

<p align="center">DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration</p> <p align="center">FORM 1A: GENERAL INFORMATION WORKSHEET</p>	FOR HRSA USE ONLY	
	Application Tracking Number	# _____

1. Applicant Information:

Applicant Name	
Application Type	
Business Entity	
Organization Type	<input type="checkbox"/> Tribal <input type="checkbox"/> Urban Indian <input type="checkbox"/> Faith based <input type="checkbox"/> Hospital <input type="checkbox"/> State government <input type="checkbox"/> City/County/Local Government or Municipality <input type="checkbox"/> University <input type="checkbox"/> Community based organization

2. Proposed Service Area:

Applicants applying for section 330 funding should provide at least one designated service area ID being proposed to serve under an MUA or MUP.

2a. Service Area Designation (Use commas to separate multiple IDs)	<input type="checkbox"/> Medically Underserved Area (ID#____) <input type="checkbox"/> Medically Underserved Population (ID#____) <input type="checkbox"/> MUA Application Pending (ID#____) <input type="checkbox"/> MUP Application Pending (ID#____)
Find a MUA/MUP	
2b. Target Population Type	<input type="checkbox"/> Urban <input type="checkbox"/> Rural

3. Current Recipient of BPHC Funding YES (see below) NO

If YES, please check all that apply:

- Primary Care Association
- National Training/TA Cooperative Agreement (Please describe: _____)
- Other (Please describe: _____)

4. Purpose of Planning Grant Application (Please check all that apply):

- Conducting a comprehensive needs assessment.
- Applying for MUA/MUP designation and/or other essential designations.
- Designing an appropriate health care delivery model (based on the needs assessment)
- Efforts to secure financial, professional, and technical assistance.
- Developing linkages/building partnerships with other providers in the community.
- Increasing community involvement in the development and/or operational stages of a comprehensive health center.
- Other (please specify): _____

5. Funding Preference:

Indicate if the following preference is requested:

- Sparsely Populated (persons/square mile: _____)

Please attach evidence that supports your preference request (e.g. census bureau documentation)

6. Funding Priority:

Select the priority type you are requesting below:

- The proposed service area for the Planning Grant funding has a poverty rate which is greater than the national poverty rate of 12.5% as determined by the Bureau of Census.

Poverty rate of service area: _____

Please attach evidence that supports your priority request (e.g. census bureau documentation)

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 .5 hours 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, 20878