U.S. Department of Health and Human Services
HRSA BPHC Bureau of Primary Health Care
Health Resources and Services Administration

PROGRAM INFORMATION NOTICE

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DOCUMENT TITLE: Federally Qualified Health Center Look-Alike Guidelines and Application

TO: Community Health Centers
Migrant Health Centers
Health Care for the Homeless Grantees
Public Housing Primary Care Grantees
Federally Qualified Health Center Look-Alikes
Primary Care Associations
Primary Care Organizations

Attached are the revised guidelines and application package for Federally Qualified Health Center (FQHC) Look-Alike designation and recertification, recently approved by the Office of Management and Budget. This document replaces Policy Information Notice (PIN) 2000-02, "Federally Qualified Health Center Look-Alike Guidelines and Application," dated October 19, 1999.

This application guidance reflects legislative, policy and technical changes since PIN 2000-02 was issued. The document contains major revisions in the program including:

- Elimination of waiver allowances under the Medicaid FQHC benefit. Organizations previously granted waivers will be given sufficient time to meet the waiver requirements.
- Applicants are asked to submit a Letter of Interest to the Bureau of Primary Health Care prior to submitting a formal application.
- A Compliance Checklist has been added.
- A checklist of required forms and documents including the affiliation checklist, detailed map, Medically Underserved Area or Medically Underserved Population designation, and not for profit status has been added.
- Reference to the Medicare, Medicaid and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000, section 702, the Medicaid Prospective Payment System for FQHCs has been added.
- Forms and data tables have changed.
- Change in Scope of Project policy and procedures have been added.

Questions regarding the FQHC Look-Alike application guide should be directed to The Division of Health Center Development.

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Attachments

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I. PURPOSE

This document provides information about the Federally Qualified Health Center (FQHC) Look-Alike Program and instructions for submitting an application for designation or recertification as a FQHC Look-Alike. The requirements described in this document are for health centers that serve a population that is medically underserved as defined in section 330 of the Public Health Service (PHS) Act.

II. LEGISLATIVE BACKGROUND FOR FEDERALLY QUALIFIED HEALTH CENTERS

The Omnibus Budget Reconciliation Acts of 1989, 1990, and 1993 amended section 1905 of the Social Security Act to create a new category of entities under Medicaid and Medicare known as FQHCs. The Social Security Act § 1905(l)(2))B) defines an FQHC for Medicaid purposes as an entity which:

> "(I) is receiving a grant under section 330 of the PHS Act, as amended;
>
> (II)(i) is receiving funding from such a grant under a contract with the recipient of such a grant, and
>
> (ii) meets the requirements to receive a grant under section 330 of such Act,
>
> (III) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant including requirements of the Secretary that an entity may not be owned, controlled or operated by another entity, or
>
> (IV) was treated by the Secretary, for the purposes of part B of title XVIII, as a comprehensive Federally funded health center as of January 1, 1990,
>
> and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law (P.L.) 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services."

A similar definition for Medicare purposes is found at § 1861(aa)(4) of the Social Security Act.

The goal of the FQHC program is to maintain, expand and improve the availability and accessibility of essential primary and preventive health care services and related "enabling" services provided to low income, medically underserved and vulnerable populations that traditionally have limited access to affordable services and face the greatest barriers to care. As fundamental components of the health care "safety net," FQHCs provide a comprehensive system of care reflective of the community's needs and available to all persons residing in their service area(s), regardless of the person's or family's ability to pay for such services. The FQHCs further ensure access to care by establishing a schedule of discounts for persons unable to pay a full fee, including nominal or no fees for services provided to the poorest of the populations served, persons whose incomes are below 200 percent of the Federal poverty guidelines.

One of the cornerstones of the FQHC program is community involvement in both the management and governance of the health center. The FQHCs must be governed by a community-based Board of Directors, a majority of whom are users of the health center's services and who represent the health center's service area in terms of demographic factors such as race, ethnicity and gender. The Board must autonomously exercise key decision-making regarding adoption and establishment of operating and service policies, approval of the budget and grant application, strategic and operational planning, and the hiring and, if necessary, dismissal of the executive director or chief executive officer. In addition, the involvement of third parties in health center governance is specifically limited by Federal policy.

To ensure that there are appropriate numbers of health centers to serve the millions of uninsured and underinsured populations throughout the country, FQHC Look-Alike status was made available to those health centers that do not receive funding under section 330, but operate and provide services similar to grant-funded programs. As such, FQHC Look-Alike entities are expected to demonstrate the same commitment as grantees to serve all populations residing in their respective medically underserved communities, and to satisfy the administrative, management, governance and service-related requirements unique to section 330 funded health centers.

The Balanced Budget Act (BBA) of 1997 (P.L. 105-33) modified the definition contained in section 1905 of the Social Security Act for a FQHC Look-Alike entity by adding the requirement that an "entity may not be owned, controlled or operated by another entity." The Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC), in collaboration with the Centers for Medicare and Medicaid Services (CMS), issued policy guidances to implement the BBA requirements for public and private nonprofit organizations: Policy Information Notice (PIN) 99-10, "Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Private Nonprofit Entities," issued April 20, 1999; and PIN 99-09, "Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Public Entities," issued April 20, 1999. Other relevant policy documents are PIN 97-27, "Affiliation Agreements of Community and Migrant Health Centers," issued July 22, 1997; and PIN 98-24, "Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers," issued August 17, 1998. These documents describe the statutory limits on the involvement of "another entity" in the ownership, control and/or operation of a public or private nonprofit FQHC Look-Alike entity. Potential applicants are encouraged to work closely with the HRSA Field Offices list of contacts if there are questions about the application of these policies to their particular case.

III. PAYMENT ELIGIBILITY UNDER MEDICAID AND MEDICARE

Under Medicaid, the FQHC covered core services include services provided by physicians, physician assistants, nurse practitioners, clinical nurse specialists, clinical psychologists, clinical social workers, and services and supplies incident to those services. Any other ambulatory service included in a State's Medicaid plan is considered a covered service under the FQHC benefit, if the FQHC offers such a service and meets applicable requirements for a provider of that service.

Under Medicare, FQHCs currently are eligible for payment at 100 percent of the reasonable costs for the same core services covered under the Medicaid FQHC benefit. Additionally,

Medicare FQHC includes reimbursement at 100 percent of reasonable cost for certain preventive health services that are not normally covered under Medicare.

The Medicaid prospective payment system (PPS) for FQHCs was enacted into law on December 21, 2000, under section 702 of the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act (BIPA) of 2000. The new Medicaid PPS requirements are effective in all States, with respect to services furnished by FQHCs on or after January 1, 2001. All States, including those operating section 1115 waiver demonstration programs, are subject to the new Medicaid PPS requirements in sections 1902(a)(15) and 1902(aa) of the BIPA.

The BIPA amends section 1902(a) of the Social Security Act ("the Act") by repealing the reasonable cost-based reimbursement requirements for FQHC services (previously at paragraph (13)(C)) and instead requiring (in paragraph (15)) payment for FQHCs consistent with a new PPS described in section 1902(aa) of the Act. Under BIPA, the new Medicaid PPS was effective on January 1, 2001. In the first phase of the new Medicaid PPS (January 1, 2001-September 30, 2001), States were required to pay current FQHCs either 100 percent of the average of their reasonable costs of providing Medicaid-covered services during fiscal year (FY) 1999 and FY 2000, adjusted for any increase or decrease in the scope of services furnished during FY 2001 by the FQHC (calculating the payment amount on a per visit basis), or an amount based on an alternative payment methodology mutually agreed to by and between the State agency and the FQHC (as described below). Beginning in FY 2002, and for each fiscal year thereafter, each FQHC is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under the Act in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC during that fiscal year. Newly qualified FQHCs after FY 2000 will have initial payments established either by reference to payments to other clinics in the same or adjacent areas, or in the absence of such other clinics, through cost reporting methods. After the initial year, payment shall be set using the MEI methods used for other clinics.

For the same period beginning January 1, 2001 and ending September 30, 2001, and for any fiscal year beginning with FY 2002, a State may, in reimbursing an FQHC for services furnished to Medicaid beneficiaries, use an alternative methodology other than the Medicaid PPS, but only if the following statutory requirements are met. First, the alternative payment methodology must be agreed to by the State and by each individual FQHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is at least equal to the amount to which it is entitled under the Medicaid PPS. Third, the methodology must be described in the approved State plan.

IV. PROGRAM ELIGIBILITY

Applicants for FQHC Look-Alike designation must be operational at the time of application and meet the following requirements:

- be a public or a private nonprofit entity;
- serve, in whole or in part, a federally-designated Medically Underserved Area (MUA) or

Medically Underserved Population (MUP). (The list of MUAs and MUPs is available through the BPHC Web site: http://www.bphc.hrsa.dhhs.gov/databases/newmua/);

- meet the statutory, regulatory and program requirements for grantees supported under section 330 of the PHS Act; and
- comply with the policy implementation documents specified in Section II of this PIN for the BBA of 1997 amendment which added the requirement that an FQHC Look-Alike entity may not be owned, controlled or operated by another entity.

