



State Rural Health Transformation Program
 Application Template (for State Use under CMS Funding)
 Administered by: State of Georgia Department of Community Health (DCH)
 Funded through: Centers for Medicare & Medicaid Services (CMS)
 Assistance Listing Number: 93.224 – Rural Health System Transformation

Section	System Number	Field	Field Type	Options (If applicable)	Instructions	Description	Required
Contact Information	N/A	First Name	Single line of text		Enter First Name		*
	N/A	Last Name	Single line of text		Enter Last Name		*
	N/A	Job Title	Single line of text		Enter Job Title		*
	N/A	Email	Single line of text		Enter Email		*
	N/A	Mobile Phone	Phone number	10-digit numeric text field	Enter Mobile Phone		*
	N/A	Business Phone	Phone number	10-digit numeric text field	Enter Business Phone		*
	N/A	Street 1	Single line of text		Enter Street 1		*
	N/A	Street 2	Single line of text		Enter Street 2		*
	N/A	City	Single line of text		Enter City		*
	N/A	State	Drop down	All 50 US States	Enter State		*
	N/A	Zip Code	Single line of text	5-digit numeric text field	Enter Zip Code		*
	N/A	Organization Name	Single line of text		Enter Organization Name		*
Applicant Information	N/A	Type of Entity	Drop down	<input type="checkbox"/> State Agency <input type="checkbox"/> Non Government <input type="checkbox"/> Quasi-Governmental Organization <input type="checkbox"/> Hospital <input type="checkbox"/> FQHC <input type="checkbox"/> Rural Health Clinic <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Consortium <input type="checkbox"/> Other	Select Type of Entity	<input type="checkbox"/> State Agency <input type="checkbox"/> Non Government <input type="checkbox"/> Quasi-Governmental Organization <input type="checkbox"/> Hospital <input type="checkbox"/> FQHC <input type="checkbox"/> Rural Health Clinic <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Consortium <input type="checkbox"/> Other	*
	N/A	If Consortium, please describe this application's entities and entity structure	Multi line of text		Enter Consortium description		*
	N/A	If Other, please describe	Single line of text		Enter Other description		*
	N/A	EIN	Single line of text	9-digit numeric text field	Enter EIN per W-9		*
	N/A	UEI	Single line of text	12-digit alphanumeric text field	Enter UEI as listed in Sam.gov		*
	N/A	County	Drop down	All GA counties	Select all counties of service		*
	N/A	Congressional District(s)	Drop down	Georgia's 1st Congressional District Georgia's 2nd Congressional District Georgia's 3rd Congressional District Georgia's 4th Congressional District Georgia's 5th Congressional District Georgia's 6th Congressional District Georgia's 7th Congressional District Georgia's 8th Congressional District Georgia's 9th Congressional District Georgia's 10th Congressional District Georgia's 11th Congressional District Georgia's 12th Congressional District Georgia's 13th Congressional District Georgia's 14th Congressional District	Please utilize https://www.census.gov/mycd/ to find the congressional district(s) impacted by your project. Select appropriate congressional district	Georgia's 1st Congressional District Georgia's 2nd Congressional District Georgia's 3rd Congressional District Georgia's 4th Congressional District Georgia's 5th Congressional District Georgia's 6th Congressional District Georgia's 7th Congressional District Georgia's 8th Congressional District Georgia's 9th Congressional District Georgia's 10th Congressional District Georgia's 11th Congressional District Georgia's 12th Congressional District Georgia's 13th Congressional District Georgia's 14th Congressional District	*
	N/A	Street 1	Single line of text		Enter Street 1		*
	N/A	Street 2	Single line of text		Enter Street 2		*
	N/A	City	Single line of text		Enter City		*
	N/A	State	Drop down	All 50 US States	Enter State		*
	N/A	Zip Code	Single line of text	5-digit numeric text field	Enter Zip Code		*
	N/A	POC First Name	Single line of text		Enter POC First Name		*
	N/A	POC Last Name	Single line of text		Enter POC Last Name		*
	N/A	POC Job Title	Single line of text		Enter POC Job Title		*
N/A	POC Email	Single line of text		Enter POC Email		*	
N/A	POC Phone Number	Phone number	10-digit numeric text field	Enter POC Phone Number		*	
N/A	Alternate POC First Name	Single line of text		Enter Alternate POC First Name		*	
N/A	Alternate POC Last Name	Single line of text		Enter Alternate POC Last Name		*	
N/A	Alternate POC Job Title	Single line of text		Enter Alternate POC Job Title		*	
N/A	Alternate POC Email	Single line of text		Enter Alternate POC Email		*	
N/A	Alternate POC Phone Number	Phone number	10-digit numeric text field	Enter Alternate POC Phone Number		*	
N/A	Vendor Number/ State Supplier ID (If Applicable)	Single line of text	10-digit alphanumeric text field	Enter Vendor Number/ State Supplier ID (If		*	
Eligibility Confirmation	1	Does the facility serve a HRSA-designated rural or	Checkbox		Check yes if applicable		*
	1	Project Title	Single line of text		Enter Project Title		*
Project Overview	2	Initiatives	Drop down	<input type="checkbox"/> Initiative 1: Transforming for a Sustainable Health System in Rural Georgia <input type="checkbox"/> Initiative 2: Strengthening the Continuum of Care in Rural Georgia <input type="checkbox"/> Initiative 3: Connecting to Care for Improved Healthcare Access <input type="checkbox"/> Initiative 4: Growing a Highly Skilled Healthcare Workforce <input type="checkbox"/> Initiative 5: Leveraging Technology in Support of Healthcare Innovations	Select a single Initiative	<input type="checkbox"/> Initiative 1: Transforming for a Sustainable Health System in Rural Georgia <input type="checkbox"/> Initiative 2: Strengthening the Continuum of Care in Rural Georgia <input type="checkbox"/> Initiative 3: Connecting to Care for Improved Healthcare Access <input type="checkbox"/> Initiative 4: Growing a Highly Skilled Healthcare Workforce <input type="checkbox"/> Initiative 5: Leveraging Technology in Support of Healthcare Innovations	*
	3	Strategies	Drop down	List of available strategies	Select a single strategy	List of available strategies	*

