment H: No Overdue Tax Debts Certification

State Grant Certification – No Overdue Tax Debts[1]

To: State Agency Head and Chief Fiscal Officer

Certification:
We certify that the _____ [Organization's full legal name] does not have any overdue tax debts, as defined by **N.C.G.S. 105-243.1**, at the federal, State, or local level. We further understand that any person who makes a false statement in violation of **N.C.G.S. 143C-6-23(c)** is guilty of a criminal offense punishable as provided by **N.C.G.S. 143C-101(b)**.

Sworn Statement:

_____ [Name of Board Chair] and

_____ [Name of Second Authorizing Official] being duly sworn, say that we are the Board Chair and _____ [Title of Second Authorizing Official], respectively, of

_____ [Entity's full legal name] of

_____ [City] in the State of _____ [State]; and that the foregoing certification is true, accurate and complete to the best of our knowledge and was made and subscribed by us. We also acknowledge and understand that any misuse of State funds will be reported to the appropriate authorities for further action.

	Board Chair	
	Title	Date
Signature	Title of Second Authorizing Official	Date

Sworn to and subscribed before me this _____ day of _____, 20__.

_____
Notary Signature and Seal

Notary's commission expires _____, 20 ___.

[1] G.S. 105-243.1 defines: Overdue tax debt – Any part of a tax debt that remains unpaid 90 days or more after the notice of final assessment was mailed to the taxpayer. The term does not include a tax debt, however, if the taxpayer entered into an installment agreement for the tax debt under G.S. 105-237 within 90 days after the notice of final assessment was mailed and has not failed to make any payments due under the installment agreement."

MS&NCD Form 0008, Eff. July 1, 2005. Revised July 18, 2006, 7/07, 8/09, 9/11

Attachment I: State Certifications

State Certifications
Contractor Certifications Required by North Carolina Law

Instructions: The person who signs this document should read the text of the statutes and Executive Order listed below and consult with counsel and other knowledgeable persons before signing. The text of each North Carolina General Statutes and of the Executive Order can be found online at:

- Article 2 of Chapter 64: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_64/Article_2.pdf
- G.S. 133-32: http://www.ncga.state.nc.us/gascripts/statutes/statutelookup.pl?statute=133-32
- Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009): https://ethics.nc.gov/media/242/download?attachment
- G.S. 105-164.8(b): http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_105/GS_105-164.8.pdf
- G.S. 143-48.5: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-48.5.html
- G.S. 143-59.1: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.1.pdf
- G.S. 143-59.2: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.2.pdf
- G.S. 143-133.3: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-133.3.html
- G.S. 143B-139.6C: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143B/GS_143B-139.6C.pdf

Certifications

(1) **Pursuant to G.S. 133-32 and Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009)**, the undersigned hereby certifies that the Contractor named below is in compliance with, and has not violated, the provisions of either said statute or Executive Order.

(2) **Pursuant to G.S. 143-48.5 and G.S. 143-133.3**, the undersigned hereby certifies that the Contractor named below, and the Contractor's subcontractors, complies with the requirements of Article 2 of Chapter 64 of the NC General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the federal E-Verify system." E-Verify System Link: www.uscis.gov

(3) **Pursuant to G.S. 143-59.1(b)**, the undersigned hereby certifies that the Contractor named below is not an "ineligible Contractor" as set forth in G.S. 143-59.1(a) because:

(a) Neither the Contractor nor any of its affiliates has refused to collect the use tax levied under Article 5 of Chapter 105 of the General Statutes on its sales delivered to North Carolina when the sales met one or more of the conditions of G.S. 105-164.8(b); **and**

(b) [check **one** of the following boxes]

☐ Neither the Contractor nor any of its affiliates has incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001; **or**

☐ The Contractor or one of its affiliates **has** incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001 **but** the United States is not the principal market for the public trading of the stock of the corporation incorporated in the tax haven country.

(4) **Pursuant to G.S. 143-59.2(b)**, the undersigned hereby certifies that none of the Contractor's officers, directors, or owners (if the Contractor is an unincorporated business entity) has been convicted of any violation of Chapter 78A of the General Statutes or the Securities Act of 1933 or the Securities Exchange Act of 1934 within 10 years immediately prior to the date of the bid solicitation.

(5) **Pursuant to G.S. 143B-139.6C**, the undersigned hereby certifies that the Contractor will not use a former employee, as defined by G.S. 143B-139.6C(d)(2), of the North Carolina Department of Health and Human Services in the administration of a contract with the Department in violation of G.S. 143B-139.6C and that a violation of that statute shall void the Agreement.

(6) The undersigned hereby certifies further that:

(a) He or she is a duly authorized representative of the Contractor named below;

(b) He or she is authorized to make, and does hereby make, the foregoing certifications on behalf of the Contractor; and

(c) He or she understands that any person who knowingly submits a false certification in response to the requirements of G.S. 143-59.1and -59.2 shall be guilty of a Class I felony.

Contractor's Name: _____

Contractor's Authorized Agent: Signature _____ Date _____

Printed Name _____ Title _____

Witness: Signature _____ Date _____

Printed Name _____ Title _____

The witness should be present when the Contractor's Authorized Agent signs this certification and should sign and date this document immediately thereafter.

Attachment J: Federal Certifications

The undersigned states that:

1. He or she is the duly authorized representative of the Contractor named below;

2. He or she is authorized to make, and does hereby make, the following certifications on behalf of the Contractor, as set out herein:

   a. The Certification Regarding Nondiscrimination;
   b. The Certification Regarding Drug-Free Workplace Requirements;
   c. The Certification Regarding Environmental Tobacco Smoke;
   d. The Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions; and
   e. The Certification Regarding Lobbying;

3. He or she has completed the Certification Regarding Drug-Free Workplace Requirements by providing the addresses at which the contract work will be performed;

4. [Check the applicable statement]

   ☐ He or she **has completed** the attached **Disclosure of Lobbying Activities** because the Contractor **has made, or has an agreement to make**, a payment to a lobbying entity for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action;
   OR

   ☐ He or she **has not completed** the attached **Disclosure of Lobbying Activities** because the Contractor **has not made, and has no agreement to make**, any payment to any lobbying entity for influencing or attempting to influence any officer or employee of any agency, any Member of Congress, any officer or employee of Congress, or any employee of a Member of Congress in connection with a covered Federal action.

5. The Contractor shall require its subcontractors, if any, to make the same certifications and disclosure.

_____

Signature **Title**

_____

Contractor [Organization's] Legal Name **Date**

[This Certification must be signed by a representative of the Grantee who is authorized to sign contracts.]

I. Certification Regarding Nondiscrimination

The Contractor certifies that it will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps;

(d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (h) the Food Stamp Act and USDA policy, which prohibit discrimination on the basis of religion and political beliefs; and (i) the requirements of any other nondiscrimination statutes which may apply to this Agreement.

