California Rural Healthcare Transformation (CalRHT) Initiative 1: Transformative Care Model Expand and Support Rural Workforce Capacity

Request for Applications (RFA): Application and Instructions

Revised 20260702

Version 1.0

2020 WEST EL CAMINO AVENUE, SUITE 1222 • SACRAMENTO, CA 95833

"A healthier California where all receive equitable, affordable, and quality health care."

If your program requires approval to contract from a coordinating authority, please inform the authority of the terms and conditions contained in the sample subaward agreement. Applicants must agree to the terms and conditions before receiving funds. The Department of Health Care Access and Information will not make changes to the terms and conditions specified in the Subaward Agreement.

The CalRHT program is 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 award totaling $233,639,308.47 with 100 percent funded by CMS/HHS. The contents are those of CalRHT and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

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Application Components

Thank you for considering applying to the Family Medicine Obstetrics (FM-OB) Fellowship Subaward Program under Expand and Support Rural Workforce through HCAI's California Rural Health Transformation Program (CalRHT). We appreciate your dedication to rural health and look forward to learning more about your work through this application. To submit a complete application, applicants must (1) complete all seven sections in the application portal provided by HCAI https://calruralhealth.submittable.com/submit, (2) gather required attachments, and (3) submit application using the HCAI application portal no later than August 14th, 2026 at 3pm for consideration in Budget Period 1. Applications submitted after the deadline or that are incomplete will not be considered.

We are committed to supporting applicants throughout the application process and encourage you to reach out with any questions. Questions regarding the application or submission process may be directed to info@calruralhealth.org.

1. Applicant Profile

This section consists of organizational identifiers and contact information for the applicant organization. This would reflect the legal entity that will execute the grant agreement.

To complete this section, applicant will fill out this editable document for the following sub-sections. No further attachments are required for this section.

a. Entity Legal Name (required)

Provide the full legal name of the Applicant Entity (including type of organization, if applicable, such as CAH, FQHC, Regional Consortium, etc.). This should reflect the legal entity that will execute the grant agreement and assume responsibility for compliance, reporting, and administration of grant funds if selected for award. The name provided should match the entity's registration records and associated federal identifiers, where applicable.

Response prompt: Provide the full legal name of the Applicant Entity.

[Maximum 100 characters]

Example: ABC Medical Center, FQHC

b. Primary Point of Contact (required)

Provide the contact information for the primary Point of Contact (POC) responsible for coordinating and managing the application on behalf of the Applicant Entity. The individual named should be prepared to serve as the POC for application-related communications, follow-up requests, clarification questions, and program notifications from HCAI or program administrators. The POC will have the authority to coordinate and submit application materials.

Response prompt: Provide the Applicant Entity's primary point of contact information below:

(Part a.) First and Last Name (required)

[Maximum 100 characters]

Example: Jane Smith

(Part b.) Professional title (required)

[Maximum 100 characters]

Example: CEO

(Part c.) Phone number (required)

[10 numeric digits required]

Example: (234) 567-8910

(Part d.) Email address (required)

[Maximum 100 characters]

Example: Jane_smith@ApplicantEntity.org

(Part e.) Mailing address (required)

[Maximum 100 characters]

Example: *123 Apple St.* *New York, New York 10001*

c. Authorized Representative (required)

Provide contact information for the individual authorized to act on behalf of the Applicant Entity in matters related to grant funding (for example, a fiduciary representative or board-authorized representative). This individual can be the same as the Point of Contact; however, this individual must also have legal authority to agree to application attestations, sign the final application, sign grant-related agreements, and make commitments with HCAI or program administrators.

Response prompt: Provide Authorized Representative's contact information below:

(Part a.) First and Last Name (required)

[Maximum 100 characters]

Example: Jane Smith

(Part b.) Professional title (required)

[Maximum 100 characters]

Example: CEO

(Part c.) Phone number (required)

[10 numeric digits required]

Example: (234) 567-8910

(Part d.) Email address (required)

[Maximum 100 characters]

Example: Jane_smith@ApplicantEntity.org

(Part e.) Mailing address (required)

[Maximum 100 characters]

Example:
123 Apple St.
New York, New York 10001

d. Additional Contact (optional)

Provide the contact information for an additional person who may serve as a backup point of contact for the Applicant Entity. This individual may assist with coordination, communications, scheduling, or follow-up activities related to the application or program participation, as needed. The additional contact does not need to have signatory or fiduciary authority unless otherwise designated by the Applicant Entity.

