

ATTACHMENT B
Family Planning Annual Report: Forms and Instructions
(Reissued January 2011)

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TITLE X FAMILY PLANNING ANNUAL REPORT



FORMS AND INSTRUCTIONS

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Health
Office of Population Affairs
Office of Family Planning

REISSUED JANUARY 2011



EFFECTIVE JANUARY 2005
REISSUED OCTOBER 2007
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TABLE OF CONTENTS

INTRODUCTION	1
GENERAL INSTRUCTIONS	3
Who Submits an FPAR.....	3
Scope of Activities Reported in the FPAR.....	3
Submitting the FPAR.....	3
Submitting Revised FPAR Tables.....	3
FPAR Consistency.....	4
FPAR Identification.....	4
TERMS AND DEFINITIONS	5
Family Planning User.....	5
Family Planning Provider.....	5
Family Planning Encounter.....	5
Family Planning Service Site.....	6
Client Records.....	6
Questions about FPAR Terms and Definitions.....	7
GRANTEE PROFILE COVER SHEET	9
Instructions.....	9
Questions about the Grantee Profile.....	10
Grantee Profile Cover Sheet.....	11
FAMILY PLANNING USER DEMOGRAPHIC PROFILE	13
Instructions.....	13
Terms and Definitions.....	13
Questions about Tables 1 to 3.....	14
Table 1 Unduplicated Number of Family Planning Users by Age and Sex.....	15
Table 2 Unduplicated Number of Female Family Planning Users by Race and Ethnicity.....	16
Table 3 Unduplicated Number of Male Family Planning Users by Race and Ethnicity.....	17

FAMILY PLANNING USER ECONOMIC AND SOCIAL PROFILE	19
Instructions	19
Terms and Definitions	19
Questions about Tables 4 to 6	20
Table 4 Unduplicated Number of Family Planning Users by Income Level	22
Table 5 Unduplicated Number of Family Planning Users by Principal Health Insurance Coverage Status	23
Table 6 Unduplicated Number of Family Planning Users with Limited English Proficiency (LEP)	24
FAMILY PLANNING METHOD USE	25
Instructions	25
Terms and Definitions	25
Questions about Tables 7 and 8	27
Table 7 Unduplicated Number of Female Family Planning Users by Primary Method and Age	29
Table 8 Unduplicated Number of Male Family Planning Users by Primary Method and Age	30
CERVICAL AND BREAST CANCER SCREENING	31
Instructions	31
Terms and Definitions	31
Questions about Tables 9 and 10	32
Table 9 Cervical Cancer Screening Activities	35
Table 10 Clinical Breast Exams and Referrals	36
SEXUALLY TRANSMITTED DISEASE (STD) SCREENING	37
Instructions	37
Terms and Definitions	37
Questions about Tables 11 and 12	37
Table 11 Unduplicated Number of Family Planning Users Tested for Chlamydia by Age and Sex	39
Table 12 Number of Gonorrhea, Syphilis, and HIV Tests	40
FAMILY PLANNING ENCOUNTERS AND UTILIZATION OF CLINICAL SERVICES PROVIDERS	41
Instructions	41
Terms and Definitions	41
Questions about Table 13	42
Table 13 Number of Family Planning Encounters by Type of Provider	44

REVENUE REPORT _____ **45**

Instructions **45**

Terms and Definitions..... **45**

Question about Table 14..... **47**

 Table 14 Revenue Report **48**

ABBREVIATIONS AND ACRONYMS _____ **51**

APPENDIX A: COLLECTING AND TABULATING MULTI-RACE RESPONSES __ **A-1**

PAPERWORK REDUCTION ACT (PRA) PUBLIC BURDEN STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-0221. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OIRM/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer.

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INTRODUCTION

This annual reporting requirement is for family planning services delivery projects authorized and funded under the Population Research and Voluntary Family Planning Programs (Section 1001 of Title X of the Public Health Service Act, 42 United States Code [USC] 300).¹ The Office of Family Planning (OFP) within the Office of Population Affairs (OPA) administers the Title X Family Planning Program.

Annual submission of the Family Planning Annual Report (FPAR) is required of all Title X family planning services grantees for purposes of monitoring and reporting program performance (45 Code of Federal Regulations [CFR] Part 74² and 45 CFR Part 92³). FPAR data are presented in summary form to protect the confidentiality of individuals who receive Title X-funded services (42 CFR Part 59).⁴

The FPAR is the only source of annual, uniform reporting by all Title X family planning services grantees. It provides consistent, national-level data on the Title X Family Planning Program and its users. Information from the FPAR is important to OPA for several reasons. First, OPA uses FPAR data to monitor compliance with statutory requirements, regulations, and operational guidance set forth in the *Program Guidelines for Project Grants for Family Planning Services* (“*Program Guidelines*”),⁵ which include

- monitoring compliance with legislative mandates, such as giving priority in the provision of services to low-income persons [42 USC 300 §1006(c)];¹ and
- ensuring that Title X grantees and their subcontractors provide a broad range of family planning methods and services [42 USC 300 §1001(a)].¹

Second, OPA uses FPAR data to comply with accountability and federal performance requirements for Title X family planning funds as required by the 1993 Government Performance and Results Act (GPRA). Current performance goals for the Title X Family Planning Program include priority in the provision of family planning services to low-income individuals, access to and utilization of cervical cancer screening as a means to reducing invasive cervical cancer, reducing infertility by screening for chlamydia, and ensuring program efficiency as measured by the cost per user served.

Finally, OPA relies on FPAR data to guide strategic and financial planning, to monitor performance, and to respond to inquiries from policymakers and Congress about the program. The FPAR allows OPA to

¹ 42 United States Code (USC) 300. *Population research and voluntary family planning programs, section 1001 of Title X of the Public Health Service Act*. Retrieved March 1, 2011, from <http://www.hhs.gov/opa/familyplanning/toolsdocs/xstatut.pdf>

² 45 Code of Federal Regulations (CFR) Part 74. *Uniform administrative requirements for awards and subawards to institutions of higher education, hospitals, other nonprofit organizations, and commercial organizations; and certain grants and agreements with states, local governments, and Indian tribal governments*. Retrieved March 1, 2011, from <http://www.hhs.gov/opa/grants/toolsdocs/45cfr74.pdf>

³ 45 CFR Part 92. *Uniform administrative requirements for grants and cooperative agreements to state and local governments*. Retrieved March 1, 2011, from <http://www.hhs.gov/opa/grants/toolsdocs/45cfr92.pdf>

⁴ 42 CFR Part 59. *Grants for family planning services*. Retrieved March 1, 2011, from http://www.hhs.gov/opa/familyplanning/toolsdocs/ofp_regs_42cfr59_10-1-2000.pdf

⁵ U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Population Affairs, Office of Family Planning. (2001, January). *Program guidelines for project grants for family planning services*. Rockville, MD: OPA/OFP. Retrieved March 1, 2011, from <http://www.hhs.gov/opa/familyplanning/toolsdocs/index.html>

assemble comparable and relevant program data to answer questions about the characteristics of the population served by Title X projects, utilization of services offered, composition of revenues, and program impact. FPAR data are the basis for objective grant reviews, program evaluation, and assessment of program technical needs.

This version (January 2011) of the FPAR consists of a Grantee Profile Cover Sheet and 14 tables. The data collected include demographic, social, and economic user characteristics; utilization of family planning and related preventive health services; utilization of health personnel; and project revenues. Minor changes to the forms and instructions include

- updates to the general instructions to reflect current FPAR submission practices and systems;
- clarification of the family planning provider definitions to improve the quality of reporting;
- review and update of the “Questions about...” sections for the Terms and Definitions and for each FPAR table; and
- minor modifications to FPAR Table 5 (user health insurance status), Table 7 and 8 (primary contraceptive method use), Table 13 (staffing and encounters), and Table 14 (revenue) that aim to simplify reporting and reduce post-submission validation queries.

GENERAL INSTRUCTIONS

This section provides general instructions for completing the FPAR. Grantees should use the general instructions in conjunction with the table-specific instructions; they are cross-referenced where appropriate. If you need additional information or guidance, please refer to the Title X *Program Guidelines* or the *Program Instruction Series* available on the OPA website at <http://www.hhs.gov/opa/familyplanning/toolsdocs/index.html>.

WHO SUBMITS AN FPAR

Grantees funded under Section 1001 of the Title X Public Health Service Act (42 USC 300) should prepare and submit the FPAR. The family planning services grantee is the direct recipient of the Title X grant. Delegates or subcontractors to the grantee receive Title X funds via the grantee. Delegate or subcontractor agencies should **not** submit an FPAR report; rather, they should follow the instructions provided to them by the grantee.

SCOPE OF ACTIVITIES REPORTED IN THE FPAR

The purpose of the FPAR is to provide a comprehensive view of the family planning activities within the scope of the grantee's Title X-funded project. Family planning services grantees should report the total, unduplicated number of users, encounters, and other outputs from activities that are within the scope of a grantee's approved grant application. **If you have questions about whether to include certain data in this report, contact your Regional Program Consultant (RPC).** A current list of RPCs is available on the OPA website at http://www.hhs.gov/opa/familyplanning/rcontacts/rcontacts_rpc.html.

SUBMITTING THE FPAR

Grantees should prepare and submit the FPAR no later than **February 15** after the end of the reporting period. If February 15 falls on a weekend, the FPAR is due on the following Monday.

Grantees can submit the FPAR electronically or in hardcopy. The two options for electronic submission include the web-based *FPAR Data System* (encouraged) or as an electronic file attached to an e-mail message. Grantees should select one of the following methods:

FPAR DATA SYSTEM SUBMISSION – Follow the instructions for preparing and submitting the FPAR in the user's guide for the FPAR Data System.

PAPER SUBMISSION – Submit **three (3)** paper copies of the completed FPAR to the RPC for your region.

E-MAIL SUBMISSION – Attach **one (1)** electronic file to an e-mail message and mail **one (1)** paper copy of the complete FPAR to the RPC for your region.

Current RPC postal and e-mail addresses are available on the OPA website at http://www.hhs.gov/opa/familyplanning/rcontacts/rcontacts_rpc.html.

SUBMITTING REVISED FPAR TABLES

Grantees submitting revised FPAR tables may submit the revised table(s) using any of the methods listed above ("Submitting the FPAR"), regardless of the method used initially to submit the tables. Furthermore,

grantees should consult with their RPC regarding any region-specific requirements or deadlines for submitting revised FPAR tables. Grantees should submit revised tables by **April 1** to ensure that data from revised tables are included in the national and regional reports.

