



# FY2026 Health Professionals Clinical Training Expansion Grant Program (HPCE)

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651-201-3895

- Program Overview
- Eligibility
- Competitive Criteria
- Application Process & Live Demo



# Overview

# Program Highlights

- The Health Professionals Clinical Training Expansion Grant Program (HPCE), authorized by [Sec. 144.1505 MN Statutes](#), was established to award health professional training site grants to eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental health professional programs.
- Funds are to be used to plan or expand clinical training programs.
- Funding will be used to support an increase in the number of clinical training slots for BOTH planning (adding slots in future) and expansion projects.
- Overarching goal: To increase the number of eligible professionals working in rural and underserved communities throughout MN.

# Eligible Applicants

- Located in MN and train, or are proposing to train, students residing & working in MN.
- Plan to establish or expand clinical training for students in the following health professional training programs:
  - **Advanced Practice Registered Nursing Programs**
    - Must be accredited as a master's, doctoral, or postgraduate level advanced practice registered nurse program by the Commission on Collegiate Nursing Education, or by the Accreditation Commission for Education in Nursing, or is a candidate for accreditation.
  - **Dental Therapy & Advanced Dental Therapy Programs**
    - Must be approved by the Board of Dentistry or currently accredited by the Commission on Dental Accreditation.

# Eligible Applicants, continued

- **Mental Health Professional Program**

- Must be accrediting by one of the governing mental health boards: clinical social work (LICSW), psychology (LP), marriage and family therapy (LMFT), or licensed professional clinical counseling (LPCC), or is a candidate for accreditation. See FAQ # 17 for details.
- Mental Health Professionals: Defined as an individual providing clinical services in the treatment of mental illness who meets one of the qualifications under Sec. 245I.04 MN Statutes.

- **Physician Assistant Program**

- Must be accredited as a physician assistant program by the Accreditation Review Commission on Education for the Physician Assistant or is a candidate for accreditation.

- **Pharmacy Program:**

- Must be accredited as a Doctor of Pharmacy program by the Accreditation Council on Pharmacy Education.

NOTE: Applicants MUST include proof of accreditation or candidacy for accreditation with application

# More on Eligibility

- An organization may hold two HPCE grants for different departments, with no overlap between clinical training programs or trainees.
- An organization that holds an active planning grant may apply for an expansion grant to implement the project ONLY if they are on track to meet all objectives in the planning grant and will not seek an amendment to extend the end date of the planning grant.
  - Current progress and spend-down on the planning grant will be considered during the review process and in making final award decisions.

# Ineligible Applicants

- Applicants who already hold an active HPCE grant in the same department and/or for the same student population for which they wish to apply again.
- Applicants who do not meet the accreditation requirements.
- Physician and dentist training programs are not eligible for this program; they are eligible for the Rural and Underserved Clinical Rotations Grant Program.
- Recipients of Rural and Underserved Clinical Rotations grants may not receive HPCE for the same program, department, or trainees.
- Activities supported by other state grants, such as Medical Education and Research Costs (MERC) funding, may not be supported by HPCE funding.
- Applicants who are NOT located in MN and who do not train students in MN.



## Planning Grants

- Maximum grant of \$75,000
- One-year project

## Expansion Grants

- Maximum grant of \$300,000
- Three-year project

# Available Funding

Funding	Estimate
Estimated Total Amount to Grant	\$700,000
Estimated Number of Grant Awards	3-5
Estimated Maximum Award (no minimum)	\$300,000

# Project Period

- Planning Projects: January 1, 2026 – December 31, 2026
- Expansion Projects: January 1, 2026 – December 31, 2028
- No expenses may be incurred until the grant agreement is signed by all parties and the grant has reached its effective date.
- No expenses may be incurred after the grant agreement end date.

All applications must be submitted online by  
4:30 p.m. on August 4, 2025

- Online application will be locked at that time.
- We do not accept applications through email or snail mail.