Executive Summary	1	The health access or capacity issue being addressed	Multi line of text		Enter response		*
	2	The target population (geography, demographics, upstream drivers of health) (2000 character limit)	Multi line of text		Enter response		*
	3	Proposed interventions or improvements (2000 character limit)	Multi line of text		Enter response		*
	4	Anticipated outcomes and alignment with state's Rural Health Transformation goals (2000 character limit)	Multi line of text		Enter response		*
Project Narrative	1	Needs Assessment (4000 character limit) Describe rural health challenges and capacity gaps as referenced on pages 28-29 on the Rural Health Transformation Program Notice of Funding Opportunity (RHTP NOFO). Be sure to reference data from the following sources: Report of History of Present Illness (RHPI), Health Resources and Services Administration (HRSA), or a Community Health Needs Assessment (CHNA) if available.	Multi line of text		Enter response		*
	2	Project Description (6000 character limit) Describe activities, services, and implementation strategies. Identify any known partner entities.	Multi line of text		Enter response		*
	3	Capabilities and Competencies (2000 character limit) Explain financial, staffing, and procedural capabilities that will allow your organization to complete the tasks within the given timeframe.	Multi line of text		Enter response		*
	4	Outcomes & Impact (4000 character limit) Please review outcomes associated with your strategy within the RHT Program application and describe how your project will achieve those outcomes. Describe additional measurable outcomes your project hopes to achieve and how your expected outcomes will impact the served community.	Multi line of text		Enter response		*
	5	Sustainability Plan (2000 character limit) Describe how the improvements will be sustained post-grant using CMS reimbursement models, value-based care, or state funding mechanisms.	Multi line of text		Enter response		*
Budget	1	Total Requested Grant Funds	Currency		Calculated field, no entry necessary		
	2	Budget Table	Table		Personnel Equipment Supplies Contractual Renovation Other (specify)		
Milestones & Timeline	1	Project Start Date	Date		Enter Project Start Date		*
	2	Project End Date	Date		Enter Project End Date		*
	3	Project Milestones	Table		Enter Project Milestones (minimum 1)		
Supporting Documentation	1	Supporting Documentation Table	Upload		Upload letters of support from state or local partners if applicable		
	N/A	Letters of Support (State or local partners)	Upload		Upload letters of support from state or local partners if applicable		
	N/A	SAM.gov registration proof	Upload		Please provide a screenshot of your entity's active registration listing from sam.gov. If your entity has submitted a registration request, please provide a screenshot of the submitted registration, Work in Progress Registration, or the Pending ID Assignment.		*
	N/A	Application Certification(s)	Upload		Provide proof of certification completion by uploading a screenshot, PDF, or other acceptable documentation that verifies the referenced certification.		
	N/A	Immigration Affidavit	Upload		The authorized official for your organization is required to review and sign this document. Additionally, this affidavit requires validation by a notary public at signature. Upon completion, please upload the executed file to your application. Access the template within the file upload window.		*
	N/A	Certification Regarding Lobbying	Upload		The authorized official for your organization is required to review and sign this document. Upon completion, please upload the executed file to your application. Access the template within the file upload window.		*
	N/A	Financial statements or Single Audit report (if applicable)	Upload		Upload audited financial statements from the prior fiscal year or a single audit form from the prior fiscal year. If this information cannot be provided, upload your unaudited financial statements from the prior fiscal year.		*
	N/A	Additional GREAT Application Documentation	Upload		Please utilize this field to provide supplementary material to your GREAT Health application as applicable.		
	1	Disclosure of Pending Application By checking this box, I attest that I have a pending application or intend to apply for other grant funding to cover the same project or cost items.	Checkbox		Check the box		

