EMS RFA -Information Session Q&A

Information Sessions held July 2, 2026 and July 13, 2026 | Updated July 15, 2026

This document compiles questions and answers from both EMS RFA information sessions (July 2 and July 13, 2026) as well as questions submitted via email to RHTP-FHC@healthynh.org.

Eligibility & Geographic Designation

Q: Which rural designation map should applicants use to verify eligibility?
A: FHC follows the HRSA (Health Resources and Services Administration) definition of rurality. Applicants should use the HRSA Rural Health Grants Eligibility Analyzer, available online at the HRSA website. You can enter your address to confirm whether your location qualifies. This is the definitive tool FHC uses for rural geographic eligibility. Rural Health Grants Eligibility Analyzer

Q: Can an out-of-state nonprofit or other entity working with NH EMS agencies be the lead applicant?
A: No. The lead applicant should be a New Hampshire agency. Out-of-state organizations may participate as partners, but the lead applicant must be a New Hampshire-based organization that meets the eligibility requirements outlined in the RFA. Additionally, the application will be based on NH Rural Communities being served only.

Q: Can two or more EMS agencies jointly apply?
A: Yes. Partnerships between eligible organizations are explicitly encouraged, with one organization designated as the lead applicant. Regional and collaborative approaches are given scoring preference, particularly for Components 2 and 3.

Q: We have a mobile health program that offers weekly primary care services rather than emergency medical services, and care coordination clinics within our service area. Would this align with this RFA?
A: Yes. If your mobile health program aligns with the goals of this RFA - expanding access to care in rural communities through mobile integrated health - it can be a fit. Make sure your application narrative clearly explains how your program supports the EMS & MIH objectives outlined in the RFA.

Q: Are the eligibility entities listed in Section 4.0 of the RFA the only ones that should pursue funding? We are a Federally Qualified Health Center (FQHC) with a mobile health program looking to expand and don't fit those guidelines.
A: The eligibility criteria in this RFA are specific to EMS-focused applications. There will be other funding opportunities coming down the pipeline for non-EMS organizations, including FQHCs. Stay tuned for additional RFAs in FHC's portfolio that may be a better fit for your organization.

Q: Do municipal EMS agencies need to be considered rural as defined by the New Hampshire Safety Net Health Care Program map? Our agency is located in a non-rural community.
A: No - applicants do not need to be located in a rural community to be eligible. However, your project must support rural communities. You will need to clearly demonstrate in your narrative how the funding will support rural populations - the areas you serve, the impact on those communities, and how the project advances rural health outcomes. FHC will not fund projects that solely support urban areas.

Q: If our hospital is not located in a rural community but serves rural populations from surrounding towns - including towns that have some areas that are rural - are we still eligible?
A: Yes. Eligibility is based on the populations your project serves, not solely on the applicant's physical address. If your project meaningfully supports rural communities, you are eligible to apply. However, the reach and impact on rural populations will factor into scoring - projects with limited rural reach may score lower than those with deeper rural coverage.

Q: Can a rural hospital be the single applicant and submit a grant request to support multiple EMS agencies covering our rural area- for example, a collaborative approach for training, device purchases, and defining best medical practices and policies across a region?
A: Yes. FHC encourages this type of regional collaboration. A rural hospital may serve as the lead applicant on behalf of multiple EMS agencies, as long as the application clearly describes the collaborative structure, the role of each participating agency, and how the project benefits rural communities.

Q: Can a private entity create a new EMS agency under Component 1 and Component 2?
A: Yes, provided the entity meets the eligibility requirements - either holding a current New Hampshire EMS license, having a formally involved licensed NH EMS unit as a partner, or being in active pursuit of licensure with appropriate documentation submitted with the application.

Q: Can a behavioral health provider apply as a standalone applicant under this RFA?
A: Not as a standalone. For this EMS RFA, a behavioral health provider would need to partner with a licensed NH EMS unit and include that EMS partner in the application. Separately, the NH Community Behavioral Health Association (NHCBHA) is one of the five GO-NORTH hubs and is directly supporting the 10 community mental health centers in the state. Behavioral health services may also be embedded within other hubs' funded projects, but the primary vehicle for behavioral health-specific funding is through NHCBHA.

