

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

Bureau of Primary Health Care  
Health Center Program

***New Access Points***

**Announcement Type:** New and Competing Supplement/Revision

**Funding Opportunity Announcement Number:** HRSA-17-009

**Catalog of Federal Domestic Assistance (CFDA) No. 93.527**

**FUNDING OPPORTUNITY ANNOUNCEMENT**

Fiscal Year 2017

**Application Due Date in Grants.gov: June 17, 2016**  
**Supplemental Information Due Date in HRSA EHBs: July 15, 2016**

*Ensure SAM and Grants.gov registrations and passwords are current immediately!*  
*Deadline extensions are not granted for lack of registration.*  
*Registration in all systems, including SAM.gov and Grants.gov,*  
*may take up to one month to complete.*

**Release Date: April 18, 2016**

**Issuance Date: April 18, 2016**

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<http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP>

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

## EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Bureau of Primary Health Care is accepting applications for fiscal year (FY) 2017 Health Center Program New Access Points (NAP). The purpose of this funding is to support new service delivery sites under the Health Center Program to provide comprehensive primary health care services to underserved and vulnerable populations.

Funding Opportunity Title:	New Access Points (NAP)
Funding Opportunity Announcement Number:	HRSA-17-009
Due Date for Applications – Grants.gov:	June 17, 2016
Due Date for Supplemental Information – EHBs:	July 15, 2016
Anticipated Total Annual Available Funding:	\$50,000,000
Estimated Number and Type of Awards:	Approximately 75 awards
Estimated Award Amount:	Up to \$650,000 per year
Cost Sharing/Match Required:	No
Project Period:	January 1, 2017 through December 31, 2018 (two years)
Eligible Applicants:	<p>Eligible applicants must be public or nonprofit private entities, including tribal, faith-based, and community-based organizations. Applicants may not apply on behalf of another organization.</p> <p>Applicants must propose a new access point that:</p> <ol style="list-style-type: none"><li>Provides comprehensive primary medical care as its primary purpose.</li><li>Provides services, either directly onsite or through established arrangements, without regard to ability to pay.</li><li>Ensures access to services for all individuals in the service area/target population.</li><li>Provides services at one or more permanent service delivery sites.</li></ol> <p>See <a href="#">Section III-1</a> of this funding opportunity announcement (FOA) for complete eligibility information, including exclusions.</p>

### Application Guide

All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 Two-Tier Application Guide*, available online at <http://www.hrsa.gov/grants/apply/applicationguide/sf424programspecificappguide.pdf>, except

where instructed in this FOA to do otherwise. A short video for applicants explaining the *Application Guide* is available at <http://www.hrsa.gov/grants/apply/applicationguide/>.

### **Summary of Changes**

- Award recipients were previously referred to as “grantees” in past funding opportunity announcements.
- Applicants must provide a verifiable street address for each proposed site on Form 5B: Service Sites.
- Legislatively-mandated Public Housing Primary Care requirements were added to the eligibility criteria.
- In the Collaboration section of the Project Narrative, applicants must describe collaboration with veterans and veteran-serving organizations, as applicable.
- In the Response section of the Project Narrative, applicants must describe how the NAP project is appropriate for the number of projected patients.
- The threshold for attaining Unserved, High Poverty Population funding priority was shifted to further prioritize the establishment of NAP sites in areas that are not currently served by the Health Center Program.
- Form 1A: General Information Worksheet has been revised to streamline data reporting and collect the patient projection by December 31, 2018. Patient projection goals are aligned with the end of a calendar year to enable HRSA to monitor progress toward those goals via annual Uniform Data System (UDS) reporting. See [Appendix A](#) for instructions.
- Form 2: Staffing Profile will no longer collect salary or federal funding data to reduce duplication with the Budget Justification Narrative. Fields have been added to collect information on use of contracted staff.
- Because comprehensive primary medical care is the main purpose of the NAP project, Form 5A: Services Provided must indicate that the applicant will provide General Primary Medical Care at the NAP site either directly by the health center (Column I) and/or through formal written contractual agreements in which the health center pays for the service (Column II).
- Form 6B: Request for Waiver of Board Member Requirements has been added to enable special populations-only applicants to request a waiver of the 51 percent patient majority governance requirement, if needed.
- Form 8: Health Center Agreements was streamlined.
- Competing supplement (satellite) applicants are no longer required to re-submit Articles of Incorporation.
- The Clinical and Financial Performance Measures establish goals to be achieved by December 31, 2018. Goals are aligned with the end of a calendar year to enable HRSA to monitor progress toward those goals via annual UDS reporting.
- To align with Uniform Data System updates, two performance measures have been added, three have been discontinued, and two have been revised. See [Appendix B](#) for details.
- Satellite applicants will not receive a NAP award if they propose the same site(s) funded in July 2016 through the Oral Health Service Expansion funding opportunity.

### **Technical Assistance**

HRSA will hold a pre-application technical assistance (TA) webinar for applicants seeking funding through this opportunity. The webinar will provide an overview of pertinent information in the FOA. Visit the New Access Points TA Web site at

<http://bphc.hrsa.gov/programopportunities/fundingopportunities/nap/> for webinar details, frequently asked questions, sample documents, and additional resources. Refer to <http://www.hrsa.gov/grants/apply> for general (i.e., not NAP-specific) videos and slides on a variety of application and submission topics.

**Other Federal Benefits**

Applicants are reminded that receipt of Health Center Program funds, while a basis for eligibility, does not, of itself, confer such federal benefits as Federal Tort Claims Act (FTCA) coverage or FQHC reimbursement, both of which depend upon compliance with applicable requirements in addition to the award of Health Center Program funding. For more information about the FTCA Health Center Program and its requirements, refer to the [FTCA Health Center Program Policy Manual](#) (as updated).

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PUBLIC BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 285. Public reporting burden for the applicant for this collection of information is estimated to average 100 hours, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Rockville, Maryland, 20857

# **I. Program Funding Opportunity Description**

## **1. Purpose**

This announcement solicits applications for Fiscal Year (FY) 2017 New Access Points (NAP) funding. The purpose of this Health Center Program funding is to provide operational support for new access points that deliver comprehensive primary health care services to underserved and vulnerable populations.

For purposes of this funding opportunity announcement (FOA), a new access point is a new, full-time, permanent service delivery site<sup>1</sup> for the provision of comprehensive primary and preventive health care services.<sup>2</sup> New access points improve the health status and decrease health disparities of medically underserved and vulnerable populations and address barriers to affordable and accessible primary health care services for a specific population and/or community. Applicants may submit a request for federal support to establish a single new access point or multiple access points in a single NAP application, with the understanding that all proposed access points must be open and operational within 120 days of Notice of Award.

For the purposes of this document, the term “health center” refers to all health centers authorized by section 330 of the PHS Act, as amended [i.e., Community Health Center (CHC – section 330(e)), Migrant Health Center (MHC – section 330(g)), Health Care for the Homeless (HCH – section 330(h)), and Public Housing Primary Care (PHPC – section 330(i))]. Applicants may request funding to serve one or multiple population types (i.e., CHC, MHC, HCH, PHPC) within a single application (e.g., an applicant proposing to serve both the general community and homeless individuals can submit a NAP application requesting both CHC and HCH funding).

## **Program Requirements**

Applicants must demonstrate that the new access point(s) will increase access to comprehensive, culturally competent, quality primary health care services and improve the health status of underserved and vulnerable populations in the service area. In addition, applicants must document a high level of unmet need within their service area and target population, a sound plan to meet this need, and readiness to implement the proposed plan. Further, applicants must demonstrate that the plan maximizes collaborative and coordinated delivery systems for the provision of health care to the underserved.

All applicants must demonstrate the following NAP funding requirements:

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<sup>1</sup> For site definitions, see PIN 2008-01 available at <http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin2008-01.pdf>.

<sup>2</sup> Comprehensive primary and preventive health care services include all the services required by section 330 of the PHS Act. See the [Service Descriptors for Form 5A: Services Provided](http://bphc.hrsa.gov/programrequirements/scope.html) at <http://bphc.hrsa.gov/programrequirements/scope.html> for descriptions of all services (required services are described on pages 6-18).

- **Compliance** with Health Center Program requirements at the time of application or a detailed plan demonstrating the necessary actions to become compliant within 120 days of the Notice of Award. See [Appendix E](#) for a summary of the Health Center Program requirements or visit <http://bphc.hrsa.gov/about/requirements/index.html>. In addition, the following compliance requirements apply based on the NAP funding requested/populations targeted.

*Community Health Center (CHC) Applicants:*

- Ensure compliance with section 330(e) and program regulations.
- 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 (MHC) Applicants:*

- Ensure compliance with section 330(g), section 330(e), and, as applicable, program regulations.
- 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.
  - *Migratory agricultural workers* are individuals who are principally employed in agriculture and who establish temporary housing for the purpose of this work, including those individuals who have had such work as their principal employment within 24 months as well as their dependent family members. Agricultural workers who leave a community to work elsewhere are classified as migratory workers in both communities. Aged and disabled former agricultural workers should also be included in this group.
  - *Seasonal agricultural workers* are individuals employed in agriculture on a seasonal basis who do not establish a temporary home for purposes of employment, including their family members.
  - *Agriculture* means farming in all its branches, as defined by the OMB-developed North American Industry Classification System (NAICS) under the following codes and all sub-codes within – 111, 112, 1151, and 1152.

*Health Care for the Homeless (HCH) Applicants:*

- Ensure compliance with section 330(h), section 330(e), and, as applicable, program regulations.
- Provide a plan that ensures the availability and accessibility of required primary and preventive health services to people experiencing homelessness in the service area, defined as patients who lack housing, including residents of permanent supportive housing, transitional housing, or other housing programs that are targeted to homeless populations.<sup>3</sup> Such plan may also allow continuing services for up to 12 months to individuals no longer homeless as a result of becoming a resident of permanent housing.
- Provide substance abuse services.

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<sup>3</sup> See the [2015 UDS Manual](#) for examples of shelter arrangements.



*Public Housing Primary Care (PHPC) Applicants:*

- Ensure compliance with section 330(i), section 330(e), and, as applicable, program regulations.
  - 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 agency-developed, owned, or assisted low-income housing, including mixed finance projects, but not public housing that is only subsidized through Section 8 housing vouchers.
  - Consult with residents of the proposed public housing sites regarding the planning and administration of the program.
- Evidence that the proposed new access point(s) will serve populations in **high need, underserved areas**. The Need for Assistance (NFA) Worksheet (see instructions in [Appendix A](#) for Form 9) will demonstrate relative need for primary health care services. A medically underserved area is evidenced by a shortage of accessible health services for the population to be served.
- Evidence of how the proposed project will **increase access to primary health care services** in the community and population to be served. The applicant must demonstrate how Health Center Program funds will expand services and increase the number of people served through the establishment of a permanent, full-time service delivery site (i.e., a site that is not currently part of any Health Center Program award recipient's scope of project, as identified on [Form 5B](#): Service Sites) and projection of new patients to be served (as specified on [Form 1A](#)).
- Evidence that **all persons in the target population will have access to the full range of required primary, preventive, and enabling health care services**, either directly onsite or through established arrangements without regard to ability to pay (as documented in [Form 5A](#): Services Provided, and throughout the application).
- Evidence of the development of **collaborative and coordinated delivery systems** for the provision of health care to the underserved through the demonstration of current or proposed partnerships and collaborative activities (based on the Collaboration section of the Project Narrative and letters of support).
- **A sound and complete plan** that demonstrates responsiveness to the identified health care needs of the target population(s), appropriate short- and long-term strategic planning, coordination with other providers of care, organizational capability to manage the proposed project, and cost-effectiveness in addressing the health care needs of the target population (as documented in the Project Narrative, and throughout the application).
- **A reasonable, appropriate budget** based on the activities proposed in the application and the number of individuals to be served. If services are already provided through the

proposed sites, the budget must demonstrate how Health Center Program funds will expand primary health care service capacity to currently underserved populations.

- **Readiness to initiate the proposed project plan.** Applicants must demonstrate in [Attachment 2](#): Implementation Plan and throughout the application how **all** new access point(s) will be operational and providing services within 120 days of the Notice of Award. At a minimum, within 120 days of the Notice of Award, awarded organizations must be able to demonstrate the following:
  - (1) Each proposed facility is operational and has begun providing services for the proposed population/community,
  - (2) Providers are available to serve patients at each proposed new access point, and
  - (3) The health center is compliant with all Health Center Program requirements (see [Appendix E](#)).

Failure to meet these NAP funding and Health Center Program requirements may jeopardize Health Center Program funding per [45 CFR§75.371](#). Award recipients are routinely assessed for compliance. When an issue is identified (e.g., an organization fails to become operational at all sites in 120 days), HRSA will place a program condition on the award and move the award into progressive action. The progressive action process provides a time-phased approach for resolution of compliance issues. If an organization fails to successfully resolve conditions via progressive action, HRSA may withdraw support through cancellation of all or part of the award. For more information, see [Program Assistance Letter 2014-08](#): Health Center Program Requirements Oversight.

## 2. Background

This program is authorized by Section 330 of the Public Health Service Act, as amended (42 U.S.C. 254b). The source of funding for this opportunity is the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10).

Health Center Program awards 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. Targeting the Nation's neediest populations and geographic areas, the Health Center Program currently funds nearly 1,400 health centers that operate more than 9,800 service delivery sites in every state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. In 2014, nearly 23 million patients, including medically underserved and uninsured patients, received comprehensive, culturally competent, quality primary health care services through the Health Center Program.

NAP applications may be submitted by new organizations (new start applicants) or by health centers currently receiving Health Center Program operational funding (satellite applicants):

- A **NEW START** applicant is an organization that is not currently a direct recipient of operational funding under the Health Center Program (authorized by section 330(e), (g), (h) and/or (i) of the PHS Act). A new start application should address the entire scope of the project being proposed for NAP funding, which cannot include a service site that is listed in the approved scope of project of any Health Center Program award recipient. A new start can be operational at the time of application, or propose to become operational within 120 days of the Notice of Award. **A current Health Center Program look-alike is considered a new start applicant for purposes of this FOA.**
- A **SATELLITE** applicant is an organization that is currently receiving direct operational funding under the Health Center Program (authorized by section 330(e), (g), (h), and/or (i) of the PHS Act). Satellite applicants must propose to establish a *new* service site that is not listed in the approved scope of project of any Health Center Program award recipient. A satellite application should address **ONLY** the proposed new access point (i.e., only the new site and service area/target population proposed in the NAP satellite application) in terms of need, population to be served, and the proposed health service delivery system.

## II. Award Information

### 1. Type of Application and Award

Type(s) of applications sought: New and Competing Supplement (Revision).

Funding will be provided in the form of a grant.

### 2. Summary of Funding

Approximately \$50,000,000 is expected to be available annually to fund an estimated 75 recipients. Of this total, approximately:

- \$40,750,000 is expected to be available for section 330(e) - CHC applicants,
- \$4,300,000 for section 330(g) – MHC applicants,
- \$4,350,000 for section 330(h) – HCH applicants, and
- \$600,000 for section 330(i) – PHPC applicants.

Applicants may apply for a maximum ceiling amount of up to \$650,000 per year. Of the \$650,000, applicants may request Health Center Program funding up to \$150,000 in Year 1 only for one-time minor capital costs for equipment and/or minor alterations/renovations (see [Appendix C](#)). The project period is January 1, 2017 through December 31, 2018 (two (2) years). Funding beyond the first year is dependent on the availability of appropriated funds for the Health Center Program in subsequent fiscal years, satisfactory award recipient performance, and a decision that continued funding is in the best interest of the Federal Government.

Effective December 26, 2014, all administrative and audit requirements and the cost principles that govern federal monies associated with this award are subject to the Uniform Guidance [2](#)

[CFR part 200](#) as codified by the Department of Health and Human Services (HHS) at [45 CFR part 75](#), which supersede the previous administrative and audit requirements and cost principles that govern federal monies.

### III. Eligibility Information

#### 1. Eligible Applicants

Applicants must meet all of the following eligibility requirements.

- 1) Eligible applicants include public and nonprofit entities. Tribes, tribal organizations, faith-based organizations, and community-based organizations are eligible to apply. Applicant demonstrates current status by submitting proof of nonprofit or public agency status ([Attachment 12](#)).
- 2) Eligible applicants are health centers that provide health services to medically underserved populations, as defined in section 330 of the PHS Act. As such, the applicant must propose a new access point project (across all proposed sites) that:
  - a) Provides comprehensive primary medical care as its main purpose as documented on [Form 1A](#): General Information Worksheet (number of projected medical patients is greater than projected patients for other service types) and [Form 5A](#): Services Provided (General Primary Medical Care is provided directly (Column I) or and/or through formal written contractual agreements in which the health center pays for the service (Column II)).
  - b) Provides services without regard to ability to pay either directly onsite or through established arrangements as documented on [Form 5A](#): Services Provided.
  - c) Ensures access to services for all individuals in the targeted service area or population (e.g., cannot exclusively serve a single age group, racial/ethnic group, or health issue/disease category).
- 3) Eligible applicants must ensure the required primary health services will be available and accessible in the service area. As such, the applicant must propose at least one new access point that is a permanent service delivery site that provides comprehensive primary medical care as its main purpose and operates for a minimum of 40 hours per week (as documented on [Form 5B](#): Service Sites). A permanent site is a fixed building location with a street address listed on Form 5B (e.g., 123 Main Street). Applicants must provide a verifiable street address for each proposed site on Form 5B: Service Sites. A mobile van is not considered a permanent site.
- 4) *NEW START APPLICANTS ONLY*: Applicant proposes to serve a defined geographic area that is federally-designated, in whole or in part, as a Medically Underserved Area (MUA) or Medically Underserved Population (MUP). If the area is not currently federally-designated as an MUA or MUP, the applicant must provide documentation that a request for designation has been submitted; designation must be received prior to a final HRSA FY 2017 NAP funding decision. *Note: If the applicant is requesting funding only for MHC, HCH, and/or*

*PHPC, the applicant is not required to have a MUA/MUP designation for the proposed service area and/or target population. See [Section I.1](#) for definitions of the MHC, HCH, and PHPC populations.*

- 5) **PUBLIC HOUSING PRIMARY CARE APPLICANTS ONLY:** Applicant applying for 330(i) funding demonstrates that it has consulted with the public housing residents in the preparation of the NAP application and will ensure ongoing consultation with the residents regarding the planning and administration of the health center, as documented in the [RESPONSE](#) section of the Project Narrative.

## **2. Cost Sharing/Matching**

Cost sharing/matching is not required 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.

## **3. Other**

Applications that exceed the ceiling amount of \$650,000 as stated in the SF-424A or maximum page limit of 200 pages 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.4](#) will be considered non-responsive and will not be considered for funding under this announcement.

The award 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, is the entity which must provide health services to medically underserved populations, demonstrate compliance with Health Center Program requirements and NAP funding requirements, and meet all eligibility criteria. Applications submitted on behalf of another organization will be considered non-responsive and will not be considered for funding under this announcement.

Applicants must propose to establish a new access point at an address that is not currently a site in the approved scope of project of any Health Center Program award recipient,<sup>4</sup> based on Form 5B: Service Sites. In other words, the application **DOES NOT** propose:

- Funding to support the relocation or consolidation of currently approved sites;
- Expansion of capacity (e.g., additional providers, additional patients, new services, new populations) at any site already in any Health Center Program award recipient's approved scope of project, including those pending verification via Change in Scope or capital development awards (i.e., Capital Development, Building Capacity, Health Infrastructure Investment Program); or

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<sup>4</sup> A current Health Center Program look-alike may propose the site(s) currently included in its Health Center Program look-alike scope of project, as well as new site(s), since look-alike sites are not supported through Health Center Program grant funding.

- A site proposed through an active Change in Scope request or Health Center Program (H80) funding opportunity application at the time of application.

