Program Specific Forms Instructions

Program Specific Forms must be completed electronically in EHB. This document provides instructions for the following forms:

Form 1A: General Information Worksheet
Form 1B: BPHC Funding Request Summary
Form 1C: Documents on File
Form 2: Staffing Profile
Form 3: Income Analysis
Form 4: Community Characteristics
Form 5A: Services Provided
Form 5B: Service Sites
Form 5C: Other Activities/Locations
Form 6A: Current Board Member Characteristics
Form 6B: Request for Waiver of Board Member Requirements
Form 8: Health Center Agreements
Form 9: Need for Assistance (NFA) Worksheet
Form 10: Emergency Preparedness Report
Form 12: Organization Contacts
Summary Page

Form 1A: General Information Worksheet

1. Applicant Information

- Complete all relevant information that is not pre-populated.
- Grant numbers will pre-populate for competing continuation applicants.
- Use the Fiscal Year End Date field to note the month and day in which the applicant organization's fiscal year ends (e.g., December 31) to help HRSA know when to expect the audit submission in the Federal Audit Clearinghouse.
- Applicants may check only one category in the Business Entity section. An applicant that is a Tribal or Urban Indian entity and also meets the definition for a public or private entity should select the Tribal or Urban Indian category.
- Applicants may select one or more categories for the Organization Type section.

2. Proposed Service Area

2a. Service Area Designation

- Applicants applying for CHC funding MUST serve at least one Medically Underserved Area (MUA) or Medically Underserved Population (MUP).
- Select the MUA and/or MUP designations for the proposed service area and enter the identification number(s).
- For inquiries regarding MUAs or MUPs, visit the Shortage Designation Web site or email sdb@hrsa.gov.

2b. Service Area Type

- Select the type (urban, rural, or sparsely populated) that describes the majority of the service area. If sparsely populated is selected, provide the number of people per square mile (values must range from .01 to 7). For information about rural populations, visit the Office of Rural Health Policy's Web site.

2c. Patients and Visits

General Guidance for Patient and Visit Numbers:

When providing the count of patients and visits within each service type category, note the following (see the UDS Manual for detailed information):

- A visit is a documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services rendered must be paid for by the applicant organization and documented in the patient's record.
- A patient is an individual who had (current data) or is projected to have (projected data) at least one visit in 2018 (January 1 through December 31, 2018).
- Since a patient must have at least one documented visit, the number of patients cannot exceed the number of visits.
- Applicants with more than one service site must report aggregate data for all sites in the proposed project.
- Baseline patient data will pre-populate from the most recent UDS report for competing continuation applicants. If UDS data does not accurately reflect current numbers (e.g., due to additional funding received, change in scope, or shifting service area characteristics such as influx of new populations), indicate the accurate current data and describe the discrepancy between UDS and current data in Item 3 of the *NEED* section of the Project Narrative.
- A new or competing supplement applicant should report baseline values based on services the applicant is currently providing in the proposed service area (report annualized data) or, if not currently operational in the service area, report baseline values as zero.

  Note: A competing supplement applicant should only include in the baseline values patients/visits occurring in the proposed service area that are **not** included in the applicant's most recent UDS report.

Unduplicated Patients and Visits by Population Type:

The population types in this section do NOT refer only to the requested funding categories in Section A of the SF-424A: Budget Information Worksheet (i.e., CHC, MHC, HCH, and/or PHPC). An applicant applying for only CHC funding (General Underserved Community) may still have patients/visits reported in the other population type categories. **All patients/visits that do not fall within the Migratory and Seasonal Agricultural Workers and Families, Public Housing Residents, or the People Experiencing Homelessness categories must be included in the General Underserved Community category**.

1. Project the number of unduplicated patients to be served by December 31, 2018 (January 1 – December 31, 2018). This value will pre-populate in the corresponding cell within the table below.

2. New or competing supplement applicants: Provide the number of current unduplicated patients and visits for each population type category to establish a baseline. **Across all population type categories, an individual can only be counted once as a patient.**

3. The total number of unduplicated patients projected by December 31, 2018 (January 1 – December 31, 2018) will pre-populate from Item 1 above. Project the **total** number of visits by December 31, 2018 (January 1 – December 31, 2018). Then categorize these projected numbers for each population type category. **Across all population type categories, an individual can only be counted once as a patient.**

Patients and Visits by Service Type:

1. Provide the number of current patients and visits within each service type category to establish a baseline. **An individual who receives multiple types of services should be counted once for each service type** (e.g., an individual who receives both medical and dental services should be counted once for medical and once for dental).

   Competing continuation applicants: Current patients and visits for each service type category will pre-populate from the 2015 UDS data.

2. Project the number of patients and visits anticipated within each service type category by December 31, 2018 (January 1 – December 31, 2018). In general, HRSA does not expect the number of patients and visits to decline over time.

   Competing supplement applicants should not include patients served through current Health Center Program funding.

3. To maintain consistency with the patients and visits reported in UDS, do not report patients and visits for vision or pharmacy services or services outside the proposed scope of project. Refer to the Scope of Project policy documents.

   Note: The Patients and Visits by Service Type section does not have a row for total numbers since an individual patient may be included in multiple service type categories (i.e., a single patient should be counted as a patient for each service type received).

