OMB No.: 0915-0285 Expiration Date: XX/XX/20XX

| **DEPARTMENT OF HEALTH AND HUMAN SERVICES  Health Resources and Services Administration   FORM 3A: LOOK-ALIKE BUDGET INFORMATION** | | | | **FOR HRSA USE ONLY** | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Grant Number** | | **Application Tracking Number** | |
|  | |  | |
| Note: The program income total on this form must match the program income total on Form 3. | | | | | | | |
| **Budget Category** | Community Health Centers **(CHC - 330(e))** | Migrant Health Centers  **(MHC - 330(g))** | Health Care for the Homeless **(HCH - 330(h))** | | Public Housing **Primary Care (PHPC - 330(i))** | | **Total**  *will auto-calculate in EHB* |
| 1. **Expenses** | | | | | | | |
| 1. Personnel |  |  |  | |  | |  |
| 1. Fringe Benefits |  |  |  | |  | |  |
| 1. Travel |  |  |  | |  | |  |
| 1. Equipment |  |  |  | |  | |  |
| 1. Supplies |  |  |  | |  | |  |
| 1. Contractual |  |  |  | |  | |  |
| 1. Construction |  |  |  | |  | |  |
| 1. Other |  |  |  | |  | |  |
| 1. Total Direct Charges   (sum of a through h)  *will auto-calculate in EHB* |  |  |  | |  | |  |
| 1. Indirect Charges |  |  |  | |  | |  |
| 1. **Total Expenses**   (sum of i and j)  *will auto-calculate in EHB* |  |  |  | |  | |  |
| 1. **Revenue** | | | | | | | |
| 1. Applicant |  |  |  | |  | |  |
| 1. Federal |  |  |  | |  | |  |
| 1. State |  |  |  | |  | |  |
| 1. Local |  |  |  | |  | |  |
| 1. Other |  |  |  | |  | |  |
| 1. Program Income |  |  |  | |  | |  |
| 1. **Total Revenue**   (sum of a through f)  *will auto-calculate in EHB* |  |  |  | |  | |  |

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0285. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N-39, Rockville, Maryland, 20857

**INSTRUCTIONS**

Form 3A collects the budget information for the look-alike project.

In **Part 1: Expenses**, enter the projected first year of expenses for each Health Center Program type for which designation is requested (i.e., CHC, MHC, HCH, PCPH). The total fields are calculated automatically when you save the form.

In **Part 2: Revenue,** enter the projected first year of revenue by funding source (applicant, Federal, State, local, and/or other sources). The total fields are calculated automatically when you save the form.

Form 3A should be consistent with amounts justified in the budget justification narrative.