FPAR CONSISTENCY

To improve FPAR consistency, do not leave any cells blank. If the value for a cell is zero, enter “0.” In addition, do not report percentages; enter only whole numbers.

The numbers reported in Table 1, Row 10 of the FPAR will serve as a reference for consistency checkpoints in subsequent tables in the report. The values in these tables are identified with unique, double-letter identifiers (AA, BB, and CC). For FPARs submitted through the *FPAR Data System*, the system will perform a set of automated validation procedures to ensure consistency within and across tables. The automated procedures include calculation of row and column totals and cross-table comparisons of selected cell values, including but not limited to the FPAR checkpoints (AA = unduplicated number of female family planning users, BB = unduplicated number of male family planning users, and CC = unduplicated number of all family planning users).

If additional written information accompanies the table, or if one or more figures in the table are estimated rather than actual, use the table-specific “Notes” field to enter a comment. Please indicate the table and cell to which the comment applies. For estimated figures, describe the rationale and method for generating the estimate.

FPAR IDENTIFICATION

Grantees must report key identifying information in the header for each FPAR table, including the Grantee Profile Cover Sheet. For grantees that submit the FPAR using the *FPAR Data System*, these fields will populate automatically. The identifying information includes the following:

FPAR NUMBER – Enter the **four-digit** number assigned to the grantee by the regional Department of Health and Human Services (HHS) office. Do **not** use your HHS grant number.

DATE SUBMITTED – Enter the report submission date.

REPORTING PERIOD – The reporting period for the FPAR is the **calendar** year (i.e., **January 1 through December 31**). Title X grantees that begin operating after January 1, stop operating before December 31, or are reporting data for a different 12-month period (e.g., December to November) should use the alternative date range fields in the header to enter the time period during which their Title X project was active and for which they are reporting data. For grantees that submit the FPAR using the *FPAR Data System*, please enter information about the alternative date range using the “Notes” field for the Grantee Profile Cover Sheet.

INITIAL SUBMISSION OR REVISION – Check the appropriate box in the header of each table to indicate whether the table is an initial or revised submission. For grantees that submit the FPAR using the *FPAR Data System*, the system will automatically update the submission status (initial or revised) of each table.

TERMS AND DEFINITIONS

OPA provides definitions for key FPAR terms to ensure uniform reporting among Title X grantees. The terms describe the individuals receiving family planning and related preventive health services at Title X-funded service sites, the range and scope of the services provided, and the family planning providers who deliver care.

FAMILY PLANNING USER

A family planning user is an individual who has at least one family planning encounter at a Title X service site during the reporting period. The same individual may be counted as a family planning user only once during a reporting period. Grantees should follow the table-specific instructions to identify applicable users.

FAMILY PLANNING PROVIDER

A family planning provider is the individual who assumes primary responsibility for assessing a client and documenting services in the client record. Providers include those agency staff that exercise independent judgment as to the services rendered to the client during an encounter. Two general types of providers deliver Title X family planning services: clinical services providers and other services providers.

CLINICAL SERVICES PROVIDER – Includes physicians (family and general practitioners, specialists), physician assistants, nurse practitioners, certified nurse midwives, and registered nurses with an expanded scope of practice who are trained and permitted by state-specific regulations to perform *all aspects* of the user (male and female) physical assessment, as described in the *Program Guidelines*. Clinical services providers are able to offer client education, counseling, referral, follow-up, and clinical services (physical assessment, treatment, and management) relating to a client's proposed or adopted method of contraception, general reproductive health, or infertility treatment, in accordance with the *Program Guidelines*.

OTHER SERVICES PROVIDER – Includes other agency staff (e.g., registered nurses, public health nurses, licensed vocational or licensed practical nurses, certified nurse assistants, health educators, social workers, or clinic aides) that offer client education, counseling, referral, or follow-up services relating to the client's proposed or adopted method of contraception, general reproductive health, or infertility treatment, as described in the *Program Guidelines*. Other services providers may also perform or obtain samples for routine laboratory tests (e.g., urine, pregnancy, STD, and cholesterol and lipid analysis), give contraceptive injections (e.g., Depo-Provera), and perform routine clinical procedures that may include some aspects of the user physical assessment (e.g., blood pressure evaluation), in accordance with the *Program Guidelines*.

FAMILY PLANNING ENCOUNTER

A family planning encounter is a documented, face-to-face contact between an individual and a family planning provider that takes place in a Title X service site. The purpose of a family planning encounter is to provide family planning and related preventive health services to female and male clients who want to avoid unintended pregnancies or achieve intended pregnancies. To be counted for purposes of the FPAR,

a written record of the service(s) provided during the family planning encounter must be documented in the client record.

There are two types of family planning encounters at Title X service sites: (1) family planning encounters with a clinical services provider and (2) family planning encounters with an other services provider. The type of family planning provider who renders the care, regardless of the services rendered, determines the type of family planning encounter. Although a client may meet with both clinical and other services providers during an encounter, the provider with the highest level of training who takes ultimate responsibility for the client's clinical or non-clinical assessment and care during the visit is credited with the encounter.

FAMILY PLANNING ENCOUNTER WITH A CLINICAL SERVICES PROVIDER – A face-to-face, documented encounter between a family planning client and a clinical services provider that takes place in a Title X service site.

FAMILY PLANNING ENCOUNTER WITH AN OTHER SERVICES PROVIDER – A face-to-face, documented encounter between a family planning client and an other services provider that takes place in a Title X service site.

Laboratory tests and related counseling and education, in and of themselves, do not constitute a family planning encounter unless there is face-to-face contact between the client and provider, the provider documents the encounter in the client's record, and the test(s) are accompanied by family planning counseling or education.

FAMILY PLANNING SERVICE SITE

A family planning service site refers to an established unit where grantee or delegate agency staff provide Title X services (clinical, counseling, educational, or referral) that comply with the Title X *Program Guidelines*, and where at least some of the encounters between the family planning provider(s) and the individual(s) served meet the requirements of a family planning encounter. Established units include clinics, hospital outpatient departments, homeless shelters, detention and correctional facilities, and other locations where Title X agency staff provide these family planning services. Service sites may also include equipped mobile vans or schools.

CLIENT RECORDS

Title X projects **must** establish a medical record for every client who obtains clinical services or other screening or laboratory services (e.g., blood pressure check, urine-based pregnancy, or STD test). The medical record contains personal data; a medical history; physical exam data; laboratory test orders, results, and follow-up; treatment and special instructions; scheduled revisits; informed consent forms; documentation of refusal of services; and information on allergies and untoward reactions to identified drug(s). The medical record also contains clinical findings; diagnostic and therapeutic orders; and documentation of continuing care, referral, and follow-up. The medical record allows for entries by counseling and social service staff. The medical record is a confidential record, accessible only to authorized staff and secured by lock when not in use. The client medical record **must** contain sufficient information to identify the client, indicate where and how the client can be contacted, justify the clinical impression or diagnosis, and warrant the treatment and end results.

If a family planning user receives no clinical services, a record still must be established for that client. Like a medical record, this client record **must** contain sufficient information to identify the client, indicate where and how the client can be contacted, and fully document the encounter. This record is confidential, accessible only to authorized staff, and secured by lock when not in use.

QUESTIONS ABOUT FPAR TERMS AND DEFINITIONS

1. **QUESTION** – Can a client have more than one family planning encounter during a single family planning visit?

ANSWER – A client may have **only one** family planning encounter **per visit**. In the family planning services setting, the term “encounter” is synonymous with “visit.” Although a client may meet with both clinical and other services providers during an encounter, only one provider is credited with the encounter. The provider with the highest level of training who takes ultimate responsibility for the client’s clinical or non-clinical assessment and care during the visit is credited with the encounter.

2. **QUESTION** – If an individual receives gynecological or related preventive health services (e.g., pelvic exam, Pap test, pregnancy test, STD screening) in a Title X-funded clinic, but does not receive services aimed at avoiding unintended pregnancy or achieving intended pregnancy (e.g., contraceptive or fertility counseling), is the encounter considered a family planning encounter?

ANSWER – If a client is an ongoing family planning user who visits the clinic to obtain any type of family planning or related preventive health services, the encounter is considered a family planning encounter.

If a client of reproductive age has been sterilized but continues to seek gynecological or related preventive health services, the encounter is considered a family planning encounter and the agency may continue to count the client as a family planning user.

If a client obtains gynecological or related preventive health services, but the client is neither an ongoing family planning user nor seeks or receives services (clinical, counseling, educational, and/or referral) to help avoid unintended pregnancy or achieve intended pregnancy, the encounter is not a family planning encounter and the client is not a family planning user.

If a post-menopausal client obtains gynecological or related preventive health services, the encounter is not a family planning encounter and the client is not a family planning user.

3. **QUESTION** – If a clinic aide or nurse is trained and authorized to give contraceptive injections (e.g., Depo-Provera), should an agency report the encounter as an encounter with a clinical services provider?

ANSWER – No. For FPAR reporting purposes, a clinic aide is classified as an other services provider even though he or she may be trained and authorized to give contraceptive injections. Regarding nurses, only advanced practice nurses (certified nurse midwife or nurse practitioner) or registered nurses with an expanded scope of practice who are trained and permitted by state-specific regulations to perform *all aspects* of the user (male and female) physical assessment as described in the *Program Guidelines*, may be reported as clinical services providers. Report full-time equivalents (FTEs) for each type of clinical services provider in Table 13, Rows 1a to 1c, and the number of encounters with a clinical services providers in Table 13, Row 1. Report the number of encounters with other services providers in Table 13, Row 2.

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GRANTEE PROFILE COVER SHEET

The Grantee Profile Cover Sheet provides important contact and summary information about each grantee and the network of service providers supported through the Title X grant. A completed Grantee Profile Cover Sheet must accompany the initial submission of the FPAR, as well as submission of any revised tables.

INSTRUCTIONS

If you are submitting the FPAR using the web-based *FPAR Data System*, the system will automatically populate the following fields: grantee legal name; address of grantee administrative offices; and name, title, and contact information for the Title X Project Director. To correct the information in these fields, please contact the RPC for the region. Enter the corrected information in the “Notes” field of the Grantee Profile Cover Sheet. Grantees can modify all other fields.

GRANTEE LEGAL NAME – Enter the name of the legal recipient of the Title X family planning services grant.

ADDRESS OF GRANTEE ADMINISTRATIVE OFFICES – Enter the grantee’s complete address, including nine-digit ZIP code.

