U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources & Services Administration

Bureau of Primary Health Care
Health Center Program

Service Area Competition-Additional Areas (SAC-AA) – Anchorage, Alaska; Sarasota, Florida; and Perth Amboy, New Jersey

Funding Opportunity Number: HRSA-18-109
Funding Opportunity Types: New, Competing Continuation, and Competing Supplement
Catalog of Federal Domestic Assistance (CFDA) Number: 93.224

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2018

Application Due Date in Grants.gov: April 27, 2018
Supplemental Information Due Date in HRSA EHB: May 11, 2018

MODIFIED March 30, 2018 to incorporate new SAM.gov registration requirements, page 31 and enactment of the Consolidated Appropriations Act, pages 26 and 32.

MODIFIED March 8, 2018 to update zip codes for the Anchorage, AK service area (ID: 229). Refer to the NOFO-Specific Service Area Announcement Table (SAAT) HRSA-18-109 for details.

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

Issuance Date: February 26, 2018

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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) 2018 Service Area Competition-Additional Areas (SAC-AA) under the Health Center Program. The purpose of this grant program is to improve the health of the Nation's underserved communities and vulnerable populations by assuring continued access to affordable, quality primary health care services.

Funding Opportunity Title:	Service Area Competition-Additional Areas (SAC-AA)
Funding Opportunity Number:	HRSA-18-109
Due Date for Applications – **Grants.gov**:	April 27, 2018 (11:59 p.m. ET)
Due Date for Supplemental Information – **HRSA EHB**:	May 11, 2018 (5 p.m. ET)
Anticipated Total Annual Available Funding:	Approximately $4.38 million
Estimated Number and Type of Awards:	Up to 3 grants
Estimated Award Amount:	Varies
Cost Sharing/Match Required:	No
Project Period/Period of Performance:	August 1, 2018 through July 31, 2021 (up to 3 years)
Eligible Applicants:	Public or nonprofit private entities, including tribal, faith-based, or community-based organizations See Section III.1 of this notice of funding opportunity (NOFO), formerly known as the funding opportunity announcement (FOA), for complete eligibility information.

Application Guide

You (the applicant organization/agency) are responsible for reading and complying with the instructions included in HRSA's *SF-424 Two-Tier Application Guide,* available online at http://www.hrsa.gov/grants/apply/applicationguide/sf424programspecificappguide.pdf, except where instructed in this NOFO to do otherwise. A short video explaining the *Application Guide* is available at http://www.hrsa.gov/grants/apply/applicationguide/.

Technical Assistance

Application resources, as well as form samples and a frequently asked questions document, are available at the SAC-AA Technical Assistance Web site (https://bphc.hrsa.gov/programopportunities/fundingopportunities/sac-aa/index.html). Refer to "How to Apply for a Grant", available at http://www.hrsa.gov/grants/apply, for

general (i.e., not SAC-AA specific) videos and slides on a variety of application and submission components.

The BPHC Primary Health Care Digest is a weekly email newsletter containing information and updates pertaining to the Health Center Program, including release of all competitive funding opportunities. Organizations interested in seeking funding under the Health Center Program are encouraged to have several staff subscribe at https://public.govdelivery.com/accounts/USHHSHRSA/subscriber/new?topic_id=USHHSHRSA_118.

Throughout the application development and preparation process, you are encouraged to work with the appropriate Primary Care Associations (PCAs) and/or National Cooperative Agreements (NCAs) to prepare a quality, competitive application. For a listing of HRSA-supported PCAs and NCAs, refer to HRSA's Strategic Partnerships Web site.

Summary of Changes from the FY 2017 SAC Application Cycle

- The term Notice of Funding Opportunity (NOFO) has replaced the term Funding Opportunity Announcement (FOA).
- The Project Narrative has been streamlined to reduce applicant burden, more closely align with Health Center Program requirements as defined by statute and regulation, and simplify the collection of information.
- Floor plans are no longer required.
- Form 1C: Documents on File is no longer included in the SAC-AA application
- Two required Clinical Performance Measures have been revised and four have been renamed. Details are provided in Appendix B and Program Assistance Letter 2017-02: Approved Uniform Data System (UDS) Changes for Calendar Year 2017, available at https://bphc.hrsa.gov/datareporting/pdf/pal201702.pdf.

Other Federal Benefits

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, 340B Drug Pricing Program participation, or Federally Qualified Health Center (FQHC) reimbursement. Such benefits depend upon compliance with applicable requirements in addition to the award of Health Center Program funding, including the completion of separate applications, as appropriate. The Centers for Medicare & Medicaid Services manages FQHC reimbursement (see https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html). More information about the FTCA Health Center Program and the 340B Drug Pricing Program is available in the Other Information section.

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I. Program Funding Opportunity Description

1. Purpose

This notice solicits applications for the Health Center Program's Service Area Competition-Additional Areas Notice of Funding Opportunity (SAC-AA). The Health Center Program supports public and private nonprofit community-based and patient-directed organizations that provide primary health care services to the Nation's medically underserved. The purpose of the SAC-AA NOFO is to ensure continued access to affordable, quality primary health care services for communities and vulnerable populations currently served by the Health Center Program.

This NOFO details the SAC-AA eligibility requirements, review criteria, and awarding factors for organizations seeking funding for operational support to provide primary health care services to an announced service area under the Health Center Program. For the purposes of this document, the term "health center" encompasses Health Center Program award recipients funded under the following subsections: 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)).

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 operational support to provide comprehensive primary health care services to defined service areas and patient populations.

The Health Center Program funding targets the Nation's high need geographic areas and populations by currently supporting nearly 1,400 health centers that operate more than 11,000 service delivery sites in every state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. Nearly 26 million patients, including medically underserved and uninsured or underinsured patients, receive accessible, affordable, quality primary health care services through the Health Center Program.

Service areas and target populations listed in the Service Area Announcement Table (SAAT) are currently served by Health Center Program award recipients whose project periods are ending in FY 2018. You must demonstrate how you will make primary health care services available in a manner that maintains continuity of care to patients already served in the announced service area. Only one award will be given for each announced service area.

Funding Requirements
Your application must document an understanding of the need for primary health care services in the service area and propose a comprehensive plan to meet this need. The plan must ensure the availability and accessibility of primary health care services to all

individuals in the service area and target population, regardless of ability to pay. You must further demonstrate that your plan includes collaborative and coordinated delivery systems for the provision of health care to the underserved.

Your application must demonstrate compliance with applicable Health Center Program requirements, as detailed in the Compliance Manual, and corresponding regulations and policies, in accordance with section 330 of the PHS Act. If you are a **new or competing supplement applicant**, you must also demonstrate readiness to meet the following requirements:

- Within 120 days of receipt of the Notice of Award (NoA), all proposed sites (as noted on Form 5B: Service Sites and described in the Project Narrative) 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, and in the Project Narrative and Attachment 12: Implementation Plan.[1]
- Within one year of receipt of the NoA, all proposed providers must be in place delivering services and all sites must be open for the proposed hours of operation.