Response prompt: Provide the Applicant Entity's additional contact information below:

(Part a.) First and Last Name (required)

[Maximum 100 characters]

Example: Jane Smith

(Part b.) Professional title (required)

[Maximum 100 characters]

Example: CEO

(Part c.) Phone number (required)

[10 numeric digits required]

Example: (234) 567-8910

(Part d.) Email address (required)

[Maximum 100 characters]

Example: Jane_smith@ApplicantEntity.org

(Part e.) Mailing address (required)

[Maximum 100 characters]

Example: *123 Apple St.* *New York, New York 10001*

e. Legal Business Address (required)

Provide the primary legal address associated with the Applicant Entity. The address listed may be used for validating hospital service area.

Response prompt: Provide the legal business address of the Applicant Entity.

[Maximum 100 characters]

Example: *123 Apple St.* *New York, New York 10001*

f. System for Award Management (SAM) status (required)

Please attest to the Applicant Entity's current System for Award Management (SAM.gov) registration status. For more information, please visit SAM.gov. Active SAM.gov registration is required at time of application submission. If your organization does not have an active registration, complete the process at SAM.gov prior to submitting this application, then return to the application to provide the attestation. Please be aware of SAM registration timelines and plan accordingly.

Response prompt: List the Applicant Entity's current SAM status.

[Maximum 100 characters]

Examples: Active Registration

g. Unique Entity Identifier (UEI) (required)

Provide the Applicant Entity's Unique Entity Identifier (UEI), which is the 12-character alphanumeric identifier assigned through SAM.gov and is mandatory for businesses and organizations to bid on, and receive, U.S. federal contracts and grants. If your organization does not yet have a UEI, register at SAM.gov prior to submitting this application, then return to the application to provide the UEI.

Response prompt: Provide the Applicant Entity's Unique Entity Identifier (UEI).

[12 characters required]

Example: XYZ123456789

h. Taxpayer Identification Number (TIN) / Employer Identification Number (EIN) (required)

Provide the federal Taxpayer Identification Number (TIN) or Employer Identification Number (EIN) assigned to the Applicant Entity by the Internal Revenue Service (IRS).

Response prompt: Provide the Applicant Entity's Taxpayer Identification Number (TIN) or Employer Identification Number (EIN).

[9 numeric digits required]

Example: 12-3456789

i. National Provider Identifier (NPI) (if applicable)

Provide the National Provider Identifier (NPI) associated with the Applicant Entity. If the entity maintains multiple NPIs, provide the primary organizational NPI most relevant to this application.

Response prompt: Provide the National Provider Identifier (NPI) associated with the Applicant Entity or lead applicant facility, if applicable. If Applicant Entity does not have an NPI, please enter "N/A"

[Maximum 10 numeric characters]

Example: 12-3456789

[Optional space for additional NPI outside of Applicant Entity or lead applicant facility]
[Maximum 10 numeric characters]

Example: 12-3456789

[Optional space for additional NPI outside of Applicant Entity or lead applicant facility]
[Maximum 10 numeric characters]

Example: 12-3456789

j. Tribal Entity (required)

Indicate whether the Applicant Entity is a tribal health organization. If yes, provide the corporate entity name.

Response prompt:

(Part a.) Is the Applicant Entity a federally recognized tribal health organization?

☐ Yes ☐ No

(Part b.) If yes, provide the name of the affiliated corporate entity.

[Maximum 200 characters]

Example: ABC Tribe

2. Proposal Overview

This section provides information about the proposed request for funds, including the specifics about the Family Medicine Obstetrics Fellowship Subaward Program you wish to establish or expand.

The program's mission is to build and sustain a skilled rural maternal health workforce by expanding fellowship training that equips family physicians with advanced obstetric competencies and prepares them to practice in rural communities, improving maternal and infant outcomes in the communities experiencing the greatest workforce shortages. As fellows complete their training, the programs will encourage their placement in rural collaboratives with maternity care focus and the CalRHT primary and maternity care regional collaboratives.