Applications that propose to establish a new access point at an address that is currently a site in the approved scope of project of any Health Center Program award recipient, including sites pending verification, will be considered non-responsive and will not be considered for funding under this announcement. Tools are available to assist applicants in determining current Health Center Program award recipient sites and the location of safety-net service providers in their proposed service area, including the UDS Mapper (<http://www.udsmapper.org>) and Find a Health Center (<http://findahealthcenter.hrsa.gov>).

Because applicants must ensure access to services for all individuals in the targeted service area or population, applicants may not propose to establish a school-based health center as a NAP site **unless** it meets the following criteria:

- The school-based health center is a permanent, full time site that provides all required primary and preventive health care services to students of the school as well as the general underserved population in the service area without regard for ability to pay; OR
- The school-based health center is proposed in addition to a permanent, full time site that provides comprehensive primary health care, as proposed on Form 5B in the NAP application.

Applications proposing school-based health centers that do not meet the listed criteria will be considered incomplete or non-responsive and will not be considered for funding under this announcement.

Applicants may not propose a mobile van as the only new access point. A mobile van may be proposed only if a permanent, full-time site is also proposed on Form 5B: Service Sites in the NAP application. A permanent site is a fixed building location. A mobile van must be affiliated with a location setting (i.e., the proposed permanent service site), and be fully equipped and staffed by health center clinicians providing direct primary care services. Applications proposing to expand the operation of an existing mobile van within the current scope of project (e.g., add new providers or services, expand hours of operation at current locations) or proposing a mobile van as the only new access point will be considered non-responsive and will not be considered for funding under this announcement.

The Project Narrative must be organized by section headers with the requested information appearing in the appropriate section of the Project Narrative or the designated forms and attachments. An application that fails to address the required elements within each of the following five Project Narrative sections will be considered incomplete or non-responsive and will not be considered for funding under this announcement: Need, Response, Collaboration, Resources/Capabilities, and Governance.

NOTE: Multiple applications from an organization are not allowable.

HRSA will only accept an applicant's first validated electronic submission, under the correct funding opportunity number, in Grants.gov. Applications submitted after the first submission will be marked as duplicates and considered ineligible for review. Applicants wishing to change



information submitted in a Grants.gov application may do so in the HRSA Electronic Handbooks (HRSA EHBs) application phase.

## **IV. Application and Submission Information**

### **1. Address to Request Application Package**

HRSA *requires* applicants for this FOA to apply electronically through Grants.gov and HRSA EHBs. Applicants must use a two-tier submission process associated with this FOA and follow the directions provided at Grants.gov and HRSA EHBs.

- **Phase 1 – Grants.gov** – Required information must be submitted via Grants.gov with a due date of June 17, 2016 at 11:59 P.M. Eastern Time.
- **Phase 2 – HRSA EHBs** – Required supplemental information must be submitted via HRSA EHBs with a due date of July 15, 2016 at 5:00 P.M. Eastern Time.

**Only applicants that successfully submit an application in Grants.Gov (Phase 1) by the due date may submit the required additional information in HRSA EHB (Phase 2).**

### **2. Content and Form of Application Submission**

#### **Application Format Requirements**

Applicants must download the Standard Form 424 (SF-424) application package associated with HRSA-17-009 at Grants.gov. Section 5 of HRSA's [\*SF-424 Two-Tier Application Guide\*](#) provides instructions for the SF-424, budget, budget justification narrative, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the Application Guide in addition to the program specific information below. All 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 FOA to do otherwise.

The following application components must be submitted in Grants.gov:

- Application for Federal Assistance (SF-424)
- Project Abstract (attached under box 15 of the SF-424)
- Assurances for Non-Construction Programs (SF-424B)
- Project/Performance Site Locations
- Grants.gov Lobbying Form

The following application components must be submitted in HRSA EHBs:

- Project Narrative
- Budget Information – Non-Construction Programs (SF-424A)
- Budget Justification Narrative
- Funding Opportunity-Specific Forms
- Attachments

See Section 9.4 of the [Application Guide](#) for the Application Completeness Checklist.

### **Application Page Limit**

The total size of all uploaded files may not exceed the equivalent of **200 pages** when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, letters of commitment and support, and implementation plan. Standard OMB-approved forms that are included in the application package and program-specific forms completed in EHB are NOT included in the page limit. The independent financial audit, indirect cost rate agreement, and proof of non-profit or public status (if applicable) will not be counted in the page limit. **We strongly urge applicants to take appropriate measures to ensure the application does not exceed the specified page limit.**

**Applications must be complete, within the specified page limit, validated by Grants.gov, and submitted under the correct funding opportunity prior to the Grants.gov and HRSA EHBs deadlines to be considered under this announcement.**

### **Funding Opportunity-Specific Instructions**

In addition to application requirements and instructions in Section 4 and 5 of HRSA's [SF-424 Two-Tier Application Guide](#) (including the budget, budget justification narrative, staffing plan and personnel requirements, assurances, certifications, and abstract), include the following.

#### **i. *Application for Federal Assistance SF-424***

See Section 3.2 of HRSA's [SF-424 Two-Tier Application Guide](#). In addition, it is critical that applicants correctly identify their application type as one of the following:

- New Start: An organization that does not currently receive Health Center Program operational funding. Select "New" on Application Form SF-424.
- Satellite: An organization that currently receives Health Center Program operational funding. Check the "Revision" box, select "Other (specify)" in the dropdown menu, and type Supplement and the H80 grant number (H80CSXXXXX) in the Other (Specify) text box.

#### **ii. *Project Abstract***

See Section 5.1 of HRSA's [SF-424 Two-Tier Application Guide](#). In addition, the abstract must describe:

- A brief overview of the organization, the community to be served, and the target population.
- How the proposed project will address the need for comprehensive primary health care services in the community and target population.
- Number of proposed new patients, visits, and providers; proposed service delivery sites and locations; and services to be provided.



### iii. *Project Narrative*

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory, and well organized so that reviewers can understand the proposed project.

A **NEW START** applicant must ensure that the Project Narrative reflects the entire proposed scope of project (all of the proposed service area, populations, providers, services, and sites).

A **SATELLITE** applicant must ensure that the Project Narrative reflects **ONLY** the scope of project **for the proposed new access point(s)**. However, reference may be made in the Project Narrative to current sites, services, policies, procedures, and capacity as they **specifically** relate to the new access point(s) (e.g., experience, transferrable procedures).

The Project Narrative must be structured using each of the following seven sections and include the requested information.

***NEED – Corresponds to Section V.1 Criterion 1: NEED***

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

- 1) Using current, relevant data, describe the characteristics of the target population and the proposed service area through the following:
  - Complete [Form 9](#): Need for Assistance Worksheet (see [Appendix A](#)).
  - Describe the following factors and how they impact access to primary health care, health care utilization, and health status, citing data resources, including local target population needs assessments when available:
    - a) Geographical/transportation barriers (consistent with [Attachment 1](#)).
    - b) Unemployment, income level, and/or literacy.
    - c) Lack of insurance coverage.
    - d) Health disparities.
    - e) Any unique health care needs of the target population (e.g., black lung disease, lyme disease).
    - f) Cultural/ethnic factors, including language barriers (consistent with [Form 4](#)).
- 2) **Applicants requesting special population funding** (see [Section I.1](#) for definitions of MHC, HCH, and PHPC) to serve migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing: Describe the specific health care needs and access issues of the proposed special population(s), using data **specific to the proposed service area and target population**.
  - a) Migratory and Seasonal Agricultural Workers needs/access issues, including agricultural environment (e.g., crops and growing seasons, demand for labor, number of temporary workers), approximate period(s) of residence of migratory workers and their families, availability of local providers to provide primary care services during these times, and

- occupation-related factors (e.g., working hours, housing, hazards including pesticides and other chemical exposures).
- b) People Experiencing Homelessness needs/access issues (e.g., the number of providers treating people experiencing homelessness and availability of homeless shelters and affordable housing).
  - c) Residents of Public Housing needs/access issues (e.g., the availability of public housing and the availability of accessible providers for residents in the targeted public housing communities).
- 3) Describe other primary health care services currently available in the service area (consistent with [Attachment 1](#)), including whether they also serve the applicant's target population.
    - Specifically list existing Health Center Program award recipients, look-alikes, rural health clinics, critical access hospitals, and other major primary care providers serving the proposed zip codes, including the location and proximity to the proposed new access point(s), referencing [Attachment 1](#).
    - Indicate the extent to which the target population is currently served by the Health Center Program (reference the Health Center Program penetration percentages on the table provided in [Attachment 1](#): Service Area Map and Table).
    - Justify the need for new or additional Health Center Program support by highlighting service gaps that the proposed new access point(s) will fill.
  - 4) Describe the health care environment and any significant changes that have affected the availability of health care services, including:
    - a) Changes in insurance coverage, including Medicaid, Medicare, and Children's Health Insurance Program (CHIP). Specifically discuss changes that have resulted from Affordable Care Act implementation.
    - 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).
    - e) Changes affecting special populations.
  - 5) Describe any statewide or regional strategic planning that has identified primary care needs in the proposed service area.

***RESPONSE – Corresponds to Section V.1 Criterion 2: RESPONSE***

- 1) As [Attachment 2](#) (see [Appendix D](#)), provide a comprehensive and realistic plan that outlines steps to ensure full program compliance<sup>5</sup> within 120 days of the Notice of Award by:
  - Detailing the action steps the applicant will take to ensure that within 120 days of the Notice of Award, all proposed site(s) on Form 5B: Service Sites will:

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<sup>5</sup> For health centers that are currently operational and compliant with program requirements, the Implementation Plan should demonstrate the new access point's compliance with program requirements and highlight changes in access to care, service expansion and outreach, new collaborations/partnerships, and any other changes that are expected to occur for each new access point within 120 days of the Notice of Award.

- a) Be open and operational.<sup>6</sup>
- b) Have appropriate staff and providers in place.
- c) Begin to deliver services as proposed (consistent with [Form 5A](#) and [Form 5C](#)) to the target population.
- Describing appropriate and reasonable time-framed tasks (i.e., developing operational policies/procedures; applying for FQHC reimbursement billing numbers; formalizing referral agreements; provider/staff recruitment and retention; facility development/operational planning; information system acquisition/integration; risk management/quality assurance procedures; governance) that ensure compliance with Health Center Program requirements (see [Appendix E](#)). Reference relevant documentation (e.g., renovation plans, provider contracts and/or agreements, provider commitment letters) as needed.

**Note:** While alteration/renovation and/or equipment purchases may extend beyond the 120-day timeframe, all sites must be open and operational within 120 days of award.

Include in the project narrative a table (consistent with the Implementation Plan) that indicates where within the application, compliance with the following Health Center Program requirements has been addressed. The table should indicate if the health center is currently compliant with Health Center Program requirements and where compliance with each requirement is described in the application. If the health center is currently NOT compliant with Health Center Program requirements, the table should indicate that the planned actions to become compliant are included in the Implementation Plan.

<b>Program Requirement</b>	<b>Currently Compliant (Indicate Where in Application Compliance is Described)</b>	<b>Planned Actions to Become Compliant Included in Implementation Plan</b>
Needs Assessment		
Required and Additional Services		
Staffing for Health Services		
Accessible Hours of Operation/Locations		
After Hours Coverage		
Hospital Admitting Privileges and Continuum of Care		
Sliding Fee Discounts		
Quality Improvement/Assurance Plan		
Key Management Staff		
Contractual/Affiliation Agreements		

<sup>6</sup> The requirement to be open and operational within 120 days means that services and providers must be available for the proposed patients/population at the new access point(s) no later than 120 days post-award to avoid progressive action.

<b>Program Requirement</b>	<b>Currently Compliant (Indicate Where in Application Compliance is Described)</b>	<b>Planned Actions to Become Compliant Included in Implementation Plan</b>
Collaborative Relationships		
Financial Management and Control Policies		
Billing and Collections		
Budget		
Program Data Reporting Systems		
Board Authority		
Board Composition		
Conflict of Interest Policy		

- 2) On [Form 1A](#), under Unduplicated Patients and Visits by Population Type, provide goals for the estimated new patients projected to be served at the proposed NAP site(s) for the calendar year ending December 31, 2018. Describe how the NAP project is appropriate for the number of projected patients, particularly the number of unduplicated projected patients (which will be added to the Patient Target for satellite applicants).
  
- 3) Describe the service delivery model(s) proposed to address health care needs identified in [NEED](#) section and how these model(s) are appropriate and responsive to identified health care needs, including specific needs of any special populations for which funding is sought (migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing). The description must address the following:
  - a) Site(s)/location(s) and service area where services will be provided (consistent with [Attachment 1](#), [Form 5B](#), and [Form 5C](#)).
  - b) Service site type (e.g., permanent, seasonal) for each site (consistent with [Form 5B](#)), with at least one permanent site.
  - c) Hours of operation, including how scheduled hours will assure services are accessible and available at times that meet the target population's needs, with at least one delivery site operating 40 or more hours per week (consistent with [Forms 5B](#) and [5C](#)).
  - d) Professional after-hours care/coverage during hours when service sites or locations are closed.
  - e) For all proposed NAP sites that are currently operational, including Health Center Program look-alike sites, provide the current number of patients and describe how NAP funding and related benefits, such as medical malpractice insurance through the Federal Tort Claims Act (FTCA) would allow the organization to increase the number of patients served.
  - f) For Public Housing Primary Care (PHPC) applicants, explain ongoing consultation with residents regarding the planning and administration of the health center.
  
- 4) Describe how proposed primary health care services (consistent with [Form 5A](#)) and other activities (consistent with [Form 5C](#)) are appropriate for the target population's needs. Description must include:

- a) Provision of required and additional clinical and non-clinical services, including whether these are provided directly or through established written arrangements and referrals (consistent with [Attachment 7](#)). **Note:** Required services are listed as such on Form 5A and in [Service Descriptors for Form 5A: Services Provided](#).
  - b) How the following special populations' criteria will be met, if applicable: Health Care for the Homeless (HCH) applicants must document how substance abuse services will be made available either directly or via a formal written referral arrangement. Migrant Health Center (MHC) applicants must document how they will address any occupational health or environmental health hazards or conditions identified in the [NEED](#) section. Public Housing Primary Care (PHPC) applicants must document that the service plan was developed in consultation with residents of the targeted public housing. (Reminder: This is an eligibility criterion).
  - c) How services will be culturally and linguistically appropriate.
  - d) Method by which enabling services such as case management, outreach, and transportation are integrated into the primary health care delivery system, as well as any translation services for serving limited English proficiency population(s). Highlight enabling services designed to increase access for targeted special populations, if any.
- 5) Describe how the service delivery model(s) assures continuity of care and access to a continuum of care. The description must address:
- a) Continuity of care, including 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, include formal arrangement(s) with one or more hospitals to ensure continuity of care (consistent with [Attachment 7](#)).
  - b) A seamless continuum of care, including discharge planning, post-hospitalization tracking, patient tracking (e.g., shared electronic health records), and referral relationships for specialty care (including relationships with one or more hospitals), with an emphasis on working collaboratively to meet local needs.
- 6) Describe the proposed clinical team staffing plan (consistent with [Form 2](#) and the [budget justification narrative](#)), include 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 written arrangements and referrals (consistent with [Form 5A](#) and [Attachment 7](#)).
- Note:** Contracted providers (current and proposed) should be included in [Attachment 7](#). If a contract/agreement for core primary care providers is for a substantial portion of the proposed scope of project, include contract/agreement as an attachment to [Form 8](#).
- 7) Describe how the established schedule of charges is board-approved, consistent with locally prevailing rates, and designed to cover the reasonable costs of operation (consistent with [Form 5A](#)).

- 8) Describe the sliding fee discount schedule(s) (consistent with [Attachment 11](#) and [PIN 2014-02: Sliding Fee Discount and Related Billing and Collections Program Requirements](#)), including:
- a) The process used 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) How the sliding fee discount schedule(s):
    - Are applied only for individuals and families with an annual income at or below 200 percent of the poverty rate according to the most current Federal Poverty Guidelines (available at <http://aspe.hhs.gov/poverty>).
    - Provide a full discount (no charge) or only a nominal charge for individuals and families with an annual income at or below 100 percent of the poverty rate.
  - d) How any nominal charges are determined. (Nominal charges may be collected from patients at and below 100 percent of the poverty rate only if a nominal charge is consistent with project goals and **does not** pose a barrier to receiving care.)
  - e) How often the governing board reviews and updates the sliding fee discount schedule(s) to reflect most recent Federal Poverty Guidelines.
  - f) How often the governing board evaluates and updates policies and procedures supporting implementation of the sliding fee discount schedule(s).
  - g) 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).
  - h) How the applicant ensures that services that are provided by a formal written contract/agreement (where the applicant will pay for the service) will be included under the applicant's sliding fee discount schedule(s).
  - i) How the applicant ensures that services that are provided by a formal written referral arrangement/agreement (consistent with [Attachment 7](#)) are included under a sliding fee discount schedule that meets Health Center Program requirements (items (b), (c), (d), and (g)).
- 9) Describe the organization's quality improvement/quality assurance (QI/QA) program, including:
- a) Accountability and communication throughout the organization for systematically improving the provision of quality health care, including a clinical director whose responsibilities clearly include oversight of the QI/QA program.
  - b) The process and parties responsible for developing and updating board-approved QI/QA policies and procedures.
  - c) The process and parties responsible to ensure that all providers (e.g., employed, contracted, volunteers, locum tenens) have appropriate credentials and are privileged to perform proposed services (consistent with [Form 5A](#)) at proposed sites/locations, including methodologies for verifying current clinical competence (e.g., peer review).
  - d) Processes for hearing and resolving patient grievances and incident reporting and management.
  - e) Monitoring the impact of services on the health outcomes of the target population.
  - f) Maintenance of confidentiality of patient records throughout the continuum of care.
  - g) Periodic assessment of the appropriateness of service utilization, quality of services delivered, and patient outcomes, conducted by physicians or other licensed health



professionals under the supervision of physician, including methodologies for the systematic evaluation of patient records to identify areas for improvement in documentation of services provided either directly or through referral.

- h) Use of appropriate information systems (e.g., electronic health records, payment management systems) for analyzing key performance data, including data necessary for 1) improving health outcomes and 2) tracking of diagnostic tests and other services provided to health center patients to ensure appropriate follow up and documentation in patient record.
- i) Use of QI results to improve performance.

**Note:** Clinical directors may be full or part-time staff and must have appropriate credentials (e.g., MD, RN, PA) to support the QI/QA program as determined by needs and size of the health center.

- 10) Describe current or proposed efforts to ensure access to health care including facilitation of enrollment in affordable health insurance options, including the Marketplace, Medicaid, and CHIP. Specifically describe how potentially-eligible individuals will be identified and informed of the insurance options; what type of assistance will be provided for determining eligibility; and what type of assistance will be provided to facilitate the relevant enrollment process.

#### ***COLLABORATION – Corresponds to Section V.1 Criterion 3: COLLABORATION***

- 1) Describe both formal and informal collaboration and coordination of services<sup>7</sup> with other health care providers and community organizations. Specifically describe collaboration and coordination with the following:
  - a) Existing health centers (Health Center Program award recipients and look-alikes)
  - b) Rural health clinics
  - c) Critical access hospitals
  - d) Other federally-supported award recipients (e.g., Ryan White programs, Title V Maternal and Child Health programs)
  - e) Health departments
  - f) Private primary care providers
  - g) Programs serving the same target population (e.g., social services; job training; Women, Infants, and Children (WIC); community groups; school districts) and, if applicable, special population(s) for which funding is sought (e.g., Public Housing Authority, homeless shelters)
  - h) If applicable, veterans service organizations, US Department of Veterans Affairs (VA), Veteran's Health Administration community based outpatient clinics, VA medical centers, and other local veteran-serving organizations.
  - 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

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<sup>7</sup> Refer to <http://bphc.hrsa.gov/programrequirements/policies/pal201102.html> for information on maximizing collaborative opportunities.