If a new organization is awarded a service area currently served by an existing Health Center Program award recipient, the sites and/or equipment of the current award recipient will not automatically transfer to the applicant selected for funding. Regulations concerning disposition and transfer of equipment are found at 45 CFR § 75.320(e).

You must provide services to the number of unduplicated patients projected to be served on Form 1A: General Information Worksheet in 2019. **If you do not serve the number of patients projected in 2019, announced funding for the service area may be reduced when it is next competed through SAC.**[2]

Failure to meet SAC-AA funding and Health Center Program requirements may jeopardize Health Center Program grant funding per Uniform Guidance 2 CFR part 200 as codified by the United States Department of Health and Human Services (HHS) at 45 CFR part 75. HRSA will assess award recipients for program compliance prior to and during the project period. When non-compliance is identified (e.g., an organization fails to become operational at all sites within 120 days, does not adhere to Health Center Program requirements), HRSA will place a condition on the recipient's award, which follows the Progressive Action process. 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

[1] HRSA may issue Notices of Award up to 60 days prior to the project period start date.
[2] If a health center is unable to meet the total unduplicated patient projection in 2019 (the patient projection from this application, plus other patient projections from funded supplemental applications for which the projections can be monitored in 2019), funding for the service area may be reduced when the service area is next competed through SAC (assuming a 3-year project period).

information, refer to Chapter 2: Health Center Program Oversight of the Compliance Manual.

In addition to the Health Center Program requirements, specific requirements for applicants requesting funding under each health center type are outlined below.

COMMUNITY HEALTH CENTER (CHC) APPLICANTS:

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

- Ensure compliance with PHS Act section 330(g); and, as applicable, section 330(e), 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 agricultural workers are individuals principally employed in agriculture and who establish temporary housing for the purpose of this work, including those individuals who have had such work as their principal employment within 24 months as well as their dependent family members. Agricultural workers who leave a community to work elsewhere are classified as migratory workers in both communities. Aged and disabled former agricultural workers should also be included in this group.
  - Seasonal agricultural workers are individuals employed in agriculture on a seasonal basis who do not establish a temporary home for purposes of employment, including their family members.
  - Agriculture means farming in all its branches, as defined by the OMB-developed North American Industry Classification System under codes 111, 112, 1151, and 1152 (48 CFR § 219.303).

HEALTH CARE FOR THE HOMELESS (HCH) APPLICANTS:

- Ensure compliance with PHS Act section 330(h); and, as applicable, section 330(e), 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 as patients who lack housing, including residents of permanent supportive housing, transitional 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 no longer homeless as a result of becoming a resident of permanent housing.
- Provide substance use disorder services.

PUBLIC HOUSING PRIMARY CARE APPLICANTS:

- Ensure compliance with PHS Act section 330(i); and, as applicable, section 330(e), 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. It does not mean public housing that is only subsidized through Section 8 housing vouchers.
- Consult with residents of the proposed public housing sites regarding the planning and administration of the program.

II. Award Information

1. Type of Application and Award

Types of applications sought:

- Competing continuation – A current Health Center Program award recipient who seeks to continue serving its current service area.
- New – A health center not currently funded through the Health Center Program that seeks to serve an announced service area through the proposal of one or more permanent service delivery sites.
- 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 addition of one or more new service delivery sites.

HRSA will provide funding in the form of a grant.

2. Summary of Funding

Approximately $4.38 million is expected to be available annually to fund 3 recipients. You may apply for a ceiling amount of up to the Total Funding listed in the SAAT for the proposed service area in total cost (includes both direct and indirect, facilities and administrative costs) per year. The actual amount available will not be determined until enactment of the final FY 2018 federal appropriation.

This program notice 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. The project period is August 1, 2018 through July 31, 2021 (3 years). Funding beyond the first year is dependent on the availability of appropriated funds for the Health Center Program in subsequent fiscal years, satisfactory recipient performance, and a decision that continued funding is in the best interest of the Federal Government.

Funding must be requested and will be awarded proportionately for all currently targeted population types. No new population types may be added. You must propose to serve at least 75 percent of the SAAT Patient Target in 2019 (January 1 through December 31, 2019). If you propose to serve fewer than the total number of patients indicated in the SAAT, you must reduce your funding request according to the following table. If you propose to serve fewer than the total number of patients indicated in the SAAT, but do not reduce the funding request, HRSA will reduce the award accordingly. A funding calculator is available at https://bphc.hrsa.gov/programopportunities/fundingopportunities/sac/patientbudgetcalculator.html to help you determine if a funding reduction is required.

Table 1: Funding Reduction by Patients Projected to Be Served

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

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

All HRSA awards are subject to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements at 45 CFR part 75.

See Section IV.2.iii for instructions on the development of the application budget.

III. Eligibility Information

1. Eligible Applicants

1) You 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

(Attachment 11). Faith-based and community-based organizations, Tribes, and tribal organizations are eligible to apply.[3]

2) You must propose to operate a health center that makes all required primary health care services available and accessible in the service area, either directly or through established arrangements, without regard for ability to pay.[4] You may **not** propose to provide **ONLY** a single service or any subset of the required primary health care services.

3) You must provide continuity of services, ensuring availability and accessibility in the service area, by proposing to serve an announced service area and its patients identified in the SAAT.

   a) The total number of unduplicated patients projected to be served in 2019 (January 1 through December 31, 2019) entered on Form 1A: General Information Worksheet must be at least 75 percent of the SAAT Patient Target. See the Summary of Funding section above if your patient projection is less than the SAAT Patient Target.
   b) If you are a **new or competing supplement applicant**, zip codes entered in the Service Area Zip Codes field on Form 5B: Service Sites for service delivery sites (administrative-only sites will not be considered) must be those where at least 75 percent of the current patients reside.[5] Refer to the SAAT to determine the zip codes where the majority of patients reside.
   c) Through the request for federal funding on the SF-424A, you must propose to serve all currently targeted populations (i.e., CHC, MHC, HCH, and/or PHPC) and maintain the current funding distribution (as identified in the SAAT). Funding must be requested and will be made available proportionately for all population types within the service area as currently funded under the Health Center Program. No new population types may be added.

Note*:* HRSA will monitor achievement of the patient commitment (SAC-AA application patient projection as well as any additional patients projected from supplemental awards). If you are unable to demonstrate via your 2019 Uniform Data System (UDS) Report that you served the cumulative projected patients in 2019, funding for the service area may be reduced when it is announced in future SAC funding opportunities.