TITLE X PROJECT DIRECTOR – Enter the name, title, mailing address, phone and fax numbers, and e-mail address for the agency representative responsible for directing the grantee’s Title X project.

GRANTEE CONTACT PERSON (PERSON COMPLETING FPAR) – Enter the name, title, mailing address, phone and fax numbers, and e-mail address for the agency representative with primary responsibility for preparing the FPAR.

NUMBER OF DELEGATES/SUBCONTRACTORS SUPPORTED BY THE TITLE X GRANT – Report the number of delegate or subcontractor agencies that receive funding through the grantee’s Title X service grant.

NUMBER OF FAMILY PLANNING SERVICE SITES SUPPORTED BY THE TITLE X GRANT – Report the total number of family planning service sites supported by the Title X grant and represented in the FPAR data. If the number of service sites supported by the Title X grant is different from the number provided in the grant application, check the box and explain the reason for this difference using the “Notes” field for the Grantee Profile Cover Sheet.

QUESTIONS ABOUT THE GRANTEE PROFILE

- 1. QUESTION** – If Title X services are provided at a clinic and two non-clinic sites, should the grantee include one or three sites in the total number of service sites reported on the Grantee Profile Cover Sheet?

ANSWER – For purposes of the FPAR, the grantee should count and report any established unit, clinic or non-clinic, where staff provide Title X services and where at least some of the encounters between the family planning provider(s) and the individual(s) served meet the requirements of a *family planning encounter*. OPA assumes that each of the sites reported in the Grantee Profile contributes data to the grantee's FPAR. If all three sites in this example contribute data to the FPAR, the grantee should include these three service sites in the total number of sites reported on the Grantee Profile Cover Sheet.

Date Submitted:

Reporting Period: January 1, 20____ through December 31, 20____
 _____ through _____
 (Month/day/year) (Month/day/year)

Check One: Initial Submission
 Revision

 See Notes**Grantee Profile Cover Sheet**

Grantee Legal Name	Name	
Address of Grantee Administrative Offices	Street	
	City	
	State	ZIP + 4 -
Title X Project Director	Name	
	Title	
	Street	
	City	
	State	ZIP + 4 -
	Phone	
	Fax	
	E-Mail	
Grantee Contact Person (Person completing FPAR)	Name	
	Title	
	Street	
	City	
	State	ZIP + 4 -
	Phone	
	Fax	
	E-Mail	
Number of Delegates/Subcontractors Supported by the Title X Grant		
Number of Family Planning Service Sites Supported by the Title X Grant	<input type="checkbox"/> Check if total number of sites is different from application	

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FAMILY PLANNING USER DEMOGRAPHIC PROFILE

Data reported in Tables 1 through 3 allow program administrators to monitor access to and use of Title X services among the diverse population these projects aim to serve. These FPAR tables describe the demographic characteristics of family planning users, including the distribution of users by age, sex, ethnicity, and race.

The numbers reported in Table 1 serve as a reference for consistency checkpoints in subsequent tables in the report. The values in these tables are identified with **unique, double-letter identifiers** (AA, BB, and CC).

INSTRUCTIONS

TABLE 1 – Report the unduplicated number of family planning users by age group and sex.

TABLE 2 – Report the unduplicated number of *female* family planning users by race and ethnicity.

TABLE 3 – Report the unduplicated number of *male* family planning users by race and ethnicity.

TERMS AND DEFINITIONS

AGE GROUP – Categorize family planning users based on their age as of June 30th of the reporting period.

RACE AND ETHNICITY – The categories for reporting ethnicity and race in the FPAR conform to the Office of Management and Budget (OMB) 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*,⁶ and are used by other HHS programs and compilers of such national data sets as the National Survey of Family Growth. If an agency wants to collect data for ethnicity or race subcategories, the agency must be able to aggregate the data reported into the OMB minimum standard set of ethnicity and race categories.

OMB encourages self-identification of race. When respondents are allowed to self-identify or self-report their race, agencies should adopt a method that allows respondents to mark or select more than one of the five minimum race categories. *Appendix A* to this form provides general guidance and a list of resources regarding collection of multi-race responses.

The **two** minimum OMB categories for reporting ethnicity are as follows:

HISPANIC OR LATINO (ALL RACES) – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

NOT HISPANIC OR LATINO (ALL RACES) – A person **not** of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

The **five** minimum categories for reporting race are as follows:

AMERICAN INDIAN OR ALASKA NATIVE – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

⁶ Office of Management and Budget. (October 30, 1997). *Revisions to the standards for the classification of federal data on race and ethnicity*, *Federal Register notice*. Retrieved March 1, 2011, from http://www.whitehouse.gov/omb/fedreg_race-ethnicity

ASIAN – A person 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.

BLACK OR AFRICAN AMERICAN – A person having origins in any of the black racial groups of Africa.

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific islands.

WHITE – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

QUESTIONS ABOUT TABLES 1 TO 3

1. **QUESTION** – Are Tables 1 through 3 different from the previous FPAR?

ANSWER – No. There are no changes to Tables 1 through 3.

2. **QUESTION** – What if a client does not self-identify with any of the OMB minimum standard race categories?

ANSWER – According to the 1997 OMB guidance, all races are represented in Tables 2 and 3, and technically every client should be included in one of these categories. Nevertheless, a client has the right not to report his or her race. Service providers should consider providing the definition of each race category in their data collection forms (if space and formatting permit) and becoming familiar with the OMB definitions for each race category so that they can assist clients who may have questions. Grantees should report the number of users with missing or unknown race information in the “unknown/not reported” race category.

Hispanic or Latino clients account for a high proportion of family planning users for whom race data are unknown or not reported. The structure of Tables 2 and 3 allows OPA to identify the number of female and male Hispanic or Latino clients who do not report race data.

3. **QUESTION** – What if a client self-identifies with more than one of the OMB minimum race categories?

ANSWER – According to the 1997 OMB guidance, when self-identification is used the data collection method should allow respondents to self-report more than one race. Grantees should report the number of users who self-report more than one race in Row 6 of Table 2 (female users) or Table 3 (male users). Appendix A to this form provides general guidelines and a sample question for collecting multi-race responses. Please note that the information in Appendix A is not comprehensive and serves only to highlight important considerations and ideas for handling multi-race response. Grantees interested in issues surrounding collection of race data should consult the resource list in Appendix A.

Date Submitted:

Reporting Period: January 1, 20____ through December 31, 20____
 _____ through _____
 (Month/day/year) (Month/day/year)

Check One: Initial Submission
 Revision

See Notes

Table 1
Unduplicated Number of Family Planning Users by Age and Sex

Age Group (Years)	Female Users (A)	Male Users (B)	Total Users (Sum Cols A + B) (C)
1 Under 15			
2 15 to 17			
3 18 to 19			
4 20 to 24			
5 25 to 29			
6 30 to 34			
7 35 to 39			
8 40 to 44			
9 Over 44			
10 Total Users (sum rows 1 to 9)			
	↓ Checkpoint Reference AA	↓ Checkpoint Reference BB	↓ Checkpoint Reference CC

Date Submitted:

Reporting Period: January 1, 20____ through December 31, 20____
 _____ through _____
 (Month/day/year) (Month/day/year)

Check One: Initial Submission
 Revision

See Notes

Table 2
Unduplicated Number of Female Family Planning Users by Race and Ethnicity

	Race	Hispanic or Latino (A)	Not Hispanic or Latino (B)	Unknown/ Not Reported (C)	Total Female Users (Sum Cols A + B + C) (D)
1	American Indian or Alaska Native				
2	Asian				
3	Black or African American				
4	Native Hawaiian or Other Pacific Islander				
5	White				
6	More than one race				
7	Unknown/not reported				
8	Total Female Users (sum rows 1 to 7)				

↓
**Checkpoint
 Reference
 AA**

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20____ through December 31, 20____
 _____ through _____
 (Month/day/year) (Month/day/year)

Check One: Initial Submission
 Revision

See Notes

Table 3
Unduplicated Number of Male Family Planning Users by Race and Ethnicity

	Race	Hispanic or Latino (A)	Not Hispanic or Latino (B)	Unknown/ Not Reported (C)	Total Male Users (Sum Cols A + B + C) (D)
1	American Indian or Alaska Native				
2	Asian				
3	Black or African American				
4	Native Hawaiian or Other Pacific Islander				
5	White				
6	More than one race				
7	Unknown/not reported				
8	Total Male Users (sum rows 1 to 7)				

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FAMILY PLANNING USER ECONOMIC AND SOCIAL PROFILE

The data reported in Tables 4 through 6 provide OPA with information on key social and economic characteristics of individuals who receive family planning and related preventive health care in Title X-funded clinics. OPA uses these data to monitor the program's role in supporting the health care safety net for individuals who confront financial or sociocultural barriers to care due to low income, lack of health insurance, or limited English proficiency (LEP). In addition, OPA uses these data to assess the program's compliance with legislative or regulatory mandates, including priority care to individuals who are low-income and ensuring meaningful access to clients with LEP.⁷

INSTRUCTIONS

TABLE 4 – Report the **unduplicated number of family planning users** by income level.

TABLE 5 – Report the **unduplicated number of family planning users** by their principal health insurance coverage status.

TABLE 6 – Report the **unduplicated number of family planning users** with LEP.

TERMS AND DEFINITIONS

INCOME LEVEL AS A PERCENTAGE OF THE HHS POVERTY GUIDELINES – Grantees are required to collect family income data from all users at least annually. In determining a user's family income, agencies should refer to the poverty guidelines updated periodically in the *Federal Register* by HHS under the authority of 42 USC 9902(2).⁸ Report the unduplicated number of users by income level, using the most current income information available. For additional guidance, see OPA Program Instruction Series documents *OPA 08-1: Verification of Income for Title X Clients* and *OPA 97-1: Fees and Charges to Title X Low-Income Clients and Teenagers (Revised)*, which are available on the OPA website at <http://www.hhs.gov/opa/familyplanning/toolsdocs/xinstruction.html>.

PRINCIPAL HEALTH INSURANCE COVERING PRIMARY MEDICAL CARE – Refers to public and private health insurance plans that provide a **broad set of primary medical care benefits** to enrolled individuals. Report the most current health insurance coverage information available for the client even though he or she may not have used this health insurance to pay for family planning services received during his or her last encounter. For individuals who have coverage under more than one health plan, **principal insurance** is defined as the insurance plan that the agency would bill first (i.e., primary) if a claim were to be filed. Categories of health insurance covering primary medical care include public and private sources of coverage.