To complete this section, the applicant will provide written responses.

a. Executive Summary (required)

Provide a concise, high-level summary of the proposed use of FM-OB Fellowship Subaward Program funding. This overview should summarize, but not repeat in full, information provided in other sections of the application. Describe why the applicant organization is well-positioned to participate in the FM-OB Fellowship Subaward Program. Responses should explain whether the applicant intends to establish a new FM-OB fellowship program or expand an existing program. Applicants should also describe the types of programmatic support for which funding is requested (e.g., program development, curriculum development, faculty capacity, clinical training infrastructure, recruitment, partnership development, or other implementation needs). The summary should highlight key partnerships, anticipated outcomes, and the organization's readiness to successfully implement the proposed fellowship activities within the grant period.

Response prompt: Provide a concise summary of the applicant's need for FM-OB Fellowship Subaward funding and proposed approach.

[Maximum 500 words]

b. Share of Time in Rural or Rural-Serving

Approximate how much time the program will require new fellows to train in rural sites and rural-serving sites.

Response prompt:

(Part a.) Approximately what percent of their time will a new fellow spend at a rural site (rural as defined by HRSA)?

[Maximum 4 numeric characters]

Example: 25%

(Part b.) Approximately what percent of their time will a new fellow spend at a rural-serving site?

[Maximum 4 numeric characters]

Example: 75%

c. Curriculum & Training Site Capacity

Provide an overview of the specialized curriculum included in, or planned for, the proposed Family Medicine–Obstetrics (FM-OB) fellowship program. Describe the curriculum's key components, areas of focus, and how it prepares fellows to deliver comprehensive obstetric care in rural and underserved communities.

Applicants should describe their capacity to provide surgical and operative obstetrics training, including clinical volume, operative experience opportunities, faculty expertise, preceptor availability, supervision capacity, and training infrastructure necessary to support fellowship activities.

Applicants should also describe any evidence-based training, mentorship, consultation, or workforce development models that are integrated into the curriculum, including but not limited to Project ECHO, PPAP, Cal-MAP, or similar programs. Explain how these models will support fellow education, clinical competency, and interdisciplinary collaboration.

Response prompt: Provide an overview of the proposed fellowship program's curriculum in sufficient detail to demonstrate the applicant's ability to provide a high-quality training experience and support fellows in achieving competency in full-scope family medicine obstetrics practice.

[Maximum 750 words]

d. Requested Funding Amount (required)

Provide the total amount of FM-OB Fellowship Subaward funding requested by the Applicant Entity. This should be a single dollar figure representing the applicant's full funding request. The requested amount should align with the applicant's proposed activities and the completed budget workbook.

Response prompt: Provide the total amount of FM-OB Fellowship Subaward funding requested.

[Numeric digits required]

Example: $500,000

e. Completed Budget Workbook (attachment, required)

HCAI will provide a budget workbook template for applicants to fill out budget line items in detail. Budget entries should align with the proposed activities described throughout the application and include all requested supporting detail. Applicant should complete and attach the completed budget workbook template with this application.

Please see further instructions for how to complete the Budget Workbook in the Budget Workbook template provided. Budget workbook will include:

- *Total funding requested, broken down by:*
  - *Category (e.g., equipment, travel)*
  - *Module (e.g., colorectal screenings, prenatal care)*

Response prompt: Have you completed and attached the budget workbook template?

☐ Yes ☐ No

3. Partnership Participants

This section provides information about proposed or existing partnerships that will support the Applicant Entity in fulfilling the new or expanded fellowship program. It includes information regarding partner organizations, and partnership documentation.

Please include up to three proposed partnerships. If your organization is pursuing more than three partnerships, please describe the three most significant partnerships in this application. Applicants who wish to discuss additional partnerships may contact the program team via email.

a. Partnership Description(s) (if applicable)

Provide a summary of the proposed partnership(s) for the project and describe how participating partner(s) will support the creation or expansion of the FM-OB Fellowship Program. Partnerships are not required; however, lack of planned fellow training at rural or rural-serving sites can impact scoring of an application.

