

RURAL HEALTH TRANSFORMATION PROGRAM

Overcoming Geographic Barriers to Care – Mobile
Healthcare Innovation (MHI)

Community Access and Rural Engagement (CARE) on the Move Illinois
Bringing Healthcare Where It's Needed Most.

SUB-AWARDEE REQUEST FOR PROPOSALS (RFP)

The Illinois Primary Health Care Association (IPHCA) is soliciting proposals for sub-awards to improve healthcare access, quality, and outcomes by transforming the healthcare delivery ecosystem through the Rural Health Transformation Program.

IPHCA

Issuing Organization	Illinois Primary Health Care Association (IPHCA)
Strategic Infrastructure Partner	Rural Health Transformation Program
Document Type	SUB-AWARDEE REQUEST FOR PROPOSALS (RFP)
Subject	The Illinois Primary Health Care Association (IPHCA) is soliciting proposals for sub-awards to improve healthcare access, quality, and outcomes by transforming the healthcare delivery ecosystem through the Rural Health Transformation Program.
Response Requested By	September 21, 2026
Submit Responses To	RHTsubmissions@iphca.org

Table of Contents

1. Funding Opportunity Information.....	2
2. Project Information.....	3
3. Eligibility.....	8
4. Scope of Work.....	9
5. Proposal Components.....	10
6. Review and Selection Process.....	12
7. Grant Agreement Terms.....	13
8. Appendix.....	13

This funding opportunity 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 five-year financial assistance award to the Illinois Department of Healthcare and Family Services' (HFS) totaling \$193,418,216.21. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS or the U.S. Government.

1. Funding Opportunity Information

- 1.1. Project Title: Community Access and Rural Engagement (CARE) on the Move Illinois
- 1.2. Pre-application Town Hall Meetings: IPHCA hosted a virtual Town Hall meeting for its member organizations on 8/20/2026 and for Local Health Departments and Rural Health Clinics on 8/21/2026. Session recordings and slide presentations are available upon request. Send an email to RHTsubmissions@iphca.org and include "CARE Town Hall Materials - [name of applicant organization]" in the subject line.
- 1.3. Solicitation Posting Date: 8/21/2026
- 1.4. Inquiry Start Date: 8/21/2026
- 1.5. Inquiry End Date: 9/16/2026 at 5 p.m. Submit all questions related to this RFP via email to RHTsubmissions@iphca.org and include "CARE Inquiry - [name of applicant organization]" in the subject line.
- 1.6. Letter of Intent. Organizations interested in applying for a CARE sub-award must submit a Letter of Intent by 5 p.m. on 8/31/2026. Send an email to RHTsubmissions@iphca.org and include "CARE LOI - [name of applicant organization]" in the subject line. The email should indicate the applicant organization's intent to submit a proposal in response to the CARE RFP. Organizations also interested in applying for a sub-award in response to the Community Care Infrastructure RFP may submit one LOI for both programs.
- 1.7. Solicitation End Date: 9/21/2026 at 5 p.m. Submit all required proposal components by this deadline via email to RHTsubmissions@iphca.org and include "CARE Proposal - [name of applicant organization]" in the subject line. Label each component per the instructions in Section 5.
- 1.8. Estimated Award Date: 11/15/2026
- 1.9. Funding Sources: Federal pass-through
- 1.10. Total Funds Available: \$8,002,281
- 1.11. Estimated Range of Awards: \$125,000 to \$1,000,000
- 1.12. Average Award: \$400,000
- 1.13. Estimated Number of Awards: 20
- 1.14. Project Period: November 1, 2026 – June 30, 2027
- 1.15. Sub-Award Agreement Term: one 8-month period ending June 30, 2027. Sub-awards in future funding cycles will be subject to HFS priorities and funding availability.

2. Project Information

- 2.1. Background: The Rural Health Transformation (RHT) Program is a federal program designed to empower states to strengthen rural communities by improving healthcare access, quality, and outcomes through transforming the healthcare delivery ecosystem.

