Notice of Funding Opportunity
Community Care Infrastructure/Integrated Care

Applications Due: October 23, 2026, 5:00 p.m. CT

This funding notice is organized to help applicants first understand the purpose and eligible service models, and then determine eligibility, prepare a compliant proposal and budget, understand review criteria, and anticipate post-award responsibilities.

A. Description of Funding Opportunity

The Community Behavioral Health Association (CBHA) of Illinois is issuing this notice of funding opportunity (NOFO) to strengthen behavioral health infrastructure and embed team-based, integrated models of care that can address behavioral health, primary care, and root causes of disease holistically. Team-based care delivery and cross-sector partnerships are central to this initiative. Applicants should describe how proposed activities will formalize care teams and strengthen partnerships with other providers and community organizations. Funds will support the implementation of the following:

- Integrated behavioral and physical health services
- Collaborative care arrangements and care coordination between behavioral health, primary care, and specialty providers
- Innovative interdisciplinary care teams that leverage new provider types
- Health information technology and data-sharing infrastructure that support integrated, coordinated care
- Regional partnerships that strengthen coordination among key health and social service providers in rural communities

A.1. Background

This grant program uses Rural Health Transformation (RHT) Program funds made available by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS). The RHT Program was designed to empower states to strengthen rural communities by improving healthcare access, quality, and outcomes through transformation of the healthcare delivery ecosystem.

Rural communities experience persistent barriers to care, including workforce shortages, limited provider capacity, inadequate technology and data infrastructure, transportation challenges, administrative burdens on rural organizations, and fragmented service delivery systems. To address these challenges, the RHT Program invests in infrastructure, workforce development, care integration, and service delivery innovations that strengthen the rural healthcare system.

Illinois' RHT Program focuses on the following goals:

- **Transforming Rural Healthcare** by catalyzing value-based care models, fostering regional healthcare partnerships, promoting operational transformation, and improving population health.
- **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 emergency medical services (EMS) 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.

To advance these goals, the Illinois Department of Healthcare and Family Services (HFS) identified CBHA as a direct recipient of RHT Program funding. As the direct recipient, CBHA is responsible for administering this funding opportunity and supporting implementation across eligible rural communities throughout Illinois.

Through this initiative, CBHA will provide targeted funding to eligible rural behavioral health providers to develop the infrastructure, staffing, technology, partnerships, and operational workflows necessary to implement integrated, team-based models of care. Funding may support the following:

- Standing up evidence-based, integrated models of care
- Implementing regionalized enhanced care coordination and health system navigation models
- Building clinical connections between rural care providers and specialists
- Establishing or expanding integrated care models that bring primary care and behavioral health services together, including embedding primary care providers and services in outpatient behavioral health settings or embedding behavioral health providers and services in primary care settings
- Expanding interdisciplinary care teams through the inclusion of community health workers, peer support professionals, doulas, and other emerging provider types
- Enhancing health information technology infrastructure to improve integration and coordination, population health management, and/or artificial intelligence-enabled clinical decision supports
- Supporting regional partnerships among healthcare and social service providers, including schools, hospitals, emergency departments, urgent care centers, local health departments, pharmacies, specialists, and community-based providers

These investments are intended to improve access to care, address social and structural barriers to health, strengthen coordination across the continuum of care, and advance the goals of the RHT Program.

About CBHA

CBHA is a statewide not-for-profit membership association. It represents more than 90 community behavioral health organizations that provide mental health and substance use disorder services to children, youth, adults, and families throughout Illinois, including rural, suburban, and urban communities.

CBHA's mission is to represent the interests of its members to ensure access to and availability of a comprehensive system of accountable, high-quality behavioral healthcare services for the people of Illinois. Its vision is to create an accessible, consumer- and family-responsive, efficient, effective, fully unified, and principled healthcare system.

An 11-member board of directors representing four geographic regions of Illinois (Northeast, Northwest, Central, Southern) governs CBHA. This regional structure ensures that the association understands and responds to the unique needs of providers and communities across the state, including those in rural and underserved areas.

CBHA has engaged Advocates for Human Potential, Inc., as its contracted operational partner to centralize and automate grant management functions of this initiative.

A.2. Authorizing Statutes or Regulations

Awardees are required to adhere to the requirements outlined in the following:

- Grant Accountability and Transparency Act (GATA), 30 ILCS 708
- Illinois Administrative Code, Government Contracts, 44 Ill. Admin Code Part 7000
- Grantmaking, Procurement, and Property Management and federal regulations under Grants and Agreements, 2 CFR Part 200

B. Need and Population Served

To inform the development of this funding opportunity, CBHA convened rural behavioral health providers, healthcare organizations, and community stakeholders from across Illinois. Participants identified workforce shortages, fragmented care coordination systems, limited specialty care access, technology and interoperability challenges, and funding sustainability concerns as key barriers to integrated care in rural communities. Stakeholders also emphasized the importance of community outreach and education, lived experience leadership, community partnerships, and organizational capacity building for smaller rural providers and community-based organizations. Participants noted that outreach, partnership development, care coordination, reporting infrastructure, and other foundational activities are often difficult to sustain despite their critical role in improving access to care, strengthening community trust, supporting integrated service delivery, and connecting individuals and families to needed services.

As the first point of contact for many individuals seeking care, outpatient behavioral health providers play a critical role in advancing integrated, person-centered healthcare delivery in rural communities. These providers serve rural residents across the lifespan, including children; youth; adults; families; justice-involved individuals; and others with behavioral health conditions, co-occurring physical health needs, and social drivers of health that affect overall well-being.

Stakeholder input highlighted the need to do the following:

- Integrate behavioral health and primary care through embedded staff, colocated services, and shared protocols

- Strengthen workforce capacity through recruitment, retention, training, and workforce pipeline development
- Expand access to specialty behavioral health services, peer support services, and family peer support services
- Improve service coordination, referral pathways, information sharing, and continuity of care across providers and systems, consistent with applicable consent and confidentiality requirements
- Enhance technology, data, organizational, and reporting infrastructure, particularly among smaller rural providers and community-based organizations, and address device, connectivity, and digital literacy barriers
- Build sustainable cross-sector partnerships that support integrated care delivery and improve outcomes
- Advance community trust, community engagement, and lived experience leadership in program design and service delivery

Participants also noted that fragmented systems and difficulties navigating services often place the burden of care coordination on individuals and families and emphasized the importance of strengthening community trust and lived experience leadership to improve engagement and outcomes. Rural residents also face persistent obstacles to care, including transportation challenges, stigma, long wait times, crisis continuum gaps, housing instability, and limited availability of specialty services and higher levels of care. In many small communities, service volume is too low to support a full-time position, so staff are centralized, and response times grow.