Disclosures and Attestation

1a	Disclosure Description Please detail your pending application or intent to apply for other funding, including the name of the grant program you have applied for or intend to apply for.	Multi line of text		Enter Description		*
2	Supplantation and Use of Funds Attestation: The Applicant hereby attests and certifies that all activities and expenditures proposed under this Rural Health Transformation (RHT) application comply with applicable Centers for Medicare & Medicaid Services (CMS) requirements and limitations, including but not limited to restrictions related to duplication of funding, supplantation, and Medicaid financing. Specifically, the Applicant certifies that: No Duplication or Supplantation of Funding RHT Program award funds will not be used to duplicate or supplant existing federal, State, or local funding sources. The Applicant affirms that proposed expenditures are additive in nature and support new, expanded, or transformed activities that would not otherwise be funded absent RHT support. No Use as Non-Federal Share of Medicaid Payments RHT Program funds will not be used to satisfy the non-federal share of Medicaid payments or any other federal health care program matching requirement. No Payment for Costs Eligible Under Other Programs The Applicant attests that RHT funds will not be used for expenses that are eligible for reimbursement or	Instructional only		No entry required		*
2a	Authorized Representative Signature	Single line of text		Enter signature text		*
2b	Authorized Representative Name	Single line of text		Enter Authorized Representative Name		*
2c	Title	Single line of text		Enter Title		*
2d	Date	Date		Enter Date		*
3	Open Records Attestation: Applicant acknowledges all written information (including contact information) and records received by Applicant are subject to the Open Records Act of Georgia (O.C.G.A. §50-18-70 et seq.) (hereinafter "ORA") and open to public inspection. If Applicant claims any portion of its material submitted to DCH or its (sub)contractors is a proprietary trade secret or subject to another lawful exemption under ORA, Applicant must clearly identify at the time of submission those portions of the material via a redacted copy of materials submitted as part of its application along with a legally sufficient trade secret affidavit ("TSA"). All claims regarding exception under the ORA are subject to final review by DCH. If there is an unresolved conflict between DCH and applicant as to what constitutes as exempt under the ORA, DCH shall provide Applicant ten (10) days advanced notice prior to release of the contested record(s).	Instructional only		No entry needed		*
3a	Authorized Representative Signature	Single line of text		Enter Authorized Representative Signature		*
3b	Authorized Representative Name	Single line of text		Enter Authorized Representative Name		*
3c	Title	Single line of text		Enter Title		*
3d	Date	Date		Enter Date		*
4	Compliance with O.C.G.A. § 36-80-23 (Sanctuary Cities): Is the applicant a local governing body as defined in O.C.G.A. § 36-80-23? "Local governing body" means any political subdivision of this state, including any county, consolidated government, municipality, authority, school district, commission, board, or any other local public body corporate, governmental unit, sheriff's office, law enforcement agency, or political subdivision.	Yes/No radio button		Select Yes or No		*

	4a	Compliance with O.C.G.A. § 36-80-23 (Sanctuary Cities) Attestation: Applicant understands and certifies that it does not currently have, and agrees for the duration of this grant, if awarded, not to enact, adopt, implement, or enforce a sanctuary policy as defined in O.C.G.A. § 36-80-23. Applicant further acknowledges this certification is a requirement of receiving any funds pursuant to this grant and that a violation of § 36-80-23 may result in the withholding of funding other than funds specified in O.C.G.A. § 50-36-1(d).	Instructional only		No entry needed		
	4b	Authorized Representative Signature	Single line of text		Enter Authorized Representative Signature		*
	4c	Authorized Representative Name	Single line of text		Enter Authorized Representative Name		*
	4d	Title	Single line of text		Enter Title		*
	4e	Date	Date		Enter Date		*
Authorized Representative Certification This attestation section and its questions will appear on the summary page upon submission of the application in the portal. It will not have its own tab in the application	1	I certify that this application is complete and accurate to the best of my knowledge and that all activities proposed will comply with applicable federal and state regulations, including 45 CFR 75 and CMS funding terms.	Instructional only		No entry needed		
	1a	Attested By	Single line of text		Enter Attested By		*
	1b	Title	Single line of text		Enter Title		*
	1c	Attested On	Date		Enter Attested On		*
	1d	Signature	Single line of text		Enter Signature		*