4) If you are a **new and competing supplement applicant,** you must propose at least one new full-time (operational 40 hours or more per week) permanent, fixed building

[3] Refer to Chapter 1: Health Center Program Eligibility of the Compliance Manual.
[4] Refer to the Service Descriptors for Form 5A: Services Provided, available at https://bphc.hrsa.gov/about/requirements/scope/form5aservicedescriptors.pdf, for details regarding required primary health care services.
[5] 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 the SAAT. For more information about service area overlap, refer to Policy Information Notice 2007-09, available at http://bphc.hrsa.gov/programrequirements/policies/pin200709.html.

site on Form 5B: Service Sites, with the exception of projects serving only migratory and seasonal agricultural workers, for which you may propose a full-time seasonal (rather than permanent) service delivery site.[6] You must also provide a verifiable street address for each proposed site on Form 5B: Service Sites. A mobile medical van may be proposed only if at least one full-time, fixed site is also proposed in the application.

5) You must propose to provide access to services for all individuals in the service area and target population, as defined in the SAAT. In instances where a sub-population is targeted (e.g., homeless children), you must ensure that health center services will be made available and accessible to others who seek services at the proposed site(s). You may **not** propose to serve **ONLY** a single population.

6) *PUBLIC HOUSING PRIMARY CARE APPLICANTS ONLY*: If you are a **new or competing supplement applicant** applying for 330(i) funding, you must demonstrate that you have consulted with residents of public housing in the preparation of the SAC-AA application. You must also ensure ongoing consultation with the residents regarding the planning and administration of the health center, as documented in the GOVERNANCE section of the Project Narrative. This requirement is an ongoing expectation for competing continuation applicants.

Note*:* If you plan to apply to serve two different service areas announced under this NOFO, you **must** contact the Office of Policy and Program Development at https://www.hrsa.gov/about/contact/bphc.aspx for guidance.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

However, under 42 CFR § 51c.104 and 42 CFR § 51c.303(r), HRSA will take into consideration whether and to what extent you present evidence that:

- You have made efforts to secure financial and professional assistance and support for the project within the proposed service area.
- You will utilize, to the maximum extent feasible, other federal, state, local, and private resources available for support of the project.

3. Other

Applications that exceed the ceiling amount (the amount of Total Funding available in the SAAT) on the SF-424A and Budget Narrative will be considered non-responsive and will not be considered for funding under this notice.

[6] See Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes, available at http://bphc.hrsa.gov/programrequirements/scope.html, which describes and defines the term "service sites."

Applications that do not include all documents indicated as "required for completeness" in Section IV.2.vi based on the application type will be considered non-responsive and will not be considered for funding under this notice.

Applications in which the applicant organization (as listed on the SF-424) does not propose to perform a substantive role in the project and instead applies "on behalf of" another organization will be considered non-responsive and will not be considered for funding under this notice.

Any application that fails to satisfy the deadline requirements referenced in Section IV.4 will be considered non-responsive and will not be considered for funding under this notice.

HRSA will only accept your first validated electronic submission, under the correct funding opportunity number, in Grants.gov.[7] Applications submitted after the first submission will be marked as duplicates and considered ineligible for review. If you want to change information submitted in a Grants.gov application, you 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*** you to apply electronically through Grants.gov and HRSA EHB. You must use a two-tier submission process associated with this NOFO and follow the directions provided at http://www.grants.gov/applicants/apply-for-grants.html and in HRSA EHB.

- **Phase 1 – Grants.gov** – Required information must be submitted and validated via Grants.gov with a due date of April 27, 2018 at 11:59 p.m. Eastern Time; **and**

- **Phase 2 – HRSA EHB** – Supplemental information must be submitted via HRSA EHB with a due date of May 11, 2018 at 5 p.m. Eastern Time.

Only applicants who successfully submit an application in Grants.Gov (Phase 1) by the due date may submit the additional information and SAC-AA Program-Specific Information in HRSA EHB (Phase 2).

[7] Grants.gov has compatibility issues with Adobe Reader DC. Direct questions pertaining to software compatibility to Grants.gov. See Section VII for contact information.

HRSA recommends that you supply an email address to Grants.gov on the grant opportunity synopsis page when downloading the notice of funding opportunity (NOFO) (also known as "Instructions" on Grants.gov) or application package. This allows Grants.gov to email organizations that supply an email address in the event the NOFO is changed and/or republished on Grants.gov before its closing date. Responding to an earlier version of a modified notice may result in a less competitive or ineligible application. *Please note you are ultimately responsible for reviewing the Find Grant Opportunities page for all information relevant to desired opportunities.*

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 narrative, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the Application Guide in addition to the program-specific information below. You are responsible for reading and complying with the instructions included in HRSA's *SF-424 Two-Tier Application Guide* except where instructed in the NOFO to do otherwise. Applications must be submitted in the English language and must be in the terms of U.S. dollars (45 CFR § 75.111(a)).

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

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

The following application components must be submitted in HRSA EHB:

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

See Section 9.5 of the *Application Guide* for the Application Completeness Checklist.

Application Page Limit

The total size of all uploaded files may not exceed the equivalent of 160 pages when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support. Standard OMB-approved forms that are included in the application package do not count in the page limitation. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) will not be counted in the page limit. **We strongly urge you to take appropriate measures to ensure your application does not exceed the specified page limit.**

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

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

1) The prospective recipient certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. 3321).
3) Where the prospective recipient is unable to attest to the statements in this certification, an explanation shall be included in Attachment 13: Other Relevant Documents.

See Section 5.1.viii of HRSA's *SF-424 Two-Tier Application Guide* for additional information on all certifications.

Program-Specific Instructions

In addition to application requirements and instructions in Sections 4 and 5 of HRSA's *SF-424 Two-Tier Application Guide* (including the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract), your application must include the following:

Application for Federal Assistance SF-424 (Submitted in Grants.gov)

See Section 3.2 of HRSA's *SF-424 Two-Tier Application Guide*. Further information for noted fields is provided below.

- *Box 2: Type of Applicant:* Incorrect selection may delay HRSA EHB access.
  - Continuation – Current Health Center Program award recipient applying to continue serving its current service area: Select "Continuation" and include your H80 grant number in box 4.
  - New – If you are not currently funded through the Health Center Program: Select "New" and leave box 4 blank.
  - Revision – Current Health Center Program award recipient applying to serve a new service area: Select "Other" and type "Supplemental" and your H80 grant number in box 4.
- *Box 5a: Federal Entity Identifier:* Leave blank.
- *Box 5b: Federal Award Identifier:* 10-digit award recipient number starting with H80 for current Health Center Program award recipients. New applicants should leave this blank.
- *Box 8c: Organization's DUNS*. An incorrect or mistyped DUNS number will cause the application to be rejected.
- *Box 14: Areas Affected by Project:* Leave Blank.

- *Box 15: Descriptive Title of Applicant's Project:* Type the title of the NOFO (Service Area Competition-Additional Areas) and upload the project abstract. See instructions in Section IV.2.i. The abstract WILL count toward the page limit.
- *Box 17: Proposed Project Start Date and End Date:* Provide the start date (August 1, 2018) and end date (July 31, 2021) for the proposed 3-year project period.
- *Box 18: Estimated Funding:* Complete the required information based on the funding request for the first year of the proposed project period. Refer to the Summary of Funding section for details.
- *Box 19: Review by State:* See Section IV.5 for guidance in determining applicability.

