Health Center Program Specific Form Instructions

Bureau of Primary Health Care (BPHC) program-specific forms should be uploaded under Attachment #1 under Attachments Form in Grants.gov. Please note that these OMB forms with control number 0915-0285, approved by the U.S. Office of Management and Budget, should be submitted with the application.

- All applicants must complete the following forms: General Information Worksheet; Income Analysis; Community Characteristics; Services Provided, Service Sites; Other Activities; Board Member Characteristics; Emergency Preparedness, and, Contact Information are required for all applicants.

- All CHC, MHC, HCH, and PHPC applicants must complete the BPHC Funding Request Summary. The BPHC Funding Request Summary is **not** required for SAC applicants.

- All CHC and MHC applicants must complete the Compliance Matrix form. The Compliance Checklist is **not** required for SAC applicants.

- Only applicants requesting a waiver for governance requirements must submit the Waiver of Governance form.[1] **Please Note:** Applicants currently receiving section 330 funding and applying to serve their current service area must also reapply for approval as part of their SAC application by completing and submitting the Waiver of Governance form to continue their existing governance waiver for a new project period.

- Only CHC and/or MHC applicants must submit the Health Center Affiliation Certification and only those CHC and/or MHC applicants with proposed affiliation arrangements must submit the Health Center Affiliation Checklist.

➢ GENERAL INFORMATION WORKSHEET (REQUIRED)

The General Information Worksheet provides a summary of information related to the proposed budget, Health Care and Business Plans, patient and encounter projections presented in the project description and other forms. The following instructions are intended to clarify the information to be reported in each section of the form.

The applicant should complete this form based on the proposed project at the time of application submission. Applicants currently receiving section 330 funding and applying to serve their current service area **cannot** request a change in their approved scope of project (e.g. adding or deleting sites or services) in the SAC application and data reported in this form should not reflect pending changes in scope that have not yet been approved by the HRSA project officer.[2]

[1] See PIN 98-12: Implementation of the 330 Governance Requirements for additional information

[2] Applicants currently receiving section 330 funding and applying to serve their current service area should ensure that their application reflects their current approved scope of project. Any proposed changes in scope requiring prior approval MUST be submitted under separate cover. The change in scope application must be emailed to bphcscope@hrsa.gov and a signed original must be sent to the HRSA's Division of

DESCRIPTION OF PROPOSED SERVICE AREA:

Check all that apply for the service area designations and target populations for the proposed service area.

Select the designation(s) and or descriptors (urban, rural, and/or sparsely populated) which best describe the applicant's proposed service area. Sparsely populated areas are geographical areas with 7 people or less per square mile for the entire service area. Multiple selections are allowed.
For inquiries regarding Medically Underserved Areas of Medically Underserved Populations, call 1-888-275-4772. Press option 1, then option 2 or contact the Shortage Designation Branch via email sdb@hrsa.gov or 301-594-0816. For additional information, visit the HRSA Bureau of Health Professions Shortage Designation website at http://bhpr.hrsa.gov/shortage/.

Target Population and Provider Information:

For this section, applicants with more than one delivery site should report aggregate data for all of the sites included in the proposed project.

This form requests both current and proposed information. "Current" refers to the number of patients and/or encounters served by the applicant at the time of application. "Proposed" refers to the number of patients and/or encounters anticipated to be served by the applicant by the end of the project period (up to 5 years) at the current level of level of funding.

Provider FTEs

An applicant currently receiving section 330 funding and applying to serve its current service area should report the number of provider FTEs by staff type at the time of application.

An applicant should report the number of proposed provider FTEs by staff type.

Users and Encounters by Service Type

1. An applicant currently receiving section 330 funding and applying to serve its current service area should list current patients and encounters based on the most recent submission to the Uniform Data System.

2. In the event an applicant currently receiving section 330 funding and applying to serve its current service area has received a New Access Point, Expanded Medical Capacity, and/or Service Expansion award in the previous budget period, the applicant should include the projected increase in the number of patients and encounters in the "proposed" column consistent with the approved application.

Grants Management Operations with a courtesy copy to the Project Officer. Please refer to the most recent guidance on this subject contained in PIN 2002-07: Scope of Project Policy (available onsite at www.bphc.hrsa.gov), or contact BPHCscope@hrsa.gov for more information.