Q: Can these funds be used to support all patients in our hospital service area, including border towns in Vermont, Maine, or Western Massachusetts?
A: RHT funds must be used to support patients in New Hampshire rural communities. However, FHC recognizes that ambulance service areas don't always follow state lines - if an EMS unit funded by this grant picks up a patient across the border, that is an operational reality FHC cannot control. Your application narrative should describe how the project primarily serves NH rural communities and explain any cross-border service realities.

Funding, Components & Multi-Year Planning

Q: For a multi-agency collaboration, is the funding cap applied per agency or per application/project? Would the cap be viewed as a limit for each participating agency or the lead applicant as a whole?
A: The funding limits are guidelines per application, not per agency. If there are multiple agencies participating in a single application, FHC will apply flexibility on the cap - we do not want individual agencies filing separate applications just to maximize funding. We prefer that organizations partner together, and we will increase the limits to support larger collaborative grant projects. For future RFAs, FHC is working on formal language with a partnership multiplier on the cap. The key point: we will not penalize partnerships by limiting total funding. If your collaboration requires funding above the stated range, reach out to discuss.

Q: Can applicants propose a five-year project, recognizing that funding may not be guaranteed beyond the current award period? The one-year funding cycle makes long-term sustainability planning a challenge.
A: Yes - absolutely. FHC wants to see multi-year planning in your application. While we are only authorized to fund Budget Period 1 (through September 30, 2027), your multi-year plan and budget estimates help us demonstrate to GO-NORTH and CMS that there is a clear roadmap. When future-year funding is approved, having a multi-year plan already in place allows us to move efficiently into an amendment or continuation contract. Please include multi-year projections in your budget template.

Q: If an existing MIH program is going to develop a new service line and create a new regional program with multiple collaborative organizations, are they limited to the funding limits for existing MIH programs (Component 2)?
A: This is a great question that requires a case-by-case review. If you have a small existing MIH program but are proposing a significantly larger regional partnership that goes well beyond the scope of your current program, please email RHTP-FHC@healthynh.org with details about your proposal. FHC wants to understand the significance of the regional approach to provide the right guidance on which component and funding range applies.

Q: Can we apply for multiple components - for example, Component 1 and Component 3?
A: Yes. Applicants may apply for multiple components. Each application is evaluated and scored independently. Submitting multiple applications does not improve or diminish the score of any individual application.

Q: Can Component 1 be used to fund several small but different projects that total $25,000?
A: Yes. If the projects are all strengthening activities within the same rural community or service area, submit them as a single application with multiple line items rather than separate applications.

Q: Can Component 1 be used to stabilize and strengthen an active paramedic intercept program?
A: Yes. An active paramedic intercept program is an existing EMS service that falls within the scope of Component 1's stabilize and strengthen objective. Your application should describe what specific stabilization or strengthening investments are needed (e.g., equipment, training, protocol development) and how they will improve the program's sustainability.

Q: Will Component 1 be offered each year if funding is available?
A: FHC intends to offer Component 1 (Stabilize & Strengthen) in future budget periods, subject to GO-NORTH authorization and continued CMS funding. However, future funding is never guaranteed. If your stabilization needs are time-sensitive, we recommend applying in the current cycle.

Q: For Component 1 one-time investments (equipment, communications, training), what does FHC expect in the sustainability section?
A: For one-time investments, the sustainability section should address how the investment will be maintained beyond the grant period - for example, ongoing maintenance costs, replacement schedules, training continuation plans, or how the equipment changes operational capacity in a way that reduces long-term costs. FHC understands that one-time investments don't require the same sustainability model as ongoing programs, but we still need to see that the investment won't become obsolete or unsupported after the grant period ends.

Q: Can Component 2 funds be used to cover labor costs of paramedics (e.g., staffing a second truck) if we don't yet have an established MIH program? NEW
A: Yes, this is allowable, however, payments cannot duplicate billable services or change existing fee schedules. If funding direct healthcare services, you must provide written justification explaining why services aren't already reimbursable, how payment fills a gap in care, and how it transforms care delivery. Please note that direct clinical service payments are capped at 15% of total NH funding in a given budget period and restrictions may apply.

Q: Can Component 3 funds be used to cover startup labor costs for establishing a new MIH program?
A: Yes. Startup labor costs - including paramedic staffing - are an allowable expense under Component 3 (New Regional MIH Programs). Your budget should clearly tie labor costs to specific startup activities and milestones.