This initiative is intended to strengthen behavioral health capacity and support team-based, integrated models of care that address behavioral health needs, physical health needs, and social drivers of health in a coordinated manner. Through investments in workforce development, care coordination, infrastructure modernization, community partnerships, and integrated care models, the initiative will help reduce fragmentation, improve access, and deliver comprehensive, person-centered care that meets the unique needs of rural populations while shifting care to lower-cost settings.

B.1. Communities to Be Served

The communities served through this initiative must align with established federal and state rural designations, including Health Resources and Services Administration (HRSA) rural classifications, Rural-Urban Commuting Area (RUCA) codes, and other rural designations recognized by federal and Illinois rural health programs. Applicants must demonstrate that grant-funded activities will exclusively serve residents of these federally or state-designated rural communities.
Subrecipients must be able to document that funded activities benefit only rural residents.

Organizations may be located within or outside designated rural areas and remain eligible to apply if proposed activities serve residents of federally or state-designated rural communities. Applications should clearly describe the following:

- Whether the applicant organization operates a behavioral health agency in a designated rural area or operates outside a designated rural area but serves individuals residing in rural communities;
- Geographic areas and rural populations to be served;
- Barriers experienced by those communities (e.g., workforce shortages, limited provider capacity, inadequate technology and data infrastructure, transportation challenges, administrative burdens on rural organizations, fragmented service delivery systems); and
- Strategies proposed to develop the infrastructure, workforce capacity, partnerships, technology, and care delivery models needed to improve behavioral health access, care coordination, integrated service delivery, and health outcomes for rural residents.

Applicants may use publicly available data to document barriers, including HRSA Health Professional Shortage Area designations, County Health Rankings & Roadmaps measures of broadband access and uninsured rates, and Centers for Disease Control and Prevention PLACES transportation barrier estimates.

B.2. Priority Populations

Beneficiaries of this initiative will be residents of rural communities where access to essential health services is limited by geographic isolation, workforce shortages, and resource constraints. Based on documented needs and barriers identified by rural providers, healthcare organizations, and community stakeholders, the following populations have been identified as priorities:

Individuals with Significant Behavioral Health and Specialized Service Needs

- Individuals with complex behavioral health, physical health, and social needs who require coordinated, multidisciplinary care
- Individuals with serious mental illness, serious emotional disturbance, substance use disorders, co-occurring mental health and substance use disorders, or chronic and persistent mental illness, particularly those lacking adequate community supports
- Youth and young adults requiring specialty behavioral health services
- Individuals experiencing behavioral health crises or at risk of avoidable emergency department utilization, hospitalization, or institutional involvement

Families and Caregivers

- Parents, caregivers, and family members supporting individuals with complex behavioral health needs, particularly those who face barriers to accessing child care
- Pregnant and postpartum individuals requiring coordinated behavioral health and physical healthcare services
- Older adults with behavioral health, primary care, and supportive service needs

Populations Facing Disproportionate Barriers to Care

- Justice-involved individuals and individuals transitioning from institutional settings
- Individuals experiencing homelessness or housing instability

- Medicaid beneficiaries and uninsured individuals
- Veterans and military families
- Agricultural workers and farming families

Applicants serving other high-need rural populations may justify their inclusion based on documented community needs and evidence of service gaps.

C. Eligibility

This competitive funding opportunity is open only to Community Mental Health Centers, Behavioral Health Clinics, Certified Community Behavioral Health Clinics, and Substance Use Treatment Facilities licensed or certified by Illinois HFS or the Illinois Department of Human Services, Division of Behavioral Health and Recovery.

Applicants are expected to partner with healthcare providers, social service organizations, schools, local governments, or other community-based organizations to implement proposed activities; however, the eligible behavioral health provider must serve as the lead applicant and assume responsibility for all grant requirements, fiscal management, program oversight, reporting, and compliance obligations.

Applicants may also identify one or more co-applicants. A co-applicant is an organization that will share responsibility for project oversight, implementation, and achievement of project outcomes. Co-applicants are not required to meet lead applicant eligibility requirements unless otherwise specified in this funding notice. The lead applicant remains solely responsible for all award requirements, compliance obligations, reporting, and fiscal management. Organizations receiving payment only for specific services or activities are considered subcontractors rather than co-applicants.

To be eligible for funding, applicants must serve eligible rural communities in Illinois; meet the requirements below; and comply with the fiscal, legal, reporting, and programmatic requirements described in this funding notice.

- Applicants must be a nonprofit, for-profit, or tax-exempt entity located in Illinois.
- Applicants must be able to fulfill the scope of services detailed in this funding notice.
- Applicants must have the capacity to comply with the legal, fiscal, reporting, and programmatic requirements as described in this funding notice.
- Applicants proposing to use program funds to provide services requiring state or federal licensure must be actively licensed.
- Applicants must be qualified to do business with the State of Illinois.
- Applicants must complete the pre-qualification and pre-award requirement described in this section.
- Applicants must identify relevant funding sources and explain how proposed activities will complement, rather than replace or duplicate, existing funding.

C.1. Pre-qualification

Per Federal Uniform Guidance (2 CFR Part 200) and GATA, all applicants must be qualified to receive an award. An eligible organization must

- Have an active System for Award Management (SAM.gov) public account,
- Complete the GATA pre-qualification and Internal Controls Questionnaire submission for the current state fiscal year through the GATA Grantee Portal,
- Have an active Unique Entity Identifier (UEI),
- Not be on the SAM.gov Exclusion List,
- Be in good standing with the Illinois Secretary of State (if the Illinois Secretary of State requires the entity's organization type to be registered),
- Not be on the Illinois Medicaid Sanctions List, and
- Not be on the Illinois Stop Payment List.

To obtain the information required to achieve qualified status, complete the steps detailed in the following table.

Pre-Qualification Requirements

Step	Action	Requirement	Link
1	Register with the State of Illinois.	Be actively registered with the Illinois Secretary of State.	Illinois Secretary of State website
2	Obtain a FEIN/EIN number.	Obtain a Federal Employer Identification Number (FEIN/EIN) from the Internal Revenue Service (IRS).	IRS FEIN/EIN application website
3	Register for a SAM.gov account and obtain a UEI.	Register for and maintain an active SAM.gov account and obtain a 12-digit UEI.	SAM.gov website

CBHA may not make a subaward until the applicant has complied with all applicable UEI and SAM.gov requirements. If an applicant has not fully complied with the requirements by the time CBHA is ready to make an award, CBHA may determine that the applicant is not qualified to receive an award and use that determination as a basis for making an award to another applicant.