PUBLIC HEALTH INSURANCE COVERING PRIMARY MEDICAL CARE – Refers to federal, state, or local government health insurance programs that provide a **broad set of primary medical care benefits**

⁷ U.S. Department of Health and Human Services. (August 8, 2003). Guidance to federal financial assistance recipients regarding Title VI prohibition against national origin discrimination affecting limited English proficient persons ("Revised HHS LEP guidance"). *Federal Register*, 68(153), 47311-47323. Retrieved March 1, 2011, from <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>

⁸ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, (2010). *Poverty guidelines, research, and measurement*. Retrieved March 1, 2011, from <http://aspe.hhs.gov/poverty/index.shtml>

for eligible individuals. Examples of such programs include Medicaid (both regular and managed care), Medicare, state Children's Health Insurance Programs (CHIPs), health plans for military personnel and their dependents (e.g., TRICARE or CHAMPVA), and state-sponsored health insurance programs.

PRIVATE HEALTH INSURANCE COVERING PRIMARY MEDICAL CARE – Refers to health insurance coverage through an employer, union, or direct purchase that provides a **broad set of primary medical care benefits** for the enrolled individual (beneficiary or dependent).

UNINSURED – Refers to clients who **do not have a public or private health insurance plan that covers broad, primary medical care benefits**. Clients whose services are subsidized through state or local indigent care programs, or clients insured through the Indian Health Service who obtain care in a non-participating facility, are considered uninsured.

LIMITED ENGLISH PROFICIENT (LEP) USERS – Refers to family planning users who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English.⁷ Because of their limited English proficiency, LEP users derive little benefit from Title X services and information provided in English. In Table 6, report the unduplicated number of family planning users who required language assistance services (interpretation or translation) to optimize their use of Title X services. Include those users who received Title X services from bilingual staff or who were assisted by a competent agency or contracted interpreter. Also, include users who opted to use a family member or friend as an interpreter after refusing an offer for a qualified interpreter at no cost. Service providers should consult the *Revised HHS LEP Guidance*⁷ for further information about identifying LEP individuals and complying with language assistance requirements.

QUESTIONS ABOUT TABLES 4 TO 6

1. **QUESTION** – Are tables 4 through 6 different from the previous FPAR?

ANSWER – There are no changes to Table 4. In Table 5, OPA has eliminated rows 2a, 2b, and 2c (level of private health insurance coverage for family planning) and modified the instructions to reflect this change. In addition, OPA has simplified the definition of an LEP user and the instructions for reporting LEP users in Table 6.

2. **QUESTION** – If a client has health insurance that covers a broad set of primary medical care benefits, including some or all family planning services, but he or she chooses not to use his or her health insurance plan to pay for some or all of the cost of services, how should an agency classify this client for purposes of Table 5 reporting?

ANSWER – Although an insured client may elect not to use his or her health insurance to pay for services, he or she is considered insured and should be reported in either Row 1 or Row 2 of the table according to the type of health insurance coverage (public or private) that he or she has.

3. **QUESTION** – Are Title X agencies required to verify client health insurance status and, if insured, the level of family planning service coverage under the health plan?

ANSWER – No. The information required to complete Table 5 is based on clients' self-reported insurance coverage. However, as stipulated in the program regulations (see 42 CFR Part 59),⁴ service providers are required to bill all third parties authorized or legally obligated to pay for services and to make reasonable efforts to collect charges without jeopardizing client confidentiality.

4. **QUESTION** – How do I classify a client who has coverage for a specific type of care or health condition—for example, dental services or expanded Medicaid coverage under the Breast and Cervical Cancer Prevention and Treatment Act of 2000—but has no health insurance that provides a broad set of primary medical care benefits?

ANSWER – Users who do not have a health insurance plan that provides a broad set of primary medical care benefits, even though they may have coverage for a specific condition, are considered uninsured.

5. **QUESTION** – If a client has coverage for family planning services under a Medicaid family planning expansion program (i.e., 1115 waiver demonstration project), is he or she considered insured for purposes of FPAR reporting?

ANSWER – A **client is insured** if (1) he or she is enrolled in a Medicaid family planning expansion program that covers a **broad set of primary medical care benefits**, in addition to family planning, or (2) he or she is enrolled in a Medicaid expansion program that covers only family planning services and he or she has coverage under another plan that covers a **broad set of primary medical care benefits**.

A **client is uninsured** if he or she is enrolled in a Medicaid family planning expansion program that covers only family planning services and he or she has no coverage under another plan that covers a **broad set of primary medical care benefits**.

6. **QUESTION** – In Table 6, should a user be reported as LEP if he or she receives care from a bilingual provider in their preferred, non-English language or if he or she receives language assistance from a trained (agency, contracted, or telephonic) or informal (friend or family member) interpreter?

ANSWER – In Table 6, report the number of users who are **best served** in a language other than English, including clients who received care from bilingual providers in their preferred, non-English language or received language assistance from trained or informal interpreters.

Confidentiality, privacy, conflicts of interest, and competence as medical services interpreters are several limitations of using family members or friends as interpreters in the Title X clinic setting. While in some cases an LEP client may feel more comfortable when a trusted family member or friend acts as an interpreter, the family member or friend may not be competent to provide quality and accurate interpretations, particularly if the service provided is complex or not of a routine nature. If a client opts to provide his or her own interpreter, and the service provider determines at any point during the service that the client's interpreter is not competent in this role, the service provider should obtain the services of a competent interpreter.⁷

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Reporting Period: January 1, 20_____ through December 31, 20_____

_____ through _____

(Month/day/year) (Month/day/year)

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Table 4
Unduplicated Number of Family Planning Users by Income Level

Income Level as a Percentage of the HHS Poverty Guidelines	Number of Users (A)
1 100% and below	
2 101% to 150%	
3 151% to 200%	
4 201% to 250%	
5 Over 250%	
6 Unknown/not reported	
7 Total Users (sum rows 1 to 6)	

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_____ through _____

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Table 5
Unduplicated Number of Family Planning Users by Principal Health Insurance Coverage Status

Principal Health Insurance Covering Primary Medical Care	Number of Users (A)
1 Public health insurance covering primary medical care	
2 Private health insurance covering primary medical care	
3 Uninsured (no public or private health insurance)	
4 Unknown/not reported	
5 Total Users (sum rows 1 to 4)	

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FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20____ through December 31, 20____
 _____ through _____
 (Month/day/year) (Month/day/year)

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Table 6
Unduplicated Number of Family Planning Users with Limited English Proficiency (LEP)

	Number of Users (A)
1 Number of users with limited English proficiency (LEP)	

FAMILY PLANNING METHOD USE

Title X projects are required to provide a broad range of acceptable and effective family planning methods and services.⁴ Tables 7 and 8 provide sex- and age-specific information on the types of family planning methods that clients use to prevent unintended pregnancy. Information on the distribution of methods by age group for female (Table 7) and male (Table 8) users allows OPA to compare the data from Title X clinics with other sources of information, including the National Survey of Family Growth. These data also permit OPA to track patterns in method use over time at the state, regional, and national levels; to examine the extent to which Title X providers contribute to increased access to and use of newer family planning technologies; and to assess the program's contribution to national health objectives (i.e., HHS's Healthy People) for family planning and disease prevention.

INSTRUCTIONS

TABLE 7 – Report the unduplicated number of female family planning users by primary method and age.

TABLE 8 – Report the unduplicated number of male family planning users by primary method and age.

TERMS AND DEFINITIONS

AGE – Use the client's age as of June 30th of the reporting period.

PRIMARY METHOD OF FAMILY PLANNING – The primary method of family planning is the user's method—adopted or continued—at the time of exit from his or her last encounter in the reporting period. If the user reports that he or she is using more than one family planning method, report the most effective one as the primary method. Family planning methods include the following:

FEMALE STERILIZATION – In Table 7, report the number of female users who rely on female sterilization as their primary family planning method. Female sterilization refers to surgical (tubal ligation) or non-surgical (implant) sterilization procedures performed on a female user in the current or any previous reporting period.

INTRAUTERINE DEVICE (IUD) – In Table 7, report the number of female users who use a long-term hormonal or other type of intrauterine device (IUD) or system as their primary family planning method.

HORMONAL IMPLANT – In Table 7, report the number of female users who use a long-term, subdermal hormonal implant as their primary family planning method.

1- MONTH HORMONAL INJECTION – In Table 7, report the number of female users who use 1-month injectable hormonal contraception as their primary family planning method.

3- MONTH HORMONAL INJECTION – In Table 7, report the number of female users who use 3-month injectable hormonal contraception as their primary family planning method.

ORAL CONTRACEPTIVE – In Table 7, report the number of female users who use any oral contraceptive, including combination and progestin-only (“mini-pills”) formulations, as their primary family planning method.

CONTRACEPTIVE PATCH – In Table 7, report the number of female users who use a transdermal contraceptive patch as their primary family planning method.

VAGINAL RING – In Table 7, report the number of female users who use a hormonal vaginal ring as their primary family planning method.

CERVICAL CAP/DIAPHRAGM – In Table 7, report the number of female users who use a cervical cap or diaphragm (with or without spermicidal jelly or cream) as their primary family planning method.

CONTRACEPTIVE SPONGE – In Table 7, report the number of female users who use a contraceptive sponge as their primary family planning method.

FEMALE CONDOM – In Table 7, report the number of female users who use female condoms (with or without spermicidal foam or film) as their primary family planning method.

SPERMICIDE (USED ALONE) – In Table 7, report the number of female users who use only spermicidal jelly, cream, foam, or film (i.e., not in conjunction with another method of contraception) as their primary family planning method.

FERTILITY AWARENESS METHOD (FAM) OR LACTATIONAL AMENORRHEA METHOD (LAM) – Fertility awareness methods (FAMs) refer to family planning methods that rely on identifying potentially fertile days in each menstrual cycle when intercourse is most likely to result in a pregnancy. FAMs include Calendar Rhythm, Standard Days, TwoDay, Billings Ovulation, and SymptoThermal methods. In Table 7, report the number of female users who use one or a combination of the FAMs listed above or who rely on the Lactational Amenorrhea Method (LAM) as their primary family planning method. In Table 8, Row 3 report male users who rely on a FAM as their primary method. Report male users who rely on LAM as their primary method in Table 8, Row 6, “Rely on female method(s).”

