

## STANDARD FORM - PERFORMANCE PROGRESS REPORT (SF-PPR)

The purpose of the SF-PPR (progress reports) is to assess the status and implementation activities of HRSA approved project(s). These reports provide HRSA program officials and administrative offices with information regarding the satisfactory progress of supported projects and the way these funds are used.

Progress report requirements applicable to the grant or award require that:

- Project activities must be consistent with those reviewed and approved for funding by HRSA.
- All post-award requests, such as significant budget revisions or a change in scope, must be submitted as a Prior Approval action via the Electronic Handbooks (EHBs) and approved by HRSA prior to implementation. See "Prior-Approval Requirements" in the DHHS Grants Policy Statement: <http://www.hrsa.gov/grants/hhsgrantspolicy.pdf>. Before submitting your Prior Approval request in the EHBs, reach out to the assigned Project Officer and Grants Management Specialist for guidance.
- Respond to each question fully with detailed, specific examples, and timelines where appropriate.
- Failure to submit timely, accurate, and complete reports will delay HRSA's review and final determination of the progress report.

***HRSA reserves the right to request subsequent information as necessary.***

### SF-PPR COVER PAGE

Authorizing Official or Designated Representative			
Point of Contact	Title	Phone	Fax
	Name	Email	
<b>OMB Control Number: 0915-0285</b>			

### SF-PPR PAGE 1

		Page	of Pages
1. Federal Agency and Organization Element to Which Report is Submitted	2. Federal Grant or Other Identifying Number Assigned by Federal Agency	3a. DUNS Number	
		3b. EIN	
4. Recipient Organization (Name and complete address including zip code)		5. Recipient Identifying Number or Account Number	
6. Project/Grant Period Start Date: (Month, Day, Year)   End Date: (Month, Day, Year)	7. Reporting Period End Date (Month, Day, Year)	8. Final Report?	Yes No
		9. Report Frequency	
		<input type="checkbox"/> semi-	<input type="checkbox"/> annual <input type="checkbox"/> quarterly

		<i>other (If other, describe:</i> _____ _____)
<p>10. Performance Narrative (<i>attach performance narrative as instructed by the awarding Federal Agency</i>)</p>		
<p>11. Other Attachments (<i>attach other documents as needed or as instructed by the awarding Federal Agency</i>)</p>		
<p><b>12. Certification: I certify to the best of my knowledge and belief that this report is correct and complete for performance of activities for the purposes set forth in the award documents.</b></p>		
<p>12a. Typed or Printed Name and Title of Authorized Certifying Official</p>	<p>12c. Telephone (<i>area code, number and extension</i>)</p>	
	<p>12d. Email Address</p>	
<p>12b. Signature of Authorized Certifying Official</p>	<p>12e. Date Report Submitted (<i>Month, Day, Year</i>)</p>	
<p>13. Agency use only</p>		

**STANDARD FORM - PERFORMANCE PROGRESS REPORT  
PAGE 3 PROJECT REPORT**

Award Recipient Name	Grant Number	BHCMS ID	Reporting Period End Date	Tracking Number
<<Project Number>><<Project Title>> (System populated data)				
Project Type	(System populated data)	Awarded Amount for the Project	(System populated data)	
1. Project Status	<input type="checkbox"/> Not Started <input type="checkbox"/> Less than or equal to 50% Complete <input type="checkbox"/> Greater than 50% and Less than 100% Complete <input type="checkbox"/> Completed			
<i>Questions 1a through 1c are applicable only if Project status is Completed.</i>				
<p>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.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If No, please explain (maximum 2000 characters)</p>				
<p>1b. Does the scope of work of the project reflect the scope of work as proposed by the award recipient and approved by HRSA?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If No, please explain (maximum 2000 characters)</p>				
<p>1c. Are you prepared to complete and submit the following forms and documents to HRSA (which will be requested through your Electronic Handbook Grant Portfolio)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If No, please explain (maximum 2000 characters)</p>				
2. Project Specific Narrative: (maximum 2000 characters)				
3. Attachment(s) (attach other documents as needed or as instructed by the awarding Federal Agency):				
<<name of attachment(s)>>				
<b>OMB Control Number: 0915-0285</b>				

**SAPR SF- PPR**

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**PROJECT EARNED VALUE MANAGEMENT (EVM) DATA**