II. Certification Regarding Drug-Free Workplace Requirements

1. **The Contractor certifies** that it will provide a drug-free workplace by:

   a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

   b. Establishing a drug-free awareness program to inform employees about:

      (1) The dangers of drug abuse in the workplace;

      (2) The Contractor's policy of maintaining a drug-free workplace;

      (3) Any available drug counseling, rehabilitation, and employee assistance programs; and

      (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

   c. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph (a);

   d. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the agreement, the employee will:

      (1) Abide by the terms of the statement; and

      (2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

   e. **Notifying the Department within ten days after receiving notice under subparagraph (d)(2) from an employee or** otherwise receiving actual notice of such conviction;

   f. Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted:

      (1) taking appropriate personnel action against such an employee, up to and including termination; or

      (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

   g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

2. The sites for the performance of work done in connection with the specific agreement are listed below (list all sites; add additional pages if necessary):

Street Address No.1:

_____

City, State, Zip Code:

_____

Street Address No.2:

_____

City, State, Zip Code:

_____

3. Contractor will inform the Department of any additional sites for performance of work under this agreement.

4. False certification or violation of the certification may be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment. 45 C.F.R. 82.510.

III. Certification Regarding Environmental Tobacco Smoke

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 services to children under the age of 18, if the services 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 services 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 $1,000.00 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor certifies that it will comply with the requirements of the Act. The Contractor further agrees that it will require the language of this certification be included in any subawards that contain provisions for children's services and that all subgrantees shall certify accordingly.

IV. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions

Instructions

[The phrase "prospective lower tier participant" means the Contractor.]

1. By signing and submitting this document, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originate may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant will provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549, 45 CFR Part 76. You may contact the person to whom this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this document that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

Certification

a. **The prospective lower tier participant certifies,** by submission of this document, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

b. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

V. Certification Regarding Lobbying

The Contractor 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, 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 Federally funded contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form SF-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) who receive federal funds of $100,000.00 or more and that all subrecipients shall certify and disclose accordingly.

4. 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 $10,000.00 and not more than $100,000.00 for each such failure.

VI. Disclosure of Lobbying Activities

Instructions

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity 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 a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or sub-award recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal Identifying number available for the Federal action identified in Item 1 (e.g., Request for Proposal (RFP) number, Invitation for Bid (IFB) number, grant announcement number, the contract

grant, or loan award number, the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate boxes. Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate boxes. Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with Federal officials. Identify the Federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Disclosure of Lobbying Activities (Approved by OMB 0348-0046)

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

1. Type of Federal Action: ☐ a. contract ☐ b. grant ☐ c. cooperative agreement ☐ d. loan ☐ e. loan guarantee ☐ f. loan insurance	2. Status of Federal Action: ☐ a. Bid/offer/application ☐ b. Initial Award ☐ c. Post-Award	3. Report Type: ☐ a. initial filing ☐ b. material change **For Material Change Only:** Year_____ Quarter_____ Date of Last Report:_____

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier _____, (if known) Congressional District (if known):	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District (if known):
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number (if applicable) _____
8. Federal Action Number (if known)	9. Award Amount (if known) : $
10. a. Name and Address of Lobbying Registrant (*if individual, last name, first name, MI*): (*attach Continuation Sheet(s) SF-LLL-A, if necessary*)	b. Individuals Performing Services (*including address if different from No. 10a.*) (*last name, first name, MI*): (*attach Continuation Sheet(s) SF-LLL-A, if necessary*)
11. Amount of Payment (*check all that apply*): $ _____ ☐ actual ☐ planned 12. Form of Payment (*check all that apply*): ☐ a. cash ☐ b. In-kind; specify: Nature _____ Value _____	13. Type of Payment (*check all that apply*): ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other; specify: _____

14. Brief Description of Services Performed or to be Performed and Date(s) of Services, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11(*attach Continuation Sheet(s) SF-LLL-A, if necessary*):

15. Continuation Sheet(s) SF-LLL-A attached: ☐ Yes ☐ No

16. Information requested through this form is authorized by title 31 U. S. C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U. S. C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No: _____ Date: _____

Federal Use Only	Authorized for Local Reproduction Standard Form - LLL

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, D. C. 20503

Attachment K: FFATA Form

Federal Funding Accountability and Transparency Act (FFATA) Data Reporting Requirement
NC DHHS Subawardee Information

A. Exemptions from Reporting

1. Entities are **exempted** from the entire FFATA reporting requirement if **any** of the following are true:
   - The entity has a gross income, from all sources, of less than $300,000 in the previous tax year
   - The entity is an individual
   - If the required reporting would disclose classified information
2. Entities who are not exempted for the FFATA reporting requirement may be exempted from the requirement to provide executive compensation data. This executive compensation data is **required only if both** are true:
   - More than 80% of the entity's gross revenues are from the federal government **and** those revenues are more than $25 million in the preceding fiscal year
   - Compensation information is *not* already available through reporting to the U.S. Securities and Exchange Commission.

By signing below, I state that the entity listed below is exempt from:

The entire FFATA reporting requirement:

☐ as the entity's gross income is less than $300,000 in the previous tax year.

☐ as the entity is an individual.

☐ as the reporting would disclose classified information.

Only executive compensation data reporting:

☐ as at least one of the bulleted items in item number 2 above is not true.

Signature _____ Name _____ Title _____

Entity _____ Date _____

B. Reporting

1. **FFATA Data** required by all entities which receive federal funding (except those exempted above) per the reporting requirements of the *Federal Funding Accountability and Transparency Act* (FFATA).

Entity's Legal Name _____ Contract Number _____

☐ Active UEI registration record is attached
An active registration with UEI is required

Entity's UEI _____

Entity's Parent's UEI (if applicable) _____

Entity's Location

street address _____
city/st/zip+4 _____
county _____

Primary Place of Performance for specified contract
Check here if address is the **same** as Entity's Location ☐

street address _____
city/st/zip+4 _____
county _____

2. **Executive Compensation Data** for the entity's five most highly compensated officers (unless exempted above):

	Title	Name	Total Compensation
1.			
2.			
3.			
4.			
5.			

Attachment L: Subcontractor/Subgrantee Information Form

The following information must be submitted for each proposed Subcontractor and Subgrantee using the following format. If the entity plans to subcontract or subgrant any of the work in their proposal but does not yet know the entity, include the following information with “TBD-Competitive” if putting out to bid or application or “TBD” if the entity plans to waive competition.

Organization or Individual’s Name (if an individual, include the person’s title):
EIN or Tax ID:
Street Address or PO Box:
City, State and ZIP Code:
Contact Name:
Contact Email:
Contact Telephone:
Fiscal Year End Date (of the entity):
Declare whether the entity is functioning as a vendor "Subcontractor" or "Subgrantee" of the applicant entity:

Attachment M: Confirmation of NC eVP Registration and Login
(NC Electronic Vendor Portal (eVP) and eProcurement)

Grantees and Grantees under contract with NCDHHS must be registered in the NC Electronic Vendor Portal (eVP) to receive reimbursements and payments. When registering, grantees must choose NC eProcurement as their registration type. There is no fee to register.