C.2. Pre-award Requirements

Per 2 CFR § 200.332(c), CBHA must evaluate each applicant's risk of noncompliance with federal statutes, regulations, and the terms and conditions of a potential subaward for purposes of determining the appropriate subrecipient monitoring. These possible conditions are included in the notice of state award (NOSA) and are described in section I.1. The pre-award process includes establishing a risk profile through assessment of the applicant's financial stability, management systems and standards, history of performance, audit reports and findings, and ability to implement requirements of the award. This risk assessment is carried out with the aid of the following information:

- Administrative, fiscal, and internal controls information
- Organizational and programmatic information

CBHA may also request additional information during the pre-award process.

A risk assessment does not, by itself, preclude entities from becoming subrecipients. CBHA will use the assessments to tailor any specific conditions, monitoring, and technical assistance to identified risks.

C.3. State and Federal Laws or Regulations

Every subrecipient awarded funds through this NOFO must also agree to comply with all applicable provisions of state and federal laws and regulations pertaining to nondiscrimination, sexual harassment, and equal employment opportunity, including but not limited to the following:

- The Illinois Human Rights Act (775 ILCS 5/1–101 et seq.), including 44 Ill. Admin Code 750-Appendix A
- The Public Works Employment Discrimination Act (775 ILCS 10/1 et seq.)
- The U.S. Civil Rights Act of 1964 (as amended) (42 USC 2000a–2000H-6)
- Section 504 of the Rehabilitation Act of 1973 (29 USC 794)
- The Americans with Disabilities Act of 1990 (as amended) (42 USC 12101 et seq.)
- The Age Discrimination Act of 1975 (42 USC 6101 et seq.)

C.4. Cost Sharing or Matching

Cost sharing is not required.

C.5. Indirect Cost Rate

Applicants may charge indirect costs under this award only through an applicable federally negotiated indirect cost rate, a State of Illinois-negotiated indirect cost rate, or the de minimis rate described below.

a) Federally Negotiated Rate. An organization with a current federally negotiated indirect cost rate may charge indirect costs at the rate and on the base specified in its current indirect cost rate agreement (NICRA). Illinois will accept the federally negotiated rate. The organization must provide a copy of its current federal NICRA.

b) State Negotiated Rate. An organization that does not have a current federally negotiated indirect cost rate may negotiate an indirect cost rate with the State of Illinois, as permitted by applicable GATA requirements. If an organization has not previously established an indirect cost rate, an indirect cost rate proposal must be submitted through the GATA Grantee Portal no later than 3 months after receipt of a NOSA. If an organization previously established an indirect cost rate, the organization must annually submit a new indirect cost proposal through the GATA Grantee Portal within 6 months after the close of the grantee's fiscal year.

c) De Minimis Rate. An organization that does not have a current federally negotiated indirect cost rate (including a provisional rate) may elect a de minimis rate of 15 percent of modified total direct costs (MTDC). The organization may elect any rate up to 15 percent. The de minimis rate does not require documentation to justify its use and may be used indefinitely. Once elected, the organization must use the de minimis rate for all Federal awards until it chooses to negotiate a rate. For this purpose, MTDC includes all direct salaries and wages, applicable fringe benefits, materials and supplies, services, travel and up to the first $50,000 of each subaward, regardless of the period of performance, and excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs, and the portion of each subaward in excess of $50,000.

All subrecipients that claim indirect costs must have a current applicable rate agreement or make the de minimis election through the GATA Grantee Portal as required by GATA. Indirect costs claimed without a valid rate or election may be subject to disallowance.

C.6. Other Eligibility Requirements

An applicant is permitted to submit only one application in response to this funding notice. An applicant may not apply for the same proposed project in response to any other RHT Program funding notice.

C.7. Grant Funds Use Requirements

Applicants must propose activities and budgets that comply with the allowable and unallowable use of funds requirements described in section D.3. Proposed costs must be reasonable, necessary, allocable, and allowable under 2 CFR 200, Subpart E, and all applicable RHT Program requirements. Applicants must comply with all requirements, conditions, and restrictions described in this funding notice and any resulting award. Applicants must use grant funds in accordance with applicable federal statutes, regulations, and award terms and conditions.

C.8. Post-Award Requirements

Successful applicants agree to provide program services as described throughout this funding notice.

Start Date

Applicants must be prepared to begin grant activities starting January 4, 2027.

Site Visits

The applicant agrees to participate in site visits/quality reviews as requested by CBHA.

D. Funding Categories, Use of Funds, and Project Requirements

Applicants must demonstrate a clear need for the proposed project, its anticipated impact on rural health access and outcomes, organizational readiness to implement proposed activities, and a realistic plan for sustaining services beyond the grant period. This section explains the types of activities applicants may propose, how grant funds may be used, and the core project plans, services, and deliverables successful applicants will be expected to carry out. Applications should

include measurable objectives and a clear evaluation approach, such as expected improvements in access, service capacity, care coordination, workforce development, integrated care delivery, and health outcomes.

Applicants may request funding under one or more of the eligible funding categories described in section D.1 and may combine multiple categories within a single application and budget. Applications should clearly identify the funding categories being proposed and must demonstrate how proposed activities contribute directly to developing the capacity for implementing integrated, team-based models of care.

For purposes of this funding opportunity, integrated care refers to structured collaboration among behavioral health, physical health, and/or social service providers to address an individual's behavioral, physical, and social needs in a coordinated manner. Integrated care may include multidisciplinary care teams, shared workflows, coordinated care planning, referral management, care transitions, information sharing, health information technology, and formal partnerships that improve communication, coordination, and whole-person care delivery. Proposed activities should contribute to developing, expanding, or strengthening integrated, team-based models of care rather than operating as stand-alone services or infrastructure investments.

D.1. Eligible Funding Categories

Funded projects must increase access to medical and behavioral health services in rural Illinois and break down barriers to creating collaborative, integrated models of care. Applicants must demonstrate a clear need for the proposed project, including documented barriers related to the following:

- Workforce shortages
- Transportation
- Geographic isolation
- Care coordination
- Provider capacity and organizational readiness
- Fragmented service delivery systems
- Technology and data infrastructure
- Administrative burden
- Reimbursement
- Other factors that limit access to care in rural communities

Applicants should describe how proposed activities will expand access to coordinated care and support the development, implementation, or strengthening of integrated, team-based care across rural communities. The application should explain how service expansion, infrastructure development, workforce capacity building, health information technology, care coordination, and structured collaboration among behavioral health, primary care, specialty care, social service, and community partners will strengthen care delivery, improve organizational readiness, and improve health outcomes for rural residents.

Funding may support new, expanded, or substantially enhanced services, infrastructure, workforce capacity, and organizational readiness activities, including health information technology, telehealth, broadband and data infrastructure improvements, care coordination systems, workforce development initiatives, and performance measurement capabilities that improve access to services, interoperability, patient engagement, care delivery, and value-based care readiness across rural communities.