V. LETTERS OF INTEREST

The submission of a Letter of Interest (LOI) is recommended but not required in order to submit an application for FQHC Look-Alike designation. It is recommended that an applicant submit a LOI to the BPHC as soon as it begins considering applying for FQHC Look-Alike designation. A copy of the LOI should be sent to the Primary Care Association (PCA). The BPHC uses the LOI process to provide feedback to the organization to improve the quality of its application and its opportunity for designation as a FQHC Look-Alike. The BPHC will provide feedback within 30 days of receipt of the LOI and the applicant should incorporate the BPHC response prior to the application.

The LOIs should be no longer than 7 pages and address the level of need in the community for additional primary care services, provide a description of the organization that will be seeking the designation and a brief description of the proposed project.

Each LOI should include a BRIEF DESCRIPTION of each of the following:

- the name and address of the organization and sites to be designated;
- the proposed target population and service area including whether (1) it is defined as urban or rural and (2) identification of any federally-designated MUA/MUP designations to be served;
- issues creating a high need for primary health services including any significant or unique barriers to care;
- a justification of the need for FQHC Look-Alike designation by documenting the lack of sufficient health care resources in the service area to meet the primary care needs of the target population. A map of the service area with the organization and sites noted, as well as all other resources in the service area, should be included;
- the level of need in the community for additional primary care services;
- the history and mission of the organization that will be seeking the designation;
- current operational capacity of the organization, providers and services; and
- the signed compliance checklist and relevant documents. (See Form 4).

LOIs may be sent via e-mail to fqhclaloi@hrsa.gov or mailed to:

Bureau of Primary Health Care
4350 East-West Highway, 7th Floor
Bethesda, Maryland 20814
ATTN: FQHC Look-Alike LOI

A copy of the LOI should be sent to the appropriate PCA. (See attached list, Appendix B).

VI. APPLICATION PROCESS

For FQHC Look-Alike designation, an original application and two copies of the application must be submitted to the BPHC. Applications are accepted anytime throughout the year. The review and designation process is carried out by staff of the BPHC, the CMS Central Office (CO) and the CMS Regional Offices (RO)s. The role and responsibilities of each entity are as follows:

BPHC:

The BPHC is responsible for distributing application materials, providing comments on LOIs, receiving completed applications, and reviewing the application for consistency and compliance with section 330 requirements and applicable policies. While the BPHC review is usually completed within a month of receipt of the application, it may be necessary to request additional information from the applicant to clarify various aspects of or to correct minor deficiencies in the application. If the BPHC review concludes that the application meets the requirements and expectations of the FQHC Look-Alike program, the BPHC will forward a recommendation for approval to the CMS CO.

When the BPHC review determines that the application is either non-compliant with FQHC Look-Alike requirements or incomplete, the application will be returned to the applicant without further consideration. The organization may re-apply for FQHC Look-Alike designation, however, the application must demonstrate full compliance with all requirements. The applicant is encouraged to contact the PCA for assistance in addressing any deficiencies prior to re-applying.

CMS CO and RO*:*

As defined by Section 1905 of the Social Security Act, only the CMS has the statutory authority to designate applicants as FQHC Look-Alikes, based on the recommendation of the HRSA/BPHC. After the BPHC forwards its recommendation for designation to the CMS CO, the CMS CO forwards a memorandum to the appropriate CMS RO requesting the applicable State Medicaid Agency/Office be notified of the applicant organization's pending designation as a FQHC Look-Alike.

The State Medicaid Agency/Office has 14 days to comment on the application and submit any additional information to the CMS RO regarding the designation. If the CMS CO receives no comments, the recommendation will be accepted and the applicant organization will be designated as a FQHC Look-Alike. The CMS RO then notifies the State Medicaid Agency/Office, the CMS CO, and the BPHC of the final approval decision and the BPHC then notifies the applicant organization of the final approval decision. **Generally, the effective date of the FQHC Look-Alike designation is the date of the CMS RO letter to the State Medicaid Agency/Office regarding the final approval decision.**

In some cases, a State may request a 60 day extension to investigate any issues raised during the initial 30 day comment period. If the issues are not satisfactorily resolved within the 60 day extension, the CMS CO will notify the applicant and the BPHC that the recommendation

for FQHC Look-Alike designation will not be accepted. The BPHC will notify the applicant and the PCA. The applicant may continue to work with the State to resolve any outstanding issues and reapply for designation when the issues have been resolved.

VII. 340 DRUG PRICING PROGRAM

Organizations designated as FQHC Look-Alikes under section 330 of the PHS Act, as amended, are eligible to purchase prescription and non-prescription medications for their outpatients at reduced cost through the 340B Drug Pricing Program. FQHCs are not required to operate/own a pharmacy in order to participate in this program. Given the pharmacist shortage nationwide, FQHCs may want to consider contracting with a local pharmacy. In order to participate in this program, a health center must submit a Program Registration Form to the Office of Pharmacy Affairs, Bureau of Primary Health Care along with its Medicaid information.

For general information on the 340B program, please contact the Office of Pharmacy Affairs at 800-628-6297 or visit the website at http://bphc.hrsa.gov/opa.

VIII. SUPPLEMENTARY DOCUMENTS

Applicants are encouraged to thoroughly review the following reference documents prior to finalizing a decision to apply. All policy documents are posted on the BPHC web site: http://www.bphc.hrsa.gov/.

1. Health Centers Consolidation Act of 1996 (P.L. 104 – 299) (section 330 of the PHS Act, as amended)
2. PIN 98-12, "Implementation of the Section 330 Governance Requirements" (signed April 28, 1998)
3. PIN 98-23, "Health Center Program Expectations" (signed August 17, 1998)
4. PIN 98-24, "Amendment to PIN 98-27 Regarding Affiliation Agreements of Community and Migrant Health Centers" (signed August 17, 1998)
5. PIN 97-27, "Affiliation Agreements of Community and Migrant Health Centers" (signed July 22, 1997)

IX. STRUCTURE AND CONTENT OF THE APPLICATION

The requirements that must be fully addressed by the applicant are detailed in Attachment A of this PIN. The total narrative portion of the application should not exceed 25 pages, exclusive of required attachments, data exhibits and relevant supporting materials. Minor deviations from these limits are acceptable.

Applicants should submit an original and one copy of the application, with all attachments, to the BPHC and one copy to the appropriate PCA. (See Appendix B).

A. STRUCTURE OF THE APPLICATION FOR DESIGNATION (APPLICATION COMPONENTS SHOULD BE ASSEMBLED AS FOLLOWS)*:*

- Form 1-A, Application for FQHC Designation cover page. This must be notarized.
- Table of Contents
- Form 2, Application Checklist
- Form 3, Compliance Checklist
- Project Summary
- Project Description – Narrative component
- Appendices
  - -Data Tables 1 - 5
  - -Forms 4 - 5
  - -Required Attachments
  - -Supplementary Attachments (at the discretion of the applicant)

B. CONTENT OF THE APPLICATION

1. PROJECT SUMMARY (recommend approximately 2 pages)

   The project summary is intended to be a **brief synopsis of the community/target population, the applicant organization and the scope of the proposed FQHC Look-Alike.** The applicant should summarize the need for health services in the community and the organization's response to that need. The following issues should be addressed:

   - Overview of the community/population
   - Overview of the organization
   - Project plan

2. PROJECT DESCRIPTION

   The narrative component of the application should be divided into four sections:

   Section A. Need and Community Impact;
   Section B. Health Services;
   Section C. Management and Finance; and
   Section D. Governance.

   (See Attachment A for further detail on the required elements to be addressed in each section).

3. REQUIRED ATTACHMENTS

   In addition to the data exhibits and tables, the following documents **MUST** be submitted with the application:

   - documentation of non-profit status or evidence of application for non-profit status (not required for a public entity applicant);
   - a map of the service area, with site location(s) and MUA/MUPs noted, as well as

other primary care providers including other including other FQHCs in the area (see Appendix C for sample);
- a complete copy of the applicant's most recent annual audit with auditor's opinion letter;
- a copy of the organization's schedule of discounts (see Appendix A for sample);
- signed copies of the organization's Articles of Incorporation and corporate bylaws; and
- copies of current or proposed management agreements, administrative or clinical services contracts, lines of credit, or any other type of formal affiliation relationship.

C. MULTIPLE SERVICE DELIVERY SITES

Organizations requesting designation of more than one service delivery site are not required to submit a separate application for each site. For each site being included in the designation, the following must be included: (1) a narrative description of need in the area, (2) demographics of the target population, (3) services provided, and (4) professional staffing. Tables 1-5 must be submitted for each site. The submission of information concerning user characteristics such as income and insurance status, age, sex and race on a site specific basis is preferred, but if the entity only keeps aggregated data on users, an entity-wide summary may be provided. Allowance will be made for the increased size of the application due to the submission of information on multiple sites.

X. ANNUAL RECERTIFICATION OF FQHC DESIGNATED ORGANIZATIONS

All designated FQHC Look-Alikes are required to submit an annual recertification statement to retain designation as a FQHC Look-Alike. The annual recertification statement must be notarized and submitted to the BPHC at least 2 months prior to the anniversary of the FQHC Look-Alike's designation date. The recertification statement requires updated information on users, staffing, and service delivery arrangements (for each designated site if applicable), as well as information on any administrative, management or clinical changes that have taken place during the past 12 months, including new or revised/amended contracts and affiliation agreements. All changes in scope approved during the previous year should also be addressed (see below). (See Attachment B – Requirements for Annual Recertification for FQHC Look-Alike Designated Organizations).