Innovation Program. If a neighborhood within your service area has been designated as a [Promise Zone](#) or named a [Strong Cities, Strong Communities](#) location, discuss how you will collaborate with these efforts (see [http://portal.hud.gov/hudportal/HUD?src=/program\\_offices/comm\\_planning/economicdevelopment/programs/pz](http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/economicdevelopment/programs/pz) and <https://www.huduser.gov/portal/sc2/home.html>).

**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<sup>8</sup> that reference specific coordination or collaboration from all of the following in the service area or within close proximity of the proposed new access point site(s):
  - a) Health centers (Health Center Program award recipients and look-alikes)
  - b) Rural health clinics
  - c) Critical access hospitals
  - d) Local health departments
  - e) Private primary care provider groups serving low income and/or uninsured populations
  - f) Other community organizations (e.g., social service organization, school, homeless shelter)

Letters of support should be consistent with providers shown on [Attachment 1](#). If such providers/organizations do not exist in the service area, state this. If such letters cannot be obtained from providers/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) Document support for the proposed project through a current dated letter of support from relevant State public agencies:
  - a) State health departments/state primary care offices
  - b) State Medicaid agencies

If such letters cannot be obtained, include documentation of efforts made to obtain the letters and an explanation why it could not be obtained.

**Note:** Merge all letters of support into a single document and submit it as [Attachment 10](#).

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<sup>8</sup> 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. Letters of support that are not submitted with the application will not be considered by the objective review committee.



***EVALUATIVE MEASURES – Corresponds to Section V.1 Criterion 4: EVALUATIVE MEASURES***

- 1) Complete the Clinical Performance Measures form for all 16 required measures (see detailed instructions in [Appendix B](#)). Goals should be responsive to the needs identified in the **NEED** section. Specifically include:
  - a) Goals for improving quality of care and health outcomes.
  - b) Key factors anticipated to contribute to and restrict progress toward the stated performance measure goals, and action steps planned for addressing described factors.
  - c) Goals relevant to the needs of migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing for applicants seeking targeted special population funding. An applicant that is not requesting targeted funding but currently serves or plans to serve special population(s) is encouraged to include relevant goals reflecting the needs of these populations.
- 2) Complete the Financial Performance Measures form for the three required measures (see detailed instructions in [Appendix B](#)). Specifically include:
  - a) Goals for improving the organization’s financial performance.
  - b) Key factors anticipated to contribute to and restrict progress toward the stated performance measure goals, and action steps planned for addressing described factors.
- 3) Describe the organization’s process for periodic assessment of the health care needs of the target population to inform and improve the delivery of health care service, including:
  - a) The frequency of assessments and when the last assessment occurred.
  - b) Community engagement.
  - c) Assessment tools and methods, including cultural and linguistic appropriateness.
  - d) Analysis and dissemination of results to board members, health center staff, community stakeholders, project partners, and patients.
  - e) How the assessment is incorporated into the organization’s ongoing strategic planning.
- 4) Describe the experience and skills of evaluation staff and the amount of time proposed for staff to perform project evaluation activities.
- 5) Describe how the NAP site’s certified electronic health record (EHR) system will be used for tracking patient and clinical data to achieve meaningful use<sup>9</sup> and improve quality outcomes. For new starts, if the EHR system is not yet functional, outline the plans for full EHR implementation at all NAP sites, by the end of calendar year 2018. For satellites, if the EHR system is not yet functional, outline the plans for full EHR implementation at all NAP (and all other health centers sites), by the end of calendar year 2018.

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<sup>9</sup> Information about meaningful use is available at [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful\\_Use.html](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html).

***RESOURCES/CAPABILITIES – Corresponds to Section V.1 Criterion 5:***  
***RESOURCES/CAPABILITIES***

- 1) Describe how the organizational structure (including any subrecipients) is appropriate for the operational needs of the NAP project (consistent with [Attachments 2](#) and [3](#), and, as applicable, [Attachments 6<sup>10</sup>](#) and [7](#), including how lines of authority are maintained from the governing board to the CEO/Executive Director down through the management structure.
- 2) Describe how the organization maintains appropriate oversight and authority in accordance with Health Center Program requirements over all contracted services, including (as applicable):
  - a) Current or proposed contracts and agreements summarized in [Attachment 7](#).
  - b) Subrecipient arrangements<sup>11</sup> referenced in [Form 8](#).
- 3) Describe how the organization's management team (CEO, CMO, CFO, CIO, and COO, as applicable):
  - a) Is appropriate and adequate for the scope of the proposed project, including operational and program oversight needs.
  - b) Has appropriately defined roles as outlined in [Attachment 4](#).
  - c) Possesses necessary skills and experience for the defined roles as demonstrated in [Attachment 5](#).
- 4) Describe the plan for recruiting and retaining health care providers necessary for achieving the proposed staffing plan for the proposed new access point(s) (consistent with [Form 2](#) and [Attachment 2](#)).
- 5) Describe how the proposed service site(s) (consistent with [Form 5B](#)) are appropriate for implementing the service delivery plan in terms of the projected number of patients and visits (consistent with [Form 1A](#)). Attach floor plans for all proposed sites in [Attachment 13](#). If the site is leased, include lease/intent to lease documents in [Attachment 15](#). If one-time funding for alteration/renovation is proposed, demonstrate that the NAP site(s) will be operational within 120 days of award, regardless of one-time funding activities (consistent with [Attachment 2](#)).

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<sup>10</sup> When a public center has a co-applicant board, the public center and co-applicant board must have a formal co-applicant agreement that stipulates roles, responsibilities, and the delegation of authorities of each party in the oversight and management of the public health center, detailing any shared roles and the responsibilities of each party in carrying out governance functions.

<sup>11</sup> A subrecipient is an organization that receives a subaward from a Health Center Program award recipient to carry out a portion of the grant-funded scope of project. Subrecipients must be compliant with all Health Center Program statutory and regulatory requirements, as well as applicable grant requirements specified in 45 CFR Part 74 or 45 CFR Part 92, as applicable. As a subrecipient of section 330 funding, such organizations are eligible to receive FQHC benefits, including enhanced reimbursement as an FQHC, 340B drug discount pricing, and FTCA coverage. All subrecipient 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 award recipient must demonstrate that it has systems in place to provide reasonable assurances that the subrecipient organization complies with—and will continue to comply with—all statutory and regulatory requirements throughout the period of award.

- 6) Describe expertise in the following areas:
  - a) Working with the NAP target population.
  - b) Developing and implementing systems and services appropriate for addressing the NAP target population's identified health care needs (consistent with [Attachment 2](#)).
- 7) Describe the processes in place to maximize collection of payments and reimbursement for services, including written policies and procedures for billing, credit, and collection.
- 8) 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 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.
- 9) Describe the organization's annual independent auditing process performed in accordance with federal audit requirements and submit the most recent financial audit and management letter (or a signed statement that no letter was issued with the audit) as [Attachment 8](#).<sup>12</sup> Explain any adverse audit findings (e.g., questioned costs, reportable conditions, material weaknesses) and corrective actions that have been implemented to address such findings. Organizations that have been operational for less than one year and do not have an audit may submit monthly financial statements for the most recent six-month period. Organizations that are not yet operational and do not have audit or financial information must provide a detailed explanation of the organization's current financial status, including supporting documentation.
- 10) 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 "No" response on [Form 10](#) must be addressed.

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<sup>12</sup> Award recipients are reminded that the annual audit must be provided to the Federal Audit Clearinghouse as required in [45 CFR Part 75](#).

**GOVERNANCE<sup>13</sup>** – Corresponds to Section V.1 Criterion 6: GOVERNANCE

**Note: Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups should respond ONLY to Item 5 below.<sup>14</sup>**

- 1) Describe how the Corporate Bylaws ([Attachment 14](#)), Articles of Incorporation ([Attachment 9](#)), and/or Co-Applicant Agreement ([Attachment 6](#))<sup>15</sup> demonstrate that the organization has an independent governing board that retains (i.e., does not delegate) the following unrestricted authorities, functions, and responsibilities:
  - a) Meets at least once a month.
  - b) Ensures that minutes documenting the board's functioning are maintained.
  - c) Determines executive committee function and composition.
  - d) Selects the services to be provided.
  - e) Determines the hours during which services will be provided.
  - f) Measures and evaluates the organization's progress and develops a plan for the long-range viability of the organization through: strategic planning and periodic review of the organization's mission and bylaws; evaluating patient satisfaction; monitoring organizational performance; setting organizational priorities; and allocating assets and resources.
  - g) Approves the health center's annual budget, funding applications, and selection, dismissal, and performance appraisal of the organization's CEO.
  - h) Establishes policies to prohibit conflict of interest by board members, employees, consultants, and those who furnish goods or services to the health center.
  - i) 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. Only public center applicants are permitted to establish a separate co-applicant health center governing board that meets all Health Center Program requirements.

- 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:

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<sup>13</sup> For detailed information regarding Health Center Program governance requirements, see Policy Information Notice 2014-01 at <http://bphc.hrsa.gov/programrequirements/policies/pin201401.html>.

<sup>14</sup> Per section 330(k)(3)(H) of the PHS Act, as amended, Health Center Program governance requirements do not apply to health centers operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or urban Indian organizations under the Indian Health Care Improvement Act.

<sup>15</sup> Public center applicants whose board cannot directly meet health center governance requirements are permitted to establish a separate co-applicant health center governing board that meets all the Health Center Program governance requirements. In the co-applicant arrangement, the public center receives the Health Center Program grant and the co-applicant board serves as the health center board. Together, the two are collectively referred to as the health center. The public center and health center board must have a formal co-applicant agreement in place.

- 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<sup>16</sup> that justify the need for a waiver in [Form 6B](#) – see instructions in Appendix A).
- b) As a group, the patient board members reasonably 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 service area and selected for their expertise in any of the following areas: community affairs; local government; finance and banking; legal affairs; trade unions and related organizations; 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.
- 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.

**Note:** An applicant requesting funding to serve general community (CHC) AND special populations (MHC, HCH, and/or PHPC) must have appropriate board representation. At minimum, there must be at least one representative from/for each of the special population group for which funding is requested. Board members representing a special population should be individuals who can clearly communicate the target population's needs/concerns (e.g., advocate for migratory and seasonal agricultural workers, former 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/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 training, development, and orientation for new board members to ensure that they have sufficient knowledge to make informed decisions regarding the strategic direction, general policies, and financial position of the organization.
- 4) **Applicants with a co-applicant or parent/affiliate/subsidiary:** Describe how this organizational structure/relationship does not impact or restrict the applicant's governing board composition and/or required authorities (reference Attachment 2: Corporate Bylaws and other attachments as needed), including:
  - a) Selection of the board chairperson, a majority of board members (both patient and non-patient), and Executive Committee members.
  - b) Selection or dismissal of the CEO, including arrangements that combine this position with other key management positions.

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<sup>16</sup> 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.

- c) Ensuring that no outside entity has the authority to override board approval (e.g., dual or super-majority voting, prior approval process, veto power, final approval).

**Note:** Upon award, the **applicant organization** is the legal entity held accountable for carrying out the approved Health Center Program scope of project.

- 5) **Indian Tribes or Tribal, Indian, or Urban Indian Applicants ONLY:** Describe the applicant organization's governance structure and how it will assure adequate:
  - a) Input from the community/target population on health center priorities.
  - b) Fiscal and programmatic oversight of the proposed project.

***SUPPORT REQUESTED – Corresponds to Section V.1 Criterion 6: SUPPORT REQUESTED***

- 1. Provide a complete, consistent, and detailed budget presentation through the submission of the following: SF-424A (Budget Information), budget justification narrative, [Form 2](#), and [Form 3](#).
- 2. Describe how the proportion of requested federal funds is appropriate given other sources of income specified in [Form 3](#) and the budget justification narrative.
- 3. Describe how the total budget is aligned and consistent with the proposed service delivery plan, number of patients to be served, and target population needs (consistent with the [RESPONSE](#) section of the Project Narrative, [Attachment 2](#), and [Form 1A](#)).
- 4. Provide the total cost per patient and federal cost per patient for the proposed NAP project broken out by funding population type (i.e., CHC, MHC, HCH, PHPC) and explain why the costs are appropriate and reasonable. The federal dollars per patient at the end of the project period will be calculated automatically when [Form 1A](#) and [1B](#) are complete. The [Forms Summary Page](#) will show this number, broken out by funding population type.

<b>NARRATIVE GUIDANCE</b>	
In order to ensure that the Review Criteria are fully addressed, this table provides a crosswalk between the narrative language and where each section falls within the review criteria.	
<b>Narrative Section</b>	<b>Review Criteria</b>
Need	(1) Need
Response	(2) Response
Collaboration	(3) Collaboration
Evaluative Measures	(4) Evaluative Measures
Resources/Capabilities	(5) Resources/Capabilities
Governance	(6) Governance

Support Requested, Budget, and Budget Justification Narrative	(7) Support Requested – the budget section should include sufficient justification to allow reviewers to determine the reasonableness of the support requested.
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#### **iv. Budget**

See Section 5.1.iv of HRSA’s [SF-424 Two-Tier Application Guide](#). Please follow the instructions included in the Application Guide and the additional budget instructions provided below.

**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 HRSA-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 as applicable.

**NOTE:** In the formulation of the budget presentation, per section 330(e)(5)(A) of the PHS Act, as amended, the amount of 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. In other words, Health Center Program funds are to be used for authorized health center operations and may not be used for profit. As stated in section 330 of the PHS Act, as amended, the federal cost principles apply only to federal grant funds.

Applicants must present the total budget for the NAP project, which includes Health Center Program funds and all non-grant funds, including both program income and all other non-grant funding sources that support of the health center scope of project. For new start applicants, the budget will encompass the total proposed health center scope of project. For satellite applicants, the budget will be based on the proposed new access point(s) only. 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. 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](#) for additional information on health center budgeting. Health centers have discretion regarding how they propose to allocate the total budget between Health Center Program (section 330) grant funds and non-grant funds, provided that the projected budget complies with all applicable HHS policies and other federal requirements.

NAP funding must supplement and not supplant other resources (federal, state, local, or private).

In addition, the NAP budget requires the following.



When entering the SF-424A in EHBs:

- In Section A – Budget Summary, the budget must be entered separately for each type of proposed Health Center Program funding (Community Health Center, Migrant Health Center, Health Care for the Homeless, and/or Public Housing Primary Care). The federal amount refers to only the NAP funding requested, not all federal funding that an applicant receives. Estimated Unobligated Funds are not applicable for this funding opportunity.
- In Year 1 only, up to \$150,000 may be requested for equipment (enter on the Equipment row in Section B) and/or minor alterations/renovations (enter on the Construction row in Section B). The SF-424A is the official budget request. If a NAP grant is awarded, the maximum amount of one-time funding HRSA will award is the amount indicated on the SF-424A. The one-time funding information entered on [Form 1B: BPHC Funding Request Summary](#) must be consistent with the request on the SF-424A. See [Appendix C](#) for detailed one-time funding instructions.
- In Section C, when providing Non-Federal Resources by funding source, include other non-NAP federal funds in the “other” category. Program Income must be consistent with the Total Program Income (patient service revenue) presented in Form 3: Income Analysis.
- In Section E, enter the federal funds requested for Year 2 in the First column broken down for each proposed type of Health Center Program funding (CHC, MHC, HCH, and/or PHPC). The maximum amount that may be requested cannot exceed \$650,000. The Second, Third, and Fourth year columns must remain \$0.

The Consolidated Appropriations Act, 2016, Division H, § 202, (P.L. 114-113) 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.iv Budget – Salary Limitation of HRSA’s [SF-424 Application Guide](#) for additional information. Note that these or other salary limitations will apply in FY 2017, as required by law.

#### ***v. Budget Justification Narrative***

See Section 5.1.v of HRSA’s [SF-424 Two-Tier Application Guide](#).

In addition, the NAP funding opportunity requires a detailed budget justification narrative and table of personnel to be paid with federal funds must be provided for **each 12-month period** of the two-year project period. The federal amount refers to only the NAP funding requested. Year 1 of the budget justification narrative should be classified into federal and non-federal resources. For Year 2, the justification narrative should highlight the changes from Year 1. See the [NAP Technical Assistance web site](#) for a sample budget justification narrative.

The budget justification narrative should be consistent with [Form 1B](#), [Form 2: Staffing Profile](#), and [Form 3: Income Analysis](#). Reference the forms as needed. For the purposes of this funding opportunity announcement, the construction line item is intended to include **ONLY** costs related to minor alteration/renovation. If one-time funding is requested for minor alteration/renovation, provide a summary of the A/R project costs. The construction line item should be consistent



with the SF-424A and the A/R budget justification submitted with the minor A/R Project Cover Page. See [Appendix C](#) for information on one-time funding for minor alteration/renovation projects and equipment purchases, allowable in Year 1 only.

Be aware that Excel or other spreadsheet documents with multiple pages (sheets) may not print out in their entirety. Reviewers will only see information that is set in the “Print Area” of the document.

#### ***vi. Funding Opportunity-Specific Forms***

The following OMB-approved forms must be completed in the EHBs and cannot be uploaded. Refer to [Appendix A](#) for Funding Opportunity-Specific Forms instructions, [Appendix B](#) for Performance Measure Forms instructions, and [Appendix C](#) for one-time funding instructions. Samples are available at the [NAP Technical Assistance web site](#).

Form 1A: General Information Worksheet  
Form 1B: BPHC Funding Request Summary  
Form 1C: Documents on File  
Form 2: Staffing Profile  
Form 3: Income Analysis  
Form 4: Community Characteristics  
Form 5A: Services Provided  
Form 5B: Service Sites  
Form 5C: Other Activities/Locations (if applicable)  
Form 6A: Current Board Member Characteristics  
Form 6B: Request for Waiver of Board Member Requirements  
Form 8: Health Center Agreements  
Form 9: Need for Assistance (NFA) Worksheet  
Form 10: Emergency Preparedness Report  
Form 12: Organization Contacts  
Clinical Performance Measures  
Financial Performance Measures  
Summary Page

Funding Opportunity-Specific Information forms for one-time funding activities (as applicable):  
Alteration/Renovation (A/R) Project Cover Page  
Other Requirements for Sites  
Environmental Information and Documentation (EID)  
Equipment List

#### ***vii. Attachments***

Provide the following items in the order specified below. **Unless otherwise noted, attachments count toward the application page limit.** The independent financial audit, indirect cost rate agreements, and proof of non-profit status (if applicable) will not count toward the page limit. Each attachment must be clearly labeled.

Merge similar documents (e.g., letters of support) into a single file. Provide a table of contents for attachments with multiple components. Attachment-specific table of contents are not counted toward the page limit.

Attachments marked “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 and will not be considered for funding. Failure to include documents marked “Required for Review” may negatively impact an application’s objective review score.

*Attachment 1: Service Area Map and Table – Required for Review*

Upload a map of the service area for the proposed NAP project, indicating the applicant’s proposed new access point(s) listed in [Form 5B](#) and any current sites (as applicable). The map must clearly indicate the proposed service area zip codes, medically underserved areas (MUAs) and/or medically underserved populations (MUPs), and Health Center Program award recipients, look-alikes, and other health care providers serving the proposed zip codes. Maps should be created using UDS Mapper (<http://www.udsmapper.org>). Include a corresponding table that lists each zip code tabulation area (ZCTA) in the service area, the number of Health Center Program award recipients serving each ZCTA, the dominant award recipient serving each ZCTA, total population, total low-income population, total Health Center Program award recipient patients, and low-income population and total population penetration levels for each ZCTA and for the overall proposed service area. This table will be automatically created in UDS Mapper when the map is created. See <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/> for samples. For a tutorial on how to create a map, see Specific Use Cases: Create a Service Area Map and Data Table at <http://www.udsmapper.org/tutorials.cfm>.

