U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

Bureau of Primary Health Care
Health Center Program

Service Area Competition

Announcement Type: New, Competing Continuation, and Supplement
Announcement Number: HRSA-15-012

Catalog of Federal Domestic Assistance (CFDA) No. 93.224

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2015

Application Due Date in Grants.gov: October 22, 2014
Supplemental Information Due Date in EHB: November 5, 2014

Ensure your SAM and Grants.gov registration and passwords are current immediately!
Deadline extensions are not granted for lack of registration.
SAM registration may take up to two weeks and
Grants.gov registration may take up to one month to complete.

Release Date: September 16, 2014
Issuance Date: September 16, 2014

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http://www.hrsa.gov/grants/apply/assistance/sac

Authority: Public Health Service Act, Section 330, as amended (42 U.S.C. 254b)

EXECUTIVE SUMMARY

The Health Resources and Services Administration, Bureau of Primary Health Care is accepting applications for fiscal year (FY) 2015 Service Area Competition (SAC) under the Health Center Program. The purpose of this grant program is to improve the health of the Nation's underserved communities and vulnerable populations by assuring continued access to comprehensive, culturally competent, quality primary health care services. Health Center Program grants support a variety of community-based and patient-directed public and private nonprofit organizations that serve an increasing number of the Nation's underserved.

Funding Opportunity Title:	Service Area Competition (SAC)
Funding Opportunity Number:	HRSA-15-012
Due Date for Applications:	Grants.gov: October 22, 2014 (11:59 p.m. ET) HRSA EHB: November 5, 2014 (5:00 p.m. ET)
Anticipated Total Annual Available Funding:	Approximately $39 million
Estimated Number and Type of Award(s):	30 grants
Average Award Amount:	$1,300,919
Cost Sharing/Match Required:	No
Length of Project Period:	Up to three years
Project Start Date:	March 1, 2015
Eligible Applicants:	Public or nonprofit private entity, including tribal, faith-based, or community-based organizations; and propose to serve a service area and its associated population(s) and patients identified in the Service Area Announcement Table (SAAT) – see http://www.hrsa.gov/grants/apply/assistance/sac [See Section III-1 of this funding opportunity announcement (FOA) for complete eligibility information.]

All applicants are responsible for reading and complying with the instructions included in HRSA *SF-424 Two-Tier Application Guide*, available at http://www.hrsa.gov/grants/apply/applicationguide/sf424programspecificappguide.doc, except where otherwise instructed in this funding opportunity announcement.

Summary of Changes

- A modification to the requirement to serve all patients listed in the Service Area Announcement Table (with an accompanying reduction in funding).
- The eligibility criteria section clarifies current policy that an organization may not apply on behalf of another organization.
- While the maximum project period length remains up to three years, the criteria for awarding a one-year project period have been revised.
- Addition of priority points for program performance available to current grantees proposing to serve their current service area.

- The Tobacco Use Assessment and Tobacco Cessation Counseling performance measures have been combined into a single measure for Tobacco Use Screening and Cessation. Two new measures have also been added: New HIV Cases with Timely Follow-Up and Depression Screening and Follow-Up. Refer to PAL 2014-01 (http://bphc.hrsa.gov/policiesregulations/policies/pal201401.html).
- The SF-424A Budget Categories form has been changed to capture details on the federal funding request and non-grant revenue supporting the project. See Appendix C for details.
- Form 3: Income Analysis has been programmed into the Program Specific Forms application section in the HRSA Electronic Handbook.
- Form 5A: Services Provided has been revised to clarify service categories and definitions. Refer to PAL 2014-06 (http://bphc.hrsa.gov/policiesregulations/policies/pal201406.html). Additionally, new and supplemental applicants may not propose Specialty or Other Additional Services via Form 5A.
- Form 5B: Service Sites has been revised. Refer to PAL 2014-06 (http://bphc.hrsa.gov/policiesregulations/policies/pal201406.html). Additionally, applicants may propose a mobile medical van, only if a permanent, full-time site is also proposed.
- Form 6B: Request for Waiver of Governance Requirements has been updated to reflect the elimination of waivers for the monthly Board meetings. Refer to PIN 2014-01 (http://bphc.hrsa.gov/policiesregulations/policies/pin201401.pdf).
- The Federal Object Class Categories form has been removed.
- A financial audit attachment is no longer required.
- Addition of a Summary Page to enable applicants to verify key application data.

Note: Each SAC project period start date (e.g., March 1 starts, April 1 starts) has a unique HRSA announcement number (e.g., HRSA-15-XXX), and each announcement number has a unique Grants.gov application package. Refer to the Service Area Announcement Table (SAAT) at http://www.hrsa.gov/grants/apply/assistance/sac to confirm your project period start date and submit the corresponding application package. **Application packages submitted to the incorrect HRSA announcement number will be deemed ineligible and will not be reviewed**.

Pre-Application Conference Call and Resources

HRSA will hold a pre-application conference call to provide an overview of this FOA and offer an opportunity for organizations to ask questions. For the date, time, dial-in number, and other information for the call, visit http://www.hrsa.gov/grants/apply/assistance/sac. Refer to http://www.hrsa.gov/grants/apply for general (i.e., not SAC-specific) videos and slides on a variety of application and submission components.

Table of Contents

I. Funding Opportunity Description

1. Purpose

Health centers improve the health of the Nation's underserved communities and vulnerable populations by ensuring access to comprehensive, culturally competent, quality primary health care services. Health Center Program grants support a variety of community-based and patient-directed public and private nonprofit organizations that serve an increasing number of the Nation's underserved.

Individually, each health center plays an important role in the goal of ensuring access to services, and combined, they have had a critical impact on the health care status of medically underserved and vulnerable populations throughout the United States and its territories. The Health Center Program targets the Nation's neediest populations and geographic areas by currently funding approximately 1,300 health centers that operate over 9,000 service delivery sites in every state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. In 2013, more than 21 million patients, including medically underserved and uninsured patients, received comprehensive, culturally competent, quality primary health care services through the Health Center Program.

This Funding Opportunity Announcement (FOA) solicits applications for the Health Center Program's Service Area Competition (SAC). The FOA details the SAC eligibility requirements, review criteria, and awarding factors for organizations seeking a grant for operational support of an announced service area under the Health Center Program, including Community Health Center (CHC – section 330(e)), Migrant Health Center (MHC – section 330(g)), Health Care for the Homeless (HCH – section 330(h)), and/or Public Housing Primary Care (PHPC – section 330(i)). For the purposes of this document, the term "health center" refers to the diverse types of health centers (i.e., CHC, MHC, HCH, and /or PHPC) supported under section 330 of the PHS Act, as amended.

2. Background

This Health Center Program is authorized by section 330 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254b). The SAC application is a competitive request for federal financial assistance to support comprehensive primary health care services for an announced service area. For a list of all announced service areas and target populations, see the Service Area Announcement Table (SAAT) available at http://www.hrsa.gov/grants/apply/assistance/sac. **All service areas listed in the SAAT are currently served by Health Center Program grantees whose project periods are ending.** HRSA intends to continue to support health services in these areas. Competitive applicants must demonstrate how they will make services available and accessible in a manner that will assure continuity of care to the individuals in the service area.

Note: HRSA will award only one grant for each listed service area.

Specific Program Requirements
Applicants must document an understanding of the need for primary health care services in the service area and propose a sound plan to meet this need. The plan must ensure the availability and accessibility of essential primary and preventive health services to all individuals in the service area and target population. Further, applicants must demonstrate that the plan maximizes established collaborative and coordinated delivery systems for the provision of health care to the underserved.

New applicants and current grantees proposing to serve a new service area must meet the following readiness requirements.

- Within 120 days of notice of award,[1] each proposed site must be operational with providers available at each site to begin providing services to the proposed population/community
- Within one year of the Notice of Award, all providers must be hired and all sites must be operational for the targeted number of hours.

All applicants must achieve full operational capacity as outlined in the application, including providing service to the number of patients projected to be served on Form 1A by December 31, 2016. Failure to meet this patient projection may result in reductions in Health Center Program grant funding.

Applicants may propose a mobile medical van only if at least one full-time (operational 40 hours or more per week) permanent, fixed building site is also proposed in the SAC application, with the exception of projects serving only migratory and seasonal agricultural workers, which may propose at least one full-time, seasonal (rather than permanent) service delivery site.

Applicants must demonstrate compliance with the applicable requirements of section 330 of the PHS Act, as amended, including corresponding regulations and policies, based on the announced service area and target population. In addition to these general requirements, there are specific requirements for applicants requesting funding under each health center type (CHC, MHC, HCH, and/or PHPC) authorized under section 330 (see below). Failure to document and demonstrate compliance will significantly reduce the likelihood of funding. Applicants are encouraged to review the Health Center Program requirements available at http://bphc.hrsa.gov/about/requirements.

Throughout the project period, grantees will be routinely assessed for program compliance. Consistent with current practice, in circumstances where a grantee is determined to be non-compliant with one or more of the Health Center Program requirements, HRSA will place a condition on the award and will follow the Progressive Action policy and process. The Progressive Action process provides a time-phased approach for resolution of compliance issues. Failure to successfully address conditions and demonstrate compliance via Progressive Action may result in cancellation of all or part of the grant award per 45 CFR 74.62(a). For more information, review the Progressive Action PAL 2014-08: Health Center Program Requirements

[1] HRSA may issue Notices of Award up to 60 days prior to the project period start date.

Oversight/Progressive Action Process available at http://www.bphc.hrsa.gov/policiesregulations/policies/pal201408.html.

COMMUNITY HEALTH CENTER APPLICANTS:

- Ensure compliance with section 330(e) and program regulations, requirements, and policies.
- Provide a plan that ensures the availability and accessibility of required primary and preventive health services to underserved populations in the service area.

MIGRANT HEALTH CENTER APPLICANTS:

- Ensure compliance with section 330(g), section 330(e), and, as applicable, program regulations, requirements, and policies.
- Provide a plan that ensures the availability and accessibility of required primary and preventive health services to migratory and seasonal agricultural workers and their families in the service area; with migratory and seasonal agricultural workers meaning individuals principally employed in agriculture on a seasonal basis within the last 24 months and who establish temporary housing for the purpose of this work; with seasonal agricultural workers meaning individuals employed in agriculture on a seasonal basis, who are not also migratory; and with agriculture meaning farming in all its branches, as defined by the OMB-developed NAICS under the following codes and all sub-codes within—111, 112, 1151, and 1152.

HEALTH CARE FOR THE HOMELESS APPLICANTS:

- Ensure compliance with section 330(h), section 330(e), and, as applicable, program regulations, requirements, and policies.
- Provide a plan that ensures the availability and accessibility of required primary and preventive health services to people experiencing homelessness, defined to include residents of permanent supportive housing or other housing programs that are targeted to homeless populations, in the service area. Such a plan may also allow for continuing to provide services for up to 12 months to individuals no longer homeless as a result of becoming a resident of permanent housing.

PUBLIC HOUSING PRIMARY CARE APPLICANTS

- Ensure compliance with section 330(i), section 330(e), and, as applicable, program regulations, requirements, and policies.
- Provide a plan that ensures the availability and accessibility of required primary and preventive health services to residents of public housing and individuals living in areas immediately accessible to such public housing. Public housing means public housing agency-developed, owned, or assisted low-income housing, including mixed finance projects, but excludes housing units with no public housing agency support other than Section 8 housing vouchers.

II. Award Information

1. Type of Award

Funding will be provided in the form of a grant.

2. Summary of Funding

Award amounts will not exceed, in any year of the proposed three-year project period, the projected annual level of Health Center Program funding for each service area. Applicants must propose to serve at least 75 percent of patients by December 31, 2016 as listed in the SAAT. Applicants proposing to serve fewer than the total number of patients indicated in the SAAT must reduce their funding request according to the following table. A funding calculator to determine any necessary reduction is available at http://www.hrsa.gov/grants/apply/assistance/sac.

Funding Reduction by Patients Projected to Be Served

Patient Projections Compared to SAAT (%)	Funding Request Reduction (%)
95-100% of patients listed in the SAAT	No reduction
90-94.9% of patients listed in the SAAT	0.5% reduction
85-89.9% of patients listed in the SAAT	1% reduction
80-84.9% of patients listed in the SAAT	1.5% reduction
75-79.9% of patients listed in the SAAT	2% reduction

The federal request for funding on the SF-424A and Budget Justification Narrative must accurately reflect any reductions in the value of the budget request.

This program will provide funding during Federal fiscal years 2015-2017. Approximately $39 million is expected to be available annually to fund 30 grantees through HRSA-15-012. The actual amount available will not be determined until enactment of the final FY 2015 Federal budget. This program announcement is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, applications can be processed, and funds can be awarded in a timely manner. Applicants may apply for a ceiling amount of up to the established cap of section 330 funding (listed as Total Funding on the SAAT) available to support the announced service area and its designated population(s) per year. The project period is three years. Funding beyond the first year is dependent on the availability of appropriated funds for the Health Center program in subsequent fiscal years, grantee satisfactory performance, and a decision that continued funding is in the best interest of the federal government.

See Section IV.2.iii for further information and instructions on the development of the application budget. Federal funding for new applicants may be adjusted based on an analysis of the budget and cost factors.

III. Eligibility Information

1. Eligible Applicants

Applicants must meet all of the following eligibility requirements. Applications that do not **demonstrate compliance with all eligibility requirements will be deemed non-responsive and will not be considered for SAC funding.**

1) Applicant is a public or nonprofit private entity, such as a tribal, faith-based, or community-based organization.

2) Applicant is one of the following:

- Competing Continuation – A current Health Center Program grantee whose project period ends on February 28, 2015 that seeks to continue serving its current service area.
- New – A health center not currently funded through the Health Center Program that seeks to serve an entire announced service area through the proposal of one or more sites.
- Supplemental – A current Health Center Program grantee that seeks to serve an entire announced service area, in addition to its current service area (select Revision on the SF-424) through the proposal of one or more new sites.

3) Applicant proposes to serve a service area and its associated population(s) and patients identified in the SAAT (see http://www.hrsa.gov/grants/apply/assistance/sac).

- Applicant must propose on Form 1A to serve at least 75 percent of patients by December 31, 2016 as listed in the SAAT. See the Summary of Funding section above if the patient projection is less than published in the SAAT.
- Applicant must propose on Form 5B the service area zip codes from which at least 75 percent of the current patients reside.[2] Applicants should use the SAAT as a resource in determining the zip codes from which the majority of patients originate.
- Applicant must propose to serve all currently targeted populations (i.e., CHC, MHC, HCH, PHPC) identified through the funding distribution in the SAAT. See Item 6 below for details on how this impacts the budget request.

Note: Health centers will be held accountable for all patients projected to be served through this funding opportunity, as well as any additional patient projections associated with supplemental awards received during the project period. If a health center is unable to demonstrate that it is serving patients within 5 percent of total patients projected on Form 1A by December 31, 2016, announced funding for the service area may be proportionally reduced.

[2] HRSA considers service area overlap when making funding determinations for new applicants and current grantees proposing to serve a new service area if zip codes are proposed beyond those listed on the SAAT. For more information about service area overlap, refer to Policy Information Notice 2007-09 located at http://bphc.hrsa.gov/policiesregulations/policies/pin200709.html.

4) Applicant requests section 330 funds to support the operation of a health center for the provision of required comprehensive primary, preventive, and enabling health care services, either directly on-site or through established arrangements, without regard to ability to pay. An applicant may **not** propose to provide only a single service, such as dental, behavioral, or prenatal services.

5) Applicant proposes access to services for all individuals in the service area and target population. In other words, applicant does not propose to exclusively serve a single age group (e.g., children, elderly) or address a health issue/disease category (e.g., HIV/AIDS). In instances where a sub-population is being targeted within the service area or target population (e.g., homeless children; lesbian, gay, bisexual, and transgender individuals (LGBT)), the applicant must ensure that health care services will be made available to others in need of care who seek services at the proposed site(s).

6) Applicant requests annual federal section 330 funding (as listed in the SAAT and presented on the SF-424A and Budget Justification Narrative) that **DOES NOT** exceed the established cap of section 330 funding (listed as Total Funding on the SAAT) available to support the announced service area and its designated population(s). Applicant maintains the current funding distribution between target populations as listed on the SAAT (i.e., CHC, MHC, HCH, PHPC).

7) Applicant does not apply on behalf of another organization. The grant recipient is expected to perform a substantive role in the project and meet the program requirements; therefore, the applicant organization, as indicated on the SF-424, must be the applicant of record and demonstrate that it meets all eligibility criteria.

8) Applicant submits only one application for consideration under a single SAC announcement number.

Note: An applicant wishing to apply to serve two different service areas announced under a single announcement number **must** contact the Office of Policy and Program Development at 301-594-4300 or BPHCSAC@hrsa.gov for guidance.

9) Applicant adheres to the 160-page limit on the length of the application when printed by HRSA. See Tables 1-4 for specific information regarding the documents included in the 160-page limit.

Refer to the SAAT, available at http://www.hrsa.gov/grants/apply/assistance/sac, for information regarding specific available service areas and their associated population(s), patients, zip codes, and funding distributions.

2. Cost Sharing/Matching

Cost sharing or matching are not requirements for this funding opportunity. Under 42 CFR 51c.203, HRSA will take into consideration whether and to what extent an applicant plans to secure and maximize federal, state, local, and private resources to support the proposed project.

Please see the budget and budget justification narrative section (Section IV.2.iii) for clarification and guidelines pertaining to the budget presentation.

3. Other

Applications that exceed the ceiling amount for the proposed service area (see the SAAT available at http://www.hrsa.gov/grants/apply/assistance/sac) will be considered non-responsive and will not be considered for funding under this announcement.

Any application that fails to satisfy the deadline requirements referenced in Section IV.3 will be considered non-responsive and will not be considered for funding under this announcement.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** applicants for this funding opportunity announcement to apply electronically through Grants.gov and in HRSA EHB. Applicants must use a two-tier submission process for the Service Area Competition. Applicants must download the SF-424 application package associated with this funding opportunity following the directions provided at Grants.gov and in HRSA EHB.

