

Request for Application (RFA): Rural Health Transformation Program Funding Opportunity to Rapid Response to Recovery – Crisis Transportation Support

A series of RFAs will be issued over the lifecycle of the Rural Health Transformation Program (RHTP) grant related to Kentucky's five priority programs. During the initial five years of funding for the Rural Health Transformation Plan, Kentucky RHT will utilize procurement methods permitted under Kentucky Revised Statutes Chapter 45A, Finance and Administration Cabinet policies, and approvals from the Centers for Medicare & Medicaid Services. Multiple procurement methods and phases may be used for each initiative. For more information on Kentucky's plan, visit our website: [Kentucky Rural Health Transformation](#).

Please submit responses to <Breanna.mcginis@ky.gov> by November, 6, 2026, to be considered for initial transportation pilot funding targeted for contract execution beginning January 1, 2027.

I. Context and Background

The Commonwealth of Kentucky has been awarded funding through the Centers for Medicare & Medicaid Services (CMS) Rural Health Transformation Fund (RHTF). This investment will empower Kentucky to launch and implement its Rural Health Transformation Plan (RHTP), a community-driven strategy to expand access and improve health outcomes for rural residents across the Commonwealth.¹

Our Plan

Kentucky's RHTP launches five interrelated programs designed to build rural health infrastructure and provide sustainable, long-term improvements. This plan directly supports Kentucky's rural counties while advancing statewide impact through innovation,

¹ For more information on this funding opportunity, see [Governor's Beshear's press release](#), the [CMS Notice of Funding Opportunity](#), and [federal assistance listing 93.798—Rural Health Transformation Program](#) on Grants.gov.

technology-enabled care and strengthened workforce recruitment pipelines for both clinical and non-clinical staff. This strategy will help build a resilient, integrated and technology-forward health system across the Commonwealth.

1. **Rural Community Hubs for Chronic Care Innovation:** Establishes local “hub-and-spoke” collaboratives focused on obesity and diabetes prevention and management. These hubs will integrate nutrition, physical activity programs, and digital self-management tools.
2. **PoWERing Maternal and Infant Health:** Expands timely prenatal and postpartum care by deploying telehealth-enabled maternal care teams who will serve maternity-care deserts and high-risk regions, to help mothers and infants receive seamless, high-quality support.
3. **Rapid Response to Recovery:** Deploys technology-enabled crisis stabilization and mobile behavioral health response teams to connect individuals with community-based treatment and recovery supports.
4. **Rooted in Health: Rural Dental Access:** Increases access to preventive oral health services through expanded dental hygiene training programs, externships, and investment in Public Health Dental Hygiene (PHDH) teams in Local Health Districts (LHDs).
5. **Crisis to Care: Integrated Emergency Medical Services (EMS) Response and Coordination:** Enhances pre-hospital capacity and trauma coordination through treat-no-transport protocols, improved data connectivity and workforce training for rural EMS providers.

About the Program

This project is 100% funded by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services (HHS) for a total of \$212.9 million in budget year 1 with 100% by CMS/HHS. The RHTF grant spans five budget periods aligned with federal fiscal years (FY2026–FY2030). Funding is disbursed annually by CMS based on achievement of performance metrics. 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. [View the Notice of Funding Opportunity from CMS.](#)

Rapid Response to Recovery (RRR):

Rural Health Transformation has a goal of transforming our rural public health system, resulting in measurable systems change and population health differences. Because of this vision, RHT is approaching this funding opportunity through a series of crisis and prevention service programs under the Rapid Response to Recovery Program:

- 1) Hospital-based EmPATH (Emergency Psychiatric Assessment, Treatment, and Healing) expansion and enhanced engagement in follow-up services,

- 2) Community-based crisis response including EMS and paramedicine models, and
- 3) A telebehavioral health hub with enhanced connection to primary care organizations.

The Rapid Response to Recovery (RRR) program seeks to strengthen the statewide behavioral health crisis continuum by supporting timely stabilization, continuity of care, and recovery following crisis events.

While there are three distinct programs under the Rapid Response to Recovery Program, Rural Health Transformation represents a unique opportunity to strengthen a welcoming and hopeful crisis behavioral health system for those individuals who are the most under-resourced and have the highest acuity-needs.

Overarching goals of the Rapid Response to Recovery Program are:

- Diversion of behavioral health crises from emergency departments and hospital admissions, reducing undue strain on rural hospitals and offering appropriately matched interventions for individuals experiencing crisis
- Increasing follow-up care engagement after individuals have experienced a crisis, keeping them engaged in services to reduce readmissions and crises episodes by creating a well-designed system that welcomes that person into care and eliminates retention barriers
- Improving “front door access” to high-quality behavioral health services by meeting individuals where they are, whether that be through at-home or in-the-field care by paramedicine teams or through collaboration with primary care providers
- Welcoming all first responders into a partnership, improving the capacity of rural emergency services and law enforcement to meet community needs by prioritizing collaborative planning and design, specialized training and protocol development, crisis response skills, alternative transportation practices, and connection into the most appropriate level of care

Transportation is a critical enabler of RRR because it helps individuals experiencing behavioral health crises reach the right place, at the right time, with support from the right people, no matter the door they enter. By addressing transportation barriers and strengthening coordination among community mental health, law enforcement, EMS, hospitals, and other crisis partners, this funding is intended to improve access to care while reducing strain on the broader crisis response system.