Applicants should describe:

- *Existing or proposed relationships between participating entities*
- *The purpose of each partnership*
- *How the partnership(s) support(s) the proposed project goals*
- *Any regional coordination, shared-service, referral, workforce, technology, or care delivery collaboration activities*

Response prompt: Describe the proposed partnership structure for the project, including the role each partner will play in supporting program creation or expansion.

[Maximum 500 words]

Example: ABC Hospital has worked with PartnerXYZ for 5 years. PartnerXYZ helps support virtual training for fellows during their rural rotations at ABC Hospital.

b. Partner Organization Information (required for each Partner Entity)

Provide organizational information for each partner entity involved in the proposed project.

Response prompt: For each participating partner entity, provide:

- Legal name
- Type of organization (e.g., hospital, community-based organization)
- County or service area (e.g., Inyo County)
- Primary contact
- Description of partner's specific role in project
- Parent organization, if applicable
- Tribal Entity status, affiliated Tribe, and Tribal Entity NPI, if applicable

[Max response = 250 words, per partner]

Partner 1 (required for each Partner Entity):

Entity legal name:

[Maximum 25 words]

Example: Hospital XYZ

Partner's county or service area:

[Maximum 25 words]

Example: County ABC

Primary contact first and last name:

[Maximum 25 words]

Example: Joe Smith

Description of partner's role in project:

[Maximum 50 words]

Example: Provide ABC screenings to region that is at least 30 mi. from another health care facility

Partner's parent organization, if applicable:

[Maximum 25 words]

Example: Same as applicant

Is the partner a Tribal Entity?

☐ Yes ☐ No

If yes to "partner is a Tribal Entity," provide the name of the affiliated Tribe

[Maximum 25 words]

Example: ABC Tribe

Partner 2 (required for each Partner Entity):

Entity legal name:

[Maximum 25 words]

Example: Hospital XYZ

Partner's county or service area:

[Maximum 25 words]

Example: County ABC

Primary contact first and last name:

[Maximum 25 words]

Example: Joe Smith

Description of partner's role in project:

[Maximum 50 words]

Example: Provide ABC screenings to region that is at least 30 mi. from another health care facility

Partner's parent organization, if applicable:

[Maximum 25 words]

Example: Same as applicant

Is the partner a Tribal Entity?

☐ Yes ☐ No

If yes to "partner is a Tribal Entity," provide the name of the affiliated Tribe

[Maximum 25 words]

Example: ABC Tribe

Partner 3 (required for each Partner Entity):

Entity legal name:

[Maximum 25 words]

Example: Hospital XYZ

Partner's county or service area:

[Maximum 25 words]

Example: County ABC

Primary contact first and last name:

[Maximum 25 words]

Example: Joe Smith

Description of partner's role in project:

[Maximum 50 words]

Example: Provide ABC screenings to region that is at least 30 mi. from another health care facility

Partner's parent organization, if applicable:

[Maximum 25 words]

Example: Same as applicant

Is the partner a Tribal Entity?

☐ Yes ☐ No

If yes to "partner is a Tribal Entity," provide the name of the affiliated Tribe

[Maximum 25 words]

Example: ABC Tribe

c. Description of Partner Funding (required for each Partner Entity)

Information regarding how funding is expected to support the roles, responsibilities, and activities of participating partner organizations, if applicable.

Response prompt: Describe how the anticipated funding allocation would support each participating partner entity's role in the FM-OB Fellowship Program. Applicants may include general descriptions of how funding would support programmatic activities. If partners do not require funding to contribute to project, indicate $0.

Partner 1 (required for each Partner Entity):

[Maximum 200 words]

Example: Funding will be used to support additional case manager time for screening for substance use behavior

Partner 2 (required for each Partner Entity):

[Maximum 200 words]

Partner 3 (required for each Partner Entity):

[Maximum 200 words]

d. Partnership Documentation (required for each Partner Entity)

Applicants must provide documentation supporting each existing or proposed partnership associated with the proposed program. Documentation may be formal or preliminary depending on the maturity of the partnership arrangement.