- **Step 1 – Grants.gov** – Required information must be submitted and validated by Grants.gov no later than October 22, 2014 at 11:59 p.m. Eastern Time

- **Step 2 - HRSA EHB** – Supplemental information must be submitted via HRSA EHB no later than November 5, 2014 at 5:00 p.m. Eastern Time

Active SAM registration is a pre-requisite to the successful submission and award of grant applications. More information is available in the *SF-424 Two-Tier Application Guide*. To learn more about SAM, please visit https://www.sam.gov.

Only applicants who successfully submit and have an application validated in Grants.gov (Step 1) by the due date/time may submit the additional required information and in HRSA EHB (Step 2).

2. Content and Form of Application Submission

Application Format Requirements

Section 5 of HRSA's *SF-424 Two-Tier Application Guide* provides instructions for the budget, budget justification narrative, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information as outlined in the Application Guide in addition to the program specific information below. Applicants are responsible for

reading and complying with the instructions included in HRSA's *SF-424 Two-Tier Application Guide* except where instructed in this funding opportunity announcement to do otherwise.

Application Page Limit

The total size of all uploaded files may not exceed the equivalent of 160 pages when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support. Standard OMB-approved forms included in the application package are NOT included in the page limit. **We strongly urge you to print your application and count all applicable pages to ensure it does not exceed the specified page limit.**

Applications must be complete, within the specified page limit, and submitted prior to the deadline to be considered under this announcement.

Application Format

The following tables detail the documents required for this funding opportunity and the order in which they must be submitted. In the Form Type column of Tables 1-4, the word "Form" refers to a document that must be downloaded, completed in the template provided, and then uploaded. "E-Form" refers to forms that are completed online in EHB and therefore do not require downloading or uploading. "Document" refers to a document to be uploaded for which no template is provided. "Fixed" refers to forms that cannot be altered.

In Tables 1-4, documents and forms marked as "required for completeness" will be used to determine if an application is complete. Applications that fail to include all forms and documents indicated as "required for completeness" will be considered incomplete or non-responsive, thereby making them ineligible. Ineligible applications will not proceed to objective review. Failure to include documents indicated as "required for review" may negatively impact an application's objective review score. Applications must include the following documents in the following order.

Table 1: Step 1–Submission through Grants.gov

http://www.grants.gov

- Applicants must follow the provided instructions to ensure that your application can be printed efficiently and consistently for review.
- Failure to follow the instructions may make your application non-responsive. Non-responsive applications will not be considered.
- Number the electronic attachment pages sequentially, resetting the numbering for each attachment (i.e., start at page 1 for each attachment). Do not attempt to number standard OMB approved form pages.
- HRSA will construct an electronic table of contents in the order specified for the electronic submission. Applicants do not need to create a table of contents for the entire application.
- Limit file attachment names to 50 or fewer characters. Attachments that do not follow this rule will cause the entire application to be rejected by Grants.gov.
- The Other Attachments Form (listed as an Optional Document in Grants.gov) is not required and should NOT be submitted.

Application Section	Form Type	Instruction	Counted in Page Limit (Y/N)

Application for Federal Assistance (SF-424)	Form	Prepare according to instructions provided in the form itself (mouse over fields for specific instructions) and the following guidelines:
		• *Box 2: Type of Applicant:* **Incorrect selection may delay EHB access.**
		  • Continuation – Current Health Center Program grantees applying to continue serving their current service area. Select Continuation and include your H80 grant number in box 4.
		  • New – Applicants not currently funded through the Health Center Program. Select New and leave box 4 blank.
		  • Revision – Current grantees applying to serve a new service area. Select Other and type Supplemental and your H80 grant number in box 4.
		• *Box 4: New applicant leave blank*
		• *Box 5a:* Leave blank.
		• *Box 5b: Federal Award Identifier:* 10-digit grant number (H80…) found in box 4b from the most recent Notice of Award for current section 330 grantees. New applicants should leave this blank.
		• *Box 8c:* Applicant organization's DUNS number. ***Note****:* An incorrect or mistyped DUNS number will cause the application to be rejected.
			N

Application Section	Form Type	Instruction	Counted in Page Limit (Y/N)
		• *Box 8f: Name and Contact Information of Person to be Contacted on Matters Involving this Application:* Provide the Project Director's name and contact information. • ***Note:*** If, for any reason, the Project Director will be out of the office between the Grants.gov submission date and the project period start date, ensure that the email Out of Office Assistant is set so HRSA will be aware of whom to contact if issues arise with the application and a timely response is required. • *Box 14: Areas Affected by Project:* Provide a summary of the areas to be served (e.g., if entire counties are served, cities do not need to be listed) and upload it as a Word document. • *Box 15: Descriptive Title of Applicant's Project:* Type the title of the FOA (Service Area Competition) and upload the project abstract. See instructions in Section IV.2.i. The abstract WILL count toward the page limit. • *Box 16: Congressional Districts:* Provide the Congressional district where the administrative office is located in 16a and the Congressional districts to be served by the proposed project in 16b. If information will not fit in the boxes provided, attach a Word document. • *Box 17: Proposed Project Start and End Date:* Provide the start date (March 1, 2015) and end date (February 28, 2018) for the proposed three-year project period. • *Box 18: Estimated Funding:* Complete the required information based on the funding request for the **first year** of the proposed project period. Refer to the Summary of Funding section for details. • *Box 19: Review by State:* See Section IV.4 for guidance in determining applicability. • *Box 21: Authorized Representative:* The electronic signature in Grants.gov (created when the Grants.gov forms are submitted) serves as the official signature for a SAC grant. The form should NOT be printed, signed, and mailed to HRSA.	

Application Section	Form Type	Instruction	Counted in Page Limit (Y/N)
Project Abstract	Document	Type the title of the funding opportunity (Service Area Competition) and upload the project abstract in Box 15 of the SF-424. See instructions in Section IV.2.i.	Y
SF-424B: Assurances – Non-Construction Programs	Form	Complete the Assurances form.	N
Additional Congressional District(s) (as applicable)	Document	Upload a list of additional Congressional Districts served by the project if all districts served will not fit in 16b of the SF-424.	Y
Project Performance Site Location(s)	Form	Current Health Center Program grantees applying to continue serving their current service area must provide ***only*** the administrative site of record. Applicants not currently receiving Health Center Program funds for the proposed service area must provide the administrative site information AND information about all project performance sites. A list of additional sites may be uploaded as necessary.	N
Grants.gov Lobbying Form	Form	Provide the requested contact information at the bottom of the form.	N
SF-LLL: Disclosure of Lobbying Activities (as applicable)	Form	Complete the form only if lobbying activities are conducted.	N

Within seven business days following successful submission of the required items in Grants.gov, you will be notified by HRSA confirming the successful receipt of your application and requiring the Project Director and Authorized Organization Representative to submit additional information in HRSA EHB. Your application will not be considered complete unless you review and validate the information submitted through Grants.gov and submit the additional required portions of the application through HRSA EHB. Refer to http://www.hrsa.gov/grants/apply for detailed application and submission instructions.

Table 2: Step 2–Submission through HRSA Electronic Handbooks (EHB)
https://grants.hrsa.gov/webexternal

- Applicants must follow the instructions below to ensure that the application can be printed efficiently and consistently for review.
- Failure to follow the instructions may make your application non-responsive. Non-responsive applications will not be considered for funding under this FOA.
- Number the electronic attachment pages sequentially, resetting the numbering for each attachment (i.e., start at page 1 for each attachment). Do not attempt to number standard OMB approved form pages.

Application Section	Required for Completeness or Review (C/R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Project Narrative	C	Document	Upload the Project Narrative. See instructions in Section IV.2.ii.	Y
SF-424A: Budget Information	C	E-Form	Complete Sections A, B, C, and E. Complete Section F if applicable. See instructions in Appendix C.	N
Budget Justification Narrative	C	Document	Upload the Budget Justification Narrative in the Budget Narrative Attachment Form field. See instructions in Appendix C.	Y
Attachments	Varies	Documents	See Table 3.	Varies
Program Specific Forms	R	Varies	See Table 4.	N
Program Specific Information	R	E-Forms	See Table 4.	N

Table 3: Attachments Submission through HRSA EHB (Step 2 continued)

https://grants.hrsa.gov/webexternal

- To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Number the electronic attachment pages sequentially, resetting the numbering (i.e., start at page 1) for each attachment.
- Merge similar documents (e.g., Letters of Support) into a single document. Add a table of contents page specific to the attachment. This page will ***not*** count toward the page limit.
- Limit file names for attachments to 50 characters or less. Attachments will be rejected by EHB if file names exceed 50 characters.
- If any attachment marked "required for completeness" is not uploaded, the application will be considered incomplete and non-responsive, thereby making it ineligible. Ineligible applications will not proceed to objective review.
- If the attachments marked "required for review" are not uploaded, the application's objective review score may be negatively impacted.

Attachment	Required for Completeness or Review (C/R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Attachment 1: Service Area Map and Table	R	Document	Upload a map of the service area for the proposed project, indicating the organization's proposed health center site(s) listed in Form 5B. The map must clearly indicate the proposed service area zip codes, any medically underserved areas (MUAs) and/or medically underserved populations (MUPs), and Health Center Program grantees, look-alikes, and other health care providers serving the proposed zip codes. Maps should be created using UDS Mapper (http://www.udsmapper.org). Please note that you will have to manually place markers for the locations of other major private provider groups serving low income/uninsured populations. Include a corresponding table that lists each zip code tabulation area (ZCTA) in the service area, the number of health centers serving each ZCTA, total population, total low-income population, total health center patients, and patient penetration levels for each ZCTA and for the overall proposed service area. This table will be automatically created in UDS Mapper. See http://www.hrsa.gov/grants/apply/assistance/sac for samples and instructions on creating maps using UDS Mapper. For a tutorial, see Specific Use Cases: Create a Service Area Map and Data Table at http://www.udsmapper.org/tutorials.cfm.	Y

Attachment	Required for Completeness or Review (C/R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Attachment 2: Corporate Bylaws	C	Document	Upload (in its entirety) the applicant organization's most recent bylaws. Public centers that have a co-applicant must submit the co-applicant governing board bylaws. See the ***GOVERNANCE*** section of the Project Narrative for more details.	Y
Attachment 3: Project Organizational Chart	R	Document	Upload a one-page document that depicts the applicant's current organizational structure, including the governing board, key personnel, staffing, and any sub-recipients or affiliated organizations.	Y
Attachment 4: Position Descriptions for Key Management Staff	R	Document	Upload current position descriptions for key management staff: Chief Executive Officer (CEO), Chief Medical Officer (CMO), Chief Financial Officer (CFO), Chief Information Officer (CIO), and Chief Operating Officer (COO). Indicate on the position descriptions if key management positions are combined and/or part time (e.g., CFO and COO roles are shared). Each position description should be limited to **one page** and must include, at a minimum, the position title; description of duties and responsibilities; position qualifications; supervisory relationships; skills, knowledge, and experience requirements; travel requirements; salary range; and work hours.	Y
Attachment 5: Biographical Sketches for Key Management Staff	R	Document	Upload current biographical sketches for key management staff: CEO, CMO, CFO, CIO, and COO. Biographical sketches should not exceed **two pages** each. When applicable, biographical sketches must include training, language fluency, and experience working with the cultural and linguistically diverse populations to be served.	Y
Attachment 6: Co-Applicant Agreement (required for public center[3] applicants that have a co-applicant board)	• New: C • Competing Continuation and Supplemental: R	Document	Public center applicants that have a co-applicant board must submit, in its entirety, the formal co-applicant agreement signed by both the co-applicant governing board and the public center. See the RESOURCES/CAPABILITIES and GOVERNANCE sections of the Project Narrative for more details.	Y

[3] Public centers were referred to as "public entities" in the past.

Attachment	Required for Completeness or Review (C/R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Attachment 7: Summary of Contracts and Agreements (as applicable)	R	Document	Upload a BRIEF SUMMARY describing current or proposed patient service-related contracts and agreements. The summary must address the following items for each contract or agreement: • Name and contact information for each affiliated agency. • Type of contract or agreement (e.g., contract, affiliation agreement). • Brief description of the purpose and scope of each contract or agreement (i.e., type of services provided, how/where services are provided). • Timeframe for each contract or agreement. If a contract or agreement will be attached to Form 8 (e.g., contract for a substantial portion of the proposed project), denote this with an asterisk (*).	Y
Attachment 8: Articles of Incorporation – Signed Seal Page	• New and Supplemental: C • Competing Continuation: N/A	Document	New applicants must upload the official signatory page (seal page) of the organization's Articles of Incorporation. A public center with a co-applicant should upload the co-applicant's Articles of Incorporation.	Y
Attachment 9: Letters of Support	R	Document	Upload current dated letters of support addressed to the appropriate organization contact (e.g., board, CEO) to document commitment to the project. See the ***COLLABORATION*** section of the Project Narrative for details on required letters of support. Reviewers will not consider letters of support that are not submitted with the application.	Y
Attachment 10: Sliding Fee Discount Schedule(s)	R	Document	Upload the current or proposed sliding fee discount schedule(s). See the ***RESPONSE*** section of the Project Narrative for details.	Y
Attachment 11: Evidence of Nonprofit or Public Center Status (as applicable)	• New: C • Competing Continuation and Supplemental: N/A	Document	Upload evidence of nonprofit or public center status **only if you are a new applicant**. Private Nonprofit: A private, nonprofit organization must submit any one of the following as evidence of its nonprofit status: • A reference to the organization's listing in the Internal	N

Attachment	Required for Completeness or Review (C/R)	Form Type	Instruction	Counted in Page Limit (Y/N)
			Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code. • A copy of a currently valid Internal Revenue Service Tax exemption certificate. • A statement from a state taxing body, state Attorney General, or other appropriate state official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals. • A certified copy of the organization's certificate of incorporation or similar document **if it clearly establishes** the nonprofit status of the organization. • Any of the above proof for a state or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate. Public Center: Consistent with Policy Information Notice 2010-10 (http://bphc.hrsa.gov/policiesregulations/policies/pin201001.html), applicants must provide documentation demonstrating that the organization qualifies as a public agency (e.g., health department, public university health system) for the purposes of section 330 of the PHS Act, as amended. Any of the following is acceptable: • Affirm Instrumentality Letter (4076C) from the IRS or a letter of authority from the federal, state, or local government granting the entity one or more sovereign powers. • A determination letter issued by the IRS providing evidence of a past positive ruling by the IRS or other documentation demonstrating that the organization is an instrumentality of government, such as documentation of the law that created the organization or documentation showing that the state or a political subdivision of the state	

Attachment	Required for Completeness or Review (C/R)	Form Type	Instruction	Counted in Page Limit (Y/N)
			controls the organization. • Formal documentation from a sovereign state's taxing authority equivalent to the IRS granting the entity one or more governmental powers.	
Attachment 12: Floor Plans (as applicable)	• New and Supplemental: R • Competing Continuation: N/A	Document	New applicants and current grantees applying to serve a new service area must provide copies of floor plans for all sites within the proposed scope of project. Current grantees applying to continue serving their current service area **do not** need to provide floor plans unless there has been a change in layout of any site(s).	Y
Attachment 13: Implementation Plan (as applicable)	• New and Supplemental: C • Competing Continuation: N/A	Document	New applicants and current grantees applying to serve a new service area must upload the Implementation Plan. Refer to Appendix D for detailed instructions and see http://www.hrsa.gov/grants/apply/assistance/sac for a sample.	Y
Attachments 14-15: Other Relevant Documents (as applicable)	R	Document	If desired, include other relevant documents to support the proposed project (e.g., charts, organizational brochures, lease agreements).	Y

Table 4: Program Specific Forms and Information Submission through HRSA EHB (Step 2 continued)

https://grants.hrsa.gov/webexternal

- All Program Specific Forms will be completed online in the HRSA EHB.
- EHB rejects file names that exceed 50 characters. Limit the file name for Form 3 and for all attachments to 50 characters or less.
- All Program Specific Information is required and will be completed online in HRSA EHB.
- Refer to Appendix A for detailed instructions for the Program Specific Forms.
- Refer to Appendix B for Program Specific Information detailed instructions and Clinical and Financial Performance Measures samples.
- The Program Specific Forms and Program Specific Information forms DO NOT count against the page limit.

Program Specific Form/Information	Form Type
Form 1A: General Information Worksheet	E-Form
Form 1C: Documents on File	E-Form
Form 2: Staffing Profile	E-Form
Form 3: Income Analysis	E-Form
Form 4: Community Characteristics	E-Form
Form 5A: Services Provided	Fixed form for current grantees applying to continue serving their current service area. E-Form for new applicants and current grantees applying to serve a new service area.
Form 5B: Service Sites	Fixed form for current grantees applying to continue serving their current service area. E-Form for new applicants and current grantees applying to serve a new service area.
Form 5C: Other Activities/Locations (if applicable)	Fixed form for current grantees applying to continue serving their current service area. E-Form for new applicants and current grantees applying to serve a new service area.
Form 6A: Current Board Member Characteristics	E-Form
Form 6B: Request for Waiver of Governance Requirements	E-Form
Form 8: Health Center Agreements	E-Form
Form 9: Need for Assistance Worksheet	E-Form

Program Specific Form/Information	Form Type
Form 10: Annual Emergency Preparedness Report	E-Form
Form 12: Organization Contacts	E-Form
Clinical Performance Measures	E-Forms
Financial Performance Measures	E-Forms
Summary Page	E-Form

Application Preparation
The SAC technical assistance Web site (http://www.hrsa.gov/grants/apply/assistance/sac) provides essential resources for application preparation. Throughout the application development and preparation process, applicants are encouraged to work with the appropriate Primary Care Associations (PCAs), Primary Care Offices (PCOs), and/or National Cooperative Agreements (NCAs) to prepare quality, competitive applications. For a complete listing of PCAs, PCOs, and NCAs, refer to http://www.bphc.hrsa.gov/technicalassistance/partnerlinks.

Applicants must follow instructions completely and provide all required information in the sequence and format described below. Information and data must be accurate and consistent throughout the application. **Applications that fail to meet all requirements may not be accepted for review or may receive a low rating from the Objective Review Committee (ORC).**

Only materials included with an application submitted by the announced deadlines will be considered. Supplemental materials submitted after the application deadlines will not be considered. Letters of support sent directly to HHS, HRSA, or BPHC will **not** be added to an application or considered by the ORC.