Funding will not support activities that duplicate existing services or replace existing federal, state, local, or other funding sources. Funds may not be used to reimburse clinical services that are billable to Medicaid, Medicare, commercial insurance, state grants, or other third-party payers. All proposed activities must comply with the allowable use of funds and funding restrictions described in section D.3., as well as all applicable federal and state requirements.

Certain capital expenditures, technology investments, equipment purchases, infrastructure improvements, and other costs may require prior written approval from CBHA, HFS, and/or CMS before funds are obligated or expended. Applicants should ensure that all proposed investments comply with applicable federal and state approval requirements.

D.2. Use of Funds

The following types of services and programs are eligible for funding consideration through a competitive grant process:

Team-Based Integrated Care Models

Funding will support the development and expansion of multidisciplinary care teams that integrate behavioral health and primary care services across community settings to improve access to coordinated, person-centered care in rural communities. As part of these efforts, funded providers will be expected to maintain collaborative partnerships with healthcare, social service, and community-based organizations that contribute to integrated, person-centered care. Projects should describe how care teams will be formally structured; how roles and responsibilities will be defined across organizations; and how partnership entities will share information, coordinate referrals, and manage care transitions. Eligible activities may include the following:

(a) Development and expansion of multidisciplinary care teams that integrate behavioral health and primary care services

(b) Partnerships among Community Mental Health Centers, Substance Use Treatment Facilities, Federally Qualified Health Centers, Rural Health Clinics, hospitals, and other community-based providers

(c) Infrastructure, staffing, and workflows to support care coordination, care navigation, referral management, and care transitions

(d) Integration of peer support specialists, community health workers, and other nonclinical team members into care delivery models

(e) Development of coordinated service delivery strategies that address individuals' behavioral health, physical health, and social needs

(f) Formal partnership agreements, memoranda of understanding, data-sharing agreements, and regional governance structures

(g) Staff time to build and maintain county and regional collaboratives, provider networks, and cross-sector partnerships

Behavioral Health and Primary Care Integration

Funding will support the integration of behavioral health and physical health services through colocated, collaborative, and technology-enabled models that improve access, quality, and continuity of care in rural communities. Eligible activities may include the following:

(a) Establishment of collaborative care arrangements, colocated services, and partnerships among behavioral health, primary care, emergency department, and other healthcare providers

(b) Embedding primary care providers and services in behavioral health settings and embedding behavioral health staff and services in primary care settings

(c) Development of screening, assessment, referral, care coordination, care transition, and follow-up protocols that promote early identification, treatment, and continuity of care for behavioral health and physical health conditions

(d) Staffing, workflow development, operational improvements, and other practice transformation activities that support integrated care delivery

(e) Shared care management systems, electronic health record integration and interoperability improvements, telehealth and tele-behavioral health infrastructure, and other technology-enabled solutions that support integrated care and improve access to services

Technology, Data Infrastructure, and Care Coordination

Funding will support technology and infrastructure investments that improve care coordination, strengthen data sharing, expand access to services, modernize healthcare delivery, and support integrated, team-based models of care in rural communities. Eligible activities may include the following:

(a) Electronic health record implementation, integration, upgrades, interoperability improvements, health information exchange participation, closed-loop referral systems, shared care management platforms[1]

(b) Remote monitoring, appointment reminder, and digital engagement tools that support treatment engagement and follow-up

(c) Computer hardware, software, broadband connectivity improvements, telehealth capabilities, mobile documentation tools, and other technology modernization efforts that improve service delivery and operational efficiency

(d) Data systems, analytics platforms, reporting tools, and performance measurement infrastructure that support care coordination, quality improvement, population health management, administrative processes, and value-based care readiness

[1] Funding may not be used to replace a Health Information Technology for Economic and Clinical Health (HITECH)-certified electronic medical record system already in place as of September 1, 2025.

(e) Technology and workflow solutions that support care coordinators, care navigators, peer support specialists, community health workers, and other members of integrated care teams

(f) Organizational and administrative capacity-building activities that strengthen grant management, data collection and analysis, reporting, performance measurement, quality improvement, technology adoption, and participation in integrated care initiatives, particularly for smaller community-based organizations

Workforce Development

Funding will support the recruitment, training, retention, and professional development of the workforce needed to implement and sustain integrated, team-based care models in rural communities, but may not supplant existing funding sources for currently funded positions or services. Eligible activities may include the following:

(a) Recruitment, retention, and workforce support strategies for behavioral health professionals, peer support specialists, family peer support providers, community health workers, care coordinators, and other critical workforce positions

(b) Workforce training, credentialing, clinical supervision, staff development, professional development, and technical assistance related to integrated care delivery, care coordination, and team-based care

(c) Workforce planning, capacity-building, and career pathway development activities, including peer support, family peer support, and community health worker workforce initiatives

(d) Staffing models designed for rural service volume, including shared, regional, part-time, or phased staffing approaches for communities where caseload volume cannot sustain a full-time position

(e) Apprenticeship, certification, educational partnership, and workforce pipeline development models that expand and sustain the rural behavioral health workforce

(f) Workforce development approaches that expand opportunities for individuals from underserved communities, including individuals with lived experience

Value-based Care Readiness

Funding will support foundational investments that prepare providers to participate in value-based care arrangements and meet RHT Program performance expectations. Eligible activities may include the following:

(a) Development of performance measurement and quality improvement processes aligned with HFS performance expectations and improvement timelines

(b) Information technology infrastructure and data-driven decision-making tools that support performance management, population health management, care coordination, reporting, and accountability

(c) Operational, administrative, and business process improvements that enhance care delivery, quality outcomes, and readiness for value-based payment models

(d) Activities that strengthen provider capacity to demonstrate performance improvement, meet RHT Program requirements, and sustain participation in value-based care initiatives

Outreach and Community Engagement

Funding will support outreach and engagement of rural communities, behavioral health education, prevention programming, chronic disease self-management, community partnerships that strengthen care navigation and referral pathways, language access services, and transportation coordination to improve access to care. Building trust and awareness in communities is essential to connecting individuals to integrated, team-based care.

Eligible activities may include the following:

(a) Community partnership development, referral network coordination, and cross-system collaboration activities that strengthen care coordination and integrated service delivery

(b) Community outreach and engagement activities that increase awareness of available services and supports, reduce stigma, and build trust

(c) Behavioral health education and prevention programming that support engagement with integrated care models

(d) Language access infrastructure and communication supports that improve equitable access to behavioral health and recovery support services

(e) Transportation coordination and other community-based operational strategies that reduce barriers to accessing care

(f) Referral navigation infrastructure and engagement processes to help individuals identify, access, and remain connected to needed behavioral health and recovery support services

(g) Startup activities necessary before new or expanded services begin[2]

Funds may not be used for marketing, advertising, or public relations activities designed solely to promote the applicant organization.