FORM 1B – BPHC Funding Request Summary

Form 1B collects the funding request for the NAP application. The maximum amount of funding in Year 1 is $650,000; any one-time funding requested for equipment or minor alteration and renovation (up to $150,000) is included in this amount. Applicants can request up to $650,000 for operations in Year 2. Before completing Form 1B, the SF-424A: Budget Information form must be completed. See Section IV.2.iii for instructions on completing the SF-424A. The SF-424A is the official budget request. Therefore, if a NAP award is received, only one-time funding as indicated on the SF-424A will be included. The one-time funding information entered on Form 1B: BPHC Funding Request Summary must be consistent with the request on the SF-424A.

For the Year 1 operational funding column, enter operational budget information by funding category (CHC, MHC, HCH, and/or PHPC). Only the types of health center programs selected in the Budget Summary (Section A) of the SF-424A will be available in Form 1B. Next, enter any one-time funds requested for minor alteration/renovation and/or equipment (up to $150,000). The one-time funding request on Form 1B must be consistent with the federal request for equipment and/or construction in Section B on the SF-424A. The budget for Year 2 on Form 1B will be pre-populated from data provided by the applicant in Federal Resources (Section E) of the SF-424A.

Applicants will not be allowed to modify the pre-populated data on this form. If changes are required, applicants must modify the appropriate section of the SF-424A. A link to the SF-424A will be provided for navigation to the appropriate budget sections.

Applicants requesting one-time funding for equipment and/or minor alteration/renovation must indicate if the one-time funds are for: 1) equipment only; 2) minor alteration/renovation with equipment; or 3) minor alteration/renovation without equipment. Applicants requesting one-time funding for equipment only or minor alteration/renovation with equipment must complete an equipment list. Equipment is considered to be loose, moveable items that are non-expendable, tangible personal property (including information technology systems[1]) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of (a) the capitalization level established by the applicant for its financial statement purposes, or (b) $5,000. See Appendix C for detailed instructions on equipment requirements.

Applicants that request one-time funding for minor alteration/renovation (with or without equipment) must complete the Alteration/Renovation (A/R) Project Cover Page, Other Requirements for Sites Form, budget justification for the minor alteration/renovation project, Environmental Information and Documentation (EID) Checklist, and architectural drawings of the proposed alteration/renovation. If the property is leased, the applicant must attach a Landlord Letter of Consent. See Appendix C for detailed instructions on alteration/renovation requirements.

Form 1C: Documents on File

[1] Licenses for electronic health records or health information technology should be reported in the "Other" cost category.

This form provides a summary of documents that support the implementation of listed Health Center Program requirements and key areas of health center operations. It does not provide an exhaustive list of all types of health center documents (e.g., policies and procedures, protocols, legal documents). Provide the date that each document was last reviewed and, if appropriate, revised. Reference the Health Center Program requirements for detailed information about each requirement.

Keep these documents on file, making them available to HRSA **upon request** within 3-5 business days. **DO NOT** submit these documents with the application.

Under Malpractice Coverage Plan listed in the Services section, new applicants should indicate when malpractice coverage will be in effect. Once funded, new award recipients can apply for FTCA coverage upon meeting the FTCA eligibility requirements; however, FTCA participation is not guaranteed. Health centers that have chosen not to apply for, or have terminated FTCA coverage, may use Federal grant funds for the purchase of private malpractice insurance. See Section VIII for more information about FTCA.

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

Form 2: Staffing Profile

Report personnel for the **first budget year** of the proposed project. Include only staff for sites included on Form 5B: Service Sites.

- Allocate staff time in the Direct Hire FTE column by function among the staff positions listed. An individual's full-time equivalent (FTE) should not be duplicated across positions. For example, a provider serving as a part-time family physician and a part-time Clinical Director should be listed in each respective category with the FTE percentage allocated to each position (e.g., Clinical Director 0.3 (30%) FTE and family physician 0.7 (70%) FTE). Do not exceed 1.0 (100%) FTE for any individual. For position descriptions, refer to the UDS Manual.
- Volunteers must be recorded in the Direct Hire FTEs column.
- For health centers that provide services through formal written contracts/agreements (Form 5A, Column II), Select Yes for contracted staff summarized in Attachment 7: Summary of Contracts and Agreements and/or included in contracts uploaded to Form 8: Health Center Agreements, as needed.
- Contracted staff are indicated by answering Yes or No only. **Do not quantify contracted staff in the Direct Hire column of this form.**

Form 3: Income Analysis

Form 3 collects the projected patient services and other income from all sources (other than the Health Center Program funds) for the **first year** of the proposed project period. Form 3 income

is divided into two parts: (1) Patient Service Revenue - Program Income and (2) Other Income - Other Federal, State, Local, and Other Income.

Part 1: Patient Service Revenue - Program Income
Patient service revenue is income directly tied to the provision of services to the health center's patients. Services to patients that are reimbursed by health insurance plans, managed care organizations, categorical grant programs (e.g., breast and cervical cancer screening), employers, and health provider organizations are classified as patient service revenue. Reimbursements may be based upon visits, procedures, member months, enrollees, the achievement of performance goals, or other service related measures.

The program income section groups billable visits and income into the same five payer groupings used in the UDS Manual. All patient service revenue is reported in this section of the form. This includes all income from medical, dental, mental health, substance abuse, other professional, vision, and other clinical services, as well as income from ancillary services such as laboratory, pharmacy, and imaging services.

