

**MISSISSIPPI STATE DEPARTMENT OF HEALTH (MSDH)**

**TELEHEALTH ADOPTION AND PROVIDER SUPPORT  
INITIATIVE (TAPS)**

**TELEHEALTH HUB CONNECTIVITY, EQUIPMENT &  
EDUCATION GRANT PROGRAM (TCE)**

**Prequalifying Questions**

1. Are you a Mississippi-located under the eligible provider under the Telehealth Hub Connectivity, Equipment and Education Grant Program (TCE)?

\*  Yes  No

**Note:** Mississippi classifies “rural” as counties with fewer than 50,000 residents, fewer than 500 people per square mile, or municipalities with populations under 15,000. Consistent with Centers for Medicare and Medicaid Services (CMS) guidance, organizations do not need to be physically located in a rural area to be eligible for participation in this initiative. Applicants must demonstrate how proposed activities will provide meaningful benefit to rural communities and rural residents in Mississippi.

**Note:** Mississippi-based eligible providers include the following: Mississippi-based hospitals, physician practices (including solo practitioners), rural health clinics, federally qualified health centers, local health departments, Native American Sovereign Tribe healthcare facilities, certified community behavioral health clinics, substance use disorder facilities, dental care services, and licensed long-term care facilities located in rural areas or servicing rural populations).

2. Does the proposed project improve connectivity, equipment availability, and technology capacity for providers and community-based telehealth hubs or enhance understanding and effective use of telehealth among both providers and patients in rural Mississippi? \*  Yes  No

**Note:** Cybersecurity, other technology solutions, electronic health record, broadband infrastructure, new construction or major building expansion, lobbying, provider payments, demolition, and other non-allowable uses identified in the Notice of Funding Opportunity (NOFO) **may not be charged to this program.** Funding for cybersecurity, other technology solutions, and electronic health records will be offered under separate grant programs.

3. Does the proposed project align with at least one TCE Program objective? \*  Yes  No  
For reference, the TCE Program objectives include the following: strengthens rural healthcare by increasing virtual care access, supporting providers in adopting telehealth, and exploring innovative payment models.
4. I understand that by accepting TCE Program funding from the State of Mississippi, I commit to supporting the Statewide Health Information Exchange (HIE) developed under the RHT Program.

**Yes – to all questions (No. 1-4) will advance to the Application**

**No- to any of these questions will result in a message stating “Currently, you are not eligible to proceed to the next stage of the application process. Additional funding opportunities are expected to become available soon, and we encourage you to continue checking [MississippiRHTP.com](http://MississippiRHTP.com) for updates and future opportunities. For further inquiries, contact [info@mississippirhtp.com](mailto:info@mississippirhtp.com).”**

## Applicant Information

\* **Applicant Legal Name:** \_\_\_\_\_

\* **Doing Business As (if applicable):** \_\_\_\_\_

\* **Federal Employer Identification Number (FEIN):** \_\_\_\_\_

**Unique Entity Identifier (UEI):** \_\_\_\_\_

**MAGIC Vendor Number:** \_\_\_\_\_

Applicants are not required to have a UEI or MAGIC Vendor Number at the time of application submission. However, any organization selected for funding will be required to obtain and maintain an active UEI and MAGIC Vendor Number prior to award execution and disbursement of funds.

\* **National Provider Identifier Number (NPI#):** \_\_\_\_\_  
If not provided, this information may be requested as part of the review process

\* **Entity Type:** \_\_\_\_\_ (Dropdown list of eligible provider types)

## Applicant Mailing Information

\* **Street Address:** \_\_\_\_\_

\* **City:** \_\_\_\_\_

\* **State:** \_\_\_\_\_

\* **Zip Code:** \_\_\_\_\_

## Applicant Primary Contact Information

\* **Name:** \_\_\_\_\_

\* **Title:** \_\_\_\_\_

\* **Email Address:** \_\_\_\_\_

\* **Phone Number:** \_\_\_\_\_

## Authorized Grant / Contract Representative

\* **Name:** \_\_\_\_\_

\* **Title:** \_\_\_\_\_

\* **Email Address:** \_\_\_\_\_

\* **Phone Number:** \_\_\_\_\_



### Facility Information

\* Is the project being submitted on behalf of a specific facility, campus, department, clinic, or subsidiary?  Yes  No

Facility / Project Site Name: \_\_\_\_\_

Facility Type: \_\_\_\_\_

Physical Address: \_\_\_\_\_

County: \_\_\_\_\_

### Organizational Capacity

#### Debarment/Suspension Certification \*

Is the organization currently debarred, suspended, or otherwise excluded from receiving federal funds? (Verification required.)