3. Applicants are expected to sustain and/or increase patients and/or encounters through the period at the current level of funding. **Therefore, HRSA does not expect the number of patients and/or encounters to decline over the project period**.

4. Do not report patients and encounters for services outside the organization's proposed project.

➢ BPHC-FUNDING REQUEST SUMMARY

The BPHC Funding Request Summary reports the Federal funds requested for each type of Health Center. Funds are reported based on a 12 month budget for each budget period.

➢ STAFFING PROFILE (FIRST YEAR ONLY - REQUIRED)

The Staffing Profile reports personnel salaries supported by the total budget for the first year of the proposed project. Applicants should include staff for the entire scope of the project (i.e., total for all sites). Anticipated staff changes within the proposed project period should be addressed in the program narrative.

➢ INCOME ANALYSIS FORM (FIRST YEAR ONLY - REQUIRED)

Each applicant must complete the Income Analysis Form. The form projects program income, by source, for the first year of the proposed project period. Anticipated changes within the proposed project period should be addressed in the budget presentation.

INSTRUCTIONS FOR THE COMPLETION OF INCOME ANALYSIS FORM

The Income Analysis Form provides a format for presenting the estimated non-federal revenues **(all other sources of income ASIDE FROM the section 330 grant funds)** for the application budget. Applicants should not use this form to provide additional narrative beyond that included in the Program narrative. The worksheet must be based on the proposed project. It may not include any grant funds from any pending supplemental grants or other unapproved changes in sites, services or capacity.

There are two major classifications of revenues, Payor Category and Other Income.

- **Payor Category** includes fees, premiums and third party reimbursements and payments generated from the projected delivery of services. This income is divided into two types of income: Fee for Service and *capitated* Managed Care.

- **Part 2: Other Income** includes State, Local or other Federal grants (e.g. Ryan White, HUD, Head Start) or contracts and local or private support that is NOT generated from charges for services delivered.

If the categories in the worksheet do not describe all possible categories of Payor or Other Income, such as "pharmacy", applicants may add lines for any additional income source <u>if necessary.</u>

PART 1: Payor Category

NOTE: *Not all visits reported on this form are reported on the UDS report and similarly, not all visits reported on the UDS are included here. This form reports only on those visits which are billable to first or third parties including individuals who, after the sliding discount, may pay little or none of the actual charge.*

<u>PROJECTED FEE FOR SERVICE INCOME</u>

Show income from Medicaid and Medicare *regardless of whether there is another intermediary involved.* For example, if the applicant has a Blue Cross fee-for-service managed Medicaid contract, this information would be included. If the State Child Health Insurance Program (S-CHIP) is paid through Medicaid, include it in the appropriate category. In addition, if the applicant receives Medicaid reimbursement via a Primary Care Case Management (PCCM) model, this income should be included on the line "Medicaid: Other Fee for Service."

Column (a): Enter the number of billable visits that will be covered by each category and payment source: Medicaid, Medicare, other third-party payors and uninsured self-pay patients.

Column (b): Enter the average charge per visit by payor category. A sophisticated analysis of charges will generally reveal different average charges, for example, Medicare charges may be higher than average Medicaid EPSDT charges. If this level of detail is not available, averages may be calculated on a more general level (i.e., at the payor or service type or agency level.)

Column (c): Enter Total Gross Charges before any discount or allowance for each payment category calculated as [columns (a)*(b)].

Column (d): Enter the average adjustment to the average charge per visit in column (b). A negative number reduces and a positive number increases the Net Charges calculated in column (e). (In actual operation, adjustments may be taken either before or after the bill is submitted to a first or third party.) Adjustments reported here do NOT include adjustments for bad debts. These are shown in column f and g. Adjustments in column (d) include those related to:

a) Projected contractual allowances or discounts to the average charge per visit.
b) Sliding discounts given to self-pay patients.
c) Adjustments to bring the average charge up/down to the negotiated FQHC or Prospective Payment System established reimbursement rate or the cost based

reimbursement expected after completion of a cost reimbursement report.

Column (e): Enter the total amount billed by payment source calculated as [columns c-(a*d)]. Net charges are gross charges less adjustments described in column d.