Application Format

i. Project Abstract
In box 15 of the SF-424, type the title of the funding opportunity (Service Area Competition) and upload the project abstract.

In addition to the information described in Section 5.1.vii of HRSA's *SF-424 Two-Tier Application Guide* please include the following at the top of the abstract*:*

Place the following at the top of the abstract:
- Project Title: Service Area Competition
- Congressional District(s) for the Applicant Organization and Proposed Service Area (if different)
- Types of Section 330 Funding Requested (i.e., CHC, MHC, HCH, and/or PHPC)
- Current Federal Funding (including HRSA funding), if applicable

The abstract must include a brief description of the proposed project, including the applicant organization, target population, needs to be addressed, and proposed services. Include the following in the body of the abstract:
- A brief history of the organization, the community to be served, and the target population.
- A summary of the major health care needs and barriers to care to be addressed by the proposed project, including the needs of special populations (migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing).
- How the proposed project will address the need for comprehensive primary health care services in the community and target population.

- Number of current and proposed patients, visits, providers, service delivery sites and locations, and services to be provided.

ii. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, consistent with other application components, and well organized so that reviewers can fully understand the proposed project. The Project Narrative must:

- Demonstrate compliance with Health Center Program Requirements (applicants should review http://bphc.hrsa.gov/about/requirements).
- Address the specific Project Narrative elements below. Unless specified, the attachments should not be used to extend the Project Narrative.
- Reference attachments and forms as needed. Referenced items must be part of the HRSA EHB submission.

A **new applicant** (not currently funded through the Health Center Program) must ensure that the Project Narrative reflects the entire proposed scope of project (all proposed services, sites, providers, service area, and target population).

A **current Health Center Program grantee applying to continue serving its current service area** must ensure that the Project Narrative reflects the current approved scope of project. Any change in scope **must** be submitted separately through HRSA EHB. Refer to the Scope of Project policy documents and resources at http://bphc.hrsa.gov/about/requirements/scope.

A **current Health Center Program grantee applying to serve a new service area** must ensure that the Project Narrative reflects only the proposed scope of project for the new service area. However, reference may be made in the Project Narrative to current sites, services, policies, procedures, and capacity as they relate to the new service area (e.g., experience, transferrable procedures, resources).

The Project Narrative and should be organized by section headers (Need, Response, Collaboration, Evaluative Measures, Resources/Capabilities, Governance, Support Requested), with the requested information appearing in the appropriate section of the Project Narrative or the designated forms and attachments.

NEED

Information provided in the ***NEED*** section must serve as the basis for, and align with, the proposed activities and goals described throughout the application.

1) Describe the characteristics of the target population within the proposed service area by:
   - Completing Form 9: Need for Assistance Worksheet to quantitatively establish target population health care needs. National median benchmark data will appear when available to facilitate comparisons to national data to fully demonstrate target population need.

- Describe the following factors in narrative format and how they impact access to primary health care, health care utilization, and health status; cite data resources, including local target population needs assessments, when available:
  a) Geographical/transportation barriers (consistent with Attachment 1).
  b) Unemployment, income level, or educational attainment.
  c) Health disparities.
  d) Unique health care needs of the target population not previously addressed (e.g., cultural/ethnic factors such as sexual orientation, language, attitudes, and beliefs).

2) **Applicants requesting special population funding** to serve migratory and seasonal agricultural workers (MHC), people experiencing homelessness (HCH), and/or residents of public housing (PHPC): Describe the specific health care needs and access issues of the proposed special population(s):
   a) Migratory and seasonal agricultural workers including agricultural environment (e.g., crops and growing seasons, demand for labor, number of temporary workers); approximate residency period(s) of migratory and seasonal agricultural workers and their families, and the availability of local providers to provide primary care services during these times; migrant occupation-related factors (e.g., working hours, housing, hazards, including pesticides and other chemical exposures); and significant increases or decreases in migratory and seasonal agricultural workers.
   b) People Experiencing Homelessness, such as the number of providers treating people experiencing homelessness, availability of homeless shelters and affordable housing, and significant increases or decreases in people experiencing homelessness.
   c) Residents of Public Housing, such as the availability of public housing, the impact of the availability of public housing on the residents in the targeted public housing communities served, and significant increases or decreases in residents of public housing.

3) Describe other primary health care services currently available in the service area (consistent with Attachment 1) and the location of the providers/organizations that provide these services, including whether they also serve the target population. Justify the need for Health Center Program support by highlighting gaps in services that the applicant currently fills (current grantees applying to continue serving their current service area) or will fill (new applicants or current grantees applying to serve a new service area).

4) Describe the health care environment and its impact on the applicant organization's current and future operations, including any significant changes that affect the availability of health care services. Include external factors within the service area and internal factors specific to the applicant's fiscal stability, including:
   a) Changes in insurance coverage, including Medicaid, Medicare, and Children's Health Insurance Program (CHIP). Specifically discuss changes that have resulted or are anticipated from the implementation of the Affordable Care Act.
   b) Changes in state/local/private uncompensated care programs.
   c) Economic or demographic shifts (e.g., influx of immigrant/refugee population; closing of local hospitals, community health care providers, or major local employers).

d) Natural disasters or emergencies (e.g., hurricanes, flooding, terrorism).
e) Changes specifically affecting special populations.

RESPONSE

1) Describe the proposed service delivery model(s) and how these model(s) are appropriate and responsive to the identified health care needs, including the specific needs of any special populations for which funding is sought (MHC, HCH, and/or PHPC). Specifically, address the following:
   a) Site(s)/location(s) where services will be provided (consistent with Attachment 1, Form 5B, and Form 5C).
   b) How the type and location of each proposed service delivery site (e.g., fixed site, mobile van, school-based clinic) (consistent with Form 5B) assures that services are, or will be, **accessible and available** at times that meet the needs of the target population (consistent with Forms 5B and 5C).
   c) Professional after-hours coverage available for medical emergencies during hours when service sites or locations are closed. Specifically discuss how these arrangements are appropriate for the size and needs of the patient population served and provisions for follow-up by the health center for patients accessing after hours coverage.

2) Describe how the service delivery model(s) assure continuity of care and access to a continuum of care. The description must address:
   a) Arrangements for admitting privileges for health center physicians at one or more hospitals (consistent with Form 5C). In cases where hospital privileges are not possible, describe other established arrangements to ensure continuity of care (i.e., timely follow-up) for patient hospitalizations.
   b) How these arrangements ensure a continuum of care, including discharge planning, post-hospitalization tracking, and patient tracking (e.g., shared electronic health records).

3) Describe how the proposed primary health care services (consistent with Form 5A) and other activities (consistent with Form 5C) are appropriate for the needs of the target population. The description must address:
   a) The provision of required and additional clinical and non-clinical services, including whether these are provided directly or through established written arrangements and referrals.
   b) How services will be culturally and linguistically appropriate (e.g., availability of culturally competent and/or bilingual/multilingual staff, interpreter/translator services).
   c) Method by which enabling services such as case management, outreach, and transportation are integrated into the primary health care delivery system. Describe any enabling services designed to increase access for targeted special populations.

Note:

- Applicants requesting HCH funding must document how substance abuse services will be made available either directly or via a formal written referral arrangement.
- Applicants requesting MHC funding must document how they will address any occupational health or environmental health hazards or conditions, as well as any necessary translation services in the case of serving limited English proficiency population(s).
- Applicants requesting PHPC funding must document that the service plan was developed in consultation with residents of the targeted public housing.

4) Describe the proposed clinical staffing plan (consistent with Form 2), including the mix of provider types and support staff necessary for:
   a) Providing services for the projected number of patients (consistent with Form 1A).
   b) Assuring appropriate linguistic and cultural competence (e.g., bilingual/multicultural staff, training opportunities).
   c) Carrying out required and additional health care services (as appropriate and necessary), either directly or through established formal written arrangements and referrals (consistent with Form 5A).

Note: Contracted providers should not be included on the staffing plan (Form 2). Such providers should be included on the summary of current or proposed contracts/agreements in Attachment 7. If a contract/agreement for core primary care providers is for a substantial portion of the proposed scope of project, include the contract/agreement as an attachment to Form 8.

5) Describe how the established schedule of charges for health center services is consistent with locally prevailing rates and designed to cover the reasonable cost of service operation (consistent with Form 5A).

6) Describe the sliding fee discount schedule(s) (consistent with Attachment 10), including the:
   a) Process utilized to develop the sliding fee discount schedule(s).
   b) Policies and procedures used to implement the sliding fee discount schedule(s), including provisions that assure that no patient will be denied service based on an inability to pay.
   c) Applicability to only those individuals and families with an annual income at or below 200 percent of the most current Federal Poverty Guidelines (available at http://aspe.hhs.gov/poverty).
   d) Provision of a full discount (no charge) or a nominal fee for individuals and families with an annual income at or below 100 percent of the Federal Poverty Guidelines.
   e) Process for determining nominal fees (Note: Nominal fees may be collected only if the imposition of a nominal fee is consistent with project goals and does not pose a barrier to receiving care).
   f) When the governing board reviews and approves updates to the sliding fee discount schedule(s) to reflect the most recent Federal Poverty Guidelines.

g) Frequency of governing board evaluation and update (as needed) of the policies and procedures that support the implementation of the sliding fee discount schedule(s).
h) How patients are made aware of available discounts (e.g., signs posted in accessible and visible locations, registration materials, brochures, verbal messages delivered by staff).

7) Describe the organization's quality improvement/quality assurance (QI/QA) and risk management plan(s) for systematically assuring and improving the provision of quality health care, including the:
   a) Process and parties responsible for accountability and communication throughout the organization, and developing, updating, and obtaining board approval for such policies and procedures. Specifically address the role and responsibilities of the Medical Director in providing oversight of the QI/QA program.
   b) Policies and procedures, including those related to patient grievances; incident reporting and management; maintaining the confidentiality of patient records; and periodic assessment of appropriateness of service utilization, quality of services delivered, and patient outcomes that are conducted by physicians or other licensed health professionals under the supervision of physician. Specifically address the:
      - Process and parties responsible for ensuring providers (e.g., employed, contracted, volunteers, locum tenens) are appropriately licensed, credentialed, and privileged to perform proposed services (consistent with Form 5A) at proposed sites/locations (consistent with Forms 5B and 5C).
      - Process and parties responsible for peer review and systematic evaluation of patient records to identify areas for improvement in documentation of services.
      - Utilization of appropriate information systems measures (e.g., electronic health records, payment management systems) for tracking, analyzing, and reporting key performance data, including data necessary for 1) required clinical and financial performance measures and 2) tracking of diagnostic tests and other services provided to health center patients to ensure appropriate follow up and documentation in the patient record.
      - Utilization of QI results to improve performance.

Note: Medical Directors may be full or part-time staff and should have appropriate credentials (e.g., CMO, DO, NP, PA) to support the QI/QA plan as determined by needs and size of the health center.

8) Describe plans for assisting individuals in determining their eligibility for, and enrolling in, health insurance options that became available in January 2014 as a result of the Affordable Care Act.[4] Specifically describe how potentially-eligible individuals (both current patients and other individuals in the service area) will be identified and informed of the new options; the type of assistance that will be provided for determining eligibility;

[4] Medicaid coverage for individuals up to 133% of the FPL in states choosing to provide this coverage; the ability to purchase insurance through an Exchange; the availability of Advanced Premium Tax Credits for insurance purchased through an Exchange for individuals with incomes up to 400% FPL; and the availability of Cost-Sharing Reductions for insurance purchased through an Exchange for persons up to 250% FPL.

and the type of assistance that will be provided for completion of the relevant enrollment process.

NEW APPLICANTS AND CURRENT GRANTEES APPLYING TO SERVE A NEW SERVICE AREA ONLY:

9) Provide a detailed implementation plan and upload to Attachment 13 (see Appendix D). The plan must include reasonable and time-framed activities that assure that, within 120 days of the Notice of Award, **all proposed sites** (as noted on Form 5B and described in the Project Narrative and work plan) will:
   - Be operational and begin providing services for the proposed population/community.
   - Have appropriate staff and providers in place.
   - Begin to deliver services as proposed (consistent with Forms 5A and 5C) to the proposed target population(s).

10) Describe plans to ensure that the organization will 1) hire providers and begin providing services at all sites for the targeted number of hours within one year of Notice of Award; and 2) minimize potential or anticipated negative impacts for patients currently served (as noted on the SAAT) that may result from a grantee transition.

COLLABORATION

1) Describe both formal and informal collaboration and coordination of services[5] with other health care providers. Specifically describe collaboration and coordination with the following:
   a) Existing health centers (Health Center Program grantees and look-alikes).
   b) Rural health and free clinics.
   c) Critical access hospitals.
   d) Other federally supported grantees (e.g., Ryan White programs, Title V Maternal and Child Health programs).
   e) State and local health departments.
   f) Private providers serving low income/uninsured patients.
   g) Programs serving the same target population (e.g., social services; job training; Women, Infants, and Children (WIC); coalitions; community groups; school districts).
   h) If applicable, organizations that provide services or support to the special population(s) for which funding is sought (e.g., Migrant Head Start, Public Housing Authority, homeless shelters).
   i) If applicable, neighborhood revitalization initiatives such as the Department of Housing and Urban Development's Choice Neighborhoods, the Department of Education's Promise Neighborhoods, and/or the Department of Justice's Byrne Criminal Justice Innovation Program.

[5] Refer to http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html for information on maximizing collaborative opportunities.

Note: Formal collaborations (e.g., contracts, memoranda of understanding or agreement) should also be summarized in Attachment 7.

2) Document support for the proposed project through current dated letters of support[6] that reference specific coordination or collaboration from all of the following in the service area:
   a) Health centers (Health Center Program grantees and look-alikes).
   b) Rural health clinics.
   c) Critical access hospitals.
   d) State and local health departments, as applicable.
   e) Major private provider groups serving low income and/or uninsured populations.

If such organizations do not exist in the service area (as defined in Attachment 1), state this. If such letters cannot be obtained from organizations in the service area, include documentation of efforts made to obtain the letters along with an explanation for why such letters could not be obtained.

3) Provide current dated letters of support that reference specific coordination or collaboration with community organizations in support of the proposed project beyond those required in Item 2 above (e.g., social service agencies, school districts, homeless shelters).

Note: Merge all letters of support from Items 2 and 3 into a single document and submit it as Attachment 9.

EVALUATIVE MEASURES

1) Within the Clinical Performance Measures form (see detailed instructions in Appendix B), outline time-framed and realistic goals that are responsive to the identified needs.

2) Within the Financial Performance Measures form (see detailed instructions in Appendix B), outline time-framed and realistic goals that are responsive to the organization's financial needs.

3) Provide a brief description of any additional evaluation activities planned to enhance the assessment of progress and project improvement throughout the project period, including tools utilized to collect and analyze relevant data (e.g., patient satisfaction surveys).

RESOURCES/CAPABILITIES

1) Describe how the organizational structure (including any sub-recipients) is appropriate for the operational needs of the project (consistent with Attachments 2 and 3, and, as applicable, Attachments 6, and 7), including how lines of authority are maintained from

[6] Letters of support should be addressed to the organization's board, CEO, or other appropriate key management staff member (e.g., Medical Director), not HRSA staff.

the governing board to the CEO/Executive Director and through the management structure.

2) Describe how the organization maintains appropriate oversight and authority over all contracted/sub-awarded sites and services, including (as applicable):
   a) Current or proposed contracts and agreements summarized in Attachment 7.
   b) Sub-recipient arrangements[7] referenced in Form 8 (any negative response to the Governance Checklist in Form 8 must be explained).

3) Describe how the organization's management team (CEO, CMO, CFO, CIO, and COO, as applicable):
   a) Is appropriate and adequate for the operational and oversight needs, scope, and complexity of the proposed project, including explanation of appropriateness of any shared key management positions (e.g., shared CFO/COO role) and time dedicated to health center activities (e.g., 0.5 FTE).
   b) Has appropriately defined roles as outlined in Attachment 4, in particular the responsibilities of the CEO or Executive Director for programmatic aspects of the health center, including day-to-day management of health center activities.
   c) Possesses needed skills and experience for the defined roles as demonstrated in Attachment 5 and ensures consistency of the staffing information provided across Attachments 2-5.
   d) If applicable, describe any changes in key management staff in the last year, including recruitment plans for vacancies or any significant changes in roles and responsibilities.

4) Describe the plan for recruiting and retaining health care providers necessary for achieving the proposed staffing plan (consistent with Form 2).

5) Describe how the proposed service site(s) (consistent with Form 5B) have appropriate capacity for implementing the service delivery plan in terms of the projected number of patients and visits (consistent with Form 1A). New applicants and current grantees applying to serve a new service area must attach floor plans for all proposed sites in Attachment 12. If desired, lease/intent to lease documents may be included in Attachments 14 or 15.

6) Describe expertise in the following areas:
   a) Working with the target population.

[7] A sub-recipient is an organization that receives a subaward from a Health Center Program grantee to carry out a portion of the grant-funded scope of project. Sub-recipients must be compliant with all Health Center Program statutory and regulatory requirements, as well as applicable grant requirements specified in 45 CFR Part 74. As a sub-recipient of section 330 funding, such organizations are eligible to receive FQHC benefits, including reimbursement as an FQHC, 340b drug pricing, and FTCA coverage. All sub-recipient arrangements must be documented through a formal written contract/agreement, and a copy must be provided to HRSA as an attachment to Form 8. The grantee must demonstrate that it has systems in place to provide reasonable assurances that the sub-recipient organization complies with – and will continue to comply with – all statutory and regulatory requirements throughout the period of award.

b) Developing and implementing systems and services appropriate for addressing the target population's identified health care needs.

Note: PHPC applicants must specifically describe how residents of public housing and will be involved in administration of the proposed project.