Q: In the info session, FHC indicated funds could be used to support mobile "primary care" - just confirming that this is acceptable, as it is a different model than MIH, or is it only viable as an integrated element of an MIH program?
A: Mobile primary care can be a component of an MIH program, but MIH is the broader framework for this RFA. If your model includes primary care services delivered in a mobile or in-home setting as part of an MIH program, describe how it integrates with your EMS/MIH objectives. If your model is purely a mobile clinic without an EMS or MIH component, it may not be the best fit for this RFA - contact FHC to discuss.

Allowable Costs & Equipment

Q: Is the purchase of an MIH van or vehicle viable with this funding stream, or does that have to be a CDFA request?
A: A vehicle is considered equipment. If the cost is $10,000 or more, it must be listed on your equipment schedule in the application and will need to go through the CMS pre-approval process before reimbursement. This is not a CDFA request - vehicle purchases for MIH programs are allowable under this RFA, subject to the equipment approval requirements.

Q: Will this cover transportation to medical appointments in rural communities?
A: If transportation services are a component of your MIH program, you should explain in your application how transportation supports your MIH model and why it is important to the EMS system. Part of MIH's role is to help EMS focus on emergencies by addressing non-emergency needs in the community. If transportation is tied to your MIH program and supports measurable outcomes (e.g., improved MIH visits, reduced ED utilization, reduced inpatient admissions), include it in your proposal with a clear justification.

Q: Can Component 1 funds be used to replace out-of-service AEDs with new ones?
A: Yes. Replacing outdated AEDs qualifies as investing in technology and equipment to strengthen EMS systems under Component 1. If the cost of any individual piece of equipment is $10,000 or more, it must go through the equipment pre-approval process.

Q: Can this RFA be used to purchase AEDs for placement in municipal buildings or other community locations?

A: No. AEDs purchased under this RFA must be deployed on EMS units or directly support EMS/MIH operations. AEDs for municipal buildings or general community placement fall outside the scope of this RFA.

Q: Are personnel costs for existing employees allowable if directly tied to implementing a new education initiative - such as curriculum development, simulation program development, or regional training coordination?
A: Yes. Personnel costs are allowable when they are directly tied to a specific funded initiative and not considered general salary support. Your budget should clearly identify the personnel, their role in the initiative, and the percentage of time allocated to the funded activity.

Q: What does the equipment pre-approval process look like for items over $10,000? Should we reach out before applying?
A: No need to reach out before applying. In your application, you will provide a list of the equipment. FHC has an equipment template within the budget application that captures the required information (description, cost, justification, disposition plan). FHC will work with you and GO-NORTH to get the required approval if your application is selected.

Q: Can we use these funds to support all patients in our hospital service area, that will include border towns in Vermont/Maine/Western Massachusetts? NEW
A: The funds must be used in NH, but if an ambulance is funded but picks up a patient in VT. We can't control this. The proposal should include how it will support NH patients in rural communities.

Budget & Financial

Q: What indirect cost rate should applicants include in their proposed budgets? The budget template notes that GO-NORTH's indirect cost policy is pending. UPDATED

A: FHC will honor a subrecipient's federally negotiated indirect cost rate. Organizations with a federally negotiated rate must include a copy of their negotiated rate agreement (NRA) with their application. For subrecipients that do not have a federally negotiated rate, the de minimis indirect cost rate provisions under 2 CFR §200.332 apply.

Please note: The One Big Beautiful Bill Act caps the combined indirect and administrative cost rate at 10% for all RHTP funds nationwide. This is a statutory cap- not a standard Uniform Guidance rate - and applies to FHC and all subrecipients in aggregate. Indirect costs may not be applied to equipment costs or to any other cost categories excluded under the terms of the applicant's federally negotiated indirect rate agreement.

Q: Is there a salary cap on these funds? Federal agencies like NIH and HRSA have a salary cap of $228,000 on high earners. Does that apply here? NEW
A: The salary cap is $225,700.

Q: Are provider payments capped at 15%?
A: The Rural Health Transformation Program does include a global cap on provider payments across the entire NH RHTP project. This is not a per-application cap - it applies to the aggregate of all GO-NORTH-funded provider payments statewide. FHC is required to monitor provider payment rates

across our subrecipients to ensure the overall GO-NORTH project does not exceed the global cap. FHC does not anticipate any provider payments in this RFA.

Q: Can food and beverages (e.g., light refreshments, training lunch) be included for trainings and meetings? UPDATED
A: Meals are not allowed unless in limited circumstances such as:

- Subject 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.

