Rural Healthcare Peer Exchange and Professional Development Program
for North Dakota CAHs
A P P L I C A T I O N

Date: _____

1) Applicant:

Organization _____

Address _____

City _____ Zip _____

Contact Name _____

E-mail _____

Phone _____ Fax _____

Name of person(s) involved in exchange: _____

_____

2) Location of Exchange:

Check one

☐ I/We want to visit the following community/organization _____

☐ I/We want to bring _____ to our community/organization.

3) Exchange Request:

a. Describe the exchange mentoring activity for which funding is requested.

_____

_____

_____

b. Anticipated date(s) of exchange *(no later than August 15, 2019):* _____

c. Intended outcome: _____

_____

d. Total estimated funding request $ _____
Details on allowable expenses can be found on the instruction page.

Mileage:	$ _____	(calculated at IRS standard mileage rate for business)
Lodging:	$ _____	(maximum 3 nights/person; limited to length of exchange)
Per Diem:	$_____	(calculated at North Dakota standard rate)
Stipend:	$ _____	Special Circumstances Only _____ (maximum $200 per exchange)

Organizations receiving travel support are required to complete the attached outcome report upon exchange completion. Original zero balance receipts for lodging are required for reimbursement.

Application Instructions for Rural Healthcare Peer Exchange and Professional Development Program

1. **Eligible Applicants:** Critical Access Hospitals (staff and board members), network representatives serving rural health entities, rural non-profit EMS agencies.

    - The mentoring exchange may involve more than one person from the same organization, if they are essential to implementing the project. *Please note: funds cannot be requested to cover consultant fees, conference expenses, or training events.*

2. **Location of Exchange:** The exchange visit may occur at the applicant's organization or the applicant may travel to the location of the peer mentor. This decision is based upon the agreed upon location of the applicant and mentor. For example, the applicant may invite a peer with expertise in quality improvement to meet with a team at their facility or an applicant may travel to another location to view and evaluate an automated medication dispensing system. Location is limited to North Dakota and bordering states where the travel expenses are comparable to costs within the state.

3. **Exchange Reimbursement Request:** Itemize and total the funding estimate for the proposed exchange reimbursement request based on the following:

    - Round-trip ground mileage between your organization and the mentor location, calculated at the IRS standard mileage rate for business travel. Mileage receipts not necessary for reimbursement; state mileage chart used for mileage verification.
    - Lodging limited to reasonable accommodations and only those nights necessary to meet the needs of the proposed exchange. Maximum three nights per person for two-day exchange. Zero balance hotel receipt required for reimbursement.
    - A stipend is available for individuals that will not be compensated by their hospital for the time spent on the exchange activity. The stipend for the mentor is limited to $200 per exchange and justification must be provided.

Approval and Reimbursement Information

A. Applications may be emailed or mailed to the ND Flex Program; applicants will receive confirmation and an approval or denial of the proposed exchange within 7 business days of receipt of the application.

B. All travel must be completed by August 15, 2019 and invoices received by August 31, 2019.

C. The attached outcome report must be submitted with your reimbursement request. Reimbursement will be denied if the outcome report and applicable receipts (lodging) are not included.

D. A sample invoice can be provided to assist with your reimbursement request.

E. Funding is allocated on "first-come, first-serve" basis for applicants meeting the criteria. The mentoring program ends when available funds are exhausted.

Rural Healthcare Peer Exchange and Professional Development Program -

OUTCOME REPORT

Due upon exchange completion and required for reimbursement

Date: _____

1) Applicant:

Organization _____

Address _____

City _____ Zip _____

Contact Name _____

E-mail _____

Phone _____ Fax _____

Name of person(s) involved in exchange _____

_____

2) Location of Exchange: _____

3) Exchange Reimbursement Request:

a. Description of completed exchange project:_____

_____

_____

_____

b. What key issues or information did you learn from this visit?_____

_____

_____

c. How will that information be used? _____

_____

_____

_____

d. Please add your comments or suggestions to improve the peer-to-peer mentoring program or application process: _____

_____

Please submit your invoice and original receipts with this report.