*Attachment 2: Implementation Plan – Required for Completeness*

Upload an Implementation Plan (as noted in the [RESPONSE](#) section of the Project Narrative) that outlines the action steps necessary to ensure that the new access point(s) will be open, operational, and compliant within the 120-day timeframe. Instructions for developing the Implementation Plan are provided in [Appendix D](#).

*Attachment 3: Applicant Organizational Chart – Required for Review*

Upload a one-page document that depicts the applicant’s organizational structure, including the governing board, key personnel, staffing, and any subrecipients or affiliated organizations.

*Attachment 4: Position Descriptions for Key Management Staff – Required for Review*

Upload position descriptions for key management staff: Chief Executive Officer (CEO), Chief Medical Officer (CMO), Chief Financial Officer (CFO), Chief Information Officer (CIO), Chief Operating Officer (COO), and Project Director (PD). 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.

*Attachment 5: Biographical Sketches for Key Management Staff – Required for Review*

Upload current biographical sketches for key management staff: CEO, CMO, CFO, CIO, COO, and PD. 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.

*Attachments 6: Co-Applicant Agreement – **Required for Completeness** for public center applicants that have a co-applicant board*

Public center<sup>17</sup> applicants that have a co-applicant board must submit the entire formal co-applicant agreement signed by the co-applicant governing board and the public center.

Note: Public centers that receive Health Center Program funding must comply with all applicable governance requirements and regulations. In cases where the public center's board cannot directly meet all applicable health center governance requirements, a separate co-applicant health center governing board must be established that meets all Health Center Program governance requirements. When a public center has a co-applicant board, the public center and co-applicant board must have a formal co-applicant agreement that stipulates roles, responsibilities, and the delegation of authorities of each party in the oversight and management of the public health center, detailing any shared roles and the responsibilities of each party in carrying out governance functions. See [PIN 2014-01](#): Health Center Program Governance for information on Governance requirements.

*Attachment 7: Summary of Contracts and Agreements – Required for Review, as applicable*

Upload a brief summary describing **all** current or proposed patient service-related contracts and agreements supporting the proposed NAP project. 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.

For required services provided by a formal written referral agreement/arrangement, explain how the services will be provided on a sliding fee scale that meets Health Center Program requirements and will be accessible regardless of ability to pay. If a contract or agreement will be attached to [Form 8](#), denote this with an asterisk (\*).

*Attachment 8: Independent Financial Audit – **Required for Completeness***

Upload the applicant organization's most recent audit. The audit must include all balance sheets, profit and loss statements, audit findings, management letter (or a signed statement that no letter was issued with the audit), and noted exceptions. Organizations that have been operational less than one year and do not have an audit may submit monthly financial statements for the most recent six-month period. Organizations that are not yet operational and do not have an audit or financial statements must provide a detailed explanation of the organization's current financial status, including supporting documentation.

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<sup>17</sup> Public centers are also referred to as "public entities."

*Attachment 9: Articles of Incorporation – **Required for Completeness** for new start applicants*  
New applicants must upload the official signatory page (including state seal) of the applicant organization's Articles of Incorporation. A public center with a co-applicant should upload the co-applicant's Articles of Incorporation, if incorporated. Tribal organizations, reference the applicant's designation in the Federally Recognized Indian Tribe List maintained by the Bureau of Indian Affairs.

*Attachment 10: Letters of Support – Required for Review*

Upload current dated letters of support addressed to the appropriate provider/organizational contact (e.g., board chair, CEO) to document commitment to the project. See the [COLLABORATION](#) section of the Project Narrative for details on required letters of support. If desired, applicants may provide a list of additional letters that are available onsite. Letters of support that are not submitted with the application will not be considered by reviewers.

*Attachment 11: Sliding Fee Discount Schedule(s) – Required for Review*

Upload the current or proposed sliding fee discount schedule(s). The scale(s) must correspond to a schedule of charges for which discounts are adjusted based on the patient's ability to pay and apply only to persons with incomes between 100-200 percent of the federal poverty level (see the Federal Poverty Guidelines at <http://aspe.hhs.gov/poverty>). Refer to [PIN 2014-02](#) for details on the Health Center Program sliding fee discount program requirements.

*Attachment 12: Evidence of Nonprofit or Public Center Status – **Required for Completeness** for new start applicants*

New applicants must upload the applicant organization's evidence of nonprofit **or** public center status. This attachment does not count toward the page limit.

Private Nonprofit: A private, nonprofit organization must submit any one of the following as evidence of its nonprofit status:

- A copy of a currently valid Internal Revenue Service (IRS) 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.
- 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 documentation 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/programopportunities/lookalike/pin201001.html>), public center applicants must provide documentation demonstrating that the organization qualifies as a public agency (e.g., health department, university health system) for the purposes of section 330 of the PHS Act, as amended. Any of the following are 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 IRS ruling 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 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 13: Floor Plans – Required for Review*

Provide floor plans of the proposed new access point(s), including proposed exam rooms and waiting area(s). Indicate the area of the building to be used (e.g., suites, floors) and the address.

*Attachment 14: Corporate Bylaws – **Required for Completeness***

Upload (in entirety) the applicant organization's most recent bylaws. Bylaws must be signed and dated by the appropriate individual indicating review and approval by the governing board.

*Attachment 15: Other Relevant Documents and Indirect Cost Rate Agreement, as applicable*

If indirect costs are requested, the Indirect Cost Rate Agreement must be provided in this attachment. If the site is/will be leased, lease/intent to lease documents must be included in this attachment. If desired, include other relevant documents to support the proposed project.

### **3. Dun and Bradstreet Universal Numbering System Number and System for Award Management**

Applicant organizations must obtain a valid Dun and Bradstreet Universal Numbering System (DUNS) number, also known as the Unique Entity Identifier, and provide that number in their application. Each applicant must also register with the System for Award Management (SAM) and continue to maintain active SAM registration with current information at all times during which it has an active federal award or an application or plan under consideration by an agency (unless the applicant is an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110(b) or (c), or has an exception approved by the agency under 2 CFR § 25.110(d)).

HRSA may not make an award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with the requirements by the time HRSA is ready to make an award, HRSA may determine that the applicant is not qualified to receive an award and use that determination as the basis for making an award to another applicant.

If an applicant/recipient organization has already completed Grants.gov registration for HRSA or another federal agency, confirm that the registration is still active and that the Authorized Organization Representative (AOR) has been approved.

The Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet (<http://fedgov.dnb.com/webform/pages/CCRSearch.jsp>)
- System for Award Management (SAM) (<https://www.sam.gov>)

- Grants.gov (<http://www.grants.gov/>)

For further details, see Section 3.1 of HRSA's [SF-424 Two-Tier Application Guide](#).

**Applicants that fail to allow ample time to complete registration with SAM or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.**

#### **4. Submission Dates and Times**

##### **Application Due Date**

The due date for applications under this FOA in Grants.gov (Phase 1) is *June 17, 2016 at 11:59 P.M. Eastern Time*. The due date to complete all other required information in HRSA's EHBs (Phase 2) is *July 15, 2016 at 5:00 P.M. Eastern Time*.

See Section 3.3 and FAQ 9.2.5 in HRSA's [SF-424 Two-Tier Application Guide](#) for additional information about application receipt acknowledgement and validation e-mails.

The Authorizing Official (AO) identified in the HRSA EHBs must submit the final application. HRSA EHBs will present a message indicating successful transmission to HRSA upon successful completion of Phase 2.

#### **5. Intergovernmental Review**

New Access Points applications are subject to the provisions of Executive Order 12372, as implemented by 45 CFR part 100. See Executive Order 12372 in the [HHS Grants Policy Statement](#).

See Section 5.1.ii of HRSA's [SF-424 Two-Tier Application Guide](#) for additional information.

#### **6. Funding Restrictions**

Applicants responding to this announcement may request funding for a project period of up to two years, at no more than \$650,000 per year. 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 must be requested and utilized by the applicant organization identified on the SF-424 submitted in Grants.gov. Applicants are expected to perform the activities indicated in the NAP application and may not apply on behalf of another organization.

Funds under this announcement may not be used for fundraising or major alteration and renovation or construction/expansion of facilities. Funds may be used for minor capital costs, including equipment and/or minor alteration and renovation of proposed new access point



facilities. Applicants may request to use up to \$150,000 of federal funds in Year 1 ONLY for such minor capital costs (see [Appendix C](#) for more information).

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 funds awarded under this announcement and is consistent with past practice and long-standing requirements applicable to awards to health centers.

The General Provisions in Division H of the Consolidated Appropriations Act, 2016 (P.L. 114-113), apply to this program. Please see Section 5.1 of HRSA's [SF-424 Two-Tier Application Guide](#) for additional information. Note that these or other restrictions will apply in FY 2017, as required by law.

All program income generated as a result of awarded 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 to 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.

These criteria are the basis upon which the reviewers will evaluate the application. The entire proposal will be considered during objective review. Reviewers will reference the Health Center Program requirements in Appendix E to assess the applicant's compliance and readiness to implement a NAP. Reviewers will also use the HRSA Scoring Rubric as a guideline when assigning scores for each criterion. The HRSA Scoring Rubric may be found at <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/>.

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. Each application will be evaluated on the following seven (7) review criteria:

***Criterion 1: NEED (10 points determined by the objective review process and 20 points determined by the NFA Worksheet calculations) – Corresponds to Section IV.2.ii NEED***

**Note:** 20 of the 30 available points in this section will be awarded based on the Need for Assistance (NFA) Score (see [Form 9](#)). The NFA score will be calculated automatically by the

HRSA EHB system. Although reviewers do not score the NFA, they will look for consistency between the NFA and other parts of the application. The remaining 10 points will be based on the criteria outlined below.

1. The strength of identified, current health care needs in the service area/target population (including any targeted special populations) described in Item 1 of the [NEED](#) section of the Project Narrative, consistent with the quantitative and qualitative data provided in the Need for Assistance Worksheet ([Form 9](#)), and Form 4.
2. For applicants requesting funding to serve migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing, (as indicated on Form 1A), how well the applicant demonstrates, with consistent and complete information, the specific health care needs and access issues of each proposed special population as documented by quantitative and qualitative data, using data sources with the greatest specificity available for the proposed service area and target population of the NAP, provided in the Need for Assistance Worksheet ([Form 9](#)), and listed in Item 2 of the [NEED](#) section of the Project Narrative.
3. How well the applicant describes, with consistent and complete information, existing primary health care services and service gaps in the service area, as well as factors affecting the broader health care environment, and any statewide or regional strategic planning that has identified primary care needs in the proposed service area as documented in Items 3, 4, and 5 of the [NEED](#) section of the Project Narrative.

***Criterion 2: RESPONSE (20 Points) – Corresponds to Section IV.2.ii RESPONSE***

1. The completeness and quality of the Implementation Plan ([Attachment 2](#)) in identifying appropriate, realistic, and achievable action steps necessary to ensure that the new access point(s) will be open, operational, and compliant within 120 days of award with appropriate staff and providers in place to deliver services to the proposed service area and how well the applicant ensures compliance with Health Center Program requirements as outlined in Item 1 of the [RESPONSE](#) section of the Project Narrative (consistent with the Implementation Plan).
2. The reasonableness of the number of projected new patients based on the proposed NAP project, particularly the total unduplicated patients, as described in [Form 1A](#) and Items 2, 3, and 4 of the [RESPONSE](#) section of the Project Narrative.
3. The degree to which the applicant demonstrates, with consistent and complete information, 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 outlined in the [NEED](#) section and related application materials are met, as documented by quantitative and qualitative descriptions provided in [Attachment 1](#), [Attachment 7](#), [Forms 5A, 5B, and 5C](#), and Items 3, 4, 5, and 6 of the [RESPONSE](#) section of the Project Narrative.



4. For applicants requesting funding to serve migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing, the extent to which the applicant demonstrates, with consistent and complete information, current and/or planned compliance with requirements for targeted special populations, as documented in [Forms 5A, 5B, and 5C](#), [Attachment 7](#), and Items 3 and 4 of the [RESPONSE](#) section of the Project Narrative. In particular, services targeting people experiencing homelessness will include provision of substance abuse services (either directly or through referral); services targeting migratory and seasonal agricultural workers will address environmental health needs and hazards; and services targeting public housing residents were developed and will continue to be informed by consultation with public housing residents.
5. How well the applicant demonstrates, with consistent and complete information, that the schedule of charges is board-approved, reasonable, and consistent with local rates; the sliding fee discount schedule(s), including any justified nominal charges, ensure services (regardless if they are provided directly, through a formal written contract/agreement, or by formal written referral arrangement/agreement) are available and accessible to all without regard to ability to pay; the system in place for determining eligibility for and application of discounts is based on a patient's income, family size, and current Federal Poverty Guidelines; and a system is in place to ensure patients are made aware of the availability of the sliding fee discounts, as reflected in [Attachment 11](#), [Attachment 7](#) (as applicable), and Items 7 and 8 of the [RESPONSE](#) section of the Project Narrative.
6. The strength of the applicant's QI/QA program, including consistent and complete information regarding: good accountability and communication within the organization to include all staff in QI/QA activities; that its QI committee/workgroup is led by a qualified leader; that its proposed focus, goals, performance measures, methodology, and evaluation plans are based on an assessment of its current service performance and analysis of current and potential risks incurred in the implementation of all services; and that key management obtained the board's input and approval on the QI/QA plan as described in Item 9 of the [RESPONSE](#) section of the Project Narrative, [Clinical Performance Measures](#), and [Attachment 2](#) (as applicable).
7. For applicants requesting funding for a subrecipient or contracted service site (see [Form 5B](#) and [Form 8](#)), how well the applicant demonstrates that the proposed subrecipient or contractor site meets the [RESPONSE](#) sub-criteria 1-5 above as documented by consistent and complete information in the [RESPONSE](#) section of the Project Narrative, [Form 8](#), subrecipient agreement/contract attached to Form 8, [Attachment 2](#), and any other relevant attachments.
8. The quality of appropriate, realistic, and achievable plans to ensure access to health care through integration with the state health care delivery plan and facilitation of enrollment in new affordable health insurance options as described in Item 10 of the [RESPONSE](#) section of the Project Narrative.

***Criterion 3: COLLABORATION (10 points) – Corresponds to Section IV.2.ii***  
***COLLABORATION***

1. The strength of the applicant's collaboration and coordination with other primary health care providers and community organizations in the proposed service area and within close proximity (as identified by the UDS Mapper tool), as documented by specific support for the proposed project in [Attachment 1](#), [Attachment 7](#) (as applicable), [Attachment 10](#), and detailed descriptions in Items 1 and 2 of the [COLLABORATION](#) section of the Project Narrative.
2. The extent to which the letters of support ([Attachment 10](#)) demonstrate that Health Center Program award recipients and look-alikes, rural health clinics, critical access hospitals, health departments, private primary care provider groups serving low income and/or uninsured populations, collaborating community organization(s) in the service area, and relevant State public agencies support the proposed project through detailed descriptions of collaboration and coordination. The letters of support must be specific to the nature of the support and the NAP project. If required letter(s) are not included from all listed organizations (e.g., those identified on the service area map and government agencies), how well the applicant justifies why such letter(s) could not be obtained, including documentation of efforts made to obtain the letter(s).

***Criterion 4: EVALUATIVE MEASURES (5 points) – Corresponds to Section IV.2.ii***  
***EVALUATIVE MEASURES***

1. The strength and appropriateness of the applicant's Clinical and Financial Performance Measures (goals), including realistic contributing and restricting factors, effective plans for addressing such factors, as well as unique special population measures corresponding to the identified special population needs, as evidenced in the [Clinical and Financial Performance Measures forms](#), and consistent with the [NEED](#) section of the Project Narrative and [Form 9](#).
2. The strength of the applicant's plans to routinely assess the needs of the target population in a way that appropriately engages the community, and incorporates the assessment into the organization's ongoing strategic planning to improve the NAP project as described in Item 3 of the [EVALUATIVE MEASURES](#) section of the Project Narrative.
3. The extent to which the applicant demonstrates that the proposed evaluation staff possess the appropriate experience and skills to perform the proposed project evaluation activities, including allotment of adequate time for activity completion as described in Item 4 of the [EVALUATIVE MEASURES](#) section of the Project Narrative.
4. How well the applicant demonstrates that certified EHR systems will appropriately track patient/clinical data and be used to improve clinical outcomes as described in Item 5 of the [EVALUATIVE MEASURES](#) section of the Project Narrative.

***Criterion 5: RESOURCES/CAPABILITIES (15 points) – Corresponds to Section IV.2.ii***  
***RESOURCES/CAPABILITIES***

1. The extent to which the applicant demonstrates, with consistent and complete information, that the sites, organizational structure, proposed management staff, staffing plan, and

policies/procedures are appropriate for implementing the proposed new access point(s) and for meeting the Health Center Program requirements (see [Appendix E](#)), including oversight and authority over all agreements, contracts, contractors, and subrecipients through information provided in Items 1, 2, 3, 4, and 5 of the [RESOURCES/CAPABILITIES](#) section of the Project Narrative, [Attachment 2](#), [Attachment 3](#), [Attachment 7](#), [Attachment 13](#), [Attachment 14](#), [Form 2](#), and [Form 8](#).

2. The degree to which the applicant's experience and expertise working with and addressing needs of the target population(s) have positioned the applicant organization to successfully implement the proposed project in the proposed timeframe, with a particular focus on experience and expertise regarding addressing primary and preventive health care needs through information provided in Items 2, 3, and 6 of the [RESOURCES/CAPABILITIES](#) section of the Project Narrative, [Attachment 3](#), [Attachment 4](#), [Attachment 5](#), [Attachment 7](#), and [Form 8](#), as applicable.
3. The strength of the applicant's plans to effectively recruit and retain key management staff and health care providers as identifies in Item 4 of the [RESOURCES/CAPABILITIES](#) section of the Project Narrative.
4. The quality of the applicant's policies and procedures for maximizing collection of payments and reimbursement for costs while ensuring access to health care without regard to ability to pay, as documented in Item 7 of the [RESOURCES/CAPABILITIES](#) section of the Project Narrative.
5. The strength of the applicant's financial status, including consistent and complete information regarding sound financial management, financial stability, and compliance with federal laws and regulations, as supported through audit and financial information, billing and collections details, and appropriate financial accounting and control systems, information systems, policies, and procedures to enable data tracking and reporting of the organization's financial status in accordance with Generally Accepted Accounting Principles (GAAP) and to support management decision making.

In instances where no audit/financial information is available, the extent to which the applicant provides a detailed explanation for the lack of this information, and the quality of the applicant's plan for how these financial accounting and control systems will be in place within 120 days of award. Information should be presented in Items 7, 8, and 9 of the [RESOURCES/CAPABILITIES](#) section of the Project Narrative, [Attachment 8](#), and [Attachment 2](#) (as applicable).

6. The strength of the applicant's plans for emergencies in Item 10 of the [RESOURCES/CAPABILITIES](#) section of the Project Narrative and [Form 10](#).
7. How well the Implementation Plan ([Attachment 2](#)) identifies appropriate, realistic, and achievable action steps that ensure the organization has the resources and capability to open and operate the compliant new access point(s) within 120 days of award (e.g., lease arrangements, staffing, policies). See Health Center Program requirements in [Appendix E](#).

