HEALTH CENTER PROGRAM FORMS - INSTRUCTIONS

INSTRUCTIONS: Form 1A: General Information Worksheet

Complete Form 1A based on the proposed project.

1. APPLICANT INFORMATION

- Complete all relevant information that is not pre-populated.
- Grant numbers are only applicable for current grantees.
- Use the Fiscal Year End Date field to note the month and day in which the applicant organization's fiscal year ends (e.g., June 30) to help HRSA know when to expect your audit submission.
- Applicants may check only one category in the Business Entity section. If an applicant is a Tribal or Urban Indian entity and also meets the definition for a public or private entity, then the applicant should select the Tribal or Urban Indian category.
- Applicants may select more than one category for the Organization Type section.

2. PROPOSED SERVICE AREA

2a. Target Population and Service Area Designation

Population Type:

- Population types for which funding is requested will be pre-populated based on information provided in Section A (Budget Summary) of the SF-424A.
- If the population types are not pre-populated or if changes are required, make them on the SF-424A using the **Change Sub-Program** link.

Service Area Designation:

- Applicants seeking CHC funding MUST provide **Medically Underserved Area (MUA)** and/or **Medically Underserved Population (MUP)** designation information.
- Select the MUA **and/or** MUP designations that best describe the proposed service area. **For inquiries regarding MUAs or MUPs, call 1-888-275-4772 (option 2) or** contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816. For additional information, visit the Shortage Designation Web site at http://bhpr.hrsa.gov/shortage.

2b. Service Area Type:

Select the type (rural, urban, or sparsely populated) that describes the majority of the target population. If sparsely populated is selected, provide the number of people per square mile (must be 7 or less).

2c. Target Population and Provider Information: For all portions of this section:

- Applicants with more than one service site must report aggregate data for all sites in the proposed project.

- **A current grantee applying to continue serving its current service area may report current numbers that are consistent with the most recent data submitted in UDS.** If UDS data does not accurately reflect current numbers (due to additional funding received, change in scope, or shifting service area characteristics such as influx of new populations), please indicate the accurate current data.
- A new applicant or current grantee applying to serve a new service area should report current numbers based on services the applicant is currently providing in the proposed service area (report annualized data) or, if not currently operational in the service area, list the current numbers as zero.
- Data should be consistent across all tables.

Service Area and Target Population:
Provide the estimated number of individuals currently composing the service area and target population. ***Note:*** Target population numbers must be less than or equal to service area numbers since the target population is generally a subset of the service area population.

Provider FTEs by Type:

1. Provide a count of current provider full-time equivalents (FTEs), paid and voluntary, by staff type. Current grantees should ensure that the FTEs reported are consistent with the reporting of FTEs in UDS (see the 2012 UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics/reporting). **Include only provider FTEs** (e.g., physician, nurse practitioner, certified nurse midwife, dentist, dental hygienist, psychiatrist, psychologist, social worker, case manager, patient educator, outreach worker).

2. Project the number of provider FTEs anticipated by the end of the three-year project period based on maintaining the current level of funding.

   Do **not** report provider FTEs providing vision or pharmacy services or functioning outside the proposed scope of project.

Patients and Visits by Service Type:

1. Provide the number of current patients and visits within each service type category: medical, dental, behavioral health, substance abuse, and enabling. Within each category, an individual can only be counted once as a patient. An individual who receives multiple types of services should be counted once for each service type (e.g., once for medical and once for dental).

2. Project the number of patients and visits anticipated within each service type category by the end of the three-year project period at the current level of funding. ***Note*: HRSA does not expect the number of patients and visits to decline over time.**
   - Applicant must propose to serve at least an equivalent number of patients by the end of the three-year project period as listed in the SAAT (see http://www.hrsa.gov/grants/apply/assistance/sac).
   - Current grantees applying to continue serving the current service area must project a realistic number of patients to be served at the end of the three-year project period, considering all additional/supplemental funding received that should impact this projection (e.g., NAP satellite grant, Capital Development Building Capacity grant).

3. To maintain consistency with the patients and visits reported in UDS, do not report patients and visits for vision services or services outside the proposed scope of project.

When providing the count of patients and visits within each service type category, note the following (see the 2012 UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics/reporting for detailed information):

- A visit is a documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services rendered must be paid for by the applicant organization and documented in the patient's record.
- A patient is an individual who had at least one visit in the previous year.
- Since a patient must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.

Unduplicated Patients and Visits by Population Type:

1. Provide the current number of patients and visits within each population type category: general community, migratory and seasonal agricultural workers, public housing residents, and homeless persons. Within each category, an individual can only be counted once as a patient.
   Note: The population types in this section of the form do NOT refer only to the requested funding for special populations (i.e., CHC, MHC, HCH, and/or PHPC). An applicant applying for only CHC funding (general underserved community) may still have patients/visits reported in the other population type categories.

2. Follow instructions 2-3 under ***Patients and Visits by Service Type***.

INSTRUCTIONS: Form 1B: BPHC Funding Request Summary

Form 1B collects the funding request for the NAP application. The maximum amount of funding in Year 1 is $650,000; any one-time funding requested for equipment or minor alteration/renovation (up to $150,000) is included in this amount. Applicants can request up to $650,000 for operations in Year 2.

For the Year 1 operational funding column, enter operational budget information by funding category (CHC, MHC, HCH, and/or PHPC) and then enter any one-time funds requested for minor alteration/renovation, which may also include equipment. No more than $150,000 can be requested for one-time funds for minor alteration/renovation and/or equipment. Only the types of health center programs identified in the Budget Summary (Section A) of the SF-424A will be available in Form 1B. The budget for Year 2 on Form 1B will be pre-populated from data provided by the applicant in Federal Resources (Section E) of the SF-424A.
Applicants will not be allowed to modify the pre-populated data on this form. If changes are required, applicants must modify the appropriate section of the SF-424A. **A link to the SF-424A will be provided for navigation to the appropriate budget sections.**
Applicants requesting one-time funding for equipment and/or minor alteration/renovation must indicate if the one-time funds are for: 1) equipment only; 2) minor alteration/renovation with equipment; or 3) minor alteration/renovation without equipment. Applicants requesting one-time funding for equipment only or minor alteration/renovation with equipment must complete an equipment list. Equipment is considered to be loose, moveable items that have a useful life of more than one year. See Appendix D for detailed instructions on equipment requirements.
Applicants that request one-time funding for minor alteration/renovation (with or without equipment) must complete the Alteration/Renovation (A/R) Project Cover Page, Other Requirements for Sites Form, budget justification for the minor alteration/renovation project, Environmental Information and Documentation (EID) Checklist, and architectural drawings of the proposed alteration/renovation. If the property is leased, the applicant must attach a Landlord Letter of Consent. See Appendix D for detailed instructions on alteration/renovation requirements.

INSTRUCTIONS: Form 1C: Documents on File

Provide the date that each document listed was last reviewed and, if appropriate, revised. This form provides a summary of documents that support the implementation of Health Center Program requirements and key areas of health center operations. The requirements numbers listed on the form correspond to the list of Health Center Program requirements found at http://bphc.hrsa.gov/about/requirements; reference this list for more detailed information about each requirement. Please note that Form 1C is not intended to provide an exhaustive list of all types of health center documents (e.g., policies and procedures, protocols, legal documents).

All documents noted on Form 1C should be maintained and updated by key management staff and, as appropriate, approved and monitored by the health center's governing board. Keep these documents on file, making them available to HRSA **upon request** within 3-5 business days. **DO NOT** submit these documents with the application.

Note: Beyond Health Center Program requirements, other federal and state requirements may apply to health centers. Applicants are encouraged to seek legal advice from their own counsel to ensure that organizational documents accurately reflect all applicable requirements.

Under "Malpractice Coverage Plan" in the "Services" section, new applicants should indicate that malpractice coverage will be in effect as soon as services become operational. Once funded, new grantees can apply for FTCA coverage upon meeting the FTCA eligibility requirements, but they must maintain malpractice coverage in the interim. FTCA participation is not guaranteed. Funded health centers who opt out of FTCA (e.g., Public Entity-Health Centers) must maintain malpractice insurance coverage at all times.

INSTRUCTIONS: Form 2: Staffing Profile

Report personnel salaries supported by the total budget and federal request (i.e., requested Health Center Program section 330 funds) for the **first budget year** of the proposed project, including those that are part of an indirect cost rate. Include only Health Center Program staff for the entire scope of project (i.e., all sites).

- Salaries in categories representing multiple positions (e.g., LPN, RN) must be averaged. To calculate the average annual salary, sum the salaries within the category and divide that amount by the total number of FTEs.
- Do not report portions of salaries that support activities outside the proposed scope of project.
- Do not include contracted staff or volunteers on this form.

Note: The amount for total salaries (this figure will auto-calculate in EHB) may not match the amount allocated for the Personnel cost category of the SF-424A due to the inclusion of salaries charged to indirect costs on the Staffing Profile.

INSTRUCTIONS: Form 3: Income Analysis

FORM 3 – INCOME ANALYSIS (REQUIRED)

Form 3 will show the projected patient services and other income from all sources (other than the section 330 federal grant) for the first year of the proposed project period. The sum of the requested section 330 federal grant and the projected total income on Form 3 must equal the total budget as presented on the SF-424A. Form 3 income is divided into two parts: (1) program income (known as patient service revenue) and (2) all other income.

Patient service revenue is revenue that is directly tied to the provision of services to the health center's patients. Services to patients that are reimbursed by health insurance plans, managed care organizations (MCOs), categorical grant programs (e.g., family planning), employers, and health provider organizations are classified as patient service revenue. Reimbursements may be based upon visits, procedures, member months, enrollees, the achievement of performance goals, or other service related measures. All income not classifiable as program income is classified as other income.