DROPDOWN BOX

Yes - Organization is excluded from receiving federal funds

No - Organization is not excluded from receiving federal funding

By submitting an application, the applicant certifies that it is not currently excluded or debarred from future contract awards by any political subdivision or agency of any state, federal, local, or county government. Offeror further certifies that it is not an agent of any such person or entity. Offeror certifies that it has not, in the five-year period preceding its offer, been convicted of or had a civil judgment rendered against it for commission of a fraud or criminal offense in connection with obtaining, attempting to obtain, or performance of a public contract; violation of antitrust laws; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property. Offeror certifies that it is not presently indicted or otherwise criminally or civilly charged with the commission of any of the acts listed herein. Offeror certifies that, within the past five years, it has not had a contract with a governmental entity terminated due to the offeror's failure to perform, default, or any other action or inaction by the offeror.

#### Federal Funding History \*

Has the organization received federal funds before?

DROPDOWN BOX

Yes - Organization has received federal funds in the past.

No - Organization has never received federal funds.



**Past Single Audit \***

Has the organization been subject to single audit requirements in the past?

DROPDOWN BOX

Yes - Organization has had single audits conducted in the past.

No - Organization has not had past single audits.

**Past Single Audit/Audited Financial Statement Findings \***

Has the organization received any single audit and/or audited financial statement findings in the past 3 years? If yes, attach a Summary Schedule of Prior Audit Findings.

DROPDOWN BOX

N/A - No past audits

Yes - Organization has audited findings within the past 3 years.

No - Organization has had no audit findings in past 3 years.

**Financial Statements \***

Please submit audited financial statements if available. If audited financial statements are not available, applicants should submit the most recent internally prepared fiscal year-end financial statements.

UPLOAD REQUIREMENT

**Financial Management System Certification \***

Does the organization have financial systems that meet federal standards for internal controls?

DROPDOWN BOX

1 Organization has a financial management system that meets federal standards for internal controls.

2 Organization has a financial management system that does not meet federal standards for internal controls.

3 Organization does not have a financial management system.

NOTE: Applicants selecting options 2 or 3 will be required to participate in additional training or technical assistance prior to award or during the period of performance.

**Written Policies and Procedures \***

Does organization maintain written policies and procedures related to the management of federal grant funds and internal financial controls?

**DROPDOWN BOX**

- 1 Organization has written policies and procedures related to the management of federal grant funds and internal financial controls.
- 2 Organization has written policies and procedures that do not cover the management of federal grant funds and internal financial controls.
- 3 Organization lacks written policies and procedures.

NOTE: Applicants identified as having limited or incomplete written policies and procedures will be required to participate in additional training or technical assistance prior to award or during the period of performance.

**Procurement Standards Certification \***

Does the organization have written procurement procedures compliant with 2 CFR 200 and can adhere to federal procurement guidelines and contracting standards?

**DROPDOWN BOX**

- 1 Organization has written procurement procedures that address 2 CFR 200 compliance and has the capacity to meet federal procurement guidelines and contracting standards.
- 2 Organization has written procurement procedures that do not address 2 CFR 200 compliance or does not have the capacity to meet federal procurement guidelines and contracting standards.
- 3 Organization does not have written procurement procedures that address 2 CFR 200 compliance.

NOTE: Applicants identified as having limited or incomplete written policies and procedures will be required to participate in additional training or technical assistance prior to award or during the period of performance.

**Compliance With Federal Award Conditions \***

Does the organization agree to comply with all terms and conditions that flow down under 2 CFR 200 & 300, and program specific guidelines?

**DROPDOWN BOX**

- 1 Organization currently complies with all terms and conditions that flow down under 2 CFR 200 & 300, and program-specific guidelines.
- 2 Organization agrees to comply with all terms and conditions that flow down under 2 CFR 200 & 300, and program-specific guidelines.
- 3 Organization does not agree to comply with all guidelines.

NOTE: By selecting options 2 or 3, applicants will be required to participate in additional training or technical assistance prior to award or during the period of performance.

**Capacity \***

Does the organization have the capacity to complete the program and submit progress reports?

DROPDOWN BOX

- 1 Organization has capacity to complete work.
- 2 Organization lacks capacity but is actively seeking resources.
- 3 Organization lacks capacity and has yet to begin seeking resources.

