

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

Bureau of Primary Health Care
Health Center Program

Service Area Competition – Additional Area (SAC-AA) – Miles City, Montana

Announcement Type: New

Funding Opportunity Announcement Number: HRSA-16-178

Catalog of Federal Domestic Assistance (CFDA) No. 93.224

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2016

**Application Due Date in Grants.gov: February 22, 2016
Supplemental Information Due Date in EHB: March 8, 2016**

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

**Release Date: December 18, 2015
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Authority: Public Health Service Act, Section 330, as amended (42 U.S.C. 254b)

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC) is accepting applications for fiscal year (FY) 2016 Service Area Competition – Additional Area (SAC-AA) for Miles City, MT under the Health Center Program. The purpose of this program is to improve the health of the Nation’s underserved communities and vulnerable populations by assuring continued access to comprehensive, culturally competent, quality primary health care services. Health Center Program funds support a variety of community-based and patient-directed public and private nonprofit organizations that provide primary and preventive health care services to the Nation’s underserved.

Funding Opportunity Title:	Service Area Competition – Additional Area (SAC-AA) – Miles City, MT
Funding Opportunity Number:	HRSA-16-178
Due Date for Applications – Grants.gov:	February 22, 2016 (11:59 p.m. ET)
Due Date for Supplemental Information – EHB:	March 8, 2016 (5:00 p.m. ET)
Anticipated Total Annual Available Funding:	Approximately \$250,000
Estimated Number and Type of Award(s):	1 award
Estimated Award Amount:	\$250,000
Cost Sharing/Match Required:	No
Length of Project Period:	August 1, 2016 through July 31, 2019 (Up to three years)
Project Start Date:	August 1, 2016
Eligible Applicants:	Public or nonprofit private entity, including tribal, faith-based, or community-based organizations that proposes to provide comprehensive primary health care services to a service area and its associated population(s) and patients identified in Table 6 . [See Section III-1 of this funding opportunity announcement (FOA) for complete eligibility information.]

All applicants are responsible for reading and complying with the instructions included in HRSA’s [SF-424 Two-Tier Application Guide](#), except where instructed in this funding opportunity announcement to do otherwise. A short video is available for applicants explaining the new [Application Guide](#).

Summary of Changes

- Award recipients were previously referred to as “grantees” in past funding opportunity announcements.

- [Form 1A: General Information Worksheet](#) has been revised to streamline data reporting and collect the patient projection by December 31, 2017. See the Form 1A instructions for details.
- [Form 2: Staffing Profile](#) will no longer collect salary or federal funding data to reduce duplication with the Budget Narrative Justification. Fields have been added to collect information on use of contracted staff.
- [Form 8: Health Center Agreements](#) has been streamlined. Select items from the form have been added to the Governance section of the Project Narrative.
- Form 9: Need for Assistance Worksheet is no longer part of the SAC-AA application. Select items from the form have been added to the *NEED* section of the Project Narrative.
- The [Summary Page](#) has been revised to collect additional service area information to enable the auto-calculation of the percentage of the Patient Target to be served.
- Competing supplement applicants are no longer required to submit Articles of Incorporation.
- Two performance measures have been added, three have been discontinued, and two have been revised. See [Appendix B](#) for details.
- Competing supplement applicants with Health Center Program compliance issues may not be funded. Refer to the [Project Period Length Criteria](#) for details.

Note: Each SAC-AA has a unique HRSA announcement number (e.g., HRSA-16-178) and Grants.gov application package. Applicants must submit the corresponding application package.

Application Resources

Application resources, including a webinar recording, form samples, and a frequently asked questions document are available at the [SAC-AA Technical Assistance web site](#). (Note that some resources are not applicable to this FOA.) Refer to [How to Apply for a Grant](#) for general (i.e., not SAC-AA specific) videos and slides on a variety of application and submission components.

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 example, health center activities identified on Form 5C: Other Activities/Locations, will only be eligible for FTCA coverage upon compliance with all applicable FTCA Health Center Program requirements. For more information about the FTCA Health Center Program and its requirements, refer to the [FTCA Health Center Program Policy Manual](#) (as updated).

Table of Contents

I. FUNDING OPPORTUNITY DESCRIPTION	1
1. Purpose	1
2. Background	1
II. AWARD INFORMATION	3
1. Type of Application and Award	3
2. Summary of Funding	4
III. ELIGIBILITY INFORMATION.....	5
1. Eligible Applicants	5
2. Cost Sharing/Matching.....	6
3. Other	6
IV. APPLICATION AND SUBMISSION INFORMATION.....	6
1. Address to Request Application Package	6
2. Content and Form of Application Submission.....	7
i. <i>Project Abstract</i>	13
ii. <i>Project Narrative</i>	13
iii. <i>Budget</i>	26
iv. <i>Budget Justification Narrative</i>	27
v. <i>Program Specific Forms</i>	27
vi. <i>Attachments</i>	27
3. Dun and Bradstreet Universal Numbering System Number and System for Award Management (formerly, Central Contractor Registration)	31
4. Submission Dates and Times.....	31
5. Intergovernmental Review	32
6. Funding Restrictions.....	32
V. APPLICATION REVIEW INFORMATION	33
1. Review Criteria	33
2. Review and Selection Process	36
3. Assessment of Risk.....	39
4. Anticipated Announcement and Award Dates.....	39
VI. AWARD ADMINISTRATION INFORMATION.....	39
1. Award Notices	39
2. Administrative and National Policy Requirements	39
3. Reporting	40
VII. AGENCY CONTACTS	40
VIII. OTHER INFORMATION	41
IX. TIPS FOR WRITING A STRONG APPLICATION.....	42
APPENDIX A: PROGRAM SPECIFIC FORMS INSTRUCTIONS	43
APPENDIX B: PERFORMANCE MEASURES INSTRUCTIONS.....	57
APPENDIX C: IMPLEMENTATION PLAN.....	63
APPENDIX D: SERVICE AREA.....	65

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, Room 14-45, Rockville, Maryland, 20857.

I. Funding Opportunity Description

1. Purpose

This funding opportunity announcement (FOA) solicits applications for the Health Center Program's Service Area Competition – Additional Area (SAC-AA). The Health Center Program supports patient-directed public and private nonprofit organizations that provide primary and preventive health care services to the Nation's medically underserved. The purpose of the SAC-AA funding opportunity is to ensure continued access to comprehensive, culturally competent, quality primary health care services for communities and vulnerable populations served by the Health Center Program.

This FOA details the SAC-AA eligibility requirements, review criteria, and awarding factors for organizations seeking funding for operational support to provide primary and preventive health care services to an announced service area under the Health Center Program, including Community Health Center (CHC – section 330(e)), Migrant Health Center (MHC – section 330(g)), Health Care for the Homeless (HCH – section 330(h)), and/or Public Housing Primary Care (PHPC – section 330(i)). For the purposes of this document, the term “health center” encompasses these types of funding (i.e., CHC, MHC, HCH, and PHPC).

2. Background

The Health Center Program is authorized by section 330 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254b). Through SAC-AA, organizations compete for Health Center Program financial support to provide comprehensive primary and preventive health care services to defined geographic areas and patient populations.

The Health Center Program targets the Nation's neediest populations and geographic areas by currently funding nearly 1,300 health centers that operate approximately 9,000 service delivery sites in every state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. In 2014, more than 21 million patients, including medically underserved and uninsured patients, received comprehensive, culturally competent, quality primary health care services through the Health Center Program.

Only one award will be made for the announced service area listed in [Table 6](#).

Program Requirements

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

Applicants must demonstrate compliance with applicable [Health Center Program requirements](#) and corresponding regulations and policies, as required by section 330 of the PHS Act, as amended.

New and competing supplement applicants (see [Section II.1](#) below for definitions of applicant types) must propose at least one full-time (operational 40 hours or more per week) permanent, fixed building site on [Form 5B: Service Sites](#)¹, with the exception of projects serving only migratory and seasonal agricultural workers, which may propose a full-time seasonal (rather than permanent) service delivery site. A mobile medical van may be proposed only if at least one full-time (operational 40 hours or more per week) permanent, fixed building site is also proposed in the application.²

New and competing supplement applicants must demonstrate readiness to meet the following requirements.

- Within 120 days of receipt of the Notice of Award³, all proposed sites (as noted on [Form 5B: Service Sites](#) and described in the [Project Narrative](#)) must be operational, including having the necessary staff and providers in place to begin operating and delivering services to the proposed community and/or target population as described on Forms [5A: Services Provided](#), [5B: Service Sites](#), and [5C: Other Activities/Locations](#).
- Within one year of receipt of the Notice of Award, all proposed providers must be in place and all sites must be delivering services for the proposed hours of operation.

All funded applicants must provide services to the number of unduplicated patients projected to be served by December 31, 2017, as indicated on [Form 1A: General Information Worksheet](#)⁴. If a health center is unable to demonstrate that it is serving the cumulative total of projected patients by December 31, 2017, announced funding for the service area may be proportionally reduced.

Failure to meet these SAC-AA funding and Health Center Program requirements may jeopardize Health Center Program grant funding per Uniform Guidance [2 CFR 200](#) as codified by HHS at [45 CFR 75](#). HRSA will assess award recipients for compliance throughout the project period. When an issue is identified (e.g., an organization fails to become operational at all sites within 120 days, failure to comply with the Health Center Program requirements), HRSA will place a program condition on the award and move the grant into progressive action. The Progressive Action process provides a time-phased approach to resolve compliance issues. If an organization fails to successfully resolve conditions via the Progressive Action process, HRSA may withdraw support through cancellation of all or part of the grant award. For more information, see [Program Assistance Letter 2014-08: Health Center Program Requirements Oversight](#).

In addition to these general requirements, specific legislative requirements for applicants requesting funding under each health center type are outlined below.

COMMUNITY HEALTH CENTER APPLICANTS:

- Ensure compliance with PHS Act section 330(e) and program regulations, requirements, and policies.

¹ See [PIN 2008-01](#), which describes and defines the term “service sites.”

² Projects serving only migratory and seasonal agricultural workers may propose a mobile medical van only if at least one full-time (operational 40 hours or more per week) seasonal, fixed building site is also proposed in the application.

³ HRSA may issue Notices of Award up to 60 days prior to the project period start date.

⁴ For this purpose, the term “patients” refers to individual patients and not patient visits; each individual patient counts as a single “patient,” notwithstanding multiple encounters/visits.

- Provide a plan that ensures the availability and accessibility of required primary and preventive health care services to underserved populations in the service area.

MIGRANT HEALTH CENTER APPLICANTS:

- Ensure compliance with PHS Act section 330(g); section 330(e); and, as applicable, program regulations, requirements, and policies.
- Provide a plan that ensures the availability and accessibility of required primary and preventive health care services to migratory and seasonal agricultural workers and their families in the service area. Migratory and seasonal agricultural workers are individuals principally employed in agriculture on a seasonal basis within the last 24 months who establish temporary housing for the purpose of this work. Seasonal agricultural workers are individuals employed in agriculture on a seasonal basis, who are not also migratory. Agriculture refers to farming in all its branches, as defined by the North American Industry Classification System⁵ under codes 111, 112, 1151, and 1152.

HEALTH CARE FOR THE HOMELESS APPLICANTS:

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

PUBLIC HOUSING PRIMARY CARE APPLICANTS

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

II. Award Information

1. Type of Application and Award

Types of applications sought:

- New – A health center not currently funded through the Health Center Program that seeks to serve an announced service area through the proposal of one or more permanent service delivery sites.

⁵ For more information about the North American Industry Classification System, see <https://www.census.gov/eos/www/naics/index.html>.

- Competing Supplement – A current Health Center Program award recipient that seeks to serve an announced service area, in addition to its current service area through the proposal of one or more new permanent delivery sites.

Funding will be provided in the form of a grant.

2. Summary of Funding

This program will provide funding during federal fiscal years 2016-2018 in the form of a grant award. Approximately \$250,000 is expected to be available annually to fund 1 awardee under HRSA-16-178. Award amounts will not exceed the total annual Health Center Program funding available for the service area (listed as Total Funding in [Table 6](#)) in any budget year of the proposed three-year project period. Funding must be requested and will be awarded proportionately for all population types within the service area as currently funded under the Health Center Program. No new population types may be added.