***Criterion 6: GOVERNANCE (10 points) – Corresponds to Section IV.2.ii GOVERNANCE***

1. The extent to which the applicant demonstrates:
  - That the governing board operates independently and oversees the proposed project in compliance with Health Center Program requirements (specifically see Program Requirements 17, 18, and 19 in [Appendix E](#)), including governing board size, composition, expertise, and unrestricted authority; effective operations; and establishment and review of policies and procedures as documented in Items 1, 2, 3, and 4 of the [GOVERNANCE](#) section of the Project Narrative, [Attachment 3](#), [Attachment 6](#) (if applicable), [Attachment 9](#), [Attachment 14](#), and [Forms 6A](#) and [8](#).
  - If the governing board is not currently operational and/or compliant, that the applicant's implementation plan ([Attachment 2](#)) will ensure that the governing board becomes operational and compliant with the Health Center Program requirements within 120 days.
2. Public center applicants with a co-applicant governance structure ONLY: The extent to which the applicant demonstrates that the co-applicant's patient/community-based governing board meets the statutory requirements for board composition (e.g., size, expertise, member selection) and appropriate implementation of all board authorities, including setting health center policy (with the exception of general fiscal and personnel policies) as evidenced in Items 1, 2, 3, and 4 of the [GOVERNANCE](#) section of the Project Narrative, [Attachment 2](#) (if applicable), [Attachment 3](#), [Attachment 6](#), [Attachment 14](#), and [Forms 6A](#) and [8](#). See [Appendix E](#) for more information on required governance composition and authorities.
3. Applicants targeting only special populations and planning to request a waiver of the patient majority requirement ONLY: The degree to which the applicant demonstrates the need for a waiver and the quality of the current/planned alternative procedures for ensuring patient participation in governance as documented in [Form 6B](#) and consistent with the [GOVERNANCE](#) section of the Project Narrative.
4. Indian tribe or tribal, Indian, or urban Indian applicants ONLY: How well the applicant demonstrates, with consistent and complete information, that the governance structure will ensure input from the community/target population on health center priorities, as well as the quality of the governing board's fiscal and programmatic oversight of the proposed project in Item 5 of the [GOVERNANCE](#) section of the Project Narrative, [Attachment 2](#) (if applicable), and [Attachment 14](#).

***Criterion 7: SUPPORT REQUESTED (10 points) – Corresponds to Section IV.2.ii SUPPORT REQUESTED***

1. The strength of the budget presentation, including planned service delivery and patient projections, as documented in Items 1 and 2 of the [SUPPORT REQUESTED](#) section of the Project Narrative, SF-424A, budget justification narrative, [Form 1B](#), and [Form 3](#), consistent with [Form 1A](#), [Form 2](#), and the [RESPONSE](#) section of the Project Narrative.

2. How well the applicant demonstrates that the budget is realistic, and aligned and consistent with the proposed service delivery plan, number of patients to be served, and target population needs, as documented in Item 3 of the [SUPPORT REQUESTED](#) section of the Project Narrative, budget justification narrative, and SF-424A, consistent with [Form 1A](#), [Form 1B](#), and [Form 3](#). If applicable, how well the applicant requesting MHC, HCH, and/or PHPC funding reflects the special population focus in the budget.
3. The reasonableness of the total cost per patient and federal cost per patient based on the proposed NAP project, considering the information provided in Item 4 of the [SUPPORT REQUESTED](#) section of the Project Narrative, the Forms Summary Page, and the Financial Performance Measures related to cost per patient.

## 2. Review and Selection Process

See Section 6.3 of HRSA's [SF-424 Two-Tier Application Guide for more details](#). 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 proceed to the Objective Review Committee.**

The NFA Worksheet ([Form 9](#)) will be scored automatically within EHB using the NFA Worksheet scoring criteria (see [Appendix A](#) of this document for form instructions and scoring details) and will determine 20 of the 30 total points for the **NEED** section. The Objective Review Committee will evaluate the technical merits of each proposal using the review criteria presented in this FOA, up to a maximum of 80 points (see Section V.1, [Review Criteria](#)). The NFA plus the objective review process findings will be summed for a total score, up to a maximum of 100 points.

HRSA will use factors other than merit criteria in selecting applications for a federal award. For this funding opportunity, HRSA will use funding priorities and special considerations.

### Funding Priorities

Following the objective review, all applications within the fundable range will be assessed by HRSA for an adjustment to the overall application score based on the funding priorities detailed below. A funding priority is defined as the favorable adjustment of review scores when applications meet specified criteria. **Applicants do not need to request funding priorities.** Prior to final funding decisions, HRSA will assess all NAP applications within the fundable range for eligibility to receive priority point adjustment(s). The FY 2017 NAP funding opportunity has three funding priorities:

- ***Unserved, High Poverty Population (10 points):*** HRSA will assess the current Health Center Program penetration in the applicant's service area (defined by all the service area zip codes for all sites listed on [Form 5B](#)) along with the number of unserved, low-income individuals in the service area. HRSA will use 2015 UDS data (available summer 2016 via UDS Mapper located at <http://www.udsmapper.org>) to complete this assessment. For priority points to be awarded, the service area must meet two criteria:

- 1) The proposed service area must have a Health Center Program (award recipients and look-alikes) penetration rate for the low-income (below 200% of the poverty limit<sup>18</sup>) population at or below 5% (i.e., 95% or more of the proposed service area's low-income population is not being served under the Health Center Program); AND
  - 2) The number of low income residents not currently served under the Health Center Program must be at least 150% of the proposed patients to be served by the NAP site(s) as identified on [Form 1A](#). For example, if the application proposes to serve 1,000 individuals, there must be at least 1,500 low-income residents in the proposed service area that are not being served under the Health Center Program.
- ***Sparsely Populated Area (5 points):*** For applicants requesting funding to serve the general community (section 330(e) – CHC) alone or in combination with special populations funding (section 330(g) - MHC, 330(h) – HCH, and/or 330(i) – PHPC), HRSA will assess whether the entire proposed service area (defined by all the service area zip codes for all sites listed on [Form 5B](#)) has seven or fewer people per square mile. Applicants requesting funding ONLY under MHC, HCH, and/or PHPC are not eligible for this priority. Applicants with a service area of seven or fewer people per square mile will receive 5 points. HRSA will use US Census data to complete this assessment.
  - ***Health Center Program Look-Alikes (5 points):*** Health Center Program look-alikes are health centers that operate and provide services consistent with all statutory, regulatory, and policy requirements that apply to Health Center Program award recipients, but do not receive Health Center Program funding. Based on this HRSA designation, applicants that were designated as Health Center Program look-alikes prior to October 1, 2015 are eligible to receive five priority points if the following conditions are met:
    - 1) The NAP application must include all current sites in the applicant's Health Center Program look-alike scope of project at the time of application (i.e., all sites listed on the look-alike Form 5B must be listed as sites on the NAP application Form 5B). Applicants may propose additional sites.
    - 2) The NAP application must include the service area zip codes on Form 5B in which at least 75% of current patients reside (based on the look-alike 2015 UDS report). Applicants may propose to serve additional service area zip codes.
    - 3) Complete 2015 patient data must have been reported in the Uniform Data System (UDS).
    - 4) The total unduplicated patient projection by December 31, 2018 on Form 1A must be greater than the total unduplicated patients included in the 2015 UDS report.
    - 5) The organization cannot have three or more Health Center Program requirement-related conditions at the time of application.

### **Special Funding Considerations and Other Factors**

This program includes the following special considerations as authorized by section 330 of the PHS Act. A special consideration is defined as the favorable consideration of an application by

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<sup>18</sup> Since publically available income data (American Community Survey) are reported for “below 200% poverty of the FPL”, data analyses (i.e., funding priorities, NFA worksheet) must be based on the population below 200%. However, sliding fee discounts must apply to individuals with incomes between of 100 and 200% of the FPL.



HRSA funding officials, based on the extent to which the application addresses the specific area of special consideration. Applications that do not receive special consideration will be given full and equitable consideration during the review process.

- *RURAL/URBAN DISTRIBUTION OF AWARDS:* Aggregate awards in FY 2017 will be made to ensure that no more than 60 percent and no fewer than 40 percent of health centers serve people from urban areas and no more than 60 percent and no fewer than 40 percent serve people from rural areas. In order to ensure this distribution, HRSA may award funds to applications out of rank order.
- *PROPORTIONATE DISTRIBUTION:* HRSA expects to make funds available across the Health Center Program in FY 2017 at proportionate levels consistent with section 330(r)(2)(B) of the PHS Act. In order to meet this intended distribution, HRSA may award funding to applications out of rank order.
- *GEOGRAPHIC CONSIDERATION:* The intent of this funding opportunity is to expand the current safety net on a national basis by creating new access points in areas not currently served by federally funded health centers. In order to meet this intent, HRSA will consider geographic distribution and the extent to which an area may currently be served by Health Center Program award recipient(s) when deciding which applications to fund.

HRSA reserves the right to review fundable applicants for compliance with HRSA program requirements through reviews of site visits, audit data, Uniform Data System (UDS) or similar reports, Medicare/Medicaid cost reports, external accreditation, and other performance reports, as applicable. The results of this review may impact final funding decisions. For example, the program compliance status of satellite applicants will be reviewed, as noted below.

*SATELLITE APPLICANTS: PROGRAM COMPLIANCE STATUS:*

Prior to award date, HRSA will assess the status of all current Health Center Program award recipients applying to establish satellite sites. Applicants within the fundable range will not receive a NAP award if they:

- Have three or more active 60 day health center program requirement conditions on current award;
- Have one or more 30 day health center program requirement condition(s) on current award; or

*SATELLITE APPLICANTS: ORAL HEALTH SERVICE EXPANSION SITES:*

Satellite applicants will not receive a NAP award if they propose the same site(s) funded in July 2016 through the Oral Health Service Expansion funding opportunity.



### **3. Assessment of Risk**

The Health Resources and Services Administration may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory or other requirements ([45 CFR § 75.205](#)).

Effective January 1, 2016, HRSA is required to review and consider any information about the applicant that is in the [Federal Awardee Performance and Integrity Information System \(FAPIIS\)](#). An applicant may review and comment on any information about itself that a federal awarding agency previously entered. HRSA will consider any comments by the applicant, in addition to other information in [FAPIIS](#), when making a judgment about the applicant's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed by applicants as described in [2 CFR § 200.205 Federal Awarding Agency Review of Risk Posed by Applicants](#).

A determination that an applicant is not qualified will be reported by HRSA to FAPIIS.

The decision not to make an award, or to make an award at a particular funding level, is discretionary and is not subject to appeal to any HHS Operating Division or HHS official or board.

### **4. Anticipated Announcement and Award Dates**

HRSA anticipates issuing/announcing awards on or around the start date of January 1, 2017.

## **VI. Award Administration Information**

### **1. Award Notices**

HRSA will issue the Notice of Award on or around January 1, 2017. 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](#).

### **3. Reporting**

The successful applicant under this FOA must comply with Section 7 of HRSA's [SF-424 Two-Tier Application Guide](#) and the following reporting and review activities:

- 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 award recipients are required to submit a

Universal Report and, if applicable, a Grant Report(s) annually. The Universal Report provides data on patients, services, staffing, and financing across all Health Center Program award recipients. The Grant Report(s) 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). See <http://bphc.hrsa.gov/datareporting/reporting/index.html> for additional information and resources on UDS reporting.

- 2) **Progress Report** – The Budget Period Progress Report (BPR) non-competing continuation application documents 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. Each award recipient will receive an email message via HRSA EHBs when it is time to begin working on the progress report.
- 3) **Prevention and Public Health Fund Reporting Requirements** – Division H, Title II, section 221 of the Consolidated Appropriations Act, 2016 (P.L. 114-113) requires that recipients awarded a grant, cooperative agreement, or contract from such funds with a value of \$25,000 or more shall produce reports on a semi-annual basis. The reporting cycle is January 1 – June 30 and July 1 – December 31; e-mail such reports (in 508 compliant format) to the HHS grants management official assigned to the grant or cooperative agreement no later than 20 calendar days after the end of each reporting period (i.e. July 20 and January 20, respectively). Recipient reports shall reference the Notice of Award number and title of the grant or cooperative agreement, and include a summary of the activities undertaken and identify any sub-grants or sub-contracts awarded (including the purpose of the award and the identity of the [sub] recipient).
- 4) **Integrity and Performance Reporting** - The Notice of Award will contain a provision for integrity and performance reporting in [FAPIIS](#), as required in [45 CFR part 75 Appendix XII](#).

## VII. Agency Contacts

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

William Davis  
Grants Management Specialist  
Division of Grants Management Operations  
Office of Federal Assistance Management  
Health Resources and Services Administration  
5600 Fishers Lane  
Rockville, MD 20857  
Telephone: 301-443-8217  
E-mail: [WDavis@hrsa.gov](mailto:WDavis@hrsa.gov)

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

Lt. Cdr. Candice West  
Public Health Analyst  
Office of Policy and Program Development  
Bureau of Primary Health Care  
Health Resources and Services Administration  
5600 Fishers Lane  
Rockville, MD 20857  
Telephone: 301-594-4300  
E-mail: [bphcnap@hrsa.gov](mailto:bphcnap@hrsa.gov)  
TA Web site: <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/>

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, (International Callers, please dial 606-545-5035)  
E-mail: [support@grants.gov](mailto:support@grants.gov)  
iPortal: <https://grants-portal.psc.gov/Welcome.aspx>

Applicants/recipients may need assistance when working online to submit the remainder of their information electronically through HRSA EHBs. For assistance with submitting the application in HRSA EHBs, contact the Bureau of Primary Health Care (BPHC) Helpline, Monday-Friday, 8:30 a.m. to 5:30 p.m. ET:

BPHC Helpline  
Telephone: (877) 974-2742 ext. 3  
Web: <http://www.hrsa.gov/about/contact/bphc.aspx>

## **VIII. Other Information**

### **Technical Assistance**

The New Access Points technical assistance (TA) Web site (<http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/>) 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) in determining their readiness to develop a quality, competitive NAP application. For a complete listing of PCAs, PCOs, and NCAs, refer to <http://bphc.hrsa.gov/qualityimprovement/supportnetworks/index.html>.

HRSA will hold a pre-application TA webinar for applicants seeking funding through this opportunity. The webinar will provide an overview of pertinent information in the FOA and an opportunity for applicants to ask questions. Visit the NAP TA Web site at <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/> for webinar details, frequently asked questions, sample forms, and additional resources.

### **Federal Tort Claims Act Coverage/Medical Malpractice Insurance**

Organizations that receive operational funds 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 award recipients 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 at <http://bphc.hrsa.gov/ftca/index.html> and contact the BPHC Help Line at 877-974-BPHC for additional information.

If an applicant is not currently deemed, the costs associated with the purchase of malpractice insurance may 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.

### **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 program limits the cost of covered outpatient drugs for certain federal award recipients, look-alikes, and qualified disproportionate share hospitals. Covered entities may realize a cost savings on outpatient drug purchases and additional savings on other value-added services through participation in the 340B Prime Vendor Program (PVP). Pharmacy related technical assistance is available at 866-PharmTA (866-742-7682). There is no cost to participate in the 340B program or the 340B Prime Vendor Program, and eligible entities are not required to have an established in-house pharmacy to participate. For additional information, contact the Office of Pharmacy Affairs (OPA) at 800-628-6297 or visit the OPA Web site at <http://www.hrsa.gov/opa/index.html>.

## **IX. Tips for Writing a Strong Application**

See Section 5.7 of HRSA's [\*SF-424 Two-Tier Application Guide\*](#).

## Appendix A: Funding Opportunity-Specific Forms Instructions

Funding Opportunity-Specific forms must be completed electronically in HRSA EHBs. To preview the forms, visit <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/>. Portions of the forms that are “blocked/grayed” out are not relevant to the application and do not need to be completed. Data provided in the forms must be consistent with information provided in the Project Narrative and other parts of the application.

### FORM 1A – GENERAL INFORMATION WORKSHEET (REQUIRED)

Data pertaining to Health Center Population Types, Target Population, and Provider Information will no longer be entered on this form.

#### 1. APPLICANT INFORMATION

- Complete all relevant information that is not pre-populated.
- Grant Number will pre-populate for satellite applicants (current award recipients).
- Applicants may check only one category in the Business Entity section. If an applicant is a Tribal or Urban Indian entity and also meets the definition for a public or private entity, then the applicant should select the Tribal or Urban Indian category.
- Applicants may select one or more category for the Organization Type section.

#### 2. PROPOSED SERVICE AREA

##### 2a. Service Area Designation

- Applicants applying for section 330(e) funding for Community Health Centers (CHC) MUST serve a Medically Underserved Area (MUA) and/or Medically Underserved Population (MUP).
- Select the MUA and/or MUP designations for the proposed service area and enter the identification number(s).
- For information regarding MUAs or MUPs, visit the Shortage Designation Web site at <http://www.hrsa.gov/shortage>, call 1-888-275-4772 (option 1 then option 2), or contact the Shortage Designation Branch at [SDB@hrsa.gov](mailto: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. To be determined sparsely populated, the entire proposed service area must have seven or fewer people per square mile. 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](http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html).

##### 2c. Patients and Visits

##### *Projecting Patients and Visits:*

When providing the count of patients and visits, ensure that the projections are realistic and appropriate based on the proposed NAP project. If funded, award recipients will be held accountable for meeting these patient projections in future continuation applications. Note the

following definitions and guidelines (see the UDS Manual available at <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting> for detailed information):

- Applicants with more than one proposed new access point should report aggregate data for all of the sites included in the NAP application.
  - New start applicants should report combined data for all of the sites to be included under the scope of project.
  - Satellite applicants should report data for the proposed new access point(s) ONLY.
- A visit is a documented face-to-face contact between a patient and a licensed or otherwise credentialed provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services must be paid for by the applicant organization and documented in the patient's record.
- A patient is an individual who had (current data) or is projected to have (projected data) at least one visit in the referenced year.
- Since a patient must have at least one documented visit, the number of patients cannot exceed the number of visits.
- Do not report patients and visits for services outside the organization's proposed scope of project. Specifically, the scope of project defines the service sites, services, providers, service area, and target population for which Health Center Program funds may be used. For more information, see PIN 2008-01 available at <http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin2008-01.pdf>.

*Patients and Visits by Service Type:*

- Project the annual number of patients and visits anticipated within each service type category across all proposed NAP sites by December 31, 2018 (January 1 – December 31, 2018).
- Within each service type category (medical, dental, mental health, substance abuse, and enabling services), 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).
- Because a new access point's main purpose must be the provision of comprehensive primary medical care, the number of projected medical patients must be greater than the number of projected patients within each of the other service types.
- Do not report patients and visits for vision or pharmacy services.

*Unduplicated Patients and Visits by Population Type:*

- Project the total annual number of patients and visits anticipated within each population type category across all proposed NAP sites by December 31, 2018 (January 1 – December 31, 2018).
- Data reported for patients and visits should not be duplicated within or across the four target population categories (i.e., an individual can only be counted once as a patient in this section of the form).
- Do not report patients and visits for pharmacy services.
- The population types in this section do not refer only to the requested funding categories (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. All patients/visits that do not fall within the Migratory and

Seasonal Agricultural Workers, Public Housing Residents, or the People Experiencing Homelessness categories must be included in the General Underserved Community category.

- The number of unduplicated patients to be served must be consistent with the [RESPONSE](#) section of the Project Narrative and other parts of the application.
- The total number of new patients to be served by December 31, 2018 from this section of the form will be:
  - Used to calculate the Unserved, High Poverty Priority Points.
  - The number of patients that award recipients will be held accountable for serving by December 31, 2018 (January 1 – December 31, 2018) as reported in UDS.
  - Added to the satellite applicant's current Patient Target.

### **FORM 1B – BPHC FUNDING REQUEST SUMMARY (REQUIRED)**

Form 1B collects the funding request for the NAP application. The maximum amount of funding in Year 1 is \$650,000; any one-time funding requested for equipment or minor alteration and renovation (up to \$150,000) is included in this amount. Applicants can request up to \$650,000 for operations in Year 2. Before completing Form 1B, the SF-424A: Budget Information form must be completed. See [Section IV.2.iii](#) for instructions on completing the SF-424A. The SF-424A is the official budget request. Therefore, if a NAP award is received, only one-time funding as indicated on the SF-424A will be included. The one-time funding information entered on [Form 1B](#): BPHC Funding Request Summary must be consistent with the request on the SF-424A.