II. Program Objectives

Innovation in Involuntary Crisis Transportation

This funding opportunity is jointly released by Kentucky’s Department for Behavioral Health, Developmental and Intellectual Disabilities and the Rapid Response to Recovery Initiative of Kentucky Rural Health Transformation. Currently there are statewide

challenges in transporting patients who are in behavioral health crisis and who are in need of acute psychiatric inpatient care. This issue is most acute in rural areas. Furthermore, there are two distinct patient populations currently facing barriers to appropriate, compassionate, and timely access to medically indicated inpatient care.

The first population includes individuals who require acute inpatient psychiatric care because they present a danger or threat of danger to themselves, family members, or others; can reasonably benefit from treatment; and cannot be appropriately treated in a less restrictive setting, but are unwilling or unable to consent to hospitalization. When an individual is hospitalized through Kentucky's civil commitment process under KRS Chapter 202A, a verified petition for involuntary hospitalization is filed with the District Court. If the court finds probable cause based on the petition, it orders the individual to be evaluated by a qualified mental health professional (QMHP). Following the examination and the QMHP's certification that the individual meets the criteria for involuntary hospitalization, the court may order hospitalization. For hospitalization ordered under **KRS 202A.028**, transportation from the individual's home county must be provided by the sheriff of that county or another peace officer as ordered by the court. The sheriff or other peace officer may, as permitted by the statute, authorize the Cabinet, a private agency under contract with the Cabinet, or a Cabinet-designated ambulance service to transport the individual. Accordingly, applicants may propose innovative partnerships involving sheriff's offices, deputy sheriffs, municipal law enforcement agencies, other qualified peace officers, ambulance services, or eligible contracted transportation providers, provided that the proposed model complies with the applicable court order and all statutory authorization requirements. **KRS 202A.028(3)**. Under the current system, these transports are often completed in marked law enforcement vehicles and may involve restraints or other security measures based on the individual's circumstances. Many individuals must be transported considerable distances to one of the Commonwealth's state psychiatric hospitals, although additional hospitals have expressed willingness to serve patients requiring involuntary hospitalization. The pilots are intended to identify more timely, safe, and dignified approaches that remain consistent with applicable legal requirements. ***Note:*** Pilot funding does not alter the transportation responsibilities established under KRS 202A.028. The sheriff of the individual's home county or another peace officer ordered by the court remains responsible for providing transportation or authorizing an eligible alternative transportation provider as permitted by statute.

The second population includes individuals experiencing acute behavioral health crisis who have been identified as needing inpatient care, including individuals experiencing suicidal ideation or acutely disordered thought processes, but who are willing and able to

consent to voluntary treatment and transport. These individuals may be identified by mobile crisis teams, law enforcement, community providers, hospital emergency departments, or future EmPATH units. Because these individuals are seeking treatment voluntarily and are not being transported under a court order for involuntary hospitalization, their transportation is not limited to a sheriff or other peace officer under KRS 202A.028. Applicants may propose a broader range of voluntary transportation partners, including EMS, ambulance services, behavioral health providers, hospitals, contracted transportation vendors, and other appropriately trained providers, subject to applicable clinical, consent, safety, licensing, insurance, and operational requirements. Voluntary transportation should function as a secondary and complementary use case, with the goal of helping individuals reach appropriate care without using an involuntary process solely to resolve a transportation barrier. In rural areas, inpatient behavioral health care is often not locally available, requiring transportation to a facility outside the individual's immediate community. Local EMS or ambulance providers may be unable or unwilling to complete these transports because of safety, liability, staffing, or capacity concerns. Applicants must clearly distinguish their voluntary and involuntary workflows, including differences in legal authority, consent, referral and dispatch procedures, staffing, safety protocols, escalation procedures, and documentation requirements.

In addition to the lack of dignity provided for patients in a behavioral health, medical crisis, the responsibility that rests on local law enforcement to provide transportation is often problematic. In small counties where they may have 1-2 officers on duties after hours, the need to transport someone that can take 4-8 hours removes a peace officer from being able to serve and protect the local community.

This project would provide the opportunity to develop alternate transportation networks of providers in pilot areas. The pilots will test models serving voluntary and involuntary patients and the capacity to respond twenty-four hours a day, seven days a week in a timely manner. This may vary by region and might include a network of off-duty officers or other EMS or ambulance providers. It is critical that this transportation model be seamlessly integrated into the overall crisis response system that is operated by DBHDID in partnership with CMHCs and other local providers.

The pilots will test different geographic and operational approaches while the Commonwealth continues to refine safety parameters, eligible partners, financing, long-term operating ownership, and statewide scalability. Objectives include:

- Establish dedicated crisis transportation capacity integrated with regional crisis systems
- Define clear eligibility, referral, dispatch, transport, escalation, and receiving workflows

- Operate with trained staff, appropriate supervision, suitable vehicles, adequate insurance, and documented safety controls
- Address regional transportation demand, time, distance, and lengthy round trips
- Collect consistent implementation, utilization, timeliness, safety, and system-impact data
- Participate in continuous quality improvement and cross-site learning
- Develop practical recommendations for sustainability and statewide expansion

