Program Guide RFA -Information Session Q&A

Information Sessions held August 5, 2026 and August 12, 2026 | Updated August 18, 2026

This document compiles questions and answers from both Program guide information sessions (August 5 and August 12, 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: Are there formulas within this funding model to disproportionately support more rural, more underserved parts of the state?
A: FHC will continue to evaluate the design of each Request for Applications (RFA) and may incorporate funding formulas, priorities, or other considerations, as appropriate, to support the goals and objectives of that specific funding opportunity. Any such approaches will be clearly outlined within the individual RFA materials.

Q: What are the guidelines for organizations applying for/receiving multiple awards from various RFA?
A: Organizations are welcome to apply for/receive multiple awards from various RFAs, as well as from multiple GO-NORTH Hubs. However, please note that duplicate activities already supported by GO-NORTH or another GO-NORTH Hub at the time of application or award are not eligible for funding and will not be considered.

Partnerships & Collaboration

Q: Are collaborative applications allowed? that permit subawards or subcontracts?
A: Collaborative applications are highly encouraged. A component of the FHC RFA's is selecting the structure of the proposal. One structure is Regional Partnership in which a lead applicant proposes an initiative that directly involves and funds multiple eligible organizations. This is designed to reward collaboration, where each partner has a defined scope of work, a dedicated budget, and accountability for outcomes. In this case, FHC will execute a single grant agreement with the lead applicant; the lead applicant is responsible for subgrant agreements with each subrecipient and for all financial and programmatic compliance across the partnership.

Partnership under Regional Partnership structures is not a letter of support, a referral relationship, or a list of named organizations with no budget, scope, or accountability. Applicants should be prepared to explain in detail the type of partnerships in their application.

Process & Logistics

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 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.

Q: Can an application identify more than one phase of organizational readiness as it relates to specific components of the application?
A: Organizations should best identify one stage of organizational readiness that describes the proposed project/application rather than relating it to a specific component.

Q: Value-based care and associated payment models will require multiple stakeholders, some of which may be government agencies such as NH Medicaid. Will the Foundation award those funds back to government agencies to manage?
A: No. FHC is a grantmaking organization, not a payer or a payment administrator. Funds awarded through FHC are distributed as awards to eligible rural health organizations - hospitals, primary care practices, FQHCs, EMS agencies - for projects that prepare them to participate in value-based payment models. FHC does not flow funds to NH Medicaid, the Department of Insurance, or any other state agency to administer VBP arrangements.

Q: If we're going to create value-based care models, and they're approved through the RFA, how are those funds going to be managed and distributed? By the Foundation? NH Medicaid? By the DOI?
A: FHC manages and distributes the grant funds. The grant funds go to the awarded organization to implement the project described in their application - which may include building VBP readiness infrastructure, conducting readiness assessments, implementing care management tools, or redesigning workflows for population health management. FHC does not create or administer value-based payment models.

Q: The RFA for Rural Primary Care includes bullet points that may also apply to home health agencies. Can agencies apply for these funds if they are not a "primary care" provider?
A: Home Health Agencies are welcome to apply for the Rural Primary Care RFA if they are applying in partnership with a rural primary care provider to support care coordination, transitional care, or hospital-at-home models.

Q: Transportation isn't in itself a fundable category, but would that be considered if partnering with community care, behavioral health or hospital? Or independently?
A: Transportation is not a standalone fundable category under any FHC-administered RFA. FHC's RFAs are designed to fund clinical transformation projects led by eligible rural health providers. However, transportation can be funded as a component of a clinical project where it is directly tied to a specific care delivery model.

For example: A hospital proposing a Hospital-at-Home or care transition program may include transportation costs for in-home provider visits or patient transport as part of the project budget, provided those costs are necessary to the clinical model being implemented. A primary care practice or FQHC proposing a closed-loop referral model may include transportation services as part of a care coordination initiative, where transportation is used to address a documented barrier to keeping appointments or accessing referred services.

In all cases, transportation must be:

- Embedded in a clinical project led by an eligible provider type - not a standalone service
- Tied to specific clinical outcomes (appointment adherence, reduced no-shows, reduced avoidable ED visits, improved chronic disease management)
- Justified as necessary to the care model, not as a general community service

A non-clinical organization (such as a transportation provider or volunteer driver program) cannot apply independently. However, such an organization could participate as a partner on a clinical applicant's project, with transportation services included in the project scope and budget as a contracted service.