For the Year 1 operational funding column, enter operational budget information by funding category (CHC, MHC, HCH, and/or PHPC). Only the types of health center programs selected in the Budget Summary (Section A) of the SF-424A will be available in Form 1B. Next, enter any one-time funds requested for minor alteration/renovation and/or equipment (up to \$150,000). The one-time funding request on Form 1B must be consistent with the federal request for equipment and/or construction in Section B on the SF-424A. The budget for Year 2 on Form 1B will be pre-populated from data provided by the applicant in Federal Resources (Section E) of the SF-424A.

**Applicants will not be allowed to modify the pre-populated data on this form. If changes are required, applicants must modify the appropriate section of the SF-424A. A link to the SF-424A will be provided for navigation to the appropriate budget sections.**

Applicants requesting one-time funding for equipment and/or minor alteration/renovation must indicate if the one-time funds are for: 1) equipment only; 2) minor alteration/renovation with equipment; or 3) minor alteration/renovation without equipment. Applicants requesting one-time funding for equipment only or minor alteration/renovation with equipment must complete an equipment list. Equipment is considered to be loose, moveable items that are non-expendable, tangible personal property (including information technology systems<sup>19</sup>) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of (a) the

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<sup>19</sup> Licenses for electronic health records or health information technology should be reported in the “Other” cost category.



capitalization level established by the applicant for its financial statement purposes, or (b) \$5,000. See [Appendix C](#) for detailed instructions on equipment requirements.

Applicants that request one-time funding for minor alteration/renovation (with or without equipment) must complete the Alteration/Renovation (A/R) Project Cover Page, Other Requirements for Sites Form, budget justification for the minor alteration/renovation project, Environmental Information and Documentation (EID) Checklist, and architectural drawings of the proposed alteration/renovation. If the property is leased, the applicant must attach a Landlord Letter of Consent. See [Appendix C](#) for detailed instructions on alteration/renovation requirements.

## **FORM 1C – DOCUMENTS ON FILE (REQUIRED)**

Form 1C provides a summary of documents that support the implementation of listed Health Center Program requirements and key areas of health center operations. It does not provide an exhaustive list of all types of health center documents (e.g., policies and procedures, protocols, legal documents). Provide the date that each document was last reviewed and, if appropriate, revised. Reference the Health Center Program requirements for detailed information about each requirement.

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. **Any document on Form 1C that is not in place or current should be included on the Implementation Plan ([Attachment 2](#)) to ensure compliance with Health Center Program requirements within 120 days of the Notice of Award.**

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 award recipients can apply for FTCA coverage upon meeting the FTCA eligibility requirements, but must maintain malpractice coverage in the interim. FTCA participation is not guaranteed. Funded health centers that opt out of FTCA (e.g., Public Entity-Health Centers) must maintain malpractice insurance coverage at all times. See [Section VIII](#) for more information about FTCA.

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.

**Note:** Beyond Health Center Program requirements, other federal and state requirements may apply. 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 for the proposed NAP project for each year of the two-year project period. Include only staff for sites included on [Form 5B](#): Service Sites, including volunteers and those that are part of an indirect cost rate. 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 in the Direct Hire FTE column 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 Clinical 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 Reporting Manual at <http://bphc.hrsa.gov/datareporting/reporting/index.html>.
- Volunteers must be recorded in the Direct Hire FTEs column.
- In the Contract/Agreement FTEs column, indicate whether contracts are used for specific provider categories. If both direct hire staff and contracts are used, provide the number of Direct Hire FTEs only and check Yes in the Contract/Agreement FTEs column. Contracted staff should be summarized in [Attachment 7: Summary of Contracts and Agreements](#) and/or included in contracts uploaded to [Form 8: Health Center Agreements](#), as needed.

### **FORM 3 – INCOME ANALYSIS (REQUIRED)**

Complete Form 3 to show the projected patient services and projected income from all sources (other than the Health Center Program award), for each year of the two-year project period. Form 3 must be based ONLY on the proposed NAP project. Form 3 income is divided into two parts: (1) Patient Service Revenue - Program Income and (2) Other Income - Other Federal, State, Local, and Other Income.

New start applicants that do not have an FQHC reimbursement rate for services provided to Medicaid and Medicare beneficiaries may contact their State/Regional Primary Care Association to inquire about FQHC rates for service delivery programs that are similar in size. For contact listings, refer to <http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/associations.html>.

#### **Part 1: Patient Service Revenue - Program 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., breast and cervical cancer screening), 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.

The program income section groups billable visits and income into the same five payer groupings used in the Uniform Data System (UDS). See the UDS Manual available at <http://bphc.hrsa.gov/datareporting/reporting/index.html> 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 which 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 NAP scope of project must 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 the UDS Manual, 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 & 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.<sup>20</sup> There may be other exclusions or additions which, if significant, should be noted in the Comments/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](#) under the payer categories 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. Applicants with no operations at the proposed NAP site(s) should enter zero for prior year income.

**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 Reporting Manual](#) must be used to define each payer category.

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

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<sup>20</sup> These visits will correspond closely with the visits reported on the UDS Manual Table 5, excluding enabling service visits.

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.

**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 Veterans 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 (not including the NAP 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 awards where the NAP applicant is the recipient of a Notice of Award from a federal agency. It does not include the NAP grant request or federal funds awarded through intermediaries (see Line 9 below). It includes funding from federal sources such as the Centers for Disease Control (CDC), Housing and Urban Development (HUD), Centers for Medicaid and Medicare Services (CMS), Health and Human Service (HHS) grants under the Ryan White Part C program, 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 Manual.

**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 as 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 which 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 Health Center Program 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-Health Center Program) income.

**Note: In-kind donations are not included as income on Form 3.** Applicants may discuss in-kind contributions in Item 2 of 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 (i.e., all proposed NAP sites) for which data are available. 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.

The service area must be specific to the proposed project and correspond to the zip codes listed on [Form 5B: Service Sites](#). Service area data must include the total number of persons in the service area 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, or 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 seasonal workers during the summer months) that are not included in the dataset used for service area data (e.g., Census data), the applicant should adjust the service area numbers accordingly to ensure that the target population numbers are always less than or equal to the service area numbers. Adjustments must be explained in Item 1 of the [NEED](#) section of the Project Narrative.

**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**.

### ***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. Use 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, Palau, Tonga, Chuuk, 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 – Persons who identify with two or more races.

### ***Guidelines for Reporting Hispanic or Latino Ethnicity***

- If ethnicity is unknown, report individuals as Unreported/Declined to Report.
- Use 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 this form does not have a row for total numbers. Individuals that represent multiple special population categories should be counted in all applicable categories.

## **FORM 5A – SERVICES PROVIDED (REQUIRED)**

Identify the services that will be available through the new access point(s) and how the services will be provided (i.e., direct by health center, formal written agreement (health center pays for service), formal written referral arrangement). The new access point(s) must provide all required services either directly onsite or through established agreements/ arrangements without regard to ability to pay and on a sliding fee discount schedule. See the Form 5A Service Descriptors at



<http://bphc.hrsa.gov/programrequirements/scope.html> for descriptions of the general elements for all services. Established agreements must be summarized in [Attachment 7](#) and, if they constitute a significant portion of the applicant's scope of project, agreements/contracts must be noted on [Form 8](#). Additional services are not required. However, when offered, they must be provided without regard to ability to pay and on a sliding fee discount schedule.

Because comprehensive primary medical care is the main purpose of the NAP project, General Primary Medical Care must be offered at the NAP site either directly by the health center (Column I) or through formal written contractual agreements in which the health center pays for the service (Column II). General Primary Medical Care cannot be provided solely by referral for the NAP project. Reminder: This is an eligibility criterion.

If the project is funded, only the services included on Form 5A will be considered to be in the approved scope of project, regardless of what is described or detailed elsewhere in the application. Refer to the Scope of Project policy documents and resources available at <http://bphc.hrsa.gov/programrequirements/scope.html> for more information on services and modes of service delivery.

**NOTE:** Specialty services may not be added to an applicant's proposed scope of project at the time of NAP submission. However, specialty services may be added to the scope of project through the Change in Scope process after NAP funding has been awarded. Refer to PIN 2009-02: Specialty Services and Health Centers' Scope of Project available at <http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin200902.pdf> for more information.

## **FORM 5B – SERVICE SITES (REQUIRED)**

On Form B, identify the proposed NAP site(s)<sup>21</sup> and provide the required data for each site, including:

- Site address (must be a verifiable street address);
- Location type (permanent, seasonal, or mobile van);
- Site Operational Date (must be within 120 days of award);
- Total hours of operation per week;
- Service area zip codes; and
- Subrecipient or contractor information, if applicable.

At least one proposed service site must be a full-time (operational 40 hours or more per week), permanent service delivery site (with the exception of proposed NAP projects serving only migratory and seasonal agricultural workers, addressed below) that provides comprehensive primary medical care as its main purpose. A permanent site is a fixed building location. Subsequent service sites may be administrative, part-time, seasonal, etc.

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<sup>21</sup> A current Health Center Program look-alike may propose the site(s) currently included in its Health Center Program look-alike scope of project, as well as new site(s), as long as those sites are not included in any Health Center Program award recipient's scope of project.

Applicants proposing to serve only migratory and seasonal agricultural workers may propose a full-time seasonal service delivery site that operates at least 40 hours per week and provides comprehensive primary medical care as its main purpose.

Provide the required data for each proposed new access point that meets the definition of a service site. Refer to PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes available at <http://bphc.hrsa.gov/programrequirements/pdf/pin2008-01.pdf> for more information on defining service sites and for special instructions for recording mobile, intermittent, or other site types. Information presented on Form 5B will be used by HRSA to determine the scope of project for the NAP award. Only the service sites included on Form 5B will be considered to be in the approved scope of project. Service sites described or detailed in other portions of the application (e.g., narratives, attachments) are not considered to be included in the approved scope of project if the application is funded.

On each Form 5B, applicants should include the zip codes for the area served by the site. The zip code of the site address must be listed in the service area zip codes on Form 5B. The applicant's entire service area (as described on Form 4) should be represented by the consolidation of all zip codes across all proposed service sites (all 5B forms). The zip codes listed on Form 5B will be used to determine the NAP service area and calculate the Unserved, High Poverty, Sparsely Populated, and Look-Alike Priority Points.

For additional instructions for each field of Form 5B, see the NAP TA webpage at <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/>. Note that in the Service Site Checklist, applicants will have to state if the proposed site is a Domestic Violence site (e.g., emergency shelter). Select "yes" for this question only if the site being added is a site serving victims of domestic violence and the street address cannot be published to protect the confidentiality of the precise location.

**NOTE:** Applicants must certify on the Summary Page Form that ALL sites included on Form 5B will be open and operational within 120 days of Notice of Award.

## **FORM 5C – OTHER ACTIVITIES/LOCATIONS (AS APPLICABLE)**

Provide requested data for other activities/locations (e.g., home visits, health fairs). List only the 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.

NAP service site(s) should not be listed on Form 5C. Refer to PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes (available at <http://bphc.hrsa.gov/programrequirements/pdf/pin2008-01.pdf>) for more details.

If the project is funded, only the activities/locations included on Form 5C will be considered to be in the approved scope of project, regardless of what is described or detailed elsewhere in the application.

## **FORM 6A – CURRENT BOARD MEMBER CHARACTERISTICS (REQUIRED)**

List all current board members (minimum of nine; maximum of 25) and provide the requested details. For more information regarding board requirements, refer to the Health Center Program Governance policy available at

<http://bphc.hrsa.gov/programrequirements/policies/pin201401.html>.

- Public entities with co-applicant health center governing boards must list the co-applicant board members.
- Special population applicants requesting a waiver of the patient majority requirement must list the health center's board members, not the members of an advisory council.
- 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). Do not list the CEO or other health center employees.<sup>22</sup>
- Indicate if each board member derives more than 10 percent of income from the health care industry.
- Indicate if each board member is a health center patient, which is part of the patient majority. 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 health center visit. (Refer to [Form 1A](#) instructions above for the definition of a visit).
- Indicate if each board member lives and/or works in the service area. Note: This is not a requirement to serve on a health center board, but assists with assessing how representative the board is of the community being served.
- Indicate if each 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 gender, ethnicity, and race of board members who are patients of the health center and make up the patient majority.

For applicants that currently receive Health Center Program funding (satellite applicants), the list of board members will be pre-populated from the latest approved application. Applicants are expected to update pre-populated information as appropriate.

**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 BOARD MEMBER REQUIREMENT**

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<sup>22</sup> The CEO may serve only as a non-voting, ex-officio board member and is generally only a member by virtue of being CEO of the health center.

This form is only applicable if you are proposing to serve only special populations (i.e., HCH, MHC, and/or PHCP). An applicant that currently receives or is applying to receive CHC (section 330(e)) funding is not eligible for a waiver. Indian tribes or tribal, Indian, or urban Indian groups are not required to complete this form and cannot enter information.

For applicants applying to serve special populations only, when requesting a waiver, briefly demonstrate good cause as to why the patient majority board composition requirement cannot be met, 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 the Item 2 of the [GOVERNANCE](#) section of the Project Narrative that identifies these individuals and their reasons/qualifications for participation on the advisory council or as governing board representatives.
- Specific types 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 presentations of the advisory group to the full board, monthly summary reports from patient surveys).
- Specifics on how the patient input will be used by the governing board for: 1) selecting health center services; 2) setting health center operating hours; 3) defining strategic 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.

***Note:*** An approved waiver does not absolve the organization's governing board from fulfilling all other statutory board responsibilities and requirements.

## **FORM 8 – HEALTH CENTER AGREEMENTS (REQUIRED)**

On Form 8, indicate whether the applicant organization:

- Has a parent, affiliate, or subsidiary organization.
- Has or proposes to make as part of this application any subawards to subrecipients.
- Has or intends to contract with another organization to carry out a substantial portion of the proposed scope of project.

Select “Yes” in Part I if:

- A subaward or contract will be made to a related organization such as a parent, affiliate, or subsidiary.
- A proposed site will be operated by a subrecipient or contractor, as identified in Form 5B: Service Sites.
- The applicant organization will contract for the majority of core primary care services and/or health center key management positions (e.g., Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO)).

Refer to Uniform Guidance 2 CFR 200 as codified by HHS at [45 CFR 75](#) for the definition of “substantial” and characteristics of a subrecipient or contractor agreement. Applicants must use judgment in classifying each agreement as a subaward or a procurement contract, based on the substance of the relationship. If there are current/proposed agreements that will constitute a substantial portion of the project, indicate the number of each type in the appropriate field and attach the complete affiliation agreement, contract, and/or subaward in Part II.

Part II will accept a maximum of 10 Affiliate/Contract/Subaward Organizations with five document uploads for each. Additional documentation that exceeds this limit should be included in [Attachment 15](#): Other Relevant Documents. As a reminder, a summary of all subrecipient 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 and 15](#) **will** count against the page limit.

## **FORM 9 – NEED FOR ASSISTANCE (NFA) 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 (available at <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/>) for recommended data sources and methodology. To ensure data consistency and validity, applicants must adhere to the following instructions when completing the form. Applicants will be asked to verify the validity of NFA data on the Summary Page Form.

### **GENERAL INSTRUCTIONS**

Only one NFA Worksheet will be submitted per applicant regardless of the number of new access points proposed.

- **New start applicants** must complete the NFA Worksheet based on the entire proposed scope of project (proposed NAP service area and/or target population).
- **Satellite applicants** must complete the NFA Worksheet based on the **proposed new access point(s) ONLY** (proposed NAP service area and/or target population only).

If an applicant proposes **multiple sites and/or populations**, the NFA Worksheet responses should represent the total combined population for all sites. Applicants with multiple sites are considered to have only one combined service area. **Only one response may be submitted for each barrier or health indicator.**

### **Guidelines for Completing the NFA Worksheet:**

- Recommended data sources are identified in the Data Resource Guide located at <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/>. 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.
- All responses must be expressed as a finite number (e.g., 212.5) and cannot be presented as a range (e.g., 31-35).

- 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:

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 I, one Core Health Indicator for each of six categories in Section II, and two of the 13 Other Health and Access Indicators in Section III. 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 extrapolation instructions in the Data Resource Guide). 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.

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 Core Barrier D, distance/time is measured from the proposed site to the nearest provider accepting new Medicaid and uninsured patients.

## 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:

- (a) 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.
- (b) Applicants must provide the following information:
  - **Data Response** – The 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 (e.g., 2010-2014), 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 used, name the data source and provide a rationale (e.g., more current, more geographically specific, more population specific).
  - **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) and data source.
    - Level of geography – Identify the 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).



**NFA WORKSHEET SCORING (Maximum 100 points to be converted to a 20-point scale)**

The NFA Worksheet will be scored out of a total possible 100 points. If no response or data source is provided for a Barrier or Indicator, **no** points will be awarded for that indicator.

**SECTION I: CORE BARRIERS (Maximum 60 points)**

A response is required for **3 of the 4 Core Barriers**. The points awarded for each Barrier response will be calculated using the point distributions provided below.

<i>Population to One FTE Primary Care Physician Ratio</i>			
<i>Scaling</i>			<i>Points</i>
	<	1,494	0
1494	to <	1,734	1
1734	to <	1,974	2
1974	to <	2,214	3
2214	to <	2,454	4
2454	to <	2,694	5
2694	to <	2,934	6
2934	to <	3,174	7
3174	to <	3,413	8
3413	to <	3,653	9
3653	to <	3,893	10
3893	to <	4,133	11
4133	to <	4,373	12
4373	to <	4,613	13
4613	to <	4,853	14
4853	to <	5,093	15
5093	to <	5,333	16
5333	to <	5,573	17
5573	to <	5,813	18
5813	to <	6,053	19
	≥	6,053	20

<i>Percent of Population Below 200 Percent of Poverty<sup>23</sup></i>			
<i>Scaling</i>			<i>Points</i>
	<	38.20%	0
38.20%	to <	39.70%	1
39.70%	to <	41.30%	2
41.30%	to <	42.90%	3
42.90%	to <	44.40%	4
44.40%	to <	46.00%	5
46.00%	to <	47.60%	6
47.60%	to <	49.10%	7
49.10%	to <	50.70%	8
50.70%	to <	52.30%	9
52.30%	to <	53.80%	10
53.80%	to <	55.40%	11
55.40%	to <	57.00%	12
57.00%	to <	58.50%	13
58.50%	to <	60.10%	14
60.10%	to <	61.70%	15
61.70%	to <	63.20%	16
63.20%	to <	64.80%	17
64.80%	to <	66.40%	18
66.40%	to <	67.90%	19
	≥	67.90%	20

<sup>23</sup> Data must be submitted for the proposed service area (not the target population), unless serving special population(s) ONLY.

<i>Percent of Population Uninsured<sup>24</sup></i>			
<i>Scaling</i>			<i>Points</i>
	<	11.50%	0
11.50%	to <	12.30%	1
12.30%	to <	13.00%	2
13.00%	to <	13.80%	3
13.80%	to <	14.60%	4
14.60%	to <	15.30%	5
15.30%	to <	16.10%	6
16.10%	to <	16.90%	7
16.90%	to <	17.60%	8
17.60%	to <	18.40%	9
18.40%	to <	19.20%	10
19.20%	to <	19.90%	11
19.90%	to <	20.70%	12
20.70%	to <	21.50%	13
21.50%	to <	22.20%	14
22.20%	to <	23.00%	15
23.00%	to <	23.80%	16
23.80%	to <	24.50%	17
24.50%	to <	25.30%	18
25.30%	to <	26.10%	19
	≥	26.10%	20

<i>Distance (miles) OR travel time (minutes) to nearest primary care provider accepting new Medicaid and uninsured patients</i>		
<b>Distance (in miles)</b>	<b>Driving time (in minutes)</b>	<i>Points</i>
<i>Scaling</i>	<i>Scaling</i>	
< 7	< 13	0
7 to <10	13 to <17	1
10 to <12	17 to <20	2
12 to <14	20 to <23	3
14 to <16	23 to <26	4
16 to <18	26 to <29	5
18 to <20	29 to <33	6
20 to <22	33 to <36	7
22 to <25	36 to <39	8
25 to <27	39 to <42	9
27 to <29	42 to <45	10
29 to <31	45 to <49	11
31 to <33	49 to <52	12
33 to <35	52 to <55	13
35 to <37	55 to <58	14
37 to <40	58 to <62	15
40 to <42	62 to <65	16
42 to <44	65 to <68	17
44 to <46	68 to <71	18
46 to <48	71 to <74	19
≥ 48	≥ 74	20

## SECTION II: CORE HEALTH INDICATORS (Maximum 30 points)

Applicant must provide a response to **1 core health indicator from each of the 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 and, where applicable, the severe (75th percentile) benchmark for each indicator within the six categories. Benchmarks are based on national public data sources such as the Centers for Disease Control, Substance Abuse and Mental Health Services Administration, Agency for Healthcare Research and Quality, HRSA, and the U.S. Census.

<sup>24</sup> Data must be submitted for the proposed service area (not the target population), unless serving special population(s) ONLY.

Applicants will receive four points for each response that **exceeds** the corresponding national median benchmark and one additional point if the response also **exceeds** the corresponding severe benchmark. Data that equal a benchmark will not receive any corresponding points.

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, the applicant must specify the indicator’s definition, data source, benchmark, source of the benchmark, and rationale for using the alternative indicator. However, the applicant will **NOT** be eligible for additional points for exceeding a severe benchmark (four points maximum for each “Other” indicator). See the Data Resource Guide for detailed instructions on providing documentation for an “Other” indicator.

<b>SECTION II: CORE HEALTH INDICATOR CATEGORIES</b>	<b>National Median Benchmark (4 Points if Exceeded)</b>	<b>Severe Benchmark (1 Additional Point if Exceeded)</b>
<b>1. Diabetes</b>		
1(a) Age-adjusted diabetes prevalence	8.1%	9.2%
1(b) Adult obesity prevalence	27.6%	30.2%
1(c) Age-adjusted diabetes mortality <sup>25</sup> rate (per 100,000)	22.5	24.8
1(d) Percent of diabetic Medicare enrollees not receiving a hemoglobin A1c (HbA1c) test	18.0%	20.4%
1(e) Percent of adults (18 years and older) with no physical activity in the past month	24.0%	26.6%
1(f) <i>Other</i>	<i>Provided by Applicant</i>	<i>N/A</i>
<b>2. Cardiovascular Disease</b>		
2(a) Hypertension hospital admission rate (18 years and older; per 100,000)	61.4	66.3
2(b) Congestive heart failure hospital admission rate (18 years and older; per 100,000)	361.7	378.3
2(c) Age-adjusted mortality from diseases of the heart <sup>26</sup> (per 100,000)	179.4	203.2
2(d) Proportion of adults reporting diagnosis of high blood pressure	28.7%	31.4%
2(e) Percent of adults who have not had their blood cholesterol checked within the last 5 years	23.1%	25.7%
2(f) Age-adjusted cerebrovascular disease mortality (per 100,000)	41.4	46.3
2(g) <i>Other</i>	<i>Provided by Applicant</i>	<i>N/A</i>
<b>3. Cancer</b>		
3(a) Cancer screening – percent of women 18 years and older with no Pap test in past 3 years	18.4%	20.1%

<sup>25</sup> 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).

<sup>26</sup> Total number of deaths per 100,000 reported as due to heart disease (includes ICD-10 codes I00-I09, I11, I13, and I20-I51).

<b>SECTION II: CORE HEALTH INDICATOR CATEGORIES</b>	<b>National Median Benchmark (4 Points if Exceeded)</b>	<b>Severe Benchmark (1 Additional Point if Exceeded)</b>
3(b) Cancer screening – percent of women 50 years and older with no mammogram in past 2 years	22.2%	25.8%
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%	85.0%
3(d) Percent of adults who currently smoke cigarettes	17.3%	20.3%
3(e) Age-adjusted colorectal cancer mortality (per 100,000)	14.0	15.2
3(f) Age-adjusted breast cancer mortality (per 100,000) among females	22.1	23.8
3(g) Other	<i>Provided by Applicant</i>	<i>N/A</i>
<b>4. Prenatal and Perinatal Health</b>		
4(a) Low birth weight (<2500 grams) rate (5 year average)	7.9%	9.4%
4(b) Infant mortality rate (5 year average; per 1,000)	6.6	7.9
4(c) Births to teenage mothers (ages 15-19; percent of all births)	8.4%	10.0%
4(d) Late entry into prenatal care (entry after first trimester; percent of all births)	16.4%	21.1%
4(e) Cigarette use during pregnancy (percent of all pregnancies)	14.1%	18.2%
4(f) Percent of births that are preterm (<37 weeks gestational age)	12.0%	13.0%
4(g) Other	<i>Provided by Applicant</i>	<i>N/A</i>
<b>5. Child Health</b>		
5(a) Percent of children (19-35 months) not receiving recommended immunizations: 4-3-1-3-3-1-4 <sup>27</sup>	30.0%	34.6%
5(b) Percent of children not tested for elevated blood lead levels by 72 months of age	84.1%	89.3%
5(c) Pediatric asthma hospital admission rate (2-17 year olds; per 100,000)	116.0	148.3
5(d) Percent of children (10-17 years) who are obese	15%	18.1%
5(e) Other	<i>Provided by Applicant</i>	<i>N/A</i>
<b>6. Behavioral Health</b>		
6(a) Percent of adults with at least one major depressive episode in the past year	6.6%	7.3%
6(b) Suicide rate (per 100,000)	13.5	15.2
6(c) Binge alcohol use in the past month (percent of population 12 years and older)	24.1%	26.1%
6(d) Age-adjusted drug poisoning (i.e., overdose) mortality rate per 100,000 population	12.3	14.8
6(e) Other	<i>Provided by Applicant</i>	<i>N/A</i>

<sup>27</sup> 4 DTap, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B, 1 varicella, and 4 Pneumococcal conjugate.

### SECTION III: OTHER HEALTH AND ACCESS INDICATORS (Maximum 10 points)

Applicants must provide responses to **2 of the 13** Other Health and Access Indicators. Applicants will receive 5 points for each response that **exceeds** the corresponding national median benchmark provided in the table below.

SECTION III: OTHER HEALTH AND ACCESS INDICATORS	National Median Benchmark (5 Points if Exceeded)
(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 <sup>28</sup> 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%

### CONVERSION OF NFA WORKSHEET SCORE TO APPLICATION SCORE

The NFA Worksheet will be converted to a 20-point scale using the following conversion table. The converted NFA Worksheet score will account for up to 20 points out of 100 total points for the overall application score (up to 20 of the available 30 points for the **NEED** section of the Project Narrative). Applicants will be able to view the scores for each NFA section in the read-only version of the form accessible in the Review section of the Program Specific Information in the EHBs. The total NFA Worksheet score can also be found on the Summary Page Form for the Program Specific Information. Applicants should ensure their understanding of the system-calculated score prior to application submission.

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<sup>28</sup> Three year average number of deaths per 100,000 due to influenza and pneumonia (ICD 10 codes J09-J18).

## NFA WORKSHEET TO APPLICATION SCORE CONVERSION TABLE

NFA Worksheet Score		Converted Application Need Score
100-96	=	20
95-91	=	19
90-86	=	18
85-81	=	17
80-76	=	16
75-71	=	15
70-66	=	14
65-61	=	13
60-56	=	12
55-51	=	11
50-46	=	10
45-41	=	9
40-36	=	8
35-31	=	7
30-26	=	6
25-21	=	5
20-16	=	4
15-11	=	3
10-6	=	2
5-1	=	1

### FORM 10 – ANNUAL EMERGENCY PREPAREDNESS REPORT (REQUIRED)

Select the appropriate responses regarding emergency preparedness. If any answer is no, explain the response in Item 10 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)

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 used by HRSA when reviewing the NAP applications. Content will be pre-populated from the Program Specific Forms. If the pre-populated data appear incorrect, verify that the pertinent data provided in the Program Specific Forms ([1A](#), [1B](#), [2](#), [5B](#), and [9](#)) have been entered correctly. Reference will be provided regarding where to make corrections if needed.

Proposed NAP site(s) and service area zip codes will pre-populate from [Form 5B](#): Service Sites. Funded applicants will be held accountable for verifying ALL proposed sites open and operational within 120 days of Notice of Award. Applicants are encouraged to use this section of the form to verify that the correct sites have been proposed, the correct service area zip codes have been proposed, and all proposed sites have street addresses.

The total number of unduplicated patients projected to be served by December 31, 2018 (January 1 – December 31, 2018) will be pre-populated from [Form 1A](#): General Information Worksheet. Funded applicants will be held accountable for meeting the **unduplicated** patient projection (from the Total line under Unduplicated Patients and Visits by Population Type on [Form 1A](#): General Information Worksheet) and any future or other supplemental funding patient commitments by December 31, 2018. Applicants are encouraged to use this section of the form to verify that total number of unduplicated patients projected to be served is realistic and appropriate based on the proposed NAP project.

Note that the population funding percentages (i.e., percentage of funding requested for CHC, MHC, HCH, and/or PHPC) will be based on operational funds requested for Year 2 and will therefore not include any one-time funding requested. The population funding percentages and federal dollars per patient will be automatically calculated. The federal dollars per patient will be calculated by dividing the federal dollar amount requested by the projected number of unduplicated patients projected to be served by December 31, 2018 by population type entered on [Form 1A](#). Applicants are encouraged to use this section of the form to verify that each year of the NAP funding request is appropriately budgeted by population type and reasonable for the number of patients projected to be served.

This form will be certified by checking a box at the bottom to signify that the applicant has double-checked all information provided to ensure accuracy, including the data provided on Form 9, the Need for Assistance worksheet. Funded applicants will be held accountable for:

- having **all proposed sites** (from [Form 5B](#)) open and operational within 120 days of Notice of Award, and
- meeting the calendar year 2018 **unduplicated patient projection** (from [Form 1A](#)) by December 31, 2018.



## **Appendix B: Performance Measures Instructions**

### **CLINICAL AND FINANCIAL PERFORMANCE MEASURES**

The Clinical and Financial Performance Measures set the clinical and financial goals to be achieved by December 31, 2018. The goals must be responsive to the proposed target population, identified community health and organizational needs, and key service delivery activities discussed in the application. For more information on the Clinical and Financial Performance Measures, see

<http://bphc.hrsa.gov/policiesregulations/performance Measures/> and <http://www.hrsa.gov/data-statistics/health-center-data/reporting> (refer to the UDS Reporting Manual for specific measurement details such as exclusionary criteria). Samples can be found at <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/>.

#### **Required Clinical Performance Measures**

1. Diabetes
2. Cardiovascular Disease/Hypertension
3. Cervical Cancer Screening
4. Prenatal Health
5. Perinatal Health/Birth Weight
6. Child Health/Immunizations
7. Oral Health/Dental Sealants (new)
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. HIV Linkage to Care
16. Depression Screening and Follow-Up

#### **Required Financial Performance Measures<sup>29</sup>**

1. Total Cost Per Patient
2. Medical Cost Per Medical Visit
3. Health Center Program Grant Cost per Patient (new)

#### **Important Details about the Performance Measures Forms**

- The Clinical and Financial Performance Measures should address ONLY the service area and target population of the proposed new access point(s).
  - New start applicants are expected to complete the Clinical and Financial Performance Measures based on the entire proposed scope of their NAP project.

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<sup>29</sup> Three audit-related measures have been discontinued.

- Satellite applicants are expected to complete the Clinical and Financial Performance Measures based on their proposed new access point(s) ONLY.
- 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, enter 0 for the numerator and denominator and state in the comments field the date when baseline data will be available.
- If applying for funds to target one or more special populations (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing) in addition to the general community, applicants *must include* at least one additional Clinical Performance Measure that addresses the unique health care needs of each of the special 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...*”
- 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.

### New and Updated Performance Measures<sup>30</sup>

- The Diabetes Clinical Performance Measure has been revised to adult patients with HbA1c levels > 9 percent.
- A new standardized Oral Health performance measure focused on use of sealants in children ages 6-9 years at elevated risk for cavities has been added.
- A Health Center Program Grant Cost per Patient performance measure has been added.

### Overview of the Performance Measures Form Fields

The following table provides details for completing the performance measures forms.

Field Name	Description
Focus Area	This field contains the content area description for each required performance measure. Applicants will specify focus areas when adding Other performance measures.
Performance Measure	This field defines each performance measure. Applicants may specify this field for Other performance measures.
Target Goal Description	In this field, applicants provide a description of the target goal to be met by December 31, 2018.

<sup>30</sup> Refer to [PAL 2015-05](#): Approved Uniform Data System Changes for Calendar Year 2015 for details about new and updated performance measures.

Field Name	Description
Numerator Description	<p>In 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.</p> <p>Applicants must specify a numerator for Other performance measures. The numerator for all other measures can be found at <a href="http://bphc.hrsa.gov/policiesregulations/performanceasures">http://bphc.hrsa.gov/policiesregulations/performanceasures</a>.</p>
Denominator Description	<p>In 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.</p> <p>Applicants must specify a denominator for Other performance measures. The denominator for all other measures can be found at <a href="http://bphc.hrsa.gov/policiesregulations/performanceasures">http://bphc.hrsa.gov/policiesregulations/performanceasures</a>.</p>
Baseline Data	This field contains subfields that provide information regarding the initial threshold used to measure progress.
Baseline Year	The Baseline Year subfield identifies the initial data reference point.
Measure Type	The Measure Type subfield provides the unit of measure (e.g., percentage, ratio).
Numerator and Denominator	Applicants provide the number for the Numerator and Denominator subfields based on patient or organizational characteristics (see above).
Projected Data	In this field, applicants provide the goal to be met by December 31, 2018.
Data Source and Methodology	<p>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.</p> <p>For Clinical Performance Measures, applicants must select the data source—EHR, Chart Audit, or Other (please specify)—before describing the methodology.</p>
Key Factors and Major Planned Actions	This field contains subfields that provide information regarding factors predicted to contribute to or restrict progress toward achievement of the projected data goal, as well as major planned actions.
Key Factor Type	Applicants select Contributing and/or Restricting factor categories. Applicants must specify at least one key factor of each type.
Key Factor Description	Applicants provide a narrative description of the factors predicted to contribute to and restrict progress toward stated goals.
Major Planned Action Description	Applicants provide a description of the major actions planned for addressing the identified key factors. Applicants must use this subfield to outline major action steps and strategies for achieving each performance measure. This field has a 1,500-character limit.

Field Name	Description
Comments	This open text field, limited to 1,500 characters, enables applicants to provide additional information.

### Resources for the Development of Performance Measures

- Current health centers are encouraged to use the UDS Health Center Trend Report and/or Summary Report available in EHB when goals for the NAP project.
- 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](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 at <http://bphc.hrsa.gov/uds/datacomparisons.aspx>).
- Use the Healthy People 2020 goals as a guide when developing performance measures. Several of these objectives can be compared directly to UDS clinical performance measures (high blood pressure under control, 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://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/>.

## Appendix C: One-Time Funding Request Information

Within the maximum annual amount of \$650,000, applicants may request to use up to \$150,000 in funding in Year 1 only for one-time costs for equipment and/or minor alterations/renovations. Applicants are required to enter budget information for one-time funding on the [SF-424A](#) (in the equipment and/or construction object class categories) and [Form 1B](#).

**Note:** Within 120 days of the Notice of Award, funded new access points must be operational and begin providing services for the population/community, regardless of the proposed one-time funding activities.

**One-time funding cannot be used for new construction activities (i.e., additions or expansions), major alterations/renovations (the total federal and non-federal cost of the alteration/renovation project cannot exceed \$500,000, minus the cost of moveable equipment), or the installation of trailers/pre-fabricated modular units.**

If the funding request summary on [Form 1B](#) includes one-time funding, applicants will be required to indicate for which activities the funds will be used:

- Equipment only;
- Equipment and minor alteration/renovation; or
- Minor alteration/renovation without equipment.

Requests for equipment-only projects or minor alteration/renovation with moveable equipment require an equipment list. Applicants requesting one-time funding for minor alteration/renovation (with or without moveable equipment) must complete additional forms in EHB. After completing Form 5B, which collects information about the new access point site, applicants will indicate whether one-time funding will be used for minor alteration/renovation at that site. If yes, applicants must complete the Alteration/Renovation (A/R) Project Cover Page and Other Requirements for Sites forms and attach the A/R project information, as specified below.

### Equipment Purchases

Applicants requesting one-time funding for equipment purchases (with or without minor alteration/renovation) must submit a complete list of the requested equipment in EHB. For each item on the equipment list, the following fields must be completed:

- **Type** – Select clinical or non-clinical.
- **Item Description** – Provide a description of each item.
- **Unit Price** – Enter the price of each item.
- **Quantity** – Enter of the number of each item to be purchased.
- **Total Price** – EHB will calculate the total price by multiplying the unit price by the quantity entered.

Any equipment purchased with grant funds must be pertinent to health center operations. Further, equipment purchased with grant funds must be procured through a competitive process and maintained, tracked, and disposed of in accordance with 45 CFR 75.

An allowable equipment-only project is limited to moveable items that are non-expendable, tangible personal property (including information technology systems<sup>31</sup>) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of (a) the capitalization level established by the applicant for its financial statement purposes, or (b) \$5,000. Moveable equipment can be readily shifted from place to place without requiring a change in the utilities or structural characteristics of the space. Moveable equipment is usually purchased outside of any construction contract. Dental chairs and radiographic equipment are considered moveable equipment.

Permanently affixed equipment (e.g., heating, ventilation, and air conditioning (HVAC), generators, lighting) is considered fixed equipment and is categorized as minor alteration/renovation (not equipment).

The selection of all equipment should be based on a preference for recycled content, non-hazardous substances, non-ozone depleting substances, energy and water efficiency, and consideration of final disposal (disposed in a manner that is safe, protective of the environment, and compliant with all applicable regulations), unless there are conflicting health, safety, and performance considerations. Applicants are strongly encouraged to employ the standards established by either the Electronic Product Environmental Assessment Tool (EPEAT) or Energy Star, where practicable, in the procurement of equipment. Following these standards will mitigate the negative effects on human health and the environment from the proliferation, rapid obsolescence, low recycling rate, high energy consumption, potential to contain hazardous materials, and increased liability from improper disposal. Additional information for these standards can be found at <http://www.epeat.net> and <http://www.energystar.gov>.

### **Minor Alteration/Renovation**

Applicants requesting one-time funding for minor alteration/renovation up to \$150,000 in Year 1 (with or without moveable equipment) must complete the Alteration/Renovation (A/R) Project Cover Page and Other Requirements for Sites forms in EHB for each site where minor alteration/renovation is proposed.

An allowable minor alteration/renovation project must be a stand-alone project consisting of work required to modernize, improve, and/or reconfigure the interior arrangements or other physical characteristics of a facility; work to repair and/or replace the exterior envelope; minor work to improve accessibility such as curb cuts, ramps, or widening doorways; and/or address life safety requirements in an existing facility. The project may also include the costs of permanently affixed items such as windows, HVAC, signs, or lighting. An allowable project would **not** increase the total square footage of an existing building or require ground disturbance (such as new parking surfaces or expansion of a building footprint).