# What is Rural? What is Underserved Urban?

For the purposes of this grant program:

- “Rural Community” means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2.
- “Underserved Community” means a Minnesota area or population included in the list of designated primary medical care health professional shortage areas, medically underserved areas, or medically underserved populations maintained and updated by the U.S. Health Resources and Services Administration (HRSA).
  - To determine whether a proposed training site is in a designated shortage area, visit the HRSA website and use the search tools: <https://data.hrsa.gov/tools/shortage-area> (find this link on page 8 of the RFP)
- Applicants are strongly encouraged to partner with providers and provider organizations in rural and underserved communities to create NEW clinical training opportunities.
- Depending on their location, tribal nations may be included as rural or underserved urban communities.

# Grant Program Priorities

- Greater access to health care in rural and underserved urban communities in Minnesota
- An increase in the number of clinical training opportunities for eligible health professionals
- Advancement of health equity in rural and underserved urban communities in Minnesota
- An increase in team-based primary care for residents of rural and underserved urban communities
- Sustainability of the training program once the grant project is completed

# Eligible Expenses

- Recruitment, training, and retention of students and faculty
- Connecting students with appropriate clinical training sites, internships, practicums, or externship activities
- Development and implementation of health equity and cultural responsiveness training
- Supporting clinical education in which trainees are part of a primary care team model
- Travel and lodging for students
- Faculty, student, and preceptor salaries, stipends, or other financial support (not incentives!)
- Training site improvements, fees, equipment & supplies required to establish, maintain, or expand eligible training programs
- Evaluations of the proposed clinical training program(s)

# Ineligible Expenses

- Costs for expenses incurred **prior to the grant agreement start date, or after the grant project end date**
- Solicitating donations
- Taxes, except sales tax on goods and services
- Lobbyists, political contributions
- Bad debts, late payment fees, finance charges, or contingency funds
- Supplanting existing program funds
- Activities supported by other state grants (such as MERC, Rural and Underserved Clinical Rotations)
- Supporting administrative costs not directly related to clinical training or obtaining accreditation



# Payment and Reporting

Grantees will be reimbursed for eligible expenses on a quarterly basis

- Grantees will enter into an agreement with MDH that outlines terms.
  - Quarterly reports and expense documentation must be submitted online. Reports are due 20 days after the close of each quarter.
    - January 20, April 20, July 20, October 20
- A Reporting Form will be provided during Grantee Orientation.
- Reports and requested reimbursements must match the approved grant budget.

## Grant Monitoring

- Minn. Stat. §16B.97 and the State's Policy on Grant Monitoring require:
  - at least one monitoring visit (30-day notice, or as scheduled), and
  - a financial reconciliation of grantees' expenditures before final payment is made on all state grants over \$50,000. We aim to reconcile the first invoice.

# Proposal Review

- Funding will be allocated through a competitive process.
- A review panel will evaluate all eligible and complete applications received by the deadline.
- The review panel consists of content and community specialists, including those with knowledge of health professional training programs.
  - The panel will meet virtually to discuss applications and make funding recommendations.
  - Reviewers will not be allowed to read or score applications where a real or perceived conflict of interest exists.
  - Reviewers remain anonymous.
- MDH will review all committee recommendations and is responsible for award decisions. **The award decisions of MDH are final and not subject to appeal.**

## **See RFP Attachment A for 100-point distribution**

- Organizational Background & Capacity (15 points)
- Project Narrative & Work Plan (75 points)
- Budget/Narrative (10 points)

# Application Requirements – Work Plan

If your application is selected for award, this section of the application will be used to develop the work plan that will serve as the basis of a contract.