***i. Project Abstract** (Submitted in Grants.gov)*

See Section 5.1.ix of HRSA's *SF-424 Two-Tier Application Guide*.

Additionally, include the identification (ID) number, city, and state of the proposed service area (available in the SAAT), and total number of unduplicated patients projected to be served in 2019 (January 1 through December 31, 2019).

***ii. Project Narrative** (Submitted in HRSA EHB)*

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

Use the following section headers for the narrative: Need, Response, Collaboration, Evaluative Measures, Resources/Capabilities, Governance, and Support Requested.

The Project Narrative must:

- Demonstrate compliance with Health Center Program requirements, as detailed in the Compliance Manual.
- 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.

If you are a **competing continuation applicant**, ensure that the Project Narrative reflects your approved scope of project. Any change in scope **must** be submitted separately through HRSA EHB.[8]

If you are a **new applicant**, ensure that the Project Narrative reflects the entire scope of the proposed project (proposed services, providers, sites, service area zip codes, and

[8] Refer to the Scope of Project policy documents and resources, available at https://bphc.hrsa.gov/programrequirements/scope.html, for details pertaining to changes to the current services, providers, sites, service area zip codes, and target population(s).

target population), inclusive of at least one new full-time (operational 40 hours or more per week) permanent service delivery site.

If you are a **competing supplement applicant**, ensure that the Project Narrative reflects only the proposed scope of project for the service area proposed in this application, inclusive of at least one new (not in your current approved Health Center Program scope of project) full-time (operational 40 hours or more per week) permanent service delivery site.[9] 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 Review Criterion 1: NEED*

Information provided in the NEED section must:

- Demonstrate compliance with the Needs Assessment Health Center Program requirement described in Chapter 3 of the Compliance Manual.
- Serve as the basis for, and align with, the activities and goals described throughout the application.
- Be utilized to inform and improve the delivery of health center services.

1) Describe the proposed service area (consistent with Attachment 1: Service Area Map and Table), including:
   a) The service area boundaries.
   b) If you are a **new or competing supplement applicant**: How you determined your service area based on where the proposed patients reside.
   If you are a **competing continuation applicant**: How you annually review and determine your service area based on where patients reside, as reported in the 2016 UDS[10] and identified in the SAAT (e.g., service area zip codes listed on Form 5B represent those from which at least 75 percent of current patients reside).

2) Citing data sources and the frequency of assessments, describe the service area/target population and the current health care needs, specifically addressing items a-d below. This description must include the unique needs of **each** special population for which you are requesting funding (MHC, HCH, PHPC).[11]
   a) Factors associated with access to care and health care utilization (e.g., geography, transportation, occupation, unemployment, income level, educational attainment, transient populations).

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[9] Projects that will serve only migratory and seasonal agricultural workers may propose a full-time seasonal (rather than permanent) service delivery site.
[10] Refer to the 2016 UDS Manual, available at https://bphc.hrsa.gov/datareporting/reporting/2016udsreportingmanual.pdf.
[11] Special populations by type of health center are MHC – Migratory and Seasonal Agricultural Workers and Families, HCH – People Experiencing Homelessness, or PHPC – Public Housing Residents.

b) Most significant causes of morbidity and mortality (e.g., diabetes, cardiovascular disease, cancer, low birth weight, mental health and/or substance use disorder).
c) Health disparities.
d) Unique health care needs or characteristics that impact health, access to care, or health care utilization (e.g., social factors, environmental factors, occupational factors, cultural/ethnic factors, language needs, housing status).

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

Information provided in the RESPONSE section must demonstrate compliance with the Health Center Program requirements described in the following chapters of the Compliance Manual:

- Chapter 4: Required and Additional Health Services
- Chapter 6: Accessible Locations and Hours of Operation
- Chapter 7: Coverage for Medical Emergencies During and After Hours
- Chapter 8: Continuity of Care and Hospital Admitting
- Chapter 9: Sliding Fee Discount Program

1) Describe how you will ensure access to all required and additional services (consistent with Form 5A: Services Provided) and other activities, as applicable, (consistent with Form 5C: Other Activities/Locations) to meet the identified needs, including:
   a) The method of provision of services (as indicated on Form 5A: Services Provided).
   b) How services provided through contractual agreements (Form 5A: Services Provided, Column II) will be documented in the patient's health center record and how the health center will pay for the services.
   c) How services provided through referral arrangements (Form 5A: Services Provided, Column III) will be managed, and the process for tracking and referring patients back to the health center for appropriate follow-up care.
   d) Interpretation and translation services for patients with limited English proficiency.
   e) Arrangements and resources that enable staff to deliver services in response to current access to care and health care utilization barriers (e.g., geography, transportation, occupation, transience, unemployment, income level, educational attainment) or any other unique health care needs or characteristics that impact health status or access to, or utilization of, primary care (e.g., social factors, the physical environment, cultural/ethnic factors, language needs, housing status). Specifically, describe any enabling services designed to increase access, particularly for any targeted special populations.
   f) **If HCH funding is requested**: Document how substance use disorder services will be made available (consistent with substance abuse listed on Form 5A: Services Provided).

2) Describe the proposed service delivery sites (consistent with Form 5B: Service Sites) and how the sites assure availability, prompt accessibility, and continuity of

services (consistent with Forms 5A: Services Provided and 5C: Other Activities/Locations) within the proposed service area relative to where the target population lives and works (e.g., areas immediately accessible to public housing for health centers targeting public housing residents). Specifically address:
   a) Access barriers (i.e., barriers resulting from the area's physical characteristics, residential patterns, or economic and social groupings).
   b) Distance and duration for patients to travel to or between service sites to access the full range of services proposed (consistent with Form 5A: Services Provided).
   c) How the total number and type (e.g., fixed site, mobile van, school-based clinic), hours of operation, and location (e.g., proximity to public housing) of each proposed service delivery site are responsive to patient needs by facilitating the ability to schedule appointments and access services.

3) Describe the clinical capacity, operating procedures, and arrangements for promptly responding to patient medical emergencies during and after regularly scheduled hours, including:
   a) Having at least one staff member certified in basic life support skills at each service delivery site (consistent with Form 5B: Service Sites) during regularly scheduled hours of operation.
   b) After-hours coverage via telephone or face-to-face by an individual with the qualification and training necessary to exercise professional judgment in assessing the need for emergency care.
   c) Referring patients for further consultation (e.g., licensed independent practitioner, emergency room, urgent care) for further assessment or immediate care.
   d) How limited English proficiency is addressed (i.e., language(s), literacy levels, and formats of materials/messages).

