DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SUMMARY PAGE (combined SAC and NAP)	FOR HRSA USE ONLY	
	Grant Number	**Application Tracking Number**

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, 2021? **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, 2021. **(**This projection is for calendar year 2021.) **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, 2021 (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 NOFO 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.

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 receipt of the 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.

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11. 120 Day Compliance Achievement Plan Certification

[ ] By checking this box, I certify that if my organization is noncompliant with any Health Center Program requirements, in accordance with Section 330(e)(1)(B), I will submit for HRSA's approval within 120 days of receipt of the Notice of Award (NoA) a Compliance Achievement Plan to come into compliance. I acknowledge that areas of noncompliance will be documented through the carryover of any unresolved, existing condition from the current project period and/or the placement of new condition(s) on the award based on the review of this application. I also acknowledge that all conditions on my award must be addressed within the timeframes and due dates specified on my Health Center Program NoA(s) and that the Compliance Achievement Plan I submit must align with such timelines.

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1) Select your applicant type:	**Select One Option:**
I am a satellite applicant (I am a current Health Center Program award recipient with an H80 grant).	[ ]
I am a new applicant (not an H80 award recipient), and I am **not** a look-alike.	[ ]
I am a new applicant (not an H80 award recipient), and I am a designated look-alike.	[ ]

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.

Site Name	Physical Street Address for Site	Service Site Type	Location Type	Hours per Week	Service Area Zip Codes
Pre-populates from Form 5B	Pre-populates from Form 5B	Pre-populates from Form 5B	Pre-populates from Form 5B	Pre-populates from Form 5B	Pre-populates from Form 5B

[ ] 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 receipt of the Notice of Award.

3) The Unmet Need Score (UNS) is the aggregate objective assessment of unmet need based on the service area zip codes entered on Form 5B (out of 100 points). The UNS converted score represents up to 20 points of the 30 available points in the Need section.

Unmet Need Score: Auto-Calculated in EHB
UNS Converted Score: Auto-Calculated in EHB

[_]   By checking this box, I understand that the UNS converted score (out of 20 points) will be included as part of my NAP application overall score and I acknowledge that the service area ZIP codes used to calculate the Unmet Need Score are accurate (as listed above and on Form 5B). In addition, I understand that these zip codes correspond to ZCTAs to determine the UNS.

NOTE: Use the UNS Workbook on the [NAP TA website](#) to determine the ZCTAs for your proposed service area (enter your Form 5B service area zip codes), view the unmet need data associated with each ZTCA, and see how that data composes the service area UNS.

4)   Total number of unduplicated patients projected to be served in calendar year 2020 (by December 31, 2020) entered on Form 1A:

Pre-populates from Form 1A

[_]   By checking this box, I acknowledge that the health center will be held accountable for meeting this NAP unduplicated patient projection in calendar year 2020. For new applicants, this becomes your Patient Target. For satellite applicants, this figure will be added to your Patient Target.

5)   I am requesting the following types of Health Center Program funding:

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

Type of Health Center	Operational funds for Year 1 (a)	Operational funds for Year 2 (b)	Funding Population % for Year 2 (c)	CY 2020 Patient Projection (d)	Federal Dollars per Patient (e=b/d)
Community Health Centers		Pre-populates from Form 1B	Auto-calculated in EHB	Pre-populates from Form 1A	Auto-calculated in EHB
Health Care for the Homeless		Pre-populates from Form 1B	Auto-calculated in EHB	Pre-populates from Form 1A	Auto-calculated in EHB
Migrant Health Centers		Pre-populates from Form 1B	Auto-calculated in EHB	Pre-populates from Form 1A	Auto-calculated in EHB
Public Housing Primary Care		Pre-populates from Form 1B	Auto-calculated in EHB	Pre-populates from Form 1A	Auto-calculated in EHB
One-time Funding					
Total	Auto-calculated in EHB	Pre-populates from Form 1B	Auto-calculated in EHB	Pre-populates from Form 1A	Auto-calculated in EHB

6)   I am requesting the following amount for one-time funding:

If changes are required, revisit Form 1B.

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

7) Total number of full time equivalent (FTE) staff:
This is this proposed FTE staff for the NAP project.
 Pre-populates from Form 2

8) Certifications

[_] By checking this box, I certify that:
   • The main purpose of this NAP project is to provide comprehensive primary medical care for all underserved individuals in the targeted service area or population.
   • I have consulted with appropriate State and local government agencies, and health care providers regarding the need for the health services to be provided at the proposed NAP site(s).

9) Compliance

[_] By checking this box, I acknowledge that, in accordance with Section 330(e)(1)(B):
   • My health center must maintain compliance with all Health Center Program requirements.
   • I must address areas of noncompliance within the timeframes specified in applicable conditions.
   • If I am a new start applicant or a look-alike with unresolved conditions on my Notice of Look-alike Designation related to Health Center Program requirements, I must submit a Compliance Achievement Plan within 120 days of Notice of Award which outlines steps the health center will take to meet the Health Center Program requirements.