Please note that grantees and Grantees ***must login to NC eVP at least once a year*** to keep your account active and out of inactive status.

In order to avoid payment delays, please provide your eVP Customer Number below and confirm that you have logged in to eVP to keep your account active. When you login to eVP, your Customer Number can be found on your Main Page and also under the Company Information Tab.

Confirmed by:

_____
eVP Customer Number

_____
Name of Organization

_____
Signature of Organization Official

_____
Date

Appendix A: Terms & Conditions

The following Terms and Conditions will apply and be included in the awarded financial assistance contracts which result from this RFA. They are for reference only.

1. North Carolina General Terms and Conditions for Financial Assistance Contracts

Note: these terms and conditions do not reflect prescribed differences in clauses specifically for local governments, state agencies, private universities, and the UNC System.

Begins on next page.

GENERAL TERMS AND CONDITIONS

Definitions

Links to definitions are provided to meet the intent and requirements of NC Administrative Rules 09 NCAC Admin Code 03M.0102,and the North Carolina General Statutes unless otherwise noted. If the rule or statute that is the source of the definition is changed by the adopting authority, the change shall be incorporated herein.

Relationships of the Parties

Independent Contractor: The Grantee is and shall be deemed to be an independent contractor in the performance of this contract and as such shall be wholly responsible for the work to be performed and for the supervision of its employees. The Grantee represents that it has, or shall secure at its own expense, all personnel required in performing the services under this agreement. Such employees shall not be employees of, or have any individual contractual relationship with, the Division.

Subcontracting: The Grantee shall not subcontract any of the work contemplated under this contract without prior written approval from the Division. Any approved subcontract shall be subject to all conditions of this contract. Only the subcontractors or subgrantees specified in the contract documents are to be considered approved upon award of the contract. The Division shall not be obligated to pay for any work performed by any unapproved subcontractors or subgrantees. The Grantee shall be responsible for the performance of all its subcontractors/subgrantees.

Assignment: No assignment of the Grantee's obligations or the Grantee's right to receive payment hereunder shall be permitted. However, upon written request approved by the issuing purchasing authority, the State may: (a) Forward the Grantee's payment check directly to any person or entity designated by the Grantee; or (b) Include any person or entity designated by Grantee as a joint payee on the Grantee's payment check. In no event shall such approval and action obligate the State to anyone other than the Grantee and the Grantee shall remain responsible for fulfillment of all contract obligations.

Beneficiaries: Except as herein specifically provided otherwise, this contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this contract, and all rights of action relating to such enforcement, shall be strictly reserved to the Division and the named Grantee. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of the Division and Grantee that any such person or entity, other than the Division or the Grantee, receiving services or benefits under this contract shall be deemed an incidental beneficiary only.

Indirect Cost

Indirect Cost: The Grantee shall use their federally negotiated indirect cost rate in the recovery of administrative expenses associated with the funded contract. If the Grantee does not have a federally negotiated indirect cost rate from a federal cognizant agency, or has a previously negotiated but expired rate, the Grantee may be allowed to take the de minimis rate or 15% of modified total direct costs. In lieu of the above, the Grantee may negotiate an indirect cost rate with the DHHS Office of the Controller, Cost Analysis/Federal Financial Reporting/Administrative Section.

If a statutory cap on administrative expense has been set by the state or federal program, either in legislation or regulation, then the cap will take precedence. (CFR Title 2, Ch.II, Part 200.414, SL2022-52, 2.(c).

Services

Service Standards: During the term of the Agreement the Grantee and its employees, agents, and subgrantees shall provide high quality professional services consistent with the standards of practice in the geographic area and with all applicable federal, state, and local laws, rules and regulations, all applicable ethical standards, and standards established by applicable accrediting agencies. The Grantee and its employees, agents and subgrantees shall exercise independent professional judgment in the treatment and care of patients.

Records: During the term of this Agreement, the Grantee and its employees, agents, and subgrantees shall maintain complete and professionally adequate medical records consistent with the standards of practice in the geographic area and their respective health care professions. The Grantee and its employees, agents, and subgrantees shall prepare all reports, notes, forms, claims and correspondence that are necessary and appropriate to their professional services.

Licenses: During the term of this Agreement, the Grantee and its employees, agents, and subgrantees shall hold, current facility and occupational licenses and certifications at the levels required to practice their professions and to provide the contracted services in the State of North Carolina.

Indemnity and Insurance

Indemnification: The Grantee agrees to indemnify and hold harmless the Division, the State of North Carolina, and any of their officers, agents and employees, from any claims of third parties arising out of any act or omission of

the Grantee or its employees, agents or subgrantees in connection with the performance of this contract.

Insurance: (a) During the term of the contract, the Grantee shall provide, at its sole cost and expense, commercial insurance of such types and with such terms and limits as may be reasonably associated with the contract. At a minimum, the Grantee shall provide and maintain the following coverage and limits:

(1) **Professional Liability Insurance:** The Grantee shall ensure that the Grantee and its employees, agents, and subgrantees each maintain through an insurance company or through a program of self-funded insurance, professional liability insurance with limits of at least $1,000,000 per occurrence and at least $3,000,000 in the aggregate.

(2) **Worker's Compensation Insurance**: The Grantee shall provide and maintain worker's compensation insurance, as required by the laws of the states in which its employees work, covering all of the Grantee's employees who are engaged in any work under the contract.

(3) **Employer's Liability Insurance:** The Grantee shall provide employer's liability insurance, with minimum limits of $500,000.00, covering all of the Grantee's employees who are engaged in any work under the contract.

(4) **Commercial General Liability Insurance**: The Grantee shall provide commercial general liability insurance on a comprehensive broad form on an occurrence basis with a minimum combined single limit of $1,000,000.00 for each occurrence.

(5) **Automobile Liability Insurance**: The Grantee shall provide automobile liability insurance with a combined single limit of $500,000.00 for bodily injury and property damage; a limit of $500,000.00 for uninsured/under insured motorist coverage; and a limit of $2,000.00 for medical payment coverage. The Grantee shall provide this insurance for all automobiles that are:

(A) owned by the Grantee and used in the performance of this contract;

(B) hired by the Grantee and used in the performance of this contract; and

(C) owned by Grantee's employees and used in performance of this contract ("non-owned vehicle insurance"). Non-owned vehicle insurance protects employers when employees use their personal vehicles for work purposes. Non-owned vehicle insurance supplements, but does not replace, the car-owner's liability insurance.

The Grantee is not required to provide and maintain automobile liability insurance on any vehicle – owned, hired, or non-owned -- unless the vehicle is used in the performance of this contract.