The intent of Illinois' RHT Program is to direct resources to reshape the way healthcare is delivered across rural Illinois. HFS' RHT program goals are as follows:

- Transforming Rural Healthcare by catalyzing value-based care models, regional health care partnerships in the hospital and primary care practice spaces, promoting operational transformation, and population health improvement.
- Overcoming Geographic Barriers to Care by creating opportunities for individuals in rural settings to receive appropriate access to services while remaining in their communities through investment in mobile health, mobile crisis, and EMS services and expanding telehealth and technological innovations.
- Building a Resilient Workforce through foundational investments that fill urgent gaps in the rural healthcare workforce through scholarship and university program expansion, regional training and certification programs, and expansion of high-school and community college programs.

Through these program goals, Illinois aims to implement a comprehensive strategy for rural health transformation that will last for generations to come.

HFS allocated \$18,000,000 of its total award to fund the RHT – Mobile Health Innovation (MHI) program for FY2027. HFS anticipates a total five-year allocation of \$46,000,000 for the MHI program, subject to funding availability and satisfactory performance. The MHI program aligns with the goal of Overcoming Geographic Barriers to Care.

In many rural regions of the state, a major barrier to care is a lack of available transportation in rural areas of the state. Without dependable transit options, rural residents face delays or forego essential preventive, primary, and specialty care, exacerbating health inequities and increasing avoidable utilization of high-cost emergency services. Stakeholders identified a lack of reliable, consistent transportation as one of the largest barriers to care in the rural regions of the state which affects individuals of all ages and care needs. Mobile service offerings present an opportunity to overcome geographic and transportation-related barriers to care.

Mobile Health Infrastructure funds will support the development, deployment, and expansion of mobile primary care, behavioral health, and crisis response services in rural Illinois. The long-term goal of this initiative is to build sustainable community infrastructure to provide mobile preventive care, behavioral health, home visits, and other mobile health services which would be eligible for commercial and non-commercial reimbursement through regular medical billing.

Mobile health investments will be directed towards rural populations that face the most significant barriers to health care access and carry the highest burden of preventable disease and high-cost utilization.

- 2.2. HFS approved IPHCA's proposal, entitled the Community Access and Rural Engagement (CARE) on the Move Illinois program, and awarded \$9,000,000 of the FY2027 RHT – MHI allocation to IPHCA to administer the CARE program. IPHCA anticipates a total five-year allocation of \$23,000,000 for the CARE program, pending funding availability and satisfactory performance.
- 2.3. Purpose and Goals: In alignment with HFS' goal to transform rural healthcare, the CARE program will support rural primary care and safety net providers in the form of funding, training, and technical assistance, as they design and deploy mobile health models to better meet the needs of rural patients. IPHCA's goals for the CARE program are as follows:

GOAL 1: Build capacity to deploy health care teams through mobile health programming to improve chronic health outcomes and behavioral health among rural populations.

GOAL 2: Improve access to care and health outcomes among rural populations.

GOAL 3: Foster partnerships to promote measurable quality improvement, share best practices in care delivery, and enhance sustainability care efforts among patients in rural communities.

- 2.4. Sample Projects: CARE-funded activities may include one or more of the following:
- The development, deployment, and expansion of mobile health models that enable direct service delivery, including primary care services, behavioral health services, maternal and child health services, preventive and wellness services, and crisis response and diversion services in rural Illinois. Funding will not duplicate existing services but will be used for new, expanded, or substantially enhanced services.
 - Investment in technology and data infrastructure to support the implementation of mobile healthcare, such as telehealth platforms, remote patient monitoring, EHR integration and mobile documentation capabilities, interoperability enhancements for cross-provider coordination, and mobile connectivity solutions (e.g., hotspots, satellite internet, tablets).
 - Capital investments in vehicles and equipment, as well as operational costs needed to deploy mobile care models, such as vehicle operations and maintenance, logistics and scheduling, and referral coordination systems.
 - Investments in team-based mobile care models, integration of virtual and mobile care, improved interoperability infrastructure, workforce development, improved care navigation and community partnerships, and sustainable financial models for mobile services that

reduce unnecessary emergency department utilization and hospitalizations.

- Funding may support staffing, telehealth infrastructure, workflow development, shared care management systems or integrated electronic health records, and screening and referral protocols that promote early identification and treatment of behavioral health and physical health conditions.
- Outreach and engagement of rural communities, health education, prevention programming, chronic disease self-management, language access services, and transportation coordination.

