HRSA
Health Center Program

Summary Page (SAC)

OMB No.: 0915-0285. Expiration Date: XX/XX/XXXX

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SUMMARY PAGE (Service Area Competition)	FOR HRSA USE ONLY Grant Number	 Application Tracking Number

Service Area	
1. What is the Service Area Announcement Table (SAAT) identifying information for the service area that you are proposing to serve?	**Service Area ID #:___** **Service Area City, State: ____, _____**
Patient Projection	
2. What is the total unduplicated patient projection for the assessment period? **Note:** If changes are required, revisit Form 1A.	
3. What is the Patient Target from the Service Area Announcement Table (SAAT) for the proposed service area?	
4. Percent of the service area Patient Target proposed to be served in the assessment period. **Note:** This value must be at least 75 percent for the application to be considered eligible for funding.	
5. [_] By checking this box, I acknowledge that HRSA will track progress toward meeting the total unduplicated patient projection (see item 2 above), which may include projections from other funded applications awarded within my period of performance.	
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 (SAAT) 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)	
Migratory and Seasonal Agricultural Workers – MSAW-330(g)	
Homeless Population – HP-330(h)	
Residents of Public Housing – RPH-330(i)	

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SUMMARY PAGE (Service Area Competition)	FOR HRSA USE ONLY	
	Grant Number	Application Tracking Number

Total **Note:** Ensure this value does not exceed the Total Funding listed in the Service Area Announcement Table (SAAT) for the service area. If a funding reduction is required based on the patient projection (value between 75 and 94.9 percent in item 4 above), this figure should be lower than the value in the SAAT. See the Funding Details section of the NOFO for details.	

Scope of Project: Sites and Services

7. I am proposing the following site(s): (New applicants and competing supplement applicants only)

Note: If changes are required, revisit Form 5B.

Site Name	Site(s)	Site Physical Street Address	Service Site Type	Location Type	Service Area Zip Code(s)
Will pre-populate from Form 5B: Service Sites					

8. Sites Certification (New 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 release of the Notice of Award (NoA).

9. Scope of Project Certification – Services

(Competing continuation applicants only) – *select only one option 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 option 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.

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 release 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(s) from the current period of performance 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 by the due dates specified on my Health Center Program NoA(s) and that the Compliance Achievement Plan I submit must align with such timelines.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SUMMARY PAGE (Service Area Competition)	FOR HRSA USE ONLY	
	Grant Number	Application Tracking Number

12. Uniform Data System (UDS) Report Certification

[_] By checking this box, I certify that 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 also 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.

13. Applicants for HP and RPH Funding: Supplement and Not Supplant Certification
(New and competing supplement applicants only)

[_] Not Applicable. My organization is submitting a competing continuation application, or submitting a new or competing supplement application, but the organization is NOT requesting HP and/or RPH funding on the SF-424A.

[_] By checking this box, I certify that my organization will use HP and/or 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.

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