D.3. Allowable Costs, Funding Restrictions, and Compliance Requirements

Allowable costs are determined in accordance with the cost principles identified in 2 CFR Part 200, including Subpart E of such regulations and in the grant program's authorizing legislation and as outlined in Federal RHT program documents. In addition, costs must be reasonable, necessary, allocable, and allowable for the proposed project and must conform to generally accepted accounting principles. Grant funds may be used to cover only eligible costs incurred by the recipient during the period of performance, and for allowable costs incurred by the recipient during the grant closeout process.

[2] Costs incurred prior to the subaward start date are not allowable and will not be reimbursed, including startup costs incurred before execution of the subaward agreement.

Allowable Uses of Funds

- Personnel costs, including salaries and wages for program, clinical, and care team staff performing program administration and management functions
- Fringe benefits associated with approved personnel costs
- Supplies
- Travel expenses, such as those related to training and program monitoring, are subject to the Illinois State Travel Guide. Out-of-state lodging and travel must be preapproved and is subject to General Services Administration rates.
- Contractors/consultants
- Program-specific uses:
    - Hiring, contracting, or expanding clinical and care team roles to stand up and deploy team-based care models
    - Investing in the infrastructure, staffing, and development of protocols to integrate behavioral health and primary care
    - Engaging and training clinical and nonclinical staff to engage in practice transformation activities
    - Designing and testing new care models, including the configuration of care teams and shifting of workflows
    - Building quality improvement infrastructure and collecting and analyzing data to conduct Plan-Do-Study-Act cycles to inform shifts to program design and implementation
    - Establishing partnerships and setting up regional governance structures
    - Identifying and investing in technological capabilities and processes to support team-based care, such as establishing referral coordination systems, closed-loop referral platforms, and shared care management systems
    - Startup funding to cover initial staffing and equipment for new and expanding services until patient volumes grow to sustainable levels

Unallowable Use of Funds

- No funding under this award may be used to fund the replacement of a HITECH-certified electronic medical record (EMR) system that was already in place as of September 1, 2025.
- Funding new construction is unallowable. Supplanting funding for in-process or planned construction projects or directing funding towards new construction builds is unallowable. Minor building renovations or alterations and equipment upgrades are allowable when clearly linked to program goals.
- 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 subrecipient plans to fund direct health services, the subrecipient may 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 they transform the current care delivery model. HFS and ultimately CMS will have final approval of whether proposed services are allowable.

- Clinician Salaries. Funds may not be used for clinician salaries or wage support for facilities that subject clinicians to noncompete contractual limitations.
- SSA Section 2105(c), paragraphs (1), (7), and (9) apply as funding limitations. These limitations are related to general funding limitations, limitations on payment for abortions, and citizenship documentation requirements for payments made with respect to an individual.
- Prohibited use of RHT Program funds. The following list contains costs that are unallowable for all CMS programs, including the RHT Program:
    - Pre-subaward start date costs
    - Costs otherwise meeting matching requirements for any other federal funds or local entities
    - Services, equipment, or supports that are the legal responsibility of another party under federal, state, or Tribal law such as vocational rehabilitation or education services. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party
    - Goods or services not allocable to the approved project
    - Supplanting existing state, local, Tribal, or private funding of infrastructure or services, such as staff salaries
    - Construction
    - Capital expenditures for improvements to land, buildings, or equipment that materially increase their value or useful life as a direct cost except with the prior written approval of CBHA
    - The cost of independent research and development, including their proportionate share of indirect costs in accordance with 2 CFR § 300.477
    - Profit to any recipient, even if the recipient is a for-profit organization. Profit is any amount in excess of allowable direct and indirect costs.
    - Funds related to 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 and 2 CFR § 200.450 - Lobbying, and applicable Appropriations Law

- Certain telecommunications and video surveillance equipment. See 2 CFR § 200.216
- Costs of promotional items and memorabilia, including models, gifts, and souvenirs
- Costs of advertising and public relations designed solely to promote the nonfederal entity
- Meals unless in limited circumstances such as
  - Where specifically approved as part of the project or program activity, such as in programs providing children's services, and
  - As part of a per diem or subsistence allowance provided in conjunction with allowable travel.

Additional Funding Conditions

Simplified Acquisition Threshold

Potential subrecipients under this funding announcement may receive a subaward in excess of the simplified acquisition threshold, currently $350,000, as defined in 2 CFR § 200.1 and tied to the threshold in 48 CFR § 2.101.

The following requirements apply to any qualifying subaward:

- Before making a subaward, CBHA will verify that a subrecipient has not been suspended or debarred;
- Before making a subaward, CBHA will also review and consider other information about the applicant accessible through SAM.gov;
- An applicant may review information in SAM.gov and comment on information about itself that an awarding agency previously entered, consistent with applicable system procedures;
- CBHA will consider that information and any comments, together with the other information described in the subrecipient risk assessment, when evaluating the applicant's integrity, business ethics, and record of performance and determining appropriate risk-based conditions and monitoring under 2 CFR §§ 200.208 and 200.332(c), as applicable.

Compliance with Funding Sources

This funding opportunity is supported by CMS/HHS as part of a financial assistance award totaling $193,418,216.21 with 100 percent funded by CMS/HHS, under Assistance Listing Number 93.798. The federal RHT Program is authorized under Public Law 119-21. 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.

Subrecipients must comply with all conditions applicable to these funding sources, including the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, 2 CFR Part 200 and 2 CFR Part 300; GATA and its implementing rules at 44 Ill. Admin. Code Part 7000; and all applicable RHT Program requirements established by CMS and HFS, including requirements set out in federal RHT Program documents.

As required by CBHA's grant agreement with HFS, the full HFS grant agreement will be attached to each subaward agreement, and its terms and conditions apply to subrecipients.

Third-Party Contractual Requirements
Any third-party contracts paid for using grant funds are subject to GATA requirements, the terms and conditions of the award, and contract provisions required by Appendix II to 2 CFR Part 200, as applicable. The subrecipient must distinguish procurement contracts from subawards in accordance with 2 CFR § 200.331, include language supplied by CBHA in contractual documents and obtain CBHA's pre-approval of subcontractor agreement(s) and budgets. The subrecipient retains sole responsibility for the performance and monitoring of contractors and lower-tier subrecipients, as applicable.

Sectarian Issue
Subrecipients may not expend federal or state funds for sectarian instruction, worship, prayer, or to proselytize. If the applicant is a faith-based or a religious organization that offers such activities, these activities shall be voluntary for the individuals receiving services and offered separately from the program.