Grantee Organization: NAME of ORGANIZATION HERE

Project Name:

Expansion Program (yes or no):

New Program (yes or no):

<div>Program Objectives</div> <div>(as outlined in the application)</div> <div>NOTE: Please include applicable year of start and end dates for each Objective.</div>	<div>Staff Role and/or Agency Responsible</div> <div>(do not include staff names)</div>	<div># of Proposed Students</div> <div>(indicate if these are new or current students)</div>	<div>Location of Training</div> <div>(enter the county, city or town, and facility where training will occur)</div>	<div>Start Date</div> <div>(proposed objective start date)</div>	<div>End Date</div> <div>(proposed objective end date)</div>

# Budget & Narrative

Budget Categories	Total Request (cannot exceed \$300,000 for an Expansion Grant or \$75,000 for a Planning Grant)	Narrative
Salaries		
Fringe		
Travel		
Supplies		
Contracted		
Equipment		
Scholarship/Support Services		
Other		
Subtotal		
Indirect (cannot exceed 15% of direct costs unless proof of federally negotiated rate is provided)		
Total		

## Required Uploads

Note: Conflict of Interest certification (COI) will be completed within the application

- Due Diligence Form (upload)
  - Financial Statement/Audit
  - Additional questions based on DD answers
- Proof of Accreditation
- Proof of federally negotiated indirect rate if more than 15%
  - Resumes/Curricula Vitae of Project Personnel (optional)
  - Letters of Support from partners (optional)

**PLEASE read the RFP and FAQ before submitting questions.**

- If your question is not addressed in either document, you may submit it to: [health.orhpc.workforcegrants@state.mn.us](mailto:health.orhpc.workforcegrants@state.mn.us).
- Phone calls are discouraged. If you do call, you will be asked to submit the question via email for MDH recordkeeping.
- FAQ will be updated periodically (within 5 business days).
- Final day to submit questions: July 18, 2025, at 4:30 p.m.
- This slide deck will be posted by July 17.

Please note:

*Applications that do not include all required elements may be deemed ineligible for consideration.*



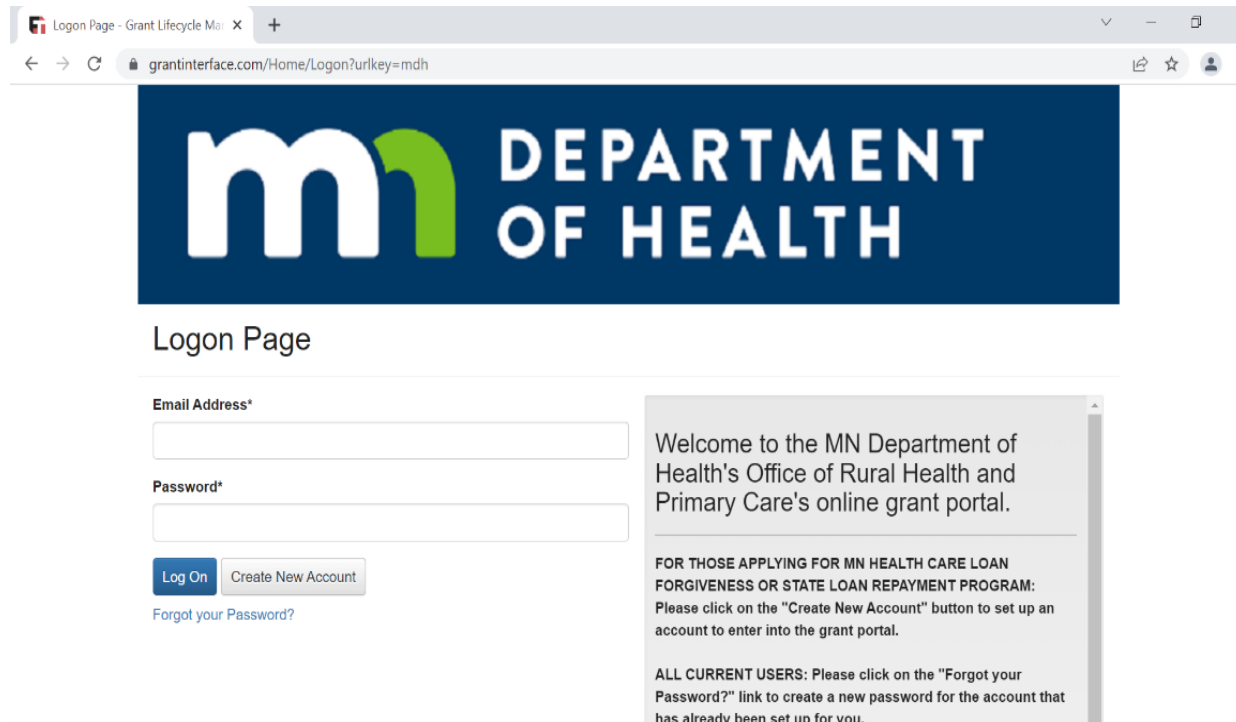
# Questions?