7) Describe the organization's ongoing strategic planning process, including:
   a) The roles of the governing board, key management staff, and any other relevant individuals in strategic planning.
   b) The frequency of strategic planning meetings (e.g., annually, bi-annually).
   c) Strategic planning products (e.g., strategic plan, operational plan).
   d) How often and when health care needs of the target population were last assessed.
   e) How the target population's health care needs and the related program evaluation plans have been, or will be, incorporated into the organization's ongoing strategic planning process.
   f) How the applicant organization's clinical quality and financial needs/performance are addressed.

8) Describe any national quality recognition the organization has received or is in the process of achieving (e.g., Patient-Centered Medical Home, Accreditation Association for Ambulatory Health Care, Joint Commission, state-based or private payer initiatives), as well as any current or planned acquisition and implementation of certified EHR systems. When describing EHR systems, include the number of sites and providers utilizing EHRs (i.e., number and types of providers that receive Medicare and Medicaid EHR Incentive Payments) for tracking patient and clinical data to achieve meaningful use.[8]

9) Describe the current status or plans for participating in FQHC-related benefits (e.g., Federal Tort Claim Act (FTCA) coverage, FQHC Medicare/Medicaid/CHIP reimbursement, 340 Drug Pricing Program, Vaccine for Children's Program, National Health Service Corps Providers).

10) Describe the processes in place to maximize collection of payments and reimbursement for services, including written policies and procedures for billing, credit, and collection from Medicare, Medicaid, CHIP, and other public and private insurance sources.

11) Describe how the financial accounting and control systems, as well as related policies and procedures:
   a) Are appropriate for the size and complexity of the organization.
   b) Reflect Generally Accepted Accounting Principles (GAAP).
   c) Separate functions/duties appropriate to the organization's size to safeguard assets and maintain financial stability.
   d) Enable the collection and reporting of the organization's financial status, as well as tracking of key financial performance data (e.g., visits, revenue generation, aged

[8] Information about meaningful use is available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html.

accounts receivable by income source or payor type, aged accounts payable, lines of credit, debt to equity ratio, net assets to expenses, working capital to expenses).

e) Support management decision-making.

12) Describe the organization's current financial status and its annual independent auditing process performed in accordance with federal audit requirements. Explain any current or previous financial issues, including audit findings, such as questioned costs, reportable conditions, and cited material weaknesses. Explain any corrective actions that have been implemented to address adverse findings.

13) Describe the status of emergency preparedness planning and development of emergency management plan(s), including efforts to participate in state and local emergency planning. Any negative response on Form 10 must be addressed.

GOVERNANCE[9]

Note: Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups should respond ONLY to Item 5 below.

1) Describe how the Corporate Bylaws (Attachment 2), Co-Applicant Agreement (Attachment 6), and/or Articles of Incorporation (Attachment 8) demonstrate that the organization has an independent governing board that retains (i.e., does not delegate) the following authorities, functions, and responsibilities:
   a) Meets at least once a month.
   b) Ensures that minutes documenting the board's functioning are maintained.
   c) Selects the services to be provided.
   d) Determines the hours during which services will be provided.
   e) Measures and evaluates the organization's progress and develops a plan for the long-range viability of the organization through strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational performance and assets.
   f) Approves the health center's annual budget, grant applications, and selection/dismissal/performance appraisal of the organization's CEO.
   g) Establishes general policies for the organization. Note: In the case of public centers with co-applicant governing boards, the public center is permitted to retain authority for establishing general fiscal and personnel policies for the health center.

Note: In the case of public centers with co-applicant governing boards, the public center is permitted to retain authority for establishing general fiscal and personnel policies for the health center.

2) Document that the structure of the board (co-applicant board for a public center) is appropriate in terms of size, composition, and expertise by describing how the following criteria are met:

[9] Refer to PIN 2014-01: Health Center Program Governance for information on Health Center Program Governance requirements.

a) At least 51 percent of board members are individuals who are/will be patients of the health center (this requirement may be waived for eligible applicants[10]; see Form 6B).
b) Patient board members represent the individuals served by the organization in terms of race, ethnicity, and gender (consistent with Forms 4 and 6A).
c) Non-patient board members are representative of the community in which the health center's service area is located and selected for their expertise in areas that include, but are not limited to, community affairs, local government, finance and banking, legal affairs, trade unions, other commercial and industrial concern, and/or social services.
d) Board has a minimum of nine but no more than 25 members, as appropriate for the complexity of the organization and diversity of the community served.
e) No more than half of the non-patient board members derive more than 10 percent of their annual income from the health care industry.
f) No board member is an employee of the health center or an immediate family member of an employee. (The CEO may serve only as a non-voting *ex officio* board member.)

Note: An applicant requesting funding to serve general community (CHC) AND special populations (MHC, HCH, and/or PHPC) must have appropriate board representation from these populations. At minimum, there must be at least one representative from/for each of the special population groups for which funding is requested. Board members representing a special population should be individuals that can clearly communicate the needs/concerns of the target populations to the board (e.g., advocate for migratory and seasonal agricultural workers, formerly homeless individual, current resident of public housing).

3) Document the effectiveness of the governing board by describing how the board:
   a) Operates, including the organization and responsibilities of board committees (e.g., Executive, Finance, Quality Improvement/Quality Assurance, Risk Management, Personnel, Planning).
   b) Monitors and evaluates its own (the board's) performance (e.g., identifies and develops processes for assessing and addressing board weaknesses, challenges, training needs).
   c) Provides board training, development, and orientation for **new members** to ensure that they have sufficient knowledge to make informed decisions regarding the strategic direction, general policies, and financial position of the organization**.**

Note: In the case of a public center with a co-applicant governing board, the public center is permitted to retain authority for establishing general fiscal and personnel policies for the health center.

4) Document that the health center's bylaws and/or other board-approved policy document(s) include specific provisions that prohibit real or apparent conflict of interest by board

[10] Eligible applicants requesting a waiver of the 51% patient majority board composition requirement must list the applicant's board members on Form 6A: Current Board Member Characteristics, NOT the members of any advisory councils.

members, employees, consultants, and others in the procurement of supplies, property (real or expendable), equipment, and other services procured with federal funds.

5) **INDIAN TRIBES OR TRIBAL, INDIAN, OR URBAN INDIAN GROUPS ONLY:** Describe the applicant organization's governance structure and how it will assure adequate (1) input from the community/target population on health center priorities and (2) fiscal and programmatic oversight of the proposed project.

SUPPORT REQUESTED

1) Provide a complete, consistent, and detailed budget presentation through the submission of the following: SF-424A, Budget Justification Narrative, Form 2: Staffing Profile, and Form 3: Income Analysis. Refer to Appendix C for detailed instructions of the budget presentation.

2) Describe how the total budget is aligned and consistent with the proposed service delivery plan and number of patients to be served (consistent with Form 1A: General Information Worksheet).

3) Describe how the proportion of requested federal grant funds is appropriate given other sources of funding, including those specified in Form 3: Income Analysis and the Budget Justification Narrative.

4) Describe expected shifts in payer mix and potential impact on the overall budget (e.g., as a result of the Affordable Care Act) and plans to mitigate expected adverse impacts.

iii. Budget and Budget Justification Narrative

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) incurred by the recipient to carry out a grant-supported project or activity. Total project or program costs include costs charged to the award and costs borne by the recipient to satisfy a matching or cost-sharing requirement.

In HRSA EHB, complete Application Form SF-424A: Budget Information. Complete Sections A, B, C, E, and F if applicable. Attach the Budget Justification Narrative in the Budget Narrative Attachment Form section in EHB. See section 5.1.iii Budget of HRSA's *SF-424 Two-Tier Application Guide* and Appendix C for detailed instructions.

The Consolidated Appropriations Act, 2014, Division H, § 203, (P.L. 113-76) states, "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II." Please see Section 5.1.iii Budget – Salary Limitation of HRSA's *SF-424 Two-Tier Application Guide* for additional information. Note that these or other salary limitations will apply in FY15, as required by law.

iv. Program Specific Forms and Information

See Appendix A for Program Specific Forms instructions. See Appendix B for Program Specific Information instructions.

v. Attachments

Please provide the items included in Table 3 in the order specified. Please note that these are supplementary in nature, and are not intended to be a continuation of the Project Narrative. Attachments must be clearly labeled and uploaded in the appropriate place within HRSA EHB. Unless otherwise noted, attachments count toward the application page limit. **Each attachment must be clearly labeled**. See Table 3 for a complete listing of required attachments, including instructions for completing them.

vi. Staffing Plan and Personnel Requirements

In HRSA EHB, staffing and personnel information will be provided through Form 1A: General Information Worksheet, Form 2: Staffing Profile, Attachment 3: Organizational Chart, Attachment 4: Position Descriptions, and Attachment 5: Biographical Sketches. Position descriptions must include the roles, responsibilities, and qualifications of proposed project staff. When applicable, biographical sketches should include training, language fluency, and experience working with the cultural and linguistically diverse populations served.

3. Submission Dates and Times

Application Due Date

The due date for applications under this funding opportunity announcement are as follows:

- Deadline 1: Grants.gov (Step 1) is ***October 22, 2014 at 11:59 p.m. Eastern Time.***
- Deadline 2: HRSA EHB (Step 2) is ***November 5, 2014 at 5:00 p.m. Eastern Time.***

4. Intergovernmental Review

State System Reporting Requirements

The Health Center Program is subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. See Executive Order 12372 in the HHS Grants Policy Statement. The Single Point of Contact (SPOC) for review within each participating state can be found at http://www.whitehouse.gov/omb/grants_spoc. Information may also be obtained from the Grants Management Specialist listed in Section VII.

Public Health System Reporting Requirements

Under the requirements approved by the Office of Management and Budget, 0937-0195, community-based non-governmental applicants must prepare and submit a Public Health System Impact Statement (PHSIS) to the heads of the appropriate state or local health agencies in the areas to be impacted by the proposed project no later than the federal application due date. For the purposes of the SAC application, the PHSIS should be submitted by the Grants.gov due date.

The PHSIS must include: (1) a copy of the SF-424 and (2) a summary of the project, not to exceed one page, which provides:

- A description of the target population whose needs would be met under the proposal.
- A summary of the services to be provided.
- A description of coordination planned with the appropriate state or local health agencies.

If applicants are unclear on where to send the PHSIS, they should contact their SPOC (see contact information above) or PCO at http://www.bphc.hrsa.gov/technicalassistance/partnerlinks.

5. Funding Restrictions

Applicants responding to this announcement may request funding for a project period of up to three (3) years, at no more than the amount listed as Total Funding on the SAAT. Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

Funds under this announcement may not be used for fundraising or the construction of facilities. The HHS Grants Policy Statement (HHS GPS) available at http://www.hrsa.gov/grants includes information about allowable expenses.

Pursuant to existing law and consistent with Executive Order 13535 (75 FR 15599); health centers are prohibited from using federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered). This includes all grants awarded under this announcement and is consistent with past practice and long-standing requirements applicable to grant awards to health centers.

The General Provisions in Division H, Title V of the Consolidated Appropriations Act, 2014 (P.L. 113-76), apply to this program. Please see Section 5.1 of the HRSA *SF-424 Application Guide* for additional information. Note that these or other provisions will apply in FY15, as required by law.

All program income generated as a result of awarded grant funds must be used for approved project-related activities.

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

Applicants should pay strict attention to addressing all these criteria, as they are the basis upon which the reviewers will evaluate their application.

Reviewers will use the HRSA Scoring Rubric as a guideline when assigning scores to each criterion. The HRSA Scoring Rubric is available at http://www.hrsa.gov/grants/apply/assistance/sac. Information presented in the application will also impact the project period if funding is awarded. See the Project Period Length Criteria section.

Review criteria are used to review and rank applications. Applicants must ensure that the review criteria are fully addressed within the Project Narrative, except where indicated, and supported by supplementary information in the other sections of the application.

In the event that a current grantee applying to continue serving its current service area submits the only application for the service area, HRSA will conduct a comprehensive internal review of the application in lieu of an external objective review. Applications receiving internal HRSA review will be subject to the same completeness and eligibility screening as those receiving external review and will be reviewed for compliance with all Health Center Program requirements and projected performance goals.

The Health Center Service Area Competition Program has seven (7) review criteria. Each application will be evaluated on the following review criteria:

Criterion 1: NEED (15 Points)

- The extent to which the applicant demonstrates the health care needs in the service area/target population, including any targeted special populations as documented by quantitative and qualitative data provided in the Form 9: Need for Assistance Worksheet and described in the Project Narrative.

- The extent to which the applicant clearly describes the existing primary health care services and service gaps in the service area, the factors affecting the broader health care environment of the service area, and the role that the applicant organization currently plays or will play in the local health care landscape through SAC grant support.

Criterion 2: RESPONSE (20 Points)

- The extent to which the applicant demonstrates that the proposed service delivery model(s), sites, services, staffing plan, and coordination with other providers/institutions in the community will provide continuity of care while ensuring that the target population's continuum of health care needs are met.

- The extent to which the applicant establishes that the schedule of charges: is reasonable and consistent with local rates and that the corresponding sliding fee discount schedule(s), including any justified nominal fees, ensures that services are available and

accessible to all without regard to ability to pay; applies discounts based on a patient's income; and is appropriately promoted.

- The extent to which the applicant establishes that the QI/QA and risk management plans are or will be integrated into the health center's routine management efforts and will be utilized to ensure ongoing improvement of services and practices.

- The extent to which the application defines reasonable plans for assisting individuals (both current patients **and** other service area residents) in determining their eligibility for, and enrolling in, health insurance options that became available in January 2014 as a result of the Affordable Care Act.

- The extent to which the applicant demonstrates compliance with requirements for targeted special populations, including demonstrating that services targeting residents of public housing (PHPC) are immediately accessible to the targeted public housing communities and that services targeting people experiencing homelessness (HCH) will include the provision of substance abuse services (either directly or through referral).

- New applicant or current grantee applying to serve a new service area: The extent to which the applicant provides a detailed implementation plan that ensures that within 120 days of the Notice of Award, all proposed site(s) will be open and operational with appropriate staff and providers in place to deliver health care services.

- New applicant or current grantee applying to serve a new service area: The extent to which the applicant ensures that 1) providers will begin providing services at all sites for the targeted number of hours within one year of Notice of Award; and 2) potential or anticipated impacts of grantee transition will be minimized for patients currently served (as noted on the SAAT).

Criterion 3: COLLABORATION (10 points)

- The extent to which the applicant establishes that other health care providers in the service area support the proposed project through detailed descriptions of specific commitment, collaboration and/or coordinated activities. Descriptions are supported by the provision of specific Letters of Support from, at a minimum, the organizations listed in Item 2 of the *COLLABORATION* section of the Project Narrative and community organizations to be involved in the proposed project (e.g., social service agencies, school districts, homeless shelters).

Criterion 4: EVALUATIVE MEASURES (15 points)

- The extent to which the applicant establishes Clinical and Financial Performance Measures that include contributing and restricting factors, realistic plans for addressing such factors, and goals for the length of the project period that address the required elements as well as unique special population needs identified in the *NEED* section.

- The extent to which the applicant establishes that additional planned evaluation activities are methodologically sound and will lead to project improvements.

Criterion 5: RESOURCES/CAPABILITIES (20 points)

- The extent to which the applicant establishes that the organizational structure, proposed sites, management staff, and policies/procedures are appropriate for the operational and oversight needs of the proposed project, including any contractors and sub-recipients.

- The extent to which the applicant establishes its experience and expertise working with and addressing the target population's health care needs.

- The extent to which the applicant establishes a commitment to sustainability by documenting: plans to effectively recruit and retain key management staff and health care providers; policies and procedures for maximizing collection of payments and reimbursement for costs; plans for emergencies; and a strategic planning process that incorporates the target population's needs and related performance measure goals.

- The extent to which the applicant describes current or planned acquisition/development, implementation, and/or enhancement of certified EHR technology systems as well as any national quality recognition the organization has received or is working towards.

- The extent to which the applicant 1) describes the organization's annual independent auditing process; and 2) establishes that appropriate financial accounting and control systems, policies, and procedures are in place to enable data tracking and reporting of the organization's financial status, including any current or previous financial issues, in accordance with Generally Accepted Accounting Principles (GAAP).

- The extent to which the applicant demonstrates compliance with requirements for targeted special populations, including involvement of residents of public housing in application development and proposed project implementation.

Criterion 6: GOVERNANCE (10 points)

- The extent to which the applicant establishes that the independent governing board appropriately oversees the proposed project through: compliance with Health Center Program requirements; appropriateness in terms of size, composition, expertise; effective operations; and establishment and review of policies and procedures

- Applicants targeting only special populations and requesting a waiver of the 51% patient majority board composition requirement: The extent to which the applicant justifies the waiver request by providing a reasonable statement of need for the request and describing sufficient alternative procedures for ensuring patient input and/or appropriate project oversight by the governing board.

- Indian tribe or tribal, Indian, or urban Indian group applicant: The extent to which the applicant documents that policy documents specifically prohibit real or apparent conflict of interest and establishes that the governance structure will assure adequate input from the community/target population as well as fiscal and programmatic oversight of the proposed project.

Criterion 7: SUPPORT REQUESTED (10 points)

- The extent to which the applicant provides a detailed and reasonable budget presentation that supports the proposed project, including planned service delivery and patient/visit projections.

- The extent to which the applicant establishes that the federal request for funds is appropriate considering other sources of project income.

- The extent to which the applicant anticipates and describes expected shifts in payer mix and potential impact on the overall budget (e.g., as a result of the Affordable Care Act), as well as mitigation plans for any adverse impacts.

2. Review and Selection Process

Please see Section 6.3 of HRSA's *SF-424 Two-Tier Application Guide*.

All applications will be reviewed initially for eligibility (see Section III), completeness (see Section IV.2), and responsiveness. **Applications determined to be ineligible, incomplete, or non-responsive to this FOA will not be considered for funding.**

Applications that pass the initial HRSA completeness and eligibility screening, with the exception of situations in which a current grantee submits the only application for its current service area, will be reviewed and rated by a panel based on the program elements and review criteria presented in this FOA.