ABSTINENCE – For purposes of FPAR reporting, abstinence is defined as refraining from oral, vaginal, and anal intercourse. In Table 7, report the number of female users who rely on abstinence as their primary family planning method or who are not currently sexually active and therefore not using contraception. In Table 8, report the number of male users who rely on abstinence as their primary family planning method or who are not currently sexually active.

WITHDRAWAL AND OTHER METHODS – In Tables 7 and 8, report the number of female and male users, respectively, who use withdrawal or other methods not listed in the tables as their primary family planning method.

METHOD UNKNOWN OR NOT REPORTED – In Tables 7 and 8, report the number of female and male users for whom the primary family planning method at exit from the last family planning encounter is unknown or not reported.

NO METHOD—[PARTNER] PREGNANT OR SEEKING PREGNANCY – In Tables 7 and 8, report the number of users who are not using any family planning method because they (Table 7) or their partners (Table 8) are pregnant or seeking pregnancy.

NO METHOD—OTHER REASON – In Tables 7 and 8, report the number of users who are not using any family planning method to avoid pregnancy due to reasons other than pregnancy or seeking pregnancy, including if either partner is sterile without having been sterilized surgically or if either partner has had a non-contraceptive surgical procedure that has rendered him or her unable to conceive or impregnate.

VASECTOMY – Refers to conventional incisional or no-scalpel vasectomy performed on a male user, or the male partner of a female user, in the current or any previous reporting period. In Table 7, report the number of female users who rely on vasectomy as their (partner’s) primary family planning method. In Table 8, report the number of male users on whom a vasectomy was performed in the current or any previous reporting period.

MALE CONDOM – In Table 7, report the number of female users who rely on their sexual partner to use male condoms (with or without spermicidal foam or film) as their primary family planning method. In Table 8, report the number of male users who use male condoms (with or without spermicidal foam or film) as their primary family planning method.

RELY ON FEMALE METHOD(S) – In Table 8, report the number of male family planning users who rely on their female partner’s family planning method(s) as their primary method. “Female” contraceptive methods include female sterilization, IUDs, hormonal implants, 1- and 3-month hormonal injections, oral contraceptives, the contraceptive patch, the vaginal ring, cervical cap/diaphragms, the contraceptive sponge, female condoms, LAM, and spermicides.

QUESTIONS ABOUT TABLES 7 AND 8

1. **QUESTION** – Are tables 7 and 8 different from the previous FPAR?

ANSWER – Yes. OPA has made several minor changes to Tables 7 and 8.

In Table 7, OPA changed the Row 7 heading from “Hormonal contraceptive patch” to “Contraceptive patch,” the Row 13 heading from “Fertility awareness method (FAM)” to “Fertility awareness method (FAM)/Lactational Amenorrhea Method (LAM),” the Row 15 heading from “Other methods” to “Withdrawal or other method,” and the Row 20 heading from “Method unknown” to “Method unknown/not reported.”

In Table 8, OPA changed the Row 5 heading from “Other methods” to “Withdrawal or other method” and the Row 9 heading from “Method unknown” to “Method unknown/not reported.” In addition, OPA has added LAM to the list of methods in the reporting category “Rely on female methods.” Grantees should report male users who rely on LAM (used by their female sexual partners) as their primary method in Table 8, Row 6 (“Rely on female method[s]”) instead of Table 8, Row 3 (“Fertility awareness method”).

In both tables, OPA has reordered the row groupings so that the “No Method” rows follow the “Primary Method” rows and the “Method unknown/not reported” row follows the “No Method” rows. OPA also has updated the list of FAM methods and expanded the “Other reason” category under “No Method” to include users or their partners who have had a non-contraceptive surgical procedure that has rendered them unable to conceive or impregnate. Furthermore, OPA has revised the definition for “Method unknown/not reported” such that users in this category are no longer assumed to be using a method and will not, therefore, be counted as using a method.

2. **QUESTION** – If family planning users, male or female, rely on their partners’ family planning method for pregnancy prevention, how should the grantee report this information in Tables 7 or 8?

ANSWER – If a female family planning user relies on a male family planning method (e.g., vasectomy or male condoms) for pregnancy prevention, report this user in Table 7, Row 16 or 17. If the female user relies on withdrawal, report this user in Table 7, Row 15 (“Withdrawal or other method”).

If a male family planning user relies on a “female” family planning method for pregnancy prevention (i.e., female sterilization, IUD, hormonal implant, 1- or 3-month hormonal injection, oral contraceptives, contraceptive patch, vaginal ring, cervical cap or diaphragm, contraceptive sponge, female condoms, LAM, or spermicides), report this user in Table 8, Row 6.

If a male client and his female sexual partner rely on pills (for pregnancy prevention) and condoms (for STD or pregnancy prevention), record the method that is most effective in terms of pregnancy prevention (i.e., pills). In this example, the male user's family planning method would be "Rely on female method(s)" (Table 8, Row 6). If this same male client were to report that he relies on condoms for pregnancy prevention because of his partner's inconsistent pill use, report male condoms (Table 8, Row 2) as this client's primary contraceptive method.

- 3. QUESTION** – How should grantees report a female or male user who has had a non-contraceptive surgical procedure that has rendered her or him unable to conceive or impregnate?

ANSWER – Report female users who have had a non-contraceptive surgical procedure that has rendered them unable to conceive in Table 7, Row 19 ("No method–Other reason"). Report male users who have had a non-contraceptive surgical procedure that has rendered them unable to impregnate a female sexual partner in Table 8, Row 8 ("No method–Other reason").

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20____ through December 31, 20____
 _____ through _____
 (Month/day/year) (Month/day/year)

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Table 7
Unduplicated Number of Female Family Planning Users by Primary Method and Age

Primary Method	Under 15 (A)	15 to 17 (B)	18 to 19 (C)	20 to 24 (D)	25 to 29 (E)	30 to 34 (F)	35 to 39 (G)	40 to 44 (H)	Over 44 (I)	Total Female Users (Sum Cols A to I) (J)
1 Female sterilization										
2 Intrauterine device (IUD)										
3 Hormonal implant										
4 1-Month hormonal injection										
5 3-Month hormonal injection										
6 Oral contraceptive										
7 Contraceptive patch										
8 Vaginal ring										
9 Cervical cap or diaphragm										
10 Contraceptive sponge										
11 Female condom										
12 Spermicide (used alone)										
13 Fertility Awareness or Lactational Amenorrhea Method										
14 Abstinence										
15 Withdrawal or other method										
Rely on Male Method										
16 Vasectomy										
17 Male condom										
No Method										
18 Pregnant or seeking pregnancy										
19 Other reason										
Method Unknown/ Not Reported										
20 Method unknown/not reported										
21 Total Female Users (sum rows 1 to 20)										

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FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20____ through December 31, 20____
 _____ through _____
 (Month/day/year) (Month/day/year)

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Table 8
Unduplicated Number of Male Family Planning Users by Primary Method and Age

Primary Method	Under 15 (A)	15 to 17 (B)	18 to 19 (C)	20 to 24 (D)	25 to 29 (E)	30 to 34 (F)	35 to 39 (G)	40 to 44 (H)	Over 44 (I)	Total Male Users (Sum Cols A to I) (j)
1 Vasectomy										
2 Male condom										
3 Fertility Awareness Method										
4 Abstinence										
5 Withdrawal or other method										
Rely on Female Method										
6 Rely on female method(s)										
No Method										
7 Partner pregnant or seeking pregnancy										
8 Other reason										
Method Unknown/ Not Reported										
9 Method unknown/not reported										
10 Total Male Users (sum rows 1 to 9)										

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CERVICAL AND BREAST CANCER SCREENING

Tables 9 and 10 provide information on the cervical and breast cancer screening activities that are performed in Title X-funded clinics. Data from these tables permit OPA to monitor compliance with legislative mandates, measure achievement of program performance objectives, and assess the program's contribution to national health objectives (i.e., HHS's Healthy People) related to early cancer detection and health promotion. OPA also uses the data from these tables to monitor the number of abnormal results that require further follow-up by Title X providers.

INSTRUCTIONS

TABLE 9 – Report the following information on cervical cancer screening activities. Refer to the chart in *Exhibit 1* for reporting information on Pap test results.

- **Unduplicated number of users** who obtained a Pap test.
- **Number of Pap tests** performed.
- **Number of Pap tests with an ASC or higher result** according to the 2001 Bethesda System⁹ (see *Exhibit 1*). ASC or higher results include: ASC-US; ASC-H; LSIL; HSIL; squamous cell carcinoma; AGC; AGC, favor neoplastic; AIS; adenocarcinoma; or other (e.g., endometrial cells in a woman \geq 40 years of age).
- **Number of Pap tests with an HSIL or higher result** according to the 2001 Bethesda System (see *Exhibit 1*). HSIL or higher results include: HSIL; squamous cell carcinoma; AGC; AGC, favor neoplastic; AIS; adenocarcinoma; or other (e.g., endometrial cells in a woman \geq 40 years of age).

TABLE 10 – Report the following information on breast health screening and referral activities.

- **Unduplicated number of users** receiving a clinical breast exam (CBE).
- **Unduplicated number of users** referred for further evaluation based on CBE results.

TERMS AND DEFINITIONS

TESTS – Report Pap tests and CBEs performed during the reporting period that are provided within the scope of the agency's Title X project.

ATYPICAL SQUAMOUS CELLS (ASC) – ASC refers to cytological changes that are suggestive of a squamous intraepithelial lesion. The 2001 Bethesda System (see *Exhibit 1*) subdivides atypical squamous cells into two categories:

- Atypical squamous cells of undetermined significance (ASC-US) – ASC-US refers to cytological changes that are suggestive of a squamous intraepithelial lesion, but lack criteria for a definitive interpretation.¹⁰

⁹ Solomon, D., Davey, D., Kurman, R., Moriarty, A., O'Connor, D., Prey, M. et al. (2002). The 2001 Bethesda System: Terminology for reporting results of cervical cytology. *Journal of the American Medical Association*, 287(16), 2116.

¹⁰ Apgar, B. S., Zoschnick, L., & Wright, T. C. (2003). The 2001 Bethesda System terminology. *American Academy of Family Physicians*, 2003(68), 1992–1998.