4) Describe continuity of care for patients in a hospital setting, including:
   a) Contracts or other appropriate documentation that address health center patient admissions, including hospital admitting privileges for health center providers, or formal arrangements between the health center and non-health center providers or entities (e.g., hospital, hospitalists, obstetrics group practice).
   b) Internal operating procedures and related provisions in formal arrangements with non-health center providers or entities, if any, that address the following for patients who are hospitalized or visit a hospital's emergency department:
      - Health center receipt and recording of medical information from non-health center providers/entities (e.g., hospital discharge follow-up instructions, laboratory, radiology, or other results).
      - Health center staff follow-up, when appropriate.

5) Describe the sliding fee discount program, including the board-approved policies (consistent with Attachment 10: Sliding Fee Discount Schedule).[12] Specifically address the:
   a) Definitions of, and requirements for verifying, income and family size.

[12] For more information, see Chapter 9: Sliding Fee Discount Program of the Compliance Manual.

b) Methods and operating procedures of assessment eligibility of all patients based only on income and family size.
c) Structuring the Sliding Fee Discount Schedule (SFDS) to ensure that charges are adjusted based on a patient's ability to pay.
d) Nominal charges for patients at or below 100 percent of the Federal Poverty Guidelines (FPG), available at https://aspe.hhs.gov/poverty-guidelines, which must: be flat charges, be considered nominal from the perspective of the patient, and not reflect the actual cost of the service provided.
e) Mechanisms for informing patients of the availability of sliding fee discounts (e.g., materials at appropriate language and literacy-levels, inclusion in the intake process, published on the health center's web site).
f) Application of discounts to patients who are eligible for sliding fee discounts and have third-party coverage, ensuring that they are charged no more for out of pocket costs than they would have paid under the applicable discount pay class.
g) Applicability to all required and additional services within the scope of project (Form 5A: Services Provided).
h) Evaluation of the sliding fee discount program, including how patient access/service utilization data (by discount pay class and those at or below 100 percent of the FPG who are accessing services) are used to determine and ensure the effectiveness of the program in reducing financial barriers to care.

6) In Attachment 10: Sliding Fee Discount Schedule, document the following components of your Sliding Fee Discount Schedule(s) (SFDS):
a) A full discount is provided for individuals and families with annual incomes at or below 100 percent of the current FPG, unless there is a nominal charge. If there is a nominal charge, it is flat and less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.
b) Partial discounts are provided for individuals and families with incomes above 100 percent of the FPG, and at or below 200 percent of the FPG, that adjust in accordance with income using a minimum of three discount pay classes.
c) No discounts will be provided to individuals and families with annual incomes above 200 percent of the FPG.
d) Incorporation of the most current FPG.
e) If you have more than one SFDS, the schedules are based on services (e.g., distinct schedules for medical and dental services, distinct schedules for preventive dental and additional dental services) or service delivery methods (Columns I, II, and III of Form 5A: Services Provided).

7) Describe how the unduplicated patient commitment (number of patients projected to be served in 2019 as documented on Form 1A: General Information Worksheet) was determined and how it is achievable, including a description of recent and anticipated changes in the local health care landscape, organizational structure, and/or workforce capacity.

If you are a new or competing supplement applicant, you must:

8) Upload a detailed implementation plan to Attachment 12: Implementation Plan (see Appendix C). The plan must include reasonable and time-framed activities which assure that, within 120 days of receipt of the NoA, **all proposed sites** noted on Form 5B: Service Sites will have the necessary staff and providers in place to begin operating and delivering services as described on Forms 5A: Services Provided and 5C: Other Activities/Locations.[13]

9) Describe plans to:
   a) Hire, contract, and/or establish formal written referral arrangements with all providers (consistent with Forms 2: Staffing Profile, 5A: Services Provided, and 8: Health Center Agreements, and Attachment 7: Summary of Contracts and Agreements) and begin providing services at all sites (consistent with Form 5B: Service Sites) for the targeted number of hours within one year of receipt of the NoA.
   b) Minimize potential disruption for patients served by the current award recipient (as noted in the SAAT) that may result from transition of the award to a new recipient.[14]

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

Information in the COLLABORATION section must:

- Demonstrate compliance with the Collaborative Relationships Health Center Program requirement as described in Chapter 14 of the Compliance Manual.
- Be consistent with Form 8: Health Center Agreements and Attachment 7: Summary of Contracts and Agreements.
- Be supported by documents provided in Attachment 9: Collaboration Documentation.

1) Describe and document (e.g., dated letters of support, signed memoranda of agreement) efforts to collaborate with other primary care providers serving similar patient populations in the service area (consistent with Attachment 1: Service Area Map and Table). At a minimum, this includes establishing, documenting, and maintaining relationships with the following in the service area:
   - Other Health Center Program award recipients and look-alikes.
   - Health departments.
   - Local hospitals.
   - Rural health clinics.

[13] HRSA may issue Notices of Award up to 60 days prior to the project period start date.
[14] If a new organization is awarded a service area currently served by an existing Health Center Program award recipient, the sites and/or equipment of the current award recipient will not automatically transfer to the applicant selected for funding. Regulations concerning disposition and transfer of equipment are found at 45 CFR § 75.320(e).

- Any additional organizations that support continuity of care and access to services beyond the scope or capacity of the health center.

If documentation of collaboration with one or more of the entities above is not provided, explain why it could not be obtained (e.g., "Health center X did not respond to a request for a letter of support" and document the request (e.g., the email requesting such support) in Attachment 9."

2) Describe both formal and informal collaboration activities with other providers or programs in the service area (consistent with Attachment 1: Service Area Map and Table), including private provider groups serving low income and/or uninsured patients or otherwise underserved communities or vulnerable populations.

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

Information in the EVALUATIVE MEASURES section must demonstrate compliance with the Health Center Program requirements described in the following chapters of the Compliance Manual:

- Chapter 10: Quality Improvement/Assurance Program
- Chapter 18: Program Monitoring and Data Reporting Systems

1) Describe how the quality improvement and quality assurance (QI/QA) program specifically addresses:
   a) The quality and utilization of health center services.
   b) Patient satisfaction and grievances processes.
   c) Patient safety, including adverse events.

2) Describe the responsibilities of the individual designated to oversee the QI/QA program related to:
   a) Implementation and frequency of updating of QI/QA operating procedures and related assessments.
   b) Monitoring of associated QI/QA outcomes.

3) Describe how the health center operating procedures address:
   a) Adherence to current evidence-based clinical guidelines and standards of care in the provision of services.
   b) Processes for:
      - Identifying, analyzing, and addressing patient safety and adverse events, including implementing follow-up actions, as necessary.
      - Assessing patient satisfaction, including hearing and resolving patient grievances.
   c) Completion of quarterly (or more frequent) QI/QA assessments to inform modifications to the provision of services.
   d) Production and sharing of QI/QA reports to support oversight of and decision-making regarding the provision of services by key management staff and the governing board.