Additional Review Information

Factors such as past performance, including unsuccessful progressive action condition resolution (see http://www.bphc.hrsa.gov/policiesregulations/policies/pal201408.html for more information), and current compliance with section 330 program requirements and regulations will be considered when selecting applications for funding (see Project Period Length Criteria section). HRSA will review fundable applicants for compliance with HRSA program requirements through site visits, audit data, Uniform Data System (UDS) or similar performance reports, Medicare/Medicaid cost reports, external accreditation, or other reports, as applicable. HRSA also reserves the right to conduct onsite verification of compliance. The results of the review of the SAC application, as well as the results of any onsite verification, may impact final funding or project period decisions.

Project Period Length Criteria

HRSA links the length of a given project period to a comprehensive evaluation of compliance with program requirements. Applicants will generally be awarded a three-year project period unless other factors (see "Additional Review Information") indicate the need for a shorter project period.

Additionally, if a current grantee has been awarded two consecutive one-year project periods, and meets the criteria for a third consecutive one-year project period in FY 2015 (per PAL 2014-08 available at http://www.bphc.hrsa.gov/policiesregulations/policies/pal201408.html), the application will not be funded and the service area will be recompeted if no other eligible, fundable applications were received.

In addition, applicants with one or more of the following characteristics will be awarded a one-year project period:

- Current grantee or new applicant with 10 or more Health Center Program requirement conditions.*
- Current grantee with 3 or more unresolved conditions related to Health Center Program requirements in the 60-day phase of Progressive Action carried over into the new project period.
- Current grantee with 1 or more unresolved conditions related to Health Center Program requirements in the 30-day phase of Progressive Action carried over into the new project period.

**New applicants*: Conditions related to Health Center Program requirements to be placed on the award based on information included in this application and review of Additional Review Information

**Current grantees*: Current unresolved conditions related to Health Center Program requirements carried over into the new project period, combined with any new conditions related to Health Center Program requirements to be placed on the award based on information included in this application and review of Additional Review Information.

Restricted Drawdown Determining Factors

A term for restricted drawdown will be included on the NoA of any applicant selected for funding whose most recent audit called into question whether the organization is able to continue as a "going concern." When a grantee is placed on restricted drawdown, all drawdown of federal funds requires approval from the Division of Grants Management Operations.

Special Funding Considerations

Other factors such as geographic distribution, past performance, and compliance with section 330 program requirements and applicable regulations may be considered as part of the selection of applications for funding. In addition, HRSA will consider the following factors in making awards:

- *RURAL/URBAN DISTRIBUTION OF AWARDS:* Aggregate awards in FY 2015 will be made to ensure that no more than 60 percent and no fewer than 40 percent of centers serve people from either rural or urban areas.

- *PROPORTIONATE DISTRIBUTION:* Aggregate awards in FY 2015 to support the various types of health centers (CHC, MHC, HCH, and/or PHPC) will be made to ensure continued proportionate distribution of funds across the Health Center Program as set forth in section 330(r)(2)(B) of the PHS Act.

Funding Priorities

A funding priority is defined as the favorable adjustment of review scores when applications meet specified criteria. **Applicants do not need to request a funding priority.** Prior to final funding decisions, HRSA will assess all SAC applications within the fundable range for eligibility to receive priority points, as demonstrated in the Health Center Profile, available at http://bphc.hrsa.gov/healthcenterdatastatistics.

The FY 2015 SAC funding opportunity has one funding priority. In order to minimize potential service disruptions and maximize the effective use of federal grant dollars, HRSA will award priority points to current grantees that have demonstrated fully satisfactory past performance and are applying to continue serving their current service area.

- **Program Compliance**: HRSA will award 5 points to current grantees applying to continue serving their current service area **and** with no Health Center Program requirement conditions (see PAL 2014-08) in 60-day, 30-day, or default status at the time of application.
- **Patient Trend**: HRSA will award an additional 5 points to current grantees applying to continue serving their current service area, if they meet the criterion for Program Compliance above AND they have a positive or neutral 3-year patient growth trend (+/- 5 percent). **Patient trend points will not be awarded if the Program Compliance criterion is not met.**

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the project period start date of March 1, 2015.

VI. Award Administration Information

1. Award Notices

The Notice of Award will be sent prior to the start date of March 1, 2015. See Section 6.4 of HRSA's *SF-424 Two-Tier Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2 of HRSA's *SF-424 Two-Tier Application Guide*.

Implementation of United States v. Windsor and Federal Recognition of Same-Sex Spouses/Marriages

A standard term and condition of award will be included in the final Notice of Award (NOA) that states: "In any grant-supported activity in which family, marital, or household considerations are, by statute or regulation, relevant for purposes of determining beneficiary eligibility or participation, grantees must treat same-sex spouses, marriages, and households on the same terms as opposite-sex spouses, marriages, and households, respectively. By "same-sex spouses," HHS means individuals of the same sex who have entered into marriages that are valid in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "same-sex marriages," HHS means marriages between two individuals validly entered into in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "marriage," HHS does not mean registered domestic partnerships, civil unions or similar formal relationships recognized under the law of the jurisdiction of celebration as something other than a marriage."

3. Reporting

The successful applicant under this funding opportunity announcement must comply with Section 7 of HRSA's *SF-424 Two-Tier Application Guide* and the following reporting and review activities:

a. Audit Requirements

Comply with audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at http://www.whitehouse.gov/omb/circulars_default. Organizations should refer to the submission process described in Program Assistance Letter 2009-06: New Electronic Process for Submitting Required Annual Financial Audits located at http://bphc.hrsa.gov/policiesregulations/policies/pal200906.html.

b. Status Reports

1) **Uniform Data System (UDS) Report –** The UDS is an integrated reporting system used to collect data on all health center programs to ensure compliance with legislative and regulatory

requirements, improve health center performance and operations, and report overall program accomplishments. All grantees are required to submit a Universal Report and, if applicable, a Grant Report annually. The Universal Report provides data on patients, services, staffing, and financing across all section 330 health centers. The Grant Report provides data on patients and services for special populations served (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing).

2) **Progress Report** – The budget period progress report (BPR) non-competing continuation application documents grantee progress on program-specific goals and collects core performance measurement data to track the progress and impact of the project. Submission and HRSA approval of a BPR will trigger the budget period renewal and release of each subsequent year of funding (dependent upon Congressional appropriation, program compliance, organizational capacity, and a determination that continued funding would be in the best interest of the federal government). Grantees will receive an email message via HRSA EHB when it is time to begin working on their progress reports.

VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting:

Donna Marx
HRSA Division of Grants Management Operations, OFAM
Telephone: 301-594-4245
Email: dmarx@hrsa.gov

Additional information related to the overall program issues and/or technical assistance regarding this funding announcement may be obtained by contacting:

Beth Hartmayer
Office of Policy and Program Development
HRSA Bureau of Primary Health Care
Telephone: 301-594-4300
Email: BPHCSAC@hrsa.gov
http://www.hrsa.gov/grants/apply/assistance/sac

Additional technical assistance regarding this FOA may be obtained by contacting the appropriate PCAs, PCOs, or NCAs. For a list of contacts, see http://www.bphc.hrsa.gov/technicalassistance/partnerlinks.

Applicants may need assistance when working online to submit their application forms electronically. Applicants should always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding Federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726
E-mail: support@grants.gov
iPortal: https://grants-portal.psc.gov/Welcome.aspx?pt=Grants

For assistance with submitting the remaining information in HRSA EHB, contact HRSA's Bureau of Primary Health Care, Monday through Friday, 8:30 a.m. to 5:30 p.m. ET, excluding federal holidays:

BPHC Helpline
1-877-974-2742
BPHCHelpline@hrsa.gov

VIII. Other Information

Technical Assistance Page
A technical assistance Web site has been established to provide applicants with copies of forms, FAQs, and other resources that will help organizations submit competitive applications. To review available resources, visit http://www.hrsa.gov/grants/apply/assistance/sac. Refer to http://www.hrsa.gov/grants/apply for general (i.e., not SAC-specific) videos and slides on a variety of application and submission components.

Federal Tort Claims Act Coverage/Medical Malpractice Insurance
Organizations that receive operational grants under the Health Center Program (sections 330(e), (g), (h), and/or (i)) are eligible for protection from claims or suits alleging medical malpractice through the Federally Supported Health Centers Assistance Act of 1992 (Act). The Act provides that health center employees may be deemed as Public Health Service (PHS) employees and thereby afforded protections of the Federal Tort Claims Act (FTCA) for the performance of medical, dental, surgical, and related functions. Once funded, new grantees can apply through EHB to become deemed PHS employees for purposes of FTCA coverage as described above; however, they must maintain private malpractice coverage until the effective date of such coverage. Deemed PHS employee status with resulting FTCA coverage is not guaranteed. The Notice of Deeming Action (NDA) for an individual health center provides documentation of HRSA's deeming determination. Funded health centers that do not have or seek FTCA coverage must maintain private medical malpractice insurance coverage at all times. Applicants are encouraged to review the FTCA Health Center Policy Manual available at http://bphc.hrsa.gov/policiesregulations/policies/pin201101.html and contact the BPHC Help Line at 877-974-BPHC for additional information.

Organizations must be aware that **participation in the FTCA program is not guaranteed**. Applicants are encouraged to review the requirements that are outlined in the FTCA Policy Manual, Policy Information Notice 2011-01 available at http://bphc.hrsa.gov/policiesregulations/policies/pin201101.html and the most current FTCA Deeming Application Program Assistance Letter (search

http://bphc.hrsa.gov/policiesregulations/policies for keyword FTCA). If an applicant is not currently deemed, the costs associated with the purchase of malpractice insurance must be included in the proposed budget. The search for malpractice insurance, if necessary, should begin as soon as possible. Applicants interested in FTCA will need to submit a new application annually. Applicants are encouraged to review the FTCA Health Center Policy Manual noted above and contact 877-974-BPHC (877-974-2742) for additional information.

340B Drug Pricing Program

The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, codified as Section 340B of the Public Health Service Act, as amended (see http://www.hrsa.gov/opa/programrequirements/phsactsection340b.pdf). The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices. Eligible health care organizations/covered entities are defined in statute and include HRSA-supported health centers and look-alikes, Ryan White clinics and State AIDS Drug Assistance programs, Medicare/Medicaid Disproportionate Share Hospitals, children's hospitals, and other safety net providers. To participate in the 340B Program**,** eligible organizations/covered entities must register and be enrolled with the 340B program and comply with all 340B Program requirements. Once enrolled, covered entities are assigned a 340B identification number that vendors verify before allowing an organization to purchase 340B discounted drugs. For additional information, please visit the Office of Pharmacy Affairs Web site at http://www.hrsa.gov/opa.

IX. Tips for Writing a Strong Application

See Section 5.7 of HRSA's *SF-424 Application Guide*.

Appendix A: Program Specific Forms Instructions

Program Specific Forms must be completed electronically in EHB. To preview the forms, visit http://www.hrsa.gov/grants/apply/assistance/sac. Portions of the forms that are "blocked/grayed" out are not relevant to the application and do not need to be completed.

Note: Current grantees applying to serve a new service area must utilize the Program Specific Forms to describe ONLY the proposed project in the new service area.

FORM 1A – General Information Worksheet (Required)
Complete Form 1A based on the proposed project.

1. APPLICANT INFORMATION

- Complete all relevant information that is not pre-populated.
- Grant numbers will pre-populate for current grantees.
- Use the Fiscal Year End Date field to note the month and day in which the applicant organization's fiscal year ends (e.g., June 30) to help HRSA know when to expect the audit submission.
- Applicants may check only one category in the Business Entity section. An applicant that is a Tribal or Urban Indian entity and also meets the definition for a public or private entity should select the Tribal or Urban Indian category.
- Applicants may select one or more categories for the Organization Type section.

2. PROPOSED SERVICE AREA

2a. Target Population and Service Area Designation

Population Type(s):

- Population types for which funding is requested will be pre-populated based on information provided in Section A (Budget Summary) of the SF-424A.
- If the population types are not pre-populated or if changes are required, go to the Budget Summary page of the standard forms and click on Change Sub-Program.

Service Area Designation:

- Applicants seeking CHC funding MUST provide Medically Underserved Area (MUA) and/or Medically Underserved Population (MUP) designation information.
- Select the MUA and/or MUP designations for the proposed service area and enter the identification number. For inquiries regarding MUAs or MUPs, visit the Shortage Designation Web site at www.hrsa.gov/shortage, call 1-888-275-4772 (option 1 then option 2), or contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816.

2b. Service Area Type

- Select the type (urban, rural, or sparsely populated) that describes the majority of the service area. If sparsely populated is selected, provide the number of people per square mile (must be 7 or less). For information about rural populations, visit the Office of Rural Health Policy's Web site at http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html.

2c. Target Population and Provider Information

For all portions of this section:

- Applicants with more than one service site must report aggregate data for all sites in the proposed project.
- A current grantee applying to continue serving its current service area may report current numbers that are consistent with the most recent data submitted in UDS. If UDS data does not accurately reflect current numbers (due to additional funding received, change in scope, or shifting service area characteristics such as influx of new populations), please indicate the accurate current data and describe the discrepancy between UDS and current data in Item 5 of the *RESOURCES/CAPABILITIES* section of the Project Narrative.
- A new applicant or current grantee applying to serve a new service area should report current numbers based on services the applicant is currently providing in the proposed service area (report annualized data) or, if not currently operational in the service area, list the current numbers as zero.

Service Area and Target Population:

Provide the number of individuals currently in the service area and target population. The target population number must be less than or equal to the number of individuals in a service area, since the target population is generally a subset of the service area population.

Provider FTEs by Type:

1. Provide a count of current provider full-time equivalents (FTEs), paid and volunteer, by staff type. Current grantees should ensure that the FTEs reported are consistent with the reporting of FTEs in UDS (see the UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics/reporting). **Include only provider FTEs** (e.g., physician, nurse practitioner, certified nurse midwife, dentist, dental hygienist, psychiatrist, psychologist, social worker, case manager, patient educator, outreach worker).
2. Project the number of provider FTEs anticipated by the end of the three-year project period based on maintaining the current level of funding.

Do **not** report provider FTEs providing vision or pharmacy services or functioning outside the proposed scope of project.

General Guidance for Patient and Visit Numbers:

When providing the count of patients and visits within each service type category, note the following (see the UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics/reporting for detailed information):

- A visit is a documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services rendered must be paid for by the applicant organization and documented in the patient's record.
- A patient is an individual who had at least one visit in the previous year.
- Since a patient must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.

Patients and Visits by Service Type:

1. Provide the number of current patients and visits within each service type category: medical, dental, mental health, substance abuse, and enabling. Within each category, an individual can only be counted once as a patient. **An individual who receives multiple types of services should be counted once for each service type** (e.g., once for medical and once for dental).
2. Project the number of patients and visits anticipated within each service type category by December 31, 2016 at the current level of funding. HRSA does not expect the number of patients and visits to decline over time.
3. Current grantees should not include new patient commitments from FY 2014 supplemental funding (e.g., Behavioral Health Integration awards, Expanded Services awards) in the Form 1A patient projection (Projected Patients by December 31, 2016). However, HRSA will track and monitor grantee progress toward the Form 1A patient projection plus any new patient commitments via the 2016 UDS.
4. To maintain consistency with the patients and visits reported in UDS, do not report patients and visits for vision or pharmacy services, or services outside the proposed scope of project. Refer to the Scope of Project policy documents available at http://bphc.hrsa.gov/about/requirements/scope.

Unduplicated Patients and Visits by Population Type:

The population types in this table do NOT refer only to the requested funding for special populations (i.e., CHC, MHC, HCH, and/or PHPC). An applicant applying for only CHC funding (general underserved community) may still have patients/visits reported in the other population type categories.

1. Provide the current number of patients and visits within each population type category: general community, migratory and seasonal agricultural workers, public housing residents, and homeless persons. **Within each category, an individual can only be counted once as a patient.**
2. Project the number of patients and visits anticipated within each population type category by December 31, 2016 at the current level of funding. HRSA does not expect the number of patients and visits to decline over time.

***Note*: HRSA will use the total number in this section to determine compliance with Eligibility Requirement 3**. Further, if a health center is unable to meet this total unduplicated patient projection (along with other patient projections for supplemental funding awarded during the project period) by December 31, 2016, funding for the service area may be reduced.

3. Current grantees should not include new patient commitments from FY 2014 supplemental funding (e.g., Behavioral Health Integration awards, Expanded Services awards) in the Form 1A patient projection (Projected Patients by December 31, 2016). However, HRSA will track and monitor grantee progress toward the Form 1A patient projection plus any new patient commitments via the 2016 UDS.
4. To maintain consistency with the patients and visits reported in UDS, do not report patients and visits for pharmacy services or services outside the proposed scope of project.

FORM 1C – Documents on File (Required)
Provide the date that each document listed was last reviewed and, if appropriate, revised. This form provides a summary of documents that support the implementation of Health Center Program requirements and key areas of health center operations. The form lists the corresponding Health Center Program requirements found at http://bphc.hrsa.gov/about/requirements. Reference this site for more detailed information about each requirement. Please note that Form 1C is not intended to provide an exhaustive list of all types of health center documents (e.g., policies and procedures, protocols, legal documents).

All documents noted on Form 1C should be maintained and updated by key management staff and, as appropriate, approved and monitored by the health center's governing board. Keep these documents on file, making them available to HRSA **upon request** within 3-5 business days. **DO NOT** submit these documents with the application.

Under "Malpractice Coverage Plan" in the "Services" section, new applicants should indicate that malpractice coverage will be in effect as soon as services become operational. Once funded, new grantees can apply for FTCA coverage upon meeting the FTCA eligibility requirements, but they must maintain private malpractice coverage in the interim. FTCA participation is not guaranteed. Funded health centers that opt out of FTCA (such as Public Entity-Health Centers) must maintain malpractice insurance coverage at all times. See Section VIII for more information about FTCA.

Note: Beyond Health Center Program requirements, other federal and state requirements may apply to health centers. Applicants are encouraged to seek legal advice from their own counsel to ensure that organizational documents accurately reflect all applicable requirements.