(b) The insurance coverage minimums specified in subparagraph (a) are exclusive of defense costs.

(c) The Grantee understands and agrees that the insurance coverage minimums specified in subparagraph (a) are not limits, or caps, on the Grantee's liability or obligations under this contract.

(d) The Grantee may obtain a waiver of any one or more of the requirements in subparagraph (a) by demonstrating that it has insurance that provides protection that is equal to or greater than the coverage and limits specified in subparagraph (a). The Division shall be the sole judge of whether such a waiver should be granted.

(e) The Grantee may obtain a waiver of any one or more of the requirements in paragraph (a) by demonstrating that it is self-insured and that its self-insurance provides protection that is equal to or greater than the coverage and limits specified in subparagraph (a). The Division shall be the sole judge of whether such a waiver should be granted.

(f) Providing and maintaining the types and amounts of insurance or self-insurance specified in this paragraph is a material obligation of the Grantee and is of the essence of this contract.

(g) The Grantee shall only obtain insurance from companies that are authorized to provide such coverage and that are authorized by the Commissioner of Insurance to do business in the State of North Carolina. All such insurance shall meet all laws of the State of North Carolina.

(h) The Grantee shall comply at all times with all lawful terms and conditions of its insurance policies and all lawful requirements of its insurer.

(i) The Grantee shall require its subgrantees to comply with the requirements of this paragraph.

(j) The Grantee shall demonstrate its compliance with the requirements of this paragraph by submitting certificates of insurance, if requested, to the Division before the Grantee begins work under this contract.

Default and Termination

Termination Without Cause: The Division may terminate this contract without cause by giving **30 days written notice** to the Grantee. In that event, all finished or unfinished deliverable items prepared by the Grantee under this contract shall, at the option of the Division, become its property and the Grantee shall be entitled to receive just and equitable compensation for any satisfactory work completed on such materials, minus any payment or compensation previously made.

Termination for Cause: If, through any cause, the Grantee shall fail to fulfill its obligations under this contract in a timely and proper manner, the Division shall have the right to terminate this contract by giving written notice to the Grantee and specifying the effective date thereof. In that event, all finished or unfinished deliverable items prepared by the Grantee under this contract shall, at the option of the Division, become its property and the Grantee shall be entitled to receive just and equitable compensation for any satisfactory work completed on such materials, minus any payment or compensation

previously made. Notwithstanding the foregoing provision, the Grantee shall not be relieved of liability to the Division for damages sustained by the Division by virtue of the Grantee's breach of this agreement, and the Division may withhold any payment due the Grantee for the purpose of setoff until such time as the exact amount of damages due the Division from such breach can be determined. In case of default by the Grantee, without limiting any other remedies for breach available to it, the Division may procure the contract services from other sources and hold the Grantee responsible for any excess cost occasioned thereby. The filing of a petition for bankruptcy by the Grantee shall be an act of default under this contract.

Waiver of Default: Waiver by the Division of any default or breach in compliance with the terms of this contract by the Grantee shall not be deemed a waiver of any subsequent default or breach and shall not be construed to be modification of the terms of this contract unless stated to be such in writing, signed by an authorized representative of the Department and the Grantee and attached to the contract.

Availability of Funds: The parties to this contract agree and understand that the payment of the sums specified in this contract is dependent and contingent upon and subject to the appropriation, allocation, and availability of funds for this purpose to the Division.

Force Majeure: Neither party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations by any act of war, hostile foreign action, nuclear explosion, riot, strikes, civil insurrection, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

Survival of Promises: All promises, requirements, terms, conditions, provisions, representations, guarantees, and warranties contained herein shall survive the contract expiration or termination date unless specifically provided otherwise herein, or unless superseded by applicable Federal or State statutes of limitation.

Compliance with Applicable Laws

Compliance with Laws: The Grantee shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business, including those of federal, state, and local agencies having jurisdiction and/or authority.

Equal Employment Opportunity: The Grantee shall comply with all federal and State laws relating to equal employment opportunity.

Health Insurance Portability and Accountability Act (HIPAA): The Grantee agrees that, if the Division determines that some or all of the activities within the scope of this contract are subject to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-91, as amended ("HIPAA"), or its implementing regulations, it will comply with the HIPAA requirements and will execute such agreements and practices as the Division may require to ensure compliance.

Confidentiality

Confidentiality: Any information, data, instruments, documents, studies or reports given to or prepared or assembled by the Grantee under this agreement shall be kept as confidential and not divulged or made available to any individual or organization without the prior written approval of the Division. The parties specifically agree that all medical and other patient records shall be treated as confidential so as to comply with all state and federal laws and regulations regarding confidentiality of such records. These confidentiality obligations shall not terminate with the termination of this Agreement.

Data Security: The Grantee shall adopt and apply data security standards and procedures that comply with all applicable federal, state, and local laws, regulations, and rules.

Duty to Report: The Grantee shall report a suspected or confirmed security breach to the Division's Contract Administrator within twenty-four (24) hours after the breach is first discovered, provided that the Grantee shall report a breach involving Social Security Administration data or Internal Revenue Service data within one (1) hour after the breach is first discovered. During the performance of this contract, the Grantee is to notify the Division contract administrator of any contact by the federal Office for Civil Rights (OCR) received by the Grantee.

Cost Borne by Grantee: If any applicable federal, state, or local law, regulation, or rule requires the Division or the Grantee to give affected persons written notice of a security breach arising out of the Grantee's performance under this contract, the Grantee shall bear the cost of the notice.

Oversight

Access to Persons and Records: The State Auditor shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions in accordance with General Statute 147-64.7. Additionally, as the State funding authority, the Department of Health and Human Services shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions.

Record Retention: See schedule for record retention for instructions on disposal timeframes. (https://www.ncdhhs.gov/about/administrative-offices/office-controller/records-retention)

Government Review: To the extent required by applicable law and pursuant to written requests from any appropriate governmental authority, Grantee and the Division shall make available to such appropriate governmental authority this Agreement and any books, records, documents and other records that are necessary to certify the nature and extent of the services provided and the cost claimed for services rendered pursuant to this Agreement or so as to otherwise comply with the requirements of any lawful agreement between the party and such governmental authority.

Miscellaneous

Choice of Law: The validity of this contract and any of its terms or provisions, as well as the rights and duties of the parties to this contract, are governed by the laws of North Carolina. The Grantee, by signing this contract, agrees and submits, solely for matters concerning this Contract, to the exclusive jurisdiction of the courts of North Carolina and agrees, solely for such purpose, that the exclusive venue for any legal proceedings shall be Wake County, North Carolina. The place of this contract and all transactions and agreements relating to it, and their situs and forum, shall be Wake County, North Carolina, where all matters, whether sounding in contract or tort, relating to the validity, construction, interpretation, and enforcement shall be determined.

UEI and SAM Registration: 2 CFR Part 25 requires all non-Federal entities that apply for grants and cooperative agreements with federal funding to obtain a Unique Entity Identifier (UEI) number.

