OMB No.: 0915-0285. Expiration Date: 03/31/2023

Select Progress Report:	
[_]	Capital
[_]	COVID-19 Related Funding

~~OMB No.: 0915-0285. Expiration Date: 03/31/2023~~

DEPARTMENT OF HEALTH AND HUMAN SERVICES **Health Resources and Services Administration** **CAPITAL SEMI ANNUAL PROGRESS REPORT (SAPR)**	**FOR HRSA USE ONLY**		
	Organization:		**Program**:
	Submission Tracking Number:	**Grant Number**:	**Reporting Period**:
	DUNS Number:	**UDS Number**:	**Project/Grant Period**:

Contact Information

Title	Name	Phone	Fax	Email

SF-PPR Page 1

8. Is this your final report?

[_]	Yes
[_]	No

10. Performance Narrative

10a. Additional Patient Capacity

SF-PPR Page 3 Project Data

Project Type:	Awarded Amount*:	Total Estimated Award Amount:
*The awarded amount may be different from the requested amount for the project.		

1. Project Status

[_]	Not Started
[_]	Less than or equal to 50% Complete
[_]	Greater than 50% and Less than 100% Complete
[_]	Completed

1a. Do the total project costs incurred reflect the approved budget for this project, and have all of the funds for this project been drawn down from the PMS account? HRSA recognizes that project budgets may change during the course of the project period. Any changes to the project budget should have been discussed with and approved by the assigned Grants Management Specialist.

[_]	Yes
[_]	No

If 'No' please explain

1b. Does the scope of work of the project reflect the scope of work as proposed by the grantee and approved by HRSA?

[_]	Yes
[_]	No

If 'No' please explain

1c. Are you prepared to complete and submit the following forms and documents to HRSA (which will be requested through your Electronic Hand Book Grant Portfolio)?	
[_]	Yes
[_]	No

If 'No' please explain

2. Project Specific Narrative

SF-PPR Page 3a Project EVM Data

Project Type:	Awarded Amount*:	Total Estimated Award Amount:
*The awarded amount may be different from the requested amount for the project.		

1. Project Schedule	
[_]	On Time
[_]	Behind Schedule
[_]	Ahead of Schedule

1a. Is the project expected to remain behind schedule?	
[_]	Yes, I will provide a revised completion date and identify how the total estimated project cost will be affected in the text box provided.

[_]	No, I will indicate how the schedule will get back on track and whether or not the total estimated project cost will be affected in the text box provided.

1. Original total estimated project costs:	

2. Total estimated project cost (if revised):	

3. Original project completion date:	

4. Revised project completion date:	

1a. Explanations

1b. Is the project expected to remain ahead of schedule?

[_]	Yes, I will provide a revised completion date and indicate whether or not the total estimated project cost will be affected within the text box provided.
[_]	No, I will indicate within the text box provided that the project will be completed by the estimated project completion date.

1. Original total estimated project costs:	

2. Total estimated project cost (if revised):	

3. Original project completion date:	

4. Revised project completion date:	

1b. Explanations

2. Project Budget

[_]	On Budget
[_]	Under Budget
[_]	Over Budget

2a. Will the project incur enough costs to allow for the drawdown of all the Federal funds by the project completion date?

[_]	Yes, I will indicate in the text box provided the strategy to utilize the excess funds, if possible (i.e., purchase additional equipment).
[_]	No, I will indicate in the text box provided that the grantee organization is aware that the remaining funds will be de-obligated.

2a. Explanations

2b. Is the project anticipated to remain over budget for the completion construction schedule (i.e., the total project cost at completion will be greater than the original proposed budget)?

[_]	Yes

[_]	No, I will provide a revised plan/supporting documentation to identify when and how the budget will no longer exceed original budget estimates (which will be requested via EHB submissions).

2b.1. Will additional funds be secured, or have additional funds been secured, to allow for the completion of the project on time?	
[_]	Yes, I will indicate within the text box provided the source(s) and amount(s) of funding that will be/have been secured.
[_]	No, I will provide a timeline for adjusting the project scope to align with the adjusted costs within the text box provided.

2b. Explanations

SF-PPR Page 4 Project Closeout Data

Project Type:	**Awarded Amount*:**	**Total Estimated Award Amount:**
*The awarded amount may be different from the requested amount for the project.		

2. Square Footage Impacted	
2. Square Footage Impacted	

Project Costs

4a. Projected amount of HRSA funds proposed for this project	

4b. Actual amount of HRSA funds expended on the project	

4c. Projected amount of non-HRSA funds i.e., state, local, and other funds - including other federal funds - proposed for this project	

4d. Actual amount of non-HRSA funds expended on the project	

Project Completion Dates

5a. Proposed project completion date	

5b. Actual project completion date	

COVID19 Progress Report

Grant Number	**Awarded Amount:**	

1. Project Status

[_]	Not Started
[_]	Less than or equal to 50% Complete
[_]	Greater than 50% and Less than 100% Complete
[_]	Completed

2. Please provide a status update on the activities supported with this funding in the following areas noted below (identify the activities that have been completed, are in progress, and/or are planned with this funding): (check all that apply)

[_]	**Staff and Patient Safety**

[__]	Testing
[__]	Maintaining or Increasing Health Center Capacity and Staffing Levels
[__]	Telehealth
[__]	Minor A/R (when applicable)

3. Are the implemented/planned activities described above and associated uses of funds consistent with what you submitted to HRSA in the initial post-award reporting requirement response?

[__]	Yes
[__]	No

If 'No' please describe any new and/or updated activities. For changes that impact your approved budget, please provide detail by cost category.

4. Are there or do you anticipate any issues or barriers in the use of the funding and/or implementing the planned activities?

[__]	Yes
[__]	No

If 'Yes' please describe.

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 u03/31/2023. 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.