Examples may include:

- *Letters of support*
- *Letters of intent*
- *Memoranda of Understanding (MOUs)*

Response prompt: Upload partnership documentation that prove proposed or existing project partnerships (e.g., Letter of Interest, MOU, etc.). Please indicate if proof of partnership has been uploaded for each Partner Entity:

[required for each Partner Entity]

☐ Partner 1 | ☐ Partner 2 | ☐ Partner 3

4. Operational Capability (required)

This section is intended to allow applicants to demonstrate that the Applicant Entity has the executional capabilities, leadership experience and capacity to successfully manage and execute the activities as part of creating or expanding an FM-OB Fellowship Program. Previous experience managing grants is not required.

This section is intended to assess whether the Applicant Entity has the experience, systems, governance structure, partnerships, workforce capacity, and operations readiness necessary to:

- *Implement the proposed project*
- *Manage grant funding and reporting requirements*
- *Coordinate across participating partners*
- *Support implementation and operations activities over time*
- *Maintain stable leadership and organizational continuity throughout implementation*

Response prompt: For each section below, select all operations capability areas that apply to the Applicant Entity. For each free response section below, please elaborate on any of the operations capability areas that have been selected, unless stated otherwise. Leave blank if not applicable.

a. Partnership management capabilities - Applicant Entity has experience in:

☐ Leading multi-organization collaborations or regional partnership efforts

☐ Serving rural and/or Frontier and Remote (FAR) populations

☐ Supporting shared-service models or cross-entity implementation efforts

☐ Other partnership or collaboration capabilities relevant to program implementation

[Maximum 500 words]

b. Operations & grant management capabilities - Applicant Entity has experience in:

☐ Managing grants, contracts, compliance activities, subrecipient relationships, or funding oversight responsibilities

☐ Establishing or managing partnership agreements, MOUs, implementation agreements, or other formal collaboration arrangements

☐ Working with legal counsel (and if legal counsel is in-house or external), executing contracts or agreements, managing formal agreements, or supporting compliance-related activities

☐ Supporting operations, administrative, financial, or project implementation activities

☐ Other operations or administrative capabilities relevant to project implementation

[Maximum 500 words]

c. IT, data & telehealth infrastructure - Applicant Entity has experience in:

☐ Collecting, tracking, analyzing, or reporting data, performance metrics, or quality measures

☐ Supporting interoperability, health information exchange, or electronic health record integration activities

☐ Delivering telehealth, e-Consult, remote patient monitoring, or virtual care services

☐ Supporting other technology or infrastructure capabilities relevant to project implementation

[Maximum 500 words]

d. Staffing & workforce readiness - **Applicant Entity has experience in:**

☐ Supporting staffing models, workforce implementation, or operations workforce readiness activities

☐ Supporting clinical staffing, clinical leadership, provider operations, or care coordination activities

☐ Supporting administrative, operations, financial, reporting, or implementation staffing activities

☐ Coordinating implementation support across partner entities

☐ Recruiting, hiring, retaining, or supporting workforce development activities

☐ Supporting other staffing or workforce capabilities relevant to project implementation

[Maximum 500 words]

e. Execution capabilities - **Applicant Entity has experience in:**

☐ Operationalizing, expanding, or scaling programs across multiple sites or regions

☐ Sustaining programs, partnerships, or operations activities over time

☐ Participating in learning collaboratives, regional implementation activities, or peer learning efforts

☐ Supporting other execution, implementation, or scaling activities relevant to project implementation

[Maximum 500 words]

5. Implementation

a. Timeline and Major Milestones (required)

This section provides information on a high-level implementation timeline, organized by quarter, that identifies the project's major phases, milestones, anticipated deliverables, and the participating entity or organization responsible for each deliverable or milestone.

Applicants are encouraged to include:

- *Early implementation activities*
- *Operational launch milestones*
- *Partnership or staffing milestones*
- *Reporting or evaluation milestone*

Please respond by completing the table below by sharing who will oversee each deliverable (e.g., individual, Partner Entity, etc.) and what the proposed deliverables and/or milestones will be.