4) Describe how the health center's physicians or other licensed health care professionals conduct QI/QA assessments using data systematically collected from patient records to ensure:
   a) Provider adherence to current evidence-based clinical guidelines, standards of care, and standards of practice.
   b) The identification of patient safety and adverse events, and the implementation of related follow-up actions.

5) Describe how the organization's record system (e.g., electronic health record (EHR) system) will be used to:
   a) Optimize health information technology.
   b) Protect the confidentiality of patient information and safeguard it against lost, destruction, or unauthorized use, consistent with federal and state requirements.
   c) Collect and organize data required to meet HHS reporting requirements, including data elements for annual UDS reporting.
   d) Monitor program performance beyond required reporting.

6) On the Clinical Performance Measures form only (see detailed instructions in Appendix B), establish realistic goals that are responsive to clinical performance and associated needs. Goals should be informed by measure-specific contributing and restricting factors affecting achievement.

7) On the Financial Performance Measures form only (see detailed instructions in Appendix B), establish realistic goals that are responsive to the organization's financial performance and associated needs. Goals should be informed by measure-specific contributing and restricting factors affecting achievement.

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

Information in the RESOURCES/CAPABILITIES section must demonstrate compliance with the Health Center Program requirements described in the following chapters of the Compliance Manual:

- Chapter 5: Clinical Staffing
- Chapter 11: Key Management Staff
- Chapter 12: Contracts and Subawards
- Chapter 13: Conflict of Interest
- Chapter 15: Financial Management and Accounting Systems
- Chapter 16: Billing and Collections

1) Describe how the organizational structure (including any subrecipients/contractors) is appropriate to implement the proposed project (consistent with Attachments 2: Bylaws and 3: Project Organizational Chart, and, as applicable, Attachments 6: Co-Applicant Agreement and 7: Summary of Contracts and Agreements), including

whether your organization is part of a parent, affiliate, or subsidiary organization (consistent with Form 8: Health Center Agreements).

2) Describe the following related to the staffing plan (consistent with Form 2: Staffing Profile):
   a) How it ensures that clinical and related support staff will be in place to provide all required and additional services (consistent with Form 5A: Services Provided).
   b) How the size, demographics, and health care needs of the service area/patient population were considered in determining the number and mix of clinical support staff.
   c) How the operating procedures for the initial and recurring review and documentation of credentials and privileges for all clinical staff members (i.e., health center employees, contractors, or volunteers) ensure verification of:
      - Current licensure, registration, or certification.
      - Education and training for initial credentialing, using primary sources for licensed independent practitioners.
      - Completion of a query through the National Practitioner Data Bank (NPDB), available at https://www.npdb.hrsa.gov/.
      - Clinical staff identification verification for initial credentialing using a government issued picture identification.
      - Drug Enforcement Administration (DEA) registration, if applicable.
      - Current documentation of Basic Life Support skills.
      - Fitness for duty, including physical and mental health status, immunization and communicable disease status, and any impairments that may interfere with the safe and effective provision of care permitted under the requested clinical privileges.
      - Current clinical competence via reference reviews, training and education for initial privileging, and peer review or other comparable methods for renewal of privileges.
      - Criteria and processes for modifying or removing privileges based on the outcomes of clinical competence assessments.
   d) Provisions in contracts and/or formal written referral agreements with provider organizations that ensure that providers are:
      - Licensed, certified, or registered as verified through a credentialing process, in accordance with applicable federal, state, and local laws.
      - Assessed as competent to perform the contracted or referred services through a privileging process.

   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 health care services will be secured via contract, include the contract/agreement as an attachment to Form 8: Health Center Agreements.

3) Describe the management team (e.g., project director (PD), clinical director (CD), chief executive officer (CEO), chief financial officer (CFO), chief information officer (CIO), chief operating officer (COO)), including:
   a) Lines of authority for the operation and oversight, scope, and complexity of the proposed project.
   b) Training, experience, skills, and qualifications necessary to execute each defined role (demonstrated in Attachment 4: Position Descriptions for Key Management Staff), as well as the amount of time that each will dedicate to Health Center Program activities (consistent with Form 2: Staffing Profile).
   c) Identification of individuals who will serve in the defined roles (demonstrated in Attachment 5: Biographical Sketches for Key Management Staff). If applicable, identify individuals that will fill more than one key management position, including the positions they will fill (e.g., CFO and COO combined role), and describe any changes in key management staff in the last year or significant changes in their roles.
   d) Responsibilities of the CEO for overseeing other key management staff and reporting to the governing board for carrying out the day-to-day activities of the proposed project.
   e) The plan to recruit qualified individuals to fill open key management positions, or those that are likely to become open, and the plan to retain current and future key management staff.

4) Describe your procurement procedures and their conformance with applicable State, local, and tribal laws and regulations.

5) Describe how your organization will maintain appropriate oversight and authority over all contracted/subawarded services and sites (consistent with Forms 5A: Services Provided, 5B: Service Sites, and 8: Health Center Agreements, and Attachment 7: Summary of Contracts and Agreements), including:[15]
   a) The structure of the agreement.
   b) Ensuring the contractor/subrecipient is compliant, and performs in accordance with all applicable award terms, conditions, and requirements, including those found in section 330 of the PHS Act, implementing program regulations, and grants regulations in 45 CFR Part 75.
   c) Mechanisms to monitor contractor or subrecipient performance.
   d) Requirements for the contractor or subrecipient to provide data necessary for you to meet applicable federal financial and programmatic reporting requirements, as well as provisions addressing record retention and access, audit, and property management.[16]

   Note: Upon award, **your organization** will be the legal entity held accountable for carrying out the approved Health Center Program scope of project, including any

[15] Excludes contracts for the acquisition of supplies, material, equipment, or general support services (e.g., janitorial services, contracts with individual providers).
[16] For further guidance on these requirements, please see the HHS Grants Policy Statement, at https://www.hrsa.gov/grants/hhsgrantspolicy.pdf.

activities in the approved scope of project that may be carried out by contractors or subrecipients.

6) Document in your health center's bylaws (Attachment 2) and/or other board-approved policy documents (Attachment 13: Other Relevant Documents) that provisions are in place to prohibit real or apparent conflict of interest by board members, employees, consultants, and others in the procurement of supplies, property (expendable), equipment, and services procured with federal funds.

7) Describe how your financial accounting and internal control systems, as well as related systems:
   a) Reflect Generally Accepted Accounting Principles (GAAP), if you are a private non-profit health center, or Government Accounting Standards Board (GASB) principles, if you are a public agency.
   b) Will maintain effective control over, and accountability for, all funds, property, and other assets associated with the proposed project.
   c) Will safeguard all assets to assure they are used solely for authorized purposes in accordance with the terms and conditions of the Health Center Program award and funding requirements.
   d) Demonstrate the capacity to track the financial performance of the health center, including identification of trends or conditions that may warrant action to maintain financial stability.
   e) Will be able to account for a Health Center Program award, as well as other federal awards.
   f) 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 payer type, aged accounts payable, lines of credit).
   g) Identify accounts of all Federal awards, including awards made under the Health Center Program.
   h) Provide accurate, current, and complete disclosure of the financial results of each Federal award or program in accordance with reporting requirements.
   i) Implement the Federal Payment Management System (PMS) requirements.
   j) Assure that costs under the award are allowable in accordance with the terms and conditions of the Federal Award and Federal Cost Principles.