FORM 2 – Staffing Profile (Required)
Report personnel salaries supported by the total budget and federal request (i.e., requested Health Center Program section 330 funds) for the **first budget year** of the proposed project, including those that are part of an indirect cost rate. Include only Health Center Program staff for the entire scope of project (i.e., all sites). Anticipated staff changes within the proposed project period must be addressed in Item 4 of the *RESOURCES/CAPABILITIES* section of the Project Narrative.

- Allocate staff time by function among the staff positions listed. An individual's full-time equivalent (FTE) should not be duplicated across positions. For example, a provider serving as a part-time family physician and a part-time medical director should be listed in each respective category with the FTE percentage allocated to each position (e.g., CMO 30% FTE and family physician 70% FTE). Do not exceed 100% FTE for any individual. For position descriptions, refer to the UDS manual at http://bphc.hrsa.gov/healthcenterdatastatistics/reporting.
- Salaries in categories representing multiple positions (e.g., LPN, RN) must be averaged. To calculate the average annual salary, sum the salaries within the category and divide that amount by the total number of FTEs.
- Do not report portions of salaries that support activities outside the proposed scope of project.

- Do not include contracted staff or volunteers on this form.

Note: The amount for total salaries (this figure will auto-calculate in EHB) may not match the amount allocated for the Personnel cost category of the Budget Summary Form due to the inclusion of salaries charged to indirect costs on the Staffing Profile.

FORM 3 – Income Analysis (Required)
Form 3 will show the projected patient services and other income from all sources (other than the section 330 federal grant) for the **first year** of the proposed project period. Form 3 income is divided into two parts: (1) program income (known as patient service revenue) and (2) all other income (known as other federal, state, local, and other income).

Patient service revenue is revenue that is directly tied to the provision of services to the health center's patients. Services to patients that are reimbursed by health insurance plans, managed care organizations, categorical grant programs (e.g., family planning), employers, and health provider organizations are classified as patient service revenue. Reimbursements may be based upon visits, procedures, member months, enrollees, the achievement of performance goals, or other service related measures. All income not classifiable as program income is classified as other income.

Part 1: Patient Service Revenue - Program Income
The program income section groups billable visits and income into the same five payer groupings used in the UDS (see the UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics for details). All patient service revenue is reported in this section of the form. This includes all income from medical, dental, mental health, substance abuse, other professional, vision, and other clinical services, as well as income from ancillary services such as laboratory, pharmacy, and imaging services.

Patient service revenue includes income earned from Medicaid and Medicare rate settlements and wrap reconciliations that are designed to make up the difference between the approved FQHC rate and the interim amounts received. It includes risk pool and other incentive income as well as primary care case management fees.

Patient service revenue associated with sites or services not in the approved scope of project including those pending approval is to be excluded.

Patients by Primary Medical Insurance - Column (a): These are the projected number of unduplicated patients classified by payer based upon the patient's ***primary medical insurance***. The primary insurance is the payer that is billed first. The patients are classified in the same way as found in UDS Table 4, lines 7 – 12. This column should not include patients who are only seen for non-billable or enabling service visits. Examples for determining where to count patients include:

- A crossover patient with Medicare and Medicaid coverage is to be classified as a Medicare patient on line 2.
- A Medicaid patient with no dental coverage who is only seen for dental services is to be classified as a Medicaid patient on line 1 with a self-pay visit on line 5.

Billable Visits - Column (b): These include all billable/reimbursable visits.[11] There may be other exclusions or additions, which, if significant, should be noted in the Comment/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column (see ancillary instructions below).

Income per Visit - Column (c): This value may be calculated by dividing projected income by billable visits.

Projected Income - Column (d): This is the projected accrued net revenue, including an allowance for bad debt from all patient services for each pay grouping in the first year of the proposed project period.

Prior FY Income: This is the income data from the most recent fiscal year, which will be either interim statement data or audit data. The fiscal year was specified because the interim data can eventually be compared to actual audit data.

Payer Categories (Lines 1 – 5): There are five payer categories including Medicaid, Medicare, Other Public, Private, and Self-Pay, reflecting the five payer groupings used in Table 9d of the UDS. The UDS instructions are to be used to define each payer category (see the UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics).

Visits are reported on the line of the primary payer (payer billed first). The income is classified by the payer groupings where the income is earned. When a single visit involves more than one payer, attribute that portion of the visit income to the payer group from which it is earned. In cases where there are deductibles and co-payments to be paid by the patient, that income is to be shown on the self-pay line. If the co-payment is to be paid by another payer, that income should be shown on the other payer's line. It is acceptable if the applicant cannot accurately associate the income to secondary and subsequent sources.

All service income is to be classified by payer, including pharmacy and other ancillary service revenue. In the event the applicant does not normally classify the projected ancillary or other service revenue by payer category, the projected income is to be allocated by payer group using a reasonable allocation method, such as the proportion of medical visits or charges. The method used should be noted in the Comments/Explanatory Notes section at the bottom of the form.

Medicaid (Line 1): This includes income from FQHC cost reimbursement; capitated managed care; fee-for-service managed care; Early Periodic Screening, Diagnosis, and Treatment (EPSDT); Children's Health Insurance Program (CHIP); and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from FQHC cost reimbursement reconciliations, wrap payments, incentives, and primary care case management income.

[11] These visits will correspond closely with the visits reported on the UDS Table 5, excluding enabling service visits.

Medicare (Line 2): This includes income from the FQHC cost reimbursement, capitated managed care, fee-for-service managed care, Medicare Advantage plans, and other reimbursement arrangements administered either directly by Medicare or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from the FQHC cost reimbursement, risk pool distributions, performance incentives, and care management fee income from the ACA Medicare Demonstration Program.

Other Public (Line 3): This includes income from federal, state, or local government programs earned for providing services that is not reported elsewhere. A CHIP operated independently from the Medicaid program is an example of other public insurance. Other public also includes income from categorical grant programs when the grant income is earned by providing services. Examples of these include CDC's National Breast and Cervical Cancer Early Detection Program and the Title X Family Planning Program.

Private (Line 4): This includes income from private insurance plans, managed care plans, insurance plans from the ACA marketplaces/exchanges, and other private contracts for service. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, service contracts with employers, and Veteran's Administration Community Based Outpatient Clinic (CBOC) contracts. Income from health benefit plans which are earned by government employees, veterans, retirees, and dependents, such as TRICARE, the federal employee health benefits program, state employee health insurance benefit programs, teacher health insurance, and similar plans are to be classified as private insurance. Private insurance is earned or paid for by the beneficiary and other public insurance is unearned or based upon meeting the plan's eligibility criteria.

Self-Pay (Line 5): This includes income from patients, including full-pay self-pay and sliding fee patients, as well as the portion of the visit income for which an insured patient is personally responsible.

Total (Line 6): This is the sum of lines 1-5.

Part 2: Other Income – Other Federal, State, Local, and Other Income
This section includes all income other than the patient service revenue shown in Part 1 (exclusive of the section 330 grant request). It includes other federal, state, local, and other income. It is income that is earned but not directly tied to providing visits, procedures, or other specific services. Income is to be classified on the lines below based upon the source from whom the revenue is received. Income from services provided to non-health center patients (patients of an entity with which the health center is contracting) either in-house or under contract with another entity such as a hospital, nursing home or other health center is to be reported in Part 2: Other Income (see examples below). This would include income from in-house retail pharmacy sales to individuals who are not patients of the health center. See Lines 9 and 10 for examples of services provided to non-health center patients (patients of an entity with which the health center is contracting).

Other Federal (Line 7): This is income from federal grants where the applicant is the recipient of a Notice of Award from a federal agency. It does not include the section 330 grant request or federal funds awarded through intermediaries (see Line 9 below). It includes grants from federal sources such as the Centers for Disease Control (CDC), Housing and Urban Development (HUD), Centers for Medicaid and Medicare Services (CMS), and others. It includes Health and Human Service (DHHS) grants under the Ryan White Part C program; DHHS Capital Development grants; and others. The CMS Medicare and Medicaid electronic health record incentive program income is reported here in order to be consistent with the UDS reporting instructions.

State Government (Line 8): This is income from state government grants, contracts, and programs, including uncompensated care grants; state indigent care income; emergency preparedness grants; mortgage assistance; capital improvement grants; school health grants; Women, Infants, and Children (WIC); immunization grants; and similar awards.

Local Government (Line 9): This is income from local government grants, contracts, and programs, including local indigent care income, community development block grants, capital improvement project grants, and similar awards. For example: (1) a health center that contracts with the local Department of Health to provide services to the Department's patients is to report all the income earned under this contract on this line, and (2) Ryan White Part A funds are federal funds awarded to municipalities who in turn make awards to provider organizations, so Ryan White Part A grants would be classified as income earned from a local government and be shown on this line.

Private Grants/Contracts (Line 10): This is income from private sources such foundations, non-profit entities, hospitals, nursing homes, drug companies, employers, other health centers, and similar entities. For example, a health center operating a 340B pharmacy in part for its own patients and in part as a contractor to another health center is to report the pharmacy income for its own patients in Part 1 and the income from the contracted health center on this line.

Contributions (Line 11): This is income from private entities and individual donors that may be the result of fund raising.

Other (Line 12): This is incidental income not reported elsewhere and includes items such as interest income, patient record fees, vending machine income, dues, and rental income. Applicants typically have at least some Other income to report on Line 12.

Applicant (Retained Earnings) (Line 13): This is the amount of funds needed from the applicant's retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why applicant funds (retained earnings) are needed to achieve a breakeven budget. Amounts from non-federal sources, combined with the Section 330 funds, should be adequate to support normal operations.

Total Other (Line 14): This is the sum of lines 7 – 13.

Total Non-Federal (Line 15): This is the sum of Lines 6 and 14 and is the total non-federal (non-section 330) income.

Note: **In-kind donations are not included as income on Form 3**. Applicants may discuss in-kind donations in the ***SUPPORT REQUESTED*** section of the Project Narrative. Additionally, such donations may be included on the SF-424A (Section A: Budget Summary—Non-Federal Resources under New or Revised Budget).

FORM 4 – Community Characteristics (Required)
Report current service area and target population data for the entire scope of the project. Information provided regarding race and ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements and will not be used as an awarding factor. Applicants compiling data from multiple data sources may find that the total numbers vary across sources. Such applicants should make adjustments as needed to ensure that the total numbers for the first four sections of this form match. Adjustments must be explained in Item 1 of the *NEED* section of the Project Narrative.

Service area data must be specific to the proposed project and include the total number of persons for each characteristic (percentages will automatically calculate in EHB). If information for the service area is not available, extrapolate data from the U.S. Census Bureau, local planning agencies, health departments, and other local, state, and national data sources. Estimates are acceptable.

Target population data is most often a subset of service area data. Report the number of persons for each characteristic (percentages will automatically calculate in EHB). ***Patient data should not be used to report target population data since patients are typically a subset of all individuals targeted for service.*** Estimates are acceptable.

If the target population includes a large number of transient individuals (e.g., the county has an influx of migratory and seasonal agricultural workers during the summer months) that are not included in the dataset used for service area data (e.g., census data), adjust the service area numbers accordingly to ensure that the target population numbers are always less than or equal to the service area numbers.

Note: The total numbers for the first four sections of this form (i.e., Race, Hispanic or Latino Ethnicity, Income as a Percent of Poverty Level, and Primary Third Party Payment Source) **must match**. These total numbers should also be consistent with the service area and target population totals reported on Form 1A.

Guidelines for Reporting Race

- All individuals must be classified in one of the racial categories, including individuals who also consider themselves Hispanic or Latino. If the data source does not separately classify Hispanic or Latino individuals by race, report them as Unreported/Declined to Report.
- Utilize the following race definitions:
  - Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.

- Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, Tonga, Palau, Truk, Yap, or other Pacific Islands in Micronesia, Melanesia, or Polynesia.
- Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- American Indian/Alaska Native – Persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- More Than One Race – Patient who chooses 2 or more races.

Guidelines for Reporting Hispanic or Latino Ethnicity

- If ethnicity is unknown, report individuals as Unreported/Declined to Report.
- Utilize the following ethnicity definition: Hispanic or Latino – Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Guidelines for Reporting Special Populations

The Special Populations section of Form 4 does not have a row for total numbers. Individuals that represent multiple special population categories should be counted in all applicable categories.

FORMS 5A, 5B, and 5C—General Notes

- Current grantees applying to continue serving their current service area: These forms will be pre-populated with no opportunity for modification. The application should reflect only the current scope of project. Changes in services, sites, and other activities/locations require prior approval through a Change in Scope request submitted in EHB. If the pre-populated data does not reflect recently approved scope changes, click the **Refresh from Scope** button to refresh the data and display the latest scope of project.

Note: In order for pre-population to occur, a current grantee applying to continue serving its current service area must select **Continuation** for Box 2 and provide the grant number for Box 4 on the SF-424. **Failure to apply in this manner will result in delayed EHB application access.**

- New applicants (not currently funded through the Health Center Program) and current grantees applying to serve a new service area: Complete these forms based only on the scope of project for the proposed service area.

FORM 5A – Services Provided (Required) – NEW APPLICANTS AND CURRENT GRANTEES APPLYING TO SERVE A NEW SERVICE AREA ONLY

Identify how the required and optional additional services will be provided. Only one form is required regardless of the number of proposed sites. All referral arrangements/agreements for required services must be formal written arrangements/agreements. Refer to the Scope of Project policy documents available at http://bphc.hrsa.gov/about/requirements/scope for more

information on services and modes of service delivery. If the project is funded, only the services included on this form will be considered to be in the approved scope of project regardless of what is described or detailed in other portions of the application.

Current grantees applying to serve a new service area are encouraged to review their current services in scope when determining their proposed services.

FORM 5B – Service Sites (Required) – NEW APPLICANTS AND CURRENT GRANTEES APPLYING TO SERVE A NEW SERVICE AREA ONLY
Provide requested data for each proposed service site. Current grantees applying to serve a new service area will be able to select sites from their current scope, but they must also propose **at least one** new full-time, permanent[12] service or service/administrative site located in the new service area. Refer to the Scope of Project policy documents available at http://bphc.hrsa.gov/about/requirements/scope for information on defining sites, including special instructions for recording mobile, intermittent, and other site types. If the project is funded, only the service sites listed on this form will be considered to be in the approved scope of project regardless of what is described or detailed in other portions of the application.

Note: Sites entered into Form 5B must be consistent with sites described in the Project Narrative and throughout the application. Sites not evident on Form 5B will not be considered by the Objective Review Committee when reviewing and scoring the application.

FORM 5C – Other Activities/Locations (As applicable) – NEW APPLICANTS AND CURRENT GRANTEES APPLYING TO SERVE A NEW SERVICE AREA ONLY
Provide requested data for other activities/locations (e.g., home visits, health fairs). List only activities/locations that (1) do not meet the definition of a service site, (2) are conducted on an irregular timeframe/schedule, and/or (3) offer a limited activity from within the full complement of health center activities included within the scope of project. Refer to the Scope of Project policy documents available at available at http://bphc.hrsa.gov/about/requirements/scope for information on the types of activities/locations that should be included. If the project is funded, only the other activities/locations listed on this form will be considered to be in the approved scope of project regardless of what is described or detailed on other portions of the application.

FORM 6A – Current Board Member Characteristics (Required)
For grantees that currently receive Health Center Program funding (current grantees applying to serve their own or a new service area), the list of board members will be pre-populated from their latest SAC/NAP/BPR submission. **Applicants must update pre-populated information as appropriate.** Refer to the Health Center Program Governance policy available at http://www.bphc.hrsa.gov/policiesregulations/policies/pin201401.html for additional information. Public centers with co-applicant health center governing boards must list the co-applicant board members. Applicants requesting a waiver of the 51 percent patient majority requirement must list the health center's board members, not the members of any advisory council(s).

[12] MHC-only applicants may propose at least one full-time seasonal rather than permanent site to meet this criterion.

Complete or update the following information:

- List all current board members; current board office held for each board member, if applicable (e.g., Chair, Treasurer); and each board member's area of expertise (e.g., finance, education, nursing).
- Indicate if the board member derives more than 10 percent of income from the health care industry.
- Indicate if the board member is a health center patient. A patient board member must be a currently registered patient of the health center and must have accessed the health center in the past 24 months to receive at least one in-scope service that generated a documented health center visit. (Refer to Form 1A instructions above for the definition of a visit.)
- Indicate if the board member lives and/or works in the service area.
- List how long each individual has served on the board.
- Indicate if the board member is a representative of/for a special population (i.e., persons experiencing homelessness, migratory and seasonal agricultural workers, residents of public housing).
- Indicate the gender, ethnicity, and race of board members who are patients of the health center.

Note: Indian tribes or tribal, Indian, or urban Indian organizations are not required to complete this form and can click Save and Continue to mark the form complete without providing the requested information. However, such applicants may include information on this form as desired.

FORM 6B – Request for Waiver of Governance Requirements (Required)

Only MHC, HCH, and/or PHPC applicants are eligible to request a waiver.

- An applicant that currently receives or is applying to receive CHC (section 330(e)) funding is not eligible for a waiver and cannot enter information on this form.
- Indian tribes or tribal, Indian, or urban Indian groups are not required to complete this form and cannot enter information.
- Current health center program grantees that wish to continue an existing waiver must reapply as part of the application.
- Eligible applicants may request a waiver of the patient majority board composition requirement. When requesting a waiver, briefly demonstrate good cause as to why you cannot meet the patient majority board composition requirement and present a plan for ensuring patient input and participation in the organization, direction, and ongoing governance of the health center. The plan must provide all of the following:
- Clear description of the alternative mechanism(s) for gathering patient input. If advisory councils or patient representatives are proposed, include a list of the members in Attachment 14 or 15 that identifies these individuals and their reasons/qualifications for participation on the advisory council or as governing board representatives.
- Specifics on the type of patient input to be collected.
- Methods for collecting and documenting such input.
- Process for formally communicating the input directly to the health center governing board (e.g., monthly or quarterly presentations of the advisory group to the full board, monthly or quarterly summary reports from patient surveys).

- Specifics on how the patient input will be used by the governing board in such areas as: 1) selecting health center services; 2) setting health center operating hours; 3) defining budget priorities; 4) evaluating the organization's progress in meeting goals, including patient satisfaction; and 5) other relevant areas of governance that require and benefit from patient input.

