

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Health Resources and Services Administration**

**FORM 3 - INCOME ANALYSIS FORM  
YEAR 1  YEAR 2 (Existing Grantees only)   
FOR HRSA USE ONLY**

Grantee Name

Grant Number

Application Tracking Number

**Payor Category  
Number Of  
Visits**

**Average**

**Charge**

**Per Visit  
Gross  
Charges**

**(a \* b)=(c)**

**Average Adjustment Per Visit  
Net Charges**

**(Amount Billed)**

**[c-(a\*d)]**

**Collection Rate (%)**

**Projected Income  
(e \* f)**

**Actual Accrued Income Past 12 Months**

(a)

(b)

(c)

(d)

(e)

(f)

(g)

(h)

1a. Medicaid: Medical

1b. Medicaid: EPSDT (if different from medical rate)

1c. Medicaid: Dental

1d. Medicaid: BH/SA

1e. Medicaid: other fee for Service

**1. Subtotal: Medicaid**

2a. Medicare: all inclusive FQHC rate

2b. Medicare: other Fee for Service

**2. Subtotal: Medicare**

3a. Private Insurance (Medical)

3b. Private Insurance (Dental)

3c. Private Insurance (BH/SA)

**3. Subtotal: Private**

4a. Self-Pay: 100% charge, no discount (Medical)

4b. Self-Pay: 0% - 99% of charge, Sliding discounts including full discount (Medical)

4c. Self-Pay: 100% charge, no discount (Dental)

4d. Self-Pay: 0% - 99% of charge, Sliding discounts including full discount (Dental)

4e. Self-Pay: 100% charge, no discount (BH/SA)

4f. Self-Pay: 0% - 99% of charge, sliding discount including full discount, (BH/SA)

**4.**

**Subtotal: Self Pay**

**5.**

**Subtotal: Other Public**

**6.**

**TOTAL FEE FOR SERVICE**

**TYPE OF PAYOR**  
**Number of Member Months**  
**(a)**  
**Rate Per Member Month**  
**(b)**  
**Risk Pool Adjustment**  
**(c)**  
**FQHC and Other Adjustments**  
**(d)**  
**Projected Gross Income**  
**(e)**

7a. Medicaid:

7b. Medicare

7c. Commercial

7d. Other Public

7.

**TOTAL CAPITATED MANAGED CARE**

8.

**Managed Care Charges**

**(a) Visits**  
**(b) Average Charge Per Visit**  
**(c) Total Charges**

**TOTAL PROGRAM INCOME [line 6, column g + line 7, column e] Matches line7 "Program Income" of SF 424A**

**Total Other Income by Source**

9. Applicant

10. State Funds

11. Local Funds

Other Support

12a. Other Federal Grants

12b. Contributions and Fundraising

12c. Foundation Grants

12d. Other \_\_\_\_\_ (please list)

**12.**

**Subtotal Other Support**

**13.**

**TOTAL OTHER INCOME**

**TOTAL NON-FEDERAL SHARE**

**[line6, row (g) + line 7, row (e) + line 13] Matches line 5, column f, "Non Federal" Totals of SF 424A**

**Comments/Explanatory Notes for Income Analysis Form (if applicable):**