Part 1: Program Income

The program income section groups billable visits and income into the same five payer groupings used in the Uniform Data System (UDS – see the UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics for details). All patient service revenue is reported in this section of the form. This includes all income from medical, dental, behavioral health, substance abuse, other professional, vision, and other clinical services as well as income from ancillary services such as laboratory, pharmacy, and imaging services.

Patient service revenue includes income earned from Medicaid and Medicare rate settlements and wrap reconciliations which are designed to make up the difference between the approved FQHC rate and the interim amounts received. It includes risk pool and other incentive income as well as primary care case management fees.

Patient service revenue associated with sites or services not in the approved scope of project including those pending approval is to be excluded.

Column (a) Patients: These are the projected number of unduplicated patients classified by payer based upon the patient's ***primary medical insurance***. The primary insurance is the payer that is billed first. The patients are classified in the same way as found in UDS Table 4, lines 7 – 12. This column should not include patients who are only seen for non-

billable or enabling service visits. Examples for determining where to count patients include:

- A crossover patient with Medicare and Medicaid coverage is to be classified as a Medicare patient on line 2.
- A Medicaid patient with no dental coverage who is only seen for dental services is to be classified as a Medicaid patient on line 1 with a self-pay visit on line 5.

Column (b): Billable Visits: These include all billable/reimbursable visits.[1] There may be other exclusions or additions which, if significant, should be noted in the Comment/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column (see ancillary instructions below).

Column (c): Income per Visit: This is the quotient arrived at by dividing projected income by billable visits.

Column (d): Projected Income: This is the projected accrued net revenue, including an allowance for bad debt from all patient services for each pay grouping in the first year of the proposed project period.

Column (e): Prior FY Income Mo/Yr: This is the income data from the most recent fiscal year, which will be either interim statement data or audit data. The fiscal year was specified because the interim data can eventually be compared to actual audit data.

(Lines 1 – 5) Payer Categories: There are five payer categories including Medicaid, Medicare, Other Public, Private, and Self-Pay, reflecting the five payer groupings used in Table 9d of the UDS. The UDS instructions are to be used to define each payer category (see the UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics).

Visits are reported on the line of the primary payer (payer billed first). The income is classified by the payer groupings where the income is earned. When a single visit involves more than one payer, attribute that portion of the visit income to the payer group from which it is earned. In cases where there are deductibles and co-payments to be paid by the patient, that income is to be shown on the self-pay line. If the co-payment is to be paid by another payer, that income should be shown on the other payer's line. It is acceptable if the applicant cannot accurately associate the income to secondary and subsequent sources.

All service income is to be classified by payer, including pharmacy and other ancillary service revenue. In the event the applicant does not normally classify the projected ancillary or other service revenue by payer category,

[1] These visits will correspond closely with the visits reported on the UDS Table 5, excluding enabling service visits.

the projected income is to be allocated by payer group using a reasonable allocation method, such as the proportion of medical visits or charges. The method used should be noted in the Comments/Explanatory Notes section at the bottom of the form.

(Line 1) Medicaid: This includes income from FQHC cost reimbursement; capitated managed care; fee-for-service managed care; Early Periodic Screening, Diagnosis, and Treatment (EPSDT); Children's Health Insurance Program (CHIP); and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from FQHC cost reimbursement reconciliations, wrap payments, incentives, and primary care case management income.

(Line 2) Medicare: This includes income from the FQHC cost reimbursement, capitated managed care, fee-for-service managed care, Medicare Advantage plans, and other reimbursement arrangements administered either directly by Medicare or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from the FQHC cost reimbursement, risk pool distributions, performance incentives, and care management fee income from the ACA Medicare Demonstration Program.

(Line 3) Other Public: This includes income from federal, state, or local government programs earned for providing services that is not reported elsewhere. A CHIP operated independently from the Medicaid program is an example of other public insurance. Other public also includes income from categorical grant programs when the grant income is earned by providing services. Examples of these include CDC's National Breast and Cervical Cancer Early Detection Program and the Title X Family Planning Program.

(Line 4) Private: This includes income from private insurance plans, managed care plans, insurance plans from the ACA marketplaces/exchanges, and other private contracts for service. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, and service contracts with employers. Income from health benefit plans which are earned by government employees, retirees, and dependents, such as TRICARE, the federal employee health benefits program, state employee health insurance benefit programs, teacher health insurance, and similar plans are to be classified as private insurance. Private insurance is earned or paid for by the beneficiary and other public insurance is unearned or based upon meeting the plan's eligibility criteria.

(Line 5) Self-Pay: This includes income from patients, including full-pay self-pay and sliding fee patients, as well as the portion of the visit income for

which an insured patient is personally responsible.

(Line 6)Total: This is the sum of lines 1-5.

Part 2: Other Income
This section includes all income other than the patient service revenue shown in Part 1 (exclusive of the section 330 SAC grant request). It includes other federal, state, local, and other income. It is income that is earned but not directly tied to providing visits, procedures, or other specific services. Income is to be classified on the lines below based upon the source from whom the revenue is received. Income from services provided to non-health center patients (patients of an entity with which the health center is contracting) either in-house or under contract with another entity such as a hospital, nursing home or other health center is to be reported in Part 2: Other Income (see examples below). This would include income from in-house retail pharmacy sales to individuals who are not patients of the health center. See Lines 9 and 10 for examples of services provided to non-health center patients (patients of an entity with which the health center is contracting).

(Line 7) Other Federal: This is income from federal grants where the SAC applicant is the recipient of a Notice of Award from a federal agency. It does not include the section 330 SAC grant request or federal funds awarded through intermediaries (see Line 9 below). It includes grants from federal sources such as the Centers for Disease Control (CDC), Housing and Urban Development (HUD), Centers for Medicaid and Medicare Services (CMS), and others.

(Line 8) State Government: This is income from state government grants, contracts, and programs, including uncompensated care grants; emergency preparedness grants; mortgage assistance; capital improvement grants; school health grants; Women, Infants, and Children (WIC); immunization grants; and similar awards.

(Line 9) Local Government: This is income from local government grants, contracts, and programs, including indigent care grants, community development block grants, capital improvement project grants, and similar awards. For example: (1) a health center that contracts with the local Department of Health to provide services to the Department’s patients is to report all the income earned under this contract on this line, and (2) Ryan White Part A funds are federal funds awarded to municipalities who in turn make awards to provider organizations, so Ryan White Part A grants would be classified as income earned from a local government and be shown on this line.

(Line 10) Private Grants/Contracts: This is income from private sources

such foundations, non-profit entities, hospitals, nursing homes, drug companies, employers, other health centers, and similar entities. For example, a health center operating a 340B pharmacy in part for its own patients and in part as a contractor to another health center is to report the pharmacy income for its own patients in Part 1 and the income from the contracted health center on this line.

(Line 11) Contributions: This is income from private entities and individual donors which may be the result of fund raising.

(Line 12) Other: This is incidental income not reported elsewhere and includes items such as interest income, patient record fees, vending machine income, dues, and rental income. Applicants typically have at least some Other income to report on Line 12.

(Line 13) Applicant (Retained Earnings): This is the amount of funds needed from the applicant's retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why the applicant funds are needed and provide an assurance that the reserves are sufficient to meet the amount budgeted and that the remaining reserves are adequate to support normal operations.

(Line 14) Total Other: This is the sum of lines 7 – 13.

(Line 15) Total Non-Federal: This is the sum of Lines 6 and 14 and is the total non-federal (non-section 330) income. When this value is added to the section 330 grant, the total equals the applicant's total budget for the first year of the proposed project period.

INSTRUCTIONS: Form 4: Community Characteristics

The Community Characteristics form reports service area and target population data for the entire scope of the project for the most recent period for which data are available. Information provided regarding race and ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements and will not be used as an awarding factor.

Service area data must be specific to the proposed project and include the total number of persons for each characteristic (percentages will automatically calculate in EHB). If information for the service area is not available, extrapolate data from the U.S. Census Bureau, local planning agencies, health departments, and other local, state, and national data sources. **Estimates are acceptable.**

Target population data is most often a subset of service area data and must include the number of persons for each characteristic within the target population (percentages will automatically calculate in EHB). ***Patient data should not be used to report target population data since patients are typically a subset of all individuals targeted for service.*** Estimates are acceptable.

If the target population includes a large number of transient individuals (e.g., the county has an influx of migratory and seasonal agricultural workers during the summer months) that are not included in the dataset used for service area data (e.g., census data), the applicant should adjust the service area numbers accordingly to ensure that the target population numbers are always less than or equal to the service area numbers.

Note: The total numbers for the first four sections of this form (i.e., Race, Hispanic or Latino Identity, Income as a Percent of Poverty Level, and Primary Third Party Payment Source) **must match**. These total numbers should also be consistent with the service area and target population totals reported on Form 1A. The Special Populations section of Form 4 does not have a row for total numbers; individuals that represent multiple special population categories should be counted in all applicable categories.

Guidelines for Reporting Race

- All individuals must be classified in one of the racial categories, including individuals who also consider themselves Hispanic or Latino. If the data source does not separately classify Hispanic or Latino individuals by race, report them as Unreported/Declined to Report.
- Utilize the following race definitions:
  - Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
  - Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, Palau, Truk, Yap, or other Pacific Islands in Micronesia, Melanesia or Polynesia.
  - Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

  - American Indian/Alaska Native – Persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
  - More Than One Race – Patient who chooses 2 or more races.