Applicants must propose to serve at least 75 percent of the Patient Target in [Table 6](#) by December 31, 2017. Applicants proposing to serve fewer than the total number of patients indicated in [Table 6](#) must reduce their funding request according to the following table. If applicants propose to serve fewer than the total number of patients indicated in [Table 6](#), but do not reduce the funding request, HRSA will reduce the award accordingly. A [funding calculator](#) is available to determine if a funding reduction is required.

Table 1: Funding Reduction by Patients Projected to Be Served

Patient Projections Compared to Table 6 Patient Target (%)	Funding Request Reduction (%)
95-100% of patients listed in Table 6	No reduction
90-94.9% of patients listed in Table 6	0.5% reduction
85-89.9% of patients listed in Table 6	1% reduction
80-84.9% of patients listed in Table 6	1.5% reduction
75-79.9% of patients listed in Table 6	2% reduction
< 75 % of patients listed in Table 6	Not eligible for funding

The federal request for funding on the SF-424A and Budget Justification Narrative must accurately reflect required reductions.

This program announcement is subject to the appropriation of funds and is a contingency action taken to ensure that, should funds become available for this purpose, applications can be processed and funds can be awarded in a timely manner. Funding beyond the first year of the three-year project period is dependent on the availability of appropriated funds for the Health Center Program in subsequent fiscal years, award recipient satisfactory 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 200](#) as codified by HHS at [45 CFR 75](#), which supersedes the previous administrative and audit requirements and cost principles that govern federal monies.

See [Section IV.2.iii](#) for instructions on the development of the application budget.

III. Eligibility Information

Applications that do not demonstrate compliance with all eligibility requirements outlined in this section will be deemed non-responsive and will not be considered for funding.

1. Eligible Applicants

- 1) An applicant must be a public or nonprofit private entity, as demonstrated through the submission of the Evidence of Non-profit/Public Center Status outlined in [Section IV.2.vi](#). Faith-based and community-based organizations, Tribes, and tribal organizations are eligible to apply.
- 2) The applicant must request funding to support the operation of a health center that provides required comprehensive primary, preventive, and enabling health care services, either directly or through established arrangements, without regard to ability to pay. An applicant may **not** propose to provide only a single service, such as dental, behavioral, or prenatal services.
- 3) The applicant must propose to serve an announced service area and its patients identified in [Table 6](#).
 - a) The total unduplicated patients projected to be served by December 31, 2017, entered on Form 1A, must be at least 75 percent of the Patient Target in [Table 6](#). See the [Summary of Funding](#) section above if the patient projection is less than the Patient Target in [Table 6](#).
 - b) Zip codes entered in the Service Area Zip Codes field on [Form 5B: Service Sites](#) must be all of the service area zip codes listed on [Table 6](#).⁶

Note: Health centers will be held accountable for all patients projected to be served, as well as any additional patient projections through supplemental awards received during the project period. If a health center is unable to demonstrate that it is serving the cumulative total of projected patients by December 31, 2017, announced funding for the service area may be proportionally reduced.

- 4) The applicant must propose access to services for all individuals in the service area and target population, as defined in [Table 6](#). Services proposed cannot be exclusive to a single age group (e.g., children, elderly) or health issue/disease category (e.g., HIV/AIDS). In instances where a sub-population is targeted (e.g., homeless children; lesbian, gay, bisexual, and transgender individuals (LGBT)), the applicant must ensure that required health care services will be made available to others who seek services at the proposed site(s).

⁶ HRSA considers service area overlap when making funding determinations for new and competing supplement applicants if zip codes are proposed on [Form 5B: Service Sites](#) beyond those listed in [Table 6](#). For more information about service area overlap, refer to [Policy Information Notice 2007-09](#).

- 5) The annual funding request (as presented on the SF-424A and Budget Justification Narrative) **MUST NOT** exceed the amount of Total Funding available in [Table 6](#). Applications that exceed this amount will be considered non-responsive and will not be considered for funding under this announcement.
- 6) Through the request for federal funding on the SF-424A, the applicant must propose to serve all currently targeted populations (i.e., CHC, MHC, HCH, PHPC) and maintain the current funding distribution (as identified in [Table 6](#)).
- 7) The application must include all forms and documents indicated as “required for completeness” in [Table 3](#), [Section IV.2.v](#), and [Section IV.2.vi](#) based on the applicant type.
- 8) The applicant cannot apply on behalf of another organization. The applicant is expected to perform a substantive role in the project and meet the program requirements. For example, the applicant organization indicated on the SF-424 must meet all eligibility criteria.

2. Cost Sharing/Matching

Cost sharing or matching are not requirements for this funding opportunity.

However, under 42 CFR 51c.203, HRSA will take into consideration whether and to what extent an applicant plans and makes efforts to secure financial and professional assistance support for the project, to include use of and maximize federal, state, local, and private resources to support the proposed project.

3. Other

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/non-responsive and will not be considered for funding: Need, Response, Collaboration, Resources/Capabilities, and Governance.

An applicant 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.

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 EHB) application phase.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA *requires* applicants for this funding opportunity announcement to apply electronically through Grants.gov and in HRSA EHB. Applicants must use a two-tier submission process for the Service Area Competition – Additional Area and follow the directions provided at Grants.gov and in HRSA EHB.

- **Step 1 – Grants.gov** – Required information must be submitted and validated by Grants.gov no later than February 22, 2016 at 11:59 p.m. Eastern Time
- **Step 2 - HRSA EHB** – Supplemental information must be submitted via HRSA EHB no later than March 8, 2016 at 5:00 p.m. Eastern Time

Only applicants who successfully submit and have an application validated in Grants.gov (Step 1) by the due date/time may submit the additional required information in HRSA EHB (Step 2). Within seven business days following successful submission of the required items in Grants.gov, applicants will be notified by HRSA confirming the successful receipt of the application and requiring the Project Director and Authorized Organization Representative to submit additional information in HRSA EHB.

2. Content and Form of Application Submission

Application Format Requirements

Section 5 of HRSA's [SF-424 Two-Tier Application Guide](#) provides instructions for the budget, budget justification narrative, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information as outlined in the Application Guide in addition to the program specific information below. Applicants are responsible for reading and complying with the instructions included in HRSA's [SF-424 Two-Tier Application Guide](#) except where instructed in this FOA to do otherwise.

Application Page Limit

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

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

Application Preparation

The [SAC-AA Technical Assistance web site](#) provides essential resources for application preparation. (Note that some resources are not applicable to this FOA.) Throughout the application development and preparation process, applicants are encouraged to work with the appropriate Primary Care Associations (PCAs), Primary Care Offices (PCOs), and/or National Cooperative Agreements (NCAs) to prepare quality, competitive applications. For a complete listing of PCAs, PCOs, and NCAs, refer to [Support Networks](#).

Application Format

The following tables detail the documents required for this funding opportunity. In the Form Type column of Table 2, the word “Form” refers to a document that must be downloaded, completed in the template provided, and then uploaded. “E-Form” refers to forms that are completed online in EHB and therefore do not require downloading or uploading. “Document” refers to a document to be uploaded for which no template is provided. “Fixed” refers to forms that cannot be altered.

Documents and forms marked as “required for completeness” will be used to determine if an application is complete. Applications that fail to include all forms and documents indicated as “required for completeness” will be considered incomplete or non-responsive, thereby making them ineligible. Ineligible applications will not proceed to objective review. Failure to include documents indicated as “required for review” may negatively impact an application’s objective review score.

Only materials included with an application submitted by the announced deadlines will be considered.

Table 2: Step 1–Submission through Grants.gov

<http://www.grants.gov>

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

Application Section	Form Type	Instruction	Counted in Page Limit (Y/N)
Application for Federal Assistance (SF-424)	Form	<p>Prepare according to instructions provided in the form itself (mouse over fields for specific instructions) and the following guidelines:</p> <ul style="list-style-type: none"> • <i>Box 2: Type of Applicant:</i> Incorrect selection may delay EHB access. <ul style="list-style-type: none"> • Continuation – Current Health Center Program award recipients applying to continue serving its current service area. Select Continuation and include your H80 grant number in box 4. • New – Applicant not currently funded through the Health Center Program. Select New and leave box 4 blank. • Revision – Current award recipient applying to serve a new service area. Select Other and type Supplemental and your H80 grant number in box 4. • <i>Box 4: New applicants leave blank</i> • <i>Box 5a: Leave blank.</i> • <i>Box 5b: Federal Award Identifier:</i> 10-digit award recipient number starting with H80 for current Health Center Program award recipients. New applicants should leave this blank. • <i>Box 8c: Applicant organization’s DUNS number. Note: An incorrect or mistyped DUNS number will cause the application to be rejected.</i> 	N

Application Section	Form Type	Instruction	Counted in Page Limit (Y/N)
		<ul style="list-style-type: none"> • <i>Box 8f: Name and Contact Information of Person to be Contacted on Matters Involving this Application:</i> Provide the Project Director’s name and contact information. • <i>Box 14: Areas Affected by Project:</i> Leave Blank. • <i>Box 15: Descriptive Title of Applicant’s Project:</i> Type the title of the FOA (Service Area Competition – Additional Area and upload the project abstract. See instructions in Section IV.2.i. The abstract WILL count toward the page limit. • <i>Box 16: Congressional Districts:</i> Provide the Congressional district where the administrative office is located in 16a and the Congressional districts to be served by the proposed project in 16b. If information will not fit in the boxes provided, attach a Word document. This upload WILL count towards the page limit. • <i>Box 17: Proposed Project Start and End Date:</i> Provide the start date (August 1, 2016) and end date (July 31, 2019) for the proposed three-year project period. • <i>Box 18: Estimated Funding:</i> Complete the required information based on the funding request for the first year of the proposed project period. Refer to the Summary of Funding section for details. • <i>Box 19: Review by State:</i> See Section IV.4 for guidance in determining applicability. • <i>Box 21: Authorized Representative:</i> The electronic signature in Grants.gov (created when the Grants.gov forms are submitted) serves as the official signature. The form should NOT be printed, signed, and mailed to HRSA. 	
SF-424B: Assurances – Non-Construction Programs	Form	Complete the Assurances form.	N
Additional Congressional District(s) (as applicable)	Document	Upload a list of additional Congressional Districts served by the project if all districts served will not fit in 16b of the SF-424.	Y

Application Section	Form Type	Instruction	Counted in Page Limit (Y/N)
Project Performance Site Location(s)	Form	Competing continuation applicants must provide <i>only</i> the administrative site of record. Applicants not currently receiving Health Center Program funds for the proposed service area must provide the administrative site information AND information about all proposed health center sites. A list of additional sites may be uploaded as necessary.	N
Grants.gov Lobbying Form	Form	Provide the requested contact information at the bottom of the form.	N
SF-LLL: Disclosure of Lobbying Activities (as applicable)	Form	Complete the form only if lobbying activities are conducted.	N

Table 3: Step 2–Submission through HRSA Electronic Handbooks (EHB)

<https://grants.hrsa.gov/webexternal>

- Applicants must follow the instructions below to ensure that the application can be printed efficiently and consistently for review.
- Number the electronic attachment pages sequentially, resetting the numbering for each attachment (i.e., start at page 1 for each attachment). Do not attempt to number standard OMB approved form pages.

Application Section	Required for Completeness or Review (C/R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Project Narrative	C	Document	Upload the Project Narrative. See instructions in Section IV.2.i . An application that fails to address the requirements in the following five Project Narrative sections will be considered incomplete/non-responsive and will not be considered for funding: Need, Response, Collaboration, Resources/Capabilities, and Governance.	Y
SF-424A: Budget Information	C	E-Form	Complete Sections A, B, C, and E. Complete Section F if applicable. See instructions in Section IV.2.iii .	N
Budget Justification Narrative	C	Document	Upload the Budget Justification Narrative in the Budget Narrative Attachment Form field. See instructions in Section IV.2.iv .	Y
Program Specific Forms	R	Varies	See instructions in Section IV.2.v .	N
Attachments	Varies	Documents	See instructions in Section IV.2.vi .	Varies

i. Project Abstract

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

In addition to the information described in Section 5.1.vii of HRSA’s [SF-424 Two-Tier Application Guide](#), include the following at the top of the abstract:

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

The abstract must include a brief description of the proposed project, including the applicant organization, target population, needs to be addressed, and proposed services. Include the following in the body of the abstract:

- A brief history of the organization, the community to be served, and the target population.
- A summary of the major health care needs and barriers to care to be addressed by the proposed project, including the needs of special populations (migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing).
- How the proposed project will address the need for comprehensive primary health care services in the community and target population.
- Number of current and proposed patients, visits, providers, service delivery sites and locations, and services to be provided.

ii. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, consistent with other application components, and organized by section headers (Need, Response, Collaboration, Evaluative Measures, Resources/Capabilities, Governance, and Support Requested). The Project Narrative must:

- Demonstrate compliance with [Health Center Program requirements](#).
- Address the specific Project Narrative elements below, with the requested information appearing under the appropriate Project Narrative section header or the designated forms and attachments.
- Reference attachments and forms as needed. Referenced items must be part of the HRSA EHB submission.