Column (f): Based on previous experience, enter the estimated collection rate (%) by payor category. The collection rate is the amount projected to be collected divided by the amount actually billed. As a rule, collection rates will not exceed 100%, and may be less than 100% due to factors such as bad debts (especially for self pay), billing errors, or denied claims not re-billable to another source.

NOTE: *Do not show sliding discount percentages here – they are included above in column (d); do show the collection rate for actual direct patient billings.*
Column (g): Enter Projected income for each payor category calculated as: column (e) * column (f)

PROJECTED CAPITATED MANAGED CARE INCOME

This section applies only to capitated programs. Visits provided under a fee-for-service managed care contract are included in the fee-for-service section of this Form. Note also that, unlike the fee-for-service section of this Form, applicants will lump together all types of services on a single line for the type of payor. Thus, capitated Medicaid dental visits and capitated Medicaid medical visits are added together and reported.

PART 2: OTHER INCOME

This category includes all non-section 330 income not entered elsewhere on this table. It includes grants for services, construction, equipment or other activities that support the project, *where the revenue is not generated from services provided or visit charges as well as* income generated from fundraising and contributions, foundations, etc.

- **COMMUNITY CHARACTERISTICS (REQUIRED)**

The Community Characteristics form reports service area and target population data for the entire scope of the project (i.e., all sites) for the most recent period for which data are available. Service area data should be specific to the proposed project. Target population data should be a subset of the service area data and reflect the population the applicant will serve. If information for your service area is not available, utilize data from US Census Bureau, local planning agencies, health departments and other local, State and national data sources. Estimates are acceptable.

- **SERVICES PROVIDED (REQUIRED)**

Applicants must identify what services will be available at the site(s) for the entire organization and how these services will be provided. Only one form is required for the services provided by the entire organization at all sites.

- **SERVICE SITES (REQUIRED)**

The applicant should provide the name and address of each service site that meets the definition of a site (see Section Appendix H for a definition of service site) on the Service Site form. An applicant currently receiving section 330 funding and applying to serve its current service area should include addresses for only those service sites that are included under the approved scope of project and may **NOT** request support of a new site under this application. Any new additions or deletions of sites must be requested through the Change in Scope process, consistent with the guidance provided in PIN 2002-07. An applicant who is not receiving section 330 funding to serve an area listed in Appendix F should list all proposed service sites**.**

Special Instructions for Recording Mobile Van Sites
A mobile van that provides primary care services at multiple locations is considered a service site. For each mobile van, applicants should identify the site as a mobile van and list the address for the applicant on the form. The specific locations where the van provides the services do not need to be listed. However, the general area where services are provided (i.e. counties, cities, towns) should be listed.

Special Instructions for Recording Intermittent Service Sites
Applicants may provide direct health care services at intermittent locations that are operated for a limited period of time and change locations frequently (e.g., every 1-2 months). Additionally, some health centers may also provide services to migrant and seasonal farmworkers and their families through contractual voucher arrangements. Under these arrangements, services may not be provided on a regular scheduled basis but are available during the limited time period necessary for that population. Health centers should list these intermittent locations as a category (e.g., "Migrant Camps," "Voucher Contract Locations") on the Service Site form. The specific service locations under the category where the health center provides the services do not need to be listed; however, the number of such locations should be indicated. Applicants should list the number of locations under "# of hours per week services are available at the site" instead of the specific hours for the locations.

- **OTHER ACTIVITIES/LOCATIONS (AS APPLICABLE)**

Applicants should reference definition of service site in Appendix H to determine those activities or locations that should be listed on this form. Service sites should be listed on the Service Site form. HRSA recognizes that some delivery "activities/locations" have been approved as part of the scope of project for applicants currently receiving section 330 funding and have therefore appeared on previously submitted Service Site Forms. Although not considered sites as defined in Appendix

H, these "activities/locations" should to be documented in continuation applications on the Other Activities form to be considered part of the approved scope of project.

Applicants may provide services at locations that are included in the scope of project that do not meet the definition of a service site. The category of these locations should be listed on the Other Activities form. The specific address of these locations is not required. Applicants should also briefly describe the services provided at these locations. Some examples of other activities and locations include:

- Providing immunizations at multiple different day care centers. Applicants should list the category "immunizations at day care centers."
- Hospitals, in instances where providers follow the organization's patients (rounding/making rounds). Applicants should list the category, "hospital."
- Hospitals, in instances where providers see non-patients as part of his/her privileges (on call). Applicants should list the category, "hospital."
- Patients' homes, if it is the policy of the organization that providers will occasionally make home visits to an organization's patients. Applicants should list "patients' homes."
- Participating in health fairs. Applicants should list "health fairs."
- Conducting street outreach. Applicants should list "street outreach."
- Providing health education. Applicants should list "health education."