NC SOS: Entities doing business with the State of North Carolina must register with the North Carolina Secretary of State (NC SOS) in accordance with all current statutes, regulations and all other requirements.

Validations: Entities listed on the NC Suspension of Funding List (SOFL), NC Debarred List, Iran Divestment List, or the Federal Exclusion List are ineligible to contract with the State until resolution of issues are validated. The Suspension of Funding List is posted at: NC OSBM Suspension of Funding.

Amendment: This contract may not be amended orally or by performance. Any amendment must be made in written form and executed by duly authorized representatives of the Agency and the Grantee.

Automatic Time-Limited Extension: If the Grantee is a Non-Profit Grantee, as defined under (11a), this Contract may be automatically extended for up to three months if a formal extension or renewal contract has not been executed within ten (10) business days of the subsequent extension or renewal contract start date, and all of the following requirements are met:

(i) the Non-Profit Grantee is receiving recurring funding or nonrecurring state and/or federal funding for each year of a fiscal biennium.

(ii) the Non-Profit Grantee has certified, on a form provided by the Department, that it has received an unqualified audit report on its most recent financial audit when an audit is required by 09 NCAC 03M.0202;

(iii) the Non-Profit Grantee has a track record of timely performance and financial reporting to the Department as required by the contract.

(iv) the Non-Profit Grantee, as identified by the Department, does not have a record of noncompliance with the requirements of any funding source used to support the contract and has not received an undisputed notice of such a noncompliance from the Department. Noncompliance in this section is subject to the provisions around noncompliance found in Section 2.(a) of HB 791, Session Law 2022-52,and:

(v) the Non-Profit Grantee has been in operation for at least five (5) years.

In the event of an automatic extension pursuant to this provision, the terms of the contract in existence at the end of the prior contract period shall govern the relationship and obligations of the party until the end of the three-month period or the execution of a formal extension or renewal of the contract, whichever occurs first. Refer to HB 791, Session Law 2022-52, Section 2 for further guidance.

Severability: In the event that a court of competent jurisdiction holds that a provision or requirement of this contract violates any applicable law, each such provision or requirement shall continue to be enforced to the extent it is not in violation of law or is not otherwise unenforceable and all other provisions and requirements of this contract shall remain in full force and effect.

Headings: The Section and Paragraph headings in these General Terms and Conditions are not material parts of the agreement and should not be used to construe the meaning thereof.

Gender and Number: Masculine pronouns shall be read to include feminine pronouns and the singular of any word or phrase shall be read to include the plural and vice versa.

Time of the Essence: Time is of the essence in the performance of this contract.

Key Personnel: The Grantee shall not replace any of the key personnel assigned to the performance of this contract without the prior written approval of the Division. The term "key personnel" includes any and all persons identified by as such in the contract documents and any other persons subsequently identified as key personnel by the written agreement of the parties.

Care of Property: The Grantee agrees that it shall be responsible for the proper custody and care of any

property furnished to it for use in connection with the performance of this contract and will reimburse the Division for loss of, or damage to, such property. At the termination of this contract, the Grantee shall contact the Division for instructions as to the disposition of such property and shall comply with these instructions.

Travel Expenses: Reimbursement to the Grantee for travel mileage, meals, lodging and other travel expenses incurred in the performance of this contract shall not exceed the rates published in the applicable State rules. International travel shall not be reimbursed under this contract.

Sales/Use Tax Refunds: If eligible, the Grantee and all subgrantees shall: (a) ask the North Carolina Department of Revenue for a refund of all sales and use taxes paid by them in the performance of this contract, pursuant to G.S. 105-164.14; and (b) exclude all refundable sales and use taxes from all reportable expenditures before the expenses are entered in their reimbursement reports.

Advertising: The Grantee shall not use the award of this contract as a part of any news release or commercial advertising.

NCDHHS TC1008 (General Terms and Conditions) (Health Care Providers) (Rev. 8/24)

2. NCDHHS Privacy & Security Office (PSO) Terms and Conditions

Note: these terms and conditions do not reflect prescribed differences in clauses specifically for local governments, state agencies, private universities, and the UNC System.

1. COMPLIANCE WITH APPLICABLE LAWS

In addition to the requirements in the Compliance with Applicable Laws paragraph of the General Terms and Conditions, the Grantee shall comply with all electronic storage standards concerning privacy, data protection, confidentiality, and security including those of federal, state, and DHHS having jurisdiction where business services are provided for accessing, receiving, or processing all confidential information.

2. NC STATE AND NC DEPARTMENT OF HEALTH AND HUMAN SERVICES PRIVACY AND SECURITY REQUIREMENTS

The Grantee shall implement internal data security measures, and other industry security best practices utilizing appropriate hardware and software necessary to monitor, maintain, and ensure data integrity in accordance with all applicable federal regulations, state regulations, DHHS privacy and security policies, and local laws. The Grantee will maintain all privacy and security safeguards throughout the term of this agreement. In addition, the Grantee agrees to maintain compliance with the following:

NCDHHS Privacy Manual and Security Manual, both located online at:
https://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-security

NC Statewide Information Security Manual, located online at:
https://it.nc.gov/statewide-information-security-policies

3. CONFIDENTIALITY

In addition to the requirements in the Confidentiality paragraph of the General Terms and Conditions, the Grantee shall protect the confidentiality of all information, data, instruments, documents, studies, or reports given to the Grantee under this Contract in accordance with the standards of the NCDHHS PSO and adhere to NCDHHS privacy and security policies, applicable local laws, state regulations, and federal regulations including: the Privacy Rule at 45 C.F.R. Parts 160 and 164, subparts A and E , Security Standards at 45 C.F.R. Parts 160, 162 and 164, subparts A and C (“the Security Rule”), and the applicable provisions of the Health Information Technology for Economic and Clinical Health Act (HITECH).

4. DATA SECURITY

In addition to the requirements in the Data Security paragraph of the General Terms and Conditions, in the event the Grantee obtains written consent by an NCDHHS Division or Office to enter into a third-party agreement to whom the Grantee provides confidential information, the Grantee shall ensure that such agreement contains provisions reflecting obligations of data confidentiality and data security stringent as those set forth in the Contract.