A **competing continuation applicant** must ensure that the Project Narrative reflects the current approved scope of project. Any change in scope **must** be submitted separately through HRSA EHB.⁷

⁷ Refer to the [Scope of Project](#) policy documents and resources for details pertaining to changes to the current services, providers, sites, service area zip codes, and target population(s).

A **new applicant** must ensure that the Project Narrative reflects the entire proposed scope of project (proposed services, providers, sites, service area zip codes, and target population), inclusive of at least one new full-time (operational 40 hours or more per week) permanent service delivery site.

A **competing supplement applicant** must ensure that the Project Narrative reflects only the proposed scope of project for the new service area, inclusive of at least one new full-time (operational 40 hours or more per week) permanent service delivery site. Current sites in scope may also be selected for this project to the extent that they will provide services to the proposed new patients. Reference may be made in the Project Narrative to current services, policies, procedures, and capacity as they relate to the new service area (e.g., experience, transferrable procedures, resources).

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 activities and goals described throughout the application.

- 1) Describe how the following characteristics of the target population impact access to primary health care, health care utilization, and health status, referencing/citing data sources.
 - a) Geographical/transportation barriers to include the distance (miles) OR travel time to the nearest primary care provider accepting new Medicaid and uninsured patients⁸ (consistent with [Attachment 1: Service Area Map and Table](#)).
 - b) Percent of the target population that is uninsured.⁸
 - c) Unemployment and educational attainment.
 - d) Income and poverty level.
 - e) Health disparities.
 - f) Unique characteristics not previously addressed (e.g., ethnicity, sexual orientation, gender identity, disability, health literacy, language, cultural attitudes and beliefs).
- 2) Describe health care access indicators of the target population, including:
 - a) Other primary health care services available in the service area, including their location and accessibility by the target population.
 - b) The number of individuals in the target population for every one full-time equivalent (FTE) primary care physician as a ratio (i.e., number of patients: 1 FTE primary care physician).⁸
- 3) Describe the health care environment and its impact on the applicant organization's current and future operations, including any significant changes that affect the availability of health care services and patient characteristics, such as shifts in the number of patients served. Include external factors specific to the service area, including:

⁸ Refer to the Available Data Sources document on the [SAC-AA Technical Assistance web site](#) for recommended data sources.

- a) Changes in insurance coverage, including Medicaid, Medicare, and Children’s Health Insurance Program (CHIP). Specifically discuss changes that have resulted from the implementation of the Affordable Care Act.
 - b) Changes in state/local/private uncompensated care programs.
 - c) Economic and demographic shifts (e.g., influx of immigrant/refugee populations; closing of local hospitals, ambulatory care sites, or major local employers).
 - d) Natural disasters or emergencies (e.g., hurricanes, flooding, terrorism).
 - e) Changes affecting specific populations (e.g., children experiencing homelessness, LGBT).
- 4) **Applicants requesting special population funding** to serve migratory and seasonal agricultural workers (MHC), people experiencing homelessness (HCH), and/or residents of public housing (PHPC):
- a) MHC: Describe the specific health care needs and access issues of migratory and seasonal agricultural workers, including the agricultural environment (e.g., crops and growing seasons, demand for labor, number of temporary workers); approximate migratory/seasonal residency period(s), including the availability of local providers to provide primary health care services during these times; occupational factors (e.g., working hours, housing, hazards, including pesticides and other chemical exposures); and significant increases or decreases in migratory and seasonal agricultural workers.
 - b) HCH: Describe the specific health care needs and access issues of people experiencing homelessness, such as the number of providers treating people experiencing homelessness, availability of homeless shelters, and significant increases or decreases in people experiencing homelessness.
 - c) PHPC: Describe the specific health care needs and access issues of residents of public housing, such as the availability of public housing and its impact on the residents in the targeted public housing communities served, and significant increases or decreases in residents of public housing.

RESPONSE – CORRESPONDS TO SECTION V.1 CRITERION 2: RESPONSE

- 1) Describe the proposed service delivery model and how it responds to the identified health care needs of the target population, including the specific needs of any special populations for which funding is sought (MHC, HCH, and/or PHPC).
- 2) Describe the proposed service delivery sites and how they are appropriate for the service delivery model. Specifically address:
 - a) Site(s)/location(s) where services will be provided (consistent with [Attachment 1: Service Area Map and Table](#), and [Forms 5B: Service Sites](#) and [5C: Other Activities/Locations](#)).
 - b) How the type (e.g., fixed site, mobile van, school-based clinic), hours of operation, and location of each proposed service delivery site (consistent with [Form 5B: Service Sites](#)) assures that services are, or will be, accessible and available at times that meet the needs of the target population (consistent with [Form 5B Service Sites](#) and [5C: Other Activities/Locations](#)).

- c) Capacity at the proposed service site(s) (consistent with [Form 5B: Service Sites](#)) to achieve the projected number of patients and visits (consistent with [Form 1A: General Information Worksheet](#)).
- d) Professional coverage for medical emergencies during hours when service sites are closed and provisions for follow-up by the health center for patients accessing after hours coverage. Specifically, discuss how these arrangements are appropriate for the size and need of the target population.

Note: New and competing supplement applicants must:

- Propose at least one full-time (operational 40 hours or more per week) permanent, fixed building site on [Form 5B: Service Sites](#), with the exception of projects serving only migratory and seasonal agricultural workers, which may propose a full-time, seasonal (rather than permanent) service delivery site. A mobile medical van may be proposed only if at least one full-time (operational 40 hours or more per week) permanent, fixed building site is also proposed in the application.
 - Upload Floor Plans as [Attachment 12](#) for all new sites proposed. If the site is/will be leased, lease/intent to lease documentation must be included in [Attachment 14: Other Relevant Documents](#).
- 3) Describe how the proposed primary health care services (consistent with [Form 2: Staffing Profile](#) and [Form 5A: Services Provided](#)) and other activities (consistent with [Form 5C: Other Activities/Locations](#)) are appropriate for the needs of the target population, including:
 - a) The provision of required and additional services, including whether these are provided directly or through formal written contracts/agreements or referral arrangements.⁹
 - b) Method by which enabling services (e.g., case management, outreach and enrollment activities, transportation) are integrated into primary care. Describe any enabling services designed to increase access for targeted special populations or populations with identified unique health care needs.

Note:

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

⁹ Refer to the [Service Descriptors for Form 5A: Services Provided](#) for details regarding required and additional services.

- 4) Describe the proposed clinical staffing plan (consistent with [Form 2: Staffing Profile](#) and the [Budget Justification Narrative](#)), including how the mix of provider types and support staff is appropriate for:
 - a) Providing services for the projected number of patients (consistent with [Form 1A: General Information Worksheet](#)) at the proposed sites (consistent with [Form 5B: Service Sites](#)).
 - b) Assuring appropriate linguistic and cultural competence (e.g., bilingual/multicultural staff, training opportunities).
 - c) Carrying out required and additional health care services (as appropriate and necessary), either directly or through established formal written arrangements and referrals (consistent with [Form 5A: Services Provided](#)).

Note: Contracted providers should be indicated on [Form 2: Staffing Profile](#) and the summary of current or proposed contracts/agreements in [Attachment 7: Summary of Contracts and Agreements](#). If a 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)) will be contracted, include the contract/agreement as an attachment to [Form 8: Health Center Agreements](#).

- 5) Describe how the service delivery model assures continuity of care for health center patients, including:
 - a) Arrangements for admitting privileges for health center physicians to ensure continuity of care for health center patients at one or more hospitals (consistent with [Form 5C: Other Activities/Locations](#)). In cases where hospital privileges are not possible, describe other established arrangements to ensure continuity of care (i.e., timely follow-up) for patient hospitalizations.
 - b) How these arrangements ensure a continuum of care for health center patients, including discharge planning, post-hospitalization tracking, and patient tracking (e.g., interoperability of electronic health records (EHRs)).
- 6) Describe policies and procedures used to implement the sliding fee¹⁰ discount program (consistent with [Attachment 10: Sliding Fee Discount Schedule](#)), including how these specifically address the following:
 - a) Definitions of income and family size.
 - b) Assessment of all patients for eligibility for sliding fee discounts based on income and family size only. Note: No other factors (e.g., insurance status) can be considered.
 - c) Documentation and verification requirements used to determine patient eligibility for sliding fee discounts and frequency of re-evaluation of patient eligibility.
 - d) Language and literacy level-appropriate methods used for making patients aware of the availability of sliding fee discounts (e.g., signs posted in accessible and visible locations, registration materials, brochures, verbal messages delivered by staff).

¹⁰ Refer to [PIN 2014-02](#) for details on the Health Center Program sliding fee discount program and related billing and collections requirements.

- e) How sliding fee discounts are applied to both required and additional services within the scope of project (consistent with the services and service delivery methods indicated on [Form 5A: Services Provided](#), Columns I, II, or III).
 - f) Method and frequency of evaluating the sliding fee discount program from the perspective of reducing patient financial barriers to care.
- 7) Describe the following aspects of the Sliding Fee Discount Schedule(s) (SFDS) (consistent with [Attachment 10: Sliding Fee Discount Schedule](#)):
- a) Annual updates to reflect the most recent [Federal Poverty Guidelines](#) (FPG).
 - b) Adjustment of fees for individuals and families with incomes above 100 percent of FPG, and at or below 200 percent of the FPG, using at least three (3) discount pay classes.
 - c) Provision of a full discount (or nominal charge) for individuals and families with annual incomes at or below 100 percent of the FPG.
 - d) If a nominal charge is applied for individuals and families with annual incomes at or below 100 percent of the FPG, how the charge is:
 - Determined to be nominal from the perspective of the patient (e.g., input from patient focus groups, patient surveys).
 - A fixed fee (not a percentage of the actual charge/cost) that does not reflect the true cost of the service(s) being provided.
 - Not more than the fee paid by a patient in the first SFDS pay class above 100 percent of the FPG.
- 8) Describe the organization's quality improvement/quality assurance (QI/QA) and risk management plan(s) for systematically assuring and improving health care quality, including policies, procedures, and parties responsible for:
- a) Addressing patient grievances.
 - b) Incident reporting and management.
 - c) Patient records, including maintaining confidentiality of such records.
 - d) Periodic assessment by physicians (or other licensed health care professionals under the supervision of a physician) of service utilization, quality of services delivered, and patient outcomes.
 - e) Ensuring providers (e.g., employed, contracted, volunteers, locum tenens) are appropriately licensed, credentialed, and privileged to perform proposed services (consistent with [Form 5A: Services Provided](#)) at proposed sites/locations (consistent with Forms [5B: Service Sites](#) and [5C: Other Activities/Locations](#)).
 - f) Utilization of appropriate information systems (e.g., EHRs, payment management systems) for tracking, analyzing, and reporting key performance data, including 1) reporting required clinical and financial performance measures and 2) tracking diagnostic tests and other services provided to ensure appropriate patient record documentation and follow-up.
 - g) Developing, updating, and obtaining board approval for such policies and procedures, including their implementation.
 - h) Communication to all project stakeholders and utilization of QI/QA results to improve performance.

- i) Accountability throughout the organization, specifically the role and responsibilities of the Clinical Director in providing oversight of the QI/QA program.
- 9) Describe plans for assisting individuals in determining their eligibility for and enrollment in affordable health insurance options available through the Marketplace, Medicaid and CHIP, including:
- a) How potentially eligible individuals (both current patients and other individuals in the service area) will be identified and informed of the available options.
 - b) The type of assistance that will be provided for determining eligibility and completing the relevant enrollment process.

Note: New and competing supplement applicants must:

- 10) Upload a detailed implementation plan to [Attachment 13: Implementation Plan](#) (see [Appendix C](#)). The plan must include reasonable and time-framed activities that assure that, within 120 days receipt of the Notice of Award,¹¹ **all proposed sites** (as noted on [Form 5B: Service Sites](#)) must have the necessary staff and providers in place to begin operating and delivering services to the proposed community and/or target population as described on Forms [5A: Services Provided](#) and [5C: Other Activities/Locations](#).
- a) Describe plans to ensure that the organization will hire/contract with all providers (consistent with [Form 2: Staffing Profile](#), [Form 8: Health Center Agreements](#), and [Attachment 7: Summary of Contracts and Agreements](#)) and begin providing services at all sites for the targeted number of hours within one year of Notice of Award.