Describe the capacity the organization will utilize to complete the proposed project including: (1) number of personnel to be utilized; (2) titles and tenure of proposed personnel; and (3) brief description of the roles and responsibilities of the identified personnel; and (4) whether or not these positions are currently filled or if hiring or contracting will need to take place if the applicant is awarded funding under this program.

**Conflict of Interest Disclosure \***

Are there any actual or potential conflicts of interest related to this award?

DROPDOWN BOX

- Yes - conflicts exist
- No - no conflicts exist

*Under 2 CFR 200, a conflict of interest exists when personal or corporate relationships compromise the impartiality of individuals involved in the selection, award, or administration of federal contracts, necessitating a mandatory written disclosure to the funding agency.*

If yes, provide the following information:

**Conflicts Explanation \***

Please describe any conflicts of interest that exist.

**Response:**

## **Applicant Questions**

### **Mississippi Telehealth Hub Connectivity, Equipment & Education Grant Program (TCE)**

Because RHTP funding is currently structured as a one-year award period, Mississippi strongly encourages applicants to propose phased or scalable projects that can achieve meaningful implementation milestones within the available funding timeframe. Applicants should ensure that Phase I activities are completed by July 31, 2027, and clearly identify how the proposed scope can operate independently or support future expansion if additional funding becomes available. See RFA for more details.

## **1. Executive Summary**

Purpose: The purpose of Section 1 of the application is to provide the grant evaluation team with a concise overview of the project and reference key values that appear in Sections 2–5.

### **1.1 Project Snapshot**

Project Name: \_\_\_\_\_

Requested Amount (**note: funds must be expended by the subrecipient by July 31, 2027**):

\$ \_\_\_\_\_

Program Objective Alignment (check all that apply):

- Strengthens rural healthcare by increasing virtual care access,
- Supporting providers in adopting telehealth, and
- Exploring innovative payment models Telehealth Education (Provider & Patient Outreach)

### **1.2 Short Executive Narrative (500-word limit)**

Summarize the snapshot above and present a clear high-level overview of why the project is needed and how it will advance the goals of the TCE Program.

## 2. Project Description

Complete Sections 2A–2D. Use objective, applicant-reported values and upload supporting documentation where available.

### 2A. Need and Intended Outcomes

#### 2A.1 Need Summary (350-word limit)

Instructions: Provide a short need summary describing the specific need or needs to be addressed through the proposed investment. Please note projects may be subject to state regulations governing certification of need requirements.

#### 2A.2 Quantified Need Indicators (provide at least 1)

Instructions: Provide at least one quantified need indicator. Examples of quantified indicators: wait time, appointment backlog, capacity utilization, travel distance, equipment downtime, etc.

Need indicator (name)	Baseline value	Baseline time period	Why this indicates a care gap (1 sentence)	Upload Supporting Documentation
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

#### 2A.3 Intended Outcomes (provide at least 2)

Instructions: Provide at least two intended outcomes.

Outcome (measurable)	Baseline	Target / expected change	Timeframe	How measured (data source)	Upload Supporting Documentation
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

### 2B. How the Investment Addresses the Need

Instructions: List the major components of the investment and map each component to the need indicator(s) and intended outcomes(s) above.

### 2B.1 Investment Components

Component / activity	Type (equipment/ education materials/ software/etc.)	What will be purchased/ built/ implemented?	Need indicator(s) addressed (from 2A.2)	Outcome(s) supported (from 2A.3)	Deliverable produced

### 2B.2 Connection Between Components and Outcomes (350-word limit)

Explain how the components above produce the outcomes proposed.

### 2C Communities/Populations Impacted

Instructions: Only list counties/sites you want counted for scoring. Rural confirmation is required for each site counted.

#### 2C.1 Service Area & Sites

Primary county served: \_\_\_\_\_

Additional counties served (list, or N/A): \_\_\_\_\_

Primary facility / project site name: \_\_\_\_\_

Project site address (street, city, zip): \_\_\_\_\_

Is this project one site or multiple sites? (check one)  One site  Multiple sites

UPLOAD Multiple Sites template

Service setting(s) impacted (check all that apply):  Hospital  Clinic  RHC  FQHC  Dental  Behavioral Health  LTC  SNF  Rehabilitation Facility  Other: \_\_\_\_\_

#### 2C.2 Populations Served & Estimated Reach

Will your project serve patients that reside in rural Mississippi based on the definition provided?

\*  Yes  No

Provide the number of rural encounters served annually \_\_\_\_\_

Provide the number of unduplicated rural patients served annually \_\_\_\_\_

Baseline time period (FFY 2025 preferred):

Estimated reach after project (annual rural patients/encounters served- please specify patient or encounters):

Baseline method/source (example: EHR report, scheduling report):

Upload Supporting Documentation:

### 2C.3 Impact Indicators (choose at least 2)

Provide at least two impact indicators with baseline and target.