Please see the FAQ, which is posted with RFP



# Online Application Form

# Creating/Managing Users



The screenshot shows a web browser window with the URL `grantinterface.com/Home/Logon?urlkey=mdh`. The page features the MN Department of Health logo at the top. Below the logo, the title "Logon Page" is displayed. The login form includes fields for "Email Address\*" and "Password\*", a "Log On" button, and a "Create New Account" button. A link for "Forgot your Password?" is also present. A sidebar on the right contains a welcome message and instructions for new and current users.

Logon Page

Email Address\*

Password\*

Log On Create New Account

[Forgot your Password?](#)

Welcome to the MN Department of Health's Office of Rural Health and Primary Care's online grant portal.

FOR THOSE APPLYING FOR MN HEALTH CARE LOAN FORGIVENESS OR STATE LOAN REPAYMENT PROGRAM: Please click on the "Create New Account" button to set up an account to enter into the grant portal.


ALL CURRENT USERS: Please click on the "Forgot your Password?" link to create a new password for the account that has already been set up for you.



- Existing Users: log in or use the forgot password button

**New Users: verify if your organization has a profile before creating a new one!**

- New organizations MUST obtain a SWIFT Supplier ID Number
- If unsure – contact MDH
- SWIFT help desk **651-201-8100 (option 1, option 1)**

# Start an Application



  APPLY

SEE OPPORTUNITIES

ASSIGNED TO YOU (0)

Jane Doe

SEARCH

Search

Action Needed (0)

No Action (0)

Completed (0) | Historical (10)

# Find the correct application

The screenshot displays a user interface for a grant management system. At the top, a green header bar contains the 'm' logo, a home icon, an 'APPLY' button, and a user profile for 'Joanne Madrid'. Below the header, the user's name 'Jane Doe' is displayed on the left, and a search bar with the placeholder 'Search or enter Access Code' is on the right. The main content area features four grant program cards arranged in a 2x2 grid. Each card provides a title, a brief description, a closing date, and buttons for 'Preview' and 'Apply'. A yellow arrow points to the 'Preview' button of the 'Health Professionals Clinical Training Expansion - FY 2026' program.

Grant Program	Description	Closes	Preview	Apply
Rural Primary Care Residency Training Grant Program - FY 2026	Please refer to the <a href="#">RFP</a> for further information about this grant program which includes information about the application process and requirements, the program statute, and award criteria.	09/05/2025	Preview	Apply
Rural and Underserved Clinical Rotations Grant - FY26	Please refer to the <a href="#">Request for Proposal</a> for further information about this grant program which includes information about the application process and requirements, the program statute, and award criteria.	07/25/2025	Preview	Apply
Health Professionals Clinical Training Expansion - FY 2026	Please refer to the <a href="#">RFP</a> for further information about this grant program which includes information about the application process and requirements, the program statute, and award criteria.  Please note: This grant opportunity is not open to individual providers to apply. It is only open to organizations who provide clinical training opportunities to students.	08/04/2025	Preview	Apply
Mental Health Grants for Health Care Professionals - FY 2026	Please refer to the <a href="#">RFP</a> for further information about this grant program which includes information about the application process and requirements, the program statute, and award criteria.  The following types of health care entities are eligible to apply for the Mental Health Grant for Health Care Professionals Program:	08/01/2025	Preview	Apply

Grant Management Software provided by Foundant Technologies © 2025

# Check for Applicant Profile, Question List

The screenshot displays the MN Department of Health application portal. At the top, the header includes the MN Department of Health logo and the user's name, Joanne Madrid. Below the header, the main content area is titled "Application" and shows the process: "Health Professionals Clinical Training Expansion - FY 2026".