Regional Development of the Ideal Crisis System

The Crisis Transportation program represents a key opportunity to coordinate a broader system-of-care strategy, enabling CMHCs to tailor RHT-funded work to address unique community needs. As the statewide behavioral health safety net, CMHCs are uniquely positioned to lead regional planning, coordinate system partners and services, and support data-driven continuous quality improvement. This regional coordination can be guided by the whitepaper, *The Roadmap to the Ideal Crisis System*, which defines an ideal crisis system as a coordinated network of structures, processes, and services rather than individual crisis programs operating independently. In this system, people can quickly reach someone to contact, someone to respond, and a safe place for help, with crisis services connected to ongoing treatment and community supports.²

Rural Health Transformation has a long-term vision of enabling systems change to increase our ability to serve entire populations through enhanced partner collaboration, as opposed to serving individuals as single providers. We encourage applicants to think about the following framework when developing their responses:

- Improving outcomes for the entire crisis system, so that every person receives the right service in the right setting, every time
- Promotion and adoption of enhanced data-sharing technology, agreements, data collection and reporting processes, and real-time information sharing between different system partners as a person moves through the crisis care journey;
- Facilitation of a data-driven quality improvement process, tracking quality outcomes and performance measures and strategizing amongst system partners for improving measures of success, access, and quality;
- Collaboration across systems through shared care planning, policy, protocols, and procedure development; engagement in collaborative structures such as coalitions, committees, workgroups; and moving beyond silos to ensure people receive the right care at the right time;

² [The Ideal Crisis System Report](#)

- Advancement of clinically effective crisis services across partners, while closing safety net gaps to strengthen prevention, early identification, and access to behavioral, physical, and social supports, primarily through improvements in crisis transitions, continuity of care, and cross-system coordination following crisis events.

The minimum set of system partners to engage in the Rural Health Transformation effort includes law enforcement, EMS, paramedicine teams, mobile crisis response teams, quick response teams, 988, 911, hospitals, behavioral health organizations, community-based organizations, social services, and more. There will be complementary funding opportunities for hospitals, EMS agencies, and community paramedicine programs. Applicants should use this framework to inform the specific response prompts and program focus areas outlined below. Responses should remain clearly tied to the allowable uses of funds under the Rapid Response to Recovery Program. We kindly request that all community partners who are interested in funding work collaboratively on applications. Please consider aligning your design and funding requests as part of a larger community partner effort. Funding requests should be designed to innovatively address gaps in the system, solve barriers to access or quality of care, and ultimately address high-priority population health outcomes in alignment with the Rapid Response to Recovery purpose.

III. Eligible Applicants

- Kentucky's 14 Community Mental Health Centers (CMHCs, Provider Type 30), as the regional boards established pursuant to KRS 210.370-210.480 as the planning authority for behavioral health programs, can apply for grants under this program. CMHCs are integral to key 202A processes including certification by qualified mental health professionals for 72-hour involuntary hospitalization assessments, and provision of court-ordered outpatient treatment services as required in judicial orders for assisted outpatient treatment or community-based outpatient treatment.
- Applicants shall include in their proposal formal partnerships with law enforcement, EMS, hospitals, private transportation providers, or other approved entities.
- For involuntary transportation, proposed staffing and partnerships must comply with KRS 202A.028(3): "The sheriff or other peace officer may, upon agreement of a person authorized by the peace officer, authorize the cabinet, a private agency on contract with the cabinet, or an ambulance service designated by the cabinet to transport the person to the hospital".
- The CMHC will remain accountable for the awarded scope, partner coordination, reporting, fiscal controls, and compliance
- Applicants must have or establish all vendor registrations required by the Commonwealth if awarded

IV. Timeline

The anticipated RFA and award timeline is listed below. Centers seeking to receive funding must submit their application by Friday, November, 6, 2026.

- Mid-October: RFA released
- November, 6, 2026: Deadline for receipt of applications
- November 13, 2026: Evaluation and award selection
- November 15 – December 30, 2026: Modification and execution of existing CMHC contracts
- January 1, 2027: Target date for CMHC access to awarded funds
- By February 1, 2027: Site onboarding, safety planning, workflow development, training, and launch readiness

V. Program Standards

Funded agencies must demonstrate a willingness and commitment to adhere to various regulatory standards.

1. **Program Leadership and Effectiveness:** Programs must demonstrate defined leadership responsibilities, systematic planning, performance monitoring, and alignment with the agency mission and community needs.
2. **Transportation Model Design and Scope:** A clearly defined service area, population, workflow, partner model, hours, response expectations, and receiving process
3. **Program Mission and Vision:** Programs must define the scope of services to be delivered in alignment with RHT goals and outcomes.
4. **Administration, Staffing, and Training:** Agencies must demonstrate adequate staffing, training, and supervision to support programmatic goals and scope of services.
5. **Patient Safety and Quality Assurance:** Programs must comply with all applicable health, safety, and infection control standards and maintain quality assurance and improvement processes to ensure safe, ethical, and effective patient care and vehicle safety.
6. **Data and Accountability:** Complete and timely reporting, source documentation, performance monitoring, incident review, and corrective action

The standards above describe the expectations against which proposed activities will be assessed. Applicants should address these expectations within the applicable response sections and are not required to submit a separate narrative for each standard.

VI. Allowable Use of Funds

Applicants must submit a detailed, itemized budget and budget narrative that clearly ties proposed costs to pilot activities and expected outcomes. Costs must be reasonable, necessary, allocable to the approved period, and supported by adequate documentation. Applicants must identify existing state, local, contractual, reimbursement, or other resources supporting behavioral health crisis transportation and explain how requested RHT funding will supplement, expand, enhance, or better coordinate those resources without supplanting existing funding or duplicating payment.