- Atypical squamous cells, cannot exclude HSIL (ASC-H) – ASC-H refers to cytological changes that are suggestive of a high-grade squamous intraepithelial lesion (HSIL), but lack criteria for a definitive interpretation.¹⁰

LOW-GRADE SQUAMOUS INTRAEPITHELIAL LESIONS (LSIL) – LSIL refers to low-grade squamous intraepithelial lesions encompassing human papillomavirus, mild dysplasia, and cervical intraepithelial neoplasia (CIN) 1.¹⁰

HIGH-GRADE SQUAMOUS INTRAEPITHELIAL LESIONS (HSIL) – HSIL refers to high-grade squamous intraepithelial lesions encompassing moderate and severe dysplasia, carcinoma in situ, CIN 2, and CIN 3.¹⁰

ATYPICAL GLANDULAR CELLS (AGC) – AGC refers to glandular cell abnormalities, including adenocarcinoma. The 2001 Bethesda System (see *Exhibit 1*) classifies AGC less severe than adenocarcinoma into three categories.¹¹

- Atypical glandular cells, either endocervical, endometrial, or “glandular cells” not otherwise specified.
- Atypical glandular cells, either endocervical or “glandular cells” favor neoplasia (AGC, favor neoplastic).
- Endocervical adenocarcinoma in situ (AIS).

QUESTIONS ABOUT TABLES 9 AND 10

1. **QUESTION** – Are tables 9 or 10 different from the previous FPAR?

ANSWER – There are minor changes to Table 9 instructions and no changes to Table 10. For Table 9, the list of Pap test results that are ASC or higher or HSIL or higher have been changed to include squamous cell carcinoma; AGC, favor neoplastic; and AIS.

2. **QUESTION** – How should grantees count and report a CBE that appears on the clinic encounter form or “super bill” as part of a “bundled” billing or service code (e.g., as part of a comprehensive exam)?

ANSWER – If grantees do not have a count of the actual number of CBEs performed due to the structure of the “bundled” billing/service code, they should report the *estimated* number of CBEs performed in Table 10, Row 1, and provide a brief explanation about the reported figure in the Table 10 “Notes” field.

3. **QUESTION** – In Table 9, does the total number of Pap tests reported in Row 3 include tests reported in Row 4?

ANSWER – Yes. Table 9, Row 3 will include the tests reported in Row 4 because tests with a result of HSIL or higher are also tests with a result of ASC or higher.

¹¹ Wright, T. C., Cox, J. T., Massad, L. S., Twiggs, L. B., & Wilkinson, E. J. (2002). 2001 consensus guidelines for the management of women with cervical cytological abnormalities. *Journal of the American Medical Association*, 287, 2120–2129. For updated consensus guidelines for managing women with abnormal tests, see Wright, T. C., Massad, L. S., Dunton, C. J., Spitzer, M., Wilkinson, E. J., & Solomon, D. (2007, October). 2006 consensus guidelines for the management of women with abnormal cervical cancer screening tests. *American Journal of Obstetrics & Gynecology*, 197(4), 337–339.

4. **QUESTION** – How should a grantee complete Table 9, Rows 3 and 4, if the results of Pap tests performed at the end of the reporting period are not received in time to include in the FPAR?

ANSWER – A grantee has two options for dealing with delayed Pap test results. Under the first option, the grantee can report the Pap testing (Table 9, Rows 1 and 2) and results (Table 9, Rows 3 and 4) figures that are available at the time it submits the FPAR. The grantee should use the Table 9 “Notes” field to explain that the figures reported in Rows 3 and 4 are estimated rather than actual due to delayed laboratory reporting.

Under the second option, the grantee can report testing and results data for a 12-month period that has complete results data and is close in time to the reporting period. For example, if Pap testing and results data are complete for the 12-month period from December to November, but not for January to December, report the figures for December to November and use the Table 9 “Notes” field to explain that Table 9 data are for a different 12-month period (specify period). Consult your RPC if you have any questions about reporting Table 9 data when Pap testing results are delayed.

Exhibit 1. The 2001 Bethesda System (Abridged)

<p>SPECIMEN ADEQUACY Satisfactory for evaluation (<i>note presence/absence of endocervical/transformation zone component</i>) Unsatisfactory for evaluation ... (<i>specify reason</i>) Specimen rejected/not processed (<i>specify reason</i>) Specimen processed and examined, but unsatisfactory for evaluation of epithelial abnormality because of (<i>specify reason</i>)</p>	
<p>GENERAL CATEGORIZATION (Optional) Negative for intraepithelial lesion or malignancy Epithelial cell abnormality Other</p>	
<p>INTERPRETATION/RESULT Negative for Intraepithelial Lesion or Malignancy Organisms <i>Trichomonas vaginalis</i> Fungal organisms morphologically consistent with <i>Candida</i> species Shift in flora suggestive of bacteria vaginosis Bacteria morphologically consistent with <i>Actinomyces</i> species Cellular changes consistent with herpes simplex virus Other non-neoplastic findings (<i>Optional to report; list not comprehensive</i>) Reactive cellular changes associated with inflammation (includes typical repair) radiation intrauterine contraceptive device Glandular cells status posthysterectomy Atrophy</p>	
<p>-----</p>	
<p>Epithelial Cell Abnormalities Squamous cell Atypical squamous cells (ASC) of undetermined significance (ASC-US) cannot exclude HSIL (ASC-H) Low-grade squamous intraepithelial lesion (LSIL) encompassing: human papillomavirus/mild dysplasia/cervical intraepithelial neoplasia (CIN) 1</p>	
<p>-----</p>	
<p> High-grade squamous intraepithelial lesion (HSIL) encompassing: moderate and severe dysplasia, carcinoma in situ; CIN 2 and CIN 3 Squamous cell carcinoma</p>	
<p>Glandular cell Atypical glandular cells (AGC) (<i>specify endocervical, endometrial, or not otherwise specified</i>) Atypical glandular cells, favor neoplastic (<i>specify endocervical or not otherwise specified</i>) Endocervical adenocarcinoma in situ (AIS) Adenocarcinoma</p>	
<p>Other (List not comprehensive) Endometrial cells in a woman ≥ 40 years of age</p>	
<p>-----</p>	
<p>AUTOMATED REVIEW and ANCILLARY TESTING (Include as appropriate) EDUCATIONAL NOTES and SUGGESTIONS (Optional)</p>	

Report in Table 9 Row 3

Report in Table 9 Row 4

Source: Solomon, D., Davey, D., Kurman, R., Moriarty, A., O'Connor, D., Prey, M., et al. (2002). The 2001 Bethesda System: Terminology for reporting results of cervical cytology. *Journal of the American Medical Association*, 287(16), 2116. (Copyright 2002, American Medical Association. All rights reserved. Reprinted with permission.)

Date Submitted:

Reporting Period: January 1, 20_____ through December 31, 20_____

_____ through _____

(Month/day/year) (Month/day/year)

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See Notes

Table 9
Cervical Cancer Screening Activities

Screening Activity	Number of Users or Number of Tests (A)
1 Unduplicated number of users who obtained a Pap test	
2 Number of Pap tests performed	
3 Number of Pap tests with an ASC or higher result	
4 Number of Pap tests with an HSIL or higher result	

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20____ through December 31, 20____
 _____ through _____
 (Month/day/year) (Month/day/year)

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**Table 10
 Clinical Breast Exams and Referrals**

	Number of Users (A)
1 Unduplicated number of users who received a clinical breast exam (CBE)	
2 Unduplicated number of users referred for further evaluation based on their CBE	

SEXUALLY TRANSMITTED DISEASE (STD) SCREENING

Tables 11 and 12 provide information on the utilization of STD testing services provided in Title X clinics. Data from these tables permit OPA to monitor compliance with legislative mandates, measure achievement of program performance objectives, and assess the program's contribution to national health objectives (i.e., HHS's Healthy People) for disease prevention (e.g., STDs and HIV) and health promotion.

INSTRUCTIONS

TABLE 11 – Report the **unduplicated number of family planning users** tested for chlamydia, by age group (under 15, 15–17, 18–19, 20–24, and 25 and over) and sex.

TABLE 12 – Report the following STD testing information:

- **Number of gonorrhea tests performed**, by sex.
- **Number of syphilis tests performed**, by sex.
- **Number of confidential HIV tests performed**, by sex.
- **Number of positive confidential HIV tests.**
- **Number of anonymous HIV tests.**

TERMS AND DEFINITIONS

AGE – Use the client's age as of June 30th of the reporting period.

TESTS – Report STD (chlamydia, gonorrhea, and syphilis) and HIV (confidential and anonymous) tests performed during the reporting period that are provided within the scope of the grantee's Title X project. Do not report tests performed in an STD clinic operated by the Title X-funded agency, unless the activities of the STD clinic are within the defined scope of the agency's Title X project.

QUESTIONS ABOUT TABLES 11 AND 12

1. **QUESTION** – Are tables 11 or 12 different from the previous FPAR?

ANSWER – No. There are no changes to Tables 11 or 12.

2. **QUESTION** – How should grantees that fund agencies operating co-located Title X and STD clinics report STD tests?

ANSWER – Do not report tests performed in an STD clinic operated by the Title X-funded agency or co-located with the Title X-funded service site unless the activities of the STD clinic are within the defined scope of the grantee's Title X project and the STD tests are provided to family planning users.

3. **QUESTION** – How should a grantee complete Table 12 if the results for HIV tests performed at the end of the reporting period are not received in time to be included in the FPAR?

ANSWER – A grantee has two options for dealing with delayed HIV test results. Under the first option, the grantee can report the HIV testing (Table 12, Row 3) and results (Table 12, Row 4) figures that are available at the time they submit the FPAR and use the Table 12 "Notes" field to

explain that the figure reported in Row 4 is estimated rather than actual due to delayed laboratory reporting.

Under the second option, the grantee can report testing and results data for a 12-month period that has complete results data and is close in time to the reporting period. For example, if HIV testing and results data are complete for the period December to November, but not for January to December, report the figures for December to November, and use the Table 12 “Notes” field to explain that Table 12 data are for a different 12-month period (specify period). Consult your RPC if you have any questions about reporting Table 12 data when HIV testing results are delayed.

4. **QUESTION** – In Table 12, Row 3, should grantees count and report confirmatory HIV tests separately from initial HIV tests (i.e., one versus two tests)?

ANSWER – To the extent possible, grantees should report all HIV tests—initial and confirmatory—performed within the scope of their Title X projects, including HIV tests performed onsite and tests for which a specimen is collected onsite and analyzed offsite (e.g., laboratory). If an offsite laboratory performs a confirmatory test using the same specimen obtained for the initial test, grantees should not count the confirmatory test unless (1) it has billing or other transaction records to document that the laboratory performed a second/confirmatory test and (2) compiling and reporting confirmatory test counts do not pose an undue burden. Grantees should use the Table 12 “Notes” field to explain if HIV test counts exclude confirmatory tests.