5. DUTY TO REPORT

In addition to the requirements in the Duty to Report paragraph of the General Terms and Conditions and any NCDHHS PSO notification requirements in a Business Associate Agreement (BAA) with a NCDHHS Division or Office, the Grantee shall (1) report all suspected and confirmed privacy/security incidents or privacy/security breaches involving unauthorized access, use, disclosure, modification, or data destruction to the NCDHHS Privacy and Security Office at https://www.ncdhhs.gov/about/administrative-divisions-offices/office-privacy-security the Division Contract Administrator within twenty-four (24) hours after the incident is first discovered. (2) If the

privacy or security incident involves Social Security Administration (SSA) data or Centers for Medicare & Medicaid Services (CMS) data, the Grantee shall report the incident within one (1) hour after the incident is first discovered. At a minimum, such privacy and security incident report will contain to the extent known: the nature of the incident, specific information about the data compromised, the date the privacy or security incident occurred, the date the Grantee was notified, and the identity of affected or potentially affected individual(s). (3) During the performance of this contract, the Grantee is to notify the NCDHHS Privacy and Security Office of any contact by the federal Office for Civil Rights (OCR) received by the Grantee. In addition, the Grantee will reasonably cooperate with NCDHHS Divisions and Offices to mitigate the damage or harm of such security incidents.

6. ENCRYPTION

The Grantee shall implement a strong encryption algorithm that meets industry encryption standard criteria as defined by NIST and HIPAA Security Standards to encrypt all confidential information including protected health information (PHI) and personally identifiable information (PII) while in transit to ensure data confidentiality and security.

7. SUBCONTRACTING

In addition to the requirements in the Subcontracting paragraph of the General Terms and Conditions, if a subcontractor or subgrantee is used in the performance of this Contract, the Grantee must include, without modification, all the NCDHHS PSO Terms and Conditions in each subcontract or subaward.

3. NCDHHS Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement (BAA)

This Agreement is made effective the ___ day of _____, 202__, by and between _____ (name of Division, Office or Institution) ("Covered Entity") and _____ (name of contractor) ("Business Associate") (collectively the "Parties").

1. BACKGROUND

a. Covered Entity and Business Associate are parties to an agreement entitled (identify agreement) _____ (the "Contract"), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

b. Covered Entity is an organizational unit of the North Carolina Department of Health and Human Services (the "Department") that has been designated in whole or in part by the Department as a health care component for purposes of the HIPAA Privacy Rule.

c. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule.

d. The Parties enter into this Business Associate Agreement as an addendum to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose Protected Health Information to a business associate and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. DEFINITIONS

Unless some other meaning is clearly indicated by the context, the following terms shall have the following meaning in this Agreement:

a. "Electronic protected health information" or "ePHI" shall have the same meaning as the term "Electronic protected health information" in 45 C.F.R. § 160.103.

b. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as modified and amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

c. "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. § 160.103 and shall include a Person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

d. "Person" shall have the same meaning as the term "person" in 45 C.F.R. § 160.103 and shall include a human being that is born alive, trust or estate, partnership,

corporation, professional association or corporation, or other entity, public or private.

e. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164.
f. "Protected Health Information" or "PHI" shall have the same meaning as the term "Protected Health Information" in 45 C.F.R. § 160.103, limited to the information compiled, created, or received by Business Associate from or on behalf of Covered Entity.
g. "Required By Law" shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.103.
h. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or the Person to whom the authority involved has been delegated.
i. "Security Rule" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Part 164, Subpart C.
j. Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the Privacy Rule.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

a. Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as Required By Law.
b. Business Associate agrees to use appropriate safeguards and comply, where applicable, with subpart C of 45 C.F.R. Part 164 with respect to ePHI, to prevent use or disclosure of the ePHI other than as provided for by this Agreement.
c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.
d. Business Associate agrees to comply with all applicable requirements of the Security Rule (45 C.F.R. Part 164, Subparts A and C) with respect to electronic protected health information.
e. Business Associate shall implement physical, administrative and technical safeguards that reasonably protect the confidentiality, integrity and availability of any ePHI that it creates, receives, maintains or transmits on behalf of the NC DHHS.
f. Business Associate agrees to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement of which it becomes aware, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410.
g. Business Associate agrees, in accordance with 45 C.F.R. § 164.502(e)(1) and § 164.308(b)(2), to ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.
h. Business Associate agrees to make available PHI as necessary to satisfy Covered Entity's obligations in accordance with 45 C.F.R. § 164.524.

i. Business Associate agrees to make available PHI for amendment and incorporate any amendment(s) to PHI in accordance with 45 C.F.R. § 164.526.
j. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by Business Associate on behalf of, Covered Entity available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
k. Business Associate agrees to make available the information required to provide an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

4. PERMITTED USES AND DISCLOSURES

a. Except as otherwise limited in this Agreement or by other applicable law or agreement, if the Contract permits, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure:
(1) would not violate the Privacy Rule if done by Covered Entity; or
(2) would not violate the minimum necessary policies and procedures of the Covered Entity.
b. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that:
(1) The disclosures are Required By Law; and
(2) Business Associate obtains reasonable assurances from the Person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the Person, and the Person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
c. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).
d. Notwithstanding the foregoing provisions, Business Associate shall not use or disclose PHI if the use or disclosure would violate any term of the Contract or other applicable law or agreements.

5. TERM AND TERMINATION

a. **Term**. This Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.
b. **Termination for Cause**. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:
(1) Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement and services provided by Business

Associate, to the extent permissible by law, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

(2) Immediately terminate this Agreement and services provided by Business Associate, to the extent permissible by law; or

(3) If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

c. **Effect of Termination**.

(1) Except as provided in paragraph (2) of this section or in the Contract or by other applicable law or agreements, upon termination of this Agreement and services provided by Business Associate, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

(2) In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

6. GENERAL TERMS AND CONDITIONS

a. This Agreement amends and is part of the Contract.

b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.

c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. In the event that a conflict then remains, the Contract terms shall prevail so long as they are in accordance with the Privacy Rule.

d. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

_____

PLEASE PRINT NAME

_____ _____

SIGNATURE Date

4. Federal Cooperative Agreement for Rural Health Transformation (RHT) Program Centers for Medicare & Medicaid Services (CMS) Program Terms and Conditions

Begins on next page.

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

[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).

5. Centers for Medicare & Medicaid Services Standard Grant and Cooperative Agreement Terms and Conditions

Begins on next page.

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.

6. Confidentiality of Substance Use Disorder Patient Records: 42 CFR Part 2

Because behavioral health is an integral feature of the NC ROOTS Hub Program, Code of Federal Regulations (CFR) 42, Part 2 shall apply to all entities who receive the federal funding associated with this program, including all pass-through subrecipients and contractors.

"Part 2" is a federal law (42 U.S.C. 290dd-2 and 42 CFR part 2) that protects the confidentiality of patient records for people receiving services for substance use disorders (SUDs). Part 2 confidentiality rules describe when and how SUD patient records may be used and disclosed. These records are called Part 2 records.

Federal law protects the privacy of patient records related to SUD. The law applies to federally assisted programs providing education, prevention, training, treatment, rehabilitation, or research for substance use disorder. The law provides safeguards and procedures for using and disclosing Part 2 records, including criteria for court orders to authorize disclosure of SUD records. It also gives the Secretary of Health and Human Services (HHS) the authority to issue regulations.