Q: What mileage reimbursement rate should be included in the budget? Is there a different rate for MIH vehicles versus personal vehicles?
A: Use the current IRS standard mileage rate (72.5 cents per mile as of 2026) for both personal and MIH vehicles.

Q: Is this grant 100% reimbursement-based, or are pre-paid funds available? UPDATED
A: Pre-advancement (pre-paid) funds will be available for qualifying applicants subject to GO-NORTH prior approval, and in accordance with 2 CFR Part 200, you may receive advance payments., particularly those with limited cash reserves. All other payments will be on a cost reimbursement basis for actual allowable expenditures incurred.

MIH Definition & Scope

Q: How is FHC defining Mobile Integrated Health for this RFA? Does a fixed access point model that connects patients to clinicians in real time qualify, or does the MIH track require a mobile or in-home delivery component?
A: FHC follows New Hampshire state standards for MIH programs. For this RFA, the MIH track requires a mobile or in-home delivery component consistent with the state's MIH program framework. A fixed access point model (e.g., a kiosk or clinic-based telehealth station) may be a complementary service but would not qualify as MIH on its own under this RFA.

Partnerships & Collaboration

Q: Would a municipal EMS service partnered with a nonprofit medical resource hospital need to include the hospital's nonprofit documentation in the application?
A: No - only the lead applicant's documentation is required at the application stage. If the municipal EMS service is the lead applicant, FHC needs your organization's documentation. Once an award is made, FHC will work with subrecipients on federal compliance requirements, including any documentation needed for partner organizations. FHC will also provide compliance training and support to subrecipients to help navigate these requirements.

Q: Do collaborations have to be within New Hampshire?
A: Yes - all RHT funds must stay within the State of New Hampshire. You may partner with an out-of-state entity if they are supporting an MIH program based in and serving New Hampshire. However, RHT funds cannot be used to expand MIH services into Vermont, Maine, or other states. If you have a unique cross-border collaboration idea, GO-NORTH is interested in hearing about it and may be able to connect with counterpart agencies in neighboring states to explore coordination.

Technical Assistance

Q: We need help identifying companies or consultants to partner with on our application. How does that work under federal rules?
A: FHC is setting up a Technical Assistance Center (T-TAC) that will connect subrecipients with expert consultants across multiple transformation areas. If you outline your plan and what you're looking to do in your application, FHC can potentially leverage that TA support to help you identify companies to partner with through a competitive process that follows federal procurement rules and guidelines. If you have a specific scenario in mind, send an email to RHTP-FHC@healthynh.org with more detail, and we can help direct you.

911 Regionalization & REACT Program

Q: We have been working towards regionalizing 911 EMS services in our area with up to six municipalities partnering and running as a district. There is a lot of discussion of MIH. Would this apply to 911-based services, especially as a startup? This is municipal-based, not private.
A: The regionalization of 911 EMS services is a priority area for FHC and is part of our broader initiatives. However, it is not specifically addressed in this RFA. FHC is actively working on a separate vehicle to support 911 EMS regionalization and will have more information soon. For the current EMS RFA, please reach out to us directly at RHTP-FHC@healthynh.org for a case-by-case discussion of whether your regionalization work could fit within an MIH component. More details will be included in future communications.

Q: What is the REACT program that was mentioned during the session?
A: REACT (Rural Emergency Access to Care and Telehealth) is a concept from New Hampshire's CMS-approved plan that would pair a clinician-led triage team with 911 dispatch to help triage individuals to the right setting when clinically appropriate and when community-based care is available. MIH is viewed as a logical starting point and partner for REACT. This work has not yet kicked off and is not part of this RFA. GO-NORTH is in active discussions with the Department of Safety and EMS agencies to determine scope, and FHC is working closely with GO-NORTH on this initiative.

Process & Logistics

Q: When does the application portal open and when is the deadline?
A: The application portal opens July 6, 2026. The application deadline is July 31, 2026.

Q: What if we've never received a federal grant before and don't know what a UEI is?
A: Organizations that have not previously received federal funding need to register with SAM.gov and obtain a Unique Entity Identifier (UEI). This process can take a couple of weeks, so please start now - do not wait until the application deadline. If you or your team are unfamiliar with SAM.gov or UEI registration, reach out to FHC at RHTP-FHC@healthynh.org and we will help guide you through the process.

Q: Who do we contact with questions during the application period?
A: Email RHTP-FHC@healthynh.org for both general program questions and one-on-one technical assistance requests. All questions submitted via email will be incorporated into this Q&A document.

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