➢ BOARD MEMBER CHARACTERISTICS (REQUIRED)

All applicants must complete the Board Member Characteristics form. Applicants should list all current board members and provide information on all characteristics as requested.

➢ REQUEST FOR WAIVER OF GOVERNANCE REQUIREMENTS (AS APPLICABLE)

This form may only be submitted by applicants requesting targeted funding ***solely*** to serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330 (h)) and/or residents of public housing (section 330(i))and that are NOT requesting general (Community Health Center - section 330(e)) funds.

These applicants may request a waiver of two of the governance requirements – the 51% consumer majority and/or monthly meetings. (see PIN 98-12: Implementation of the section 330 Governance Requirements, for additional information). **Note:** An

approved waiver does not absolve the organization's governing board from fulfilling all other statutory board responsibilities and requirements.

Applicants should clearly describe why the project cannot meet the statutory requirements requested to be waived and describes the appropriate alternative strategies detailing how the program intends to ensure regular oversight (if no monthly meetings) and consumer participation (if board is not 51% consumers) in the direction and ongoing governance of the organization.

Applicant should respond to **(a)** if they are requesting a waiver for the consumer majority or **(b)** if they are requesting a waiver for monthly meetings. Applicants requesting a waiver for both should respond to **(a) AND (b)**.

(a) If the consumer majority is requested to be waived, the applicant must briefly discuss why the project cannot meet this requirement and describe the alternative mechanism(s) for gathering consumer input (e.g. separate advisory boards, patient surveys, focus groups). Areas of discussion may include:

- Specifics on the type of consumer input to be collected.
- Methods for documenting such input in writing.
- Process for formally communicating the input directly to the organization's governing board (e.g. quarterly presentations of the advisory group to the full board, quarterly summary reports from consumer surveys).
- Specifics on how the consumer input will be used by the governing board in such areas as: 1) selecting services; 2) setting operating hours; 3) defining budget priorities; and 4) other relevant areas of governance that require and benefit from consumer input.

(b) If monthly meetings are waived, the applicant must briefly discuss why the project cannot meet this requirement and describe and outline the proposed alternative schedule of meeting and how the alternative schedule will assure that the board can still maintain appropriate oversight and operation of the project.

- **COMPLIANCE CHECKLIST (REQUIRED FOR CHC AND/OR MHC APPLICANTS ONLY)**

This checklist and certification form is required for CHC and/or MHC applicants, but is not required for SAC applicants.

- **HEALTH CENTER AFFILIATION CERTIFICATION (REQUIRED FOR CHC AND/OR MHC APPLICANTS ONLY)**

This form is required for CHC and/or MHC applicants, but is not required for SAC applicants. Applicants should indicate if any of the identified affiliation arrangements are present or proposed. Applicants must complete a separate form for each organization with which they have any identified affiliation arrangements. If any of

the affiliation arrangements are present or proposed, applicants must also complete and submit a Health Center Affiliation Checklist form.

- **HEALTH CENTER AFFILIATION CHECKLIST (AS APPLICABLE)**

  CHC and/or MHC applicants with current or proposed affiliation arrangements identified in the Health Center Affiliation Certification must also submit a completed Health Center Affiliation Checklist form. The completed checklist will provide information regarding any current or proposed affiliation arrangements. This information will be used to assure that organizations receiving section 330 funds comply with the requirements set forth in PIN 98-23 Health Center Program Expectations and PINs 97-27 and 98-24 (available at www.bphc.hrsa.gov/pinspals/pinsarchive.htm). A summary of all subrecipient arrangements, contracts and affiliations agreements should be included.

- **ANNUAL EMERGENCY PREPAREDNESS AND MANAGEMENT (EPM) REPORT (REQUIRED)**

  The Annual Emergency and Management Report will be used to assess the status of emergency preparedness planning, progress towards developing and implementing an emergency management plan and assist in determining technical assistance, training and resource needs.