

Checklist for Deleting a Service from Scope

Background

Your change in scope (CIS) request will not become part of your health center's HRSA-approved Health Center Program scope of project until all the following steps have been completed:

1. HRSA sends your health center the Notice of Award (NoA) or Notice of Look-Alike Designation (NLD) approving the CIS request.
2. Next, your health center responds to a scope verification task that asks when this scope change will be implemented. HRSA will allow up to 120 days for your health center to respond to the scope verification task. After 120 days, this scope change will be recorded by HRSA as implemented.
3. Finally, HRSA sends your health center an NoA or NLD documenting that this scope change is reflected in your health center's scope of project.

For more information, refer to the [Scope of Project Resources](#).

1. Has your health center recently submitted or is it in the process of submitting any other CIS requests related to this service or related to any attachments within this CIS request?
For example, contracts or arrangements within this CIS request are referenced within other CIS requests.
 - ☐ Yes
 - ☐ No
 - 1.1 If YES: Provide the CIS tracking numbers and describe the connection to this CIS request.
[textbox]
2. Is this CIS request a scope correction in preparation for or resulting from one or more site visits?
 - ☐ Yes
 - ☐ No
 - 2.1 If YES: Identify the related site visits:
[textbox]
 - 2.2 If YES: Explain: [textbox]

Description and Rationale

3. Why are you requesting to delete this service from your health center's scope of project?

Select all reasons that apply:

- € The service is not financially sustainable.
- € Patient volume has substantially decreased to a point where the service cannot be sustained.
- € There is insufficient staff to support the service.
- € Other.

Explain: [textbox]

Required Service: Changing to Column III-Only

4. Provide a justification for why your health center is proposing to provide this service only through a cooperative arrangement (Column III ONLY on Form 5A: Services Provided).

[textbox]

5. Describe:

5.1 The impact of providing the service only through a cooperative arrangement on your health center's current patient population, specifically addressing the total number and percentage of patients who will be impacted.

[textbox]

5.2 The average travel time or distance for patients to access this service through the cooperative arrangement provider, and any new or enhanced transportation or patient support services to support access to the service.

[textbox]

5.3 How your health center will assist patients in making an appointment for the service.

[textbox]

5.4 How your health center will provide care coordination as well as follow-up care, based on the care and instructions provided by the other party. [textbox]

5.5 How data will be obtained from the cooperative arrangement provider if required for [UDS data reporting](#) purposes.

[textbox]

6. Attach a copy of your health center's cooperative arrangement with the other party for the service and, if needed, other documentation agreed to by both your health center and the other party.

The attachments **must** contain the **complete cooperative arrangement executed by all parties** (for example, a signed paper copy, electronically-signed documents, or emails documenting acceptance). The attachments must include any additional documentation, such as appendices or addenda.

Within the attachments, **clearly mark or highlight the language that addresses each criterion.**

Provide the **citation** (for example, page numbers) for where each criterion is addressed in the attached documentation. You may provide additional narrative if necessary.

[attachments – multiple, with at least one required]

- 6.1 The specific activity(ies) or services to be performed by the other party.

Citation within the attached (for example, page numbers): [textbox]

Brief Narrative: [textbox]

- 6.2 The process for exchanging patient information between the health center and the other party to ensure patient access to services.

Citation within the attached (for example, page numbers): [textbox]

Brief Narrative: [textbox]

- 6.3 How patient medical records or documentation of services provided will be maintained and shared with your health center. Specifically, the process for the other party to provide

information to your health center related to the services provided by the other party, such as follow-up instructions or laboratory, radiology, or other results.

Citation within the attached (for example, page numbers): [textbox]

Brief Narrative: [textbox]

6.4 How the other party will apply a discount to its schedule of charges for services it provides to health center patients.

Note: The other party's schedule of charges may differ from a health center's schedule of charges.

Citation within the attached (for example, page numbers): [textbox]

Brief Narrative: [textbox]

6.5 Any provisions required by federal and state laws, including those related to patient privacy and civil rights.

Note: A cooperative arrangement provision that requires the parties to comply with all laws generally (sometimes called a "catch-all" provision) may satisfy this criterion.

Citation within the attached (for example, page numbers): [textbox]

Brief Narrative: [textbox]

Additional Service: Changing to No Service Delivery Columns

7. Describe the impact of deleting the service on your health center's current patient population, specifically addressing the total number and percentage of patients who will be impacted.

[textbox]

Additional Service: Changing to Column III-Only

8. Provide a brief justification for why your health center is proposing to provide this service only through a cooperative arrangement (Column III ONLY on Form 5A: Services Provided).

[textbox]

9. Describe the impact of this change on your health center's current patient population, specifically addressing the total number and percentage of patients who will be impacted.

[textbox]

10. Describe how data will be obtained from the cooperative arrangement provider if required for [UDS data reporting](#) purposes.

[textbox]

11. Attach a copy of your health center's cooperative arrangement with the other party for the service and, if needed, other documentation agreed to by both your health center and the other party.

The attachments **must** contain the **complete cooperative arrangement executed by all parties** (for example, a signed paper copy, electronically-signed documents, or emails documenting acceptance). The attachments must include any additional documentation, such as appendices or addenda.

Within the attachments, **clearly mark or highlight the language that addresses each criterion.**

Provide the **citation** (for example, page numbers) for where each criterion is addressed in the attached documentation. You may provide additional narrative if necessary.

[attachments – multiple, with at least one required]

11.1 The specific activity(ies) or services to be performed by the other party.

Citation within the attached (for example, page numbers): *[textbox]*

Brief Narrative: *[textbox]*

11.2 The process for exchanging patient information between the health center and the other party to ensure patient access to services.

Citation within the attached (for example, page numbers): *[textbox]*

Brief Narrative: *[textbox]*

11.3 How patient medical records or documentation of services provided will be maintained and shared with your health center. Specifically, the process for the other party to provide information to your health center related to the services provided by the other party, such as follow-up instructions or laboratory, radiology, or other results.

Citation within the attached (for example, page numbers): *[textbox]*

Brief Narrative: *[textbox]*

11.4 How the other party will apply a discount to its schedule of charges for services it provides to health center patients.

Note: The other party's schedule of charges may differ from a health center's schedule of charges.

Citation within the attached (for example, page numbers): *[textbox]*

Brief Narrative: *[textbox]*

11.5 Any provisions required by federal and state laws, including those related to patient privacy and civil rights.

Note: A cooperative arrangement provision that requires the parties to comply with all laws generally (sometimes called a "catch-all" provision) may satisfy this criterion.

Citation within the attached (for example, page numbers): *[textbox]*

Brief Narrative: *[textbox]*

Outreach and Communication

12. Describe how your health center will communicate with current health center patients and the community (for example, other Health Center Program award recipients and look-alikes, rural health clinics, critical access hospitals, health departments) to let them know that your health center will no longer provide this service.

[textbox]

13. Attach documents relevant to this service change that demonstrate your health center's outreach and communications (for example, sample patient notification documents, local media announcements).

[attachment – multiple, with at least one required]

Reminder: *If any information in this CIS request is incomplete, HRSA may disapprove this CIS request.*

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/2029. 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.