| OMB No.: 0915-0285. Expiration Date: XX/XX/20XX | | |
| --- | --- | --- |
| **DEPARTMENT OF HEALTH AND HUMAN SERVICES  Health Resources and Services Administration   FORM 6A: CURRENT BOARD MEMBER CHARACTERISTICS** | **FOR HRSA USE ONLY** | |
| Grant Number | Application Tracking Number |
| **Note:** The list of Board Members will pre-populate for competing continuation and competing supplement applicants. | | |

| **Name** | **Current Board Office Position Held** | **Area of Expertise** | **>10% of Income from Health Industry** | | **Health Center Patient** | **Live or Work in Service Area** | **Special Population Representative**  **(If yes, specify Special Population)** |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | |  |  |  |
|  |  |  |  | |  |  |  |
|  |  |  |  | |  |  |  |
|  |  |  |  | |  |  |  |
|  |  |  |  | |  |  |  |
|  |  |  |  | |  |  |  |
|  |  |  |  | |  |  |  |
|  |  |  |  | |  |  |  |
|  |  |  |  | |  |  |  |
| **PATIENT BOARD MEMBER CLASSIFICATION** | | | | | | | |
| **Gender** | | | | **Number of Patient Board Members** | | | |
| Male | | | |  | | | |
| Female | | | |  | | | |
| Unreported/Declined to Report | | | |  | | | |
| **Ethnicity** | | | | **Number of Patient Board Members** | | | |
| Hispanic or Latino | | | |  | | | |
| Non-Hispanic or Latino | | | |  | | | |
| Unreported/Declined to Report | | | |  | | | |
| **Race** | | | | **Number of Patient Board Members** | | | |
| Native Hawaiian | | | |  | | | |
| Other Pacific Islanders | | | |  | | | |
| Asian | | | |  | | | |
| Black/African American | | | |  | | | |
| American Indian/Alaska Native | | | |  | | | |
| White | | | |  | | | |
| More Than One Race | | | |  | | | |
| Unreported/Declined to Report | | | |  | | | |
| **Note:** This section is ONLY required if you selected Public (non-Tribal or Urban Indian) as the Business Entity on Form 1A of this application. In all other cases, select N/A. | | | | | | | |
| **If the applicant is a public organization/center, do the board members listed above represent a co-applicant board?** | | | | | | | |
| |  |  |  | | --- | --- | --- | | **Yes** | **No** | **N/A** | | | | | | | | |
| If yes, ensure that the co-applicant agreement is included as Attachment 6 in the Appendices form of this application. | | | | | | | |

Public Burden Statement: Health centers (section 330 grant funded and Federally Qualified Health Center look-alikes) deliver comprehensive, high quality, cost-effective primary health care to patients regardless of their ability to pay. The Health Center Program application forms provide essential information to HRSA staff and objective review committee panels for application evaluation; funding recommendation and approval; designation; and monitoring. The OMB control number for this information collection is 0915-0285 and it is valid until XX/XX/XXXX. This information collection is mandatory under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act ([42 U.S.C. 254b](http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section254b&num=0&edition=prelim)). 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 14N136B, Rockville, Maryland, 20857 or [paperwork@hrsa.gov](https://sharepoint.hrsa.gov/sites/bphc/oppd/ED1/OMB%20Forms%20Approval%202020/paperwork@hrsa.gov).