Response prompt: Provide a high-level implementation timeline for each module describing:

- Which participating entity or organization is responsible for each major deliverable or milestone
- Proposed deliverables and/or milestones

[Maximum 100 words per cell]

Implementation timeline

Federal Fiscal Quarter *FFY = Federal Fiscal Year*	**Individual (or Partner Entity) in charge of deliverables and/or milestones**	**Proposed deliverables and/or milestones** (please put "N/A" if no proposed deliverables and/or milestones in a quarter)
FFY27 Q1 Oct 1, 2026 – Dec 31, 2026	*Example: Hospital ABC*	*Example:* *- Agreement document between applicant and XYZ regional hospital* *- Detailed fellow rotation schedule*
FFY27 Q2 Jan 1, 2027 – Mar 31, 2027		
FFY27 Q3		

April 1, 2027 – Jun 30, 2027		
FFY27 Q4 Jul 1, 2027 – Sep 30, 2027		

6. Additional Documents

a. Form 990 (optional)

Applicants must submit the most recent IRS Form 990 available for the Applicant Entity, if applicable. This information may be used to support organizational review, financial assessment, and grant administration activities.

Upload the most recent IRS Form 990 for the Applicant Entity, if applicable. If the Applicant Entity does not file a Form 990, provide a brief explanation and upload alternative supporting documentation, if available.

Response prompt: Have you attached Form 990?

☐ Yes ☐ No

If no to "attached Form 990," provide a brief explanation

[Maximum 50 words]

If no to "attached Form 990," have you attached alternative supporting documentation?

☐ Yes ☐ No

If no to "attached alternative supporting documentation," provide a brief explanation

[Maximum 50 words]

7. Attestations

This section requires an authorized signature for final submission certifications. The Authorized Representative identified in this application must be authorized to act on behalf of the Applicant Entity and to make all representations, certifications, and attestations in

this application. By selecting and submitting these attestations, the Authorized Representative affirms that they are authorized to bind and represent the Applicant Entity with respect to the commitments described in this application.

a. Disclosure of investigations or enforcement actions (required)

Applicants should disclose whether the Applicant Entity is currently under local, state, or federal investigation actions that could materially affect the organization's operational standing or ability to successfully fulfill the commitments associated with this program. This information is intended to support program integrity and assess organizational readiness and capacity.

☐ I attest that the Applicant Entity is not currently under any local, state, or federal investigation that would materially impair the Applicant Entity's ability to participate in or fulfill the commitments associated with this program.

If Applicant Entity cannot attest, please explain why:

[Maximum 50 words]

b. Non-duplicative funding (required)

CalRHT funding may not duplicate or supplant existing federal, state, local, Tribal, or private funding supporting the same activities or purposes. Applicants are responsible for ensuring that requested funds are used for allowable, non-duplicative transformation activities consistent with CMS and CalRHT requirements.

Response prompt:

☐ I attest that CalRHT Transformative Payments funding will not supplant existing funding or result in duplicative funding for the same activities from another funding source.

If Applicant Entity cannot attest, please explain why:

[Maximum 50 words]

c. Acknowledgment of allowable-use restrictions (required)

Applicants must acknowledge that CalRHT funding is subject to Centers for Medicare & Medicaid Services (CMS)-approved allowable-use restrictions and applicable federal grant requirements. Funding may only be used for approved transformation activities consistent with the CMS-approved CalRHT proposal, Rural Health Transformation Program requirements, and applicable Department of Health Care Access and Information (HCAI) guidance. Reference links included below:

- *Center for Medicare and Medicaid Services (CMS) Rural Health Transformation Program (RHTP) Notice of Funding Opportunity (NOFO): https://grants.gov/search-results-detail/360442*
- *Rural Health Transformation, Frequently Asked Questions: https://www.cms.gov/files/document/rural-health-transformation-frequently-asked-questions.pdf*

Response prompt:

☐ I attest that the Applicant Entity understands and agrees to comply with all applicable CMS-approved allowable-use restrictions and CalRHT funding requirements.

If Applicant Entity cannot attest, please explain why:

[Maximum 50 words]

d. Documentation (required)

Applicants are responsible for maintaining documentation and supporting records related to grant fund management, implementation progress, milestone achievement, reporting, and performance against defined metrics. Documentation may be subject to monitoring, audit, validation, or review by HCAI, CMS, or other authorized entities.