The BPHC will review the recertification and either contact the organization for additional information or submit a recommendation to recertify to the CMS CO. The CMS CO then notifies the appropriate CMS RO who will notify the State Medicaid Agency/Office with copies to the CMS CO and the BPHC. The BPHC will notify the FQHC Look-Alike of the continued designation.

If issues of compliance are raised during the review of the recertification, the BPHC will contact the organization for their response to the issues to assure continued compliance with the FQHC Look-Alike program. If all the issues are resolved satisfactorily within 60 days of notification, the BPHC will notify CMS CO of its recommendation to recertify. If all the issues are not satisfactorily resolved after 60 days, the organization will be notified by the BPHC that the FQHC Look-Alike designation will expire immediately.

In the event that a designated FQHC Look-Alike does not submit the documentation required for its annual recertification by the anniversary of the designation date, the BPHC will notify the FQHC Look-Alike, which, in turn, will have 30 days to submit the documentation. If the FQHC Look-Alike does not submit the documentation within the 30 day period, CMS will be notified by the BPHC and the FQHC Look-Alike designation will be terminated.

XI. CHANGE IN SCOPE OF PROEJCT

The Scope of Project defines the health center's approved project for the FQHC Look-Alike designation. An approved scope of project may be a part of a larger health care delivery system and, as such, needs to be distinctly defined within that context. FQHC Look-Alike health centers may have other activities that are not part of their approved scope of project, referred to as Other Lines of Business (OLB) and, thus, are not subject to section 330 requirements and expectations. **It is important to note that only those activities that are a part of the health center's approved scope of project are entitled to certain benefits (i.e., Medicaid PPS and FQHC payments, Medicare FQHC reimbursements, and Drug Pricing benefits).** (Note: Services that are within the approved scope of project but that are not covered as a FQHC service by Medicaid or Medicare, or not provided on an outpatient basis, are not eligible for PPS or cost-based reimbursement.)

A Scope of Project is categorized by five core elements: services, sites, providers, target population, and service area(s) and:

- Defines for the section 340B Drug Pricing Program, the necessary site information enabling covered entities to purchase discounted drugs for patients;

- Defines the approved service delivery sites and services necessary for State Medicaid Offices to calculate payment rates under the PPS or other State-approved alternative payment methodology (see Program Assistance Letter 2001-09 Department of Health and Human Services Fiscal Year 2001 Appropriations, Other Legislation, and Regulation Issuances) and subsequent information posted on www.bphc.hrsa.gov; and

- Defines the approved service delivery sites necessary for the CMS to determine a health center's eligibility for FQHC Medicare cost-based reimbursement.

All FQHC Look-Alike health centers must request prior approval from the BPHC of any changes to their approved scope of project. The requests are to be submitted to the BPHC at least 60 days before the change is anticipated to take place. All Change in Scope requests must demonstrate approval by the Board of Directors and include the Change in Scope Assurances Checklist (Form 6). If the change in scope includes additional site(s) that have a different service area and/or target population than those already being served, Board representation must be modified to represent users of the added site(s). The Change in Scope request may **not** be included as part of the recertification package but must be submitted as a separate request from the organization. The request should state whether it is to add a new site(s) or service(s), reduce services at an existing site(s), or decrease the number of previously approved sites, and must include all the required documentation (as described below).

A. REQUESTS TO ADD OR DECREASE SITE(S)

Change in Scope requests to add or decrease site(s) must include:

- a narrative description of need in the area served by each site, demographics of the target population, services provided at the site, and professional staffing, and a description of the impact of adding a or decreasing a site while ensuring the financial viability of the health center
- a map of the new site(s) service area, with site(s) location and MUA/MUPs noted, as well as other primary care providers (including other FQHCs) in the new or deleted site's service area
- any applicable referral agreements
- Tables 1-5 completed for each new or deleted site
- updated Form 5, Service Sites
- Change in Scope Assurances Checklist (Form 6)

B. REQUESTS TO ADD OR REDUCE SERVICE(S)

Change in Scope requests to add or reduce services must include:

- a narrative description of the services and the impact of adding or reducing service(s) while ensuring the financial viability of the health center.
- updated Table 1
- any applicable referral agreements
- Change in Scope Assurances Checklist (Form 6)

ATTACHMENTS, APPENDICES AND FORMS

ATTACHMENT A

REQUIREMENTS FOR DESIGNATION AS A FQHC LOOK-ALIKE

It is important that the applicant fully address ALL requirements within the narrative component of the application. Submission of data tables without supportive narrative information may result in an application being returned to the applicant as an incomplete application.

Health Center Program Expectations (PIN 98-23, dated August 17, 1998) contains a detailed description of the requirements for grantees under section 330 of the PHS Act and provides the basis for FQHC Look-Alike requirements. The FQHC Look-Alike entities are to be governed by these expectations to the same extent as federally supported health centers. This PIN, and others, are available through the BPHC Web site http://www.bphc.hrsa.gov/pinspals/.

Listed below are the required areas to be addressed in each of the four narrative sections and the information the applicant must provide to demonstrate compliance with the program requirements.

SECTION A. NEED AND COMMUNITY IMPACT

Each FQHC Look-Alike is expected to gain a thorough knowledge of the community and populations groups it intends to serve. In particular, the entity must assess and understand the needs, resources and priorities of the underserved populations residing in its community and design a health care program that is culturally and linguistically appropriate to those populations. Needs and resources should be monitored on an ongoing basis and comprehensively assessed on a periodic basis.

Requirements:

1. Applicants must demonstrate the need for primary health care services in the community(ies) that make up its service area based on geographic, demographic, and economic factors.

2. Applicants must justify the need for FQHC Look-Alike designation by documenting the lack of sufficient health care resources in the service area to meet the primary health care needs of the target population. If there are other FQHCs located in the applicant's proposed service area, the applicant should address the need for additional FQHC services, as well as any efforts to collaborate with existing FQHCs.

3. Applicants must demonstrate that the health center location will permit it to provide services to the greatest number of those in need in the service area.

4. Applicants must demonstrate that it is serving those most in need within the service area, including low income and special need individuals/groups, such as the uninsured, minorities, pregnant women, the elderly, and, where applicable, migrant or seasonal farmworkers, HIV-infected persons, the homeless, and substance abusers.

5. Applicants must serve, in whole or in part, a designated MUA or MUP.

In order to demonstrate that it meets the requirements of 1 - 5 above, the applicant should provide, at a minimum, the following information:

A. A narrative description of the Service Area, which includes:

- the geographic boundaries of the service area of the health center, e.g., the names of counties, localities and/or census tracts;
- a description of the major health problems and special health needs of the target population within the service area, and a description of any unique health status indicators or barriers to their accessing health care;
- identification of the unserved and underserved populations in the community;
- the geographic area and/or population groups that constitute its principal target population, including any unique populations (for example migrant/seasonal farmworkers);
- the characteristics of the target population in terms of age, gender, socioeconomic status, health insurance status, ethnicity/culture, education, language, health status, unemployment, poverty level, etc.;
- other providers of health and social services accessible to the population; and
- gaps in services and health disparities the health center proposes to address.

B. A narrative description of the user population, which includes:

- total number of users and total number of encounters for the most recent 12-month period available (state the period covered by the data);
- economic, demographic and other characteristics identified in Section A above, as they apply to the user population, and;
- the major health needs of the user population, including any special health care needs among population segments (migrant/seasonal agricultural workers, public housing residents, homeless persons, low-income school children, etc.).

C. A map of the service area that clearly shows the location of the applicant's service area; the applicant's service delivery site(s); the designated MUA/MUP(s) served; and the other providers (including other FQHCs) in the area available to the target population.

Tables 1-5 are required formats for providing demographic information on the service area and user populations. Information provided in the Tables should also be described in the narrative.

As previously noted, organizations that provide services through more than one service delivery site must submit the information from sections A and B above, including all tables, for each site included in the application. Please identify other FQHCs in the proposed service area and the need for additional FQHC services, as well as any efforts to collaborate with existing FQHCs.

SECTION B. HEALTH SERVICES

The FQHC Look-Alikes must have a system of care that contributes to the availability, accessibility, quality, comprehensiveness and coordination of health services in the service area. They must ensure that basic primary health care and support services appropriate to the health needs of the target population are available and accessible to all persons in the service area, regardless of ability to pay. They must also have a sufficient number and range of qualified providers and a clinical management system that ensures quality and continuity. Program accountability must be maintained by the applicant.

Applicant organizations are expected to collaborate appropriately with other health and social service providers in their area. Such collaboration is critical to ensuring the effective use of limited resources and for achieving the mission of assuring access to primary and preventive health care for the underserved and vulnerable populations. While health centers are encouraged to collaborate with other entities, they must ensure that all laws, regulations and expectations regarding the health center governing board member selection process, composition, functions and responsibilities are protected. Accountability must be maintained by the health center and its governing board. The BPHC PINs 97-27, 98-24, 99-09 and 99-10 provide policy clarification regarding limits on FQHC Look-Alike affiliation relationships. Information regarding any proposed affiliation arrangements will be used to assure that organizations comply with the requirements and guidelines set forth in the above BPHC PINs, including the center directly employs the Chief Financial Officer, Chief Medical Officer and the core staff of full-time primary care providers, the center directly employees all non-provider health center staff, and the arrangements presented in affiliation agreements do no compromise the Governing Board authorities or limit its legislative and regulatory mandated functions and responsibilities.