On the left, there are tabs for "Contact Info", "Request", and "Documents" (with a count of 0). The "Contact Info" tab is active, showing the applicant's details:

- Applicant:** Joanne Madrid, jemadrid@test.com, 651-201-3895, 123 Test Ave, St Paul, MN 55126 United States of America (the). A yellow arrow points to this section.
- Organization:** Jane Doe, 00-0000000, 000-111-0000, 123 Test Ave, St Paul, MN 55111.

Below the contact information, there is a note: "If your Organization information does not appear correct, please contact the funder. Thank you." and a link for "Contact Email History".




On the right side of the application details, there are buttons for "Public Profile" and "Collaborate".

Below the application details, there is a section for "Application" with a "Question List" button. A yellow arrow points to this button.

At the bottom, there are instructions: "Due by 08/04/2025 04:30 PM CDT." and "Fields with an asterisk (\*) are required." Below this is a section for "Application Instructions" which includes the MN Department of Health logo and the text "Health Professional Clinical Training Expansion Grant Program".

At the very bottom, it says "APPLICATION DEADLINE:".

# Read the RFP and authorizing legislation

 APPLY

## Health Professional Clinical Training Expansion Grant Program

**APPLICATION DEADLINE:**  
**August 4, 2025 by 4:30 pm Central Time**


For more information contact:  
[Health.ORHPC.WorkforceGrants@state.mn.us](mailto:Health.ORHPC.WorkforceGrants@state.mn.us)






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The Health Professional Clinical Training Expansion Grant Program, authorized by [Minnesota Statute Sec. 144.1505](#), supports the establishment or expansion of clinical training for eligible health professional training programs. The grant program provides funding for planning clinical training programs, and/or expanding existing clinical training programs in rural and urban underserved areas of Minnesota.

Please refer to the Request for Proposal ([RFP](#)) for further information about the Health Professional Clinical Training Expansion Grant Program. This document provides application instructions.

- > Section 1: Organization and Applicant Information
- > Section 2: Project Information
- > Section 3: Organization Background and Capacity
- > Section 4: Project Narrative and Work Plan
- > Section 5: Budget
- > Section 6: Required Attachments
- > Section 7: Applicant Conflict of Interest Disclosure
- > Certification

 Due by 08/04/2025 04:30 PM CDT.

Abandon RequestSave ApplicationSubmit Application

# Organization & Applicant

## ✓ Section 1: Organization and Applicant Information

### Project Name - Legal Name / Assumed Name (DBA)\*

Please enter in the legal name / assumed name (DBA) of your organization.

### Applying Organization

#### Organization Legal Name\*

#### Organization Assumed Name / DBA

Enter in your organization's assumed name / DBA if different from above.

#### Organization Address 1\*

#### Organization Address 2

If there is an associated PO Box or additional address line, please provide that here.

#### Organization City\*

#### Organization State\*

Enter in the state abbreviation.



# Remit = Payment address

## Remit Address \*

If your organization's remit address/payment address is different from the address provided above, please enter in that information here.  
This address would be the address used to submit payments and must match address associated with the Vendor SWIFT number with the State of Minnesota.

### Remit Address / Payment Address 1

### Remit Address / Payment Address 2

If there is an associated PO Box or additional address line, please provide that here.

### Remit Address / Payment City

### Remit Address / Payment State

Enter in the state abbreviation.

### Remit Address / Payment Zip

## Parent Company

If your organization has a parent company or operating hospital affiliation, please enter that information below.


### Parent Company or Operating Hospital Legal Name

### Parent Company or Operating Hospital Assumed Name / DBA

# Supplier Type does not mean you are eligible

**Federal Tax ID\***  
Enter in your Federal Tax ID in XX-XXXXXXX format.


**State Tax ID\***  
Enter in your seven digit State Tax ID.

 **MN State SWIFT Vendor ID\***  
Enter in your organization's MN State SWIFT Vendor ID.  
Include all 10 digits, including leading zeros. You do not need to enter 'VN' at the beginning of the number.