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

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

Patients by Primary Medical Insurance - Column (a): These are the projected number of unduplicated patients classified by payer based upon the patient's primary medical insurance. The primary insurance is the payer that is billed first. The patients are classified in the same way as found in the UDS Manual, Table 4, lines 7 – 12. This column should not include patients who are only seen for non-billable or enabling service visits. Examples for determining where to count patients include:

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

Billable Visits - Column (b): This includes all billable/reimbursable visits.[2] The value is typically based on assumptions about consolidated individual clinician time, productivity, and visits by payer. There may be other exclusions or additions, which, if significant, should be noted in the Comment/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column (See ancillary instructions below.)

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

Income per Visit - Column (c): This value may be calculated by dividing projected income in Column (d) by billable visits in Column (b).

Projected Income - Column (d): This is the projected accrued net revenue, including an allowance for bad debt from all patient services for each pay grouping in the first year of the proposed project period. Pharmacy income may be estimated by using historical data to determine the number of prescriptions per medical visit and the average income per prescription. All separate projections of income are consolidated and reported in Column (d).

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

Alternative Instructions for Capitated Managed Care:
Health centers may use their own methods for budgeting patient service income than those noted above, but must report the consolidated result in Projected Income Column (d) along with the related data requested in Columns (a) through (e). Income for each service may be estimated by multiplying the projected visits by assumed income per visit. For example, capitated managed care income may be based upon member-month enrollment projections, and estimated capitation rates for each plan grouped by payer and added to the projected income. The estimated visits associated with these managed care plans are entered in Column (b).

Payer Categories (Lines 1 – 5): There are five payer categories including Medicaid, Medicare, Other Public, Private, and Self-Pay, reflecting the five payer groupings in UDS. The UDS Manual must be used to define each payer category.

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

All service income is to be classified by payer, including pharmacy and other ancillary service revenue. In the event the applicant does not normally classify the projected ancillary or other service revenue by payer category, the projected income is to be allocated by payer group using a reasonable allocation method, such as the proportion of medical visits or charges. The method used should be noted in the Comments/Explanatory Notes section at the bottom of the form.

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

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

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

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

Self-Pay (Line 5): This includes income from patients, including full-pay, self-pay, and sliding fee patients, as well as the portion of the visit income for which an insured patient is personally responsible.

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

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

and 10 for examples of services provided to non-health center patients (patients of an entity with which the health center is contracting).

Other Federal (Line 7): This is income from federal funds where the applicant is the recipient of a Notice of Award from a federal agency. It does not include the Health Center Program funding request or federal funds awarded through intermediaries (see Line 9 below). It includes funds from federal sources such as the CDC, Housing and Urban Development (HUD), Centers for Medicare and Medicaid Services (CMS), and others. It includes Department of Health and Human Service (DHHS) funding under the Ryan White HIV/AIDS Program Part C, DHHS Capital Development funding, and others. The CMS Medicare and Medicaid EHR incentive program income is reported here in order to be consistent with the UDS Manual.

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

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

Private Grants/Contracts (Line 10): This is income from private sources, such foundations, non-profit entities, hospitals, nursing homes, drug companies, employers, other health centers, and similar entities. For example, a health center operating a 340B pharmacy in part for its own patients and in part as a contractor to another health center is to report the pharmacy income for its own patients in Part 1 and the income from the contracted health center on this line.

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

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

Applicant (Retained Earnings) (Line 13): This is the amount of funds needed from the applicant's retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why applicant funds (retained earnings) are needed to achieve a breakeven budget. Amounts from non-federal sources, combined with the Health Center Program funds, should be adequate to support normal operations.

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

Total Non-Federal (Line 15): This is the sum of Lines 6 and 14 and is the total non-federal (non-Health Center Program) income.

Note*:* In-kind donations are not included as income on Form 3. Applicants may discuss in-kind donations in the *SUPPORT REQUESTED* section of the Project Narrative. Additionally, such donations may be included on the SF-424A (Section A: Budget Summary—Non-Federal Resources under New or Revised Budget).

Form 4: Community Characteristics

Report current service area and target population data. Information provided regarding race and ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements and will not be used as an awarding factor. Applicants compiling data from multiple data sources may find that the total numbers vary across sources. Such applicants should make adjustments as needed to ensure that the total numbers for the first four sections of this form match. Adjustments must be explained in Item 1 of the *NEED* section of the Project Narrative.

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

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

If the target population includes a large number of transient individuals (e.g., the county has an influx of migratory and seasonal agricultural workers and families during the summer months) that are not included in the dataset used for service area data (e.g., census data), adjust the service area numbers accordingly to ensure that the target population numbers are always less than or equal to the service area numbers.
Note*:* The total numbers for the first four sections of this form (i.e., Race, Hispanic or Latino Ethnicity, Income as a Percent of Poverty Level, and Primary Third Party Payment Source) **must match**.

Guidelines for Reporting Race

- All individuals must be classified in one of the racial categories, including individuals who also consider themselves Hispanic or Latino. If the data source does not separately classify Hispanic or Latino individuals by race, report them as Unreported/Declined to Report.
- Utilize the following race definitions:

- Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Indonesia, Thailand, and Vietnam.
- Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
- Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, Tonga, Palau, Truk, Yap, or other Pacific Islands in Micronesia, Melanesia, or Polynesia.
- American Indian/Alaska Native – Persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- More Than One Race – Person who chooses 2 or more races.