Allowable budget categories to include:

Personnel and Fringe Benefits

- Dedicated transportation staff and supervision, including eligible personnel or subcontracted staffing costs
- Scheduling, 24/7 coverage, relief capacity, shift differentials, and overtime
- Proportionate program management and administration directly tied to pilot implementation, partner coordination, and regional development of the ideal crisis system
- Staff time associated with dispatch, transport coordination, receiving-facility confirmation, handoffs, and escalation support

Training and Onboarding

- Required onboarding before staff begin conducting transport
- Core and supplemental training related to plain-clothes behavioral health transportation, KRS Chapter 202A workflows, crisis intervention, trauma-informed engagement, and de-escalation
- Training on individual rights, least-restrictive practices, transportation risk assessment, safety, escalation, civil commitment documentation, confidentiality, and transportation procedures
- Training on hospital and CMHC handoffs, suicide and medical risk recognition, ADA procedures, and pilot data collection and reporting
- Ongoing competency development and annual refresher training
- Approved training materials, instructors, and certifications directly related to pilot operations

Vehicles and Equipment

- Purchase, lease, retrofit, or configuration of approved commercial-duty crisis transportation vehicles
- ADA-accessibility modifications, including wheelchair-accessible vehicle configurations
- Approved safety features designed to support safe transportation without creating a marked police-vehicle appearance
- Privacy treatments, first-aid supplies, safety supplies, and other approved equipment necessary for pilot transportation
- Equipment necessary to support individual safety, dignity, confidentiality, and least-restrictive transportation practices

Technology, Communications, and Dispatch

- Discreet communications equipment, GPS technology, and approved dispatch or scheduling tools
- Technology used to coordinate referrals, dispatch, routes, transport status, receiving-facility confirmation, and handoffs
- Approved technology and equipment supporting timely communication among CMHCs, hospitals, courts, law enforcement, EMS, crisis providers, and other pilot partners

Any technology, communications, GPS, dispatch, or related equipment purchased with RHTP funds must comply with applicable federal restrictions, including 2 CFR 200.216 regarding covered telecommunications and video surveillance equipment.

Vehicle Operations and Maintenance

- Fuel, preventive maintenance, tires, repairs, registration, tolls, roadside support, and limited replacement transportation

Insurance and Liability

- Incremental auto, general liability, umbrella, and other required pilot coverage

Supplemental Transportation and Escalation Support

- Approved reserve capacity for individualized transportation needs, including priority voluntary transportation through EMS or private transportation when included in the approved model
- Approved costs associated with obtaining additional law-enforcement, EMS, or other qualified support when an unanticipated safety or medical risk exceeds transport staff capabilities

Partnership and Contractual Costs

- Approved contracts or subawards with law enforcement, EMS, hospitals, private transportation providers, crisis providers, or other eligible pilot partners. Statutory parameters for 202A transportation are that “the sheriff or other peace officer may, upon agreement of a person authorized by the peace officer, authorize the cabinet, a private agency on contract with the cabinet, or an ambulance service designated by the cabinet to transport the person. The transportation costs...shall be paid by the cabinet.”
- Partner costs directly associated with staffing, transportation, dispatch, coordination, handoffs, or other approved pilot responsibilities

Data Collection and Continuous Improvement

- Staff time, technology, or other approved costs required to collect and report pilot measures, including transport volume, timeliness, completion, safety events, and destination
- Costs associated with required program monitoring, recurring quality-improvement activities, evaluation, and cross-site learning

Indirect Costs

- Indirect costs if permitted under the final award requirements and within the approved cap

Capital construction is not allowed. Services billable to insurance or another payer may not be charged to this award unless specifically permitted and non-duplication is documented. Vehicle, equipment, renovation, and other costs requiring prior approval may not be incurred without advance approval.

Vehicle purchase, lease, retrofit, and configuration costs may be proposed but will be reviewed individually, and approval is not guaranteed. Selection for funding does not authorize vehicle-related obligations or expenditures, which require separate written approval following applicable compliance and CMS review. Project timelines may be adjusted to accommodate the review and approval process.

VII. Funding Timeline

Applicants may apply for funding to establish and operate a behavioral health crisis transportation pilot as described in this RFA. Award amounts will vary based on the scope, scale, geographic coverage, transportation demand, and operating model proposed. The funding agency reserves the right to fund proposals in whole or in part and to negotiate final funding amounts and scope of work.

Applicants should submit budgets and implementation plans aligned to the timeframes below, identifying the activities, deliverables, milestones, and expenditures anticipated during each funding period. One-time startup costs should be distinguished from ongoing operating costs. Funds must be used within their assigned funding period and cannot carry over unless otherwise authorized. A combined submission for BP1 and BP2 is preferred. When completing the budget template, applicants should select the appropriate Budget Period for each line-item using the designated column.

- **Funding Year 1 Period (BP1):** January 1, 2027, or the date of contract execution, through September 30, 2027
- **Funding Year 2 Period (BP2):** October 31, 2027, through June 30, 2028 (contract end date)
- **Future Funding Periods:** Continuation or expansion beyond Funding Year 2 may be considered based on pilot performance, funding availability, and future RHTP program decisions

Continuation beyond Funding Year 1 is optional and not automatic. Organizations that meet required implementation, performance, training, safety, reporting, and fiscal requirements may be considered for continued funding. However, the focus of this effort is to identify and pilot sustainable initiatives. Therefore, projects should focus on efforts that support identification of alternative long-term funding mechanisms for transportation services. Applicants should expect RHT funding to decrease after the initial funding period and should use the pilot to test approaches that can transition toward sustainable financing, including potential billable services, existing transportation funding, and partner contributions. Funding in subsequent years may be adjusted based on pilot performance, actual transportation demand, progress toward sustainability, availability of funds, and decisions regarding the future transportation operating model.