COLLABORATION – CORRESPONDS TO SECTION V.1 CRITERION 3: COLLABORATION

- 1) Describe both formal and informal collaboration and coordination of services¹² with other community providers in the service area (consistent with in [Attachment 1: Service Area Map and Table](#)). Specifically describe collaboration and coordination with the following or explain if such community services are not available:
 - a) Existing health centers (Health Center Program award recipients and look-alikes).
 - b) State and local health departments.
 - c) Rural health clinics.
 - d) Free clinics.
 - e) Critical access hospitals.
 - f) Other federally supported award recipients (e.g., Ryan White programs, Title V Maternal and Child Health programs).
 - g) Private provider groups serving low income/uninsured patients.
 - h) Evidence-based home visiting programs serving the same target population.¹³

¹¹ HRSA may issue Notices of Award up to 60 days prior to the project period start date.

¹² Refer to [PAL 2011-02: Health Center Collaboration](#) for information on maximizing collaborative opportunities.

¹³ Examples of evidence-based home visiting programs are available at the [Maternal, Infant, and Early Childhood Home Visiting Program web site](#).

- i) Additional programs serving the same target population (e.g., social services; job training; Women, Infants, and Children (WIC); coalitions; community groups; school districts).
- j) If applicable, organizations that provide services or support to the special population(s) for which funding is sought (e.g., Migrant Head Start, Public Housing Authority, homeless shelters).
- k) If applicable, neighborhood revitalization initiatives such as the Department of Housing and Urban Development's Choice Neighborhoods, the Department of Education's Promise Neighborhoods, and/or the Department of Justice's Byrne Criminal Justice Innovation Program.

Note: Formal collaborations (e.g., contracts, memoranda of understanding or agreement) should also be summarized in [Attachment 7: Summary of Contracts and Agreements](#).

- 2) Document support for the proposed project through current dated letters of support that reference specific coordination or collaboration from all of the following in the service area (as defined in [Attachment 1: Service Area Map and Table](#)), or state if such organizations do not exist in the service area:
 - a) Existing health centers (Health Center Program award recipients and look-alikes).
 - b) State and local health departments.
 - c) Rural health clinics.
 - d) Critical access hospitals.

If such letters cannot be obtained from organizations in the service area, include documentation of efforts made to obtain the letters along with an explanation for why such letters could not be obtained.

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

Note: Merge all letters of support from Items 2 and 3 into a single document and submit it as [Attachment 9: Letters of Support](#).

***EVALUATIVE MEASURES – CORRESPONDS TO SECTION V.1 CRITERION 4:
EVALUATIVE MEASURES***

- 1) Within the Clinical Performance Measures form (see detailed instructions in [Appendix B](#)), outline time-framed and realistic goals that are responsive to the identified needs.
- 2) Within the Financial Performance Measures form (see detailed instructions in [Appendix B](#)), outline time-framed and realistic goals for the project period that are responsive to the organization's financial performance.
- 3) Describe the organization's evaluation process for additional assessment of the health care needs of the target population, including:
 - a) The frequency and when the last assessment occurred.

- b) Community engagement.
 - c) Assessment tools/methods (e.g., written or verbal patient satisfaction surveys), and analysis, including cultural appropriateness.
 - d) Dissemination of results to board members, health center staff, community stakeholders, project partners, and patients.
- 4) Provide a brief description of any additional evaluation activities planned throughout the project period, including planned data collection tools.

***RESOURCES/CAPABILITIES – CORRESPONDS TO SECTION V.1 CRITERION 5:
RESOURCE/CAPABILITIES***

- 1) Describe how the organizational structure (including any subrecipients/contractors) is appropriate for the operational needs of the project (consistent with Attachments [2: Corporate Bylaws](#) and [3: Project Organizational Chart](#), and, as applicable, Attachments [6: Co-Applicant Agreement](#) and [7: Summary of Contracts and Agreements](#)), including:
 - a) How lines of authority are maintained from the governing board to the CEO.
 - b) Whether the applicant organization is part of a parent, affiliate, or subsidiary organization (consistent with [Form 8: Health Center Agreements](#)).

- 2) Describe how the organization maintains appropriate oversight and authority over all proposed service sites, including contracted/sub-awarded sites, and services including (as applicable):
 - a) Current or proposed contracts and agreements summarized in [Attachment 7: Summary of Contracts and Agreements](#).
 - b) Subrecipient arrangements,¹⁴ subawards, contracts, or parent/affiliate/subsidiary agreements uploaded in [Form 8: Health Center Agreements](#).

Note: Exclude contracts for the acquisition of supplies, material, equipment, or general support services (e.g., janitorial services, contracts with individual providers).

- 3) Describe how the organization’s management team (CEO, CMO, CFO, CIO, and COO, as applicable) is appropriate for the operational and oversight needs, scope, and complexity of the proposed project, including:
 - a) Defined roles (consistent with [Attachment 4: Position Descriptions for Key Management Staff](#)), in particular the CEO’s responsibilities for day-to-day program management of health center activities.

¹⁴ 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 funding requirements specified in [Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75](#). As a subrecipient of Health Center Program funding, such organizations are eligible to receive FQHC benefits, including reimbursement as an FQHC, 340b drug 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.

- b) Skills and experience for the defined roles (consistent with [Attachment 5: Biographical Sketches for Key Management Staff](#)).
 - c) If applicable, shared key management positions (e.g., shared CFO/COO role) and time dedicated to health center activities (e.g., 0.5 FTE).
 - d) If applicable, changes in key management staff in the last year or significant changes in roles and responsibilities.
- 4) Describe the plan for recruiting and retaining key management staff and health care providers necessary for achieving the proposed staffing plan (consistent with [Form 2: Staffing Profile](#)).
- 5) Describe organizational experience in the following areas:
- a) Working with the target population.
 - b) Developing and implementing systems and services appropriate for addressing the target population's identified health care needs.
- 6) Describe the organization's ongoing strategic planning process, including:
- a) The roles of the governing board and key management staff.
 - b) The frequency of strategic planning meetings.
 - c) Strategic planning products (e.g., strategic plan, operational plan).
 - d) Incorporation of needs assessment and program evaluation findings.
- 7) Describe current or planned acquisition and implementation of certified EHR systems.¹⁵ When describing EHR systems, include the number of sites and providers utilizing, or that will utilize, EHRs (e.g., number and types of providers that receive Medicare and Medicaid EHR Incentive Payments) for tracking patient and clinical data to achieve meaningful use.¹⁶
- 8) Describe any national quality recognition the organization has received or is in the process of achieving (e.g., Patient-Centered Medical Home, Accreditation Association for Ambulatory Health Care, Joint Commission, state-based or private payer initiatives).
- 9) Describe the current status or plans for participating in FQHC-related benefits (e.g., Federal Tort Claim Act (FTCA) coverage, FQHC Medicare/Medicaid/CHIP reimbursement, 340 Drug Pricing Program, National Health Service Corps Providers).
- 10) Describe the billing and collections policies and procedures, including:
- a) How the established schedule of charges for health center services (consistent with [Form 5A: Services Provided](#)) is consistent with locally prevailing rates and is designed to cover the reasonable cost of service operation.

¹⁵ Information about certified EHR systems is available at [HealthIT.gov: ONC – Authorized Testing and Certification Body](#).

¹⁶ Information about meaningful use is available at [Centers for Medicare and Medicaid Services Definition for Meaningful Use](#).

- b) Efforts to collect appropriate reimbursement from Medicaid, Medicare, and other public and private insurance sources (e.g., CHIP, Marketplace qualified health plans) (consistent with [Form 3: Income Analysis](#)).¹⁷
 - c) Efforts to secure payments owed by patients that do not create barriers to care.
 - d) Criteria for waiving charges and staff authorized to approve such waivers.
- 11) Describe how the financial accounting and control systems, as well as related policies and procedures:
- a) Are appropriate for the size and complexity of the organization.
 - b) Reflect Generally Accepted Accounting Principles (GAAP).
 - c) Separate functions/duties, as appropriate for 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).
 - e) Support management decision-making.
- 12) Describe the organization's current financial status, including profitability (change in net income/total expenses), cash-on-hand (total unrestricted cash/daily expenses), and solvency (total liabilities/total net assets). Source documents (e.g., current income statement and balance sheet) may be uploaded to [Attachment 14: Other Relevant Documents](#), as desired.
- 13) Describe the annual independent auditing process performed in accordance with federal audit requirements.¹⁸ Explain any adverse audit findings (e.g., questioned costs, reportable conditions, cited material weaknesses) and corrective actions that have been implemented to address such findings.
- 14) Describe the status of emergency preparedness planning and development of emergency management plan(s), including efforts to participate in state and local emergency planning. If applicable, explain negative responses on [Form 10: Emergency Preparedness Report](#) and plans for resolution.

GOVERNANCE¹⁹ – 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.

- 1) Describe how Attachments [2: Corporate Bylaws](#), [6: Co-Applicant Agreement](#), and [8: Articles of Incorporation](#) demonstrate that the organization has an independent governing

¹⁷ Refer to [PIN: 2013-01](#) Health Center Budgeting and Accounting Requirements for information on Health Center Program budgeting and accounting requirements.

¹⁸ Information about administrative and audit requirements, and the cost principles that govern federal funding under this announcement are available at [Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75](#).

¹⁹ Refer to [PIN 2014-01](#): Health Center Program Governance for information on Governance requirements.

board that retains (i.e., does not delegate) the following unrestricted authorities, functions, and responsibilities:²⁰

- a) Meets at least once a month.
- b) Determines board composition with patient majority (51 percent) required.
- c) Determines executive committee function and composition.
- d) Ensures that minutes documenting the board's functioning are maintained.
- e) Selects the services to be provided.
- f) Determines the hours during which services will be provided.
- g) 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.
- h) Approves the health center's annual budget, federal applications for funding, and selection/dismissal/performance appraisal of the organization's CEO.
- i) Establishes general policies for the organization.

Note: An applicant requesting funding to serve the general community (CHC) AND special populations (MHC, HCH, and/or PHPC) must have appropriate board representation from these populations. At minimum, there must be at least one representative from/for each special population group for which funding is requested who can clearly communicate the target population's needs/concerns (e.g., advocate for migratory and seasonal agricultural workers, formerly homeless individual, current resident of public housing). Applicants targeting only special populations may request a waiver of the 51% patient majority board composition requirement on [Form 6B: Request of Waiver of Board Member Requirements](#).

- 2) Describe how the governing board:
 - a) Operates, including the organization and responsibilities of board committees (e.g., Executive, Finance, QI/QA, Risk Management, Personnel, Planning).
 - b) Monitors and evaluates its performance, inclusive of identifying training needs.
 - c) Provides training, development, and orientation for **new members** to ensure that they have sufficient knowledge to make informed decisions regarding the strategic direction, general policies, and financial position of the organization.
- 3) **Applicants with a co-applicant or parent/affiliate/subsidiary** (consistent with [Form 8: Health Center Agreements](#)): Describe how this organizational structure/relationship does not impact or restrict the applicant's governing board composition and/or 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, if applicable, Executive Committee members.
 - b) Selection or dismissal of the CEO/Executive Director, including arrangements that combine this position with other key management positions.
 - 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).

²⁰ In the case of public centers with co-applicant governing boards, the public center is permitted to retain authority for establishing general fiscal and personnel policies for the health center.

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

- 4) Document that the health center’s bylaws and/or other board-approved policy document(s) and procedures include specific provisions that prohibit real or apparent conflict of interest by board members, employees, consultants, and others in the procurement of supplies, property (real or expendable), equipment, and other services procured with federal funds.

Describe how the health center’s bylaws and governing board will be updated as changes occur in the target population and service area.