Guidelines for Reporting Hispanic or Latino Identity

- If ethnicity is unknown, report individuals as Unreported/Declined to Report.
- Utilize the following ethnicity definition: Hispanic or Latino – Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Note:

- Applicants compiling data from multiple data sources may find that the total numbers vary across sources. Such applicants should make adjustments as needed to ensure that the total numbers for the first four sections of this form match. When completing Form 4, please note that all information provided regarding race and/or ethnicity will be used only to ensure compliance with statutory and regulatory Governing Board requirements. Data on race and/or ethnicity collected on this form will not be used as an awarding factor.

INSTRUCTIONS: Form 5A: Services Provided

Identify the services that will be available through the proposed new access point(s) and how the services will be provided (i.e., Applicant, Formal Written Contract/Agreement (Applicant Pays for Service), Formal Written Referral Arrangement/Agreement). The new access point(s) must provide the required services either directly onsite or through established agreements/arrangements without regard to ability to pay and on a sliding fee discount schedule.

Established agreements must be summarized in Attachment 7 and, if they constitute a significant portion of the applicants scope of project, agreements/contracts must be noted on Form 8.

Information presented on Form 5A will be used by HRSA to determine the scope of project for the NAP grant. Only the services included on Form 5A will be considered to be in the approved scope of project. Services described or detailed in other portions of the application (e.g., narratives, attachments) are not considered to be included in the approved scope of project if the application is funded.

NOTE: Specialty services and Other Services may not be included in an applicant’s proposed scope of project at the time of NAP submission. However, specialty services may be added to the scope of project through the Change in Scope process after a NAP grant has been awarded. Refer to PIN 2009-02: Specialty Services and Health Centers’ Scope of Project available at http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin200902.pdf for more information.

INSTRUCTIONS: Form 5B: Service Sites

Identify the NAP site(s). Provide the required data for each proposed new access point that meets the definition of a service site. Refer to PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes available at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html for more information on defining service sites and for special instructions for recording mobile, intermittent, or other site types. Information presented on Form 5B will be used by HRSA to determine the scope of project for the NAP grant. Only the service sites included on Form 5B will be considered to be in the approved scope of project. Service sites described or detailed in other portions of the application (e.g., narratives, attachments) are not considered to be included in the approved scope of project if the application is funded. On each Form 5B, applicants should include the zip codes for the area served by the site. The zip code of the site address must be listed in the service area zip codes on Form 5B. The applicant's entire service area (as described on Form 4) should be represented by the consolidation of all zip codes across all proposed service sites (all 5B forms). The zip codes listed on Form 5B will be used to calculate the Unserved, High Poverty and Sparsely Populated Priority Points.

NOTE: At least one proposed service site must be a full-time (operational 40 hours or more per week), permanent service delivery site (with the exception of proposed NAP projects serving only migratory and seasonal agricultural workers, which may propose a full-time, seasonal service delivery site). Subsequent service sites may be administrative, part-time, seasonal, etc.

NOTE: In HRSA EHB, applicants will have to state if the proposed site is a Domestic Violence site (e.g., emergency shelter). If so, applicants will not provide a street address to protect the confidentiality of the precise location.

INSTRUCTIONS: **<u>Form 5C: Other Activities/Locations</u>**

Provide requested data for other activities/locations (e.g., home visits, health fairs). List only the activities/locations that: 1) do not meet the definition of a service site; 2) are conducted on an irregular timeframe/schedule; and/or 3) offer a limited activity from within the full complement of health center activities included within the scope of project. NAP service site(s) should not be listed. Refer to PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes (available at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html) for more details. Information presented on Form 5C will be used by HRSA to determine the scope of project for the NAP grant. Note that Form 5C will only add activities/locations to the scope of the project that meet the criteria listed above. Any additional activities/locations described or detailed in other portions of the application (e.g., narratives, attachments) that are not listed on Form 5C are not considered to be included in the approved scope of project if the application is funded.

INSTRUCTIONS: Form 6A: Current Board Member Characteristics

List all current board members and provide the requested details.

- Public entities with co-applicant health center governing boards must list the co-applicant board members.
- Applicants requesting a waiver of the 51% patient majority requirement must list the health center's board members, not the members of any advisory councils.
- List the current board office held for each board member, if applicable (e.g., Chair, Treasurer).
- List each board member's area of expertise (e.g., finance, education, nursing).
- Indicate if each board member is a health center patient.
- Indicate if each board member lives and/or works in the service area.
- List how long each individual has been on the board.
- Indicate if each board member is a representative of a special population (i.e., homeless, agricultural, public housing).

NOTE: Indian tribes or tribal, Indian, or urban Indian organizations are not required to complete this form and can click Save and Continue to mark the form complete without providing the requested information. However, such applicants may include information on this form as desired.

INSTRUCTIONS: Form 6B: Request for Waiver of Governance Requirements

Only applicants requesting funding to ***ONLY*** serve migratory and seasonal agricultural workers (section 330(g)), people experiencing homelessness (section 330 (h)), and/or residents of public housing (section 330(i)) are eligible to request a waiver.

- An applicant that currently receives or is applying to receive CHC (section 330(e)) funding is not eligible for a waiver. Form 6B will not permit the applicant to enter information on this form.
- Indian tribes or tribal, Indian, or urban Indian groups are not required to complete this form. Form 6B will not permit the applicant to enter information on this form.
- Current health center program grantees with an existing waiver must reapply for governance waiver approval as part of the NAP application.

Eligible applicants may request a waiver of the patient majority board composition and/or board monthly meetings. When completing Form 6B, applicants requesting a waiver must briefly justify why the applicant cannot meet the statutory requirements requested to be waived and summarize the alternative strategies that will assure consumer/patient participation/input (if board is not 51 percent consumers/patients) and/or regular oversight in the direction and ongoing governance of the organization (if no monthly meetings). The text boxes are limited to 500 characters in this section.

INSTRUCTIONS: Form 8: Health Center Agreements

Complete Part I, indicating whether current or proposed agreements constitute a substantial portion of the proposed scope of project. If a proposed site is operated by a sub-recipient or contractor, as identified in Form 5B, the answer must be yes. If **Yes**, indicate the number of each type in the appropriate field. If **No**, skip to the Governance Checklist in Part II.

Complete the Governance Checklist. If the response to any of the Governance Checklist items is **No**, the response to the question regarding agreements/arrangements affecting the governing board's composition, authorities, functions, or responsibilities must be **Yes**, and the number of such agreements/arrangements must be indicated.

Part III should be completed only by applicants that responded **Yes** to Part I.1 or Part II.2. In Part III, use the Organization Agreement Details section to provide the contact information for each organization (up to 10) with which an agreement/arrangement either (1) constitutes a substantial portion of the proposed scope of project (as described in Part I) or (2) impacts the governing board's composition, authorities, functions, or responsibilities (as described in Part II). If a proposed site is operated by a sub-recipient or contractor, as identified in Form 5B, the applicant must attach the agreement or contract. **Upload each agreement/arrangement** (up to 5 for each organization) in full. Agreements/arrangements that exceed these limits should be included in Attachment 15. As a reminder, a summary of all sub-recipient arrangements, contracts, and affiliation agreements must be included in Attachment 7.

Note: Items attached to Form 8 will **not** count against the page limit. Items included in Attachment 15 **will** count against the page limit.

INSTRUCTIONS: Form 9: Need for Assistance Worksheet

The worksheet is presented in three sections: Core Barriers, Core Health Indicators, and Other Health and Access Indicators.

Please note that the following changes have been made to the worksheet since the FY 2011 NAP FOA:

- Core Barrier, "Percent of Population below 200 Percent Federal Poverty Level (FPL)": Applicants are required to report the percentage of the **service area** population below 200 percent of the FPL. Only applicants applying to serve special populations exclusively (MHC, HCH, and/or PHPC) may use this barrier to report the percentage of the target population in poverty. See the Data Reporting Guidelines Table for additional clarification.

- Core Barrier, "Percent of Population Uninsured": Applicants are required to report the percentage of the **service area** population that is uninsured. Only applicants applying to serve special populations exclusively (MHC, HCH, and/or PHPC) may use this barrier to report the percentage of the target population that is uninsured. See the Data Reporting Guidelines Table for additional clarification.

- The scaling of the core barriers has been changed so that points are awarded only for indicators for which the applicant scores higher than the national median.

- Indicators in Section 2: "Core Health Indicators" and Section 3: "Other Health and Access Indicators" have been added, removed, or modified to include the most current indicators for which data are readily available at the sub-state level. In addition, corresponding benchmarks for each indicator have been updated.

To ensure data consistency and validity, applicants must adhere to the following instructions when completing the form. Applicants will be asked to verify the validity of NFA data on the Forms Summary Page.

GENERAL INSTRUCTIONS

Only one NFA Worksheet will be submitted per applicant regardless of the number of new access points proposed.