### **Alteration/Renovation (A/R) Project Cover Page**

Applicants requesting one-time funding for minor alteration/renovation (with or without the purchase of moveable equipment) must provide the following information for each site where minor alteration/renovation activities will occur:

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<sup>31</sup> Note the licenses for electronic health records or health information technology should be reported in "Other Costs".

**1. Site Information** – The name and physical address of the site will be pre-populated from Form 5B. In the box for **Improved Project Square Footage**, enter the square footage that will be improved as a result of the proposed project.

**2. Project Description** – Provide a detailed description of the scope of work of the minor alteration/renovation project. Identify the major clinical and non-clinical spaces that will result from or be improved by the project. Include the area (in square feet) or dimensions of the spaces to be altered or renovated. The description should also list major improvements, such as permanently affixed equipment to be installed; modifications and repairs to the building exterior; HVAC modifications (including the installation of climate control and duct work); electrical upgrades; and plumbing work. Describe how potential adverse impacts on the environment will be reduced. Indicate whether the project will implement green/sustainable design practices/principles (e.g., using project materials, design/renovation strategies). This field has a maximum of 4,000 characters, including spaces.

***Example Project Description** - Renovation of five 12x15 square-foot exam rooms within existing interior space; installation of 300 feet of interior ductwork and two condenser units on the exterior roof; installation of 40 energy efficient windows, and replacement of front entry door with automated glass doors; repair of 1,500 square feet of asphalt roof; installation of 10x20 square-foot fabric canopy over entryway.*

**3. Project Management/Resources/Capabilities** – Explain the administrative structure and oversight for the project, including the roles and responsibilities of the health center’s key management staff as well as oversight by the governing board. Identify the Project Manager and the individuals who will comprise the Project Team responsible for managing the minor alteration/renovation project. Describe how the Project Team has the expertise and experience necessary to successfully manage and complete the project and achieve the goals and objectives established for this project. This field has a maximum of 4,000 characters, including spaces.

**4. Is the proposed minor alteration/renovation project (ONLY) part of a larger scale renovation, construction, or expansion project?** – Select “no” to certify that the proposed project is a stand-alone project and includes only minor alteration/renovation costs, or select “yes” and provide comments if the proposed project is part of a larger scale renovation, construction, or expansion project. This field has a maximum of 2,000 characters, including spaces.

### **Project Budget Justification**

Applicants requesting one-time funding for minor alteration/renovation must attach a project budget justification. Describe in detail each cost element and explain how the costs contribute to meeting the project’s objectives/goals. Clearly identify other funding sources needed to support the minor alteration/renovation project and indicate whether these funds are secured or not. See <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP> for a sample A/R budget justification.

A list of permissible costs for the one-time funding request is presented in the following chart.



	ALLOWABLE	UNALLOWABLE
<b>Administrative and legal expenses</b>	<ul style="list-style-type: none"> <li>Salary of applicant's staff and consultant fees that are <b>directly</b> related to the administration of the technical aspects of the proposed project. Generally, administrative and legal expenses should be less than 10% of total project costs</li> <li>Costs of obtaining required data for the environmental analysis report</li> <li>Performance/Payment bonds and insurance costs</li> </ul>	<ul style="list-style-type: none"> <li>Bonus payments to contractors</li> <li>Costs of groundbreaking and dedication ceremonies and items such as plaques</li> <li>Indirect costs</li> <li>General department operations and maintenance</li> </ul>
<b>Architectural and engineering fees</b>	<ul style="list-style-type: none"> <li>Fees associated with architectural and engineering professional services</li> <li>Expenses for preparation of specifications and reproduction of design documents</li> <li>Costs incurred no more than 90 days before the Notice of Award for architect's fees and consultant's fees necessary to the planning and design of the project (if the project is approved and funded)</li> </ul>	<ul style="list-style-type: none"> <li>Architectural and engineering fees for work not within the scope of the approved project</li> <li>Costs of abandoned designs (designs that will not be used in the minor alteration/renovation project)</li> <li>Elaborate or extravagant designs, materials, or projects that are above the known local costs for comparable buildings</li> </ul>
<b>Other architectural and engineering fees</b>	<ul style="list-style-type: none"> <li>Other architectural and engineering services such as surveys and tests</li> <li>Preliminary expenses associated with the approved award</li> </ul>	
<b>Project inspection fees</b>	<ul style="list-style-type: none"> <li>Clerk-of-the-works, inspection fees</li> </ul>	<ul style="list-style-type: none"> <li>Fees not associated with the requested project</li> </ul>
<b>Site work</b>	<ul style="list-style-type: none"> <li>See Alteration and renovation</li> </ul>	<ul style="list-style-type: none"> <li>Fees not associated with the requested project</li> </ul>
<b>Demolition and removal</b>	<ul style="list-style-type: none"> <li>Costs of demolition or removal for improvements such as wall finishings and fixtures. Reduce the costs on this line by the amount of expected proceeds from the sale of salvage.</li> </ul>	<ul style="list-style-type: none"> <li>Costs of hazard material abatement and remediation</li> <li>Costs not associated with the requested award</li> </ul>
<b>Alteration and renovation</b>	<ul style="list-style-type: none"> <li>Costs of fixed equipment necessary for the functioning of the facility. <b>FIXED EQUIPMENT</b> is equipment that requires modification of the facility for its satisfactory installation or removal and is included in the construction contract. Examples include fume hoods, linear accelerator, laboratory casework, sinks, fixed shelving, built-in sterilizers, built-in refrigerators, and drinking fountains.</li> <li>Costs for remodeling and alteration of existing buildings which will be used for the program</li> <li>Installation of fixed items such as</li> </ul>	<ul style="list-style-type: none"> <li>Relocation of utilities</li> <li>Prorated cost of existing central utility plant and distribution systems, which serve the proposed facility</li> <li>Sanitary sewer, storm sewer, and portable water connections, providing that such municipal utilities are located in streets, roads, and alleys contiguous to the site</li> <li>Works of art</li> <li>Otherwise allowable costs</li> </ul>

	ALLOWABLE	UNALLOWABLE
	windows, HVAC, and generators <ul style="list-style-type: none"> <li>• Costs of connecting to existing central utility distribution systems contiguous to the site, such as steam and chilled water that service a campus from centrally located boiler and refrigeration plants</li> <li>• Prorated costs for new boilers and chillers</li> <li>• Resurfacing of existing parking areas located onsite and deemed essential for the use and operation of an approved project</li> <li>• Special features for earthquake resistance code requirements (use nationally recognized codes adopted by authorities having jurisdiction)</li> <li>• Costs of eliminating architectural barriers to the handicapped</li> <li>• Costs of pollution-control equipment for the facility's boilers, incinerators, waste water treatment, etc., which may be required by local, state, or federal regulations</li> </ul>	incurred beyond 90 days prior to the Notice of Award
<b>Equipment</b>	<ul style="list-style-type: none"> <li>• Moveable equipment</li> <li>• The cost to train individuals to operate the equipment, if included in the purchase contract</li> <li>• Fixed equipment if it is not part of the construction contract</li> <li>• Sales tax (unless the applicant is otherwise exempt) and shipping costs on equipment</li> <li>• Service contract costs if it is included in the purchase contract</li> </ul>	<ul style="list-style-type: none"> <li>• Equipment that does not meet the moveable equipment definition</li> <li>• Donated equipment, leased equipment, or equipment purchased through a conditional sales contract (lease purchasing)</li> </ul>

**Note:** Any facility proposed for a minor alteration/renovation project must meet requirements of both current and future pollution abatement regulations as described in currently approved pollution plans.

### **Environmental Information and Documentation (EID) Checklist**

Applicants requesting one-time funding for minor alteration/renovation must attach an EID Checklist for each site where minor alteration/renovation activities will occur. A template is available in EHB for applicants to download, complete, and upload to the A/R Project Cover Page.

The National Environmental Policy Act of 1969 (NEPA) (P.L. 91-190; 42 U.S.C. 4321 *et seq.*), the National Historic Preservation Act (NHPA) (P.L. 89-665; 16 U.S.C. 470 *et seq.*), and other associated laws require, among other things, that HRSA consider the environmental impacts and potential effects on historical and archeological resources of any federal action, including minor alteration and renovation projects supported in whole or in part through federal funds. In order to initiate reviews under NEPA and NHPA, applicants must submit a completed EID Checklist

(OMB Form No. 0915-0324) **for each proposed NAP site for which any federal funds are being requested for minor alteration/renovation.** Applicants are required to explain each response of “yes” on the EID Checklist. If funded, award recipients must receive HRSA approval prior to beginning any projects involving minor alteration/renovation.

Following the review of the EID Checklist and the project proposal, HRSA will determine if the potential exists for the project to have a significant impact on the environment. If HRSA determines additional reviews or compliance requirements are necessary, HRSA will contact the applicant and require documentation such as a hazardous materials survey, abatement plans, or initiating Section 106 consultation. It is advised that if the applicant does not possess in-house expertise in environmental and historic preservation compliance, that the services of a consultant with the appropriate background be secured.

Until the environmental and historic preservation reviews are completed and any associated conditions are lifted from the Notice of Award, award recipients are not authorized to acquire fixed equipment or initiate work beyond the design and permitting stage of the project. For additional information on environmental and historic preservation compliance, see <http://bphc.hrsa.gov/about/healthcentersaca/acacapital/capitaldevelopment.html>.

### **Floor Plans/Schematic Drawings**

Applicants requesting one-time funding for minor alteration/renovation must attach line drawings for each site where minor alteration/renovation activities will occur that indicate the location of the proposed renovation area in the existing building and the total net and gross square footage of space to be altered/renovated. The schematic drawings should be legible on an 8.5" x 11" sheet of paper with a scale, as well as indicate the linear dimensions and the net and gross square feet for each room. These drawings should not be blueprints and do not need to be completed by an architect. Changes or additions to existing mechanical and electrical systems should be clearly described in notes made directly on the drawings. If desired, applicants can also include a site plan.

### **Other Requirements for Sites**

Applicants requesting one-time funding for minor alteration/renovation must complete the Other Requirements for Sites form for each site where minor alteration/renovation activities will occur. This form addresses site control, federal interest, and cultural resources and historic preservation considerations related to the project.

#### **1. Site Control and Federal Interest**

1a. Identify the current status of the property site – If the site is owned by the applicant organization, select “owned.” If the site is not owned by the applicant organization, regardless of whether the applicant organization will pay a recurring fee to use the property, select “leased.”

If the site is leased, applicants must certify that:

- *The existing lease will provide the health center reasonable control of the project site;*
- *The existing lease is consistent with the proposed scope of project;*
- *We understand and accept the terms and conditions regarding federal interest in the property.*

## **2. Cultural Resource Assessment and Historic Preservation Considerations**

Applicants are required to respond to the following questions by indicating yes or no:

- 2a. Was the project facility constructed prior to 1975?
- 2b. Is the project facility 50 years or older?
- 2c. Does any element of the overall work at the project site include:
  - 1) Any renovation/modification to the exterior of the facility (e.g., roof, HVAC, windows, siding, signage, exterior painting, generators); or
  - 2) Ground disturbance activity (e.g., expansion of building footprint, parking lot, sidewalks, utilities)?
- 2d. Does the project involve renovation to a facility that is, or near a facility that is, architecturally, historically, or culturally significant; or is the site located on or near Native American, Alaskan Native, Native Hawaiian, or equivalent culturally significant lands?

### **Landlord Letter of Consent**

Applicants proposing a minor alteration/renovation project at a leased site must provide a Landlord Letter of Consent. This document must include the property owner's agreement of the proposed minor alteration/renovation, recognition of the federal interest or the agreement to file the Notice of Federal Interest, and must be signed by both the owner and applicant. This attachment is also required for applicants that use "in-kind" space at no charge. A sample Landlord Letter of Consent is available at

<http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP>.

## Appendix D: Implementation Plan

Applicants are expected to demonstrate that they will be operational and compliant with Health Center Program requirements (see [Appendix E](#)) within 120 days of award. The Implementation Plan (as noted in the [RESPONSE](#) section of the Project Narrative) is the applicant's opportunity to demonstrate this readiness to initiate the proposed project plan. Instructions for developing the Implementation Plan are provided below. A sample Implementation Plan is provided on the NAP technical assistance Web site at <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/>.

Applicants are expected to include the goals and action steps necessary to ensure that within 120 days of the Notice of Award, all proposed site(s) will:

- Be open and operational.
- Have appropriate staff and providers in place.
- Deliver services (consistent with Forms [5A](#) and [5C](#)) to the proposed target population.
- Be compliant with Health Center Program requirements.

The Implementation Plan must be specific to the proposed NAP project and should include operational, administrative, governance, and program policy activities (e.g., EHR implementation, staffing, reimbursement enrollment, board composition, revising policies and procedures to be compliant) to be undertaken as appropriate. Applicants may choose any of the following from the below list of focus areas and goals, or may include other focus areas and goals as desired. Health centers may use the Health Center Program Site Visit Guide at <http://bphc.hrsa.gov/programrequirements/centerguide.html> to assess compliance with program requirements.

The Implementation Plan will be reviewed in conjunction with the Project Narrative, Program Specific Forms, and required attachments to evaluate the application. Action steps described in the Implementation Plan related to compliance with program requirements and becoming operational in 120 days should be consistent with those discussed in the Project Narrative and other parts of the application. If required services are provided by contract or referral, specify action steps and timeframes for the development of these formal arrangements.

For NAP applicants proposing site(s) that are currently operational and compliant with Health Center Program requirements, the Implementation Plan should demonstrate compliance and highlight proposed changes in access to care, such as planned service expansion and outreach activities, new collaborations/partnerships, and any other changes that would occur within 120 days of the Notice of Award as a result of the NAP funding. If activities related to compliance and operational readiness are not thoroughly documented (i.e., included in the Program Narrative and Implementation Plan and corroborated in Attachments or Forms, as appropriate), the review/scoring of the application may be negatively impacted.

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

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: Operational NAP Site(s) within 120 Days

- C.1. Physical Location Ready to Receive Patients (e.g., alteration/renovation complete)
- C.2. Readiness to Serve the Target Population

Focus Area: Implementation of a Sliding Fee Discount Program (SFDP) and Billings and Collections System

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

Focus Area: Quality Improvement/Quality Assurance (QI/QA) Program

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

Focus Area: Governing Board

- F.1. Required Composition Recruitment
- F.2. Required Authority & Functions
- F.3. Conflict of Interest Policies and Procedures

### ***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 and compliance 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.

## Appendix E: Health Center Program Requirements

A summary of the Health Center Program requirements is provided below. For additional information on these requirements, please review:

- Health Center Program Statute: Section 330 of the Public Health Service Act, as amended (42 U.S.C. §254b, as amended)
- Program Regulations (42 CFR Part 51c and 42 CFR Parts 56.201-56.604 for Community and Migrant Health Centers)
- Grants Regulations (45 CFR Part 75, as applicable)

NEED	
1.	<b>Needs Assessment:</b> Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)
SERVICES	
2.	<p><b>Required and Additional Services:</b> Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. (Section 330(a) of the PHS Act)</p> <p><b>Note:</b> Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services (Section 330(h)(2) of the PHS Act)</p>
3.	<b>Staffing Requirement:</b> Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed and privileged. (Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act)
4.	<b>Accessible Hours of Operation/Locations:</b> Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. (Section 330(k)(3)(A) of the PHS Act)
5.	<b>After Hours Coverage:</b> Health center provides professional coverage for medical emergencies during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act and 42 CFR Part 51c.102(h)(4))
6.	<b>Hospital Admitting Privileges and Continuum of Care:</b> Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. (Section 330(k)(3)(L) of the PHS Act)
7.	<p><b>Sliding Fee Discounts:</b> Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay.</p> <ul style="list-style-type: none"> <li>• This system must provide a full discount to individuals and families with annual incomes at or below 100% of the federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.*</li> <li>• No discounts may be provided to patients with incomes over 200 % of the federal poverty guidelines.*</li> <li>• No patient will be denied health care services due to an individual's inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived.</li> </ul> <p>(Section 330(k)(3)(G) of the PHS Act, 42 CFR Part 51c.303(f)), and 42 CFR Part 51c.303(u))</p>



8.	<p><b>Quality Improvement/Assurance Plan:</b> Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include:</p> <ul style="list-style-type: none"> <li>• a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;*</li> <li>• periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall: * <ul style="list-style-type: none"> <li>○ be conducted by physicians or by other licensed health professionals under the supervision of physicians;*</li> <li>○ be based on the systematic collection and evaluation of patient records;* and</li> <li>○ identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.*</li> </ul> </li> </ul> <p>(Section 330(k)(3)(C) of the PHS Act, 45 CFR Part . 75.308 and 42 CFR Part 51c.303(c)(1-2))</p>
<b>MANAGEMENT AND FINANCE</b>	
9.	<p><b>Key Management Staff:</b> Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director/Executive Director/CEO position is required. (Section 330(k)(3)(I) of the PHS Act, 42 CFR Part 51c.303(p) and 45 CFR Part 75.308)</p>
10.	<p><b>Contractual/Affiliation Agreements:</b> Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center program requirements. (Section 330(k)(3)(I)(ii), 42 CFR Part 51c.303(n), (t)), Section 1861(aa)(4) and Section 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 75.101(b)(1))</p>
11.	<p><b>Collaborative Relationships:</b> Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers (section 330 award recipients and FQHC Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained. (Section 330(k)(3)(B) of the PHS Act and 42 CFR Part 51c.303(n))</p>
12.	<p><b>Financial Management and Control Policies:</b> Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. (Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 75.207, 75.302, and 75.501-512)</p>
13.	<p><b>Billing and Collections:</b> Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures. (Section 330(k)(3)(F) and (G) of the PHS Act)</p>
14.	<p><b>Budget:</b> Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the federal award) necessary to accomplish the service delivery plan, including the number of patients to be served. (Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 75.308(a))</p>
15.	<p><b>Program Data Reporting Systems:</b> Health center has systems which accurately collect and organize data for program reporting and which support management decision making. (Section 330(k)(3)(I)(ii) of the PHS Act)</p>
16.	<p><b>Scope of Project:</b> Health center maintains its funded scope of project (sites, services, service area, target population and providers), including any increases based on recent funding awards. (45 CFR Part 75.308(b))</p>

## GOVERNANCE

17.	<p><b>Board Authority:</b> Health center governing board maintains appropriate authority to oversee the operations of the center, including:</p> <ul style="list-style-type: none"> <li>• holding monthly meetings;</li> <li>• approval of the health center application and budget;</li> <li>• selection/dismissal and performance evaluation of the health center CEO;</li> <li>• selection of services to be provided and the health center hours of operations;</li> <li>• measuring and evaluating the organization’s progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization’s mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and</li> <li>• establishment of general policies for the health center.</li> </ul> <p>(Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)</p> <p><b>Note:</b> In the case of public centers (also referred to as public entities) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center (Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304(d)(iii) and (iv)).</p> <p><b>Note:</b> Upon a showing of good cause the Secretary may waive, for the length of the project period, the monthly meeting requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (Section 330(k)(3)(H) of the PHS Act)</p>
18.	<p><b>Board Composition:</b> The health center governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically:</p> <ul style="list-style-type: none"> <li>• Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.*</li> <li>• The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community. *</li> <li>• No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry. *</li> </ul> <p><b>Note:</b> Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)</p>
19.	<p><b>Conflict of Interest Policy:</b> Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center.</p> <ul style="list-style-type: none"> <li>• No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as a non-voting ex-officio member of the board.*</li> </ul> <p>(45 CFR Part 75.327(c)(1) and (c)(2) and 42 CFR Part 51c.304(b))</p>
<p><b>NOTE:</b> Portions of program requirements notated by an asterisk “*” indicate regulatory requirements that are recommended <b>but not required</b> for award recipients that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.</p>	