5. **QUESTION** – Should grantees include *preliminary* positive rapid HIV tests in the total number of positive HIV test results reported in Table 12, Row 4?

ANSWER – No. The total number of confidential positive HIV tests should only include the number of standard (i.e., not rapid) HIV tests with a positive result and the number of *preliminary* positive rapid HIV tests confirmed to be positive.

Date Submitted:

Reporting Period: January 1, 20____ through December 31, 20____
 _____ through _____
 (Month/day/year) (Month/day/year)

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Table 11
Unduplicated Number of Family Planning Users Tested for Chlamydia by Age and Sex

Age Group (Years)	Female Users (A)	Male Users (B)
1 Under 15		
2 15 to 17		
3 18 to 19		
4 20 to 24		
5 25 and over		
6 Total Users (sum rows 1 to 5)		

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20____ through December 31, 20____
 _____ through _____
 (Month/day/year) (Month/day/year)

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See Notes

Table 12
Number of Gonorrhea, Syphilis, and HIV Tests

Test Type	Female Tests (A)	Male Tests (B)	Total Tests (Sum Cols A + B) (C)
1 Gonorrhea			
2 Syphilis			
3 HIV – All confidential tests			
4 HIV – Positive confidential tests			
5 HIV – Anonymous tests			

FAMILY PLANNING ENCOUNTERS AND UTILIZATION OF CLINICAL SERVICES PROVIDERS

Table 13 provides information on the number and type of family planning encounters, as well as the utilization of clinical services providers in the delivery of Title X-funded family planning and related preventive health services.

INSTRUCTIONS

TABLE 13 – Report the following provider utilization and encounter data:

- **Number of full-time equivalent (FTE) family planning clinical services providers**, by type of provider.
- **Number of family planning encounters with clinical services providers.**
- **Number of family planning encounters with other services providers.**

TERMS AND DEFINITIONS

FAMILY PLANNING PROVIDER – A family planning provider is the individual who assumes primary responsibility for assessing a client and documenting services in the client record. Providers include those agency staff that exercise independent judgment as to the services rendered to the client during an encounter. Two general types of providers deliver Title X family planning services: clinical services providers and other services providers.

CLINICAL SERVICES PROVIDER – Includes physicians (family and general practitioners, specialists), physician assistants, nurse practitioners, certified nurse midwives, and registered nurses with an expanded scope of practice who are trained and permitted by state-specific regulations to perform *all aspects* of the user (male and female) physical assessment, as described in the *Program Guidelines*. Clinical services providers are able to offer client education, counseling, referral, follow-up, and clinical services (physical assessment, treatment, and management) relating to a client’s proposed or adopted method of contraception, general reproductive health, or infertility treatment, in accordance with the *Program Guidelines*.

OTHER SERVICES PROVIDER – Includes other agency staff (e.g., registered nurses, public health nurses, licensed vocational or licensed practical nurses, certified nurse assistants, health educators, social workers, or clinic aides) that offer client education, counseling, referral, or follow-up services relating to the client’s proposed or adopted method of contraception, general reproductive health, or infertility treatment, as described in the *Program Guidelines*. Other services providers may also perform or obtain samples for routine laboratory tests (e.g., urine, pregnancy, STD, and cholesterol and lipid analysis), give contraceptive injections (e.g., Depo-Provera), and perform routine clinical procedures that may include some aspects of the user physical assessment (e.g., blood pressure evaluation), in accordance with the *Program Guidelines*.

FAMILY PLANNING ENCOUNTER – A family planning encounter is a documented, face-to-face contact between an individual and a family planning provider that takes place in a Title X service site. The purpose of a family planning encounter—whether clinical or non-clinical—is to provide family planning and related preventive health services to female and male clients who want to avoid unintended pregnancies or achieve intended pregnancies. To be counted for purposes of the FPAR, a written record of the service(s) provided during the family planning encounter must be documented in the client record.

There are two types of family planning encounters at Title X service sites: (1) family planning encounters with a clinical services provider and (2) family planning encounters with an other services provider. The type of family planning provider who renders the care, regardless of the services rendered, determines the type of family planning encounter. Although a client may meet with both clinical and other services providers during an encounter, the provider with the highest level of training who takes ultimate responsibility for the client's clinical or non-clinical assessment and care during the visit is credited with the encounter.

FAMILY PLANNING ENCOUNTER WITH A CLINICAL SERVICES PROVIDER – A face-to-face, documented encounter between a family planning client and a clinical services provider that takes place in a Title X service site.

FAMILY PLANNING ENCOUNTER WITH AN OTHER SERVICES PROVIDER – A face-to-face, documented encounter between a family planning client and an other services provider that takes place in a Title X service site.

Laboratory tests and related counseling and education, in and of themselves, do not constitute a family planning encounter unless there is face-to-face contact between the client and provider, the provider documents the encounter in the client's record, and the test(s) is/are accompanied by family planning counseling or education.

FULL-TIME EQUIVALENT (FTE) – For each type of **clinical services provider**, report the time in FTEs that these providers are involved in the direct provision of Title X services (i.e., engaged in a family planning encounter).

QUESTIONS ABOUT TABLE 13

1. **QUESTION** – Is table 13 different from the previous FPAR?

ANSWER – Yes. To improve the quality of provider FTE and encounter data, OPA has changed the term “non-clinical services providers” to “other services providers.” OPA has also clarified the definitions for clinical and other (formerly “non-clinical”) services providers. More specifically, OPA has clarified that registered nurses are classified as clinical services providers only if they have an expanded scope of practice and are trained and permitted by state-specific regulations to perform *all aspects* of the user (male and female) physical assessment, as described in the *Program Guidelines*. Otherwise, grantees should classify registered nurses without an expanded scope of practice and all other nurses (e.g., LPNs/LVNs, public health nurses) as other services providers.

2. **QUESTION** – Can a client have more than one family planning encounter during a single family planning visit?

ANSWER – As noted in the “Terms and Definitions” section of the report, a client may have **only one** family planning encounter **per visit**. In the family planning services setting, the term “encounter” is synonymous with “visit.” Although a client may meet with both clinical and other services providers during an encounter, only one provider is credited with the encounter. The provider with the highest level of training who takes ultimate responsibility for the client's clinical or non-clinical assessment and care during the visit is credited with the encounter.

3. **QUESTION** – If a nurse provides a contraceptive injection (e.g., Depo-Provera), should the grantee report the encounter as an encounter with a clinical services provider?

ANSWER – If the nurse who provides the injection is a registered nurse with an expanded scope of practice who is trained and permitted by state-specific regulations to perform *all aspects* of the user (male and female) physical assessment as described in the *Program Guidelines*, then the encounter is an encounter with a clinical services provider and should be reported in Table 13, Row 1.

However, if the injection is provided by a registered nurse who does not have an expanded scope of practice or by another type of nurse (e.g., LPN/LVN or public health nurse), then the encounter should be reported as an encounter with an other services provider in Table 13, Row 2.

4. **QUESTION** – If an individual receives gynecological or related preventive health services (e.g., pelvic exam, Pap test, pregnancy test, STD screening) in a Title X-funded clinic, but does not receive services aimed at avoiding unintended pregnancy or achieving intended pregnancy (e.g., contraceptive or fertility counseling), is the encounter considered a family planning encounter?

ANSWER – If a client is an ongoing family planning user who visits the clinic to obtain any type of family planning or related preventive health services, the encounter is considered a family planning encounter.

If a client of reproductive age has been sterilized, but continues to seek gynecological or related preventive health services, the encounter is considered a family planning encounter and the agency may continue to count the client as a family planning user.

If a client obtains gynecological or related preventive health services, but the client is neither an ongoing family planning user nor seeks or receives services (clinical, counseling, educational, and/or referral) to help avoid unintended pregnancy or achieve intended pregnancy, the encounter is not a family planning encounter and the client is not a family planning user.

If a post-menopausal client obtains gynecological or related preventive health services, the encounter is not a family planning encounter and the client is not a family planning user.

Date Submitted: _____

Reporting Period: January 1, 20____ through December 31, 20____
 _____ through _____
 (Month/day/year) (Month/day/year)Check One: Initial Submission
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Table 13
Number of Family Planning Encounters by Type of Provider

Provider Type	Number of FTEs (A)	Number of Family Planning Encounters (B)
1 Clinical Services Providers		
1a Physicians		
1b Physician assistants/nurse practitioners/ certified nurse midwives		
1c Registered nurses with an expanded scope of practice who are trained and permitted by state- specific regulations to perform all aspects of the user physical assessment		
2 Other Services Providers		
3 Total Family Planning Encounters (sum rows 1 + 2)		

REVENUE REPORT

Title X Section 1001 grantees are required to maintain a financial management system that meets the standards for grant administration and to document and keep records of all income and expenditures.^{2,3} Table 14 identifies the sources and amounts of financial support received during the reporting period that support activities within the scope of the grantee's Title X family planning services project ("Title X project").

INSTRUCTIONS

TABLE 14 – Report the revenues (i.e., actual *cash* receipts or *drawdown* amounts) received during the reporting period from each funding source to support activities within the scope of the grantee's Title X services grant (Section 1001), even if the funds were not expended during the reporting period. Include (1) all receipts from the Title X services grant; (2) collections from patients and reimbursements from third parties for services rendered; and (3) receipts from other sources, including block grants, state and local governments, and other sources. If the value for a cell is zero, enter "0." The agency must retain for audit purposes all worksheets that document how the agency derived the reported amounts.^{2,3} Do not report the monetary value of in-kind contributions as revenue in Table 14.

TERMS AND DEFINITIONS

TITLE X GRANT – Refers to funds received from the Title X Section 1001 family planning services grant. Report the amount received (cash receipts or drawdown amounts) during the reporting period from the Title X services grant. Do not report the amount of grant funds awarded unless this figure is the same as the actual *cash* receipts or *drawdown* amounts.

PAYMENT FOR SERVICES – Refers to funds collected directly from clients and revenues received from public and private third party payers (capitated or fee-for-service) for services provided within the scope of the grantee's Title X project.

TOTAL CLIENT COLLECTIONS/SELF-PAY – Report the amount collected directly from clients during the reporting period for services provided within the scope of the grantee's Title X project.

THIRD-PARTY PAYERS – For each third-party source listed, report the amount received (i.e., reimbursed) during the reporting period for services provided within the scope of the grantee's Title X project. Only revenue from pre-paid (capitated) managed care arrangements (e.g., capitated Medicare, Medicaid, and private managed care contracts) should be reported as prepaid. Revenues received after the date of service, even under managed care arrangements, should be reported as not prepaid.