**MN State SWIFT Vendor Location Code\***  
Enter in your organization's MN State SWIFT Vendor Location Code.  
Enter 3 digits, including leading zeros. Supplier/Vendor Location Codes are associated with and assigned at the same time as your Supplier/Vendor ID number.

**Supplier Type\***  
Please identify the Supplier Type of the applying organization.  
*Note: This question does not indicate your eligibility if this opportunity is only available to specific organization types. This question determines information necessary for the Due Diligence Review process.*

- ☐ Non-profit Non-government Organization
- ☐ Private Non-government Organization
- ☐ Higher Education
- ☐ Interagency (another State Agency)
- ☐ Community Health Board
- ☐ Tribal Nation
- ☐ Political Subdivision, including municipalities (county, town, city, school districts)
- ☐ Individual



Section 2: Project Information

**Authorized Organization Representative Information**  
The Authorized Organization Representative (AOR) should be your agency's Chief Executive Officer or officer legally allowed to enter contracts on behalf of the agency.

**AOR First Name\***

# Roles: AOR, Fiscal Manager, Project Administration

**AOR Phone\***

Enter in the AOR's phone number in ###-###-#### x### format.

**AOR Email\*****Fiscal Management Officer Information**

The Fiscal Management Officer should be the person within your organization who will prepare financial statements for a grant or answer questions about future reimbursement requests. This can be the same individual as the AOR if applicable.

**Fiscal Management Officer First Name\*****Fiscal Management Officer Last Name\*****Fiscal Management Officer Title\*****Fiscal Management Officer Phone\***

Enter in the Fiscal Management Officer's phone number in ###-###-#### x### format.

**Fiscal Management Officer Email\*****Contact Person for Project Administration**

The Contact Person should be the person within your organization that will answer questions about the grant application and prepare future activity reports. This can be the same individual as the AOR if

# Organization Background/Capacity & Project/Program Type

## Section 3: Organization Background and Capacity

### Organizational Overview\*

Provide a brief overview of your organization's history, location, and administrative structure. Describe any unique characteristics or circumstances pertaining to your organization.

5,000 characters left of 5,000

### Organizational Capacity\*

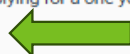
Provide information on your organization's experience training health care professionals, including any experience in the type(s) of clinical training you are proposing in this submission. If a clinical training program similar to the one you are proposing has been offered in the past, provide numbers of trainees, number and types of faculty, faculty experience with training diverse students, training locations, and any other key data.

5,000 characters left of 5,000

## Section 4: Project Narrative and Work Plan

### Project Type\*

Please indicate if you are applying for a one-year Planning grant or a three-year Expansion grant.



### Program Type\*

Indicate the type of program in which your grant will establish or expand clinical training:

- ☐ Advanced Practice Registered Nursing Program
- ☐ Mental Health Professional Program
- ☐ Pharmacy Program
- ☐ Dental Therapy/Advanced Dental Therapy Program
- ☐ Physician Assistant Program



# RFP Attachment A for Guidance; Character Limits

## Statement of Need\*

Describe why your proposed project to establish or expand clinical training is needed. How will it positively impact Minnesota's health professional workforce? Provide relevant data. Include information from employers, current and prospective trainees, and any other stakeholders.

3,000 characters left of 3,000

## Proposed Project\*

Describe what you propose to do: Briefly describe the clinical training program and how you will establish or expand it. If applying for a planning grant, what planning steps are necessary to prepare for establishing or expanding clinical training? What is your expected timeline for implementing the program after your planning grant is completed?

10,000 characters left of 10,000

## Collaborating Partners\*

Provide a brief overview of each entity collaborating with your organization on this program and their role in the program. How long have you collaborated with these partners, and what kinds of past projects have you worked on together? Letters of support may be uploaded in the optional upload field at the end of this application.