Guidelines for Reporting Hispanic or Latino Ethnicity

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

Guidelines for Reporting Special Populations

The Special Populations section of Form 4 does not have a row for total numbers. Individuals that represent multiple special population categories should be counted in all applicable categories.

Forms 5A, 5B, and 5C

General Notes

- **Competing continuation applicants**: The application should reflect only the current scope of project. Therefore, these forms will be pre-populated and cannot be modified. Changes in services, sites, and other activities/locations require prior approval through a Change in Scope request submitted in EHB. If the pre-populated data does not reflect recently approved scope changes, click the **Refresh from Scope** button in the EHB to display the latest scope of project.

- **New and competing supplement applicants** must complete Forms 5A: Services Provided and 5B: Service Sites. Form 5C: Other Activities/Locations may be completed, as applicable. Complete these forms based only on the scope of project for the proposed service area.

- If the project is funded, only the services, sites, and other activities/locations listed on these forms will be considered to be in the approved scope of project, regardless of what is described or detailed elsewhere in the application.

- Refer to the Scope of Project policy documents and resources for details pertaining to defining and changing scope (i.e., services, sites, service area zip codes, target population).

FORM 5A – SERVICES PROVIDED

Identify the services that will be available through the new access point(s) and how the services will be provided (i.e., direct by health center, formal written agreement (health center pays for service), formal written referral arrangement). The new access point(s) must provide all required services either directly onsite or through established agreements/ arrangements without regard to ability to pay and on a sliding fee discount schedule. See the Form 5A Service Descriptors at http://bphc.hrsa.gov/programrequirements/scope.html for descriptions of the general elements for all services. Established agreements must be summarized in Attachment 7 and, if they constitute a significant portion of the applicant's scope of project, agreements/contracts must be noted on Form 8. Additional services are not required. However, when offered, they must be provided without regard to ability to pay and on a sliding fee discount schedule.

Because comprehensive primary medical care is the main purpose of the NAP project, General Primary Medical Care must be offered at the NAP site either directly by the health center (Column I) or through formal written contractual agreements in which the health center pays for the service (Column II). General Primary Medical Care cannot be provided solely by referral for the NAP project. Reminder: This is an eligibility criterion.

If the project is funded, only the services included on Form 5A will be considered to be in the approved scope of project, regardless of what is described or detailed elsewhere in the application. Refer to the Scope of Project policy documents and resources available at http://bphc.hrsa.gov/programrequirements/scope.html for more information on services and modes of service delivery.

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

FORM 5B – SERVICE SITES (REQUIRED)

On Form B, identify the proposed site(s)[3] and provide the required data for each site, including:

- Site address (must be a verifiable street address);
- Location type (permanent, seasonal, or mobile van);
- Site Operational Date (must be within 120 days of award);
- Total hours of operation per week;
- Service area zip codes; and
- Subrecipient or contractor information, if applicable.

[3] A current Health Center Program look-alike may propose the site(s) currently included in its Health Center Program look-alike scope of project, as well as new site(s), as long as those sites are not included in any Health Center Program award recipient's scope of project.

At least one proposed service site must be a full-time (operational 40 hours or more per week), permanent service delivery site (with the exception of proposed projects serving only migratory and seasonal agricultural workers, addressed below) that provides comprehensive primary medical care as its main purpose. A permanent site is a fixed building location. Subsequent service sites may be administrative, part-time, seasonal, etc.

Applicants proposing to serve only migratory and seasonal agricultural workers may propose a full-time seasonal service delivery site that operates at least 40 hours per week and provides comprehensive primary medical care as its main purpose.

Provide the required data for each proposed new access point that meets the definition of a service site. Refer to PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes available at http://bphc.hrsa.gov/programrequirements/pdf/pin2008-01.pdf for more information on defining service sites and for special instructions for recording mobile, intermittent, or other site types. Information presented on Form 5B will be used by HRSA to determine the scope of project for the Health Center Program award. Only the service sites included on Form 5B will be considered to be in the approved scope of project. Service sites described or detailed in other portions of the application (e.g., narratives, attachments) are not considered to be included in the approved scope of project if the application is funded.

On each Form 5B, applicants should include the zip codes for the area served by the site. The zip code of the site address must be listed in the service area zip codes on Form 5B. The applicant's entire service area (as described on Form 4) should be represented by the consolidation of all zip codes across all proposed service sites (all 5B forms). The zip codes listed on Form 5B will be used to determine the NAP service area and calculate the Unserved, High Poverty, Sparsely Populated, and Look-Alike Priority Points.

Note that in the Service Site Checklist, applicants will have to state if the proposed site is a Domestic Violence site (e.g., emergency shelter). Select "yes" for this question only if the site being added is a site serving victims of domestic violence and the street address cannot be published to protect the confidentiality of the precise location.

FORM 5C – OTHER ACTIVITIES/LOCATIONS

Provide requested data for other activities/locations (e.g., home visits, health fairs). List only the activities/locations that:

1) Do not meet the definition of a service site;
2) Are conducted on an irregular timeframe/schedule; and/or
3) Offer a limited activity from within the full complement of health center activities included within the scope of project.

NAP service site(s) should not be listed on Form 5C. Refer to PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes (available at http://bphc.hrsa.gov/programrequirements/pdf/pin2008-01.pdf) for more details.