FORM 8 – Health Center Agreements (Required)
Complete Part I, indicating whether current or proposed agreements constitute a substantial portion of the proposed scope of project. If a proposed site is operated by a sub-recipient or contractor, as identified in Form 5B, the answer must be yes. If **Yes**, indicate the number of each type in the appropriate field. If **No**, skip to the Governance Checklist in Part II.

Complete Part II, Governance Checklist. If the response to any of the Governance Checklist items is **No**, the response to the question regarding agreements/arrangements affecting the governing board's composition, authorities, functions, or responsibilities must be **Yes**, and the number of such agreements/arrangements must be indicated. Additionally, **No** responses for the Governance Checklist must be explained in Item 2 of the *RESOURCES/CAPABILITIES* section of the Project Narrative. Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups may select **Yes** for all items on the Governance Checklist.

Part III should be completed only by applicants that responded **Yes** to Part I.1 or Part II.2. In Part III, use the Organization Agreement Details section to provide the contact information for each organization (up to 10) with which an agreement/arrangement either (1) constitutes a substantial portion of the proposed scope of project (as described in Part I) or (2) impacts the governing board's composition, authorities, functions, or responsibilities (as described in Part II). If a proposed site is operated by a sub-recipient or contractor, as identified in Form 5B, the applicant must attach the agreement or contract. **Upload each agreement/arrangement** (up to 5 for each organization) in full. Agreements/arrangements that exceed these limits should be included in Attachment 14 or 15. As a reminder, a summary of all sub-recipient arrangements, contracts, and affiliation agreements must be included in Attachment 7.

Note: Items attached to Form 8 will **not** count against the page limit. Items included in Attachments 7, 14, and 15 **will** count against the page limit.

FORM 9 – Need for assistance worksheet (Required)
The worksheet is presented in three sections: Core Barriers, Core Health Indicators, and Other Health and Access Indicators. Refer to the Data Resource Guide located at http://www.hrsa.gov/grants/apply/assistance/sac for recommended data sources and methodology.

Only one NFA Worksheet will be submitted per applicant. If an applicant proposes multiple sites, the NFA Worksheet responses should represent the total combined population for all sites. **Only one response may be submitted for each barrier or health indicator.**

Guidelines for Completing the NFA Worksheet:

- All responses must be expressed as a finite number (e.g., 212.5) and cannot be presented as a range (e.g., 31-35).
- Recommended data sources are identified in the Data Resource Guide located at http://www.hrsa.gov/grants/apply/assistance/sac. Alternative sources must have the same parameters for each indicator as the source in the Data Resource Guide. For example, any source used for diabetes prevalence must provide age-adjusted rates. See the Data Resource Guide for more information.
- Responses to all indicators must be expressed in the same format/unit of analysis identified on the worksheet (e.g., a mortality ratio cannot be used to provide a response to age-adjusted death rate). The following table provides examples of the unit and format of responses:

Table 5: Indicator Response Formats and Units

Format/Unit of Analysis	Example Format	Example Description
Percent	25%	25 percent of target population is uninsured
Prevalence expressed as a percent	8.5%	8.5 percent of population has asthma
Prevalence expressed as a rate	9 per 1,000 population	9 of every 1,000 infants die
Rate	50 per 100,000	50 hospital admissions for hypertension per 100,000 population
Ratio	3,000:1	3,000 people per every 1 primary care physician

Note: When entering rate or ratio data in EHB, provide only the variable number, not the entire ratio (i.e., 3,000:1 would be entered as 3,000).

POPULATION BASIS FOR DATA

Provide data for three of four Core Barriers in Section 1, one Core Health Indicator for each of six categories in Section 2, and two of the 13 Other Health and Access Indicators in Section 3. All responses, with the exception of those for Core Barriers B, C, and D, should be based on data for the target population within the proposed service area to the extent appropriate and possible per the following table.

Data Reporting Guidelines Table

Applicants should report data for the NFA Worksheet measures based on the population groups specified in the table below. In cases where data are not available for the specific service area or target population, applicants may use extrapolation techniques to make valid estimates using data available for related areas and population groups (see below). Where data are not directly available and extrapolation is not feasible, applicants should use the best available data describing the area or population to be served. In such a case, applicants must explain the data provided.

Table 6: Data Reporting Guidelines Table

Form Sections	General Community 330(e) ONLY	General Community 330(e) plus one or more Special Populations (330(g), (h), and/or (i))	One or more Special Populations 330(g), (h), and/or (i)) ONLY
Core Barrier A: Population to One FTE Primary Care Physician	Target Population	Target Population	Target Population
Core Barrier B: Percent of Population below 200% of Poverty	Service Area	Service Area	Target Population
Core Barrier C: Percent of Population Uninsured	Service Area	Service Area	Target Population
Core Barrier D: Distance or Travel Time to Nearest Primary Care Provider Accepting New Medicaid and Uninsured Patients	N/A	N/A	N/A
Core Health Indicator Reporting	Target Population	Target Population	Target Population
Other Health and Access Indicator Reporting	Target Population	Target Population	Target Population

Note: Core Barrier D: Distance or Travel Time to Nearest Primary Care Provider Accepting New Medicaid and Uninsured Patients is not calculated based on population. For this core barrier, distance/time is measured from the proposed site to the nearest provider accepting new Medicaid and uninsured patients.

Extrapolation

For detailed instructions for each indicator and information on using and documenting acceptable extrapolation techniques, refer to the Data Resource Guide available at http://www.hrsa.gov/grants/apply/assistance/sac. Extrapolation to the service area, target population, or both may be needed. The need for extrapolation will depend on:

- Which Core Barrier or Health Indicator is being reported?
- Whether the applicant is targeting the entire population within the service area or a specific subset of the population.
- The availability and specificity of data for each Core Barrier and Health Indicator.

Note: Applicants must document how extrapolation was conducted and what data sources were used. The Data Resource Guide provides additional detail on using and documenting acceptable extrapolation techniques. If data are not available to conduct a valid extrapolation to the specific service area and/or target population, the applicant should use data pertaining to the immediately surrounding geographic area/population (e.g., if target population data are not available, service area data may be used; if county level data are available, state level data cannot be used).

DATA RESPONSE AND SOURCES

The Data Resource Guide provides a listing of recommended data sources and instructions on utilizing these sources to report each indicator. Applicants may use these sources or other alternate publicly available data sources if the data is collected and analyzed in the same way as the suggested data source. Applicants must use the following guidelines when reporting data:

1. All data must be from a reliable and independent source, such as a state or local government agency, professional body, foundation, or other well-known organization using recognized, scientifically accepted data collection and/or analysis methods. Applicants must assure that any alternate sources used collect and report data in the same manner as the suggested data source.
2. Applicants must provide the following information:

- **Data Response—**Data reported for each indicator on which the NFA score will be based.
- **Year to which Data Apply—**Provide the year of the data source. If the data apply to a period of more than one year, provide the most recent year for the data reported.
- **Data Source/Description**—If a data source other than what is included in the Data Resource Guide is utilized, name the data source and provide a rationale (e.g., more current, more geographically specific, more population specific). For example, if a county-level survey was used, name that survey and provide a rationale for using it.
- **Methodology Utilized/Extrapolation Method**—Provide the following information:
  - Extrapolation methodology used – State whether extrapolation was from one geographic area to another, one population to another, both, or none.
  - Differentiating factor used – Describe the demographic factor upon which the extrapolation was based (e.g., rates by age, gender, race/ethnicity) and data source.
  - Level of geography – State geographic basis for the data (e.g., the data source may be a national survey, but the geographic basis for extrapolation was at the county level).
- **Identify Geographic Service Area or Target Population for Data**—Define the service area and/or target population used (e.g., zip codes, Census tracts, MUA or MUP designation, population type).

SECTION 1: CORE BARRIERS

A response is required for **3 of the 4 Core Barriers**. The table below provides the national median (50th percentile) benchmark for three of the four core barriers as a point of reference.

Table 7: Core Barriers

SECTION 1: CORE BARRIERS	National Median Benchmark
A: Population to One FTE Primary Care Physician	1,641
B: Percent of Population below 200% of Poverty	36.6%
C: Percent of Population Uninsured	14.1%
D: Distance or Travel Time to Nearest Primary Care Provider Accepting New Medicaid and Uninsured Patients	N/A

SECTION 2: CORE HEALTH INDICATORS

Applicant must provide a response to **1 core health indicator from each of the following 6 categories**: Diabetes, Cardiovascular Disease, Cancer, Prenatal and Perinatal Health, Child Health, and Behavioral Health. The table below provides the national median (50th percentile) benchmark for each indicator.

If an applicant determines that none of the specified indicators represent the applicant's service area or target population, the applicant may propose to use an "Other" alternative for that core health indicator category. In such a case, all fields other than the benchmark field must be completed. See the Data Resource Guide for detailed instructions on providing documentation for an "Other" indicator.

Table 8: Core health Indicator Categories

SECTION 2: CORE HEALTH INDICATOR CATEGORIES	National Median Benchmark
1. Diabetes	
1(a) Age-adjusted diabetes prevalence	8.1%
1(b) Adult obesity prevalence	27.6%
1(c) Age-adjusted diabetes mortality[13] rate (per 100,000)	22.5
1(d) Percent of diabetic Medicare enrollees not receiving a hemoglobin A1c (HbA1c) test	18.0%
1(e) Percent of adults (18 years and older) with no physical activity in the past month	24.0%
1(f) Other	*N/A*
2. Cardiovascular Disease	
2(a) Hypertension hospital admission rate (18 years and older; per 100,000)	61.4
2(b) Congestive heart failure hospital admission rate (18 years and older; per 100,000)	361.7
2(c) Age-adjusted mortality from diseases of the heart[14] (per 100,000)	179.4
2(d) Proportion of adults reporting diagnosis of high blood pressure	28.7%
2(e) Percent of adults who have not had their blood cholesterol checked within the last 5 years	23.1%
2(f) Age-adjusted cerebrovascular disease mortality (per 100,000)	41.4
2(g) Other	*N/A*
3. Cancer	
3(a) Cancer screening – percent of women 18 years and older with no Pap test in past 3 years	18.4%

[13] Number of deaths per 100,000 reported as due to diabetes as the underlying cause or as one of multiple causes of death (ICD-10 codes E10-E14).

[14] Total number of deaths per 100,000 reported as due to heart disease (includes ICD-10 codes I00-I09, I11, I13, and I20-I51).

SECTION 2: CORE HEALTH INDICATOR CATEGORIES	National Median Benchmark
3(b) Cancer screening – percent of women 50 years and older with no mammogram in past 2 years	22.2%
3(c) Cancer screening – percent of adults 50 years and older with no fecal occult blood test (FOBT) within the past 2 years	83.3%
3(d) Percent of adults who currently smoke cigarettes	17.3%
3(e) Age-adjusted colorectal cancer mortality (per 100,000)	14.0
3(f) Age-adjusted breast cancer mortality (per 100,000) among females	22.1
3(g) Other	*N/A*
4. Prenatal and Perinatal Health	
4(a) Low birth weight (<2500 grams) rate (5 year average)	7.9%
4(b) Infant mortality rate (5 year average; per 1,000)	6.6
4(c) Births to teenage mothers (ages 15-19; percent of all births)	8.4%
4(d) Late entry into prenatal care (entry after first trimester; percent of all births)	16.4%
4(e) Cigarette use during pregnancy (percent of all pregnancies)	14.1%
4(f) Percent of births that are preterm (<37 weeks gestational age)	12.0%
4(g) Other	*N/A*
5. Child Health	
5(a) Percent of children (19-35 months) not receiving recommended immunizations: 4-3-1-3-3-1-4[15]	30.0%
5(b) Percent of children not tested for elevated blood lead levels by 72 months of age	84.1%
5(c) Pediatric asthma hospital admission rate (2-17 year olds; per 100,000)	116.0
5(d) Percent of children (10-17 years) who are obese	15%
5(e) Other	*N/A*
6. Behavioral Health	
6(a) Percent of adults with at least one major depressive episode in the past year	6.6%
6(b) Suicide rate (per 100,000)	13.5
6(c) Binge alcohol use in the past month (percent of population 12 years and older)	24.1%
6(d) Age-adjusted drug poisoning (i.e., overdose) mortality rate per 100,000 population	12.3
6(e) Other	*N/A*

SECTION 3: OTHER HEALTH AND ACCESS INDICATORS

Applicants must provide responses to **2 of the 13** Other Health and Access Indicators. The table below provides the national median (50th percentile) benchmark for each Other Health and Access Indicator as a point of reference.

[15] 4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B, 1 varicella, and 4 Pneumococcal conjugate.

Table 9: Other Health and Access Indicators

OTHER HEALTH AND ACCESS INDICATORS	National Median Benchmark
(a) Age-adjusted death rate (per 100,000)	764.8
(b) HIV infection prevalence	0.2%
(c) Percent elderly (65 and older)	15.2%
(d) Adult asthma hospital admission rate (18 years and older; per 100,000)	130.7
(e) Chronic Obstructive Pulmonary Disease hospital admission rate (18 years and older; per 100,000)	227.2
(f) Influenza and pneumonia death[16] rate (3 year average; per 100,000)	18.6
(g) Adult current asthma prevalence	9.0%
(h) Age-adjusted unintentional injury deaths (per 100,000)	40.0
(i) Percent of population linguistically isolated (people 5 years and over who speak a language other than English at home)	10.3%
(j) Percent of adults (18+ years old) that could not see a doctor in the past year due to cost	13.4%
(k) Percentage of adults 65 years and older who have not had a flu shot in the past year	32.6%
(l) Chlamydia (sexually transmitted infection) rate (per 100,000)	389.5
(m) Percent of adults without a visit to a dentist or dental clinic in the past year for any reason	30.4%

FORM 10 – Annual Emergency Preparedness Report (Required)
Select the appropriate responses regarding emergency preparedness. If any answer is no, explain the response in Item 12 of the *RESOURCES/CAPABILITIES* section of the Project Narrative. This form will be used to assess the status of emergency preparedness planning and progress towards developing and implementing an emergency management plan.

FORM 12 – Organization Contacts (Required)
For grantees that currently receive Health Center Program funding (current grantees applying to serve their own or a new service area), the data will be pre-populated from their latest SAC/NAP/BPR submission. It can be revised as necessary.

New applicants, provide the requested contact information. For the Contact Person field, provide an individual who can represent the organization in communication regarding the application.

Summary Page (Required)
This form will enable applicants to verify key application data utilized by HRSA when reviewing the applications. Content will be pre-populated from the Budget Summary Form and the Program Specific Forms. If the pre-populated data appear incorrect, verify that the pertinent data

[16] Three year average number of deaths per 100,000 due to influenza and pneumonia (ICD 10 codes J09-J18).

provided in the Budget Summary Form and Program Specific Forms 1A and 5B have been entered correctly. A link to the appropriate forms will be provided if changes are required.

To ensure eligibility, the health center funding requested and funding types must match the information on the SAAT. The Total Funding amount listed in the SAAT includes prorated funding to align all past supplemental awards to the announced project/budget period.

Funded applicants will be held accountable for meeting the **unduplicated** patient projection (from the Total line at the bottom of Form 1A) and supplemental funding patient commitments by December 31, 2016.

To ensure continuity of services in areas already being served by Health Center Program grantees, new applicants and current grantees proposing to serve a new service area must certify that **all sites** described in the application are included on Form 5B and will be open and operational within 120 days of Notice of Award.

To ensure an accurate scope of project, current grantees applying to continue serving their current service area must certify that:

- Form 5A accurately reflects all services and service delivery methods included in the current approved scope of project OR Form 5A requires changes that the applicant has already submitted through the change in scope process.
- Form 5B accurately reflects all sites and zip codes included in the current approved scope of project OR Form 5B requires changes that the applicant has already submitted through the change in scope process.

Note: Use the Refresh from Scope Button to ensure the most recent scope information is reflected in the SAC application.

Appendix B: Performance Measures Instructions

CLINICAL AND FINANCIAL PERFORMANCE MEASURES

The Clinical and Financial Performance Measures set the clinical and financial goals for the project period. The goals must be responsive to identified community health and organizational needs and correspond to key service delivery activities and organizational capacity discussed in the Project Narrative. The Clinical and Financial Performance Measures goals must be inclusive of all sites and services within scope. Further detail on the Clinical and Financial Performance Measures can be found at http://www.hrsa.gov/data-statistics/health-center-data/reporting (refer to the UDS Reporting Manual for specific measurement details such as exclusionary criteria). Sample forms can be found at http://www.hrsa.gov/grants/apply/assistance/sac.

Required Clinical Performance Measures

Applicants ***must include*** the following required clinical performance measures:

1. Diabetes
2. Cardiovascular Disease
3. Cancer
4. Prenatal Health
5. Perinatal Health
6. Child Health
7. Oral Health
8. Weight Assessment and Counseling for Children and Adolescents
9. Adult Weight Screening and Follow-Up
10. Tobacco Use Screening and Cessation
11. Asthma: Pharmacological Therapy
12. Coronary Artery Disease: Lipid Therapy
13. Ischemic Vascular Disease: Aspirin Therapy
14. Colorectal Cancer Screening
15. New HIV Cases With Timely Follow-Up
16. Depression Screening and Follow-Up

Required Financial Performance Measures

Applicants ***must include*** the following required financial performance measures:

1. Total Cost Per Patient
2. Medical Cost Per Medical Visit
3. Change in Net Assets to Expense Ratio
4. Working Capital to Monthly Expense Ratio
5. Long Term Debt to Equity Ratio

Important Details about the Performance Measures Forms

- Current grantees applying to continue serving their current service area should report on their previously developed, pre-populated oral health performance measure as long as it remains relevant to the project.

- For new applicants and Health Center Program grantees applying to serve a new service area, baselines for performance measures should be developed from data that are valid, reliable, and whenever possible, derived from currently established management information systems**.** If baselines are not yet available, state when data will be available**.**

- Applicants applying for funds to target special populations (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing), ***must include*** additional performance measures that address the health care needs of these populations. In providing additional performance measures specific to a special population, applicants must reference the target group in the performance measure. For example, if an applicant seeks funds to serve migratory and seasonal agricultural workers, then the applicant must propose to measure *"the percentage of migratory and seasonal agricultural workers who…"* ***rather than*** simply *"the percentage of patients who…"* To add these required additional performance measures, click on "Add Other Performance Measure" in EHB.