Response prompt:

☐ I attest that the Applicant Entity will maintain documentation and supporting records related to grant fund management, implementation progress, milestone achievement, reporting, and performance measurement consistent with applicable grant requirements.

If Applicant Entity cannot attest, please explain why:

[Maximum 50 words]

e. Certification of accuracy and completeness (required)

Provide attestation signature certifying that all information and documentation provided in this application is true and accurate, and that all required documents are attached.
Response prompt:

☐ I attest that the information contained herein is complete, true, and accurate to the best of my knowledge and that I am authorized to submit this application on behalf of the organization.

Signature:

[Signature]

Appendix A: Glossary

- **Applicant Entity:** Legally recognized organization that is applying for funding.
- **Behavioral Health:** In the context of CalRHT, services addressing mental health conditions, substance use disorders, and emotional well-being, integrated into primary and maternal care settings.
- **California Department of Health Care Access and Information (HCAI):** The state agency leading the California Rural Health Transformation (CalRHT) program and responsible for program oversight and implementation.
- **California Rural Health Transformation Program (CalRHT):** A statewide initiative designed to improve access, quality, workforce capacity, and financial sustainability of health care delivery in rural and Frontier and Remote (FAR) California communities.
- **Centers for Medicare & Medicaid Services (CMS):** The federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid, and other national health care programs.
- **Decision rights:** Authority provided to the person or entity authorized to approve decisions.
- **Emergency Department (ED):** The area of a hospital that provides immediate treatment for urgent and emergency medical conditions.
- **Electronic Health Record (EHR):** Electronic records containing a patient's medical history and key administrative and clinical data relevant to that person's care.
- **Employer Identification Number (EIN):** A unique nine-digit number assigned by the IRS to identify a business entity.
- **Grant agreement:** The formal funding contract after final funding subrecipients are chosen.
- **Human Resources (HR):** The department responsible for workforce management activities such as hiring, employee relations, benefits, training, and staffing.
- **Internal Revenue Service (IRS):** The U.S. federal agency responsible for tax collection and enforcement.
- **Interoperability:** The ability of different health information systems and EHRs to exchange, interpret, and use data effectively.

- **Limited Liability Company (LLC):** A business structure authorized under state law whose owners, known as members, generally have limited personal liability for the company's debts and obligations.

- **Maternity Care Desert:** A county lacking hospitals, birth centers, or obstetric providers that offer maternity care services.

- **Memorandum of Understanding (MOU):** A written agreement, typically non-binding, outlining intentions, objectives, and general framework of collaborating parties.

- **Notice of Funding Opportunity (NOFO):** A formal notice typically issued by a federal agency to announce the availability of funding and describe application requirements.

- **National Provider Identifier (NPI):** A unique identification number assigned to healthcare providers in the U.S.

- **Obstetrics (OB):** The medical specialty focused on pregnancy, childbirth, and postpartum care.

- **Obstetrician-Gynecologist (OB-GYN):** A physician specializing in women's reproductive health, pregnancy, childbirth, and related medical care.

- **Office of Statewide Health Planning and Development (OSHPD):** The former California state office responsible for health care data collection and planning, now integrated into HCAI.

- **Point of Contact (POC):** The designated individual responsible for coordinating and managing the application, and potential project, on behalf of the Applicant Entity.

- **Request for Application (RFA):** A formal announcement issued by government agencies, foundations, or organizations to solicit proposals for grants.

- **Rural Health Transformation Program (RHTP):** A federal initiative created by the One Big Beautiful Bill Act (H.R. 1) to reshape and strengthen healthcare systems in rural communities across the United States, with a total of $50 billion available in funding across 50 states over a 5-year period.

- **System for Award Management (SAM):** The U.S. government system used to register organizations for federal funding and contracts.

- **Supplanting:** Replacing existing State, local, tribal, or private funding with federal RHT funds. This is explicitly prohibited.

- **Taxpayer Identification Number (TIN):** A number used by the IRS to identify taxpayers and organizations.

- **Transformative Care Model (TCM):** The CalRHT program's core initiative that integrates workforce, technology, telehealth, and payment strategies through regional care collaboratives and hub-and-spoke relationships.

- **Unique Entity Identifier (UEI):** A federal identifier assigned to organizations doing business with the U.S. government.