



Type of Application: Community Health Needs Assessment Implementation Activity

North Dakota Medicare Rural Hospital Flexibility Program Subcontract Application Form Community Health Needs Assessment Implementation Activity

This Request for Proposal (RFP) is released on behalf of the North Dakota Medicare Rural Hospital Flexibility (Flex) Program and the State Office of Rural Health (SORH). The North Dakota Flex Program is administered by the University of North Dakota Center for Rural Health, School of Medicine & Health Sciences. Its partners include the North Dakota Hospital Association, the North Dakota EMS Association, and Quality Health Associates of North Dakota (North Dakota's quality improvement organization). The Flex Program's Steering Committee is comprised of one or more members from each of the partners. The North Dakota Critical Access Hospital (CAH) Subcontract Program is designed to support the goals of the Flex and SORH programs by

supporting rural hospitals in remaining viable to maintain access to care for rural North Dakotans. The funding for this program is supported through the Medicare Rural Hospital Flexibility Program, the State Office of Rural Health, and the Centers for Disease Control and Prevention. The Flex and SORH programs are funded through the Federal Office of Rural Health Policy (FORHP), Department of Health and Human Services.

All North Dakota CAHs are eligible to apply for subcontract funding. A CAH may submit more than one application; however, may only have one active subcontract for each area of focus. Expenses for proposed activities cannot be incurred prior to award. A separate online application must be submitted for each area of focus.

The objective is to support new collaborative population health improvement programming and activities that address a significant need identified by the hospital's most recent Community Health Needs Assessment (CHNA); assess determinants of health based on data review, encourage collaboration between the CAH, Local Public Health Units, and other community organizations and stakeholders; and promote community engagement and healthy behaviors. The ND CAH subcontract program anticipates supporting up to 3 subcontracts up to \$5,000 each for this effort that must be complete by 8/31/22, and 1

subcontract up to \$5,000 for this effort that is anticipated to be available 7/1/22-5/31/23.

Hospital Information

Hospital Name

County

Address

Phone Number

Name of Contact Person

Email Address of Contact Person

SUMMARY

Provide a brief description of why your facility should be selected to receive subcontract funding.

Provide a brief description of anticipated outcomes, overview of intended use of information gathered, plan for results, and follow-through.

Total dollar amount of funding being requested (\$5,000 maximum).

BUDGET & BUDGET NARRATIVE

The budget section should cover such areas as line item expenses, contractual costs, as well as in-kind contribution.

A sample budget and narrative can be found on the Flex website at:

<http://ruralhealth.und.edu/projects/flex/funding-programs>

NOTE: Rural Hospital Flexibility funds cannot be used: *for direct patient care, healthcare services, equipment, or supplies; to purchase vehicles or communications equipment; to purchase or acquire real property or to improve existing property; for building and/or physical structural improvements; for hospital personnel time or associated expenses; for t-shirts, hats, prizes, etc., for the purchase of food.*

PLEASE TAKE NOTE: These subcontracts are intended to fund new activities, not any activity or projects which begin before the Flex subcontract is awarded. Any expenditures incurred prior to the formal contractual signing by both parties are the responsibility of the hospital. Prior expenses **cannot** be submitted for reimbursement. All project activities must be completed by **August 31, 2022 or March 31, 2023.**

Upload your line-item budget. Be sure to include all expenses (contractual, in-kind, etc.)

Budget Narrative: Following in the order of your line-item budget, please describe the items listed in detail that will assist the reviewers in understanding the proposed budget. The budget narrative should identify line item expenses and explain how the line items are determined and/or calculated.



PROJECT DESCRIPTION

Provide a description of why your facility should be selected to receive Community Health Needs Assessment (CHNA) Implementation funding.

Which CHNA-related need(s) are you seeking to address with this funding application?

Explain in detail the proposed activity or program, include the goals, action steps, and specific project deliverables. Make sure they are time sensitive and measurable. Include a timeline with specific dates. Project activities must be completed by either August 31, 2022 or March 31, 2023. If your project completion date could be flexible, please note this.

If you prefer to upload a workplan, you may do that below.

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Upload workplan (optional - may include as a supplement/replacement of the goals, action steps, deliverables, and timeline).

Describe the cohort and collaborative partnerships involved, including information detailing specific project roles and responsibilities of each partner identified.

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Will hospital or clinic personnel be involved in carrying out the proposed activity or program?

- Yes
- No

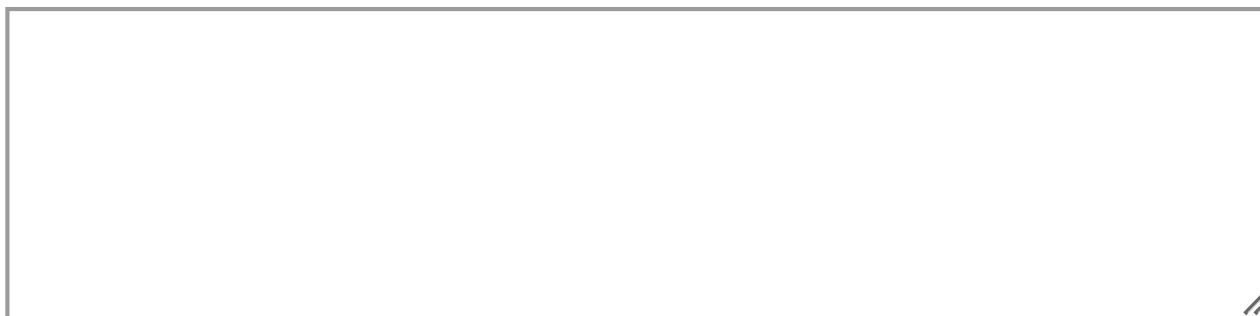
Explain which personnel will be involved and what each individual's role will be.

Define the anticipated impact and proposed activity or program will have on the community.

State the duration of the proposed activity or program. Is it a continuing program or of limited duration?

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Explain how the activity or program will be measured for effectiveness.

A large, empty rectangular box with a thin black border, intended for the user to explain how the activity or program will be measured for effectiveness. A small double-slash icon is visible in the bottom right corner of the box.

Additional Uploads - Use this if you have anything else you would like to share with us that you have not already uploaded.

PROJECT MANAGEMENT

Please identify the individual responsible for management and oversight of this project and include contact information.

Contact Name

Contact's Title

Email

Contact's Signature

SIGN HERE

× clear

Hospital official authorized to enter into contract:

Name

Title

Email

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