D.4. Sustainability

Applicants must describe how funded activities will be sustained after the grant period. Sustainability plans should address reimbursement and financing strategies, approaches for maintaining nonbillable and partially reimbursable services, partnership and community investment strategies, operational efficiencies, and plans for maintaining services in low-volume rural communities, including how services will reach sustainable volume or secure alternative support before grant funding ends.

Sustainability may include reimbursement strategies, braided funding, partnerships, community investment, state or local funding opportunities, phased implementation approaches, or shared staffing or cross-agency service integration among neighboring providers. Sustainability plans will be considered during application review.

Applicants are encouraged to consider how their proposed models could align with value-based care and alternative payment approaches over time, including how the project may generate cost, utilization, quality, and outcome data needed to support such arrangements. This may include tracking avoidable emergency department utilization and hospitalizations; developing cost analysis for service delivery; or establishing partnerships with payers, hospitals, or provider networks positioned to support future value-based arrangements. In Years 4 and 5, HFS anticipates allocating additional funds to support the transition to value-based payment models, which may take the form of performance improvement payments or incentives tied to risk-based contracting.

E. Scope of Services and Performance Expectations

Subrecipients will implement CBHA-approved activities proposed in their application and consistent with their selected funding category or categories. The following scope of services and performance expectations apply to all funded projects.

E.1. Fulfill Award Administration Requirements

The subrecipient must fulfill all award administration requirements described in section I, including

(a) Performance reporting,

(b) Fiscal reporting, and

(c) Participation in training and technical assistance activities offered by federal and state agencies, CBHA, and other vendors, as scheduled.

E.2. Implement Approved Project Activities

Subrecipients must implement CBHA-approved activities proposed in their application and aligned with the funding categories, allowable uses of funds, and project requirements described in section D.

E.3. Establish and Maintain Partnerships

Subrecipients must establish or strengthen the partnerships described in their application and document each partner organization, its role, and the coordination activities completed. Subrecipients are expected to coordinate with other RHT Program-funded organizations, when applicable, to support regional healthcare partnerships, avoid duplication of effort, strengthen referral networks, align workforce and technology investments, and improve continuity of care for rural residents. Subrecipients may also be required to participate in cross-project coordination, peer learning, and information-sharing activities with other RHT Program-funded organizations to support statewide rural health transformation efforts.

E.4. Measure Performance, Report Results, and Support Continuous Improvement

Throughout the period of performance, subrecipients must collect data and participate in performance monitoring activities established by CBHA. Performance measures and reporting requirements will align with approved project activities, implementation and sustainability planning, and the scope of services. To support sustainability and potential continuation funding in Years 2 through 5, measures and reporting requirements will also align with metrics established by HFS, as applicable.

Subrecipients may be required to do the following:

(a) Track project outputs, outcomes, and implementation progress in accordance with CBHA requirements. At a minimum, required performance measures are expected to include the following:

   i. Number of staff hired for RHT Program integrated/team-based care

   ii. Number of patients/clients served (unique/deduplicated), including breakouts for rural status and payer mix

   iii. Patient demographics: age, gender, race, ethnicity

   iv. Number of patient visits (total and by category)

v. Number of patient telehealth visits (total and by category)
vi. Number of health risk assessments completed
vii. Number of social determinants of health assessments completed
viii. Number of social determinants of health service referrals made (total and by category)
ix. Number of community health worker-client interactions
x. Number of care gaps closed (total and by category)
xi. No-show rate
xii. Screening for depression and follow-up plan (National Committee for Quality Assurance)
xiii. Controlling high blood pressure
xiv. Diabetes: Hemoglobin A1c (HbA1c) poor control (>9%)
xv. Follow-up after emergency department visits for mental illness
xvi. Follow-up after emergency department visits for substance use

(b) Participate in applicable data-sharing and reporting activities necessary to support measurement of required indicators, including connection to the HealthChoice Illinois ADT (admission, discharge, and transfer) feed, as required by CBHA and HFS.

(c) Participate in technical assistance related to performance measurement, electronic health record configuration, data collection, reporting, quality improvement, and other evaluation activities identified by CBHA.

(d) Track additional measures that demonstrate project effectiveness, impact, sustainability, and progress toward approved goals.

(e) Participate in quality improvement activities and document challenges, successes, and lessons learned throughout implementation.

(f) Submit performance and financial reports at the frequency specified in the subaward agreement, which may range from quarterly to annually, and provide supplementary information or participate in virtual meetings upon request.

(g) Submit a final project summary report within 60 days of the end of the first-year period of performance. The report must summarize project activities, accomplishments, outcomes, challenges, lessons learned, and progress toward approved goals and performance measures. The report must also include a final accounting of expenditures and any other financial information required by CBHA to document the use of award funds and compliance with award requirements.

Specific measures, reporting requirements, and data collection expectations will be established by CBHA and communicated prior to award execution.

F. Funding Information

This is a new competitive subaward opportunity. The release of this NOFO does not obligate CBHA to make an award. Funding availability, award amounts, period of performance, renewal opportunities, and final budget approval requirements are summarized below.

- CBHA reserves the right to negotiate with successful applicants to adjust award amounts, targets, deliverables, and other terms. Such negotiations do not constitute a commitment to provide funding, and applicants should not interpret participation in negotiations as an indication of funding decisions.
- CBHA anticipates awarding 30–40 awards. No minimum or maximum award amount has been established; however, CBHA anticipates that most awards will fall between $200,000 and $1,000,000.
- Funds awarded in the first year must be expended by **June 30, 2027**. Costs incurred after June 30, 2027, are not allowable unless an extension to the grant agreement is approved in advance. Opportunities for renewal for up to four subsequent years will be outlined in future communications.
- Final award amounts will be based on CBHA-approved budgets. Applicants must submit detailed, reasonable, and adequately justified budgets for review and approval by CBHA.

G. Application and Submission Information

All applications will be submitted through the Euna Solutions system. The application will be available for review and submission on September 23, 2026.

Application Opens: September 23, 2026, at 9:00 a.m. CT

Deadline: October 23, 2026, at 5:00 p.m. CT

Applicants are solely responsible for ensuring timely and complete submissions. CBHA is not responsible for reviewing late, incomplete, or incorrectly submitted applications due to technical issues, system errors, internet connectivity problems, or other submission-related difficulties. Applicants must upload all required documents in the designated sections of this opportunity. CBHA will not accept documents sent by email, mail, or any method outside of the Euna Solutions system. Applicants may correct, modify, or withdraw the original applications up to the application deadline.

All costs involved in preparing the application must be borne by the applicant. CBHA will not be liable for any costs associated with submitting the application or any pre-award costs. Pre-award costs are not allowable.

The applicant is responsible for familiarizing themselves with all applicable state, local, and other laws relating to this type of work, including licensure requirements, if applicable.

