**OMB No. 0915-0319**

 **Expiration Date:**

**Office of Rural Health Policy: Rural Health**

 **Community-Based Grant Programs**

**Performance Improvement and Measurement System (PIMS) Database**

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The OMB control number for this project is 0915-0319. Public reporting burden for this collection of information is estimated to be 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857.

**Rural Health Network Development Planning Grant Program**

**Table 1: ACCESS TO CARE**

*Table Instructions: Access to Care*

Information collected in this table provides an aggregate count of the number of counties within the service area.

Number of counties served

* Denotes the number of counties served through the program. Please include entire, as well as partial counties served through the grant program. If your project is serving only a fraction of a county, please count that as one (1) county.

|  |  |  |
| --- | --- | --- |
| 1 | **Number of Counties:**(If you serve a sub-county area please count this as 1) | **Number/DK** |
|  | Number of counties served in program |  |

**Table 2: NETWORK**

*Table Instructions: Network*

Please identify the types of formal member organizations in the consortium or network by non-profit and for-profit status for your program. Please indicate a number for each category.Please provide the total number of member organizations in the consortium or network. Then, out of the total number of organizations in consortium/network, please provide the total number of ***new*** member organizations acquired within the budget year.  Please refer to the detailed definitions for consortium/networks, as defined in the program guidance. Please select the focus area(s) of the consortium/network for the budget yea

|  |  |  |
| --- | --- | --- |
| 2 | **Type(s) of Member Organizations in the Consortium / Network** | **Number** |
| Non-Profit Organization: | Area Health Education Center (AHEC) |  |
|                 | Community College |   |
| Community Health Center |   |
| Critical Access Hospital |   |
| Faith-based organization |   |
| Free Clinic |   |
| Health Department |   |
| Hospital  |   |
| Migrant Health Center |   |
| Private Practice |   |
| Rural Health Clinic |   |
| School District |   |
| Social Services Organization |   |
| University |   |
| Other – Specify Type: |   |
| TOTAL for Non-Profit Organization |  Number (automatically calculated by the system) |
| For-Profit Organization:  | Community College |  |
|  | Community Health Center |  |
| Critical Access Hospital |  |
|  | Faith-based organization |  |
| Organization Free Clinic |  |
|  | Health Department |  |
| Hospital |  |
|  | Migrant Health Center |  |
| Private Practice |  |
|  | Rural Health Clinic |  |
| School District |  |
|  | Social Services |  |
| University |  |
|  | Other – Specify Type: |  |
| TOTAL for For-Profit Organization |  Number (automatically calculated by the system) |
| 3 | **Total Number of Member Organizations in the Consortium/Network:** | **Number** |
| 4 | **Total Number of New Member Organizations in the Consortium/Network:****If applicable, check the area of focus your network was established to eventually impact.**  | **Number**  |
| 5 | **Focus Area(s) of the Consortium/Network** (Check all that apply) | **Number** |
|  | Cardiovascular Disease | **Selection list** |
|  | Case Management |  |
|  | Diabetes/Obesity Management |  |
|  | Elderly Geriatric Care |  |
|  | Emergency Medical Services (EMS) |  |
|  | Health Education |  |
|  | Health Literacy/Translation Services |  |
|  | Health Promotion/Disease Prevention |  |
|  | Maternal and Child Health/Women’s Health School Board |  |
|  | Mental/Behavioral Health |  |
|  | Network Development Activities |  |
|  | Nutrition |  |
|  | Oral Health  |  |
|  | Pharmacy |  |
|  | Primary Care |  |
|  | Substance Abuse Treatment |  |
|  | Telehealth/Telemedicine |  |
|  | Transportation |  |
|  | Workforce |  |
|  | Other – Specify Type: |  |
|  |  |  |
|  |  |  |

**Table 6: SUSTAINABILITY**

*Table Instructions: Sustainability*:

Please provide the funding/revenue amount, and identify the sources of revenue and sustainability activities. If your grant program has not received any additional funding/revenue, please type zero. Please indicate if the network/consortium will sustain, if the activities of the network consortium will sustain, and if the original need (to create the network/provide services) for the Network/Consortium has been met.

|  |  |  |
| --- | --- | --- |
| 6 | **Funding/Revenue:** | **Dollar Amount** |
|  | Annual Network revenue |  |
|  | Additional funding secured to assist in sustaining the project |  |
|  | Estimated amount of cost-savings due to participation in the network |  |
| 7 | **Sources of Revenue:**(Check all that apply) | **Selection list** |
|        | Network/Consortium revenue |  |
| In-Kind Contributions |  |
| Member Fees |  |
| Fundraising |  |
| Contractual Services |  |
| Other – Specify Type: |  |
| Has a sustainability plan been developed using sources of funding besides grants? | **Y/N** |
| 8 | **Sustainability Activities:**(Check all that apply) | **Selection list** |
|  | Local, State and Federal Policy Changes |  |
|  | Media Campaigns |  |
|  | Consolidation of activities, services and purchases |  |
|  | Communication Plan Development |  |
|  | Economic Impact Analysis |  |
|  | Return on Investment Analysis |  |
|  | Marketing Plan Development |  |
|  | Community Engagement Activities |  |
|  | Business Plan Development |  |
|  | Incorporation |  |
|  | Organization Bylaws |  |
|  | SWOT Analysis |  |
|  | Other – Specify Activity: |  |
| 9 | **Will the Network/Consortium sustain?**  | **Y/N** |
| 10 | **Will any of the activities of the Network/Consortium sustain?**  | **Y/N** |
| 11 | **Has the objectives of the Network/Consortium been met?**  | **Y/N** |