Texas Rural Health Capacity Building Grant

Texas Rural Health Clinics (RHCs) are an integral part of the state's healthcare safety net and vital primary care access points in rural communities.

We know that *rural matters* – that rural Texas is a place of enormous significance, and those who live and work in rural communities deserve the best possible care and equal chance to live their healthiest life. The challenges of our time amplify the importance of meaningful partnerships, of strategic capacity-building, and of alignment and optimization of primary care for rural, underserved communities. Thus, the TORCH Foundation, in coordination with the Texas Association of Rural Health Clinics (TARHC), is pleased to announce the new Texas Rural Health Capacity Building Grant program. This program is made possible through the generous contribution and support of Amerigroup Texas, Inc.

PURPOSE OF GRANT

The purpose of this grant is to strengthen the state's rural health safety net and Texas RHCs through community-based innovation and collaborations that address the healthcare needs of rural residents. Specifically, this program supports initiatives that build organizational, value-driven capacities and innovation that yield impact.

ELIGIBILITY

To qualify, Applicants must be a current Medicare certified Rural Health Clinic in Texas.

ALLOWABLE AND NON-ALLOWABLE USE OF FUNDS

Allowable use of funds include:

- Acquisition of capital asset for clinic operation or patient care delivery
- Facility improvement, renovation, repairs, remodeling, construction, maintenance; projects that address life safety code issues will receive funding preference
- Workforce development and capacity building, recruitment cost, provider loan repayment[1], staff training/development or instructional programming
- Initiatives that support social determinants of health (SDOH) and advance health equity

Non-allowable use of funds include:

- Delivery of direct patient care or patient expenses
- Staff or provider salaries, benefits, bonuses or gifts
- Outstanding organizational debt or payment recoupments
- Real estate purchase or office rent payments

Funded projects must be completed and funds spent within one year of the award issue date.

GRANT AMOUNTS

Award ranges between $25,000 to $50,000 per clinic.

MATCH REQUIREMENTS

This grant requires matching expenditures equal to or greater than 15% of the total grant amount requested. For example, if you are requesting $25,000, you must contribute at least $3,750, showing the total project cost of $28,750.

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[1]Clinicians cannot receive loan repayment funds with services obligations from more than one entity at a time.

GRANT REPORTING REQUIREMENTS

Grant recipients are required to submit:

(1) A mid-project status report describing completed/successful activities, planned activities, challenges and related outcomes; and
(2) A final project report describing completed activities/successes and outcomes from the funded project.

SCHEDULE OF EVENTS CRITICAL DATES

Event	Date
Program announcement	06/01/2022
Application deadline	07/29/2022
Estimated award date and start date of project	08/26/2022
Mid-project report	02/28/2023
End date of project	08/31/2023
Final report (no later than 1 month following project end date)	09/29/2023

APPLICATION DEADLINE

All completed applications must be received by TORCH Foundation **no later than 5:00 P.M. Central Time (CT), July 29, 2022**. Submit application by email to Quang Ngo, TORCH Foundation, at qngo@torchnet.org or by mail to: TORCH Foundation, 3309 Forest Creek Drive, Suite 305, Round Rock, Texas 78664, ATTN: Quang Ngo

QUESTIONS

Direct any questions about this grant program to Quang Ngo at qngo@torchnet.org or (512) 497-5357.

TEXAS RURAL HEALTH CAPACITY DEVELOPMENT GRANT APPLICATION

I. APPLICANT INFORMATION

Name of Clinic ______________________________

Address ______________________________ ☐ Physical ☐ Mailing

City ______________________________ State ________ ZIP Code ____________

Organization's EIN ______________________________ Clinic CCN# ______________________________

Clinic is (check one) ☐ Provider-based (PB) ☐ Independent (IND)

Name of Clinic Administrator/Director ______________________________

Phone ______________________________ Email ______________________________

Name of Hospital CEO (if clinic is PB) ______________________________

Phone ______________________________ Email ______________________________

II. FUNDING REQUEST INFORMATION

Name of Project/Purpose of Request ____

Does this project address Life Safety Code Deficiencies/issues? ☐ Yes ☐ No

1. Describe the purpose of the project or request for funding. What activities will be accomplished, what are the proposed purchases, and what community or patient needs does this address? If the project involves capital equipment purchases, attach vendor quotes/estimates (if available). If the project addresses Life Safety Code deficiencies, describe the citation(s)/issue(s) to be addressed (response: 2-page limit – attach additional page if necessary)

II. FUNDING REQUEST INFORMATION, cont'd

2. Describe how this funding, if awarded, will impact your clinic, your community or the populations you serve. List and describe specific outcome(s) or impact. (1-page maximum)

III. PROJECT BUDGET & NARRATIVE

Complete the budget form and provide a clear description of the purpose/use for each item or activity for which funding is requested.

	$ Requested	Description of purpose/use
Capital equipment/asset (list) • • • • •	$	
Facility Improvement or Life Safety Code	$	
Workforce development/training	$	
SDOH, health equity	$	
Total Funding Request	$	
15% Required Applicant Match	$	
Total Project Budget	$	

IV. CERTIFICATIONS & AUTHORIZING OFFICIAL SIGNATURE

By signing below, Applicant

(1) Certifies all information provided in this application is true and correct to the best of Applicant's knowledge, and acknowledges any misrepresentation or false statement made by Applicant, or an authorized agent of Applicant, in connection with this application, whether intentional or not, will constitute grounds for denial of this application;
(2) Certifies that Applicant is not in bankruptcy or delinquent on any State or Federal debt; and
(3) By submission of this application, Applicant acknowledges that as a condition of receipt of grant funds under this program that Applicant agrees to requirements and expectations established herein.

Name of Authorized Official Representative	Title:
Signature of Authorized Official Representative	Date: