

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 #: <input type="text"/> Service Area City, State: <input type="text"/> , <input type="text"/>	
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.	<i>Will pre-populate from the Unduplicated Patients and Visits By Population Type section of Form 1A</i>	
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. (.1 Note: The value must be at least 75 percent for the application to be considered eligible for funding.	<i>Will auto-calculate in EHB</i>	
5. <input type="checkbox"/> 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)	<i>Will pre-populate from the SF-424A, section A</i>	
Health Care for the Homeless – HCH-330(h)	<i>Will pre-populate from the SF-424A, section A</i>	
Migrant Health Centers – MHC-330(g)	<i>Will pre-populate from the SF-424A, section A</i>	
Public Housing Primary Care – PHPC-330(i)	<i>Will pre-populate from the SF-424A, section A</i>	

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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.		<i>Will pre-populate from the SF-424A, section A</i>			
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)					
<input type="checkbox"/> 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) – <i>select only one below</i>					
<input type="checkbox"/> 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.					
<input type="checkbox"/> 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) – <i>select only one below</i>					
<input type="checkbox"/> 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.					
<input type="checkbox"/> 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. Plan Certification Compliance Achievement 120 Day		
<input type="checkbox"/> I submit must align with such timelines. P Compliance Achievement 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 I am 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 P Compliance Achievement 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 By checking this box, I certify that if my organization is		

DEPARTMENT OF HEALTH AND HUMAN SERVICES Summary Page Health Resources and Services Administration (NAP)	FOR HRSA USE ONLY				
	Grant Number	Application Tracking Number			
1)					
2) 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).					<input type="checkbox"/>
I am a new applicant (not an H80 award recipient), and I am a look-alike. not					<input type="checkbox"/>
I am a new applicant (not an H80 award recipient), and I am a designated look-alike.					<input type="checkbox"/>
3) 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 B5	Pre-populates from Form B5	Pre-populates from Form B5	Pre-populates from Form B5	Pre-populates from Form B5	Pre-populates from Form B5
<input type="checkbox"/> By checking this box, I certify that all sites described in my application are included on Form 5B (as summarized above) 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. and					
4) 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.					

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9)
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10)
11)
12)
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HYPERLINK "<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 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 30 minutes paperwork@hrsa.gov HYPERLINK "paperwork@hrsa.gov" .