Form 6A: Current Board Member Characteristics

The list of board members will be pre-populated for competing continuation and competing supplement applicants. **Applicants must update pre-populated information as appropriate.**[4] Public centers with co-applicant health center governing boards must list the co-applicant board members.

Complete or update the following information:

- List all current board members; current board office held for each board member, if applicable (e.g., Chair, Treasurer); and each board member's area of expertise (e.g., finance, education, nursing). Do not list the CEO or other health center employees.[5]
- Indicate if the board member derives more than 10 percent of income from the health care industry.
- Indicate if the board member is a health center patient. A patient board member must be a currently registered patient of the health center and must have accessed the health center in the past 24 months to receive at least one in-scope service that generated a documented health center visit.
- Indicate if the board member lives and/or works in the service area.
- Indicate if the board member is a representative of/for a special population (i.e., persons experiencing homelessness, migratory and seasonal agricultural workers and families, residents of public housing).
- Indicate the total gender, ethnicity, and race of board members who are patients of the health center.

Note*:*

- Indian tribes or tribal, Indian, or urban Indian organizations are not required to complete this form, but may include information, as desired.
- Applicants requesting a waiver of the 51% patient majority board composition requirement (see below) must list the applicant's board members, NOT the members of any advisory council.

Form 6B: Request for Waiver of Board Member Requirements

- An applicant that currently receives or is applying to receive CHC (section 330(e)) funding is not eligible for a waiver and cannot enter information.
- Indian tribes or tribal, Indian, or urban Indian groups are not required to complete this form and cannot enter information.
- Competing continuation applicants that wish to continue an existing waiver must complete this form.
- When requesting a waiver, briefly demonstrate good cause as to why the patient majority board composition requirement cannot be met, and present a plan for ensuring patient input and participation in the organization, direction, and ongoing governance of the health center. The plan must provide all of the following:

---

[4] Refer to PIN 2014-01: Health Center Program Governance for information on Governance requirements.

[5] The CEO may serve only as a non-voting, ex-officio board member and is generally only a member by virtue of being CEO of the health center.

- Clear description of the alternative mechanism(s) for gathering patient input. If advisory councils or patient representatives are proposed, include a list of the members in Attachment 14: Other Relevant Documents that identifies these individuals and their reasons/qualifications for participation on the advisory council or as governing board representatives.
- Specifics on the type of patient input to be collected.
- Methods for collecting and documenting such input.
- Process for formally communicating the input directly to the health center governing board (e.g., monthly presentations of the advisory group to the full board, monthly summary reports from patient surveys).
- Specifics on how the patient input will be used by the governing board for: 1) selecting health center services; 2) setting health center operating hours; 3) defining budget priorities; 4) evaluating the organization's progress in meeting goals, including patient satisfaction; and 5) other relevant areas of governance that require and benefit from patient input.

Form 8 – Health Center Agreements

Complete Part I, by selecting **Yes** if the applicant has 1) a parent, affiliate, or subsidiary organization; and/or 2) any current or proposed agreements that will constitute a substantial portion of the proposed scope of project, including a proposed site to be operated by a subrecipient or contractor, as identified in Form 5B: Service Sites.

Refer to Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75 for the definition of "substantial" and characteristics of a subrecipient or contractor agreement. Applicants must use judgment in classifying each agreement as a subaward or a procurement contract, based on the substance of the relationship. If there are current/proposed agreements that will constitute a substantial portion of the project, indicate the number of each type in the appropriate field and attach the complete agreements in Part II.

If either of questions 1 or 2 were answered, "Yes" in Part I, applicants must upload associated agreements in Part II. Part II will accept a maximum of 10 Affiliate/Contract/Subaward Organizations with five document uploads for each. Additional documentation that exceeds this limit should be included in Attachment 14: Other Relevant Documents.

Note: Items attached to Form 8 will **not** count against the page limit; however documents included in Attachments 14 **will** count against the page limit.

Form 9 – NEED FOR ASSISTANCE (NFA) WORKSHEET (NAP ONLY)

The worksheet is presented in three sections: Core Barriers, Core Health Indicators, and Other Health and Access Indicators. Refer to the Data Resource Guide (available at http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/) for recommended data sources and methodology. To ensure data consistency and validity, applicants must adhere to the

following instructions when completing the form. Applicants will be asked to verify the validity of NFA data on the Summary Page Form.

GENERAL INSTRUCTIONS

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

- **New start applicants** must complete the NFA Worksheet based on the entire proposed scope of project (proposed NAP service area and/or target population).
- **Satellite applicants** must complete the NFA Worksheet based on the **proposed new access point(s) ONLY** (proposed NAP service area and/or target population only).

If an applicant proposes **multiple sites and/or populations,** the NFA Worksheet responses should represent the total combined population for all sites. Applicants with multiple sites are considered to have only one combined service area. **Only one response may be submitted for each barrier or health indicator.**

Guidelines for Completing the NFA Worksheet:

- Recommended data sources are identified in the Data Resource Guide located at http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/. Alternative sources must have the same parameters for each indicator as the source in the Data Resource Guide. For example, any source used for diabetes prevalence must provide age-adjusted rates. See the Data Resource Guide for more information.
- All responses must be expressed as a finite number (e.g., 212.5) and cannot be presented as a range (e.g., 31-35).
- Responses to all indicators must be expressed in the same format/unit of analysis identified on the worksheet (e.g., a mortality ratio cannot be used to provide a response to age-adjusted death rate). The following table provides examples of the unit and format of responses:

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

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

POPULATION BASIS FOR DATA

Provide data for three of four Core Barriers in Section I, one Core Health Indicator for each of six categories in Section II, and two of the 13 Other Health and Access Indicators in Section III.

