OMB Number: 4040-0004
Expiration Date: 11/30/2025

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier: State of South Carolina

8. APPLICANT INFORMATION:

* a. Legal Name: South Carolina Department of Health and Human Services

* b. Employer/Taxpayer Identification Number (EIN/TIN): 57-0859576

* c. UEI: V1KXFRCQMGL5

d. Address:

* Street1: 1801 Main St
Street2: Jefferson Square
* City: Columbia
County/Parish:
* State: SC: South Carolina
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 29202-0000

e. Organizational Unit:

Department Name: Health Programs

Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:
* First Name: Jordan
Middle Name:
* Last Name: Desai
Suffix:

Title: Deputy Director of Programs

Organizational Affiliation: South Carolina Department of Health and Human Services

* Telephone Number: 8038982060
Fax Number:

* Email: jordan.desai@scdhhs.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Centers for Medicare & Medicaid Services

11. Assistance Listing Number:

93.798

Assistance Listing Title:

Rural Health Transformation Program

*** 12. Funding Opportunity Number:**

CMS-RHT-26-001

* Title:

Rural Health Transformation Program

13. Competition Identification Number:

CMS-RHT-26-001-117822

Title:

Rural Health Transformation Program

14. Areas Affected by Project (Cities, Counties, States, etc.):

Areas Affected By Project SF--424 SCRHT

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Transforming Rural Healthcare in South Carolina

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: SC-002 * b. Program/Project: SC-ALL

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 12/31/2025 * b. End Date: 09/30/2030

18. Estimated Funding ($):

* a. Federal	1,000,000,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,000,000,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name: Jordan

Middle Name:

* Last Name: Desai

Suffix:

* Title: Deputy Director of Programs

* Telephone Number: 8038982060 Fax Number:

* Email: jordan.desai@scdhhs.gov

* Signature of Authorized Representative: Completed by Grants.gov upon submission. * Date Signed: Completed by Grants.gov upon submission.