- **New start applicants** must complete the NFA Worksheet based on the entire proposed scope of project.
- **Satellite applicants** must complete the NFA Worksheet based on the **proposed new access points ONLY.**

If an applicant proposes **multiple sites, populations, and/or service areas**, the NFA Worksheet responses should represent the total combined population for all sites. Data values for different sites/populations/service areas should be combined using population weighting described below and in the Data Resource Guide located at http://www.hrsa.gov/grants/apply/assistance/NAP. **Only one response may be submitted for each barrier or health indicator.**

Guidelines for Completing the NFA Worksheet:

- If no response is provided for a particular barrier or health indicator, or if the data source and date for the response are not provided, no points will be awarded for that barrier or health indicator.
- All responses must be expressed as a finite number (e.g., 212.5) and cannot be presented as a range (e.g., 31-35).
- The data sources used should be those identified in the Data Resource Guide. Alternative sources must have the same parameters for each indicator as the source in the Data Resource Guide. For example, any source used for diabetes prevalence must provide age-adjusted rates. See the Data Resource Guide for more information.
- Responses to all indicators must be expressed in the same format/unit of analysis identified on the worksheet (e.g., a mortality ratio cannot be used to provide a response to age-adjusted death rate). The following table provides examples of the unit and format of responses:

Format/Unit of Analysis	Example Format	Example Description
Percent	25%	25 percent of target population is uninsured
Prevalence expressed as a percent	8.5%	8.5 percent of population has asthma
Prevalence expressed as a rate	9 per 1,000 population	9 of every 1,000 infants die
Rate	50 per 100,000	50 hospital admissions for hypertension per 100,000 population
Ratio	3,000:1	3,000 people per every 1 primary care physician

Note: When entering rate or ratio data in EHB, provide only the variable number, not the entire ratio (i.e., 3,000:1 would be entered as 3,000).

POPULATION BASIS FOR DATA

Provide data for three of four Core Barriers in Section 1, one Core Health Indicator for each of six categories in Section 2, and two of the 13 Other Health and Access Indicators in Section 3. All responses, with the exception of those for Core Barriers B, C, and D, should be based on data for the target population within the proposed service area to the extent appropriate and possible per the following table.

Data Reporting Guidelines Table

Applicants should report data for the NFA Worksheet measures based on the population groups specified in the table below. In cases where data are not available for the specific service area or target population, applicants are encouraged to explore the use of extrapolation techniques to make valid estimates using data available for related areas and population groups. See the Data Resource Guide for further information on the use of extrapolation. Where data are not directly available and extrapolation is not feasible, applicants should use the best available data describing the area or population to be served. In such a case, applicants must explain the data provided.

Form Sections	General Community 330(e) ONLY	General Community 330(e) plus one or more Special Populations (330(g), (h), and/or (i))	One or more Special Populations 330(g), (h), and/or (i)) ONLY
Core Barrier A: Population to One FTE Primary Care Physician	Target Population	Target Population	Target Population
Core Barrier B: Percent of Population below 200% of Poverty	Service Area	Service Area	Target Population
Core Barrier C: Percent of Population Uninsured	Service Area	Service Area	Target Population
Core Barrier D: Distance or Travel Time to Nearest Primary Care Provider Accepting New Medicaid and Uninsured Patients	N/A	N/A	N/A
Core Health Indicator Reporting	Target Population	Target Population	Target Population
Other Health and Access Indicator Reporting	Target Population	Target Population	Target Population

Note: Core Barrier D: Distance or Travel Time to Nearest Primary Care Physician Accepting New Medicaid and Uninsured Patients is not calculated based on population. For Core Barrier D, distance/time is measured from the proposed site to the nearest physician accepting new Medicaid and uninsured patients.

Extrapolation

For detailed instructions for each indicator and information on using and documenting acceptable extrapolation techniques, refer to the Data Resource Guide (available at http://www.hrsa.gov/grants/apply/assistance/NAP). Extrapolation to the service area, target population, or both may be needed. The need for extrapolation will depend on:

- Which Core Barrier or Health Indicator is being reported
- Whether the applicant is targeting the entire population within the service area or a specific subset of the population
- The availability and specificity of data for each Core Barrier and Health Indicator

The following scenarios assume that data is available according to differentiating demographics, and that the applicant can describe the target area or subpopulation to be served according to the

demographics.

Scenario 1: Extrapolation to a Service Area from a larger area
Data are available at the county level but the applicant's service area includes only certain Census tracts within that county. The applicant would follow instructions in the Data Resource Guide for how to extrapolate data from the larger geographic area to the service area.

Scenario 2: Extrapolation to a Target Population from the Service Area population
Data are available at a geographic level that matches the service area, but the applicant is serving a specific target population within that area. The applicant would follow instructions in the Data Resource Guide for how to extrapolate data from the service area to the target population.

Scenario 3: Extrapolation to a Service Area and Target Population from the total population in a larger area
Data are available at the county level. The applicant's target population is the low-income population in a service area comprised of certain Census tracts within that county. The applicant would follow instructions in the Data Resource Guide for how to extrapolate data from the county to the service area and the target population within that area.

Note: Applicants must document how extrapolation was conducted and what data sources were used. The Data Resource Guide provides additional detail on using and documenting acceptable extrapolation techniques. If data are not available to conduct a valid extrapolation to the specific service area and/or target population, the applicant must use data pertaining to the immediately surrounding geographic area/population (e.g., if target population data are not available, service area data may be used; if county level data are available, state level data cannot be used).

DATA RESPONSE AND SOURCES
The Data Resource Guide provides a listing of recommended data sources and instructions on utilizing these sources to report each indicator. Applicants may use these sources or other alternate publicly available data sources if the data is collected and analyzed in the same way as the suggested data source. Applicants must use the following guidelines when reporting data:

(a) All data must be from a reliable and independent source, such as a state or local government agency, professional body, foundation, or other well-known organization using recognized, scientifically accepted data collection and/or analysis methods. Applicants must assure that any alternate sources used collect and report data in the same manner as the suggested data source.

(b) Applicants must provide the following information:
  - **Data Response—**The data reported for each indicator on which the NFA score will be based.
  - **Year to which Data Apply—**Provide the year of the data source. If the data apply to a period of more than one year, provide the most recent year for the data reported.
  - **Data Source/Description**—If a data source other than what is included in the Data Resource Guide is utilized, name the data source and provide a rationale (e.g., more current, more geographically specific, more population specific). For

example, if a county-level survey which meets all the required criteria was used, name that survey and provide a rationale for using it.

- **Methodology Utilized/Extrapolation Method**—Provide the following information:
  - Extrapolation methodology used – State whether extrapolation was from one geographic area to another, one population to another, both, or none.
  - Differentiating factor used – Describe the demographic factor upon which the extrapolation was based (e.g., rates by age, gender, race/ethnicity) and data source.
  - Level of geography – State geographic basis for the data (e.g., the data source may be a national survey, but the geographic basis for extrapolation was at the county level).
- **Identify Geographic Service Area or Target Population for Data**—Define the service area and/or target population used (e.g., zip codes, Census tracts, MUA or MUP designation, population type).

NFA WORKSHEET SCORING (Maximum 100 points to be converted to a 20-point scale)
The NFA Worksheet will be scored out of a total possible 100 points. If no response or data source is provided for a Barrier or Indicator, **no** points will be awarded for that indicator.

SECTION 1: CORE BARRIERS (Maximum 60 points)
A response is required for **3 of the 4 Core Barriers**. The points awarded for each Barrier response will be calculated using the point distributions provided below.

a. Population to One FTE Primary Care Physician

Population to One FTE Primary Care Physician	
Scaling	**Points**
< 1641	0
1641 to <1979	1
1979 to <2318	2
2318 to <2656	3
2656 to <2995	4
2995 to <3333	5
3333 to <3672	6
3672 to <4010	7
4010 to <4348	8
4348 to <4687	9
4687 to <5025	10
5025 to <5364	11
5364 to <5702	12
5702 to <6040	13
6040 to <6379	14
6379 to <6717	15

b. Percent of Population Below 200 Percent of Poverty[2].

Percent of Population Below 200% of Poverty	
Scaling	**Points**
< 36.6%	0
36.6% to <38.2%	1
38.2% to <39.8%	2
39.8% to <41.5%	3
41.5% to <43.1%	4
43.1% to <44.7%	5
44.7% to <46.3%	6
46.3% to <47.9%	7
47.9% to <49.6%	8
49.6% to <51.2%	9
51.2% to <52.8%	10
52.8% to <54.4%	11
54.4% to <56.1%	12
56.1% to <57.7%	13
57.7% to <59.3%	14

[2] Data must be submitted for the proposed service area (not the target population), unless serving special population(s) ONLY.

6717 to <7056	16
7056 to <7394	17
7394 to <7733	18
7733 to <8071	19
≥ 8071	20

59.3% to <60.9%	15
60.9% to <62.5%	16
62.5% to <64.2%	17
64.2% to <65.8%	18
65.8% to <67.4%	19
≥ 67.4%	20

c. Percent of Population Uninsured[3]

Percent of Population Uninsured	
Scaling	Points
< 14.1%	0
14.1% to <14.9%	1
14.9% to <15.8%	2
15.8% to <16.6%	3
16.6% to <17.5%	4
17.5% to <18.3%	5
18.3% to <19.2%	6
19.2% to <20.0%	7
20.0% to <20.9%	8
20.9% to <21.7%	9
21.7% to <22.6%	10
22.6% to <23.4%	11
23.4% to <24.3%	12
24.3% to <25.1%	13
25.1% to <26.0%	14
26.0% to <26.8%	15
26.8% to <27.7%	16
27.7% to <28.5%	17
28.5% to <29.4%	18
29.4% to <30.2%	19
≥ 30.2%	20

d. Distance (miles) OR travel time (minutes) to nearest primary care provider accepting new Medicaid and uninsured patients

Distance (in miles)	Driving time (in minutes)	
Scaling	Scaling	Points
< 7	< 13	0
7 to <10	13 to <17	1
10 to <12	17 to <20	2
12 to <14	20 to <23	3
14 to <16	23 to <26	4
16 to <18	26 to <29	5
18 to <20	29 to <33	6
20 to <22	33 to <36	7
22 to <25	36 to <39	8
25 to <27	39 to <42	9
27 to <29	42 to <45	10
29 to <31	45 to <49	11
31 to <33	49 to <52	12
33 to <35	52 to <55	13
35 to <37	55 to <58	14
37 to <40	58 to <62	15
40 to <42	62 to <65	16
42 to <44	65 to <68	17
44 to <46	68 to <71	18
46 to <48	71 to <74	19
≥ 48	≥ 74	20

SECTION 2: CORE HEALTH INDICATORS (Maximum 30 points)

Applicant must provide a response to **1 core health indicator from each of the 6 categories**: Diabetes, Cardiovascular Disease, Cancer, Prenatal and Perinatal Health, Child Health, and Behavioral Health. The table below provides the national median (50th percentile) benchmark and, where applicable, the severe (75th percentile) benchmark for each indicator within the six categories. Benchmarks are based on national public data sources such as the Centers for Disease Control, Substance Abuse and Mental Health Services Administration, Agency for Healthcare Research and Quality, HRSA, and the Census.