VIII. Funding Limitations

This funding opportunity is subject to restrictions from CMS per federal guidance.³ If awarded, applicants will be expected to execute the grant agreement in compliance with federal rules, laws, and regulations and specific requirements established by CMS.

- **Funding is intended to build near-term transportation capacity and operational readiness:** RHT funding may support approved startup and implementation costs associated with the behavioral health crisis transportation pilot; applicants must clearly distinguish one-time startup costs from ongoing operating costs
- **The model is expected to transition toward sustainability:** RHTP is explicitly designed as system transformation and is not intended to fund activities that are unsustainable after the program ends; awardees will be expected to maintain and periodically update a sustainability plan that may include items such as:

³ For more detail on funding limitations, reference the [CMS Notice of Funding Opportunity](#), [CMS Frequently Asked Questions](#), and [CMS Notice of Award](#).

- How core transportation functions may be maintained, adjusted, or transitioned as RHT funding changes
- How transportation workflows and partner responsibilities will be integrated into routine crisis-system operations
- How longer-term financing, operational ownership, and partner contributions will be assessed
- How pilot experience will inform future scalability and integration into Kentucky’s behavioral health crisis continuum
- **Reporting is a condition of award:** Awardees will be required to participate in program monitoring and to submit complete, timely reports in the format and cadence defined in the contract
- **RHTP funding is organized into five budget periods (FY2026–FY2030):** Across RHTP, budget periods are awarded annually and are structured with an extended spending window (i.e., budget periods are awarded annually, with additional time to fully expend funds)
- **There are expectations around expenditure of funds:** Applicants must maintain clear documentation demonstrating that costs are reasonable, necessary, directly related to the approved transportation pilot, and not duplicative of another payment source; services that can be billed to an insurance provider may not be included as reimbursable costs under the award
- **Vehicle and equipment costs are subject to applicable requirements:** Awardees must comply with the approval, documentation, ownership, inventory, management, and disposition requirements included in the final agreement
- **This RFA is competitive, and all applicants may not be funded.** DBHDID reserves the right to modify or reduce funding based on program performance, progress toward stated objectives, or availability of appropriate staffing support.
- **Budget ceiling and period:** Applicants may request up to \$715,000 total per CMHC across the following periods of performance: Budget Period 1 (January 1 through September 30, 2027), for startup and initial operating costs (recommended cap of \$450,000), and Budget Period 2 (October 1, 2027 through June 30, 2028), for ongoing operating expenses (recommended cap of \$300,000). Proposed costs must be separated by period and clearly distinguish one-time startup costs from ongoing operational expenses.

IX. Response Scoring

Applications will be scored on a cumulative basis, with total points calculated by summing scores across all applicable sections of the rubric. Applicants will not be penalized for having existing transportation capacity or partnerships in place, provided the application clearly explains how requested funds will establish, expand, enhance, or better integrate behavioral health crisis transportation services. Applicants may describe the broader crisis-system context for clarity; however, scoring will focus on the activities and costs for which funding is requested under this RFA

5 Points Design Layout

- (1 points) Is the application formatted as one Adobe PDF? Is the budget submitted as an attached excel spreadsheet?
- (1 points) Does the application include a cover page with all listed requirements?
- (1 point) Is the application in Times New Roman 12-point font, single line spacing.
- (2 points) Is the application structured using the same section headers listed in the Application Instructions of this RFA?

10 Points Section A: Executive Summary

- 10 = Provides a clear, concise, and well-organized executive summary that comprehensively describes the proposed behavioral health crisis transportation pilot. Clearly identifies the proposed geographic coverage, population or transportation use cases, operating approach, anticipated staffing and vehicle approach, primary transportation and crisis-system partners, requested funding, and readiness to begin implementation. Clearly explains how the proposal will improve patient access, dignity, transportation timeliness, public-safety impact, and connection to appropriate behavioral health care.
- 5 = Addresses the required elements but contains gaps in clarity, specificity, or completeness. The service area, transportation use cases, operating approach, partners, funding request, or readiness may be described at a high level without a clear connection to the proposed pilot.
- 0 = The executive summary is missing, exceeds the established length requirement, or does not adequately describe the proposed transportation pilot.

15 Points Section B: Project Narrative

- 15 = Provides a clear and well-organized project narrative that explains the need for the proposed transportation pilot and how the model will operate. Defines the proposed service area and describes the current transportation challenge using available information related to transportation demand, time, distance, trip duration, existing capacity, and reliance on law enforcement, EMS, hospitals, or other partners (please use local, recent data to illustrate the need). Clearly describes the proposed transportation use cases, geographic coverage, service assumptions, hours or availability, staffing considerations, vehicle approach, partner responsibilities, referral and receiving relationships, and implementation approach. Clearly distinguishes the proposed approach for KRS Chapter 202A involuntary transportation from any approved voluntary transportation activity.