- 5) **INDIAN TRIBES OR TRIBAL, INDIAN, OR URBAN INDIAN GROUPS 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 REQUESTED²¹ – *CORRESPONDS TO SECTION V.1 CRITERION 7: SUPPORT REQUESTED*

- 1) Provide a complete, consistent, and detailed budget presentation through the submission of the following: [SF-424A](#), [Budget Justification Narrative](#), [Form 2: Staffing Profile](#), and [Form 3: Income Analysis](#).
- 2) Describe how the total budget is appropriate for the proposed project and the total number of unduplicated patients projected to be served (consistent with [Form 1A: General Information Worksheet](#), [Table 1: Funding Reduction by Patients Projected to Be Served](#), and the [Summary Page](#)).
- 3) Describe how the proportion of federal funds requested in this application is appropriate given other sources of funding, including those specified in [Form 3: Income Analysis \(e.g., in-kind donations\)](#) and the [Budget Justification Narrative](#).
- 4) Describe expected shifts in the payer mix (consistent with payer categories listed on [Form 3: Income Analysis](#)) and the potential impact on the overall budget, including plans to mitigate any expected adverse impacts.

NARRATIVE GUIDANCE

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.

²¹ Refer to [PIN: 2013-01](#) Health Center Budgeting and Accounting Requirements for information on Health Center Program budgeting and accounting requirements.

<u>Narrative Section</u>	<u>Review Criteria</u>
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.

iii. Budget

See Section 5.1 of HRSA’s [SF-424 Two-Tier Application Guide](#). Funding must be requested and will be awarded proportionately for all population types within the service area as currently funded under the Health Center Program. No new population types may be added.

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 federally supported project or activity. Total project or program costs include costs charged to the award and costs borne by the recipient to satisfy a matching or cost-sharing requirement.

In addition, Service Area Competition – Additional Area funding opportunity applicants must present the total budget for the project, which includes Health Center Program federal funds and all non-grant funds that support the health center scope of project. The total budget represents projected operational costs for the health center scope of project where all proposed expenditures directly relate to and support in-scope activities. 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-Health Center Program grant sources” such as state, local, or other federal grants or contracts, private contributions, and income generated from fundraising. Health centers have discretion regarding how they propose to allocate the total budget between Health Center Program grant funds and non-grant funds, provided that the projected budget complies with all applicable HHS policies and other federal requirements. See [PIN 2013-01](#) for additional information on health center budgeting.

The Consolidated and Further Continuing Appropriations Act, 2015, Division G, § 203, (P.L. 113-235) 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” (\$183,300). Please see Section 5.1.iii Budget – Salary Limitation of HRSA’s [SF-424 Two-](#)

[Tier Application Guide](#) for additional information. Note that these or other salary limitations will apply in FY 2016, as required by law.

iv. Budget Justification Narrative

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

In addition, the Service Area Competition – Additional Area funding opportunity requires a detailed budget justification narrative and table of personnel to be paid with federal funds must be provided for **each requested 12-month period** (budget year) of three-year project period. Year 1 of the budget justification narrative should be classified into federal and non-federal resources. For subsequent budget years, the justification narrative should highlight the changes from Year 1 or clearly indicate that there are no substantive changes during the project period. See the [SAC-AA Technical Assistance web site](#) for a sample Budget Justification Narrative.

v. Program Specific Forms

All of the following forms, with the exception of [Form 5C: Other Activities/Locations](#), are required. These OMB-approved forms must be completed in EHB and cannot be uploaded. Refer to [Appendix A](#) for Program Specific Forms instructions and [Appendix B](#) for Performance Measure Forms instructions. Samples are available at the [SAC-AA Technical Assistance web site](#).

[Form 1A](#): General Information Worksheet

[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 10](#): Emergency Preparedness Report

[Form 12](#): Organization Contacts

[Clinical Performance Measures](#)

[Financial Performance Measures](#)

[Summary Page](#)

vi. Attachments

Provide the following items in the order specified below to complete the content of the application. **Unless otherwise noted, attachments count toward the application page limit.** Proof of non-profit status will not count toward the page limit.

Label each attachment according to the number provided (e.g., Attachment 2: Corporate Bylaws). 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. Number the electronic pages sequentially, restarting at page 1 for each attachment. NOTE: The HRSA EHB will not accept file attachments with names that exceed 100 characters.

Applications that do not include attachments marked “C”, (required for completeness), will be considered incomplete or non-responsive and will not be considered for funding. Failure to include attachments marked “R”, (required for review), may negatively impact an application’s objective review score.

Attachment 1: Service Area Map and Table (R)

Upload a map of the service area for the proposed project, indicating the organization’s proposed health center site(s) listed in Form 5B: Service Sites. The map must clearly indicate the proposed service area zip codes, any medically underserved areas (MUAs) and/or medically underserved populations (MUPs), and Health Center Program award recipients, look-alikes, and other health care providers serving the proposed zip codes. Maps should be created using [UDS Mapper](#). Please note that you will have to manually place markers for the locations of other major private provider groups serving low income/uninsured patients.

Include a corresponding table that lists each zip code tabulation area (ZCTA) in the service area, the number of health centers serving each ZCTA, total population, total low-income population, total health center patients, and patient penetration levels for each ZCTA and for the overall proposed service area. This table will be automatically created in UDS Mapper. See the [SAC-AA Technical Assistance web site](#) for samples and instructions on creating maps using UDS Mapper. For a tutorial, see [Specific Use Cases: Create a Service Area Map and Data Table](#).

Attachment 2: Corporate Bylaws (C)

Upload (in its entirety) the applicant organization’s most recent bylaws. Public centers that have a co-applicant must submit the co-applicant governing board bylaws. See the [GOVERNANCE](#) section of the Project Narrative for more details.

Attachment 3: Project Organizational Chart (R)

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

Attachment 4: Position Descriptions for Key Management Staff (R)

Upload current position descriptions for key management staff: Chief Executive Officer (CEO), Chief Medical Officer (CMO), Chief Financial Officer (CFO), Chief Information Officer (CIO), and Chief Operating Officer (COO). Indicate on the position descriptions if key management positions are combined and/or part time (e.g., CFO and COO roles are shared). Each position description should be limited to **one page** and must include, at a minimum, the position title; description of duties and responsibilities; position qualifications; supervisory relationships; skills, knowledge, and experience requirements; travel requirements; salary range; and work hours.

Attachment 5: Biographical Sketches for Key Management Staff (R)

Upload current biographical sketches for key management staff: CEO, CMO, CFO, CIO, and COO. Biographical sketches should not exceed **two pages** each. When applicable, biographical sketches must include training, language fluency, and experience working with the cultural and linguistically diverse populations to be served.

Attachment 6: Co-Applicant Agreement (as applicable) (New: C) (Competing Continuation and Competing Supplement: R)

Public center²² applicants that have a co-applicant board must submit, in its entirety, the formal co-applicant agreement signed by both the co-applicant governing board and the public center. See the [RESOURCES/CAPABILITIES](#) and [GOVERNANCE](#) sections of the Project Narrative for more details.

Attachment 7: Summary of Contracts and Agreements (as applicable) (R)

Upload a brief summary describing all current or proposed patient service-related contracts and agreements, consistent with Form 5A: Services Provided, columns II and III, respectively. The summary must address the following items for each contract or agreement:

- Name of contract/referral organization.
- Type of contract or agreement (e.g., contract, referral agreement, Memorandum of Understanding or Agreement).
- Brief description of the type of services provided and how/where services are provided.
- Timeframe for each contract or agreement (e.g., ongoing contractual relationship, specific duration).

If a contract or agreement will be attached to [Form 8: Health Center Agreements](#) (e.g., subrecipient agreement; contract or subaward to a parent, affiliate, or subsidiary organization), denote this with an asterisk (*).

Attachment 8: Articles of Incorporation (as applicable) (New: C) (Competing Continuation and Competing Supplement: N/A)

New applicants must upload the official signatory page (seal page) of the organization's Articles of Incorporation. A public center with a co-applicant will upload the co-applicant's Articles of Incorporation signatory page, if incorporated.

Attachment 9: Letters of Support (R)

Upload current dated letters of support addressed to the appropriate organization contact (e.g., board, CEO) to document commitment to the project. See the [COLLABORATION](#) section of the Project Narrative for details on required letters of support. Letters of support should be addressed to the organization's board, CEO, or other appropriate key management staff member (e.g., Clinical Director).

Note: Only letters of support submitted with the application will be considered by reviewers.

Attachment 10: Sliding Fee Discount Schedule(s) (R)

²² Public centers were referred to as "public entities" in the past.

Upload the current or proposed sliding fee discount schedule(s). See the [RESPONSE](#) section of the Project Narrative for details.

*Attachment 11: Evidence of Nonprofit or Public Center Status (as applicable) (New: C)
(Competing Continuation and Competing Supplement: N/A)*

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

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

- A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.
- A copy of a currently valid 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 and that none of the net earnings accrue to any private shareholders or individuals.
- A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- Any of the above proof for a state or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

Public Centers: Consistent with [PIN 2010-01](#), applicants must provide documentation demonstrating that the organization qualifies as a public agency (e.g., health department) for the purposes of section 330 of the PHS Act, as amended. Any of the following is acceptable:

- Affirm Instrumentality Letter (4076C) from the IRS or a letter of authority from the federal, state, or local government granting the entity one or more sovereign powers.
- A determination letter issued by the IRS providing evidence of a past positive ruling by the IRS or other documentation demonstrating that the organization is an instrumentality of government, such as documentation of the law that created the organization or documentation showing that the state or a political subdivision of the state controls the organization.
- Formal documentation from a sovereign state's taxing authority equivalent to the IRS granting the entity one or more governmental powers.

Attachment 12: Floor Plans (as applicable) (New and Competing Supplement: R) (Competing Continuation: N/A)

New and competing supplement applicants must provide copies of floor plans for all sites within the proposed scope of project. Competing continuation applicants **do not** need to provide floor plans for approved sites in the currently funded Health Center Program scope of project unless there has been a change in layout of any site(s).

*Attachment 13: Implementation Plan (as applicable) (New and Competing Supplement: C)
(Competing Continuation: N/A)*

New and competing supplement applicants must upload the Implementation Plan. Refer to [Appendix C](#) for detailed instructions and the [SAC-AA Technical Assistance web site](#) for a sample.

Attachment 14: Other Relevant Documents (as applicable) (R)

If desired, include other relevant documents to support the proposed project (e.g., charts, organizational brochures, lease agreements). Maximum of two uploads.

Note: New and competing supplement applicants must include lease/intent to lease documentation in this attachment if a proposed site is or will be leased.

3. Dun and Bradstreet Universal Numbering System Number and System for Award Management (formerly, Central Contractor Registration)

An applicant organization must obtain a valid DUNS number and provide that number in their application. An 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 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 organization/awardee has already completed Grants.gov registration for HRSA or another federal agency, confirm that it 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](#)
- [System for Award Management](#)
- [Grants.gov](#)

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

4. Submission Dates and Times

Application Due Date

The due date for applications under HRSA-16-178 in Grants.gov (Step 1) is **February 22, 2016 at 11:59 p.m. Eastern Time**.

See Section 8.2.5 – Summary of e-mails from Grants.gov of HRSA's [SF-424 Two-Tier Application Guide](#) for additional information.

The due date to complete all other required information in the HRSA EHB (Step 2) is **March 8, 2016 at 5:00 p.m. Eastern Time.**

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

5. Intergovernmental Review

State System Reporting Requirements

The Health Center Program is subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. See Executive Order 12372 in the [HHS Grants Policy Statement](#). See Section 5.1 of HRSA's [SF-424 Two-Tier Application Guide](#) for additional information.

Public Health System Reporting Requirements

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

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

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

If applicants are unclear on where to send the PHSIS, they should contact their [Single Point of Contact](#) (SPOC) or [PCO](#).

6. Funding Restrictions

Applicants responding to this announcement may request funding for a project period of up to three years, at no more than the amount listed as Total Funding in [Table 6](#). 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.

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. Health Center Program

funds are to be used for authorized health center operations and may not be used for profit. Further, as stated in section 330 of the PHS Act, the federal cost principles apply only to federal funds.

Funds under this announcement may not be used for fundraising or the construction of facilities. The [HHS Grants Policy Statement](#) (HHS GPS) includes information about allowable expenses.

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

The General Provisions in Division G, of the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235), apply to this program. Please see Section 5.1 of the HRSA [SF-424 Two-Tier Application Guide](#) for additional information. Note that these or other provisions will apply in FY 2016, as required by law.

V. Application Review Information

1. Review Criteria

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

These criteria are the basis upon which the reviewers will evaluate the application. The entire proposal will be considered during objective review.

Reviewers will use the [HRSA Scoring Rubric](#) when assigning scores to each criterion. Information presented in the application will also impact the project period if funding is awarded. See the [Project Period Length Criteria](#) section.