Requirements:

1. Required Primary Health Services: The applicant must demonstrate that it provides the following services, either directly, through contract, or through documented cooperative arrangements (see Table 1) and access must be assured for **all** patients regardless of ability to pay:

   A. Primary health care services by physicians, and, where appropriate, mid-level practitioners
      - family medicine
      - internal medicine
      - pediatrics
      - obstetrics
      - gynecology

   B. Diagnostic laboratory services

   C. Diagnostic radiologic services

D. Preventive health services
- prenatal and perinatal services
- screening for breast and cervical cancer
- well-child services
- immunizations against vaccine-preventable diseases
- screenings for elevated blood lead levels, communicable diseases, and cholesterol
- pediatric eye, ear and dental screenings to determine the need for vision and hearing correction and dental care
- voluntary family planning services
- preventive dental services

E. Emergency medical services

F. Pharmaceutical services as may be appropriate for the health center

G. Referrals to providers of medical services and other health related services
- substance abuse services
- mental health services
- oral health services

H. Patient case management including a system for tracking and follow-up

I. Enabling services
- outreach
- transportation
- language interpretation if a substantial number of patients are of limited English proficiency

J. Education regarding the availability and proper use of health services

Additional services may be critical to improve the health status of a specific community or population group. Services beyond the required health center services should be provided based on the needs and priorities of the community, the availability of other resources to meet those needs, and the resources of the organization.

2. The applicant must demonstrate that all contracted services (including management agreements, administrative services contracts, etc.) remain under the governance, administration, clinical management and quality assurance of the applicant organization.

3. The applicant must assure all required services are available to all persons in the service area or target population. Services may not be limited by race, group affiliation, age, gender, or the patient's ability to pay. This requirement may be achieved directly by the applicant or through established arrangements that meets the collaboration and/or contracting arrangements described on page 15.

4. The applicant must demonstrate that the organization maintains, either directly or through contractual arrangements, a core staff of full-time primary care providers appropriate for the population served (i.e., family practice, pediatricians, internists, etc., physicians and mid-level practitioners). (See Table 3 for required format). A core staff of several part-time employees does not meet this requirement. Applicants that do not directly employ a core staff of primary care providers are subject to the requirements in PIN 98-24 regarding contracting for core staff.

5. All of the primary care providers working at the health center must be licensed to practice in the State where the center is located.

6. The applicant's physicians should obtain admitting privileges at their referral hospital(s) so health center patients can be followed as inpatients by health center clinicians in order to ensure continuity of care. When this is not possible, the applicant must have firmly established arrangements for patient hospitalization, discharge planning and patient tracking.

7. The applicant must provide assurance that services are available to all persons within the service area, regardless of their ability to pay.

8. The applicant must demonstrate use of a charge schedule with a corresponding discount schedule based on income for persons between 100 percent and 200 percent of the Federal poverty level (see Appendix A for a sample schedule of discounts). Patients below 100 percent of the Federal poverty level should not be charged more than a nominal fee.

9. The applicant's health center should be open at least 32 hours per week, with services provided at times that meet the needs of the majority of potential users (including evenings and/or weekends as appropriate).

10. The applicant must provide professional coverage during hours when the health center is closed. Applicant must demonstrate firm arrangements for after-hours coverage by their own providers and/or, if necessary, by other community providers. The arrangements must ensure telephone access to a health care provider who is part of the health center's after-hours system;

11. The applicant must have an ongoing quality assurance program that identifies problems and allows for necessary actions to remedy problems.

In order to demonstrate that it meets the requirements of 1-11 above, the applicant should provide, at a minimum, the following information:

A. A check list showing which of the required services are provided directly, by contract, or by a documented cooperative arrangement (see Table 1), and a discussion in the narrative of how each of these services is provided. For services provided through contracting

arrangements, the applicant must demonstrate that the services remain under the governance, administration and clinical management of the applicant organization. All contracts should state the time period during which the agreement is in effect, the specific services it covers, any special conditions under which the services are to be provided, and the terms for billing and payment. Copies of all contract documents must be submitted with the application. Health centers may be eligible for FQHC reimbursement of the cost of contracted services; however, they are not eligible to receive FQHC reimbursement for referred services not paid for by the health center.

B. A description of its clinical staff, including:

- Who provides clinical leadership, their training and skills, and the reporting relationship between that individual and the Chief Executive Officer (CEO).

- Authorities and responsibilities of the clinical director are expected to include: 1) leadership and management for all health center clinicians whether employees or contractors; and 2) ability to function as an integral part of the management team.

- The current physician and mid-level staffing (i.e., the number, FTEs and discipline of providers, licensure, board certification/eligibility status or completed residency training program), hospital admitting privileges, whether directly employed or provided under contract, and the reporting relationship of contract providers to the clinical director and/or CEO. (See Table 3 for the format. Describe all aspects in the narrative section.)

- The availability of specialty medical and diagnostic services through a system of contractual or organized referral arrangements. These services must be available to all regardless of ability to pay.

C. Written clinical policies and procedures, which address, at a minimum:

- Days and hours per week of operation which assure accessibility for the population being served. Applicant should provide a schedule of the days and hours each site is open each week, and the schedule of days and hours that providers are available to see patients.

- After-hours coverage arrangements which assure a continuum of care for center users, i.e., patients must have direct access to a provider.

- Assurance of the availability of services to all persons in the service area or target population, regardless of their ability to pay, and the organization’s sliding fee schedule.

- The use of clinical protocols.

- Procedures for assessing patient satisfaction.

D. A description of the case management system that demonstrates care coordination at all levels of health care, including arrangements for referrals, hospital admissions, discharge planning and patient tracking. The system must ensure a continuum of care.

E. A description of the ongoing quality assurance program, including patient satisfaction and patient grievance procedures. The applicant should discuss how it integrates and applies the components of the quality assurance system into its planning and management, as well as into the evaluation of its overall program effectiveness, i.e., utilization and peer review.

F. A description of the arrangements or plan to provide services for individuals with limited English-speaking ability with respect to bridging language and cultural differences. The applicant should discuss assurances that care is provided in a culturally, linguistically and appropriate manner.

SECTION C. MANAGEMENT AND FINANCE

To meet the challenge of efficient and effective operation, FQHC Look-Alikes must have a strong management team. Center management must work with the governing board and operationalize the health center's mission and strategic objectives. They must operate within available resources, respond to opportunities, and plan for future events. Management involves a team process, and must be supported by strong personnel, financial, information and clinical systems.

Health centers are encouraged to affiliate with other entities to strengthen their ability to achieve their mission of assuring access to primary and preventive health care for the underserved and vulnerable populations. The BPHC recognizes that there are certain situations in which there are exceptions to the BPHC's preference that health centers directly employ personnel in certain positions (CFO, CMO, clinicians) may be necessary and appropriate in order to maximize access to comprehensive, efficient, cost-effective, and quality health care. PIN 98-24 clarifies PIN 97-27 with respect to affiliation arrangements that involve a community and migrant health center contracting for the services of a Chief Financial Officer, Chief Medical Officer and/or the majority of its primary care clinicians The requirement that the health center directly employ the Executive Director remains in effect.

Requirements:

1. Management Structure:

   The applicant must demonstrate a line of authority from the Governing Board to a chief executive (President, CEO or Executive Director) who delegates, as appropriate, to other management and professional staff. The CEO must be directly employed by the health center. NOTE: It is preferable, but not required, that all other key management staff be directly employed by the health center (see PIN 98-24).

The other key management staff should include: a) a Finance Director (Chief Financial Officer (CFO), Fiscal Officer) who is responsible for financial affairs and reports to the CEO, and b) a Clinical and/or Medical Director who is responsible for clinical services and programs and who participates actively in management activities and decision-making. In some situations (i.e., small centers) the CEO may also serve as the Finance Director or Medical Director; in other situations (i.e., integrated service delivery networks), the Finance Director or Medical Director may operate at the network level.

2. Management Information Systems:

The applicant must have systems which accurately collect and organize data for reporting and which support management decision-making. The applicant must be able to integrate clinical, utilization and financial information to reflect the operations and status of the organization as a whole.

3. Financial Systems:

The applicant must have accounting and internal control systems separate and specific to the proposed FQHC Look-Alike entity, and appropriate to the size and complexity of the organization. An accounting system reflecting Generally Accepted Accounting Principles which accurately reflects financial performance must be in place. Separation of function appropriate to organizational size should be implemented to safeguard assets. Appropriate and regular financial reports to reflect the current financial status of the organization are necessary to good management.

While FQHC Look-Alikes are expected to ensure access to their services without regard for a person's ability to pay, they are also expected to maximize revenue from third party payers and from patients to the extent they are able to pay. To meet these expectations, each FQHC Look-Alike must have in place written billing, credit and collection policies and procedures, which include:

- a system for billing patients and third parties within 45 days of a service being rendered;
- a procedure for aging accounts receivable;
- a procedure for producing appropriate aging reports;
- a procedure for following up on overdue accounts to ensure collection;
- a procedure for handling bad debts on a regular basis; and
- a procedure for internal controls.