MEDICAID/TITLE XIX – Report the amount received from Medicaid (federal and state shares) during the reporting period for services provided within the scope of the grantee's Title X project, regardless of whether the reimbursement was paid directly by Medicaid or through a fiscal intermediary or a health maintenance organization (HMO). For example, in states with a capitated Medicaid program (i.e., the grantee has a contract with a private plan like Blue Cross), the payer is Medicaid, even though the actual payment may come from Blue Cross. Include revenue from family planning waivers (both federal and state shares) in Row 3a, Column B. If the amount

reported in Row 3a, Column B includes family planning waiver revenue, indicate this in the Table 14 “Notes” field.

MEDICARE/TITLE XVIII – Report the amount received from Medicare during the reporting period for services provided within the scope of the grantee’s Title X project, regardless of whether the reimbursement was paid directly by Medicare or through a fiscal intermediary or an HMO. For clients enrolled in a capitated Medicare program (i.e., where the grantee has a contract with a private plan like Blue Cross), the payer is Medicare, even though the actual payment may come from Blue Cross.

STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP) – Report the amount of funds received during the reporting period from SCHIP for services provided within the scope of the grantee’s Title X project. If the grantee is unable to report SCHIP revenue separately from Medicaid (Row 3a), indicate this in the Table 14 “Notes” field.

OTHER PUBLIC HEALTH INSURANCE – Report the amount reimbursed by other federal, state, or local government health insurance programs during the reporting period for services provided within the scope of the grantee’s Title X project. Examples of other sources of public third-party insurance programs include health insurance plans for military personnel and their dependents (e.g., TRICARE, CHAMPVA) and state health insurance plans.

PRIVATE HEALTH INSURANCE – Report the amount of funds received from private third-party health insurance plans during the reporting period for services provided within the scope of the grantee’s Title X project.

OTHER REVENUE – Refers to revenue received from other sources during the reporting period that supported services provided within the scope of the grantee’s Title X project. Other revenue sources include block grants, TANF, state and local governments (e.g., contracts, state and local indigent care programs), the Bureau of Primary Health Care, private and client donations, or other public or private revenues.

MATERNAL AND CHILD HEALTH (MCH) BLOCK GRANT/TITLE V – Report the amount of Title V funds received during the reporting period that supported services provided within the scope of the grantee’s Title X project.

SOCIAL SERVICES BLOCK GRANT/TITLE XX – Report the amount of Title XX funds received in the reporting period that supported services provided within the scope of the grantee’s Title X project.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) – Report the amount of TANF funds received in the reporting period that supported services provided within the scope of the grantee’s Title X project.

LOCAL GOVERNMENT REVENUE – Report the amount of funds from local government sources (including county and city grants or contracts) that were received during the reporting period and that supported services provided within the scope of the grantee’s Title X project.

STATE GOVERNMENT REVENUE – Report the amount of funds from state government sources (including grants or contracts) that were received during the reporting period and that supported services provided within the scope of the grantee’s Title X project. Do not report as “state government revenue” funding from sources like the Centers for Disease Control and Prevention (CDC) (e.g., Infertility Prevention Project) or block grant funds that are awarded to and distributed by the state. Report these revenues as “Other revenue” and specify their source(s).

BUREAU OF PRIMARY HEALTH CARE (BPHC) – Report the amount of revenue received from BPHC grants (e.g., Section 330) during the reporting period that supported services provided within the scope of the grantee’s Title X project.

OTHER REVENUE – Report the amount and specify the source of funds received during the reporting period from other sources that supported services provided within the scope of the grantee’s Title X project. This may include revenue from such sources as the CDC (infertility, STD, or HIV prevention; breast and cervical cancer detection), private grants and donations, fundraising, interest income, or other sources.

QUESTION ABOUT TABLE 14

1. **QUESTION** – Is Table 14 different from the previous FPAR?

ANSWER – Yes. OPA has made minor changes to the structure of Table 14. The “Federal Grants” section has been reduced to one row for reporting revenue from the Title X services grant, and the three other rows that were previously included under “Federal Grants,” specifically the row for reporting grants from BPHC and two rows for reporting “Other” federal grants, have been moved to “Other Revenue.” The “Federal Grants” section has been renamed “Title X Services Grant” and the row for reporting BPHC grant revenue is now row 11. All rows in Table 14 have been renumbered to reflect these changes.

2. **QUESTION** – Can a grantee report an estimate of the monetary value of in-kind donations of goods, services, or other noncash contributions as revenue in Table 14?

ANSWER – No. In Table 14, revenues include actual cash receipts or drawdown amounts only. Do not report the monetary value of in-kind contributions as revenue in Table 14.

Date Submitted: _____

Reporting Period: January 1, 20____ through December 31, 20____
 _____ through _____
 (Month/day/year) (Month/day/year)Check One: Initial Submission
 Revision See Notes**Table 14**
Revenue Report

Revenue Source		Amount	
Title X			
1	Title X grant (Section 1001: family planning services)		
Payment for Services			
2	Total client collections/self-pay		
3	Third-party payers	Amount Prepaid (A)	Amount Not Pre-paid (B)
3a	Medicaid (Title XIX)		
3b	Medicare (Title XVIII)		
3c	State Children's Health Insurance Program (SCHIP)		
3d	Other public health insurance		
3e	Private health insurance		
4	Total – Third-Party Payers (sum rows 3a to 3e)		
5	Total – Payment for Services (sum row 2 + cell 4a + cell 4b)		
Other Revenue			
6	Title V (MCH Block Grant)		
7	Title XX (Social Services Block Grant)		
8	Temporary Assistance for Needy Families (TANF)		
9	Local government revenue		
10	State government revenue		
11	Bureau of Primary Health Care (BPHC)		
12	Other (Specify: _____)		
13	Other (Specify: _____)		
14	Other (Specify: _____)		
15	Other (Specify: _____)		
16	Other (Specify: _____)		
17	Total– Other Revenue (sum rows 6 to 16)		
18	Total Revenue (sum rows 1 + 5 + 17)		

NOTES

NOTES (CONTINUED)

ABBREVIATIONS AND ACRONYMS

AGC	atypical glandular cells
AIS	adenocarcinoma in situ
ASC	atypical squamous cells
ASC-H	atypical squamous cells, cannot exclude HSIL
ASC-US	atypical squamous cells of undetermined significance
BPHC	Bureau of Primary Health Care
CBE	clinical breast exam
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CIN	cervical intraepithelial neoplasia
FAM	fertility awareness method
FPAR	Family Planning Annual Report
FTE	full-time equivalent
GPRA	Government Performance and Results Act
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HMO	health maintenance organization
HSIL	high-grade squamous intraepithelial lesion
IUD	intrauterine device
LAM	Lactational Amenorrhea Method
LEP	limited English proficiency, limited English proficient
LPN	licensed practical nurse
LVN	licensed vocational nurse
LSIL	low-grade squamous intraepithelial lesion
MCH	maternal and child health
OFP	Office of Family Planning
OMB	Office of Management and Budget
OPA	Office of Population Affairs
PRA	Paperwork Reduction Act
SCHIP	State Children's Health Insurance Program
RPC	regional program consultant
STD	sexually transmitted disease
TANF	Temporary Assistance for Needy Families
USC	United States Code

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APPENDIX A: COLLECTING AND TABULATING MULTI-RACE RESPONSES

Background. On October 24, 1997, the Department of Health and Human Services (HHS) issued a *Policy Statement on Inclusion of Race and Ethnicity in DHHS Data Collection Activities*.¹² This policy requires the inclusion of racial and ethnic categories in HHS-funded and -sponsored data collection and reporting systems. Implementation of this policy is intended to help to identify major health conditions of minority populations, monitor progress in meeting their needs, and ensure nondiscrimination in access to and provision of appropriate HHS services for various racial and ethnic groups. Although programs that are directed to minority racial or ethnic populations have exemptions, these programs are encouraged to collect and report data on subgroups within their target populations.

The HHS inclusion policy refers to the Office of Management and Budget (OMB) 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*,¹³ and any subsequent revisions, as the standard for racial and ethnic reporting categories in HHS-funded programs. The FPAR race and ethnicity categories comply with the 1997 OMB revised minimum standards.

Reporting more than one race. According to the 1997 OMB revised standards, the following apply when respondents are allowed to self-identify with or self-report more than one race:

- Agencies should adopt a method that allows respondents to mark or select more than one of the five minimum race categories.
- The method for respondents to report more than one race should take the form of *multiple responses* to a single question and *not* a single “multiracial” category.
- When a list of races is provided to respondents, the list should not contain a “multiracial” category.
- Based on research conducted so far, two recommended forms for the instruction accompanying the multiple-response question are “Mark one or more...” and “Select one or more....”
- If the criteria for data quality and confidentiality are met, provision should be made to report, at a minimum, the number of individuals identifying with more than one race. Data producers are encouraged to provide greater detail about the distribution of multiple responses.

Agencies are encouraged to consult with their Regional Program Consultant (RPC) if they have further questions about collecting multi-race responses. On the following page is a sample question, designed to be self-administered, for collecting race data. A list of references on this topic is also included.

¹² U.S. Department of Health and Human Services. (October 24, 1997). *Policy statement on inclusion of race and ethnicity in DHHS data collection activities*. Retrieved March 1, 2011, from <http://aspe.hhs.gov/datacncl/inclusrn.htm>

¹³ Office of Management and Budget. (October 30, 1997). *Revisions to the standards for the classification of federal data on race and ethnicity, Federal Register notice*. Retrieved March 1, 2011, from http://www.whitehouse.gov/omb/fedreg_race-ethnicity

What is your race? Select one or more.

- American Indian or Alaskan Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Asian:** A person 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.
- Black or African American:** A person having origins in any of the black racial groups of Africa.
- Native Hawaiian or Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

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- Office of Management and Budget. (March 9, 2000). *Guidance on aggregation and allocation of data on race for use in civil rights monitoring and enforcement*. OMB Bulletin No. 00-02. Retrieved March 1, 2011, from <http://www.whitehouse.gov/omb/bulletins/b00-02.html>
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- U.S. Census Bureau. (2001). *The two or more races population: 2000*. Census 2000 Brief No. C2KBR/01-6. Retrieved March 1, 2011, from <http://www.census.gov/prod/2001pubs/c2kbr01-6.pdf>
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