In the event that a competing continuation applicant submits the only application for the service area, HRSA will conduct a comprehensive internal review of the application in lieu of an external objective review. Applications receiving an internal review will be subject to the same completeness and eligibility screening as those receiving an external review and will be assessed for compliance with all [Health Center Program requirements](#) and projected performance goals.

Each Health Center Program Service Area Competition – Additional Area application will be evaluated on the following review criteria:

Criterion 1: NEED (15 Points) – Corresponds to Section IV.2.ii NEED

- The extent to which the applicant demonstrates through quantitative and qualitative data an understanding of the nature and extent of the need for the proposed project by detailing significant health care needs in the service area/target population, including any targeted special populations.
- The extent to which the applicant clearly describes the existing primary health care services, service gaps, and access indicators; factors affecting the broader health care environment; and the role that the applicant organization currently plays or will play in the local health care landscape.

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

- The extent to which the applicant demonstrates that the proposed service delivery model(s), sites, services, clinical staffing plan, and coordination with other providers/institutions in the community will meet the needs of the target population, provide continuity of care, incorporate enabling services, and ensure that the target population's continuum of health care needs are met.
- The extent to which the applicant establishes that: 1) the schedule of charges is reasonable and consistent with locally prevailing rates, and 2) the corresponding sliding fee discount schedule(s), including any nominal fees, ensures that services are available and accessible to all without regard to ability to pay; applies discounts based on a patient's income; and is appropriately promoted.
- The extent to which the applicant establishes that the QI/QA and risk management plans are or will be integrated into the health center's routine management efforts and will be utilized to ensure ongoing improvement of services and practices.
- Applicants requesting funds to serve special populations: The extent to which the applicant demonstrates compliance with requirements for targeted special populations, including demonstrating that services targeting residents of public housing are: 1) immediately accessible, and 2) developed and administered in consultation with the targeted public housing communities; and that services targeting people experiencing homelessness will include the provision of substance abuse services (either directly or through referral).
- New or competing supplement applicant: The extent to which the applicant provides a detailed implementation plan that ensures that within 120 days of the Notice of Award, all proposed site(s) will be operating with necessary staff and providers in place to deliver health care services.
- New or competing supplement applicant: The extent to which the applicant demonstrates how providers will begin providing services at all sites for the targeted number of hours within one year of Notice of Award.

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

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

Criterion 4: EVALUATIVE MEASURES (15 points) – Corresponds to Section IV.2.ii
EVALUATIVE MEASURES

- The extent to which the applicant establishes Clinical and Financial Performance Measure goals and plans for achieving goals that are informed by documented contributing and restricting factors and any additional unique special population needs identified in the [NEED](#) section.
- The extent to which the applicant establishes that the needs of the target population are routinely assessed and that any additional planned evaluation activities are methodologically sound.

Criterion 5: RESOURCES/CAPABILITIES (20 points) – Corresponds to Section IV.2.ii
RESOURCES/CAPABILITIES

- The extent to which the applicant establishes that the proposed organizational structure, management staff, and policies/procedures are appropriate for the operational and oversight needs of the proposed project, including any contractors and subrecipients, or parent, affiliate, or subsidiary arrangements.
- The extent to which the applicant establishes its experience and expertise working with and addressing the target population's health care needs.
- The extent to which the applicant establishes a commitment to sustainability by documenting: 1) plans to recruit and retain key management staff and health care providers; 2) policies and procedures for maximizing collection of payments and reimbursement for costs; 3) participation in FQHC-related benefits; 4) emergency planning; and 5) a strategic planning process that incorporates the target population's needs and related performance measure goals.
- The extent to which the applicant describes current or planned acquisition/development, implementation, and/or enhancement of certified EHR systems, as well as any national quality recognition the organization has received or is working towards.

- The extent to which the applicant: 1) establishes that appropriate financial accounting and control systems, policies, and procedures are in place in accordance with GAAP; 2) describes the organization's current financial status; and 3) describes the organization's annual independent auditing process, including any current or previous financial issues and how any identified issues are being resolved.

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

- The extent to which the applicant establishes that the governing board operates independently, without conflicts of interests, to oversee the proposed project's: 1) compliance with [Health Center Program requirements](#); 2) appropriateness in terms of size, composition, expertise, and unrestricted authority; 3) effective operations; and 4) establishment and review of policies and procedures.
- **Applicants targeting only special populations and requesting a waiver of the 51% patient majority board composition requirement:** The extent to which the applicant justifies the waiver request by 1) providing a reasonable statement of need for the request, and 2) describing sufficient alternative procedures for ensuring patient input and/or appropriate project oversight by the governing board.
- **Indian tribe or tribal, Indian, or urban Indian group applicants:** The extent to which the applicant demonstrates that: 1) policy documents specifically prohibit real or apparent conflict of interest and 2) the governance structure will assure adequate input from the community/target population as well as fiscal and programmatic oversight of the proposed project.

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

- The extent to which the applicant provides a detailed and reasonable budget presentation that supports the proposed project, including planned service delivery.
- The extent to which the applicant establishes that the federal request for funds is appropriate considering other sources of project income and the total number of unduplicated patients projected to be served.
- The extent to which the applicant anticipates and describes expected shifts in payer mix and potential impact on the overall budget as well as mitigation plans for any adverse impacts.

2. Review and Selection Process

Please see Section 6.3 of HRSA's [SF-424 Two-Tier Application Guide](#).

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

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

Additional Review Information

HRSA will use other factors other than merit criteria in selecting applications for federal award. For this program, factors such as past performance, including unsuccessful progressive action condition resolution²³ and current compliance with Health Center Program requirements and regulations, will be considered when selecting applications for funding and determining project period length (see [Project Period Length Criteria](#) section). HRSA may determine compliance through several strategies, such as site visits, audit data, Uniform Data System (UDS) or similar performance reports, Medicare/Medicaid cost reports, and external accreditation. HRSA reserves the right to conduct onsite verification of compliance. The results of a compliance review may impact final funding decisions. For example, based on review of applicants by the Division of Financial Integrity, applicants with financial sustainability concerns may not receive an award.

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](#)). 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 OPDIV or HHS official or board.

Project Period Length Criteria

The length of an awarded project period is determined by a comprehensive evaluation of compliance with program requirements by HRSA. Applicants with one or more of the following characteristics will be awarded a one-year project period:²⁴

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

²³ See [PAL: 2014-08](#) Health Center Program Requirements Oversight for more information on progressive action.

²⁴ *New applicants*: Conditions related to Health Center Program requirements to be placed on the award based on information included in this application and review of [Additional Review Information](#).

Competing continuation applicants: Current unresolved conditions related to Health Center Program requirements carried over into the new project period, combined with any new conditions related to Health Center Program requirements to be placed on the award based on information included in this application and review of [Additional Review Information](#).

If a competing continuation applicant has been awarded two consecutive one-year project periods in FY 2014 and FY 2015, and meets the criteria for a third consecutive one-year project period in FY 2016, the application will not be funded and the service area will be recompleted if no other fundable applications were received.

Any competing supplement applicant with 5 or more unresolved conditions related to Health Center Program requirements in the 60-day phase of Progressive Action or 1 or more unresolved conditions related to Health Center Program requirements in the 30-day phase of Progressive Action will not be funded and the service area will be recompleted if no other fundable applications were received.

Restricted Drawdown Determining Factors

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

Special Funding Considerations

Other factors such as geographic distribution and past performance may be considered as part of the selection of applications for funding. In addition, HRSA will consider the following factors when making awards:

- *RURAL/URBAN DISTRIBUTION OF AWARDS*: Aggregate awards in FY 2016 will be made to ensure that no more than 60 percent and no fewer than 40 percent of centers serve people from either rural or urban areas.
- *PROPORTIONATE DISTRIBUTION*: Aggregate awards in FY 2016 to support the various types of health centers (CHC, MHC, HCH, and/or PHPC) will be made to ensure continued proportionate distribution of funds across the Health Center Program as set forth in section 330(r)(2)(B) of the PHS Act.

Funding Priorities

This funding opportunity includes a funding priority for competing continuation applicants. A funding priority is defined as the favorable adjustment of review scores when applications meet specified criteria. **Applicants do not need to request a funding priority.** Prior to final funding decisions, HRSA will assess all SAC-AA applications within the fundable range for eligibility to receive priority points, as demonstrated in the [Health Center Profile](#).

The FY 2016 SAC-AA funding opportunity has one funding priority. To minimize potential service disruptions and maximize the effective use of federal dollars, HRSA will award priority points to competing continuation applicants according to the criteria below.

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

3. 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 in 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 [§ 200.205 Federal Awarding Agency Review of Risk Posed by Applicants](#).

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

It is anticipated that awards will be announced prior to the project period start date of August 1, 2016.

VI. Award Administration Information

1. Award Notices

The Notice of Award will be sent prior to the start date of August 1, 2016. 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 funding opportunity announcement 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 annually. The Universal Report provides data on patients, services, staffing, and financing across all Health Center Program award recipients. The Grant Report provides data on patients and services for special populations served (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing).
- 2) **Progress Report** – The Budget Period Progress Report (BPR) non-competing continuation application documents award recipient's progress on program-specific goals and collects core performance measurement data to track the progress and impact of the project. Submission and HRSA approval of a BPR will trigger the budget period renewal and release of each subsequent year of funding (dependent upon Congressional appropriation, program compliance, organizational capacity, and a determination that continued funding would be in the best interest of the Federal Government). Award recipients will receive an email message via HRSA EHB when it is time to begin working on their progress reports.
- 3) **Integrity and Performance Reporting** - The Notice of Award will contain a provision for integrity and performance reporting in [FAPIS](#), as required in [2 CFR 200 Appendix XII](#).

VII. Agency Contacts

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

Donna Marx
HRSA Division of Grants Management Operations
Office of Federal Assistance Management
301-594-4245
dmarx@hrsa.gov

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

Beth Hartmayer
HRSA Office of Policy and Program Development
Bureau of Primary Health Care
301-594-4300
BPHCSAC@hrsa.gov
[SAC-AA Technical Assistance web site](#)

Additional technical assistance regarding this FOA may be obtained by contacting the appropriate PCAs, PCOs, or NCAs. For a list of contacts, see [Support Networks](#).

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
1-800-518-4726, (International Callers, please dial 606-545-5035)
support@grants.gov
[Grants.gov Self-Service Web Portal](#)

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

BPHC Helpline
1-877-974-2742
www.hrsa.gov/about/contact/bphc.aspx (select Grant Application as the Issue Type)

VIII. Other Information

Technical Assistance Page

A technical assistance Web site has been established to provide applicants with copies of forms, FAQs, and other resources that will help organizations submit competitive applications. To review available resources, visit the [SAC-AA Technical Assistance web site](#). (Note that some resources are not applicable to this FOA.)

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](#) and contact the BPHC Help Line at 877-974-BPHC for additional information.

Organizations must be aware that **participation in the FTCA program is not guaranteed**. Applicants are encouraged to review the requirements that are outlined in the [FTCA Health Center Policy Manual](#) and the most current [FTCA Deeming Application Program Assistance Letter](#) (search for keyword FTCA). If an applicant is not currently deemed, the costs associated with the purchase of malpractice insurance must be included in the proposed budget. The search for malpractice insurance, if necessary, should begin as soon as possible. Applicants interested in FTCA will need to submit a new application annually.

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. 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 of 20-50 percent 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 [Office of Pharmacy Affairs web site](#).

Health Centers Hire Veterans Challenge

HRSA encourages health centers to consider hiring qualified veterans for positions supported by federal funding.

IX. Tips for Writing a Strong Application

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

Appendix A: Program Specific Forms Instructions

Program Specific Forms must be completed electronically in EHB. All forms are required, except [Form 5C: Other Activities/Locations](#). Sample forms are available at the [SAC-AA Technical Assistance web site](#).

Note: Competing supplement applicants must utilize the Program Specific Forms to describe ONLY the proposed project in the new service area.

Form 1A: General Information Worksheet

Data pertaining to 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 numbers will pre-populate for competing continuation applicants.
- Use the Fiscal Year End Date field to note the month and day in which the applicant organization's fiscal year ends (e.g., December 31) to help HRSA know when to expect the audit submission in the [Federal Audit Clearinghouse](#).
- Applicants may check only one category in the Business Entity section. An applicant that is a Tribal or Urban Indian entity and also meets the definition for a public or private entity should select the Tribal or Urban Indian category.
- Applicants may select one or more categories for the Organization Type section.