3,000 characters left of 3,000

## Clinical Training Location(s)

Provide information about where the clinical training or other eligible activities will take place. For planning grants, include the planned training sites if known. Provide the geographic location of each training site. Confirm that each site is in an eligible rural or underserved community (see RFP section 2.2). To determine whether a proposed training site is in a designated shortage area, visit the HRSA website and use the search tools: [Find Shortage Areas \(hrsa.gov\)](https://www.hrsa.gov/shortage).

R1:C1	Site Name	Site Location	Designated Rural or Underserved Community (See RFP section 2.2)
Site A	A*	A*	▼* ▼
Site B	A	A	▼ ▼



# Work Plan

## Work Plan

List key project activities. For each activity, indicate the title/position of each person who will be involved (if contracted services, indicate the contractor), a brief description of the activity, the expected outcomes, and the expected timeline. For clinical training activities, indicate the location(s) where training will take place. Your work plan should include evaluation and reporting activities.

### Activity 1: Description\*

### Activity 1: Outcomes\*

1,000 characters left of 1,000

### Activity 1: Staff Role Responsible\*

Please do not include real staff names, only use role or job title.

### Activity 1: Number of proposed students\*

Please enter N/A if objective is not applicable to the number of students.

### Activity 1: Location(s) of Training\*

Please enter N/A if objective is not applicable to a training location.

### Activity 1: Start Date\*

### Activity 1: End Date\*

# Increase in # of Trainees

## Additional Trainees\*

For expansion grants, how many additional students will be trained using grant funds over the three-year grant period?

For planning grants, how many additional students are expected to be trained following program implementation?

Submission of your application is considered an attestation that funding will be used to support an increase in the number of clinical training slots.

1,000 characters left of 1,000

## Recruitment and Retention\*

Describe how your proposed program will recruit and retain students. Summarize enrollment data from the past three years in any similar training programs your organization administers and explain any low or declining enrollment numbers. Describe any other factors influencing recruitment and retention.

3,000 characters left of 3,000

## Health Equity\*

Include details on how your project will advance health equity goals.

3,000 characters left of 3,000

## Access to Primary Care\*

How will your program increase access to primary care and/or mental health services for rural and underserved communities, now and in the future?

# Budget & Budget Narrative

## Section 5: Budget

### Budget Line Items and Narratives

Expansion proposals must include a three-year budget, not to exceed \$300,000.

Planning proposals must include a one-year budget, not to exceed \$75,000.

Provide a detailed justification of the estimated expenses to successfully meet the goals of the proposed project.

The [Grant Budget Worksheet](#) may be used to calculate your budget before entering the information into the online grants portal. Please see [RFP Part 4, Section 5](#) for guidance on categorizing budget expenses.

#### Salaries - Request\*

Requested grant amount. Please enter in 0 if there is not an amount requested for salaries.

#### Salaries - Narrative\*

Please enter N/A if request is 0.

1,000 characters left of 1,000

#### Salaries - Additional funding source details\*

Please enter N/A if no other funding sources will be used towards this category.

1,000 characters left of 1,000

#### Fringe - Request\*

Requested grant amount. Please enter in 0 if there is not an amount requested for fringe.

#### Fringe - Narrative\*

Please enter N/A if request is 0.



# Budget Clarifications

Salary – Rate x hours, % of pay based on hours

Travel – must use Commissioner's Plan!

- Mileage at IRS rate
- Lodging
- Food
- No out-of-state travel without pre-approval

Supplies – less than \$10,000 for a single item

Contracted – Software, venue rental, contracted project staff

Scholarship/Student Supports - Do not ask for double travel if offering stipend. NO incentives

Indirect – 15% of SUBTOTAL (if NICRA provide proof)

# Attachments & COI

## Section 6: Required Attachments

Due Diligence Review Section 6a or 6b will branch open to make upload fields available based on the response to the question: Supplier Type in Section 1 if the applying organization will be required to submit a Due Diligence Review Form.