Part 2 rules apply to any federally assisted program that provides SUD diagnosis, treatment, or referral for treatment. These programs are called Part 2 programs. Some Part 2 requirements also apply to people and organizations who receive Part 2 records, such as other health care providers, Qualified Service Organizations (QSOs), HIPAA covered entities and business associates, intermediaries, and investigative agencies.

Confidentiality protections are important because fear of discrimination or legal trouble can deter people from seeking SUD treatment. Part 2 rules establish:

- **Limitations on when SUD patient records can be shared**. In general, Part 2 programs cannot share any information that would identify someone as having, or having had, a substance use disorder unless Part 2 specifically permits it. With limited exceptions, such as for emergency medical treatment, records may only be shared if the patient gives written consent or there is a court order and subpoena (or similar legal mandate).
- **Single consent and redisclosure**. Patients can provide a single consent for all future uses and disclosures of Part 2 records for treatment, payment, and health care operations. This is called a "TPO consent." When an entity that is subject to HIPAA, such as a covered health care provider or a patient's health plan, receives a Part 2 record with the TPO consent, that entity can share the record again without consent in all the ways that HIPAA allows, except for using the information in legal proceedings against the patient.
- **Prohibitions on the use of SUD patient records against a patient**. Part 2 prohibits SUD patient records from being used or disclosed in legal proceedings against patients without their consent or a court order and subpoena (or a similar legal mandate). It also establishes requirements for court orders that permit use and disclosure under limited circumstances.

Appendix B: NCRHTP Success Measures

	Outcome	Metric	Baseline	Target	Data Source(s)
Initiative 1	Establish NC ROOTS Hubs*	Number of NC ROOTS Hubs established	0	6	NCDHHS/NCDHHS Overseeing Program
	Safety Net Provider Hub Participation*	Proportion of eligible hospitals, providers, and CBOs participating in Hub collaborative activities	0%	Dependent upon eligible Hub Network entities per region. By PY2	Self-report from NC ROOTS Hub Annual to NCDHHS
	Deploy Community Based Initiatives*	Number of community-specific targeted initiatives deployed, relative to baseline	0	Dependent upon eligible Hub Network entities per region. By PY3	Self-report from NC ROOTS Hub Annual to NCDHHS
	Referral Activity for Hub Services*	% of successful referrals to community provider network	0%	Dependent upon eligible Hub Network entities per region. By PY5	Derived from Referral Management System Annual to NCDHHS
Initiative 2	**Perinatal Care:** Increase Access to Prenatal Care*	% of births to women who receive prenatal care during the first trimester of pregnancy	Statewide: 72%[3]	80% By PY5	NC State Center for Health Statistics Annual State dashboard
	Chronic Disease: Reduction in Chronic Disease High-Cost Comorbidity Burden*	Reduction in the % of adults in the target rural population reporting three or more chronic health conditions	12.1%[4]	9.7%[5] By PY5	Annual EMR data Collected at the regional level by ROOTS Hubs.
	Chronic Care: Increase Patient Use of Self-Monitoring Blood Pressure*	% increase in # of patients who are offered/received SMBP out of those eligible	TBD[6]	5% PY3 10% PY5	Annual EMR data Collected at the regional level by ROOTS Hubs.
	Chronic Care: Decrease Tobacco Use*	% increase of referrals to QuitlineNC from participating counties / organizations	TBD	5% PY 3 10% PY5	(QuitlineNC Vendor) Quarterly report to NCDHHS

[3] Rural county rates to be established from existing data.
[4] Hubs to establish new baselines for region.
[5] Note: during this period, we anticipate a boost in uninsured populations. Maintaining would be a success.
[6] To be established for each NC ROOTS Region.

	Outcome	Metric	Baseline	Target	Data Source(s)
	Food As Medicine: Increase access to healthy food prescriptions	% of high-risk individuals (as defined by NCDHHS) receiving healthy food boxes.	TBD[7]	15-20% By PY5	Collected at the regional level by ROOTS Hubs.
Initiative 3	Establish New Rural CCBHCs*	Number of rural CCBHCs	0	5 By PY2	NCDHHS/NCDHHS Overseeing Program
	Increase in Percent of Individuals Medicaid Members Beginning Mental Health Treatment	% of Medicaid members beginning treatment	20%	5% increase each year By PY5	Quarterly reporting from Medicaid Managed Care Tailored Plans to NCDHHS
	Decrease ED Utilization for Mental Health Needs	Average daily # individuals in the emergency department seeking treatment for mental health needs	409	8-10% decrease By PY5	Quarterly reporting from NC Detect to NCDHHS
	Decrease ED Utilization for Opioid Overdose	# of annual ED encounters related to opioid overdose	4,971	20% decrease By PY5	Monthly reporting from NC Detect to NCDHHS
	Decrease ED Occupancy for Youth Mental Health Needs	Average daily ED occupancy rate of members under the age of 18 for visits > 24 hours related to mental health needs	74	8-10% decrease By PY5	Quarterly reporting from NC Detect to NCDHHS
Initiative 4	Increase Rural Residencies & Fellowship Programs*	# of rural residency and fellowship programs launched in rural counties	10	8-12 new programs in high-need specialties By PY5	UNC System Office, Sheps Center Technical Assistance Center (TAC) Annual Report Routinely analyzed
	Increase EMS Professionals in Rural Communities*	# of graduates each year accepting full/part-time positions in rural counties	0/New Baseline	150 EMTs per year For each of PY 2-5	Annual Report From regional partners to ROOTS Hubs
	Improve Rural Clinician Vacancy Rates*	County-level six-month clinician vacancy rate	TBD	10% reduction By PY5	Annual Report From regional partners to ROOTS Hubs
	Improve Rural County Primary Care Clinician Ratio*	Number of rural counties where ratio of population to primary care clinician is less than 1500:1	TBD	15% reduction By PY5	NC State Center for Health Statistics Annual State Dashboard Routinely analyzed
Initiative 5	**PCP Pilot** - Adults' Access to Preventive /Ambulatory Health Care (AAP)	Adults' Access to Preventive/Ambulatory Health Services: The percentage of persons 20 years of age and older	Comparable (rural, regional) AAP rate for most recent year	Improvement by greater than statewide trend By PY5	Administrative data stratified by rurality and region

[7] To be established for each NC ROOTS Region.