All responses, with the exception of those for Core Barriers B, C, and D, should be based on data for the target population within the proposed service area to the extent appropriate and possible per the following table.

Data Reporting Guidelines Table

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

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

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

DATA RESPONSE AND SOURCES

The Data Resource Guide provides a listing of recommended data sources and instructions on utilizing these sources to report each indicator. Applicants may use these sources or other

alternate publicly available data sources if the data is collected and analyzed in the same way as the suggested data source. Applicants must use the following guidelines when reporting data:

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

(b) Applicants must provide the following information:

- **Data Response –** The data reported for each indicator on which the NFA score will be based.
- **Year to which Data Apply –** Provide the year of the data source. If the data apply to a period of more than one year (e.g., 2010-2014), provide the most recent year for the data reported.
- **Data Source/Description –** If a data source other than what is included in the Data Resource Guide is used, name the data source and provide a rationale (e.g., more current, more geographically specific, more population specific).
- **Methodology Utilized/Extrapolation Method –** Provide the following information:
    - Extrapolation methodology used – State whether extrapolation was from one geographic area to another, one population to another, both, or none.
    - Differentiating factor used – Describe the demographic factor upon which the extrapolation was based (e.g., rates by age, gender) and data source.
    - Level of geography – Identify the geographic basis for the data (e.g., the data source may be a national survey, but the geographic basis for extrapolation was at the county level).
- **Identify Geographic Service Area or Target Population for Data –** Define the service area and/or target population used (e.g., zip codes, Census tracts, MUA or MUP designation, population type).

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

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

Population to One FTE Primary Care Physician Ratio			
Scaling			*Points*
	<	1,494	0
1494	to <	1,734	1
1734	to <	1,974	2
1974	to <	2,214	3
2214	to <	2,454	4
2454	to <	2,694	5
2694	to <	2,934	6
2934	to <	3,174	7
3174	to <	3,413	8
3413	to <	3,653	9
3653	to <	3,893	10
3893	to <	4,133	11
4133	to <	4,373	12
4373	to <	4,613	13
4613	to <	4,853	14
4853	to <	5,093	15
5093	to <	5,333	16
5333	to <	5,573	17
5573	to <	5,813	18
5813	to <	6,053	19
	≥	6,053	20

Percent of Population Below 200 Percent of Poverty[6]			
Scaling			*Points*
	<	38.20%	0
38.20%	to <	39.70%	1
39.70%	to <	41.30%	2
41.30%	to <	42.90%	3
42.90%	to <	44.40%	4
44.40%	to <	46.00%	5
46.00%	to <	47.60%	6
47.60%	to <	49.10%	7
49.10%	to <	50.70%	8
50.70%	to <	52.30%	9
52.30%	to <	53.80%	10
53.80%	to <	55.40%	11
55.40%	to <	57.00%	12
57.00%	to <	58.50%	13
58.50%	to <	60.10%	14
60.10%	to <	61.70%	15
61.70%	to <	63.20%	16
63.20%	to <	64.80%	17
64.80%	to <	66.40%	18
66.40%	to <	67.90%	19
	≥	67.90%	20

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

***Percent of Population Uninsured*[7]**			
Scaling			*Points*
	<	11.50%	0
11.50%	to <	12.30%	1
12.30%	to <	13.00%	2
13.00%	to <	13.80%	3
13.80%	to <	14.60%	4
14.60%	to <	15.30%	5
15.30%	to <	16.10%	6
16.10%	to <	16.90%	7
16.90%	to <	17.60%	8
17.60%	to <	18.40%	9
18.40%	to <	19.20%	10
19.20%	to <	19.90%	11
19.90%	to <	20.70%	12
20.70%	to <	21.50%	13
21.50%	to <	22.20%	14
22.20%	to <	23.00%	15
23.00%	to <	23.80%	16
23.80%	to <	24.50%	17
24.50%	to <	25.30%	18
25.30%	to <	26.10%	19
	≥	26.10%	20

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

SECTION II: CORE HEALTH INDICATORS (Maximum 30 points)

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

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

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

If an applicant determines that none of the specified indicators represent the applicant's service area or target population, the applicant may propose to use an "Other" alternative for that core health indicator category. In such a case, the applicant must specify the indicator's definition, data source, benchmark, source of the benchmark, and rationale for using the alternative indicator. However, the applicant will **NOT** be eligible for additional points for exceeding a severe benchmark (four points maximum for each "Other" indicator). See the Data Resource Guide for detailed instructions on providing documentation for an "Other" indicator.