Applicants will receive four points for each response that **exceeds** the corresponding national median benchmark and one additional point if the response also **exceeds** the corresponding severe benchmark. Data that equal a benchmark will not receive any corresponding points.

If an applicant determines that none of the specified indicators represent the applicant's service area or target population, the applicant may propose to use an "Other" alternative for that core health indicator category. In such a case, the applicant must specify the indicator's definition,

[3] Data must be submitted for the proposed service area (not the target population), unless serving special population(s) ONLY.

data source, proposed benchmark, source of the benchmark, and rationale for using the alternative indicator. However, the applicant will **NOT** be eligible for additional points for exceeding a severe benchmark (four points maximum for each "Other" indicator). See the Data Resource Guide for detailed instructions on providing documentation for an "Other" indicator.

SECTION 2: CORE HEALTH INDICATOR CATEGORIES	**National Median Benchmark (4 Points if Exceeded)**	**Severe Benchmark (1 Additional Point if Exceeded)**
1. Diabetes		
1(a) Age-adjusted diabetes prevalence	8.1%	9.2%
1(b) Adult obesity prevalence	27.6%	30.2%
1(c) Age-adjusted diabetes mortality[4] rate (per 100,000)	22.5	24.8
1(d) Percent of diabetic Medicare enrollees not receiving a hemoglobin A1c (HbA1c) test	18.0%	20.4%
1(e) Percent of adults (18 years and older) with no physical activity in the past month	24.0%	26.6%
1(f) Other	*Provided by Applicant*	*N/A*
2. Cardiovascular Disease		
2(a) Hypertension hospital admission rate (18 years and older; per 100,000)	61.4	66.3
2(b) Congestive heart failure hospital admission rate (18 years and older; per 100,000)	361.7	378.3
2(c) Age-adjusted mortality from diseases of the heart[5] (per 100,000)	179.4	203.2
2(d) Proportion of adults reporting diagnosis of high blood pressure	28.7%	31.4%
2(e) Percent of adults who have not had their blood cholesterol checked within the last 5 years	23.1%	25.7%
2(f) Age-adjusted cerebrovascular disease mortality (per 100,000)	41.4	46.3
2(g) Other	*Provided by Applicant*	*N/A*
3. Cancer		
3(a) Cancer screening – percent of women 18 years and older with no Pap test in past 3 years	18.4%	20.1%

[4] Number of deaths per 100,000 reported as due to diabetes as the underlying cause or as one of multiple causes of death (ICD-10 codes E10-E14).

[5] Total number of deaths per 100,000 reported as due to heart disease (includes ICD-10 codes I00-I09, I11, I13, and I20-I51).

SECTION 2: CORE HEALTH INDICATOR CATEGORIES	**National Median Benchmark (4 Points if Exceeded)**	**Severe Benchmark (1 Additional Point if Exceeded)**
3(b) Cancer screening – percent of women 50 years and older with no mammogram in past 2 years	22.2%	25.8%
3(c) Cancer screening – percent of adults 50 years and older with no fecal occult blood test (FOBT) within the past 2 years	83.3%	85.0%
3(d) Percent of adults who currently smoke cigarettes	17.3%	20.3%
3(e) Age-adjusted colorectal cancer mortality (per 100,000)	14.0	15.2
3(f) Age-adjusted breast cancer mortality (per 100,000) among females	22.1	23.8
3(g) Other	*Provided by Applicant*	*N/A*
4. Prenatal and Perinatal Health		
4(a) Low birth weight (<2500 grams) rate (5 year average)	7.9%	9.4%
4(b) Infant mortality rate (5 year average; per 1,000)	6.6	7.9
4(c) Births to teenage mothers (ages 15-19; percent of all births)	8.4%	10.0%
4(d) Late entry into prenatal care (entry after first trimester; percent of all births)	16.4%	21.1%
4(e) Cigarette use during pregnancy (percent of all pregnancies)	14.1%	18.2%
4(f) Percent of births that are preterm (<37 weeks gestational age)	12.0%	13.0%
4(g) Other	*Provided by Applicant*	*N/A*
5. Child Health		
5(a) Percent of children (19-35 months) not receiving recommended immunizations: 4-3-1-3-3-1-4[6]	30.0%	34.6%
5(b) Percent of children not tested for elevated blood lead levels by 72 months of age	84.1%	89.3%
5(c) Pediatric asthma hospital admission rate (2-17 year olds; per 100,000)	116.0	148.3
5(d) Percent of children (10-17 years) who are obese	15%	18.1%
5(e) Other	*Provided by Applicant*	*N/A*
6. Behavioral Health		
6(a) Percent of adults with at least one major depressive episode in the past year	6.6%	7.3%

[6] 4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B, 1 varicella, and 4 Pneumococcal conjugate.

SECTION 2: CORE HEALTH INDICATOR CATEGORIES	**National Median Benchmark (4 Points if Exceeded)**	**Severe Benchmark (1 Additional Point if Exceeded)**
6(b) Suicide rate (per 100,000)	13.5	15.2
6(c) Binge alcohol use in the past month (percent of population 12 years and older)	24.1%	26.1%
6(d) Age-adjusted drug poisoning (i.e., overdose) mortality rate per 100,000 population	12.3	14.8
6(e) Other	*Provided by Applicant*	*N/A*

SECTION 3: OTHER HEALTH AND ACCESS INDICATORS (Maximum 10 points)
Applicants must provide responses to **2 of the 13** Other Health and Access Indicators. Applicants will receive 5 points for each response that **exceeds** the corresponding national median benchmark provided in the table below.

OTHER HEALTH AND ACCESS INDICATORS	National Median Benchmark (5 Points if Exceeded)
(a) Age-adjusted death rate (per 100,000)	764.8
(b) HIV infection prevalence	0.2%
(c) Percent elderly (65 and older)	15.2%
(d) Adult asthma hospital admission rate (18 years and older; per 100,000)	130.7
(e) Chronic Obstructive Pulmonary Disease hospital admission rate (18 years and older; per 100,000)	227.2
(f) Influenza and pneumonia death[7] rate (3 year average; per 100,000)	18.6
(g) Adult current asthma prevalence	9.0%
(h) Age-adjusted unintentional injury deaths (per 100,000)	40.0
(i) Percent of population linguistically isolated (people 5 years and over who speak a language other than English at home)	10.3%
(j) Percent of adults (18+ years old) that could not see a doctor in the past year due to cost	13.4%
(k) Percentage of adults 65 years and older who have not had a flu shot in the past year	32.6%
(l) Chlamydia (sexually transmitted infection) rate (per 100,000)	389.5
(m) Percent of adults without a visit to a dentist or dental clinic in the past year for any reason	30.4%

[7] Three year average number of deaths per 100,000 due to influenza and pneumonia (ICD 10 codes J09-J18).

CONVERSION OF NFA WORKSHEET SCORE TO APPLICATION SCORE
The NFA Worksheet will be converted to a 20-point scale using the following conversion table. The converted NFA Worksheet score will account for up to 20 points out of 100 total points for the overall application score (up to 20 of the available 30 points for the *NEED* section of the Project Narrative). Applicants will be able to view the scores for each NFA section in the read-only version of the form accessible in the Review section of the Program Specific Forms. The total NFA Worksheet score can also be found on the Summary Page for the Program Specific Forms. Applicants should ensure their understanding of the system-calculated score prior to application submission.

NFA WORKSHEET TO APPLICATION SCORE CONVERSION TABLE

NFA Worksheet Score		Converted Application Need Score
100-96	=	20
95-91	=	19
90-86	=	18
85-81	=	17
80-76	=	16
75-71	=	15
70-66	=	14
65-61	=	13
60-56	=	12
55-51	=	11
50-46	=	10
45-41	=	9
40-36	=	8
35-31	=	7
30-26	=	6
25-21	=	5
20-16	=	4
15-11	=	3
10-6	=	2
5-1	=	1

INSTRUCTIONS: Form 10: Annual Emergency Preparedness Report

FORM 10 – ANNUAL EMERGENCY PREPAREDNESS REPORT (REQUIRED)

Select the appropriate responses regarding emergency preparedness. This form will be used to assess the status of emergency preparedness planning and progress towards developing and implementing an emergency management plan.

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INSTRUCTIONS: Form 12: Organization Contacts

FORM 12 – ORGANIZATION CONTACTS (REQUIRED)

Provide the requested contact information. For the Contact Person field, provide an individual who can represent the organization in communication regarding the application.

