OMB No.: 0915-0285. Expiration Date: 10/31/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 3: INCOME ANALYSIS YEAR 1 ☐ YEAR 2 ☐	FOR HRSA USE ONLY		
	Applicant Name		
	Grant Number	Application Tracking Number	

PART 1: NON FEDERAL SHARE, PROGRAM INCOME

Payor Category	Number Of Visits	Average Charge Per Visit	Gross Charges (a*b)=(c)	Adjustment Rate (%)	Net Charges (Amount Billed) [c*(100-d)]	Collection Rate (%)	Projected Income (e*f)	Actual Accrued Income Past 12 Months**
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
PROJECTED FEE FOR SERVICE INCOME								
1a. Medicaid: Medical								
1b. Medicaid: EPSDT (if different from medical rate)								
1c. Medicaid: Dental								
1d. Medicaid: BH/SA								
1e. Medicaid: Other Fee for Service								
1. Subtotal: Medicaid								
2a. Medicare: All Inclusive FQHC Rate								
2b. Medicare: Other Fee for Service								
2. Subtotal: Medicare								
3a. Private Insurance: Medical								
3b. Private Insurance: Dental								
3c. Private Insurance: BH/SA								
3d. Private Insurance: Other Fee for Service								
3. Subtotal: Private								
4a. Self-Pay: 100% Charge, No Discount (Medical)								
4b. Self-Pay: 0-99% of Charge, Sliding Discounts Including Full Discount (Medical)								
4c. Self-Pay: 100% Charge, No Discount (Dental)								
4d. Self-Pay: 0-99% of Charge, Sliding Discounts Including Full Discount (Dental)								
4e. Self-Pay: 100% Charge, No Discount (BH/SA)								
4f. Self-Pay: 0-99% of Charge, Sliding Discount Including Full Discount (BH/SA)								
4g. Self-Pay: 100% Charge, No Discount (Other)								

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4h. Self-Pay: 0-99% of Charge, Sliding Discount Including Full Discount (Other)								
4. Subtotal: Self Pay								
5. Subtotal: Other Public								
6. TOTAL FEE FOR SERVICE								

** State the time period used for **Actual Accrued Income Past 12 Months** by listing the 12-month period end date (month and year):

PROJECTED CAPITATED MANAGED CARE INCOME					
TYPE OF PAYOR	**Number of Member Months (a)**	**Rate Per Member Month (b)**	**Risk Pool and Other Adjustments (c)**	**FQHC Cost Settlement and Wrap Adjustments (d)**	**Projected Gross Income (e)**
7a. Medicaid					
7b. Medicare					
7c. Commercial					
7d. Other Public					
7. TOTAL CAPITATED MANAGED CARE					
	Visits (a)		**Average Charge Per Visit (b)**		**Total Charges (c)**
8. Capitated Managed Care					
9. TOTAL PROGRAM INCOME [line 6, column g + line 7, column e] matches line 7 "Program Income" of the SF-424A					

PART 2: NON-FEDERAL SHARE, OTHER INCOME	
	Total Other Income by Source
10. Applicant Funds (Retained Earnings)	
11. State Funds	
12. Local Funds	
Other Support	
13a. Other Federal Grants	
13b. Contributions and Fundraising	
13c. Foundation Grants	
13d. Other____________(please list)	
13. Subtotal Other Support	
14. TOTAL OTHER INCOME	
15. TOTAL NON-FEDERAL SHARE [line 6, column g + line 7, column e + line 14] matches line 5, column f, "Non- Federal Totals" of the SF-424A	

Comments/Explanatory Notes (if applicable):

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Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0285. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857.