Award Recipient Name	Grant Number	BHCNIS ID	Reporting Period End Date	Tracking Number
<<Project Number>><<Project Title>> (System populated data)				
Project Type	(System populated data)	Awarded Amount for the Project		(System populated data)
Project Status	(System populated data)	Total Estimated Project Cost		(System populated data)
1. Project Schedule	<input type="checkbox"/> On Time <input type="checkbox"/> Behind Schedule <input type="checkbox"/> Ahead of Schedule	2. Project Budget	<input type="checkbox"/> On Budget <input type="checkbox"/> Under Budget <input type="checkbox"/> Over Budget	
<b>If Behind Schedule</b> , please answer the questions below:				
<p>1a. Is the project expected to remain behind schedule?</p> <p><input type="checkbox"/> Yes, I will provide a revised completion date and identify how the total estimated project cost will be affected in the text box provided.</p> <p>1. Original total estimated project cost: (System populated data)</p> <p>2. Total estimated project cost (if revised): \$_____</p> <p>3. Original project completion date: (System populated data)</p> <p>4. Revised project completion date: _____ (MM/YYYY)</p> <p><input type="checkbox"/> 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.</p> <p>Explanation (maximum 2000 characters):</p>				
<b>If Ahead of Schedule</b> , please answer the questions below:				
<p>1b. Is the project expected to remain ahead of schedule?</p> <p><input type="checkbox"/> 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.</p> <p>1. Original total estimated project cost: (System populated data)</p> <p>2. Revised total estimated project cost: \$_____</p> <p>3. Original project completion date: (System populated data)</p> <p>4. Revised project completion date: _____ (MM/YYYY)</p> <p><input type="checkbox"/> No, I will indicate within the text box provided that the project will be completed by the estimated project completion date.</p> <p>Explanation (maximum 2000 characters):</p>				
<b>If Under Budget</b> , please answer the questions below:				
<p>2a. Will the project incur enough costs to allow for the drawdown of all the Federal funds by the project completion date?</p> <p><input type="checkbox"/> Yes, I will indicate in the text box provided the strategy to utilize the excess funds, if possible (i.e., purchase additional equipment).</p> <p><input type="checkbox"/> No, I will indicate in the text box provided that the award recipient organization is aware that the remaining funds will be de-obligated.</p> <p>Explanation (maximum 2000 characters):</p>				
<b>If Over Budget</b> , please answer the questions below:				

Award Recipient Name	Grant Number	BHCMIS ID	Reporting Period End Date	Tracking Number
<p>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)?</p> <p><input type="checkbox"/> Yes</p> <p>If Yes to 2b. above answer the following questions:</p> <p>2b.1 Will additional funds be secured, or have additional funds been secured, to allow for the completion of the project on time?</p> <p><input type="checkbox"/> Yes, I will indicate within the text box provided the source(s) and amount(s) of funding that will be/have been secured</p> <p><input type="checkbox"/> No, I will provide a timeline for adjusting the project scope to align with the adjusted costs within the text box provided.</p> <p><input type="checkbox"/> 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).</p> <p>Explanation (<i>maximum 2000 characters</i>):</p>				
<b>OMB Control Number:</b> 0915-0285				

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PROJECT CLOSEOUT REPORT**

Award Recipient Name	Grant Number	BHCMIS ID	Reporting Period End Date	Tracking Number
<<Project Number>><<Project Title>> (System populated data)				
<b>Square Footage Data</b> (Applicable only for completed projects of the type – ‘Construction’, and ‘Alteration/Repair/Renovation’)				
2. Square Feet Impacted (Construction and Alteration/Renovation projects only)				
<b>Project Costs</b> (Applicable only for all projects that are completed)				
4a. Funds awarded for this project	(System populated data)	4b. Actual amount of funds expended on the project		
4c. Projected amount of non-Program Specific funds, i.e., state, local, and other funds - including other federal funds - proposed for this project	(System populated data)	4d. Actual amount of non-Program Specific funds expended on the project		
<b>Project Completion Dates</b> (Applicable only for all projects that are completed)				
5a. Proposed project completion date	(System populated data)			
5b. Actual project completion date	(MM/YYYY)			
<b>OMB Control Number: XX</b>				

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](mailto:paperwork@hrsa.gov). Please see <https://www.hrsa.gov/about/508-resources> for the HRSA digital accessibility statement.