Impact type	Indicator (measurable)	Baseline	Source of Baseline Data	Target / expected change	Upload Supporting Documentation
Increased service capacity					
Improved access / reduced travel burden					<input type="checkbox"/>
Improved care continuity / coordination					<input type="checkbox"/>
Improved operational efficiency					<input type="checkbox"/>
Improved patient experience					<input type="checkbox"/>
Improved interoperability / information exchange					<input type="checkbox"/>
Other (specify)					<input type="checkbox"/>

### 2C.4 Short Narrative (350-word limit)

Summarize C.1–C.3 and explain how the project creates rural impact. Reference the rural encounters and/or patients treated and your indicator targets.

## 2D. Challenges, Risks, and Barriers

Instructions: Provide at least two challenges, obstacles, or risks that may affect achievement of the intended outcomes. Each risk must include an owner and mitigation steps.

Risk category	Risk description (1–2 sentences)	Mitigation (1–2 sentences)	Owner (role/title)	When addressed (phase/date range)

## 3. Implementation

Instructions: Provide a detailed workplan with tasks, milestones, procurement steps, approvals, and dates. Identify responsible parties. Include planned obligation timing. (Note: **funds must be expended by the subrecipient by July 31, 2027**)

### 3A. Implementation Workplan and Timeline

For each row, first select an activity:

- Planning;
- Procurement;
- Configuration/Integration;
- Launch;
- Closeout.

Applicants are expected to use each phase at least once. You may use each activity multiple times (multiple rows per activity are expected).

Then list the milestone/task and deliverable for that activity (one milestone/task per row) and include Responsible Party (role/title) and the Start Date and End Date for each milestone/task. If the row involves procurement, complete Procurement Method and Procurement Step; otherwise enter N/A.

Because RHTP funding is currently structured as a one-year award period, Mississippi strongly encourages applicants to propose phased or scalable projects that can achieve meaningful implementation milestones within the available funding timeframe. Applicants should ensure that Phase I activities are completed by July 31, 2027, and clearly identify how the proposed scope can operate independently or support future expansion if additional funding becomes available.

Activity	Milestone / Task	Deliverable	Responsible Party (role/title)	Procurement Method (if applicable)	Procurement Step (if applicable)	Start Date	End Date
<i>Example Procurement</i>	<i>Procure software</i>	<i>Executed contract</i>	<i>Procurement officer</i>	<i>\$</i>	<i>Formal ad and bid evaluation contract execution</i>	<i>09/2026</i>	<i>10/2026</i>

### 3A.2 Planned Obligation

For each procured component, identify the obligation method and planned obligation timing (date or days post-award). Applicants are not expected to have executed contracts at application time; this is a planning field. DO NOT NAME SPECIFIC VENDOR NAMES IN THIS APPLICATION.

Procured Component	Obligation Method (Contract / Purchase Order / Direct Cost / Other)	Planned Obligation Timing (date or days post-award)
<i>Example: Clinical Equipment</i>	<i>Purchase Order</i>	<i>Within 90 days post award</i>

### 3B. Project Management and Readiness

Instructions: Assign owners for each management area. If a dedicated project manager will be used (internal or contracted), identify them. If external vendors/partners are involved, describe their roles and note 'Vendor TBD'. DO NOT NAME SPECIFIC VENDOR NAMES IN THIS APPLICATION.

Management Area	Owner (name or role/title)
Scope	
Schedule	
Budget	
Approvals / decision authority	
Reporting	

### 3C. Sustainability Plan

Instructions: Address each category below. If a category does not apply, enter N/A.

Topic	Addressed?	Plan (1–2 sentences)
How will you ensure completion by July 31, 2027?	Required	
Maintenance (includes factors such as cost to maintain the investment long term and any replacement costs)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Staffing	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Operations (includes overall operations as well as patient satisfaction and experience)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reimbursement / revenue strategy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Partnerships (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

Sustainability owner (role/title):

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### 4. Budget Narrative

Instructions: Complete sections 4A–4C. This section is required for completeness/responsiveness. Please provide reasonable estimates related to the budget for your proposed project. Use brief narrative and cite assumptions. Please highlight the amounts that be will applied to indirect and/or administrative costs.

#### 4A. Alignment to Project Scope and Activities (500-word limit)

Explain how each major budget category supports the proposed project scope, implementation of tasks, and intended outcomes. Please highlight the amounts that be will applied to indirect and/or administrative costs.