2.5. Use of Funds:

- 2.5.1. Allowable Uses: Allowable costs are determined in accordance with the cost principles identified in 2 C.F.R. Part 200 (<https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200>), including Subpart E of such regulations and in the grant program's authorizing legislation and as outlined in Federal RHT program documents.

Costs charged to a federal award must meet all of the following:

- The cost must be necessary and reasonable for the performance of the award and reflect what a prudent person would pay under similar circumstances.
- The cost must directly benefit the award and be allocable to it in proportion to the benefit received. Costs benefiting multiple activities must be distributed appropriately.
- The organization must apply its internal policies and procedures uniformly to both federally funded and non-federally funded activities.
- Accorded consistent treatment A cost cannot be charged as a direct cost in one context and an indirect cost in another if the circumstances are similar.
- Costs must conform to limitations and exclusions stated in the Uniform Guidance or the specific federal award (see Section 2.5.3).
- Costs must comply with generally accepted accounting principles.
- A cost cannot be charged to the award if it is already counted as match for a federal award.
- Sufficient records must exist to demonstrate the nature, purpose, and benefit of the cost.
- Costs must be incurred within the award's authorized timeframe.

Allowable use of funds may include:

- 2.5.1.1. Personnel. Compensation paid for employees engaged in grant activities must be consistent with that paid for similar work within the applicant organization. Personnel cannot exceed 100% of their time on all active projects.
- 2.5.1.2. Fringe Benefits. Fringe benefits should be based on actual known costs or an established formula. Fringe benefits are for the positions listed in the Personnel budget section and only for the percentage of time devoted to the project.
- 2.5.1.3. Contractual Costs. Expenses in this category may include the following:
- 2.5.1.3.1. Products or services obtained through a procurement process.
- 2.5.1.3.2. Allowable capital expenditures for existing rural health care facility buildings and infrastructure, including minor building alterations or renovations. Capital expenditures must be tied directly to the goals of the RHT funded program.

- 2.5.1.3.3. Sub-awards to a subrecipient organization to carry out a portion of the scope of work or objectives for the RHT funded program.
- 2.5.1.4. Travel. Expenses to attend training events and IPHCA- and/or HFS-sponsored meetings are subject to the [Illinois State Travel Guide](https://cms.illinois.gov/employees/travel.html) at <https://cms.illinois.gov/employees/travel.html>
- 2.5.1.5. Supplies. Generally, supplies include any materials that are expendable or consumed during the project.
- 2.5.1.6. Equipment. Equipment is defined as an article of tangible personal property that has a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level established by the non-Federal entity for financial statement purposes, or \$5,000. An applicant organization may classify equipment at a lower dollar value but cannot classify it higher than \$5,000. (Note: Organization's own capitalization policy for classification of equipment can be used). Applicants should analyze the cost benefits of purchasing versus leasing equipment, especially high cost items and those subject to rapid technical advances. Rented or leased equipment costs should be listed in the Contractual Services category.
- 2.5.1.7. Telecommunications. This budgetary line item is to be used for direct program telecommunications, all other indirect or administrative telecommunication costs should be listed in the indirect expense section of the Budget worksheet and narrative.
- 2.5.1.8. Other Costs. This category contains items not included in the previous categories.
- 2.5.1.9. Indirect Costs. To charge indirect costs to a grant, the applicant organization must have an annually negotiated indirect cost rate agreement (NICRA).
- 2.5.1.8.1. Federally Negotiated Rate. Organizations that receive direct federal funding may have an indirect cost rate that was negotiated with the Federal Cognizant Agency. If the organization claims this rate in the project budget, the organization must provide a copy of the federally NICRA with its application.
- 2.5.1.8.2 De Minimis Rate. An organization that has never negotiated an indirect cost rate with the Federal Government is eligible to elect a de minimis rate of 15% of modified total direct cost (MTDC). Once established, the De Minimis Rate may be used indefinitely. The State of Illinois must verify the calculation of the MTDC annually.
- 2.5.2. Examples of program-specific uses:
- IT infrastructure and equipment to enable mobile care models.
 - Direct delivery of mobile healthcare services that are not reimbursable through Medicaid or other payers.
 - Costs related to expanding care in rural communities and standing up innovative models to Treat People in Place.
 - Training, coordination, and staffing clinical and non-clinical roles to design and operate mobile healthcare models.