SECTION II: CORE HEALTH INDICATOR CATEGORIES	**National Median Benchmark (4 Points if Exceeded)**	**Severe Benchmark (1 Additional Point if Exceeded)**
1. Diabetes		
1(a) Age-adjusted diabetes prevalence	8.1%	9.2%
1(b) Adult obesity prevalence	27.6%	30.2%
1(c) Age-adjusted diabetes mortality[8] rate (per 100,000)	22.5	24.8
1(d) Percent of diabetic Medicare enrollees not receiving a hemoglobin A1c (HbA1c) test	18.0%	20.4%
1(e) Percent of adults (18 years and older) with no physical activity in the past month	24.0%	26.6%
1(f) Other	*Provided by Applicant*	*N/A*
2. Cardiovascular Disease		
2(a) Hypertension hospital admission rate (18 years and older; per 100,000)	61.4	66.3
2(b) Congestive heart failure hospital admission rate (18 years and older; per 100,000)	361.7	378.3
2(c) Age-adjusted mortality from diseases of the heart[9] (per 100,000)	179.4	203.2
2(d) Proportion of adults reporting diagnosis of high blood pressure	28.7%	31.4%
2(e) Percent of adults who have not had their blood cholesterol checked within the last 5 years	23.1%	25.7%
2(f) Age-adjusted cerebrovascular disease mortality (per 100,000)	41.4	46.3

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

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

SECTION II: CORE HEALTH INDICATOR CATEGORIES	National Median Benchmark (4 Points if Exceeded)	Severe Benchmark (1 Additional Point if Exceeded)
2(g) Other	*Provided by Applicant*	*N/A*
3. Cancer		
3(a) Cancer screening – percent of women 18 years and older with no Pap test in past 3 years	18.4%	20.1%
3(b) Cancer screening – percent of women 50 years and older with no mammogram in past 2 years	22.2%	25.8%
3(c) Cancer screening – percent of adults 50 years and older with no fecal occult blood test (FOBT) within the past 2 years	83.3%	85.0%
3(d) Percent of adults who currently smoke cigarettes	17.3%	20.3%
3(e) Age-adjusted colorectal cancer mortality (per 100,000)	14.0	15.2
3(f) Age-adjusted breast cancer mortality (per 100,000) among females	22.1	23.8
3(g) Other	*Provided by Applicant*	*N/A*
4. Prenatal and Perinatal Health		
4(a) Low birth weight (<2500 grams) rate (5 year average)	7.9%	9.4%
4(b) Infant mortality rate (5 year average; per 1,000)	6.6	7.9
4(c) Births to teenage mothers (ages 15-19; percent of all births)	8.4%	10.0%
4(d) Late entry into prenatal care (entry after first trimester; percent of all births)	16.4%	21.1%
4(e) Cigarette use during pregnancy (percent of all pregnancies)	14.1%	18.2%
4(f) Percent of births that are preterm (<37 weeks gestational age)	12.0%	13.0%
4(g) Other	*Provided by Applicant*	*N/A*
5. Child Health		
5(a) Percent of children (19-35 months) not receiving recommended immunizations: 4-3-1-3-3-1-4[10]	30.0%	34.6%
5(b) Percent of children not tested for elevated blood lead levels by 72 months of age	84.1%	89.3%
5(c) Pediatric asthma hospital admission rate (2-17 year olds; per 100,000)	116.0	148.3
5(d) Percent of children (10-17 years) who are obese	15%	18.1%
5(e) Other	*Provided by Applicant*	*N/A*
6. Behavioral Health		
6(a) Percent of adults with at least one major depressive episode in the past year	6.6%	7.3%
6(b) Suicide rate (per 100,000)	13.5	15.2
6(c) Binge alcohol use in the past month (percent of population 12 years and older)	24.1%	26.1%

[10] 4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B, 1 varicella, and 4 Pneumococcal conjugate.

SECTION II: CORE HEALTH INDICATOR CATEGORIES	National Median Benchmark (4 Points if Exceeded)	Severe Benchmark (1 Additional Point if Exceeded)
6(d) Age-adjusted drug poisoning (i.e., overdose) mortality rate per 100,000 population	12.3	14.8
6(e) Other	*Provided by Applicant*	*N/A*

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

SECTION III: OTHER HEALTH AND ACCESS INDICATORS	National Median Benchmark (5 Points if Exceeded)
(a) Age-adjusted death rate (per 100,000)	764.8
(b) HIV infection prevalence	0.2%
(c) Percent elderly (65 and older)	15.2%
(d) Adult asthma hospital admission rate (18 years and older; per 100,000)	130.7
(e) Chronic Obstructive Pulmonary Disease hospital admission rate (18 years and older; per 100,000)	227.2
(f) Influenza and pneumonia death[11] rate (3 year average; per 100,000)	18.6
(g) Adult current asthma prevalence	9.0%
(h) Age-adjusted unintentional injury deaths (per 100,000)	40.0
(i) Percent of population linguistically isolated (people 5 years and over who speak a language other than English at home)	10.3%
(j) Percent of adults (18+ years old) that could not see a doctor in the past year due to cost	13.4%
(k) Percentage of adults 65 years and older who have not had a flu shot in the past year	32.6%
(l) Chlamydia (sexually transmitted infection) rate (per 100,000)	389.5
(m) Percent of adults without a visit to a dentist or dental clinic in the past year for any reason	30.4%

CONVERSION OF NFA WORKSHEET SCORE TO APPLICATION SCORE
The NFA Worksheet will be converted to a 20-point scale using the following conversion table. The converted NFA Worksheet score will account for up to 20 points out of 100 total points for the overall application score (up to 20 of the available 30 points for the ***NEED*** section of the Project Narrative). Applicants will be able to view the scores for each NFA section in the read-

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

only version of the form accessible in the Review section of the Program Specific Information in the EHBs. The total NFA Worksheet score can also be found on the Summary Page Form for the Program Specific Information. Applicants should ensure their understanding of the system-calculated score prior to application submission.