- 8 = Provides a general description of the transportation pilot, but the transportation need, geographic coverage, operating approach, voluntary and involuntary use cases, staffing, vehicle approach, partnerships, or implementation assumptions are described at a high level or contain material gaps.
- 0 = Does not provide a coherent description of the transportation need, proposed pilot model, service area, or implementation approach.

10 Points Section C: Service Provisions and Care Coordination

- 10 = Clearly describes the proposed transportation workflow from an authorized request through screening or acceptance, dispatch, pickup, transport, receiving-facility handoff, and completion. Defines the responsibilities of the applicant and relevant partners, which may include law enforcement, EMS, hospitals, courts, dispatch, state psychiatric facilities, crisis-stabilization providers, and other transportation entities. Clearly explains eligibility, prioritization, escalation, backup transportation, referral-source coordination, receiving-facility coordination, and the distinction between voluntary and KRS Chapter 202A involuntary transportation. Demonstrates how the transportation model will be integrated into Kentucky's broader behavioral health crisis continuum.
- 5 = Describes the transportation workflow and partner relationships at a high level, but contains gaps in role delineation, referral or handoff processes, voluntary and involuntary pathways, escalation, backup transportation, or integration with the broader crisis system.
- 0 = Does not adequately describe how transportation services will be requested, coordinated, delivered, escalated, or integrated with relevant crisis-system partners.

5 Points Section D: Data Collection and Reporting

- 5 = Provides a feasible approach to collecting and submitting complete and timely transportation data. Identifies the staff, systems, source documentation, and processes that will support monthly reporting. Addresses, as applicable, the number of behavioral health transports, the breakdown of voluntary and involuntary transportation, time from the 202A assessment or transportation request to transport, effects on EMS or law-enforcement capacity, use of restraints, safety incidents, training completed, policies and procedures developed, MOUs in place, implementation successes and challenges, and sustainability efforts. Describes how data will be reviewed to identify barriers and support continuous quality improvement.

- 3 = Describes a general reporting approach but does not clearly identify the responsible staff, systems, source documentation, reporting process, applicable transportation measures, or quality-improvement process.
- 0 = Does not provide an adequate approach to transportation data collection, reporting, or continuous quality improvement.

5 Points

Section E: Special Populations

- 5 = Clearly explains how the transportation model will protect individual rights, safety, dignity, and access for people whose transportation needs require additional consideration (e.g., co-occurring intellectual or developmental disability, physical disability). Describes how transportation risk, individual needs, escalation needs, and appropriate vehicle or staffing considerations will be addressed while remaining within the approved pilot population and transportation scope.
- 3 = Acknowledges individual rights, dignity, safety, or differing transportation needs but does not provide sufficient detail about how the proposed model will address those considerations.
- 0 = Does not address individual rights, dignity, safety, or differing transportation needs within the proposed model.

10 Points

Section F: Workforce and Training

- 10 = Clearly describes the transportation staffing and supervision model, including proposed roles, staffing levels, coverage assumptions, relief capacity, and responsibilities. Demonstrates that staffing assumptions account for proposed geographic coverage, transportation demand, time and distance, and potentially lengthy round trips. Describes required behavioral health and crisis training and onboarding, including proposed core training components that could inform minimum standards across pilot sites and any additional training tailored to regional needs. Explains how staff will be prepared to meet the pilot's safety, risk-management, escalation, individual-rights, transportation-procedure, and reporting expectations.
- 5 = Describes the proposed workforce and training approach but contains gaps in staffing levels, supervision, coverage, relief capacity, geographic or travel-time assumptions, training, onboarding, proposed core training components, region-specific training needs, or readiness.
- 0 = Does not demonstrate an adequate transportation workforce, supervision, training, or onboarding approach.

5 Points

Section G: Access and Nondiscrimination

- 5 = Clearly describes how the program will ensure accessible and nondiscriminatory service delivery, including strategies to address language access, disability, and other barriers. Describes use of plain language in client materials and communication and explains how reasonable accommodation and language access services will be coordinated when needed.
- 3 = Describes access and nondiscrimination at a high level, but with limited detail on how barriers will be addressed, how plain language will be used, or how accommodation and language access will be coordinated.
- 0 = Does not adequately describe how the program will ensure access or nondiscriminatory service delivery.

5 Points

Section H: Partnerships and Community Engagement

- 5 = Clearly identifies the partners necessary to implement the proposed transportation model and defines each partner's role. Describes how the applicant will coordinate with relevant law enforcement, EMS, hospitals, courts, dispatch, state and private psychiatric facilities, crisis-stabilization providers, transportation providers, and other entities applicable to the proposed region. Explains how roles, referral processes, handoffs, escalation responsibilities, and governance will be documented or sustained. Demonstrates willingness to participate in DBHDID-led governance, advisory activities, technical assistance, site support, monitoring, and continuous quality improvement.
- 3 = Identifies relevant partners but describes roles, coordination processes, governance, agreements, or ongoing participation at a high level or with material gaps.
- 0 = Does not identify the partners or coordination structure needed to implement the proposed transportation pilot.

10 Points

Section I: Sustainability Plan

- 10 = Provides strong plan for financial viability post-RHTP, including identification of alternative funding sources or revenue mechanisms to support the program beyond the grant period.
- 5 = Alternative funding resources or revenue mechanisms to support the program beyond the grant period are identified, but do not appear fully sufficient.
- 0 = Plan for financial viability post-RHTP is not adequately demonstrated.