G.1. Applicant Technical Assistance

An optional informational webinar will be held on September 23, 2026 from 11:00 to 12:30 p.m. CT to provide an overview of this funding opportunity, the application process, and available technical assistance. Attendance is recommended but not required.

- Register for the webinar: Webinar link
- Access the recording: CBHA.net

Applicants may submit questions by email to ccolombo@cbha.net with the subject line **"CCI/Integrated Care in IL"** no later than **October 13, 2026, at 5:00 p.m. CT**. Responses to submitted questions, along with additional application guidance and resources, will be posted on CBHA.net and updated weekly by **Friday at 5:00 p.m. CT**. Applicants are responsible for monitoring this website and complying with any updates, instructions, or requirements related to this NOFO.

To support prospective applicants, weekly virtual office hours will be held during the application period. Office hours will provide an informal forum for applicants to ask questions about the NOFO and application requirements. Details will be available on CBHA.net.

H. Application Review

CBHA is committed to ensuring a fair and open process for making this award. Applying does not guarantee project funding.

H.1. Criteria

Trained reviewers will review and score applications using the evaluation criteria below, with final review and approval by CBHA.

Organizational Overview, Experience, and Capacity (10 points)

Describes the applying organization, including its mission, populations served, organizational structure, geographic location of organization, and infrastructure to support program delivery. Demonstrates relevant experience providing similar programs and the capacity and readiness to successfully implement the proposed project.

Need (20 points)

Describes the need the project is addressing, including the target population, geographic service area, and key challenges related to accessible care in rural communities. Includes relevant data, community input, or other evidence to support the identified need, such as federal shortage area designations, county-level transportation or broadband measures, or service utilization data. Applications should demonstrate that proposed activities respond to documented rural healthcare challenges and are targeted to populations and communities with the greatest unmet needs and barriers to integrated, coordinated care.

Project Description and Approach (40 points)

Clearly describe the proposed project, including the target population, geographic service area, key activities, implementation approach, and alignment with one or more funding categories.

Explain how the project responds to documented rural healthcare needs and advances sustainable improvements in access, care coordination, integrated care, workforce capacity, technology, or service delivery systems.

Applications will be evaluated on the extent to which they do the following:

- Clearly describe the proposed project, target population, geographic service area, implementation approach, and alignment with one or more funding categories.
- Demonstrate a clear need for the proposed activities and responsiveness to documented rural healthcare access, workforce, infrastructure, care coordination, or service delivery challenges.
- Strengthen integrated, team-based care through workforce development, technology modernization, data infrastructure, care coordination, operational improvements, or practice transformation activities.
- Demonstrate meaningful collaboration among behavioral health providers, primary care providers, hospitals, Federally Qualified Health Centers, Rural Health Clinics, schools, local health departments, EMS, 988 providers, community-based organizations, or other community partners.
- Incorporate individuals with lived experience, family members, peer support specialists, family peer support providers, or peer-led organizations in project planning, implementation, governance, quality improvement, or evaluation activities.
- Build the organizational capacity of small rural providers or community-based organizations through investments in workforce, technology, reporting infrastructure, quality improvement, data systems, care coordination, partnership development, or grant management capacity.
- Address workforce shortages through recruitment, retention, supervision, certification or credentialing pathways, apprenticeships, educational partnerships, peer workforce development, or other workforce pipeline strategies.
- Improve access to integrated, coordinated care populations experiencing significant barriers to care, including justice-involved individuals, individuals experiencing homelessness, agricultural workers, veterans, and other underserved rural populations.
- Include strategies that strengthen patient engagement, referral pathways, care navigation, and community partnerships to improve access to and participation in integrated, coordinated care.
- Demonstrate a realistic plan for sustaining funded activities beyond the grant period through reimbursement strategies, value-based care readiness, operational efficiencies, payer partnerships, diversified funding, or other long-term financing approaches.

Outcomes and Impact (15 points)

Describes the intended outcomes of the project and the expected impact on the target population, organization, and rural communities served. Identifies realistic measures of success and a clear plan for tracking and reporting progress.

Applications will be evaluated on the extent to which they do the following:

- Identify measurable outcomes that are aligned with the proposed project activities and selected funding category or categories.
- Establish realistic performance measures and targets appropriate to the proposed project.
- Demonstrate how the project will improve access to care, care coordination, service capacity, workforce development, integrated care delivery, or other relevant rural health outcomes.
- Describe a plan for collecting, analyzing, and using data to monitor implementation, evaluate progress, and support continuous quality improvement.
- Describe how project results will inform long-term sustainability, value-based care readiness, or future service improvements.

Budget (15 points)

Presents a complete and clearly justified budget and narrative that aligns with allowable uses of funding.

H.2. Finalist Recommendations

While the recommendation of the review panel will be a key factor in the funding decision, CBHA maintains final authority over funding decisions and considers reviewer findings to be nonbinding recommendations. The numerical score may not be the sole award criterion. CBHA reserves the right to consider other factors, such as demonstrated need and past performance as a subrecipient, and to make awards that ensure statewide rural representation. Any internal documentation used in scoring or awarding grants shall not be considered public information.

H.3. Anticipated Announcement and Award

The announcement of this award is anticipated by December 1, 2026.

I. Award Administration

I.1. Award Notices

Applicants recommended for funding following the review process and budget approval will receive a NOSA via email to the contacts identified in the application. The NOSA shall include the following:

- The grant award amount,

- The terms and conditions of the award, and
- Specific conditions, if any, assigned to the applicant based on risk assessments and merit-based review.

NOTE: The initial budget submitted at the time of application might not be approved due to unallowable costs, errors in budget, or a difference between the requested award amount and the approved final award amount. CBHA will inform the organization point of contact if the proposed budget is rejected. CBHA cannot issue a NOSA until the successful applicant has an approved budget.

Upon receipt of the NOSA, selected applicants should review and make an informed decision about whether to accept the funds. The NOSA must be signed by the applicant's authorized signatory. This signature effectively accepts the award amount and all conditions set forth within the notice. This signed NOSA is the document authorizing CBHA to proceed with issuing an agreement. The signed NOSA must be remitted to CBHA, as instructed in the NOSA. **The NOSA is not an authorization to begin performance.**

Applicants not receiving the award will be notified.

Subaward Agreement

Upon receipt of acceptance of an award, CBHA will initiate development of the Subaward Agreement and statement of work. The Subaward Agreement will include the information and terms required by 2 CFR § 200.332(b), applicable GATA requirements, the Federal award, and the terms of CBHA's grant agreement with HFS, as applicable.