- Investing in the infrastructure, staffing, and development of mobile health operations and care coordination.
- Engaging and training clinical and non-clinical staff to engage in mobile health models and workflows.
- Outreaching and engaging rural communities to educate about mobile care offerings, promote health, and overcome language or other barriers.
- Establishing partnerships.

2.5.3. Unallowable Use of Funds:

- Non-RHT-Related Capital Expenditures. Activities such as new construction, improvements to land, and equipment upgrades that do not support RHT goals are unallowable.
- Duplicate Payments. Funds may not be used to replace payment for clinical services that could be reimbursed by insurance (including Medicaid). Funds also may not be used for payments for clinical services if they duplicate billable services and/or attempt to change the payment amounts of existing fee schedules. If the sub-awardee plans to fund direct health care services, the sub-awardee must justify why they are not already reimbursable, how the payment will fill a gap in care coverage (such as uncompensated care or services not covered by insurance), and/or how the services transform the current care delivery model. HFS and ultimately CMS will have final approval of whether proposed services are allowable.
- Clinician Salaries. Funds also may not be used for clinician salaries or wage support for facilities that subject clinicians to non-compete contractual limitations.
- SSA Section 2105(c). SSA Section 2105(c), paragraphs (1), (7), and (9) establish funding limitations. These include general funding limitations, limitations on payment for abortions, and citizenship documentation requirements for payments made with respect to an individual.
- Electronic Health Record System. Funds may not be used for the total replacement of a sub-awardee's current EHR system that was already in place as of September 1, 2025.
- Pre-Award Costs. Funds may not be used for costs incurred prior to the sub-award start date.
- Matching Funds. Funds may not be used for costs otherwise meeting matching requirements for any other federal funds or local entities.
- Third Party Responsibilities. Services, equipment, or supports that are the legal responsibility of another party under federal, state, or tribal law are unallowable.
- Out-of-State Travel. Costs associated with out-of-state travel are unallowable.
- Other Non-RHT-Related Costs. Goods or services not allocable to the approved project are not allowed.
- Supplanting. Supplanting existing state, local, tribal, or private funding of infrastructure or services is not allowed.
- R & D. The cost of independent research and development, including their proportionate share of indirect costs in accordance with 2 CFR 300.477, is unallowable.
- Profit. Profit to any recipient even if the recipient is a for-profit organization is prohibited. Profit is any amount in excess of allowable direct and indirect costs.

- Lobbying. Funds may not be used to support any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the Congress or any state government, state legislature or local legislature or legislative body. See also 45 CFR part 93, 2 CFR 200.450 - Lobbying, and applicable Appropriations Law.
- Telecommunications and Video Surveillance Equipment. Funds may not be used for certain telecommunications and video surveillance equipment. See 2 CFR 200.216.
- Promotional Costs. Use of funds to purchase promotional items and memorabilia, including models, gifts, and souvenirs, is prohibited. Costs of advertising and public relations solely to promote the non-Federal entity is prohibited.
- Meals. Funds may be used to provide meals in limited circumstances such as:
 - Where specifically approved as part of the project or program activity, e.g., in programs providing children's services; and
 - As part of a per diem or subsistence allowance provided in conjunction with allowable travel.

3. Eligibility

Sub-award applicants must meet the following requirements to be eligible for a sub-award through the CARE program:

- 3.1. Entity Type: Be an FQHC, an FQHC Look-Alike, a Local Health Department (LHD) that provides ambulatory care services, or a Rural Health Clinic (RHC) that is not associated with a hospital.
- 3.2. Geography:
 - 3.2.1. Have its headquarters in Illinois
 - 3.2.2. Serve rural populations
 - 3.2.2.1. Tier 1: Operate sites of care in rural areas of Illinois and serve rural Illinois residents, as documented by a list of the number of current patients who are eligible per the [Rural Health Grants Eligibility Analyzer](#) and grouped by zip code
 - 3.2.2.2. Tier 2: Operate sites in urban or suburban areas and serve some rural residents
 - 3.2.3. Propose one or more projects that will be implemented in rural areas, as documented by a list of all zip codes in the proposed service area
- 3.3. Data Collection: All CARE sub-awardees must
 - 3.3.1. Consent to connecting their current EHRs to the VedaPointe data platform (see Section 4.9).
 - 3.3.2. Have the capacity to collect and report data for project-related outputs and outcomes, including, but not limited to, the following:

- Screening for Depression and Follow-Up Plan (NCQA)
- Controlling High Blood Pressure
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)
- Breast Cancer Screening (NCQA)
- Colorectal Cancer Screening (NCQA)
- No-show rate
- Number of care gaps closed (total and by category)
- Number of health risk assessments completed
- Number of patient telehealth visits (total and by category)
- Number of patient visits (total and by category)
- Number of patients/clients served (unique/deduplicated), including breakouts for rural and payor mix
- Number of health related social needs of health assessments completed
- Number of health related social needs of health service referrals made (total and by category)
- Patient demographics: age, gender, race, ethnicity
- Number of community health worker-client interactions (provided on-site or through partnerships)
- Number of staff hired for the CARE program

4. Scope of Work

All CARE sub-awardees will be required to complete each of the following:

- 4.1. Work Plan. Submit a final work plan within 30 days of a signed sub-award agreement
- 4.2. Budget. Submit a final budget within 30 days of a signed sub-award agreement
- 4.3. Training and Technical Assistance (T/TA). Participate in group TA calls, webinars on relevant topics, one-on-one TA sessions with IPHCA staff, and other relevant T/TA opportunities offered by federal and state agencies, IPHCA, and other vendors, as scheduled.
- 4.4. Peer Networking. Engage with peers through RuralReach Illinois, a virtual super network hosted by IPHCA.
- 4.5. Implementation. Implement activities as specified in the approved work plan.
- 4.6. Enrollment and Retention. Enroll and retain rural residents in CARE-funded services.
- 4.7. Health Related Social Needs. Identify patient needs and preferences, offer culturally- and linguistically-appropriate services, and address social health needs and other barriers to care.
- 4.8. Quality Improvement. Engage in the Plan-Do-Study-Act (PDSA) process for quality

improvement purposes as a method to test incremental changes within their projects.

- 4.9. VedaPointe Services. Coordinate with IPHCA’s contractual vendor VedaPointe to connect to the sub-awardee’s existing EHR to support real-time data collection and reporting through the VedaPointe Core system.
- 4.10. Other Data Collection. Collect data for all other measures specified in the sub-awardee agreement but not reported through the VedaPointe dashboard.
- 4.11. Reporting. Submit the following reports within 10 calendar days after the reporting period. Failure to submit required reports in a timely manner will result in delays with approval of reimbursements. The sub-award agreement will specify reporting format and deadlines.
 - 4.11.1. Quarterly performance reports on work plan objectives including a brief narrative update on implementation progress, performance measure trends, successes, challenges, and strategies to overcome barriers.
 - 4.11.2. Monthly fiscal expenditure reports.
 - 4.11.3. Annual final report that includes a summary of system changes, patient health improvements, performance measure trends, sustainability efforts, success stories, and more.

5. Proposal Components

With the exception of the questionnaire, save each component with the following filename protocol: CARE - [component title] - [organization name] and email them to RHTsubmissions@iphca.org before the submission deadline (see Section 1.7). Submit the budget template as an Excel file. All other components may be submitted as Word documents or PDF files.

- 5.1. Project Narrative. Describe the proposed project that addresses the unique needs of rural patients and aligns with all three CARE program goals (see Section 2.3). Organize the narrative using the headings in 5.1.1 through 5.1.6. Consult the scoring rubric (see Appendix) to strengthen the narrative content. Be succinct, cross-referencing other sections, as appropriate, to avoid repeating information and to comply with the stated page limit. Use a standard 12-point font (Arial or Times New Roman). The Project Narrative is limited to 10 single spaced pages. Do not include hyperlinks to external sources.
 - 5.1.1. Organizational Capacity
 - 5.1.1.1. Mission and History
 - 5.1.1.2. Existing Services
 - 5.1.1.3. Staffing
 - 5.1.1.4. Experience Managing Grants
 - 5.1.1.5. Rural Populations Served
 - 5.1.1.6. Operational Readiness