10 Points

Section J: Budget and Budget Narrative

- 10 = Budget reflects a sound understanding of program needs and available resources, with costs appropriately scaled to reflect planned programming and staffing.
- 5 = Budget is mostly appropriate but leaves gaps in cost justification, resource alignment, or funding continuity.
- 0 = Budget does not demonstrate financial viability, includes unclear or misaligned costs, or fails to meet program requirements.

10 Points

Section K: Implementation Timeline

- (5 points) Are milestones detailed enough to be actionable?
 - 5 = Milestones are clearly defined and time-bound, with specific activities, responsible parties, and sequencing that demonstrate readiness for implementation.
 - 3 = Milestones are identified but lack sufficient detail, clarity, or linkage to specific activities or responsible parties.
 - 0 = Milestones are vague, incomplete, or not provided.
- (5 points) What is the feasibility of the proposed timeline?
 - 5 = Timeline is realistic and feasible given staffing plans, infrastructure readiness, and scope of services, and demonstrates the ability to initiate services within the proposed timeframe.
 - 3 = Timeline appears generally feasible but includes assumptions or dependencies that are not fully addressed.
 - 0 = Timeline is not feasible, internally inconsistent, or does not align with program requirements.

X. Application Instructions

Design Layout (5 points)

Applicants should submit the following information as a clearly labeled application packet to Breanna McGinnis Breanna.mcginis@ky.gov by **October 23, 2026** for funding available January 1, 2027:

- 1) Application Information:
 - a. Name of organization
 - b. Name, title, and email address of main point(s) of contact
- 2) An application narrative **not to exceed ten (10) pages** that responds to the requested information in Sections A – K listed below.
- 3) Supporting documentation not included in the ten (10) pages:
 - a. Letter(s) of support from proposed transportation and crisis-system partners (*strongly encouraged*)
 - b. Budget for FY27 using the provided budget template (“Attachment A”)

Section A: Executive Summary (10 points)

Applicants must provide a one-page executive summary describing their proposed use of RRR RHT funding to establish and operate a behavioral health crisis transportation pilot in their service region. Please use section headers and bolded key components to organize the response (A, B.1.1, B.2 etc.). Only information included in the section will be considered by reviewers.

The executive summary must include:

- 1) Program Overview: A brief description of the CMHC’s proposed behavioral health crisis transportation pilot, including the transportation populations and use cases to be served.
- 2) Core Activities: A summary of the activities to be supported, including transportation staffing, training and onboarding, vehicle acquisition, lease, or configuration (will need additional approval), vehicle operations, partner coordination, safety and risk-management planning, reporting, and implementation readiness
- 4) Service Area: The geographic area to be served, by county, including the anticipated relationship to relevant sending and receiving facilities
- 5) Partner Organizations: The transportation providers, law enforcement agencies, EMS agencies, hospitals, courts, dispatch entities, state psychiatric facilities, crisis-stabilization providers, and other applicable crisis-continuum partners involved in the proposed pilot
- 6) Populations Served: Individuals requiring transportation under KRS Chapter 202A and, if included in the approved pilot design, priority voluntary transportation populations

Section B: Project Narrative (15 points)

Applicants must provide a clear, organized description of their proposed RRR project.

B.1 Overall Project Description: Describe the purpose, structure, and implementation approach for the proposed RRR-funded transportation activities. Use local data to illustrate why this pilot plan was identified for the service area.

1. **Transportation Need and Current-State Challenges:** Describe:

- Current behavioral health crisis transportation gaps in the proposed service area using current, local data
- Available information regarding transportation demand and volume
- Transportation delays or capacity limitations, especially in rural areas
- Travel distance, trip duration, and lengthy round trips
- Current reliance on law enforcement, EMS, hospitals, CMHCs, or other partners to complete behavioral health transports
- The effect of current transportation challenges on access to appropriate behavioral health care

2. **Transportation Pilot Operating Model:** Describe the proposed:

- Geographic coverage
- Hours or periods of transportation availability
- Staffing and supervision approach
- Vehicle approach, including the proposed number of vehicles and whether vehicles will be purchased, leased, configured, or provided through a partner
- Method for receiving and coordinating transportation requests
- Relief or backup transportation capacity
- Relationships with referral sources and receiving facilities
- Approach to responding to time and distance constraints within the proposed region

3. **KRS Chapter 202A Involuntary Transportation Plan:** Describe how the proposed model will support transportation of individuals requiring transportation under KRS Chapter 202A, including:

- Proposed transportation use cases (i.e., who is being transported, from where, to where, under what circumstances, and why the transportation resource is needed.)
- Applicant and partner responsibilities
- Referral and authorization assumptions
- Staffing and vehicle assumptions
- Safety and escalation considerations

- Coordination with sending and receiving entities
- 4. **Voluntary Transportation Plan, if applicable:** Describe any priority voluntary interfacility transportation activity proposed as a secondary component of the pilot, including:
 - The voluntary transportation needs to be addressed
 - Proposed eligibility or prioritization considerations
 - Anticipated transportation partners
 - How voluntary transportation will be distinguished operationally from KRS Chapter 202A involuntary transportation
 - Supplemental transportation through EMS or private transportation providers, if proposed

B.2 Populations and Scale: Describe the anticipated volume of:

- Involuntary 202a transports to be conducted
- Voluntary transports to be conducted, if applicable
- Proposed eligibility or prioritization considerations, including priority counties, routes, or other considerations
- Anticipated transportation partners

Community Partnerships: Identify applicable, law enforcement, EMS, hospital, court, dispatch, state psychiatric facility, crisis-stabilization, private transportation, and other regional partners.