2. Proposed Service Area

2a. Service Area Designation

- Applicants applying for CHC funding MUST serve at least one Medically Underserved Area (MUA) or Medically Underserved Population (MUP).
- Select the MUA and/or MUP designations for the proposed service area and enter the identification number(s).
- For inquiries regarding MUAs or MUPs, visit the [Shortage Designation web site](#) or call 1-888-275-4772 (option 1 then option 2), or contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816.

2b. Service Area Type

- Select the type (urban, rural, or sparsely populated) that describes the majority of the service area. If sparsely populated is selected, provide the number of people per square mile (values must range from .01 to 7). For information about rural populations, visit the [Office of Rural Health Policy's web site](#).

2c. Patients and Visits

General Guidance for Patient and Visit Numbers:

When providing the count of patients and visits within each service type category, note the following (see the [UDS Manual](#) for detailed information):

- A visit is a documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services rendered must be paid for by the applicant organization and documented in the patient's record.
- A patient is an individual who had (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.
- Applicants with more than one service site must report aggregate data for all sites in the proposed project.
- Baseline value data will pre-populate from the most recent UDS report for competing continuation applicants. If UDS data does not accurately reflect current numbers (e.g., due to additional funding received, change in scope, or shifting service area characteristics such as influx of new populations), indicate the accurate current data and describe the discrepancy between UDS and current data in [Item 3 of the NEED section](#) of the Project Narrative.
- A new or competing supplement applicant should report baseline values based on services the applicant is currently providing in the proposed service area (report annualized data) or, if not currently operational in the service area, report baseline values as zero.
Note: A competing supplement applicants should only include in the baseline values patients/visits occurring in the proposed service area that are **not** included in the applicant's most recent current UDS report.

Patients and Visits by Service Type:

1. New or competing supplement applicants: Provide the number of current patients and visits within each service type category. **An individual who receives multiple types of services should be counted once for each service type** (e.g., an individual who receives both medical and dental services should be counted once for medical and once for dental).
2. Project the number of patients and visits anticipated within each service type category by December 31, 2017 (January 1 – December 31, 2017). In general, HRSA does not expect the number of patients and visits to decline over time. Competing supplement applicants should not include patients served through current Health Center Program funding.
3. To maintain consistency with the patients and visits reported in UDS, do not report patients and visits for vision or pharmacy services or services outside the proposed scope of project. Refer to the [Scope of Project](#) policy documents.

Note: The Patients and Visits by Service Type section does not have a row for total numbers since an individual patient may be included in multiple service type categories (i.e., a patient should be counted once for each service type received).

Unduplicated Patients and Visits by Population Type:

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.**

1. New or competing supplement applicants: Provide the number of current unduplicated patients and visits for each population type category. **Across all population type categories, an individual can only be counted once as a patient.** Competing continuation applicants: Provide the number of visits across the population type categories; current patients will pre-populate from the 2014 UDS data.
2. To maintain consistency with the patients and visits reported in UDS, do not report patients and visits for pharmacy services or services outside the proposed scope of project. Refer to the [Scope of Project](#) policy documents.
3. Project the **total** number of unduplicated patients and visits within each population type category to be served by December 31, 2017 (January 1 – December 31, 2017). Note: The unduplicated patient projection must be at least 75% of the Patient Target in [Table 6](#).

HRSA will use the number of patients projected in the Total row for the Patients Projected by December 31, 2017 column of this section to determine compliance with [Eligibility Requirement 3a](#). Further, if a health center is unable to meet this total unduplicated patient projection (along with other patient projections for supplemental funding awarded during the project period such as FY 2015 Expanded Services) by December 31, 2017, funding for the service area may be reduced.

Note: HRSA will add new patient commitments awarded after June 1, 2015 to the FY 2016 SAC-AA patient projection. To avoid double counting of patients, your FY 2016 SAC-AA application patient projection must not include patients from your FY 2015 Expanded Services (ES) award or your August 2015 NAP award, if applicable.

4. Review the Patient Target in [Table 6](#) and the [Summary of Funding](#) for Patient Target reduction details to ensure that the Patient Target and funding request are aligned. Other resources are available at the [SAC-AA Technical Assistance web site](#).

Form 1C: Documents on File

This form 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. Keep these documents on file, making them available to HRSA **upon request** within 3-5 business days. **DO NOT** submit these documents with the application.

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

Note: Beyond [Health Center Program requirements](#), other federal and state requirements may apply. 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

Report personnel for the **first budget year** of the proposed project. Include only staff for sites included on Form 5B: Service Sites.

- 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](#).
- Volunteers must be recorded in the Direct Hire FTEs column.
- Select the relevant options for contracted staff 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

Form 3 will show the projected patient services and other income from all sources (other than the Health Center Program funds) for the **first year** of the proposed project period. 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.

Part 1: Patient Service Revenue - Program Income

Patient service revenue is income 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 [UDS Reporting Manual](#). All patient service revenue is reported in this section of the form. This includes all income from medical, dental, mental health, substance abuse, other professional, vision, and other clinical services, as well as income from ancillary services such as laboratory, pharmacy, and imaging services.

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

Patient service revenue associated with sites or services not in the approved scope of project including those pending approval 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 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 and Medicaid coverage is to be classified as a Medicare patient on line 2.
- A Medicaid patient with no dental coverage who is only seen for dental services is to be classified as a Medicaid patient on line 1 with a self-pay visit on line 5.

Billable Visits - Column (b): These include all billable/reimbursable visits.²⁵ There may be other exclusions or additions, which, if significant, should be noted in the Comment/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column (see [ancillary instructions](#) below).

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

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

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

²⁵ These visits will correspond closely with the visits reported on the [UDS Reporting Manual](#) Table 5, excluding enabling service visits.

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 UDS Table. 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 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 Veteran's Administration Community Based Outpatient Clinic (CBOC) contracts. Income from health benefit plans which are earned by government employees, veterans, retirees, and dependents, such as TRICARE, the federal employee health benefits

program, state employee health insurance benefit programs, teacher health insurance, and similar plans are to be classified as private insurance. Private insurance is earned or paid for by the beneficiary and other public insurance is unearned or based upon meeting the plan's eligibility criteria.

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

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

Part 2: Other Income – Other Federal, State, Local, and Other Income

This section includes all income other than the patient service revenue shown in Part 1 (exclusive of this Health Center Program funding 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 funds where the applicant is the recipient of a Notice of Award from a federal agency. It does not include the Health Center Program funding request or federal funds awarded through intermediaries (see Line 9 below). It includes funds from federal sources such as the Centers for Disease Control (CDC), Housing and Urban Development (HUD), Centers for Medicaid and Medicare Services (CMS), and others. It includes Health and Human Service (DHHS) funding under the Ryan White Part C program, DHHS Capital Development funding, and others. The CMS Medicare and Medicaid EHR 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 funding, contracts, and programs, including uncompensated care funding; state indigent care income; emergency preparedness funding; mortgage assistance; capital improvement funding; school health funding; Women, Infants, and Children (WIC); immunization funding; 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 funding, 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 funding would be classified as income earned from a local government and be shown on this line.

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

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

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

Applicant (Retained Earnings) (Line 13): This is the amount of funds needed from the applicant's retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why applicant funds (retained earnings) are needed to achieve a breakeven budget. Amounts from non-federal sources, combined with the 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 donations in the [SUPPORT REQUESTED](#) section of the Project Narrative. Additionally, such donations may be included on the SF-424A (Section A: Budget Summary—Non-Federal Resources under New or Revised Budget).

Form 4: Community Characteristics

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

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

agencies, health departments, and other local, state, and national data sources. Estimates are acceptable.

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

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

Note: The total numbers for the first four sections of this form (i.e., Race, Hispanic or Latino Ethnicity, Income as a Percent of Poverty Level, and Primary Third Party Payment Source) **must match**.

Guidelines for Reporting Race

- All individuals must be classified in one of the racial categories, including individuals who also consider themselves Hispanic or Latino. If the data source does not separately classify Hispanic or Latino individuals by race, report them as Unreported/Declined to Report.
- Utilize the following race definitions:
 - Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
 - Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, Tonga, Palau, Truk, Yap, or other Pacific Islands in Micronesia, Melanesia, or Polynesia.
 - Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Indonesia, Thailand, and Vietnam.
 - American Indian/Alaska Native – Persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
 - More Than One Race – Patient who chooses 2 or more races.

Guidelines for Reporting Hispanic or Latino Ethnicity

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

Guidelines for Reporting Special Populations

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

Forms 5A, 5B, and 5C

General Notes

- **New and competing supplement applicants** must complete Forms 5A: Services Provided and 5B: Service Sites. Form 5C: Other Activities/Locations may be completed, as applicable. Complete these forms based only on the scope of project for the proposed service area.
- If the project is funded, only the services, sites, and other activities/locations listed on these forms 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 for details pertaining to defining and changing scope (i.e., services, sites, service area zip codes, target population).

Form 5A: Services Provided

Identify how the required and optional additional services will be provided. Only one form is required regardless of the number of proposed sites. All referral arrangements/agreements for required services must be formal written arrangements/agreements.²⁶

Competing supplement applicants:

- **This application may not be used to propose new services for your current scope of project that should be submitted through the Change in Scope process.**
- All services in your current scope of project must be accessible to patients at any sites proposed in this application, though the mode of service delivery (Column I, II, or III) may be different across sites.
- If new services are proposed on Form 5A of this application, these services must be consistent with the proposed project for the new service area.
- If this application is funded, any new services must be accessible to patients at all current sites in scope, though the mode of service delivery may be different across sites.

²⁶ Refer to the [Service Descriptors for Form 5A: Services Provided](#) for details regarding required and additional services.

Form 5B: Service Sites

Provide requested data for each proposed service site. Competing supplement applicants may select sites from their current scope, but must also propose **at least one** new full-time, permanent²⁷ service or service/administrative site located in the new service area.

Zip codes entered in the Service Area Zip Codes field must be all of those listed in [Table 6](#).²⁸
Zip codes entered in this field will determine compliance with [Eligibility Requirement 3b](#).

Note: Sites described in the Project Narrative that are not listed on Form 5B will not be considered by the Objective Review Committee when reviewing and scoring the application.

Form 5C: Other Activities/Locations (As Applicable)

Provide requested data for other activities/locations (e.g., home visits, health fairs). List only activities/locations that 1) do not meet the definition of a service site, 2) are conducted on an irregular timeframe/schedule, and/or 3) offer a limited activity from within the full complement of health center activities included within the scope of project.

Form 6A: Current Board Member Characteristics

The list of board members will be pre-populated for competing continuation and competing supplement applicants. **Applicants must update pre-populated information as appropriate.**²⁹ Public centers with co-applicant health center governing boards must list the co-applicant board members.

Complete or update the following information:

- List all current board members; current board office held for each board member, if applicable (e.g., Chair, Treasurer); and each board member's area of expertise (e.g., finance, education, nursing). Do not list the CEO or other health center employees.³⁰
- Indicate if the board member derives more than 10 percent of income from the health care industry.
- Indicate if the board member is a health center patient. A patient board member must be a currently registered patient of the health center and must have accessed the health center in the past 24 months to receive at least one in-scope service that generated a documented health center visit.
- Indicate if the board member lives and/or works in the service area.

²⁷ MHC-only applicants may propose at least one full-time seasonal rather than permanent site to meet this criterion.

²⁸ HRSA considers service area overlap when making funding determinations for new and competing supplement applicants if zip codes are proposed on [Form 5B: Service Sites](#) beyond those listed in [Table 6](#). For more information about service area overlap, refer to [Policy Information Notice 2007-09](#).

²⁹ Refer to [PIN 2014-01: Health Center Program Governance](#) for information on Governance requirements.

³⁰ 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.

- Indicate if the board member is a representative of/for a special population (i.e., persons experiencing homelessness, migratory and seasonal agricultural workers, residents of public housing).
- Indicate the gender, ethnicity, and race of board members who are patients of the health center.

Note:

- Indian tribes or tribal, Indian, or urban Indian organizations are not required to complete this form, but may include information, as desired.
- Applicants requesting a waiver of the 51% patient majority board composition requirement (see below) must list the applicant's board members, NOT the members of any advisory council.