5.1.2. Community Needs Assessment. Use local data (include brief citations) to describe the following:

- 5.1.2.1. Population Demographics
- 5.1.2.2. Healthcare Access Barriers
- 5.1.2.3. Workforce Shortages
- 5.1.2.4. Behavioral Health Needs
- 5.1.2.5. Existing Service Gaps

5.1.3. Proposed Model

- 5.1.3.1. Rationale for Selecting the Proposed Model
- 5.1.3.2. Services to be Implemented
- 5.1.3.3. Mobile Healthcare Approach

5.1.4. Implementation Plan

- 5.1.4.1. Timeline
- 5.1.4.2. Staffing Plan
- 5.1.4.3. Patient Recruitment and Retention
- 5.1.4.4. Workflows
- 5.1.4.5. Technology Solutions

5.1.5. Partnerships and Regional Collaborations. Explain applicable existing and proposed collaborations.

- 5.1.5.1. Behavioral health providers
- 5.1.5.2. Hospitals
- 5.1.5.3. Rural Health Centers or Community Health Centers
- 5.1.5.4. Local Health Departments
- 5.1.5.5. Community-based organizations
- 5.1.5.6. Other Entities

5.1.6. Sustainability Plan – Describe strategies to continue the project after CARE funding ends.

- 5.2. Work Plan. Use the Work Plan template to outline the objectives, activities, and timeframe for planning and implementation for the period beginning November 1, 2026, and ending June 30, 2027.
- 5.3. Project Budget. Complete the Project Budget template, providing a detailed spending plan for the period beginning November 1, 2026, and ending June 30, 2027. Complete the budget justification section below the budget table on each tab of the budget template.
- 5.4. Geographic Service Area. Use the Service Area template to:
 - 5.4.1. Indicate the number of current patients that are eligible per the HRSA [Rural Health Grants Eligibility Analyzer](#), grouped by zip code (Tab 1);
 - 5.4.2. List of all zip codes in the proposed service area
- 5.5. Letters of Commitment. Submit up to 5 letters of commitment from key partners and stakeholders that will contribute to the success of the proposed project(s).

- 5.6. Assurances. Sign the following Statements of Assurance provided in the application packet:
- 5.6.1 Data Collection Capacity and Agreement to Link with the VedaPointe Core system
 - 5.6.2. CARE funding will support services for rural populations
 - 5.6.3. Compliance with Grant Accountability and Transparency Act (GATA) pre-qualification and ICQ submission for the current state fiscal year through the GATA Grantee Portal at www.grants.illinois.gov/portal.
- 5.7. Other Attachments.
- 5.7.1. Organizational Chart. Provide a one-page organizational chart with names and titles of all key staff, including all planned staff that will be involved with the proposed project(s).
 - 5.7.2. Federally Negotiated Indirect Cost Rate Agreement (NICRA), if applicable
- 5.8. Questionnaire. After submitting the proposal components listed in Sections 5.1 through 5.7, respond to the questions in the [Microsoft Office form](#).

6. Review and Selection Process

- 6.1. Administrative Review. IPHCA staff will screen all applications for eligibility and completeness and send written notification to organizations whose applications did not advance to the Technical Review stage.
- 6.2. Technical Review. IPHCA will contract with an independent third-party vendor to review the applications that passed the Administrative Review. The vendor will use a rubric (see Appendix) to score the proposals.
- 6.3. Merit Review. IPHCA staff will review the results of the Technical Review stage, rank the proposals, apply a geographic lens for statewide coverage, and make funding recommendations. Projects serving multiple counties will receive priority consideration.
- 6.4. Executive Review. IPHCA leadership and HFS – RHT program staff will review the funding recommendations and finalize the list of sub-awardees. They will apply a sliding scale to determine the funding amounts, with larger investments reserved for high-impact regional collaborative models closely aligned with HFS priority areas.
- 6.5. Notifications. IPHCA will issue written notifications to applicants, indicating the status of their proposals.

8. Grant Agreement Terms

IPHCA will execute formal sub-award agreements that outline the terms of the award, as well as sub-awardee and IPHCA roles and responsibilities.

9. Appendix

- 8.1. Work Plan Template
- 8.2. Budget Template
- 8.3. Service Area Template
- 8.4. Statements of Assurance
- 8.5. Scoring Rubric