

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b> Health Resources and Services Administration  <b>Expanded Services</b> <b>(formerly Increased Demand for Services)</b>	FOR HRSA USE ONLY		
	Grant Number		Application Tracking Number
	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 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)*

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	<b>Grant Number</b>		<b>Application Tracking Number</b>
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	<b>Service Types Selected:</b>		

[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]

**Existing Patient Impact**

1. **Total Unduplicated Existing Patients:** Enter the number of existing patients who will newly access SUD and/or mental health services.

2. **Existing Patients by Service Type:** Enter the number of existing patients who will newly access each service below.

Count each existing patient according to the service(s) they are expected to newly access. If an existing patient will newly access more than one service, they should be counted once for each service accessed.

Enabling Services

Medical Services

Oral Health Services

Mental Health Services

Substance Use Disorder Services

Pharmacy Services

Vision Services

**New Patient Impact**

3. **Total Unduplicated New Patients:** Enter the number of new patients (new to the

health center) who will access the proposed service(s) as a result of Expanded Services funding.	
<p><b>4. <u>New Patients by Service Type:</u> Enter the number of new patients (new to the health center) who will access each service below.</b></p> <p>Count each projected new patient according to the service(s) they are expected to access. If a new patient will access more than one service, they should be counted once for each service accessed.</p>	
Enabling Services	
Medical Services	
Oral Health Services	
Mental Health Services	
Substance Use Disorder Services	
Pharmacy Services	
Vision Services	

**New Patients by Population Type**

Enter the total number of new unduplicated patients by Health Center Program population type. The total must equal the number of new unduplicated patients entered in response to Question 3 above, if any. The information entered in the table below will be used to populate future Budget Period Progress Reports.

Population Type	NEW Patients Projected
<b>Total NEW Patients (from Question #3)</b>	[Prepopulated by EHB from response to Question 3 above]
<ul style="list-style-type: none"> <li>General Underserved Community</li> </ul>	
<ul style="list-style-type: none"> <li>Migratory and Seasonal Agricultural Workers</li> </ul>	
<ul style="list-style-type: none"> <li>People Experiencing Homelessness</li> </ul>	
<ul style="list-style-type: none"> <li>Public Housing Residents</li> </ul>	
<b>Total NEW Patients by Population Type</b>	[Calculated by EHB by adding patients in each type - must match the number entered for Question 3 above]

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](#)). 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](mailto:paperwork@hrsa.gov).