NFA WORKSHEET TO APPLICATION SCORE CONVERSION TABLE

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

FORM 10 –EMERGENCY PREPAREDNESS REPORT

Select the appropriate responses regarding emergency preparedness. If any answer is no, explain the response in Item 10 of the ***RESOURCES/CAPABILITIES*** section of the Project Narrative. This form will be used to assess the status of emergency preparedness planning and progress towards developing and implementing an emergency management plan.

FORM 12 – ORGANIZATION CONTACTS

Provide the requested contact information. For the Contact Person field, provide an individual who can represent the organization in communication regarding the application. Data will pre-populate for competing continuation and competing supplement applicants to revise as necessary.

SUMMARY PAGE (SAC)

This form enables applicants to verify key application data. If pre-populated data appear incorrect, verify that the pertinent data provided in the SF-424A and Forms 1A: General Information Worksheet and 5B: Service Sites have been entered correctly. A link to the appropriate source forms will be provided.

Service Area
Enter the identification number, City, and State of the service area that you are proposing to serve, as indicated in the SAAT.

Patient Projection
The total number of unduplicated patients projected to be served by December 31, 2018 (January 1 – December 31, 2018) will pre-populate from Form 1A: General Information Worksheet. Enter the Patient Target for the proposed service area from the SAAT. The percentage of patients to be served by December 31, 2018 will auto-calculate. **The auto-calculated percentage must be 75 percent of greater to ensure eligibility.** HRSA is committed to monitoring achievement of the SAC application patient projection, as well as any additional patient projections through supplemental awards received during the project period by December 31, 2018.

Federal Request for Health Center Program Funding
To ensure eligibility, the total Health Center Program funding requested must not exceed the Total Funding available in the SAAT for the proposed service area.[12] Additionally, ensure that the funding requested for each population type does not exceed the values in the SAAT. If the unduplicated patient projection on Form 1A General Information Worksheet is less than 95 percent of the SAAT Patient Target ensure the annual Health Center Program funding request is adjusted based on the auto-calculated percentage of patients to be served by December 31, 2018 from the Patient Projection section of this form, if necessary.

Note: If a required funding reduction based on the unduplicated patient projection is not made in the application, HRSA will make the required funding reduction before issuing the award.

Scope of Project: Sites and Services
To ensure continuity of services in areas already being served by Health Center Program award recipients, new and competing supplement applicants must certify that **all sites** described in the application are included on Form 5B: Service Sites and will be open and operational within 120 days of Notice of Award.

To ensure an accurate scope of project, competing continuation applicants must certify that:

- Form 5A: Services Provided accurately reflects all services and service delivery methods included in the current approved scope of project OR Form 5A: Services Provided requires changes that the applicant has already submitted through the change in scope process.

[12] Due to supplemental awards made to the Health Center Program award recipient currently serving the service area, Total Funding announced in the SAAT may increase while this funding opportunity is open, but it will not decrease.

Form 5B: Service Sites accurately reflects all sites included in the current approved scope of project OR Form 5B: Service Sites requires changes that the applicant has already submitted through the change in scope process.

SUMMARY PAGE (NAP)

This form will enable applicants to verify key application data used by HRSA when reviewing the NAP applications. Content will be pre-populated from the Program Specific Forms. If the pre-populated data appear incorrect, verify that the pertinent data provided in the Program Specific Forms (1A, 1B, 2, 5B, and 9) have been entered correctly. Reference will be provided regarding where to make corrections if needed.

Proposed NAP site(s) and service area zip codes will pre-populate from Form 5B: Service Sites. Funded applicants will be held accountable for verifying ALL proposed sites open and operational within 120 days of Notice of Award. Applicants are encouraged to use this section of the form to verify that the correct sites have been proposed, the correct service area zip codes have been proposed, and all proposed sites have street addresses.

The total number of unduplicated patients projected to be served by December 31, 2018 (January 1 – December 31, 2018) will be pre-populated from Form 1A: General Information Worksheet. Funded applicants will be held accountable for meeting the **unduplicated** patient projection (from the Total line under Unduplicated Patients and Visits by Population Type on Form 1A: General Information Worksheet) and any future or other supplemental funding patient commitments by December 31, 2018. Applicants are encouraged to use this section of the form to verify that total number of unduplicated patients projected to be served is realistic and appropriate based on the proposed NAP project.

Note that the population funding percentages (i.e., percentage of funding requested for CHC, MHC, HCH, and/or PHPC) will be based on operational funds requested for Year 2 and will therefore not include any one-time funding requested. The population funding percentages and federal dollars per patient will be automatically calculated. The federal dollars per patient will be calculated by dividing the federal dollar amount requested by the projected number of unduplicated patients projected to be served by December 31, 2018 by population type entered on Form 1A. Applicants are encouraged to use this section of the form to verify that each year of the NAP funding request is appropriately budgeted by population type and reasonable for the number of patients projected to be served.

This form will be certified by checking a box at the bottom to signify that the applicant has double-checked all information provided to ensure accuracy, including the data provided on Form 9, the Need for Assistance worksheet. Funded applicants will be held accountable for:

- having **all proposed sites** (from Form 5B) open and operational within 120 days of Notice of Award, and

- meeting the calendar year 2018 **unduplicated patient projection** (from Form 1A) by December 31, 2018.