Virginia Rural Health Transformation Program
Mobile and Hybrid Care FAQ
Northern Piedmont Regional PDC Collaborative
(REVISED as of November 3, 2026)

1. For a project involving deployment of a medical device as part of a mobile or hybrid care model, could a healthcare distributor serve as the primary applicant, with the manufacturer and licensed healthcare provider participating as implementation partners?

   Yes.

2. Alternatively, would you generally view a healthcare provider serving the eligible rural population, such as a hospital, FQHC, Rural Health Clinic, or medical group, as the stronger or more appropriate primary applicant for this type of project?

   We view a strong application as one that has explicit established partnerships necessary to complete the proposed program within the given timeline.

3. If the distributor were the primary applicant, would you expect a formal relationship with a healthcare provider serving the eligible rural population to already be in place at the time of application? If so, would a letter of commitment, MOU, existing agreement, or similar documentation be appropriate?

   Where clinical partnerships are necessary for implementation, a competitive application has the partnerships necessary to complete the proposed program within the given timeline. Applications will be scored based on the rubric provided in the RFA. The "Implementation Feasibility & Organizational Capacity" section includes scoring relevant to the work plan and timeline, timely deployment, and applicant and partner capacity, among other considerations. A letter of commitment, MOU, existing agreement, or similar documentation are all appropriate for demonstrating partner capacity.

4. If a local healthcare provider serves as the primary applicant, would a structure where the provider leads the clinical implementation, the distributor supports fulfillment and program operations, and the manufacturer supplies the technology be consistent with the intent of the RFA?

   Yes.

5. More broadly, is there any guidance you can provide on the applicant/partner structure that would best demonstrate a meaningful connection to the eligible rural population and align with the goals of the Mobile & Hybrid Care initiative?

   We view a strong application as one that has explicit and established partnerships that will serve the specific healthcare needs of the eligible rural population within your program.

6. What documentation is needed to confirm credentials? Can we provide a copy of the state license or do you need a copy of the terminal degree for applicable personnel?

   Any documentation confirming appropriate licensure is sufficient.

7. Can the primary RHTP investment be technology and supporting infrastructure, with clinical services subsequently delivered by licensed healthcare partners?

   Yes.

8. Can clinical partners be finalized during the post-award implementation period, with required agreements/licenses submitted before clinical services begin?

   Where clinical partnerships are necessary for implementation, a competitive application has the partnerships necessary to complete the proposed program within the given timeline. Applications will be scored based on the rubric provided in the RFA. The "Implementation Feasibility & Organizational Capacity" section includes scoring relevant to the work plan and timeline, timely deployment, and applicant and partner capacity, among other considerations.

9. Can the technology organization establish secure EHR/data connectivity with clinical partners after award for patient identification, care coordination, referrals, and outcomes?

   Yes.

10. Can mobile technology + CHWs + community access points + telehealth qualify as a mobile/hybrid model without requiring a physical mobile clinic or vehicle?

    Yes.

11. Are technology infrastructure, EHR integration, mobile devices, telehealth equipment, connectivity, analytics, cybersecurity, training, and implementation allowable startup costs?

    Please reference additional details regarding allowable and unallowable costs listed on pages 7 and 16 in the posted RFA.

12. Can CHWs serve as the community-facing workforce while licensed clinical partners remain responsible for clinical care?

    Yes.

13. Are Virginia for-profit mobile-health technology companies eligible to serve as the direct applicant under this RFA, provided they satisfy the federal, financial, reporting, and service-area requirements?

    Yes.

14. May an applicant headquartered outside the posted region apply if the proposed project directly serves eligible rural residents in the listed counties?

    Yes.

15. If a healthcare provider, nonprofit organization, or other eligible entity serves as the lead applicant, may Appalachian Access serve as its contracted implementation, deployment, technology, and patient-navigation partner?

    Yes.

16. In that structure, must only the lead applicant maintain an active SAM.gov registration and UEI, or must all material project partners and contractors also maintain active registrations?

    Material project partners and contractors do not need to maintain active SAM.gov registration and UEI. Lead applicant must have an active UEI.

17. When clinical providers bill Medicare, Medicaid, or commercial insurance for covered medical services, may RHTP funding support the separate, nonbillable infrastructure and access-related expenses required to make those encounters possible, provided no expense is charged to more than one funding source?

    Yes.

18. Are applicants permitted to submit separate proposals to multiple Virginia Planning District Commission RFAs when each application targets a distinct eligible rural population and contains separate, nonduplicative costs?

    Yes.

19. Do you require or strongly prefer a formal local healthcare or community partner within the proposed service area? If so, what documentation should be submitted to demonstrate that partnership?

    Where clinical partnerships are necessary for implementation, a competitive application has the partnerships necessary to complete the proposed program within the given timeline. Applications will be scored based on the rubric provided in the RFA. The "Implementation Feasibility & Organizational Capacity" section includes scoring relevant to the work plan and timeline, timely deployment, and applicant and partner capacity, among other considerations.

20. Could you please provide us some guidance on the application process?

    No additional guidance will be provided. Please refer to the Request for Applications document for information.

21. Would specialized forensic medical examinations, including sexual assault, domestic violence, strangulation, trafficking, and child abuse examinations, qualify as specialty or diagnostic healthcare services under this initiative? These examinations include medical assessment, injury evaluation, appropriate treatment, and forensic documentation.

    Yes, but keep in mind that RHT funds cannot supplant billable activities.

22. A group is a for-profit LLC providing healthcare services. We understand that for-profit entities may apply. Can you confirm that a privately owned forensic medical practice is eligible to apply directly, provided all other requirements are met?

    Yes.

