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

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SUMMARY PAGE (NEW ACCESS POINTS)	FOR HRSA USE ONLY	
	Grant Number	Application Tracking Number

Summary Information

1. I am applying as a new start applicant.

Suggested Resource(s): Form 1A *Pre-populates from Form 1A*

[_] Yes [_] No

Note:

- "Yes" indicates that you are a new organization applying for Health Center Program operational funds.
- "No" indicates that you are a current Health Center Program award recipient. Therefore, you are applying as a satellite/supplemental applicant.

2. I am proposing the following sites, which will be open within 120 days of award:

These are the NAP proposed sites and service area. If changes are required, revisit Form 5B. *Pre-populates from Form 5B*

Site Name	Physical Street Address for Site	Service Site Type	Location Type	Service Area Zip Codes

3. Total number of unduplicated patients projected to be served in calendar year 2018 (by December 31, 2018):

This is this NAP patient projection. If you are a satellite applicant, this figure will be added to your Patient Target. If changes are required, revisit Form 1A. *Pre-populates from Form 1A*

4. I am requesting for the following types of Health Center funding:

This is this NAP Federal funding request. If changes are required, revisit Form 1A and/or Form 1B.

Type of Health Center	Program	Operational funds for Year 1 (a)	Operational funds for Year 2 (b)	Funding Population % for Year 2 (c)	Number of Patients at 12/31/2018 (d)	Federal Dollars per Patient (e=b/d)
Community Health Centers	CHC-330 (e)	*Pre-populates from Form 1B*	*Pre-populates from Form 1B*	*Pre-populates from Form 1B*	*Pre-populates from Form 1A*	*Auto-calculates*
Health Care for the Homeless	HCH-330 (h)	*Pre-populates from Form 1B*	*Pre-populates from Form 1B*	*Pre-populates from Form 1B*	*Pre-populates from Form 1A*	*Auto-calculates*
Migrant Health Centers	MHC-330 (g)	*Pre-populates from Form 1B*	*Pre-populates from Form 1B*	*Pre-populates from Form 1B*	*Pre-populates from Form 1A*	*Auto-calculates*
Public Housing Primary Care	PHPC-330 (i)	*Pre-populates from Form 1B*	*Pre-populates from Form 1B*	*Pre-populates from Form 1B*	*Pre-populates from Form 1A*	*Auto-calculates*
Total		*Pre-populates from Form 1B*	*Pre-populates from Form 1B*	*Pre-populates from Form 1B*	*Pre-populates from Form 1A*	*Auto-calculates*

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5. I am requesting the following amount for one-time funding:

This is this NAP one-time Federal funding request. If changes are required, revisit Form 1B.
Pre-populates from Form 1B

One time funding requested for Year 1:

[_] Equipment Only
[_] Minor alteration/renovation with equipment
[_] Minor alteration/renovation without equipment
[_] N/A

6. Total number of full time equivalent (FTE) staff at full capacity:

This is this proposed FTE staff for the NAP project. If changes are required, revisit Form 2.
Pre-populates from Form 2

7. Total score from Form 9, Need for Assistance worksheet:

The converted score represents up to 20 points of the 30 available points in the Need section. If changes are required, revisit Form 9. *Pre-populates from Form 9*

NFA Score:
Converted Score:

Certification

[_] By checking this box, I certify that information provided in this application is complete and accurate, including the Need for Assistance (NFA) data sources and calculations. I certify that, if funded, all sites included on Form 5B will be open and operational within 120 days of Notice of Award, and I acknowledge that the health center will be held accountable for reaching the patient projections on Form 1A in calendar year 2018 (by December 31, 2018).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SUMMARY PAGE (SERVICE AREA COMPETITION)	FOR HRSA USE ONLY	
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Service Area	
1. What is the identification number in the Service Area Announcement Table of the service area that you are proposing to serve?	**Service Area ID #:___** **Service Area City, State: ____, _____**
Patient Projection	
2. What is the total number of unduplicated patients projected to be served by December 31, 2018? **Note:** If changes are required, revisit Form 1A.	*Will pre-populate from the Unduplicated Patients and Visits By Population Type section of Form 1A*
3. What is the Patient Target from the Service Area Announcement Table for the proposed service area?	
4. Percent of the service area Patient Target proposed to be served by December 31, 2018. **Note:** The value must be at least 75 percent for the application to be considered eligible for funding.	*Will auto-calculate in EHB*

5. [_] By checking this box, I acknowledge that in addition to the total unduplicated patient projection made on Form 1A (see item 2 above), I will also meet the additional patient projections for any other funding awarded within my project period that can be monitored by December 31, 2018 (i.e., patient commitments from awarded applications, if any).

Federal Request for Health Center Program Funding

6. I am requesting the following types of Health Center funding:

Note: Compare these values with those on the Service Area Announcement Table to ensure that you are proposing to serve all currently targeted populations and maintain the funding distribution. If changes are required, revisit the SF-424A, Section A.

Funding Type	Funding Requested
Community Health Centers – CHC-330(e)	*Will pre-populate from the SF-424A, section A*
Health Care for the Homeless – HCH-330(h)	*Will pre-populate from the SF-424A, section A*
Migrant Health Centers – MHC-330(g)	*Will pre-populate from the SF-424A, section A*
Public Housing Primary Care – PHPC-330(i)	*Will pre-populate from the SF-424A, section A*

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Total **Note:** Ensure this value does not exceed the total annual federal request for funding under the Health Center Program that is available for the service area from the Service Area Announcement Table (Total Funding column). If a funding reduction is required based on the patient projection (value between 75 and 94.9 percent for item 4 above), this figure should be lower than the value in the Service Area Announcement Table. See the Summary of Funding section of the FOA for details.	*Will pre-populate from the SF-424A, section A*

Scope of Project: Sites and Services

7. I am proposing the following new site(s): (New applicants and competing supplement applicants only)

Note: If changes are required, revisit Form 5B. *Pre-populates from Form 5B*

Site Name	New Site or Site Currently in Scope	Site Physical Street Address	Service Site Type	Location Type	Service Area Zip Code(s)

8. Sites Certification (New applicants and competing supplement applicants only)

[_] By checking this box, I certify that all sites described in my application are included on Form 5B (as summarized above) **and** that all sites included on Form 5B (as summarized above) will be open and operational within 120 days of Notice of Award.

9. Scope of Project Certification – Services
(Competing continuation applicants only) – *select only one below*

[_] By checking this option, I certify that I have reviewed my Form 5A: Services Provided and it accurately reflects all services and service delivery methods included in my current approved scope of project.

[_] By checking this option, I certify that I have reviewed my Form 5A: Services Provided and it requires changes that I have submitted through the change in scope process.

10. Scope of Project Certification – Sites
(Competing continuation applicants only) – *select only one below*

[_] By checking this option, I certify that I have reviewed my Form 5B: Service Sites and it accurately reflects all sites included in my current approved scope of project.

[_] By checking this option, I certify that I have reviewed my Form 5B: Service Sites and it requires changes that I have submitted through the change in scope process.