

<p align="center">DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration</p> <p align="center">Summary Page (NAP)</p>	FOR HRSA USE ONLY				
	Grant Number			Application Tracking Number	
<p>1) Select your applicant type:</p>					
					Select One Option:
I am a current Health Center Program award recipient with an H80 grant (I am a satellite applicant).					<input type="checkbox"/>
I am not an H80 award recipient, and I am not a designated look-alike (I am a new start applicant).					<input type="checkbox"/>
I am a designated look-alike, and I am not an H80 award recipient (I am a look-alike applicant).					<input type="checkbox"/>
<p>2) I am proposing the following site(s), which will be open within 120 days of award:</p>					
<p>These are the proposed NAP site(s) and service area. If changes are required, revisit Form 5B.</p>					
Site Name	Physical Street Address for Site	Service Site Type	Location Type	Hours per Week	Service Area Zip Codes
<p><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 service sites included on Form 5B (as summarized above) will be open and operational within 120 days of receipt of the Notice of Award.</p>					
<p>3) The Unmet Need Score (UNS) is based on data from all the service area zip codes entered on Form 5B. The UNS converted score is up to 20 points of the 30 available points in the Need section.</p>					
<p>Unmet Need Score (out of 100 points): UNS Converted Score (up to 20 points):</p>					
<p><input type="checkbox"/> By checking this box, I understand that the UNS converted score (up to 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.</p> <p>NOTE: Visit the NAP TA webpage for UNS resources and see the Unmet Need Score Map Tool to view the unmet need data for each ZCTA.</p>					
<p>4) Total number of unduplicated patients projected to be served in calendar year 20XX (January 1, 20XX through December 31, 20XX) entered on Form 1A:</p>					
<p>If changes are required, revisit Form 1A.</p>					

By checking this box, I acknowledge that HRSA will assess my progress toward serving this number of patients in calendar year 20XX, and that assessment may impact future funding. For new start and look-alike applicants, this becomes your Patient Target. For satellite applicants, this figure may 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 the Budget Information Form and/or Form 1A.

Type of Health Center Funding	Federal Funds Requested (a)	CY 20XX Patient Projection (b)	Federal Dollars per Patient (c=a/b)
Community Health Center			
Migratory and Seasonal Agricultural Workers			
Homeless Population			
Residents of Public Housing			
Total			

6) I am requesting one-time funding for the following type of project:

If changes are required, revisit the Budget Information form (populated from SF-424A Section B) and Form 1B.

- N/A (no funding requested for equipment or minor A/R)
- Equipment (no minor A/R)
- Minor alteration/renovation with equipment
- Minor alteration/renovation without equipment

NAP one-time funding request for minor A/R and equipment:

7) Total number of full time equivalent (FTE) staff:

This is this proposed FTE staff for the NAP project. If changes are required, revisit Form 2.

8) Certifications

- By checking this box, I certify that:
- The main purpose of this NAP project is to provide required comprehensive primary medical care for medically underserved populations in the service area.
 - 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).
 - I have reviewed the [UDS resources](#), including the most recent UDS Manual, and understand that my organization will be required to report data on patients, services, staffing, and financing

annually. I acknowledge that failure to submit a complete report by the specified deadline may result in conditions or restrictions being placed on the Health Center Program award.

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 my organization is noncompliant with any Health Center Program requirements or is a new start health center, I must submit a Compliance Achievement Plan within 120 days of Notice of Award which outlines steps my health center will take to meet Health Center Program requirements.

10) Applicants for Homeless population (HP) and Residents of Public Housing (RPH) Funding: Supplement and Not Supplant Certification

Not Applicable. My organization is NOT requesting Homeless population (HP) and/or Residents of Public Housing (RPH) funding on the SF-424A: Budget Information Form.

By checking this box, I certify that my organization will utilize Homeless population (HP) and/or Residents of Public Housing (RPH) grant funding to supplement, and not supplant, the expenditures of the health center and the value of in-kind contributions for the delivery of services to these populations (the homeless population and residents of public housing).

Describe, with specific examples, how you will utilize the requested federal funds to add new or expand existing services to the homeless population and/or residents of public housing within your proposed service area. Specifically address how this is an increase or expansion of the services your organization is currently providing for these populations. (maximum 1,000 characters)

Public Burden Statement: Health centers (section 330 grant funded and Federally Qualified Health Center look-alikes) are patient-directed organizations that deliver affordable, accessible, quality, and cost-effective primary health care services to patients and adjust fees based on income and family size. 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. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0285 and it is valid until XX/XX/202X. 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 Information Collection Clearance Officer, 5600 Fishers Lane, Room 13N82, Rockville, Maryland, 20857 or paperwork@hrsa.gov. Please see <https://www.hrsa.gov/about/508-resources> for the HRSA digital accessibility statement.