INSTRUCTIONS: Clinical Performance Measures (formerly Health Care Plan) & Financial Performance Measures (formerly Business Plan)

CLINICAL AND FINANCIAL PERFORMANCE MEASURES

The Clinical and Financial Performance Measures set the clinical and financial goals for the two-year project period (enter 9/1/2013 – 8/31/2015). The goals and performance measures should be responsive to the proposed target population, identified community health and organizational needs, and key service delivery activities discussed in the project narrative. For more information on the Clinical and Financial Performance Measures, see http://www.hrsa.gov/grants/apply/assistance/nap and http://bphc.hrsa.gov/policiesregulations/performancemeasures/.

Important Details about the Performance Measures Forms

- Applicants ***must include*** one **behavioral health** (e.g., mental health/substance abuse screening, treatment, or referral) and one **oral health** (e.g., screenings and exams, referrals, dental caries) Clinical Performance Measure of their choice.

- If applying for funds to target a special population (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing), in addition to the general community, applicants *must include* additional Clinical Performance Measures that address the unique health care needs of these populations. In providing additional performance measures specific to a special population, applicants must reference the target group in the performance measure. For example, if an applicant seeks funds to serve migratory and seasonal agricultural workers, then the applicant must propose to measure *"the percentage of migratory and seasonal agricultural workers who…"* ***rather than*** simply *"the percentage of patients who…"*

- If applicants have identified unique health issues or described populations/life cycles targeted for services in the *NEED* section of the project narrative, they are encouraged to include additional related performance measures.

The Clinical and Financial Performance Measures should address ONLY the service area and target population of the proposed new access point(s).

- New start applicants are expected to complete the Clinical and Financial Performance Measures based on the entire proposed scope of their project.
- Satellite applicants are expected to complete the Clinical and Financial Performance Measures based on their proposed new access point(s) ONLY.

Special Instructions for the Clinical Performance Measures

Report the **Diabetes Performance Measure** as follows:

- Report adult patients with HbA1c levels ≤ 9 percent in the Baseline Data (numerator and denominator subfields) and Projected Data fields.
- If desired, report the additional measurement thresholds (i.e., < 7 percent, < 8 percent, > 9 percent) in the Comments field.

The **Child Health Performance Measure** includes the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 2 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumococcal conjugate vaccines.

Overview of the Performance Measures Form Fields

Table 8: Overview of Measures Form Fields

Field Name	Notes
Focus Area	This field contains the content area description for each required performance measure. Applicants must specify focus areas for Oral Health and Behavioral Health measures and when adding non-required Other performance measures.
Performance Measure	This field defines each performance measure. Applicants may specify this field for Oral Health, Behavioral Health, and Other performance measures.
Performance Measure Applicability	The Prenatal Health and Perinatal Health Clinical Performance Measures can be marked Not Applicable by applicants who do not provide or pay for such services (those who have selected only the third column on Form 5A for these services). Such designation requires justification in the Comments field regarding referral and tracking practices. Audit-related Financial Performance Measures (Change in Net Assets to Expense Ratio, Working Capital to Monthly Expense Ratio, and Long Term Debt to Equity Ratio) may be marked *Not Applicable* ONLY by tribal and public center applicants. As desired, these applicants may choose to include substitute measures.
Target Goal Description	This field provides a description of the target goal. Applicants must specify this field for all measures.
Numerator Description	In the case of the Clinical Performance Measures, the numerator is the number of patients that meet the criteria identified by the measure (e.g., patients in a specified age range that received a specified service). In the Financial Performance Measures, the numerator field must be specific to the organizational measure. Applicants must specify a numerator for Oral Health, Behavioral Health, and Other performance measures. The numerator for all other measures can be found at http://bphc.hrsa.gov/policiesregulations/performancemeasures.
Denominator	In the case of the Clinical Performance Measures, the

Field Name	Notes
Description	denominator is all patients to whom the measure applies (e.g., patients in a specified age range, regardless of whether they received a specified service). In the Financial Performance Measures, the denominator field must be specific to the organizational measure. Applicants must specify a denominator for Oral Health, Behavioral Health, and Other performance measures. The denominator for all other measures can be found at http://bphc.hrsa.gov/policiesregulations/performancemeasures.
Baseline Data Baseline Year Measure Type Numerator Denominator	This field contains subfields that provide information regarding the initial threshold used to measure progress over the course of the 2-year project period. The Baseline Year subfield identifies the initial data reference point. The Measure Type subfield provides the unit of measure (e.g., percentage, ratio). The Numerator and Denominator subfields specify patient or organizational characteristics (see above).
Projected Data	This field provides the goal for the end of the 2-year project period.
Data Source and Methodology	This field provides information about the data sources used to develop the performance measures. Applicants are required to identify data sources and discuss the methodology used to collect and analyze data (e.g., electronic health records (EHR), disease registries). Data must be valid, reliable, and derived from established management information systems. For Clinical Performance Measures, applicants must select the data source—EHR, Chart Audit, or Other (please specify)—before describing the methodology. For Financial Performance Measures, note if data are based on the most recent audit.
Key Factors and Major Planned Actions Key Factor Type Key Factor Description Major Planned Action Description	The Key Factor Type subfield requires applicants to select Contributing and/or Restricting factor categories. Contributing factors are those that are predicted to positively impact goal attainment, while restricting factors are those predicted to negatively impact goal attainment. Applicants must specify at least one key factor of each type. In the Key Factor Description subfield, applicants provide a narrative description of the factors predicted to contribute to and restrict progress toward stated goals. In the Major Planned Action Description subfield, applicants provide a description of the major actions planned for addressing the identified key factors. Applicants must use this subfield to outline major action steps and strategies for achieving each performance measure. This field has a 1,000-character limit.
Comments	This open text field, limited to 1,000 characters, enables applicants to provide additional information. Information

Field Name	Notes
	exceeding the character limit should be placed in the *EVALUATIVE MEASURES* section of the Project Narrative.

The instructions for the CIS checklist forms are imbedded in the forms and have not been added to this document.

- **Check list for Adding a New Service Delivery Site:** this form is a combination of a checklist and narratives. It provides program with an understanding of the impact to the community and the population by the addition of this service site.
- **Check List for Deleting Existing Service Delivery Site:** this form is a combination of a checklist and narratives. It provides program with an understanding of the impact to the community and the population by the deletion of this service site.
- **Checklist for Adding New Service:** this form is a combination of a checklist and narratives. It provides program with an understanding of the impact to the community and the population by the addition of the service(s).
- **Checklist for Deleting Existing Service:** this form is a combination of a checklist and narratives. It provides program with an understanding of the impact to the community and the population by the deletion of the service.
- **Checklist for Replacing Existing Service Delivery Site:** this form is a combination of a checklist and narratives. It provides program with an understanding of the impact to the community and the population by replacing this service site.

INSTRUCTIONS: Proposal Cover Page:

The Proposal Cover Page provides a comprehensive consolidated description of the proposed CD-BC project. Responses should be succinct, self-explanatory, and well organized so that reviewers can understand the proposed CD-BC application. Applicants should ensure that all of the specific elements in the Proposal Cover Page are completely addressed.

a) Need
Describe the target populations for the proposed project and how the current facility(ies) capacity will be unable to support the current and/or increased demand for services from the target population. Describe the significant barriers to health care for the target population and the unmet need for services within the proposed service area. (Maximum 8000 characters)

b) Project Response
Describe why the proposed project is appropriate given the current state of the existing facility(ies). Indicate how the proposed project will be immediately and effectively utilized by the health center upon completion. Indicate whether or not the proposed project has started construction activities and/or issued a construction contract. Describe why the proposed project is appropriate given the unmet need for services and the target population. Explain how the proposed project will require no additional section 330 funding to support operating costs, including increases in utilities, daily maintenance and repair, and capital reinvestment for the project. If appropriate, describe how the organization will pay or retire the capital debt related to the proposal. (Maximum 8000 characters)

c) Collaboration
Identify the safety-net providers (i.e. a neighboring health center or FQHC look-alike, rural health clinic, health department, and hospital) within the proposed service area for the project. Describe the formal and informal collaboration and coordination of services with other health care providers (e.g., from a neighboring health center or FQHC look-alike, rural health clinic, local school board, hospital, public health department, homeless shelters, patient advocacy groups, and other service providers). Describe the health center's efforts to coordinate its activities with neighborhood revitalization initiatives supported through the Department of Housing and Urban Development's Choice Neighborhoods and/or Department of Education's Promise Neighborhoods (if applicable). Identify how the health center will leverage other primary health services provided in the service area. (Maximum 8000 characters)

d) Service Impact
Describe how the proposed project will enhance the quality of care and patient outcomes, and improve access to care within the community. Describe how the proposed project will facilitate improved access to health services at the health center and how the project will contribute to meeting the goals outlined in the health center's most recent strategic plan. Describe how the proposed project improvements are appropriate given other providers (section 330 health centers, FQHC Look-Alikes, health departments, rural health clinics, hospitals, etc.) within the service area. Project the impact of the CD-BC grant on the health

center's service delivery. Projections should reflect expected levels upon completion of all projects in the proposal including the number of additional, unduplicated patients to be served. (Maximum 8000 characters)

e) Resources/Capabilities
Describe how the health center has the appropriate resources and capabilities to successfully implement and complete the proposed project (e.g., prior experience). Identify the health center's acquisition strategy, policies, and procedures, and its compliance with the appropriate Federal procurement requirements. Explain how the applicant organization will ensure the project will be completed on time (within the 3-year project period) and within budget. Explain how the health center has the appropriate financial management capability, accounting and control systems, and policies and procedures appropriate for the size and complexity of the organization. Describe efforts to secure other capital funding to support the proposed project. Provide details of the health center's analysis of its debt capacity as related to the proposed project. (Maximum 8000 characters)

INSTRUCTIONS: <u>Project Cover Page</u>

The Project Cover Page should be succinct, self-explanatory, and well organized so that reviewers can clearly understand the proposed CD-BC project.