Form 6B: Request for Waiver of Board Member Requirements

- An applicant that currently receives or is applying to receive CHC (section 330(e)) funding is not eligible for a waiver and cannot enter information.
- Indian tribes or tribal, Indian, or urban Indian groups are not required to complete this form and cannot enter information.
- Competing continuation applicants that wish to continue an existing waiver must complete this form.
- 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 [Attachment 14: Other Relevant Documents](#) that identifies these individuals and their reasons/qualifications for participation on the advisory council or as governing board representatives.
 - Specifics on the type of patient input to be collected.
 - Methods for collecting and documenting such input.
 - Process for formally communicating the input directly to the health center governing board (e.g., monthly 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 budget priorities; 4) evaluating the organization's progress in meeting goals, including patient satisfaction; and 5) other relevant areas of governance that require and benefit from patient input.

Form 8 – Health Center Agreements

Complete Part I, by selecting **Yes** if the applicant has 1) a parent, affiliate, or subsidiary organization; and/or 2) any current or proposed agreements that will constitute a substantial

portion of the proposed scope of project, including a proposed site to be operated by a subrecipient or contractor, as identified in [Form 5B: Service Sites](#).

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 agreements 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 14: Other Relevant Documents](#).

Note: Items attached to Form 8 will **not** count against the page limit; however documents included in Attachments 14 **will** count against the page limit.

Form 10: Emergency Preparedness Report

Select the appropriate responses regarding emergency preparedness. If any answer is no, explain the response in [Item 14 of the RESOURCES/CAPABILITIES](#) section of the Project Narrative.

Form 12: Organization Contacts

Data will be pre-populated for competing continuation and competing supplement applicants to revise as necessary.

New applicants must 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

This form will enable applicants to verify key application data. If pre-populated data appear incorrect, verify that the pertinent data provided in the SF-424A and Forms [1A: General Information Worksheet](#) and [5B: Service Sites](#) have been entered correctly. A link to the appropriate source forms will be provided.

Service Area

Enter the identification number, City and State of the service area that you are proposing to serve, as indicated in [Table 6](#). **Patient Projection**

The total number of unduplicated patients projected to be served will be pre-populated from [Form 1A: General Information Worksheet](#). Enter the Patient Target for the proposed service area, as indicated in [Table 6](#). The percentage of patients to be served by December 31, 2017 will auto-calculate. Funded applicants will be held accountable for meeting the **unduplicated** patient

projection (from the Total line at the bottom of [Form 1A: General Information Worksheet](#)) and any future or other supplemental funding patient commitments by December 31, 2017.

Federal Request for Health Center Program Funding

To ensure eligibility, the total Health Center Program funding requested must not exceed the Total Funding available in [Table 6](#). Additionally, ensure that the funding requested for each population type does not exceed the values in [Table 6](#). Ensure the annual Health Center Program funding request is adjusted based on the auto-calculated percentage of patients to be served by December 31, 2017 from the Patient Projection section of this form, if necessary.

Note: If a required funding reduction based on the unduplicated patient projection is not made in the application, HRSA will make the required funding reduction before issuing the award.

Scope of Project: Sites and Services

To ensure continuity of services in areas already being served by Health Center Program award recipients, new and competing supplement applicants must certify that **all sites** described in the application are included on [Form 5B: Service Sites](#) and will be open and operational within 120 days of Notice of Award.

To ensure an accurate scope of project, competing continuation applicants must certify that:

- [Form 5A: Services Provided](#) accurately reflects all services and service delivery methods included in the current approved scope of project OR Form 5A: Services Provided requires changes that the applicant has already submitted through the change in scope process.
- [Form 5B: Service Sites](#) accurately reflects all sites included in the current approved scope of project OR Form 5B: Service Sites requires changes that the applicant has already submitted through the change in scope process.

Appendix B: Performance Measures Instructions

CLINICAL AND FINANCIAL PERFORMANCE MEASURES

The Clinical and Financial Performance Measures forms record the clinical and financial goals for the three-year project period. The goals must be responsive to identified community health and organizational needs and correspond to service delivery and organizational capacity activities discussed in the [Project Narrative](#). Further detail is available at the [Clinical and Financial Performance Measures web site](#) (refer to the [UDS Reporting Manual](#) for specific measurement details such as exclusionary criteria). Sample forms can be found at the [SAC-AA Technical Assistance web site](#).

Required Clinical Performance Measures

1. Diabetes (updated)
2. Cardiovascular Disease
3. Cancer
4. Prenatal Health
5. Perinatal Health
6. Child Health
7. Oral Health (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 (updated)
16. Depression Screening and Follow-Up

Required Financial Performance Measures³¹

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

New and Updated Performance Measures³²

- 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.
- The New HIV Cases with Timely Follow-up performance measure has been renamed HIV Linkage to Care.
- The Diabetes Clinical Performance Measure has been revised to adult patients with HbA1c levels > 9 percent.
- A Health Center Program Grant Cost per Patient performance measure is new in FY 2016.

³¹ Three audit-related measures have been discontinued.

³² Refer to [PAL 2015-01](#): Proposed Uniform Data System Changes for Calendar Year 2015 for details about new and updated performance measures.

Important Details about the Performance Measures Forms

- For the new Oral Health Clinical Performance Measure for sealants, applicants without baseline data can enter 0 and provide a date by which baseline data will be available. The projected data field must be completed with a goal to be met by December 31, 2017 (estimates are acceptable).
- Due to the addition of the required new Oral Health measure for sealants, competing continuation applicants are no longer required to track previously self-defined Oral Health performance measures. Similarly, due to the addition of the Depression Screening and Follow-Up measure in FY 2015, competing continuation applicants are no longer required to track previously self-defined Behavioral Health measures. If self-defined Other measures will no longer be tracked, they can be marked *Not Applicable* (a justification must be provided in the Comments field).
- For new and competing supplement applicants baselines for performance measures should be developed from data that are valid, reliable, and whenever possible, derived from currently established information management systems. If baselines are not yet available, enter 0 and provide a date by which baseline data will be available.
- Applicants applying for funds to serve special populations (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing), **must include** additional clinical performance measures that address the health care needs of these populations. Additional performance measures specific to special populations may not replace the required measures listed above. 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.

Other Performance Measures

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

Overview of the Performance Measures Form Fields

The columns titled **Field Is Pre-Populated** and **Field is Editable** only apply to competing continuation applicants. Pre-populated data will be sourced from the 2014 UDS report for competing continuation applicants. For competing continuation applicants that did not submit a

2014 UDS report, information will be pre-populated where possible from the latest SAC/NAP/BPR submission.

Table 4: Overview of Measures Form Fields

Field Name	Pre-Populated	Editable	Notes
Focus Area	YES	NO	This field contains the content area description for each required performance measure. Applicants will specify focus areas when adding Other performance measures.
Performance Measure	YES	NO	This field defines each performance measure and is editable for Oral Health and Other performance measures. Edits must be explained in the Comments field.
Is this Performance Measure applicable to your organization?	YES (for required measures)	NO (for required measures)	This field is pre-populated and <u>is not</u> editable for the required performance measures.
Is this Performance Measure applicable to your organization?	NO (for self-defined measures)	YES (for self-defined measures)	This field is editable for previously self-defined performance measures. If “No” is selected, provide justification in the Comments field and the measure will no longer be tracked.
Target Goal Description	NO	YES	This field provides a description of the target goal.
Numerator Description	YES	NO	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. This field can be edited for any previously self-defined performance measure. All edits require justification in the Comments field.

Denominator Description	YES	NO	<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).</p> <p>In the Financial Performance Measures, the denominator field must be specific to the organizational measure.</p> <p>This field can be edited for any previously self-defined performance measure. All edits require justification in the Comments field.</p>
Baseline Data			<p>This field contains subfields that provide information regarding the initial threshold used to measure progress over the course of the project period.</p> <p>Competing continuation applicants: These fields will be editable for the new Oral Health performance measure, since no UDS data is available. Otherwise, data is not editable for the required performance measures. To report more current data, include information in the Comments field.</p> <p>For previously-self defined performance measures, pre-populated information can be edited; justification is required in the Comments field.</p>
Baseline Year	YES	NO	The Baseline Year subfield identifies the initial data reference point.
Measure Type	YES	NO	The Measure Type subfield provides the unit of measure (e.g., percentage, ratio).
Numerator	YES	NO	The Numerator and Denominator subfields specify patient or organizational characteristics (see rows above).
Denominator	YES	NO	The Numerator and Denominator subfields specify patient or organizational characteristics (see rows above).
Progress Field	NO	YES	Competing continuation applicants MUST use this field to provide information regarding progress since the application that initiated the budget period. This field is not applicable for new and competing supplement applicants. Limit to 1,500 characters.
Projected Data	NO	YES	This field provides the goal to be met by December 31, 2017.

Data Source and Methodology	NO	YES	This field provides information about the data sources used to develop the performance measures. Applicants are required to identify a data source and discuss the methodology used to collect and analyze data. Data must be valid, reliable, and derived from established information management systems. Limit to 500 characters. For Clinical Performance Measures, applicants must select the data source—EHR, Chart Audit, or Other (please specify)—before describing the methodology.
Key Factors and Major Planned Actions			This field contains subfields that provide information regarding the factors that must be minimized or maximized to ensure goal achievement.
Key Factor Type	NO	YES	The Key Factor Type subfield requires applicants to select Contributing and/or Restricting factor categories. Applicants must specify at least one key factor of each type.
Key Factor Description	NO	YES	The Key Factor Description subfield provides a description of the factors predicted to contribute to and/or restrict progress toward stated goals.
Major Planned Action Description	NO	YES	The Major Planned Action Description subfield provides a description of the major actions planned for addressing key factors. Applicants must use this subfield to provide planned overarching action steps and strategies for achieving each performance measure. Limit to 1,500 characters.
Comments	NO	YES	Provide justifications required from changes made to other form fields as well as any additional information desired. Information exceeding the character limit should be placed in the EVALUATIVE MEASURES section of the Project Narrative. Limit to 1,500 characters.

Resources for the Development of Performance Measures

Competing continuation applicants are encouraged to use their UDS Health Center Trend Report and/or Summary Report available in EHB when considering how improvements to past performance can be achieved. For help with accessing reports in EHB, contact the BPHC Helpline by submitting a request through the [web portal](#) or call 877-974-2742. Applicants may also find it useful to do the following:

- Recognize that many UDS Clinical Performance Measures are aligned with the [meaningful use measures](#).

- 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 [Health Center Data](#)).
- 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 is available at [Healthy People 2020/Health Center Program Measures](#).

Appendix C: Implementation Plan

New and competing supplement applicants must outline a plan, specific to the proposed project, with appropriate and reasonable time-framed goals and action steps necessary to achieve the following required operational status at the proposed site(s):

- 1) Within 120 days of receipt of the Notice of Award³³, all proposed sites will have the necessary staff and providers contracted/hired to begin operating and delivering services to the proposed community and/or target population as described on Forms [5A: Services Provided](#) and [5C: Other Activities/Locations](#).
- 2) Within 1 year of receipt of the Notice of Award, all proposed providers must be hired and all sites must be delivering services for the proposed hours of operation.

Table 5: Key Elements of the Implementation Plan

Element	Implementation Strategy
Focus Area	Choose focus areas from the list below or identify different focus areas necessary to achieve the required operational status.
Goal	For each Focus Area, provide at least one goal. Goals should describe measureable results.
Key Action Steps	Identify at least one action step that must occur to accomplish each goal.
Person/Area Responsible	Identify who will be responsible and accountable for carrying out each action step.
Time Frame	Identify the expected time frame for carrying out each action step.
Comments	Provide supplementary information as desired.

A sample Implementation Plan is provided on the [SAC-AA Technical Assistance web site](#).

Optional Focus Areas

Operational Service Delivery Program

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

Functioning Key Management Staff/Systems/Arrangements

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

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

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

³³ HRSA may issue Notices of Award up to 60 days prior to the project period start date.

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

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

Governing Board

- E.1. Recruitment of Members to Ensure Compliance with Board Composition and Expertise Requirements
- E.2. Conflict of Interest Requirements
- E.3. Strategic Planning

Appendix D: Service Area

Table 6: Service Area Details Table

For the service area listed below, the following apply:

- Project Period Start Date: August 1, 2016
- Grants.gov deadline: February 22, 2016 at 11:59 PM ET
- HRSA EHB deadline: March 8, 2016 at 5:00 PM ET

Service Area Identification Number	City	State	Total Funding	CHC Funding	Service Area Zip Code	Patient Target
474	Miles City	MT	\$250,000	\$250,000	59012, 59317, 59324, 59332, 59351	780