**4B. Non-Duplication of Funding (500-word limit)**

Explain how the proposed expenditures do not duplicate other existing funding sources. If any portion is supported by another source, identify the source and describe how costs are separated.

**4C. Cost Estimate Basis and Assumptions (500-word limit)**

Describe the basis for estimates (quotes, internal estimates, prior purchases, market comparisons). Upload supporting documentation.

**5. Evaluation**

Instructions: Provide measures and describe how you will collect, verify, track, and report data related to performance metrics for the proposed project. Identify the owner and cadence. Include at least one implementation and one outcome measure where appropriate.

By submitting the application, the applicant certifies that they will provide monthly progress reports and any additional required reporting.

**5.1 Measures Table**

Measure	Type (Implementation/ Outcome)	Data Source	Baseline (or how baseline will be established)	Target / expected change	Responsible Owner (role/title)	Collection frequency

## 5.2 Methods (All required — 200-word limit each)

Collection method:

Verification method:

Tracking method:

## Part 6 – Required Documentation and Uploads

Include the following attachments with the application package, consistent with the Request for Application and any final application instructions issued by the Mississippi State Department of Health:

- Completed and signed IRS Form W-9.
- SAM.gov documentation (if available)
- Most recent financial statement audit or internal financial documentation
- Summary of Findings, if applicable
- Written policies and procedures
- Documentation showing proof of rural population served
- Completed budget template (Microsoft Excel format / Portal).

## Part 7 – Applicant Attestations

By submitting this application, the authorized representative attests to the following statements:

- I certify to the best of my knowledge and belief that the information provided herein is true, complete, and accurate. I am aware that the provision of false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil, or administrative consequences including, but not limited to violations of U.S. Code Title 18, Sections 2, 1001, 1343 and Title 31, Sections 3729-3730 and 3801-3812.
- By submitting this application, the Applicant attests that funds awarded under this program will not supplant, existing funding, services, activities, or obligations currently supported through other federal, state, local, or private funding sources. The Applicant further attests that program funds will not be used to replace or substitute for existing budgeted expenditures or ongoing financial commitments.
- The Applicant attests that awarded funds will be used solely for allowable activities and costs consistent with applicable federal laws, regulations, program guidance, award conditions, and CMS requirements, and will not be used for unallowable activities or expenditures.
- The Applicant hereby certifies that it understands and will comply with all duties and requirements applicable under the Rural Health Transformation Program (RHTP), including the RHTP Terms and Conditions, the Notice of Funding Opportunity (NOFO), the RHTP Frequently Asked Questions, and all other programmatic supporting documentation provided or referenced by the awarding entity. The applicant acknowledges the following: All federal statutes, regulations, and award conditions apply to entities participating in RHTP, including those set forth in 2 CFR Part 200 and applicable provisions in 2 CFR Part 300, which are incorporated by reference into the NOFO and related federal award materials. The terms and conditions of federal awards flow down to subawards, as required under 2 CFR 200.101(b)(1), and RHTP funds—once passed through—remain subject to 2 CFR Part 200 and 2 CFR Part 300 as explained in the RHT Program FAQs. As stated in the NOFO, compliance with administrative, financial, and national policy requirements under 2 CFR Part 200 and 2 CFR Part 300 is mandatory, including any modifications adopted by CMS. The Applicant understands that these regulations include obligations related to financial management, internal controls, procurement, performance measurement, reporting, cost allowability, and other standardized requirements described in 2 CFR Part 200. If selected as a subrecipient, the organization will maintain an adequate working knowledge of the RHTP program and all associated federal regulatory requirements sufficient to fulfill all subrecipient duties imposed under 2 CFR Part 200, 2 CFR Part 300, the NOFO, the FAQs, and all programmatic guidance referenced by the awarding entity. By providing this certification, the Applicant attests that it has reviewed all relevant governing documents, understands the compliance obligations associated with the RHTP, and agrees to adhere to all requirements as a condition of being considered for a subaward under the program.



- By submitting this application, the Applicant acknowledges and understands that applicable federal and/or state laws, regulations, reporting requirements, guidance, and program requirements may change over time. The Applicant attests that it will remain in compliance with all current and future applicable requirements, including any updates, modifications, revised reporting obligations, or additional guidance issued by CMS or other authorized entities throughout the period of performance.
  
- By submitting this application, the Applicant acknowledges that they will commit to supporting the Statewide Health Information Exchange (HIE) developed under the RHT Program.

**Authorized Representative Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_