

**FOR HRSA USE ONLY****Grant Number****Application Tracking  
Number****DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Health Resources and Services Administration****Expanded Services  
(formerly Increased Demand for Services)****Maximum  
Eligible  
Amount:****Total Federal  
Requested  
Amount:****Service  
Types  
Selected:****Need**

Describe the need to expand or begin providing the proposed service(s), and how this proposal will respond to the health care needs of the target population (with reference to relevant special populations, demographic characteristics, and/or access to care/health status indicators).

*(2,000 characters maximum – about one page)*

[Applicant enters required response here]

**Response**

Describe the following:

1. An appropriate timeline for project implementation that demonstrates operational readiness within 120 days of award for the provision of new and expanded existing services.

*(1,000 characters maximum – about half of a page)*

[Applicant enters required response here]

2. How the health center will ensure that all proposed services are or will be integrated into the existing service delivery model.

*(1,000 characters maximum – about half of a page)*

[Applicant enters required response here]

3. How the health center will ensure that all proposed services are accessible without regard to ability to pay through a sliding fee discount program.

*(1,000 characters maximum – about half of a page)*

[Applicant enters required response here]

4. How the health center plans to ensure that all patients will have reasonable access to any proposed new services, as appropriate. Include details about any services or staff proposed under the Other Enabling Services category on Form 5A and/or the Staffing Impact Form.

*(1,000 characters maximum – about half of a page)*

[Applicant enters required response here]

5. If any services will be provided by a Formal Written Agreement (via Column II on Form 5A), describe how the health

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	<b>Service Types Selected:</b>		

center maintains oversight over all services provided via contracts/agreements or sub-recipient arrangements in accordance with Health Center Program requirements. If services are not provided via Formal Written Agreement, indicate that this question is not applicable.

*(1,000 characters maximum - about half of a page)*

[Applicant enters required response here]

**Impact**

Describe the following:  
 The impact of the proposed project, including the number of 1) proposed new patients, 2) existing patients with increased access to services (as applicable), and 3) new providers.

Include a detailed explanation for how the projections were calculated (including data sources).

*(2,000 characters maximum - about one page)*

[Applicant enters required response here]

**Patient Impact Questions**

1. As a direct result of this funding, how many NEW patients do you predict will access services at your health center?

[Applicant enters whole number here]

	NEW Patients by Service Category (as applicable)					
	Enabling Services (EN)	Medical Services (MS)	Oral Health Services (OH)	Behavioral Health Services (BH)	Pharmacy Services (PS)	Vision Services (VS)
Projected <b>NEW</b> Patients						
<b>Total NEW patients for all services</b>	[Total calculated by EHB - must match the number the applicant entered for Question 1 above]					

2. As a direct result of this funding, how many current/existing health center patients will access newly expanded services to which they did not previously have access?

[Applicant enters whole number here]

NEW Patients by Service Category (as applicable)					
EXISTING Patients by Service Category (as applicable)					
	Enabling Services (EN)	Oral Health Services (OH)	Behavioral Health Services (BH)	Pharmacy Services (PS)	Vision Services (VS)
Projected EXISTING Patients					
Total EXISTING patients for all services		[Total calculated by EHB - must match the number the applicant entered for Question 2 above]			
New Patients by Population Type					
Population Type			NEW Patients Projected		
Total NEW Patients (from Q1)			[Prepopulated from response to Question 1 above]		
• General Underserved Community					
• Migratory and Seasonal Agricultural Workers					
• People Experiencing Homelessness					
• Public Housing Residents					
Total NEW Patients by Population Type			[Total calculated by EHB - must match the number the applicant entered for Question 1 above]		

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.