(a) The subaward identification and amount, including the Federal Award Identification Number, Assistance Listing number and program name, Federal awarding agency, Federal award date, pass-through entity and subrecipient names and UEIs, subaward period of performance and budget period, and whether the subaward is for research and development, as applicable

(b) The purpose and activities to be performed, approved budget, performance measures, deliverables, and time schedule

(c) All applicable federal and state statutes, regulations, policies, and terms and conditions, including requirements that must flow down to lower-tier subrecipients and contractors

(d) The applicable indirect cost rate or de minimis election

(e) The dollar limitation, period of performance, budget period, payment terms, and requirements for prior written approval of budget, scope, or other changes

(f) Allowable costs, procurement standards, audit requirements, monitoring and reporting requirements, access to records, corrective-action requirements, and record-retention requirements

The primary point of contact for the organization will receive an email notification that the agreement is ready for review and signature. The signed agreement should be returned to CBHA as prescribed.

I.2. Administrative and National Policy Requirements

Subrecipients shall provide services as set forth in the subaward agreement and shall act in accordance with all state and federal statutes and administrative rules applicable to the provision of the services. Additional terms and conditions not specified in this section may apply.

I.3. Monitoring

Subrecipients funded through this NOFO are subject to risk-based fiscal and programmatic monitoring in accordance with 2 CFR §§ 200.329 and 200.332 (d)-(h) and applicable GATA requirements. Monitoring may include but is not limited to review of performance and financial reports, supporting documentation, policies and procedures, and audit reports; desk reviews; site visits; interviews with relevant personnel; technical assistance; and follow-up on prior findings. Subrecipients must provide CBHA access to subaward records pursuant to 2 CFR § 200.337 and must make books, records, supporting documentation, and relevant personnel available to CBHA, HFS, the Federal awarding agency, Inspectors General, the Comptroller General of the United States, the Illinois Auditor General, and other authorized parties upon request. CBHA may increase monitoring or modify subawards based on risk, performance, or identified delays or difficulties, consistent with the Subaward Agreement and applicable law.

I.4. Participation in Training and Technical Assistance

Subrecipients will participate in training, technical assistance, and peer learning opportunities as identified by CBHA, with a goal of supporting successful program implementation and promoting sustainability after the conclusion of the period of performance. In addition to topic-specific training, CBHA may convene learning collaboratives and provide hands-on practice transformation support from state, local, and national subject matter experts. Technical assistance may also support the development of quality improvement and performance management systems to track, measure, and report outcomes.

Training and technical assistance opportunities will be specified by CBHA throughout the grant period and may include the following:

- Integrated care, collaborative care, and practice transformation
- Workforce recruitment, retention, supervision, and pipeline development
- Community partnership development and cross-sector collaboration
- Care coordination, service navigation, and referral management
- Health information sharing, technology adoption, and interoperability
- Quality improvement, data collection, performance measurement, and reporting

- Strategies to address rural access barriers and specialty service gaps
- Stakeholder engagement, community outreach, and lived experience integration
- Organizational capacity building and program administration
- Medicaid reimbursement, value-based care readiness, and sustainability planning

Program Status Meetings

Program Status Meetings will be held with subrecipients to review project progress and provide ongoing support and guidance. Details will be established by CBHA and communicated following award.

J. Definitions

The following definitions clarify terms used throughout this funding notice and related award documents. These definitions are provided to support consistent interpretation of application, award, and implementation requirements.

- **Capital expenditures**: Expenditures to acquire capital assets or to make additions, improvements, modifications, replacements, rearrangements, reinstallations, renovations, or alterations to capital assets that materially increase their value or useful life. For this funding opportunity, allowable capital expenditures must be directly tied to the goals of the RHT Program and comply with 2 CFR §§ 200.1 and 200.439.
- **Co-applicant:** An organization that is jointly applying for funding with the lead applicant and will participate in project planning, implementation, service delivery, project oversight, and achievement of project outcomes.
- **Community:** A group of people who live in the same area (such as a city, town, neighborhood, tent city, or shelter). Services in the community are offered outside of a state-licensed or certified facility.
- **Recovery support services**: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (Substance Abuse and Mental Health Services Administration). Recovery support services are designed to support individual recovery from a substance use disorder that may be delivered pre-, during, or post-treatment. These services are generally delivered by a peer with the patient in various settings to support the individual in meeting their recovery support goals. They include employment training, continuing care, employment coaching, peer recovery coaching, recovery coaching, recovery skills, spiritual support, and transportation.
- **Rural:** For purposes of this funding opportunity, rural communities are those that align with established federal or state rural designations, including HRSA rural classifications, RUCA codes, and other rural designations recognized by federal or Illinois rural health programs. Applicants must be able to demonstrate that proposed activities benefit residents of eligible rural communities. Subrecipients must maintain documentation sufficient to

demonstrate that grant-funded activities benefited only residents of communities that meet an eligible rural designation. Eighty-five of Illinois' 102 counties are classified as rural under HRSA's methodology, and certain communities within metropolitan counties may also qualify as rural based on census tract-level designations.

- **Subaward**: An award provided by a pass-through entity to a subrecipient for the subrecipient to contribute to the goals and objectives of the project by carrying out part of a federal award received by the pass-through entity, (2 CFR § 200.1). A subaward does not include payments to a contractor, beneficiary, or participant.
- **Substance use disorder:** "A treatable mental disorder that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications. Symptoms can be mild, moderate, or severe." (National Institute of Mental Health)
- **Supplanting:** The use of grant funds to replace funding already committed to or available for an existing position, service, or activity, rather than to add resources that expand or enhance what is currently provided. Funds must be used for activities that are new, expanded, or substantially enhanced. RHT Program funds may not be used to replace or duplicate payment for services that are reimbursable through Medicaid, Medicare, commercial insurance, state grants, or other third-party payers. RHT Program funds also may not be used to replace existing federal, state, or local funding.
- **Treatment:** Services provided according to Administrative Code Title 77: Public Health, Chapter X: Department of Human Services, Subchapter d: Licensure, Part 2060 Alcoholism and Substance Abuse Treatment and Intervention Licenses. Section 2060.401 Levels of Care. Treatment is offered in varying degrees of intensity based on the level of care the patient is assessed in need/placed and the subsequent treatment plan developed for that patient. The level of care provided shall be in accordance with that specified in the most current American Society of Addiction Medicine Patient Placement Criteria and Administrative Rule 2060.

K. Conflict of Interest and Financial Disclosures

Subrecipients must immediately disclose in writing to CBHA any actual or potential conflict of interest as soon as it becomes known, in accordance with 30 ILCS 708/35, 30 ILCS 708/60(a)(5), 44 Ill. Admin. Code 7000.330(f), and the subaward agreement. This disclosure must be submitted for the grantee and all subrecipients or pass-through entities, whenever an actual or potential conflict may exist. Subrecipients have a continuing obligation to disclose to CBHA financial or other interests (public, private, direct, or indirect) that may be a potential conflict of interest or could prohibit the subrecipient from entering or continuing the programs for which the grant is intended.