23. Does the eligible vehicle category include purchasing a brand-new, purpose-built mobile medical clinic that arrives fully equipped for patient examinations, rather than purchasing and converting an existing vehicle? Would the integrated clinical buildout, medical equipment, and necessary technology be allowable expenses?

    Yes.

24. We understand that the grant operates on a reimbursement basis without advance payments. For a mobile medical clinic requiring a substantial capital investment, can reimbursement be requested for documented manufacturer deposits or contractual progress payments, or must the completed vehicle be delivered and paid for in full before reimbursement is available? Are installment financing or other approved purchasing arrangements permitted, and what is the anticipated reimbursement frequency and processing timeline?

    When a payment is made, reimbursement can be submitted, including deposits for large purchases. Reimbursement frequency details will be established in an eventual sub awardee contract. For large upfront capital expenses, additional arrangements are available and can be explored after awards and contracts are completed.

25. If awarded, could a group retain ownership of the mobile medical unit, subject to applicable federal property management, use, and disposition requirements?

    If purchased, the mobile unit is wholly owned by the purchasing entity.

26. Because manufacturing a purpose-built mobile clinic may require several months, would an approved purchase contract and documented manufacturing progress satisfy interim implementation milestones if final delivery occurs after the initial deployment target? Is an extension available when necessary due to documented manufacturer lead times?

    Yes; however, funds must be spent by September, 30, 2027.

27. Is there any required applicant match or cost-sharing contribution for this funding opportunity?

    No.

28. Would a standalone, consumer-facing, nonclinical care navigation and access model qualify as an eligible technology-enabled mobile or hybrid care project under the RFA?

    Yes.

29. Could a for-profit technology organization serve as the sole applicant without a formal clinical provider partner, provided that it does not deliver licensed clinical services?

    We view a competitive application as one that has explicit and established partnerships that will serve the specific healthcare needs of the eligible rural population with your program.

30. Would proposed community-based access points, combined with telephone/SMS navigation and connections to existing healthcare services, satisfy the program's expectations for a hybrid care delivery model?

    Yes, depending on program specifics.

31. Are letters of commitment from community organizations or healthcare providers mandatory at application for such a model, or may implementation arrangements be finalized following an award?

    Such letters are not required; however, competitive applications will have explicit and established partnerships necessary to complete the proposed work within the required timelines.

32. Are software development, platform configuration, AI-supported navigation, outreach operations, and community deployment expenses allowable within an approved project budget?

    Generally, yes.

33. May a project include technology-enabled, nonclinical patient-access support, navigation, and follow-through when integrated into a licensed provider's mobile or hybrid care model? Yes. Must these functions support a new or expanded care-delivery model, or may they expand access through an existing model?

    Either is allowable.

34. May a for-profit entity incorporated and headquartered outside Virginia apply directly if its project serves eligible residents within the specified counties? Yes. If so, is Virginia foreign-entity registration required at application, award execution, or commencement of services?

Any entity that meets the application eligibility requirements in Section 1.4 of the RFA is eligible to apply, including for-profit organizations or those based outside of Virgina. However, the funded program must only deliver services within Virginia. Any required registrations must be obtained by the time the award is executed.

35. May approved project costs include software subscriptions or licensing, usage-based technology charges, configuration, integration, training, and time-limited implementation personnel? Yes; however, sustainability is key and subscription model charges will be seen as less sustainable than upfront, one time, investment purchases. How does the prohibition on recipient profit apply to commercial pricing charged by an independent technology contractor, and what supporting documentation is required? Generally, RHT funds cannot be used to fund services that produce revenue on their own. For additional allowable and unallowable cost information, please refer to the RFA.

36. What reimbursement submission frequency and typical processing interval should applicants use for cash-flow planning? Does payment to a subrecipient depend on TJPDC first receiving the corresponding funds from DMAS, and are there deadlines governing each stage?

    Department of Treasury regulations stipulate that federal funds should be drawn only to meet immediate needs and must not be held for more than three working days. This rule applies to both recipients and subrecipients. Reimbursement frequency will be determined in sub awardee agreements with the PDC.

37. How will the federal license described in Section 6.7 apply when a project uses pre-existing commercial software? What documentation should distinguish pre-existing intellectual property from grant-funded modifications or deliverables, and which requirements apply to technology contractors?

    The Federal government only has rights to intellectual property that was acquired or developed with Federal funds, including any copyrighted material developed or acquired, or data generated, under the Federal award. For modifications to existing technologies, the license and rights apply only to those copyrighted materials and data produced in connection with the award.

    Federal guidance does not prescribe a specific form for documenting pre-existing intellectual property. Applicants intending to produce copyrighted modifications to pre-existing commercial software or other intellectual property should clearly distinguish the existing technology from the specific work, modifications, deliverables, or data that will be supported by RHTP funds.

    Please refer to 2 CFR 200.315 for full details of the Federal license.

Contractors are subject to different requirements than awardees in general because they fulfill a different role than subrecipients. However, the license is applicable regardless of whether the material was generated under contract or through another method. For Federally required contract provisions, please refer to 2 CFR 200 Appendix II. In addition, some other requirements are imposed by Virgina, such as Drug-Free Workplace and anti-trafficking provisions.

38. For projects combining nonclinical access support with clinical services, when may an eligible resident be counted as served? Must a healthcare encounter be completed, or may documented navigation or access assistance qualify? How should applicants establish the baseline and demonstrate that residents served are incremental?

Both measures can be reported. For the Primary Care Visits metric, an eligible healthcare encounter must be completed. For the incremental lives served metric, it will need to be net new lives served as a result of the RHTP funded work (i.e. new program, program expansion, etc.). Documented navigation or access support could be counted in the incremental lives served metric.