OMB No.: 0915-0285. Expiration Date: 08/31/2010

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| **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 | | |  | |
| **PART 1: NON FEDERAL SHARE, PROGRAM INCOME** | | | | | | | | | | | | | | | | | | | |
| **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) |
| **PROJECTED FEE FOR SERVICE INCOME** | | | | | | | | | | | | | | | | | | | |
| 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** | | |  |  | |  | | |  | | |  | |  | | |  | | |  |
| **PROJECTED CAPITATED MANAGED CARE INCOME** | | | | | | | | | | | | | | | | | | | |
| **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** | | | | | | | | |  | | | | | | | |  | | |
| **PART 2: NON-FEDERAL SHARE, OTHER INCOME** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | **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):** | | | | | | | | | | | | | | | | | | |