8) Describe your billing and collections systems, including:
   a) Requesting applicable payments from patients, while ensuring that no patient is denied service based on inability to pay.
   b) Educating patients on insurance and, if applicable, related third-party coverage options available to them.
   c) Billing Medicare, Medicaid, Children's Health Insurance Program (CHIP), and other public and private assistance programs or insurance in a timely manner, as applicable.
   d) Incorporating additional elements such as payment plans, grace periods, and prompt payment incentives, if applicable.

e) Policies and operating procedures that address the waiving or reducing of amounts owed by patients due to a patient's specific circumstances related to inability to pay.
f) Collecting reimbursements for costs in providing health care services, consistent with the terms of such contracts and arrangements.
g) Policies regarding informing patients of out of pocket costs prior to the time of service if you provide supplies or equipment that are related to, but not included in, a service as part of prevailing standards of care (e.g., eyeglasses, prescription drugs, dentures) and you charge patients for these items.
h) Policies that distinguishes between refusal to pay and inability to pay if a health center elects to limit or deny services based on a patient's refusal to pay.

9) Describe any national quality recognition your 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).

10) Describe your current status or plans for participating in related federal benefits (e.g., Federal Tort Claim Act (FTCA) coverage, FQHC Medicare/FQHC Medicaid/CHIP reimbursement, 340 Drug Pricing Program, National Health Service Corps providers). If you do not have plans to seek FTCA coverage, describe plans for maintaining or obtaining private malpractice insurance. Refer to Section VIII for details.

GOVERNANCE *– Corresponds to Section V.1 Review Criterion 6: GOVERNANCE*

Information in the GOVERNANCE section must demonstrate compliance with the Health Center Program requirements described in the following chapters of the Compliance Manual:

- Chapter 19: Board Authority
- Chapter 20: Board Composition

Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups are required ONLY to respond to Item 3 below.

1) Document your governing board composition requirements, member selection and removal process, and authorities and responsibilities in Attachment 2: Bylaws. This attachment must specify the following:[17]
   a) Board size must be at least 9 and no more than 25 members, with either a specific number or range of board members prescribed (compliance demonstrated on Form 6A: Board Member Characteristics).

[17] The health center must maintain documentation of adherence to requirements outlined in the bylaws.

b) At least 51 percent of board members must be patients served by the health center (compliance demonstrated on Form 6A: Board Member Characteristics).[18,19]
c) Patient members of the board, as a group, must reasonably represent the patient population in terms of demographic factors (e.g., race, ethnicity, gender) (compliance demonstrated on Form 6A: Board Member Characteristics, consistent with Form 4: Community Characteristics).
d) Non-patient members must be representative of the community in which the health center is located, either by living or working in the community or by having a demonstrable connection to the community.
e) Non-patient members must be selected to provide relevant expertise and skills (e.g., community affairs, local government, finance and banking, legal affairs, trade unions and other commercial and industrial concerns, social services) (compliance demonstrated on Form 6A: Board Member Characteristics).
f) No more than one-half of non-patient board members may earn more than ten percent of their annual income from the health care industry (compliance demonstrated on Form 6A: Board Member Characteristics).
g) Health center employees, contractors, and immediate family members of employees may not be health center board members.[20]
h) Meetings must occur monthly.
i) Approving the selection and dismissal or termination of the Project Director/CEO.
j) Evaluating the Project Director/CEO.
k) Approving applications related to the health center project, including approving the annual budget, which outlines the proposed uses of both federal Health Center Program award and non-federal resources and revenue.
l) Approving proposed sites, hours of operation, and services, including subawarding or contracting for a substantial portion of the proposed services.
m) Evaluating the performance of the health center.
n) Establishing or adopting policy related to the operations of the health center.
o) Assuring the health center operates in compliance with applicable federal, State, and local laws and regulations.
p) If you are **requesting funding to target any special populations**, you must have one representative on the board from/for each of the special populations who can clearly communicate the special population's needs/concerns (e.g., migratory and seasonal agricultural workers advocate, former or current homeless individual, current resident of public housing).

2) Describe how your governing board effectively operates within the organization's structure (consistent with Attachment 3: Project Organizational Chart) to ensure that

[18] For the purposes of the Health Center Program, the term "board member" refers only to voting members of the board.
[19] For the purposes of board composition, a patient is an individual who has received at least one service in the past 24 months that generated a health center visit, where both the service and the site where the service was received are within the HRSA-approved scope of project.
[20] In the case of public agencies with co-applicant boards, this includes employees or immediate family members of either the co-applicant organization or of the public agency component in which the health center project is located (for example, employees within the same department, division, or agency).

the board maintains authority and oversight of the project, as outlined in Attachments 2: Bylaws, 6: Co-Applicant Agreement, and 8: Articles of Incorporation, and recorded in board minutes and other relevant documents. Specifically:

a) Describe how the board ensures that no individual, entity, or committee (including, but not limited to, an executive committee authorized by the board) may reserve or have approval/veto power over the board with regard to the required authorities and functions.
b) Describe how collaboration or agreements with the other entities do not restrict or infringe upon the board's required authorities and functions.
c) Describe the process (vs. the content of the policies themselves) for adopting, evaluating (at least once every 3 years), and updating (if necessary) the following policies:
   - Sliding Fee Discount Program.
   - Quality Improvement/Assurance Program.
   - Billing and Collections.
   - Financial Management.
   - Personnel.
d) **New public agency applicants with a co-applicant board**: Document in Attachment 6: Co-Applicant Agreement delegation of the required authorities and functions to the co-applicant board and delineation of the respective roles and responsibilities of the public agency and the co-applicant in carrying out the project.
e) **Applicants requesting PHPC funding:** Document how 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.

3) **INDIAN TRIBES OR TRIBAL, INDIAN, OR URBAN INDIAN GROUPS ONLY:** Describe your organization's governance structure, operation, and process for assuring adequate:
   a) Input from the community/target population on health center priorities.
   b) Fiscal and programmatic oversight of the proposed project.

SUPPORT REQUESTED[21]*– Corresponds to Section V.1 Review Criterion 7: SUPPORT REQUESTED*

1) Provide a complete, consistent, and detailed budget presentation through the submission of the following: SF-424A, Budget Narrative, Form 2: Staffing Profile, and Form 3: Income Analysis that reflects projected costs and revenues necessary to support the proposed project.