- Applicants that have identified unique issues (e.g., populations, age groups, health issues, risk management efforts) in the ***NEED*** section of the Project Narrative are encouraged to include additional related performance measures. To add a performance measure of your choice, click on "Add Other Performance Measure" in EHB.

- Applicants are required to report prenatal and perinatal performance measures along with three new measures: depression screening and follow up, tobacco screening and cessation, and new HIV cases with timely follow up. Please refer to Program Assistance Letter 2014-01 located at http://bphc.hrsa.gov/policiesregulations/policies/pal201401.pdf. Applicants reporting these measures for the first time can enter 0 for the baseline data and provide a date by which baseline data will be gathered. The projected data field must be completed with a predicted three-year goal (estimates are acceptable).

- Due to the addition of the depression screening and follow up measure, current grantees applying to continue serving their current service area are no longer required to track previously self-defined behavioral health Other measures. If such Other measures will no longer be tracked, they can be marked *Not Applicable* (a justification must be provided in the Comments field).

Special Instructions for Performance Measures

Report the **Diabetes Clinical Performance Measure** as follows:

- Report adult patients with HbA1c levels ≤ 9 percent in the Baseline Data (numerator and denominator subfields) and Projected Data fields.
- If desired, report the additional measurement thresholds (i.e., < 8 percent or > 9 percent) in the Comments field.

Overview of the Performance Measures Form Fields

In Table 10, YES in the **Is this Field Pre-Populated?** Column notes an item that is pre-populated for current grantees applying to continue serving their current service area. A single asterisk (*) in this column denotes a field pre-populated from the latest SAC/NAP/BPR

submission for the standard performance measures. A double asterisk (**) denotes a field pre-populated from 2013 UDS data.

Table 10: Overview of Measures Form Fields

Field Name	Is this Field Pre-Populated?	Can I Edit this Field?	Notes
Focus Area	YES	NO	This field contains the content area description for each required performance measure. Applicants will specify focus areas when adding Other performance measures.
Performance Measure	YES	NO	This field defines each measure and is editable for Oral Health and Other performance measures. Edits must be explained in the Comments field.
Performance Measure Applicability	YES*	YES	Audit-related Financial Performance Measures (Change in Net Assets to Expense Ratio, Working Capital to Monthly Expense Ratio, and Long Term Debt to Equity Ratio) may be marked Not Applicable ONLY by tribal and public center applicants. As desired, these applicants may choose to include substitute measures.
Target Goal Description	NO	YES	This field provides a description of the target goal.
Numerator Description	YES	NO	In the case of the Clinical Performance Measures, the numerator is the number of patients that meet the criteria identified by the measure (e.g., patients in a specified age range that received a specified service). In the Financial Performance Measures, the numerator field must be specific to the organizational measure. This field can be edited for only Oral Health and Other performance measures. All edits require justification in the Comments field.
Denominator Description	YES	NO	In the case of the Clinical Performance Measures, the denominator is all patients to whom the measure applies (e.g., patients in a specified age range, regardless of whether they received a specified service). In the Financial Performance Measures, the denominator field must be specific to the organizational measure. This field can be edited for only Oral Health and Other performance measures. All edits require justification in the Comments field.

Baseline Data Baseline Year Measure Type Numerator Denominator	 YES** YES YES** YES**	 NO NO NO NO	This field contains subfields that provide information regarding the initial threshold used to measure progress over the course of the project period. The Baseline Year subfield identifies the initial data reference point. The Measure Type subfield provides the unit of measure (e.g., percentage, ratio). The Numerator and Denominator subfields specify patient or organizational characteristics (see rows above). Current grantees applying to continue serving their current service area will not be able to edit this data for the required standard measures. If such applicants would like to report more current data, this information should be included in the Comments field. Since no UDS data is available for the three new clinical performance measures, these fields will be editable. For Oral Health and Other performance measures, pre-populated information can be edited, but justification is required in the Comments field.
Progress Field	NO	YES	Current grantees applying to continue serving their current service area MUST use this field to provide information regarding progress since the application that initiated the budget period.
Projected Data	NO	YES	This field provides the goal for the end of the three-year project period. Current grantees applying to continue serving their current service area should ensure that this goal is a three-year projection from the 2013 UDS baseline data (i.e., to be met by December 31, 2016).
Data Source and Methodology	NO	YES	This field provides information about the data sources used to develop the performance measures. Applicants are required to identify a data source and discuss the methodology used to collect and analyze data. Data must be valid, reliable, and derived from established management information systems. For Clinical Performance Measures, applicants must select the data source—EHR, Chart Audit, or Other (please specify)—before describing the methodology. For Financial Performance Measures, note if data are based on the most recent audit.

Key Factors and Major Planned Actions Key Factor Type Key Factor Description Major Planned Action Description	 NO NO NO	 YES YES YES	This field contains subfields that provide information regarding the factors that must be minimized or maximized to ensure goal achievement. The Key Factor Type subfield requires applicants to select Contributing and/or Restricting factor categories. Applicants must specify at least one key factor of each type. The Key Factor Description subfield provides a description of the factors predicted to contribute to and/or restrict progress toward stated goals. The Major Planned Action Description subfield provides a description of the major actions planned for addressing key factors. Applicants must use this subfield to provide planned overarching action steps and strategies for achieving each performance measure. This field has a 1,500-character limit.
Comments	NO	YES	This open text field, limited to 1,500 characters, enables applicants to provide justifications required from changes made to other form fields as well as any additional information desired. Information exceeding the character limit should be placed in the *EVALUATIVE MEASURES* section of the Project Narrative.

Other Performance Measures

In addition to the required Clinical and Financial Performance Measures, applicants may identify other measures relevant to their health center and/or target population. Each additional measure must be defined by a numerator and denominator, and progress must be tracked over time. If a Health Center Program grantee applying to continue serving its current service area no longer tracks a self-defined Other measure, note this by marking the measure *Not Applicable* and including a justification in the Comments field as to why reporting is no longer possible and/or relevant.

Resources for the Development of Performance Measures

Current grantees are encouraged to use their UDS Health Center Trend Report and/or Summary Report available in EHB when considering how improvements to past performance can be achieved. For help with accessing reports in EHB, please contact the BPHCHelpLine@hrsa.gov or 877-974-2742 (877-974-BPHC). Applicants may also find it useful to do the following:

- Recognize that many UDS clinical performance measures are aligned with the meaningful use measures specified at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_MeasuresTable_Posting_CQMs.pdf.
- Examine the performance measures of other health centers that serve similar target populations.
- Consider state and national performance UDS benchmarks and comparison data (available http://bphc.hrsa.gov/healthcenterdatastatistics/index.html).
- Use the Healthy People 2020 goals as a guide when developing performance measures. Healthy People 2020 objectives are at

http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf. Several of these objectives can be compared directly to UDS clinical performance measures (high blood pressure under control, diabetes HbA1c readings less than or equal to nine, low and very low birth weight infants, access to prenatal care in the first trimester, colorectal cancer screening, cervical cancer screening). A table outlining the Healthy People 2020 objectives related to these performance measures can be found at http://www.hrsa.gov/grants/apply/assistance/sac.

Appendix C: Budget Presentation Instructions

Applicants must note that in the formulation of their budget presentation, per section 330(e)(5)(A) of the PHS Act (42 U.S.C. 254b), the amount of grant funds awarded in any fiscal year may not exceed the costs of health center operation in such fiscal year less the total of: state, local, and other operational funding provided to the center; and the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in such fiscal year. Section 330 grant funds are to be used for authorized health center operations and may not be used for profit. Further, as stated in section 330 of the PHS Act, the federal cost principles apply only to federal grant funds.

Applicants must present the total budget for the project, which includes section 330 grant funds and all non-grant funds, including both program income and all other non-grant funding sources that support the health center scope of project. The total budget represents projected operational costs for the health center scope of project where all proposed expenditures directly relate to and support in-scope activities. The total budget is inclusive of section 330 grant funds and non-grant funds, which includes both program income and all other non-grant funding sources. Therefore, the total budget must reflect projections from all anticipated revenue sources from program income (e.g., fees, premiums, third party reimbursements, and payments) that is generated from the delivery of services, and from "other non-section 330 grant sources" such as state, local, or other federal grants or contracts, private contributions, and income generated from fundraising. See Policy Information Notice 2013-01 (http://www.bphc.hrsa.gov/policiesregulations/policies/pin201301.html) for additional information on health center budgeting. Health centers have discretion regarding how they propose to allocate the total budget between section 330 grant funds and non-grant funds, provided that the projected budget complies with all applicable HHS policies and other federal requirements.

Example of Application of this Limitation
If an individual's base salary is $225,000 per year plus fringe benefits of 25 percent ($56,250), and that individual is devoting 50 percent of his/her time to this award, the base salary must be adjusted to $181,500, plus fringe benefits of 25 percent ($45,375), when calculating what may be charged to the SAC grant. This results in a total of $113,437.50 that may be included in the project budget and charged to the award in salary/fringe benefits for this individual. See the breakdown below:

Table 11: Actual versus Claimed Salary

Current Actual Salary Individual's actual base full time salary: $225,000 (50% of time will be devoted to project)	
Direct Salary	$112,500
Fringe (25% of salary)	$ 28,125
Total	$140,625
Amount of Actual Salary Eligible to be Claimed on the Application Budget due to the Legislative Salary Limitation Individual's base full time salary adjusted to Executive Level II: $181,500 (50% of time will be devoted to the project)	
Direct Salary	$ 90,750
Fringe (25% of salary)	$ 22,687.50
Total	$113,437.50

Budget for Multi-Year Award

This announcement is inviting applications for project periods up to three (3) years. Competitive awards will be for a budget period of one year, although the project period may be for up to three (3) years. Submission and HRSA approval of the yearly Federal Financial Report (FFR) and Budget Period Progress Report (BPR) is the basis for the budget period renewal and release of subsequent year funds. Funding beyond the one-year budget period but within the three-year project period is subject to availability of funds, satisfactory grantee progress, and a determination that continued funding is in the best interest of the federal government.

STANDARD FORM 424A

Complete Sections A, B, C, E, and F (if F is applicable) of the SF-424A: Budget Information form. The budget must clearly indicate the projected revenue and expense for a **12-month period based on the project period start date.** The 12-month total federal funding request cannot be greater than the total funding amount listed on the SAAT (available at http://www.hrsa.gov/grants/apply/assistance/sac).

Use the following guidelines to complete the SF-424A: Budget Information. Budget amounts must be rounded to the nearest whole dollar. In addition, please review the sample SF-424A located on the SAC technical assistance website (http://www.hrsa.gov/grants/apply/assistance/sac).

SECTION A – BUDGET SUMMARY

In EHB, click "Update Sub-Program" to select each section 330 program type for which funding is requested (CHC, MHC, HCH, and/or PHPC). Next, click "Update" to enter the proposed federal and non-federal budget for the **first 12-month budget period**. Under New or Revised Budget, provide the section 330 funding request in the "Federal" column for each sub-program. The federal amount refers to only the section 330 Health Center Program grant funding requested, not all federal grant funding that an applicant receives. In the "Non-

Federal" column, provide the total projected non-section 330 revenue for each sub-program. Estimated Unobligated Funds are not applicable for this funding opportunity.

SECTION B – BUDGET CATEGORIES
Update the budget for the **first 12-month budget period**. Enter the budget amount for each object class category with the federal section 330 funding request and the non-federal (non-section 330) funding in separate columns. Each line represents a distinct object class category that must be addressed in the Budget Justification Narrative. Indirect costs may only be claimed with an approved indirect cost rate (see details in the Budget Justification Narrative section below).

Section C – Non-Federal Resources
For each sub-program, provide the total projected non-section 330 revenue by funding source (i.e., Applicant, State, Local, Other, Program Income). Amounts under the "Applicant" field refer to revenue that the applicant itself is contributing to the project, which may be zero. If the applicant is a state agency, state funding should be included in the "Applicant" field. Include other non-section 330 federal funds in the "Other" field. Program Income must be consistent with the Total Program Income (patient service revenue) presented in Form 3: Income Analysis.

SECTION D – FORECASTED CASH NEEDS (optional)
Enter the amount of cash needed by quarter during the first year for both the federal request and all other sources (Non-federal), if desired.

SECTION E – BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR THE BALANCE OF THE PROJECT
Enter the federal section 330 funds requested for Year 2 in the First column and Year 3 in the Second column for each section 330 program for which funding is requested. **The requested amount for each future year of the project period must not exceed the requested level of funding for the first year.** The Third and Fourth columns must remain $0.

SECTION F – OTHER BUDGET INFORMATION (IF APPLICABLE)
Direct Charges: Explain amounts for individual direct object class categories that may appear to be out of the ordinary.

Indirect Charges: Enter the type of indirect rate (provisional, pre-determined, final, or fixed) that will be in effect during the project period, the estimated amount of the base to which the rate is applied, and the total indirect expense.

Remarks: Provide other explanations as necessary.

BUDGET JUSTIFICATION NARRATIVE

A detailed budget justification in line-item format with accompanying narrative must be provided for **each requested 12-month period** of federal funding (see section 5.1.iii Budget of HRSA's *SF-424 Two-Tier Application Guide* for details). A three-year Budget Justification Narrative is required. Year 1 of the budget justification should be classified into federal and

non-federal resources. For subsequent budget years, the justification narrative should highlight the changes from year one or clearly indicate that there are no substantive changes during the project period. See http://www.hrsa.gov/grants/apply/assistance/sac for a sample Budget Narrative Justification.

Attach the Budget Justification Narrative in the Budget Narrative Attachment Form section in EHB. The Budget Justification Narrative must be concise and should not be used to expand the Project Narrative. If using Excel or other spreadsheet documents, be aware that reviewers will only see information that is set in the "Print Area" of the document.

Revenue should be consistent with information presented in the SF-424A – Budget Information form. Provide the total projected revenue by funding source (i.e., Grant Request, Applicant, State, Local, Other Federal Funding, Other Support, Program Income).

It is important to **ensure that the Budget Justification Narrative contains detailed calculations explaining how each line-item expense is derived** (e.g., number of visits, cost per unit). Refer to the HHS Grants Policy Statement available at http://www.hrsa.gov/grants/hhsgrantspolicy.pdf for information on allowable costs. If there are budget items for which costs are shared with other programs (e.g., other HRSA programs), the basis for the allocation of costs between the programs must be explained.

Note: Funds under this announcement may not be used for fundraising or the construction of facilities.

See Table 12 below for the information that **must** be included for each staff position supported in whole or in part with federal section 330 grant funds in the *Personnel* section of the Budget Narrative Justification. This level of information is **not** required for staff positions supported entirely with non-federal section 330 grant funds; applicants should reference Form 2: Staffing Profile in the justification for such staff positions.

Table 12: Budget Justification Narrative Sample for Salary Adjustment

Name	Position Title	% of FTE	Base Salary	Adjusted Annual Salary	Federal Amount Requested
J. Smith	Physician	50	$225,000	$181,500	$90,750
R. Doe	Nurse Practitioner	100	$75,950	No adjustment needed	$75,950
D. Jones	Data/AP Specialist	25	$33,000	No adjustment needed	$ 8,250

Appendix D: Implementation Plan

New applicants and current grantees applying to serve a new service area must provide a plan with appropriate and reasonable time-framed tasks necessary to achieve the required operational status at the proposed site(s). In the Implementation Plan, outline goals and action steps necessary to ensure that within 120 days of the Notice of Award, all proposed sites will:

- Be operational and begin providing services for the proposed population/community.
- Have appropriate staff and providers in place.
- Begin to deliver services as proposed (consistent with Forms 5A and 5C) to the proposed target population(s).

Additionally, the Implementation Plan must demonstrate that all providers will be hired and all sites will be operational for the targeted number of hours within one year of Notice of Award.

The Implementation Plan must be specific to the proposed project. Applicants may choose from the following list of focus areas and goals within each area, or may include other goals as desired. The Implementation Plan will be reviewed in conjunction with the Project Narrative, Program Specific Forms, and required attachments to evaluate the application.

Focus Area: Operational Service Delivery Program

A.1. Provision of Required & Additional Services (Form 5A)
A.2. Core Provider Staff Recruitment Plan
A.3. System for Professional Coverage for After Hours Care
A.4. Admitting Privileges
A.5 Readiness to Serve the Target Population

Focus Area: Functioning Key Management Staff/Systems/Arrangements

B.1. Appropriate Management Team Recruitment
B.2. Documented Contractual/Affiliation Agreements
B.3. Financial Management and Control Policies
B.4. Data Reporting System

Focus Area: Implementation of the Compliant Sliding Fee Discount Program and Billings and Collections System at Proposed Site(s)

C.1. Implementation of a Compliant Sliding Fee Scale
C.2. SFDP and Billing and Collections Policies and Procedures

Focus Area: Integration of the Proposed Site(s) into the Quality Improvement/Quality Assurance (QI/QA) Program

D.1. Leadership and Accountability
D.2. QI/QA Policies and Procedures
D.3. QI/QA Plan and Process to Evaluate Performance

Focus Area: Governing Board

E.1. Composition Recruitment

Key Elements of the Project Work Plan

1. Focus Area: Applicants may choose a focus area based on the list above or provide a different focus area based on the action steps necessary to achieve the required operational status.

2. Goal: For each Focus Area, provide at least one goal. Goals should describe measureable results.

3. Key Action Steps: Identify the action steps that must occur to accomplish each goal. For each goal, provide at least one action step. For each action step, identify at least one person/area responsible and time frame.

4. Person/Area Responsible: Identify who will be responsible and accountable for carrying out each action step.

5. Time Frame: Identify the expected time frame for carrying out each action step.

6. Comments: Provide supplementary information as desired.

A sample Implementation Plan is provided on the SAC technical assistance Web site at http://www.hrsa.gov/grants/apply/assistance/sac.