Project Title
Identify the title for the project.

Project Type
Identify the type of project:

- Alteration and renovation (A&R); or
- Construction (new site or expansion of existing site).

Site Information
Project Square Footage and Cost per Square Foot

Project Description
Provide a detailed description of the scope of work for the project. Identify the major clinical and/or non-clinical spaces that will result from the project. Include the area (in square feet) or dimensions of the spaces to be constructed, altered, or renovated. The description should also list major improvements, such as permanently affixed equipment to be installed; modifications and repairs to the building exterior (including windows); heating, ventilation and air conditioning (HVAC) modifications (including the installation of climate control and duct work); electrical upgrades; plumbing work; and improvements/additions to parking lots. Applicants must also describe plans for how the project's potential adverse impacts on the environment will be reduced and/or mitigated. Indicate whether or not the project will implement green/sustainable design practices/principles (e.g., using project materials, construction and design strategies, equipment selection, etc.). (Maximum 4000 characters)

Project Management
Explain the administrative structure and oversight for the project, including the role and responsibilities of the health center's key management staff as well as oversight by the governing board. Identify the individual who will be the Project Manager and the individuals who comprise the Project Team responsible for managing the project. Indicate the qualifications of the Project Manager who will be responsible for managing the project and the Project Team that will be implementing the project. Describe how the Project Team has the expertise and experience necessary to successfully manage the project within the timeline outlined and achieve the goals and objectives established for this project. Describe the Project Team's ability to manage risk and take corrective action as necessary. (Maximum 4000 characters)

Project Timeline
Indicate the timeframe for demonstrating progress for the project by identifying the start and end dates for each of the following critical milestones within the three-year budget/project period (36 months): planning, project development, alteration/renovation/repair or

construction phase, and project completion. Describe the current status of the project planning, including any steps that may have been accomplished to date and identify the person or entity accountable for each milestone. Provide a justification for the reasonableness of the applicant's proposed timeframe for implementing the project during the project period. (Maximum 2000 characters)

Project Equipment List
List all moveable equipment, which includes non-expendable items with a useful life of more than one year and a unit cost of $5,000 or more (or equal to the applicant's capitalization threshold, if less than $5,000) that are not permanently affixed and can be easily moved, such as x-ray equipment, freezers, autoclaves, medical exam tables, dental chairs, computers, and modular workstations. Furniture, and administrative equipment (i.e., computers, servers, telephones, fax machines, copying machines, software, etc.) with a useful life of one year or greater and a unit cost of less than $5,000 to be purchased for the CD-BC project should also be indicated within the Project Equipment List. If applicable, provide a description of the current status of existing equipment as part of a detailed justification when requesting funds for the purchase of computers and furniture items that will supplement existing items.

Equipment type will be categorized as clinical or non-clinical. Other associated equipment, such as servers and computers, should be categorized as non-clinical. Office supplies (e.g., paper, pencils, toner, etc.); medical supplies (e.g., syringes, blood tubes, plastic gloves, etc.), and educational supplies (e.g., pamphlets, educational videotapes, etc.) are not defined as moveable equipment and are unallowable.

Please note that equipment must be maintained, tracked, and disposed of in accordance with 45 CFR Parts 74 and 92. While title to the equipment vests with the grantee, the Federal government retains interest in the equipment purchased with Federal funds in accordance with 2 CFR 215.34.

INSTRUCTIONS: **Equipment List:**

Project Equipment List

List all moveable equipment, which includes non-expendable items with a useful life of more than one year and a unit cost of $5,000 or more (or equal to the applicant's capitalization threshold, if less than $5,000) that are not permanently affixed and can be easily moved, such as x-ray equipment, freezers, autoclaves, medical exam tables, dental chairs, computers, and modular workstations. Furniture, and administrative equipment (i.e., computers, servers, telephones, fax machines, copying machines, software, etc.) with a useful life of one year or greater and a unit cost of less than $5,000 to be purchased for the CD-BC project should also be indicated within the Project Equipment List. If applicable, provide a description of the current status of existing equipment as part of a detailed justification when requesting funds for the purchase of computers and furniture items that will supplement existing items.

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Please note that equipment must be maintained, tracked, and disposed of in accordance with 45 CFR Parts 74 and 92. While title to the equipment vests with the grantee, the Federal government retains interest in the equipment purchased with Federal funds in accordance with 2 CFR 215.34.

INSTRUCTIONS: <u>Other Requirements for Sites</u>

Site Control and Federal Interest
Identify whether the property is owned or leased.

- If the applicant has a title to the property:
  - Attach the title and plot plan survey; or
  - Attach an opinion from counsel describing the interest that the applicant has in the site and certifying that the estate or interest is legal and valid. A plot plan must be attached as well; and
  - Identify potential issues, such as procurement issues, e.g., property ownership is not at arm's length.
- If the applicant is leasing the project space, the following requirements must be met:
  - The property owner must agree in writing to the renovation of the property;
  - The applicant must provide evidence that the lease includes the language outlined within the Leasehold Improvements section, whether as a provision of a new lease or an amendment to an existing lease, agreed to by both the recipient and lessor; and
  - Agreement to file a Notice of Federal Interest (NFI) in the land records of the local jurisdiction before the project begins (if the proposed net project cost, less movable equipment, is greater than $500,000).

If neither is available at the time of the application, describe steps taken to obtain title or lease. The awardee will not be allowed to draw down funds until this information is available.

Cultural Resource Assessment and Historic Preservation Considerations
For alteration/renovation projects only (construction projects will undergo a required cultural resource assessment and historic preservation review), applicants are required to respond to the following questions:

1) Is the project facility 50 years or older?
2) Does the overall proposed project include 1) any renovation/modification to the exterior of the facility (including the installation of new signage), or 2) ground disturbance activities (including installation of permanent access ramps, utility work, installation of curb cuts, fencing, and parking)?
3) Does the project involve alteration/renovation/repair to a project facility that is architecturally, historically, or culturally significant?

Is the site located on Native American, Alaskan Native, Native Hawaiian, or equivalent culturally significant lands?

The instructions for the CIS checklist form is imbedded in the form and has not been added to this document.

Checklist for Adding a New Target Population: this form is a combination of a checklist and narratives. It provides program with an understanding of the impact to the community and the existing target population by the addition of the new target population.

INSTRUCTIONS: Increased Demand for Services (IDS):

PROJECT DESCRIPTION

The project description should provide a framework and description of all aspects of the proposed IDS project, including how the funds will be used. Please be aware that all information presented in the description is publishable and may be used to provide information to the public and Congress. Grantees are expected to describe the impact of IDS funding to be achieved over the 2-year IDS project period. Please see Appendix 2 for proposed staffing and utilization for IDS funds.

The project description should address the following:

1. NEED. The need for health services in the community and target population(s), including the needs of special populations (i.e., migrant and seasonal farmworkers, people experiencing homelessness, and/or residents of public housing) and the uninsured.
2. PROJECT TYPES. How the proposed IDS project(s) will impact the need for health services in the community and target populations. Grantees will be required to identify how IDS funds will be applied to:
   a. Increase health center staffing (i.e., full-time equivalents)
   b. Extend hours of operations
   c. Expand existing services
   d. Other (specify)
3. PROJECT DESCRIPTION. How the grantee will implement the IDS project(s) in a manner that is appropriate and responsive to the identified community and target population health care needs. Include a description of the types of services impacted as well as strategies/methods for expanding access to primary care services and increasing capacity.
4. IMPACT. How the proposed outcomes of IDS project(s) will be measured, including projected:
   a. Number of new patients (unduplicated)
   b. Number of new visits
   c. Number of new uninsured patients
   d. Number of new full-time equivalents (FTEs)
   e. Number of retained jobs

For the purposes of the IDS funding under the Recovery Act, the following definitions will be used:

- *New jobs* include new positions created and filled or previously existing unfilled positions that are filled as a result of IDS funding.
- *Retained jobs* include those positions preserved from layoffs or terminations and those restored to full-time as a result of IDS funding.
- New and retained FTEs include both direct hire and contractual staff.

INSTRUCTIONS: <u>Funding Sources:</u>

Identify the total cost associated with the CD-BC project and describe all public, private or other sources of funding, including governmental agencies, or other grant funds or proposed debt. Identify the status of obtaining the full funding needed to undertake the project (e.g., whether the funds are secured, expected, or forthcoming including the date, the source, and amount). Describe the plan for securing the balance of the funds that are neither secured nor committed within the Budget Justification. Include letters of commitment from potential funding sources, including those that are contingent upon receipt of a CD-BC grant.

INSTRUCTIONS: Project Qualification Criteria

The FOA does not have instructions for the Project Qualification Criteria form separate from the actual criteria and the form itself.

Project Qualification Criteria: This form requires applicants to specifically address eligibility criteria identified in the funding opportunity.

INSTRUCTIONS: Implementation Plan

Applicants are expected to demonstrate that they will be operational and compliant with Health Center Program Requirements (see Appendix F) within 120 days of award. The Implementation Plan (as noted in the *RESPONSE* section of the Project Narrative) is the applicant's opportunity to outline the action steps that it will take to achieve operational and compliance status within the 120-day timeframe. Instructions for developing the Implementation Plan are provided below. A sample Implementation Plan is provided on the NAP technical assistance Web site at http://www.hrsa.gov/grants/apply/assistance/nap.