4. The applicant must demonstrate that it is responsible for ensuring that an annual independent financial audit is performed in accordance with Federal audit requirements.

Audits for nonprofit organizations must follow Office of Management and Budget (OMB) Circular A-133 "Audits of Institutions of Higher Education and Other Nonprofit Institutions." Audits of public entities and those nonprofit organizations under mandate

by the State (i.e., those also receiving a threshold level of state financial assistance) must comply with the Single Audit Act of 1984 and, therefore, are subject to the audit requirements of OMB Circular A-128, "Audits of State and Local Governments."

The audit report must provide an opinion on the scope of the audit, the fairness of the applicant's financial statements, and an evaluation of the applicant's system of internal accounting controls. The auditor shall determine whether the applicant is operating in accordance with generally accepted accounting principles. The applicant should receive an unbiased opinion to that effect. Any problems cited in the audit or report on internal controls must be explained, and adequate procedures must be in place to correct those problems.

5. As a test of fiscal soundness, the applicant must demonstrate that revenues for the proposed FQHC Look-Alike equal at least 90 percent of expenditures. Revenues and expenditures are to be reported in the application and substantiated by an independent financial audit.

6. The applicant must be, or has applied to be, a Medicaid provider.

7. The applicant must be, or has applied to be, a Medicare provider.

In order to demonstrate that it meets the requirements of 1-7 above, the applicant must provide, at a minimum, the following information:

A. An organizational chart showing the organizational and management structure and lines of authority, key employee position titles and names, and the actual FTEs devoted to the health center operation. The Board and individuals with the following responsibilities should be clearly identified: CEO, Clinical Director, and CFO/Financial Manager.

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B. A description of data systems in place to accurately collect and organize data for required reporting of program related statistics, as well as for internal monitoring, quality improvement and the support of management decisions and planning. Applicant should be able to integrate clinical, administrative, and financial information to allow adequate monitoring of the operations and status of the organization as a whole.

C. A description of financial systems, including accounting and internal controls in place that ensures the fiscal integrity of financial transactions and reports. Specifically, this should include a description of:

1. the accounting and internal control systems appropriate to the size and complexity of the organization;

2. the billing, credit and collection policies and procedures (i.e., patient and third party billing, aging accounts and producing reports, following up on overdue accounts and the handling of bad debts), including current fee schedules for all billable services, which should be updated annually, covering all reimbursable costs and comparable in the aggregate to prevailing fee schedules in the area;

3. the financial checks and balances for accounts receivable; and provisions for ensuring that an annual independent audit is performed.

D. A complete copy of the applicant's most recent annual audit, including the auditor's opinion statement (cover letter.)

The application should list the applicant's Medicaid and Medicare provider numbers. Applicants that do not have a Medicaid and/or Medicare provider number at the time of application should demonstrate that applications have been submitted.

SECTION D. GOVERNANCE

An FQHC Look-Alike must be governed by a Board of Directors which is representative of the community and users being served and which has full authority and responsibility as required by the section 330 of the Public Health Service Act governing regulations and program policies. The governing board is legally responsible for ensuring that the FQHC Look-Alike is operated in accordance with applicable Federal, State and local laws and regulations. It carries out its legal and fiduciary responsibility by providing policy level leadership and by monitoring and evaluating all elements of the FQHC Look-Alike's performance.

The governance requirements under section 330 are unique among health service programs and are the basis for ensuring that each FQHC Look-Alike is responsive to the needs of the community. The requirements presented below are essential for assuring a responsive board with the necessary authority and responsibility over the FQHC Look-Alike's operations. The requirements are expected to be addressed in the applicant's bylaws.

Requirements:

1. Applicant must demonstrate that it is either a private non-profit organization or a public entity.

2. Applicant must demonstrate that it has a governing Board that:

   a. Is comprised of at least 9 but no more than 25 members.

   b. At least 51 percent of the governing board's members must be active users of the FQHC Look-Alike's services and must reasonably represent the individuals served by the health center in terms of such factors as race, ethnicity, and gender. These

factors are not, however, meant to impose quotas. As a general rule, user board members should live and/or work in the service area.

c. No more than one-half of the non-user members may be health professionals, which is defined as deriving more than 10 percent of their income from the health care industry. An individual's leadership role in the community and functional expertise should be major criteria in selecting non-user members. As a general rule, non-user board members should live and/or work in the service area.

3. a. For private, non-profit organizations, the governing board must meet at least once a month, and be vested with full authority and responsibility for health center operations. At a minimum, the board must have the authority to: 1) select the services to be provided by the center; 2) schedule the hours during which such services will be provided, 3) approve the center's budget and major resource decisions, 4) establish general policies for the center, and 5) select, dismiss and evaluate the performance of the Executive Director/CEO for the center.

b. For public entities, the governing board must meet at least once a month and have the following authorities: 1) select the services to be provided by the center; 2) approve the center's budget; 3) approve the selection and dismissal of the CEO/ Executive Director; 4) adopt health care policies; 5) assure center is operated in compliance with applicable laws and regulations, and 6) evaluate center activities. A public entity may achieve compliance in two ways. First, the public entity Board may itself meet all the requirements of section 330 of the Public Health Service Act. In the second form of public center, there is a public entity applicant with a co-applicant entity which, when combined, meet all the requirements of section 330 of the Public Health Service Act. In co-applicant arrangements, the public entity receives the FQHC Look-Alike designation and the co-applicant entity serves as the "health center board," with the two collectively referred to as the "health center." Where responsibilities are split between the co-applicant board and the public entity, the public agency and the board MUST execute an agreement which defines each party's role, responsibilities and authorities. For example, the public entity may retain authority to establish general fiscal and personnel policies for the center. (See PIN 99-09 for specific requirements).

4. The applicant's by-laws must demonstrate compliance with the requirements of section 330 of the Public Health Service Act and include provisions that prohibit conflict of interest or the appearance of conflict of interest by board members, employees, consultants and those who provide services or furnish goods to the applicant. No board member may be an employee of the center or be an immediate family member of an employee.

In order to demonstrate that it meets the requirements of 1 – 4 above, the applicant should provide, at a minimum, the following information:

A. For a private, non-profit organization, evidence of non-profit status (e.g., a letter from the State or the Federal government, or a copy of the Articles of Incorporation filed with the State, designating the organization as having such, or evidence that an application for non-profit status has been submitted).

B. For a private, non-profit organization, evidence of current or pending tax exempt status (Internal Revenue Service (IRS) Tax Exempt Certification for the Applicant or acknowledgement of request to the IRS for exemption). For a public entity applicant, evidence of the Co-Applicant Board's current or pending tax exempt status (IRS Tax Exempt Certification or acknowledgement of request from IRS) if independently incorporated.

C. A list of board members, including user status, occupation, area of professional expertise, and residence and/or employment within the service area (see Table 5). Board officers should be indicated on this list as well. Applicants with a formal affiliation relationship with another entity must demonstrate compliance with PIN 97-27 regarding the board selection process (no other entity or entities may select a majority of the health center board members or select a majority of the non-user members), composition, authorities, and committee structure. These issues should be addressed in the narrative if not fully covered in the attached corporate documents or affiliation agreements.

D. A description of the governing board's authorities and responsibilities. There must be documentation (i.e., in the bylaws) that the governing board has the authority to, at a minimum, 1) select the services to be provided; 2) schedule the hours during which services will be provided; 3) approve the center's annual budget and major resource decisions; 4) adopt administrative, health care, financial and personnel policies; and 5) select, dismiss and annually evaluate the performance of the CEO for the FQHC Look-Alike. The governing board's authorities, meeting schedule, composition and selection process must also be specified in the organization's by-laws.

E. For public entities with a co-applicant board, a copy of the written agreement between the public agency and the co-applicant board, identifying the authorities, duties and responsibilities of each entity must be submitted.

F. A description of procedures for avoidance of Conflict of Interest. This description must be included in the organization's by-laws.

G. Indicate whether the entity is currently a hospital outpatient department or part of a hospital outpatient department, and whether it is currently certified by Medicare or Medicaid as part of a hospital.

ATTACHMENT B

REQUIREMENTS FOR ANNUAL RECERTIFICATION FOR FQHC LOOK-ALIKE DESIGNATED ORGANIZATIONS

To fulfill the requirements for recertification, all designated FQHC's must submit updated information, by site if applicable, which reflects the previous 12 months and includes information on the following:

1. Completed Form 1-B – notarized

2. A brief description of and any changes in:

    - the number of users and encounters;
    - characteristics of the user population;
    - demographic characteristics of the service area and user population;
    - economic characteristics of the service area and user population;
    - insurance status of the user population;
    - description of services provided;
    - description of professional staff;
    - description of board members;
    - the number and location of all service delivery sites; and
    - completed Health Center Affiliation Checklist signed and dated by the Board Chair with copies of most recent corporate Articles of Incorporation, bylaws and affiliation agreements if not currently on file.

3. Completed Forms 2 - 5

4. Updated Tables 1-5 (for each site if applicable).

5. A copy of their most recent audit which includes a statement of revenues and expenditures for the audit period and auditor's letter.

6. Copies of Change in Scope requests approved during the previous 12 months, under which the health center added a site(s), decreased existing sites and/or reduced approved services.

APPENDIX A

EXAMPLE OF A SCHEDULE OF DISCOUNTS

The following is an example of a schedule of discounts (i.e., charge schedule with a corresponding discount schedule based on annual income). Applicants for FQHC Look-Alike designation must submit a copy of the center's schedule of discounts to meet the requirement under the Health Services section of the FQHC Look-Alike application. A schedule of discounts must be based on the most current Department of Health and Human Services (HHS) Poverty Guidelines.

This example, for the contiguous 48 states and the District of Columbia, is to be used merely as a guide and should not be submitted as the schedule of discounts attachment.

Example:

Based on the Annual Update of the HHS Poverty Guidelines,
Federal Register, February 16, 2001

#	0 Pay or Minimum Fee		25% Fee		50% Fee		75% Fee		Full Fee
	From	To	From	To	From	To	From	To	More than
1	$0.	$8,590	$8,591	$11,453	$11,454	$14,317	$14,318	$17,180	$17,180
2	$0.	$11,610	$11,611	$15,480	$15,481	$19,350	$19,351	$23,220	$23,220
3	$0.	$14,630	$14,631	$19,507	$19,508	$24,383	$24,384	$29,260	$29,260
4	$0.	$17,650	$17,651	$23,533	$23,534	$29,417	$29,418	$35,300	$35,300
5	$0.	$20,670	$20,671	$27,560	$27,561	$34,450	$34,451	$41,340	$41,340
6	$0.	$.23,690	$23,691	$31,587	$31,588	$39,483	$39,484	$47,380	$47,380
7	$0.	$26,710	$26,711	$35,613	$35,614	$44,517	$44,518	$53,420	$53,420
8	$0.	$29,730	$29,731	$39,640	$39,641	$49,550	$49,551	$59,460	$59,460
9	$0.	$32,750	$32,751	$43,667	$43,668	$54,583	$54,584	$65,500	$65,500
10	$0.	$35,770	$35,771	$47,693	$47,694	$59,617	$59,618	$71,540	$71,540

APPENDIX B

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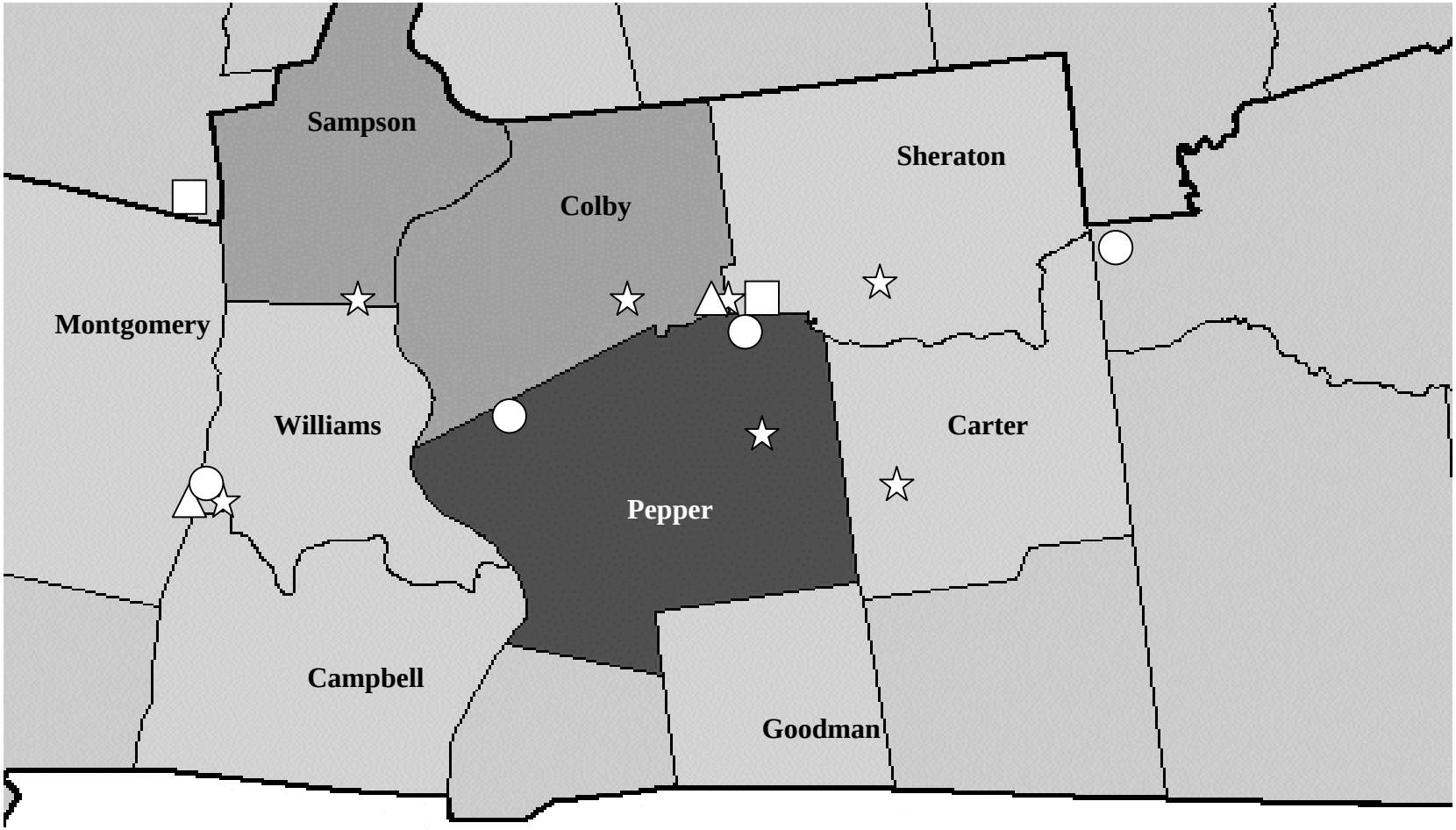
SAMPLE MAP **APPENDIX C**



FORM 1-A

APPLICATION COVER PAGE FOR NEW FQHC DESIGNATION

Applicant's Legal Name: _____ Medicaid Number: _____

Address: _____ Medicare Number: _____

_____

_____(State)_____(Zip Code - 9 digit)

Type of Applicant : ☐ Private Non-Profit ☐ Public ☐ Other

☐ Urban ☐ Rural

Geographic Area(s) served by the applicant: _____

Have you applied for FQHC Look-Alike designation previously ? ☐ Yes ☐ No

ASSURANCES:

This is to certify that to the best of my knowledge and belief all data provided in this application are true and correct. This application for designation is executed by me as the Authorized Representative of the organization.

Authorized Representative:

Name: _____

Title: _____

Full Address: _____

_____

_____(State) _____(Zip Code - 9 digit)

Telephone: _____ Fax: _____ E-mail: _____

SIGNATURE: _____ DATE _____

Notary:

SIGNATURE: _____ DATE _____

FORM 1-B

ANNUAL RECERTIFICATION APPLICATION COVER PAGE

Applicant's Legal Name: _____

Address: _____

_____

_____(State) _____(Zip Code - 9 digit)

Medicaid Number: _____ Medicare Number: _____

Date of FQHC Designation: _____ No. of sites:_____

Is the organization currently receiving cost-based reimbursement? ☐ Yes ☐ No
If no, please explain.

ASSURANCES:

This is to certify that to the best of my knowledge and belief all data provided in this application are true and correct. This application for designation is executed by me as the Authorized Representative of the organization.

Authorized Representative:

Name: _____

Title: _____

Full Address: _____

_____

_____(State)_____(Zip Code - 9 digit)

Telephone: _____ Fax: _____ E-mail:_____

SIGNATURE: _____ DATE: _____

Notary:

SIGNATURE: _____ DATE : _____

FORM 2

APPLICATION CHECKLIST

DOCUMENTS TO BE INCLUDED WITH APPLICATION/RECERTIFICATION				
ALL DOCUMENTS MARKED WITH "XX" MUST BE INCLUDED WITH APPLICATION	INITIAL APPLICATION FOR FQHC LOOK-ALIKE STATUS		RECERTIFICATION FOR FQHC LOOK-ALIKE STATUS	
		APPLICATION PAGE # (s)		RECERTIFICATION PAGE # (s)
Form 1-A/1-B (as appropriate): Application for FQHC Designation/Recertification Cover Sheet – Notarized	**XX**		**XX**	
Table of Contents	**XX**			
Project Summary	**XX**			
Eligibility Checklist	**XX**		**XX**	
BODY OF APPLICATION				
Need and Community Impact	**XX**		*	
Health Services	**XX**		*	
Management and Finance	**XX**		*	
Governance	**XX**		*	
REQUIRED ATTACHMENTS				
Form 2: Application Checklist	**XX**		**XX**	
Form 3: Compliance Checklist	**XX**		**XX**	
Form 4: Health Center Affiliation Checklist	**XX**		**XX**	
Form 5: Service Sites	**XX**		**XX**	
Form 6: Change in Scope Assurances Checklist			**XX**	
Table 1: Services Offered and Delivery Method	**XX**		**XX**	
Table 2, Part A: Users by Age and Gender	**XX**		**XX**	
Table 2, Part B: Users by Race/Ethnicity	**XX**		**XX**	
Table 2, Part C: Users by Income Levels	**XX**		**XX**	
Table 2, Part D: Users by Payment Source	**XX**		**XX**	
Table 3: Providers	**XX**		**XX**	
Table 4: Patient Service Charges, Collections and Self-Pay Adjustments	**XX**		**XX**	
Table 5: Current Board Member Characteristics	**XX**		**XX**	
Map of service area identifying site(s), MUAs/MUPs, and other primary care providers	**XX**		**XX**	
Corporate Bylaws	**XX**		**XX**	
Articles of Incorporation	**XX**		**XX**	
Other contracts as applicable	**XX**		**XX**	
Co-Applicant Agreement (if applicable)	**XX**		*	
Organization Chart	**XX**		*	
Job or Position Description for Key Personnel	**XX**		*	
Resumes for Key Personnel	**XX**		*	
Most recent independent financial audit including all management letters	**XX**		**XX**	
Schedule of discounts (Sliding Fee Schedule)	**XX**			
Current or requested MUA or MUP designation	**XX**			
Current or requested HPSA designation	**XX**			
Internal Revenue Service (IRS) Tax Exempt Certification for the Applicant, (or documentation of pending certification) OR, if the Applicant is a public entity, the Co-Applicant Board	**XX**			
* Update, as necessary, for any changes since last recertification				

FORM 3– Page 1 of 2

COMPLIANCE CHECKLIST

		YES	NO
1.	Is the applicant organization a non-profit or public entity?		
2.	Does the applicant organization demonstrate the need for primary health care services in the community(ies) that make up its service area based on geographic, demographic, and economic factors?		
3.	Does the applicant organization serve, in whole or in part, a designated MUA or MUP?		
4.	Does the applicant organization have a system of care that contributes to the availability, accessibility, quality, comprehensiveness and coordination of health services in the service area?		
5.	Does the applicant organization provide ready access for all persons to all of the required primary, preventive and supplemental health services, including oral health care, mental health care and substance abuse services without regard to ability to pay either directly on-site or through established arrangements?		
6.	Does the applicant organization provide all additional health services as appropriate and necessary?		
7.	Does the applicant organization have patient case management services (including counseling, referral and follow-up services) designed to assist health center patients in establishing eligibility for and gaining access to Federal, State and local programs that provide or financially support the provision of medical, social, educational or other related services?		
8.	Does the applicant organization collaborate appropriately with other health and social service providers in their area?		
9.	Are all contracted services (including management agreements, administrative services contracts, etc.) under the governance, administration, quality assurance and clinical management policies of the applicant organization?		
10.	Does the applicant organization arrange referrals to providers as may be appropriate to assure ready access for all persons to all of the required primary, preventive and supplemental health services without regard to ability to pay?		
11.	Are all services available to all persons in the service area or target population regardless of age, gender, or the patient's ability to pay?		
12.	Does the applicant organization maintain a core staff of primary care providers appropriate for the population served?		
13.	Are the primary care providers working at the health center licensed to practice in the State where the center is located?		
14.	Have all providers been properly credentialed and privileged according to PINs 99-08 and 2001-11?		
15.	Do the applicant organization's physicians have admitting privileges at their referral hospital(s), or other such arrangement to ensure continuity of care?		
16.	Does the applicant organization use a charge schedule with a corresponding discount schedule based on income for persons between 100 percent and 200 percent of the Federal poverty level?		
17.	Is/will the health center be open to provide services at the times that meet the needs of the majority of potential users?		

FORM 3 – Page 2 of 2

COMPLIANCE CHECKLIST

		YES	NO
18.	Does the applicant organization provide professional coverage during hours when the center is closed?		
19.	Does the applicant organization have clear lines of authority from the Board to a chief executive (President, Chief Executive Officer or Executive Director) who delegates, as appropriate, to other management and professional staff?		
20.	Does the applicant organization have systems which accurately collect and organize data for reporting and which support management decision-making and which integrate clinical, utilization and financial information to reflect the operations and status of the organization as a whole?		
21.	Does the applicant organization have accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separating functions appropriate to organizational size to safeguard assets?		
22.	Does the applicant organization maximize revenue from third party payers and from patients to the extent they are able to pay?		
23.	Does the applicant organization have written billing, credit and collection policies and procedures?		
24.	Does the applicant organization assure that an annual independent financial audit is performed in accordance with Federal audit requirements?		
25.	Does the applicant organization have a governing board that is composed or individuals, a majority of whom are being served by the organization and, who as a group, represent the individuals being serviced by the center?		
26.	Does the governing board have at least 9 but no more than 25 members?		
27.	Do the applicant organization's corporate bylaws demonstrate that the governing board has the required authority and responsibility to oversee the operation of the center?		
28.	Do the corporate bylaws include provisions that prohibit conflict of interest or the appearance of conflict of interest by board members, employees, consultants and those who provide services or furnish goods to the center?		

I certify that the information contained herein is accurate to the best of my knowledge.

Signature of Governing Board Chairperson

Date

Printed Name

FORM 4 - PAGE 1 OF 3

HEALTH CENTER AFFILIATION CHECKLIST

Organization: _____

1. Does your organization have, or propose to establish as part of the new access point application, any of the following arrangements with another organization? (NOTE: You must complete a checklist for each organization with which you have any of the following arrangements. Copies of all applicable documents must be included with the application.)

YES _____ *(Please check all that apply and proceed to question #2)*

NO _____ *(Go to question #2)*

- ☐ a) Contract for a substantial portion of the approved scope of project
- ☐ b) Memorandum of Understanding (MOU)/Agreement (MOA) for a substantial portion of the approved scope of project
- ☐ c) Contract with another organization or individual contract for core providers
- ☐ d) Contract with another organization for staffing health center
- ☐ e) Contract with another organization for the Chief Medical Officer (CMO) or Chief Financial Officer (CFO)
- ☐ f) Merger with another organization
- ☐ g) Parent Subsidiary Model arrangement
- ☐ h) Acquisition by another organization
- ☐ i) Establishment of a New Entity (e.g., Network corporation)

Name of Affiliating Organization: _____
Address: _____
_____

STAFFING

2) The center directly employs the CFO, CMO and the core staff of full-time primary care providers. **YES** ☐ **NO** ☐

3) The center directly employs all non-provider health center staff. **YES** ☐ **NO** ☐

If NO in question 2 or 3, the applicant must submit a request for a good cause exception. Please see PIN 98-24.

If NO in question 2 or 3, the CEO of the center retains the authority to select and dismiss staff assigned to the center. **YES** ☐ **NO** ☐

(Please cite reference document and page #.) _____

FORM 4 - Page 2 of 3
HEALTH CENTER AFFILIATION CHECKLIST

GOVERNANCE:

4) The Governing Board structure is in compliance with all requirements of section 330 of the Public Health Service Act. **YES** ☐ **NO** ☐

5) The Governing Board retains its full authorities, responsibilities and functions as prescribed in legislation/regulations/BPHC guidelines in regard to the following as identified below. **YES** ☐ **NO** ☐

	Reference Document	Page #
• board composition		
• executive committee function and composition		
• selection of board chairperson		
• selection of members		
• strategic planning		
• approval of the annual budget of the center		
• directly employs, selects/dismisses and evaluates the Chief Executive Officer (CEO)/Executive Director		
• adoption of policies and procedures for personnel and financial management		
• establishes center priorities		
• establishes eligibility requirements for partial payment of services		
• provides for an independent audit		
• evaluation of center activities		
• adoption of center's health care policies including scope and availability of services, location, hours of operation and quality of care audit procedures		
• establishes and maintains collaborative relationships with other health care providers in the service area		
• existence of a conflict of interest policy		

6) The arrangements presented in the affiliation agreements, as defined in Question 1, do not compromise the Board authorities or limit its legislative and regulatory mandated functions and responsibilities. *(Examples of compromising arrangements are: overriding approval or veto authority by another entity; dual majority requirements; super-majority requirements; or hiring and selection of the CEO).* **YES** ☐ **NO** ☐

FORM 4 - Page 3 of 3
HEALTH CENTER AFFILIATION CHECKLIST

CONTRACTING

7) The center has justified the performance of the work by a third party. **YES** ☐ **NO** ☐

(Please cite reference document and page #.) _____

8) Written affiliation agreement(s) comply with current Department of Health and Human Services (HHS) policies, i.e.: **YES** ☐ **NO** ☐

	Reference Document	Page #
• contains appropriate provisions around the activities to be performed, time, schedules, the policies and procedures to be followed in carrying out the agreement, and the maximum amount of money for which the grantee may become liable to the contractor under the agreement;		
• requires the contractor to maintain appropriate financial, program and property management systems and records in accordance with 45 CFR Part 74 and provides the center, HHS and the U.S. Comptroller General with access to such records;		
• requires the submission of financial and programmatic reports to the health center;		
• complies with Federal procurement standards or grant requirements including conflict of interest standards;		
• is subject to termination (with administrative, contractual and legal remedies) in the event of breach by the contractor.		

PLEASE INCLUDE LIST AND COPIES OF ALL RELEVANT AND CITED DOCUMENTS

I certify that the information contained herein is accurate to the best of my knowledge.