Service Gaps Addressed: Explain how the proposed pilot will address the transportation gaps identified in B.1.1. For each applicable gap, describe the proposed solution, the partners or resources involved, and the anticipated improvement in transportation access, timeliness, rural travel, capacity for lengthy round trips, law-enforcement or EMS burden, ED boarding, or connection to appropriate behavioral health care.

Section C: Service Provision and Care Coordination (10 points)

Alignment with RRR Goals: Describe how the proposed transportation pilot will improve timely access to appropriate behavioral health care, support individual dignity and safety, and reduce transportation-related burden on law enforcement, EMS, hospitals, and other crisis-system partners. Identify any specific clinical or systems outcomes that align with the goals of Rural Health Transformation and Rapid Response to Recovery.

Transportation Coordination and Handoffs: Explain how transportation will be coordinated among referral sources, transportation providers, CMHC services, law enforcement, EMS, hospitals, state psychiatric facilities, and other sending or receiving entities, as applicable

Transportation Workflows and Escalation: Describe the proposed approach to receiving and prioritizing transportation requests, coordinating pickup and receiving-facility handoffs, distinguishing voluntary and KRS Chapter 202A involuntary transportation, and responding when additional support or backup transportation is needed

Section D: Data Collection and Reporting (5 points)

Applicants must describe their approach to data collection and reporting, including:

- 1) Tracking behavioral health transportation volume, including voluntary and involuntary transports
- 2) Tracking transportation timeliness, safety incidents, and use of restraints
- 3) Tracking implementation activities, including training, policies and procedures, and partner agreements
- 4) Participation in monitoring, evaluation, and continuous quality improvement
- 5) Identified metrics of priority

Specific reporting requirements will be outlined in the award contract.

Section E: Special Populations (5 points)

Describe how the proposed transportation pilot will meet the needs of individuals requiring additional transportation considerations, including how the program will protect individual rights, access, and safety throughout the transportation process.

Section F: Workforce and Training Capacity (10 points)

Applicants must describe:

- 1) Transportation staffing, supervision, and coverage
- 2) How staffing accounts for geographic coverage, travel distance, trip duration, and anticipated transportation demand
- 3) Required behavioral health and crisis training and onboarding
- 4) Ongoing staff development and supervision, and performance monitoring

Section G: Access and Nondiscrimination (5 Points)

Applicants must ensure communication access is provided using the method preferred by the client, including the availability of qualified in-person interpreters when requested, as well as telephonic or video interpretation services, consistent with accessibility and nondiscrimination requirements.

Briefly describe how the transportation pilot will ensure access for all eligible individuals and nondiscriminatory service delivery, including: Limit this section to less than one page.

- 1) How individuals can obtain transportation services regardless of language, disability, or other barriers
- 2) How program materials and communication will use plain language that clients can easily understand
- 3) How you will coordinate reasonable accommodation and language access when needed
- 4) How individual rights and dignity will be protected during transportation

Section H: Partnerships and Community Engagement (5 Points)

Describe how your organization will engage in the following activities for Rural Health Transformation programing:

- 1) Engagement of transportation partners in a continuous quality improvement partnership. Applicants must describe how key partnerships will be formalized or sustained over time (e.g., MOUs, shared protocols, recurring governance structures), particularly as grant funding tapers.
- 2) Engagement of individuals with lived experience in the planning, implementation, and evaluation of RHT programs

Applicants must include a table of active community partners that identifies each partner's role in the proposed program and the current level of collaboration, using the SAMHSA Levels of Collaboration framework (Networking, Coordinating, Cooperating, Collaborating).

Section I: Sustainability Plan (10 points)

Applicants must describe their approach to sustaining core program activities as RHT funding tapers over time. A fully developed long-term financing model is not required at the application stage.

Applicants must address the following:

- 1) Approach to sustaining core functions as grant funding tapers, including how key roles or activities will be maintained, adjusted, or transitioned.

- 2) Integration of funded activities into routine operations or partner workflows to reduce reliance on grant funding over time.
- 3) Key assumptions or risks affecting sustainability and how the organization plans to monitor and adapt over the course of the program.
- 4) Commitment to ongoing refinement of a sustainability plan, including annual updates as the RHT program progresses.

Section J: Budget and Budget Narrative (10 Points)

Applicants must submit a budget – using a DBHDID budget form – and narrative describing:

- 1) Personnel costs
- 2) Fringe benefits
- 3) Travel costs
- 4) Equipment costs
- 5) Supplies' costs
- 6) Training costs
- 7) Consultants' costs
- 8) Contracts' costs
- 9) Other costs
- 10) Indirect costs, if permitted under the final award requirements

Section K: Implementation Timeline (10 Points)

Applicants must submit a high-level implementation timeline describing:

- High-level implementation timeline that describes anticipated milestones across the proposed period of performance. Milestones should demonstrate readiness to implement proposed activities and alignment with the phased rollout of Rapid Response to Recovery Program.
- Anticipated expenditure of funds by the end of BP1, September 30, 2027.
- Anticipated expenditure of funds by the end of BP2, June 30th, 2028

Thank you for your interest in applying for funding through the Rural Health Transformation Program to support the expansion and modernization of behavioral health services. We value your commitment to expanding care coordination and alternative destination transport in Kentucky.