Q: Where are the funding opportunities for non-clinical community-based organizations to implement/expand innovative models to address the barriers to accessing and benefitting from care, especially strategies available to all community-members and not just system patients (i.e., public health)?
A: Every FHC RFA allows lead applicants to include partner organizations in their project scope and budget. A hospital or FQHC proposing a care coordination initiative could include a community-based organizations (CBOs) as a funded subrecipient responsible for delivering a specific component -such as closed-loop referral navigation, CHW services, or community-based screening. The CBO must have a defined scope of work, budget, and outcome responsibilities, and must be identified in the application with a signed Letter of Commitment or MOU. In addition, FHC's portfolio should include several pathways for CBOs to participate in and benefit from funding, although the specific mechanisms are being developed and will vary depending on the RFA. In year two, for example, FHC will be exploring establishing community-based access points, which we suspect would need to include CBOs.

Q: With all of these different RFA's, will it be possible to create our initial background/overview and not having to recreate this each time? A consolidated profile vs having to do a profile each time?
A: Yes, organizations will soon have the option to upload basic information once to use for different RFAs. This will be available once FHC launches its grant making platform on BlackBaud.

Q: Any sense if the forthcoming RFA for Tech & Digital Infrastructure will allow for costs already incurred for EMR modernization?
A: Subrecipient award agreements executed by FHC may include a provision allowing retroactive reimbursement of eligible costs incurred on or after March 16, 2026, but prior to the date the subaward agreement is fully executed. This means that if FHC executes an award agreement with a subrecipient on, for example, August 15, 2026, the agreement may include a provision to reimburse the subrecipient for permissible costs incurred between March 16, 2026 and August 15, 2026 - provided all conditions below are met.

To be eligible for retroactive reimbursement, <u>all four</u> of the following conditions must be satisfied:

<u>Timing</u>: The cost was incurred on or after March 16, 2026. Costs incurred before this date are not eligible under any circumstances.

<u>Scope</u>: The cost is directly related to a project within the scope of FHC's contract with GO-NORTH and the funding component under which the applicant is applying. Costs unrelated to the proposed initiative are not eligible.

No Supplanting: The reimbursement supplements, and does not replace (supplant), non-federal funds or other federal funding. Per the State of New Hampshire's Notice of Award: "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 or expected receipt of federal funds."

Allowability: The cost meets all applicable requirements under 2 CFR Part 200, including but not limited to cost principles (§200.400–§200.476), allowability (§200.403), and equipment pre-approval requirements (§200.313). Costs that would have required FHC's prior written approval before being incurred- such as equipment purchases of $10,000 or more- must still meet all pre-approval requirements and will be evaluated for allowability at the time of award.

As a condition of retroactive reimbursement, the subrecipient must provide FHC with a written certification that all four conditions above are met, along with supporting documentation (e.g., invoices, purchase orders, bank records, payroll records) evidencing each cost for which retroactive reimbursement is requested. FHC reserves the right to request additional documentation as needed to verify allowability and compliance. This will be completed if the applicant is selected.

Important Notes

- No guarantee of funding: Incurring costs prior to execution of a subaward agreement is done at the applicant's sole risk. FHC's willingness to consider retroactive reimbursement does not constitute a guarantee that any application will be funded or that any specific cost will be determined to be allowable. Applicants who incur pre-award costs should be prepared to absorb those costs if they are not selected for funding or if the costs are determined to be unallowable.
- Retroactive period limit: Retroactive reimbursement is limited to costs incurred between March 16, 2026 and the date the subaward agreement is fully executed. No costs incurred outside this window are eligible for retroactive coverage.

Q: Does the dollar amount in each category, example 12 M for Primary care, reflect the maximum proposed budget per application? or, is the 12M the cumulative amount being awarded for all awardees in that category?
A: The amount per RFA is the cumulative amount being awarded to all awardees. Each RFA will give specific details on the maximum proposed budget allowed per application based on specifics such as number of partners or specific project category outlined in the RFA.

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