	Outcome	Metric	Baseline	Target	Data Source(s)
		who had an ambulatory or preventive care visit.	data available		This measure is a HEDIS measure and is routinely assessed
	PCP Pilot - Improving Perinatal Care: Well Child Visits	% of children receiving recommended well-child visits in the first 30 months of life	Comparable (rural, regional) WCV rate for most recent year data available	Improvement by greater than statewide trend By PY5	Administrative data stratified by rurality and region This measure is a HEDIS measure and is routinely assessed
	Value-Based Care - Primary Care	Increase in number of rural primary care practices participating in a primary care capitation payment model.	0	To be determined during implementation planning with rural practices By PY5	PHP Data PHPs report practice VBP participation on an annual basis using an existing format
	Hospital VBP Capacity Building Pilot - Reduce Transfers to Urban Hospitals*	Number of patients transferred from participating rural hospital to larger, urban hospital for care (county level performance based on hospital county)	Comparable rate for most recent year data available	To be determined during implementation planning with rural hospitals By PY5	Admission, Discharge and Transfer (ADT) data These data are available for DHHS analysis
Initiative 6	Rural Provider HIE Connectivity*	% of rural providers connected to NC Health Connex	1,153 rural practices currently connected	100 additional rural practices connected (new or repaired connections) By PY3	NC HealthConnex routinely tracks provider connections
	AI Tools: Clinical Decision Support	% of rural providers utilizing ambient CDS tools	TBD	TBD By PY5	Provider survey conducted by NC ROOTS Hub
	Emerging tech: Provider Education	# of rural providers participating in TACs (Technical Assistance Centers)	TBD	TBD By PY5	Activity registration data collected by NC ROOTS Hub
	Rural Resident Engagement	Number of rural residents who receive 1:1 training or attend a group training session	0 (not yet launched)	TBD By PY5	Activity registration data collected by NC ROOTS Hub

Appendix C: Resources

Rural Health Data

- **Rural Health Information Hub** -https://www.ruralhealthinfo.org/ -
  - Site provides rural health data – NC data https://www.ruralhealthinfo.org/states/north-carolina/charts
  - Rural data visualizations by state- **Rural Data Explorer**-Interactive map for exploring county-level data on issues that impact rural health, including rural demographics, health disparities, the health workforce, and other topics.
  - **Evidence-Based Toolkits for Rural Community Health**
    - Tools for Success includes toolkits and other resources to support rural health

- **Rural Health Research Gateway** -https://www.ruralhealthresearch.org/

- **Sheps Center- NC Rural Health Research Program**
  https://www.shepscenter.unc.edu/programs-projects/rural-health/

- **NC Data Portal** - https://ncdataportal.org/ - Explore Conditions in your community in the North Carolina Map Room including 30,000 mappable data layers covering topics such as demographics, health and education.

- **NC Health Statistics-**
  - NC State Center on Health Statistics
    https://schs.dph.ncdhhs.gov/
    County Health Data 2025
    https://schs.dph.ncdhhs.gov/data/databook/

- CDC Office of Rural Health - https://www.cdc.gov/rural-health/php/index.html
  - Rural Health Data
  - Rural Health Strategic Plan - CDC Rural Public Health Strategic Plan

  - Cancer in Rural America - Cancer is the second leading cause of death in the United States. Compared to urban areas, rural areas have lower rates of new cancer cases, but the cancer death rate is higher.2
  - Child Health in Rural America - Parents of children with mental, behavioral, and developmental disorders in rural communities often report more hardships than their urban counterparts. Children with these disorders who live in rural areas could benefit from better access to mental and behavioral healthcare programs that support parents and caregivers.
  - COPD Urban-Rural Differences - People living in rural areas face higher risks for chronic obstructive pulmonary disease (COPD). Rural areas have more smoking, less access to programs to help quit smoking, and limited healthcare. Improved access to healthcare can lead to better quality of life and reduced deaths.
  - COPD Burden - Chronic obstructive pulmonary disease, or COPD, is a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema and chronic bronchitis. People living in rural areas experience higher rates of COPD, COPD-related hospitalizations covered by Medicare, and COPD deaths than urban Americans.

- Diabetes Self-Management in Rural America - 1 in 10 Americans have diabetes. Diabetes self-management education and support (DSMES) helps manage diabetes, but most rural areas don't have DSMES programs. 62% of rural counties in the United States do not have diabetes self-management education and support.
- Drug Overdose in Rural America - Drug overdoses are the leading cause of injury or death in the U.S. People who live in rural areas are now at greater risk of death from drug overdose than those who live in urban areas. Understanding differences in rural and urban drug overdose deaths can lead to better responses by healthcare professionals.
- Health Behaviors in Rural America - People living in rural areas in the U.S. are more likely than their urban counterparts to be at higher risk for certain diseases and health conditions. Most chronic diseases can be prevented by eating well, being physically active, avoiding tobacco and excessive drinking, and getting regular health screenings.
- Motor Vehicle Safety in Rural America - Deaths from motor vehicle accidents in rural areas are much higher than those in urban areas. The resources on this page help show why this is happening in rural areas and how they can be addressed.
- Suicide in Rural America - People who live in rural areas are at a higher risk for suicide than people who live in urban areas. Suicide rates almost doubled between 2000-2020 in rural areas.
- Vaccination in Rural Communities - Many adolescents in rural communities are not getting the recommended vaccines to protect against diseases. It is important to support healthcare professionals in effectively recommending vaccines for adolescents and addressing parents' concerns.

Hospital Resources

- **The Rural Health Redesign Center** - https://rhrco.org/
  The Rural Health Redesign Center (RHRC) Congress allocated funding to the **Federal Office of Rural Health Policy** (FORHP), a division of the **Health Resources and Services Administration** (HRSA), to support hospitals exploring or converting to the REH designation through dedicated technical assistance (TA)**[ii]**. The Rural Health Redesign Center (RHRC) was awarded a Cooperative Agreement with FORHP to serve as the national REH Technical Assistance Center (TAC)**[iii]**. At no cost to rural hospitals the RHRC offers a wide range of services to promote healthier communities, which include innovative programs, technical assistance, strategic planning, financial analysis, and emergency support for distressed hospitals.

Aspen Institute – Rural Development

- Building a Better Rural Development Ecosystem - https://www.aspeninstitute.org/wp-content/uploads/2019/11/CSG-Rural-Dev-Hubs-Building.pdf

- Fostering Community Well-Being with Asset-Based Development
  https://www.aspencsg.org/four-principles-for-fostering-community-well-being-with-asset-based-develo…

- Insights and recommendations to foster rural & Indigenous well-being with asset-based development.
  https://www.aspencsg.org/pathways-to-health-equity-rural-wellbeing-and-regional-assets/

Telehealth and Broadband

- NCTNA - North Carolina Telehealth Network Association- https://nctna.org/
  The North Carolina Telehealth Network Association (NCTNA) is a dynamic, member-led nonprofit that works to connect and empower North Carolina's public and non-profit healthcare providers with medical-grade broadband connectivity services. As a telehealth consortium led by industry experts, we specialize in two areas that can be challenging to navigate alone: broadband connectivity and federally funded discounts on broadband for eligible providers.

- NC DIT-Broadband and Digital Opportunity Office
  - **https://www.nconemap.gov/pages/broadband**
  - **https://www.ncbroadband.gov/**
  - Digital Skills Standards- https://www.ncbroadband.gov/digital-skills-standards

- Mid-Atlantic Telehealth Resource Center - Home - MATRC
  - MATRC Resources in NC - North Carolina - MATRC

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