_____ _____
Signature of Governing Board Chairperson Date

_____
Printed Name

FORM 5

SERVICE SITES

Sites to be included in designation: (Tables 1 – 5 must be included for each site if possible.) Each site must be discussed in the narrative of the application.

Site # 1

Name: _____ Urban _____ Rural _____

Address:_____

_____(State)_____(Zip Code - 9 digit)

Phone:_____ Fax: _____

Site # 2

Name: _____ Urban _____ Rural _____

Address:_____

_____(State)_____(Zip Code - 9 digit)

Phone:_____ Fax: _____

Site # 3

Name: _____ Urban _____ Rural _____

Address:_____

_____(State)_____(Zip Code - 9 digit)

Phone:_____ Fax: _____

Add additional pages if necessary

FORM 6
CHANGE IN SCOPE ASSURANCES CHECKLIST

1. The Board has approved the change in scope.
   Yes No Documentation: Board minutes dated_____

2. The health center organization will continue to serve a Medically Underserved Area or Medically Underserved Population.
   Yes No

3. The change in scope will maintain or improve access to primary and/or preventive care for the underserved population.
   Yes No

4. The change in scope will maintain or improve the appropriateness of care, quality of care, and outcomes.
   Yes No

5. The health center will offer discounts to individuals with incomes below 200 percent of poverty level at the new site or for the new service, as applicable, and services will be provided regardless of patients' ability to pay.
   Yes No

6. The change in scope will not reduce the scope of primary care services offered to the target population or the total number of patients seen.
   Yes No

7. If added sites(s) have a different service area and/or target population than those already being served, board representation will be modified to represent users of those added or relocated sites.
   Yes No N/A

8. If added sites(s) are serving the same target population and/or the same service area as another FQHC, efforts have been made to collaborate on this specific change.
   Yes No N/A

9. The change in Scope will be fully compliant with section 330-related requirements and BPHC Program Expectations.
   Yes No N/A

*If you answered "No" to any of the assurances, briefly explain and discuss any relevant factors (attach additional pages, if necessary):

To the best of my knowledge, I assure that the above information is true and correct.

Signature: _____

Name: _____

Date: _____

TABLE 1
SERVICES OFFERED AND DELIVERY METHOD

Service Type	**Provided by Site** *(a)*	**By Referral or Contract Site Pays*** *(b)*	**By Referral or Contract No Pymt** *(c)*	**Not Provided** *(d)*
Medical Care Services				
1.) General Primary Medical Care *(other than below)*				
2.) Diagnostic Laboratory *(technical component)*				
3.) Diagnostic X-Ray *(technical component)*				
4.) Diagnostic Tests/Screenings *(professional comp.)*				
5.) Emergency Medical Services				
6.) Urgent Medical Care				
7.) 24-hour Coverage				
8.) Family Planning				
9.) HIV Testing				
10.) Immunizations				
11.) Following Hospitalized Patients				
Obstetrical and Gynecological Care				
12.) Gynecological Care				
13.) Prenatal Care				
14.) Antepartum Fetal Assessment				
15.) Ultrasound				
16.) Genetic Counseling and Testing				
17.) Amniocentesis				
18.) Labor and Delivery Professional Care				
19.) Postpartum Care				
Specialty Medical Care				
20.) Directly Observed TB Therapy				
21.) Other Specialty Care				
Dental Care Services				
22.) Dental Care – Preventive				
23.) Dental Care – Restorative				
24.) Dental Care – Emergency				

Service Type	**Provided by Site** *(a)*	**By Referral or Contract Site Pays *** *(b)*	**By Referral or Contract No Pymt** *(c)*	**Not Provided** *(d)*
Mental Health / Substance Abuse Services				
25.) Mental Health Treatment/Counseling				
26.) Developmental Screening				
27.) 24-hour Crisis Intervention/Counseling				
28.) Other Mental Health Services				
29.) Substance Abuse Treatment/Counseling				
30.) Other Substance Abuse Services				
Other Professional Services				
31.) Hearing Screening				
32.) Nutrition Services other than WIC				
33.) Occupational or Vocational Therapy				
34.) Physical Therapy				
35.) Pharmacy				
36.) Vision Screening				
37.) WIC Services				
Other Services				
38.) Case Management				
39.) Child Care *(during visit to Site)*				
40.) Discharge Planning				
41.) Eligibility Assistance				
42.) Employment/Educational Counseling				
43.) Environmental Hlth Risk Redctn *(via Detectn)*				
44.) Food Bank / Delivered Meals				
45.) Health Education				
46.) Housing Assistance				
47.) Interpretation/Translation Services				
48.) Nursing Home & Assisted Living Placement				
49.) Outreach				
50.) Transportation				
51.) Home Visiting				
52.) Parenting Education				
53.) Other (Specify:)				

* Copies of all contracts and agreements for referral and contracted services paid for by the site should be included in the application.

TABLE 2 – PART A USERS BY AGE AND GENDER			
Age Groups	Male Users	Female Users	Prenatal Users
1.) Under age 1			
2.) Ages 1-4			
3.) Ages 5-12			
4.) Ages 13-14			
5.) Ages 15-19			
6.) Ages 20-24			
7.) Ages 25-44			
8.) Ages 45-64			
9.) Ages 65-74			
10.) Ages 75-84			
11.) Ages 85 and over			
12.) Total Users			

TABLE 2 - PART B USERS BY RACE		
Race//Language	Number of Users	Number in Service Area
1.) Asian		
2.) American Indian or Alaska Native		
3.) Black or African American		
4.) Native Hawaiian or Other Pacific Islander		
5.) White		
7.) Unreported/Unknown		
8.) Total Users		
9.) Users Needing Interpretation Services		

TABLE 2 - PART B USERS BY ETHNICITY		
Ethnicity	Number of Users	Number in Service Area
1.) Hispanic or Latino		
2.) Unreported/Unknown		
3.) Total Users by Ethnicity		

TABLE 2 - PART C USERS BY INCOME LEVELS		
Percent of Poverty Level	Number of Users	Number in Service Area
1.) 100% and below		
2.) 101 - 200%		
3.) Above 200%		
4.) Unreported/Unknown		
5.) Total Users		

TABLE 2 - PART D USERS BY PAYMENT SOURCE		
Payment Sources	Number of Users	Percent of Users
1.) Medicare		
2.) Medicaid		
3.) Other Public Insurance		
4.) Other Third Parties		
5.) Self-Pay		
6.) Total Users		100%

TABLE 3
PROVIDERS

Personnel by Major Service Categories	Total FTEs	Status (Place "X" if Employed directly; "C" if by contract)	State License (Y/N)	Hospital Admitting Privileges (Y/N)	Board Certified (Y/N)	Total Encounters
Medical Providers (i.e., General Practitioners, Internists, Obstetrician/Gynecologists, Pediatricians, Other Physician Specialists, Nurse Practitioners, Certified Nurse Mid-Wives)						
Dental Providers (i.e., Dentists, Dental Hygienists)						
Mental Health & Substance Abuse Providers (i.e., Psychiatrists, other specialists)						

Add additional pages as necessary

TABLE 4

PATIENT SERVICE CHARGES, COLLECTIONS, AND SELF-PAY ADJUSTMENTS

Payment Source	Full Charges	Amount Collected	Adjustments
Medicare			
1.) Medicare Fee-for-Service			
2.) Medicare Capitated			
3.) Total Medicare *(Lines 1 and 2)*			
Medicaid			
4.) Medicaid Fee-for-Service			
5.) Medicaid Capitated			
6.) Total Medicaid *(Lines 4 and 5)*			
Other Public Payers			
7.) Other Public Fee-for-Service			
8.) Other Public Capitated			
9.) Total Other Public *(Lines 7 and 8)*			
Other Third Party			
10.) Other Third Party Fee-for-Service			
11.) Other Third Party Capitated			
12.) Total Other Third Party *(Lines 10 and 11)*			
Self-Pay			
13.) Self-Pay			
14.) Total *(Lines 3, 6, 9, 12, and 13)*			
Self-Pay Adjustment Type			
15.) Self-Pay Sliding Fee Adjustments			
16.) Other Self-Pay Adjustments (Self-Pay Bad Debt and Charity Care)			
17.) Total Self-Pay Adjustments *(Lines 15 and 16)*			

TABLE 5

CURRENT BOARD MEMBER CHARACTERISTICS

Total Number/Range of Members Established in By-Laws or
Articles of Incorporation:_____ Positions Filled: _____ as of_____/_____/_____

Name	Board Office Held	User Status (Y/N)	Area of Expertise	Live (L) or Work (W) in Service Area	Years of Continued Board Service
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Indicate # Board Members by Sex: F = _____ M = _____
Indicate # Board Members by Race/Ethnicity:
White: _____ Hispanic or Latino: _____
Black/African American: _____ Asian/Pacific Islander: _____
American Indian & Alaska Native: _____

Notes: - Use additional pages if necessary.
- If board member is not a user (i.e., "N" in column 3) indicate if that member derives more than 10% of his/her income from the health care industry (e.g., “N > 10%” or “N < 10%”).
- Migrant/Seasonal Farmworkers should be noted under Area of Expertise, and should reflect a reasonable proportion to their share of the user population.