### Proof of Accreditation\*

Applications must include documentation of current accreditation, candidacy for accreditation, or applicable Board approval, for the eligible health profession(s) you are proposing to train as listed in the request for proposal. If your grant application is for multiple health professions, provide this documentation for each profession type.

[Upload a file](#) [30 MiB allowed]

### Optional: Letters of Support from Partner Organizations

Applicants may provide letters of support from partner organizations indicating their commitment to collaborating with the applicant organization on the proposed project.

[Upload a file](#) [30 MiB allowed]

### Optional: Documentation of Federally Negotiated Indirect Cost Rate

Provide proof of current federally negotiated indirect cost rate, if applicable.

[Upload a file](#) [50 MiB allowed]

### Optional: Resumes/Curricula Vitae of key Project Personnel

Please upload resumes and CVs as a single document if project personnel are known at the time of application.

[Upload a file](#) [30 MiB allowed]

## Section 7: Applicant Conflict of Interest Disclosure

### Applicant Conflict of Interest Disclosure

Please review the applicant conflict of interest instructions on the [External Grants and Loans Resources Page](#). This section completes the disclosure, there is no need to sign or attach the document.

### Conflict(s)\*

A: To the best of Applicant's knowledge and belief, and except as otherwise disclosed, there are no relevant facts or circumstances that could give rise to individual or organizational conflicts of interest.

B: Applicant, or employees of applicant, have an actual, potential, or perceived conflict(s) of interest which are listed below.

☐ A: No conflict

☐ B: Conflict(s) - listed below

### Conflict(s) listed

To the best of your knowledge, write the names of entities/individuals with which you have an actual, potential, or perceived conflict. Please also include the relationship you have with the entities/individuals.

# Due Diligence Form

## Section 6a: Due Diligence Review Form

### Due Diligence Form\*

Please download the [Due Diligence Form](#) to complete and then upload here.

[Upload a file](#) [30 MiB allowed]

### Audited Financial Statements\*

Please provide one copy of the applicable financial statements for your organization per Section 4: Financial Review of the Due Diligence Form.

If the audit or financial statements encompasses multiple facilities within a system/umbrella organization, please provide additional financial information, such as income statement specific to the applicant facility or facilities.

[Upload a file](#) [70 MiB allowed]

### Question 9A: Unresolved findings following an audit

If you answered Yes to Question 9A in Section 3: Financial Health, please attach a copy of the management letter and a written explanation to include the finding's and why they are unresolved.

[Upload a file](#) [20 MiB allowed]

### Question 10: Instances of misuse or fraud

If you answered Yes to question 10 in Section 3: Financial health, please attach a written explanation of the issue(s), how they were resolved and what safeguards are now in place.

[Upload a file](#) [20 MiB allowed]

### Question 11: Lawsuit Explanation

If you answered Yes to Question 11 in Section 3: Financial health, please attach a written explanation of the lawsuit(s) per your response to Question 11A and why they would not or would impact the organization's financial status or stability.

[Upload a file](#) [20 MiB allowed]

### Evidence of good standing

Is your grant application requesting funding that exceeds \$50,000?

Organizations for applications requesting funding that exceeds \$50,000 must certify their organization has a status of "In Good Standing" with the Minnesota Secretary of State as required by Minnesota Statutes, section 16B.981, subdivision 2 (4). Search for your business name on the Minnesota Secretary of State's website at Search Business Filings(<https://mblsportal.sos.state.mn.us/Business/Search>).

[Upload a file](#) [20 MiB allowed]

# Deadline for Submissions

August 4, 2025

4:30 pm

*Please follow instructions in the RFP  
(<https://www.health.state.mn.us/facilities/ruralhealth/funding/grants/index.html#hcbs>)*



Do you still have questions after reading through the RFP  
and reviewing the FAQ?

Please submit via email to: **[Health.ORHPC.WorkForceGrants@state.mn.us](mailto:Health.ORHPC.WorkForceGrants@state.mn.us)**

# Thank you!

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