In the Implementation Plan, outline goals and action steps necessary to ensure that within 120 days of the Notice of Award, all proposed site(s) will:

- Be open and operational.
- Have appropriate staff and providers in place.
- Deliver services (consistent with Forms 5A and 5C) to the proposed target population.

The Implementation Plan must be specific to the proposed NAP project. Applicants may choose from the following list of focus areas and goals within each area, or may include other goals as desired. The Implementation Plan will be reviewed in conjunction with the Project Narrative, Program Specific Forms, and required attachments to evaluate the application.

Focus Area: Operational Service Delivery Program

- A.1. Provision of Required & Additional Services (Form 5A)
- A.2. Core Provider Staff Recruitment Plan
- A.3. System for Professional Coverage for After Hours Care
- A.4. Admitting Privileges

Focus Area: Functioning Key Management Staff/Systems/Arrangements

- B.1. Appropriate Management Team Recruitment
- B.2. Documented Contractual/Affiliation Agreements
- B.3. Financial Management and Control Policies
- B.4. Data Reporting System

Focus Area: Operational NAP Site(s) within 120 Days

- C.1. Physical Location Ready to Receive Patients (e.g., alteration/renovation complete)
- C.2. Readiness to Serve the Target Population

Focus Area: Implementation of a Sliding Fee Discount Program (SFDP) and Billings and Collections System

- D.1. Implementation of a Compliant Sliding Fee Scale
- D.2. SFDP and Billing and Collections Policies and Procedures

Focus Area: Quality Improvement/Quality Assurance (QI/QA) Program

- E.1. Leadership and Accountability
- E.2. QI/QA Policies and Procedures
- E.3. QI/QA Plan and Process to Evaluate Performance

Focus Area: Governing Board

- F.1. Required Composition Recruitment
- F.2. Required Authority & Functions
- F.3. Conflict of Interest Policies and Procedures

Key Elements of the Project Work Plan

1) **Focus Area:** Applicants may choose a focus area based on the list above or provide a different focus area based on the action steps necessary to achieve the required operational and compliance status.

2) **Goal:** For each Focus Area, provide at least one goal. Goals should describe measureable results.

3) **Key Action Steps:** Identify the action steps that must occur to accomplish each goal. For each goal, provide at least one action step. For each action step, identify at least one person/area responsible and time frame.

4) **Person/Area Responsible:** Identify who will be responsible and accountable for carrying out each action step.

5) **Time Frame:** Identify the expected time frame for carrying out each action step.

6) **Comments:** Provide supplementary information as desired.

Key Elements of the Project Work Plan

1. Focus Area: Applicants may choose a focus area based on the list above or provide a different focus area based on the action steps necessary to achieve the required operational status.
2. Goal: For each Focus Area, provide at least one goal. Goals should describe measureable results.
3. Key Action Steps: Identify the action steps that must occur to accomplish each goal. For each goal, provide at least one action step. For each action step, identify at least one person/area responsible and time frame.
4. Person/Area Responsible: Identify who will be responsible and accountable for carrying out each action step.
5. Time Frame: Identify the expected time frame for carrying out each action step.
6. Comments: Provide supplementary information as desired.

INSTRUCTIONS: Project Work Plan

Project Work Plan:

Overview

As described in section 330(l), the recipient organization is expected to use PCA funds to provide training and technical assistance (T/TA) to potential and existing health centers. A list of required PCA T/TA focus areas and performance measures are provided in Section II of the FOA, under PCA Recipient Roles and Responsibilities. The PCA Project Work Plan is expected to detail the T/TA activities to be conducted over the first 12-month budget period. Applicants may identify additional focus areas beyond those identified on the list.

The Project Work Plan is a structured document that will be completed electronically in the HRSA EHB system. Refer to the PCA Cooperative Agreement User Guide on the PCA TA website for step-by-step instructions (with screen shots) on how to complete the form online.

Key Components of the Project Work Plan

1. **Goals:** Enter a percentage goal for each performance measure. *This will be your target goal for the end of the project period.* This information will be used to measure the statewide/regional impact of the T/TA activities and monitor progress toward achievement of the goals throughout the 5-year project period.
   - Provide a goal percentage for the end of the project period (e.g., 95). Note: You do not need to add the % sign

2. **Key Factors:** Identify 3 to 5 key factors (i.e., contributing and restricting factors) impacting performance on the goals. The key factors should be based on data from the HRSA program reports (e.g., UDS reports, program requirement reports, PCA satisfaction survey results) and annual T/TA needs assessment.
   - Identify at least 3 Key Factors that contribute to and restrict progress on achieving the goal. Up to 2 additional Key Factors may be added by clicking on the "Add More Key Factor(s)" button.
   - Identify at least 1 restricting key factor and 1 contributing factor.

3. **T/TA Focus Areas:** Based on the key factor analysis, identify T/TA focus areas that are appropriate and effective in achieving the proposed goal(s).
   - Section A (Health Center Program Requirements): Address at least 3 T/TA Focus Areas on the list.
   - Section B (Health Center Performance Improvement): Address the required Clinical and Financial Performance Improvement T/TA Focus Areas.
   - Section C (Statewide/Regional Program Assistance): Address ALL of the statewide/regional T/TA Focus Areas on the list.

- A maximum of 2 additional T/TA Focus Areas may be added for each Goal by clicking on the expansion icon or plus sign next to “Other Focus Area(s)”. Note: The additional T/TA focus area(s) will not be counted toward the required focus areas.

4. Activities: Identify the major T/TA activities that must be taken to achieve the goal(s).

- Identify at least 2 major Activities that you will implement for each T/TA Focus Area.
- Within each Activity, identify at least 1 Person/Area Responsible, Time Frame, and Expected Outcome. It is optional to add supplementary information related to the entries in the Comments box.

5. Expected Outcomes: Identify what you anticipate will happen as a result of the proposed T/TA activities (i.e., quantifiable results). It should describe what you hope to accomplish, such as the number of health centers you will train.

- Identify at least 1 Expected Outcome for each Activity.

6. Person(s)/Area(s) Responsible: Identify who will be responsible and accountable for carrying out the specific activities.

- Identify at least 1 Person/Area Responsible for each Activity.

7. Time Frames: Identify the expected time frame for carrying out the specific activities.

- Identify at least 1 Time Frame for each Activity.

8. Comments (optional): This is an optional field. Indicate supplementary information related to entries in the project work plan.

- This field can be left blank.

INSTRUCTIONS: Verification Checklist

Applicants should answer all checklist questions based upon current knowledge of the status of the originally proposed NAP project (as described in the fiscal year 2011 NAP application). Applicants may reference the original application in its entirety, as well as the program-specific forms directly, via links within the Verification Checklist. Applicants will be required to certify that the information provided within the checklist is current and accurate.

INSTRUCTIONS: EHR Readiness Checklist

EHR Readiness Checklist: This form collects responses from applicants regarding their readiness to implement a certified EHR system.

Applicants requesting any Federal funding for the purchase or enhancement of an Electronic Health Record system must respond to all questions on the EHR Readiness Form.

INSTRUCTIONS: Look- Alike Budget

FORM 3A – Look-Alike Budget Information (Required)

Part 1: Expenses: includes personnel, fringe benefits, travel, equipment, supplies, contractual, construction, and other. Indirect charges may also be included.
For each of the expense categories enter the projected first year expenses for each of the applicable Programs, Functions, or Activities. If the categories in the form do not describe all possible expenses, organizations may enter expenses in the "Other" category. The total fields are calculated automatically as you move through the form.

Part 2: Revenue: includes funds supplied by the applicant and/or Federal, State, local, other sources. For each of the revenue categories, enter the projected first year revenue from each of the applicable Programs, Functions, or Activities. If revenue is collected from sources other than the listed sources, indicate those in the "Other" category. The total fields are calculated automatically as you move through the form.

INSTRUCTIONS: O&E Supplemental Form

Applicants must complete an electronic application that includes a brief discussion of:

1. How the health center will use outreach and enrollment assistance funding and leverage current resources to meet the new eligibility assistance and enrollment needs in the health center's approved service area; and

2. How the health center will coordinate outreach and enrollment assistance efforts with other health centers (grantees and look-alikes) and with other state, local, and/or regional efforts.

INSTRUCTIONS: O&E Progress Report

The awardee must submit quarterly progress reports (QPRs) to HRSA. The QPRs will document grantee progress on meeting outreach and enrollment assistance-specific goals, particularly the number of outreach and enrollment assistance workers trained, the number of individuals assisted through outreach and enrollment assistance activities, and the number of uninsured individuals newly insured. Further information will be provided in the Notice of Award. All standard Health Center Program grantee reporting requirements also apply.

INSTRUCTIONS: <u>Supplemental Line Item Budget</u>

This form will collect details about the federal section 330 funding request and the total non-federal (non-section 330) funding for the first year of the proposed project period. This information will enable HRSA to review the proposed use of federal grant dollars to ensure that all applicable requirements described in 45 CFR 74 or 45 CFR 92 are met.

In the Budget Summary section, the federal section 330 funding request and the total non-federal (non-section 330) funding amounts will pre-populate from the total column of the Section A of the SF-424A: Budget Information – Non-Construction Programs. If the pre-populated values are incorrect, adjustments must be made in Section A (Budget Summary) of the SF-424A: Budget Information – Non-Construction Programs.

In the Budget Categories section, break down the federal section 330 funding request by the object class categories (see the Budget Justification section for details regarding these categories). The Total column should match the equivalent Total column of the SF-424A: Budget Information – Non-Construction Programs.