2) Describe how the proportion of federal funds requested in this application is appropriate given other projected revenue sources that will support the health center project. Such sources include fees, premiums, and third-party reimbursements and

[21] Refer to Chapter 17: Budget of the Compliance Manual.

payments that are generated from the delivery of services; revenues from state, local, or other federal grants or contracts (e.g., Ryan White, Healthy Start); private support or income generated from contributions; and any other funding expected to be received for purposes of supporting the health center project, including those specified in Form 3: Income Analysis (e.g., in-kind donations) and the Budget Narrative.

3) Describe potential financial changes (e.g., shifting payer mix, workforce recruitment or retention challenges) and plans to mitigate adverse impacts.

NARRATIVE GUIDANCE
To ensure that you fully address the review criteria, this table provides a crosswalk between the narrative language and where each section falls within the review criteria.

Narrative Section	**Review Criteria**
Need	(1) Need
Response	(2) Response
Collaboration	(3) Collaboration
Evaluative Measures	(4) Evaluative Measures
Resources/Capabilities	(5) Resources/Capabilities
Governance	(6) Governance
Support Requested	(7) Support Requested

iii. Budget *(Submitted in HRSA EHB)*

See Section 5.1.iv of HRSA's *SF-424 Two-Tier Application Guide*. Please note: the directions offered in the SF-424 Two-Tier Application Guide may differ from those offered by Grants.gov. Please follow the instructions included in the Application Guide and the additional budget instructions provided below. A budget that follows the Application Guide will ensure that, if the application is selected for funding, you will have a well-organized plan and by carefully following the approved plan can avoid audit issues during the implementation phase.

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

In addition, the Health Center Program requires the following:
In the formulation of the budget presentation, per section 330(e)(5)(A) of the PHS Act, as amended, the amount of funds awarded in any fiscal year may not exceed the costs of health center operation in such fiscal year less the total of: state, local, and other operational funding provided to the center; and the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in such fiscal year. In other words, Health Center Program funds are to be

used for authorized health center operations and may not be used for profit. The federal cost principles apply only to federal grant funds.

You must present the total budget for the proposed SAC-AA project, which includes SAC-AA federal request for funding and all non-SAC-AA grant funds that support the health center scope of project. The total budget represents projected operational costs for the proposed 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 SAC-AA grant funds and non-SAC-AA grant funds, provided that the projected budget complies with all applicable HHS policies and other federal requirements.[22]

When completing the SF-424A:

- In Section A, Budget Summary, you must enter the budget on separate rows for each requested population type of Health Center Program funding (Community Health Center, Migrant Health Center, Health Care for the Homeless, and/or Public Housing Primary Care). The federal amount refers to only the SAC-AA funding requested, not all federal funding that you receive. Estimated Unobligated Funds are not applicable for this NOFO. **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**.
- In Section B, Budget Categories, you must enter an object class category (line item) budget for Year 1 of the 3-year project period. The amounts for each category in the federal and nonfederal columns, as well as the totals should align with the Budget Narrative.
- In Section C, when providing Non-Federal Resources by funding source, include non-SAC-AA federal funds supporting the proposed project in the "other" category. Program Income must be consistent with the Total Program Income (patient service revenue) presented in Form 3: Income Analysis.
- In Section E, provide the federal funds requested for Year 2 in the First column and Year 3 in the Second column, entered on separate rows for each proposed type of Health Center Program funding (CHC, MHC, HCH, and/or PHPC). The Third and Fourth columns must remain $0.

The Consolidated Appropriations Act, 2018 (P.L. 115-141), Division H, § 202, 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." See Section 5.1.iv Budget – Salary Limitation of HRSA's *SF-424*

[22] Refer to Chapter 17: Budget of the Compliance Manual.

Two-Tier Application Guide for additional information. *Note* that these or other salary limitations will apply in FY 2019, as required by law.

iv. Budget Narrative *(Submitted in HRSA EHB – required for completeness)*

See Section 5.1.v of HRSA's *SF-424 Two-Tier Application Guide*.

In addition, the Service Area Competition-Additional Areas NOFO requires a detailed budget narrative for **each requested 12-month period** (budget year) of the 3-year project period. Classify Year 1 of the budget narrative into federal and non-federal resources, and provide a table of personnel to be paid with federal funds. For subsequent budget years, the 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 Narrative.

v. Program-Specific Forms *(Submitted in HRSA EHB)*

All of the following forms, with the exception of Form 5C: Other Activities/Locations, are required. You must complete these OMB-approved forms directly in HRSA EHB. 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 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 *(Submitted in HRSA EHB)*

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.** Indirect cost rate agreements and proof of non-profit status (if applicable) will not count toward the page limit. **Each attachment must be clearly labeled.**

Label each attachment according to the number provided (e.g., Attachment 2: Bylaws). Merge similar documents (e.g., collaboration documentation) into a single file. Provide a table of contents for attachments with multiple components. Attachment-specific table of contents pages are not counted toward the page limit. Number the electronic pages

sequentially, restarting at page 1 for each attachment. NOTE: 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 affect 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. You should create the maps using UDS Mapper, available at http://www.udsmapper.org/. You may need to manually place markers for the locations of other major private provider groups serving low income/uninsured patients.

Include the corresponding table created automatically by the UDS Mapper. This table lists:

- Each zip code tabulation area (ZCTA) in the service area.
- The number of Health Center Program award recipients and look-alikes serving each ZCTA.
- The dominant award recipient serving each ZCTA.
- Total population for each ZCTA.
- Low-income population for each ZCTA.
- Total Health Center Program award recipient patients, low-income population, and total population penetration levels for each ZCTA and for the overall proposed service area.

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, available at http://www.udsmapper.org/tutorials.cfm.

Attachment 2: Bylaws (R)
Upload a complete copy of your organization's most recent bylaws. Bylaws must be signed and dated, indicating review and approval by the governing board. Public centers that have a co-applicant must submit the co-applicant governing board bylaws. See the GOVERNANCE section of the Project Narrative for details.

Attachment 3: Project Organizational Chart (R)
Upload a one-page document that depicts your 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: CEO, CD, CFO, CIO, COO, and PD. Indicate on the position descriptions if key management positions are combined and/or part time (e.g., CFO and COO roles are shared). Limit each position description to **one page** and include, at a minimum, the role, responsibilities, and qualifications.

Attachment 5: Biographical Sketches for Key Management Staff (R)
Upload current biographical sketches for key management staff: CEO, CD, CFO, CIO, COO, and PD. Biographical sketches should not exceed **two pages** each. Biographical sketches must include training, language fluency, and experience working with the cultural and linguistically diverse populations to be served, as applicable.

Attachment 6: Co-Applicant Agreement (as applicable) (new applicants: C) (competing continuation and competing supplement applicants: R)
Public center applicants that have a co-applicant board must submit a complete copy of 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 and 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 applicants: R) (competing continuation and competing supplement applicants: N/A)
New applicant: Upload the official signatory page (seal page) of the organization's Articles of Incorporation.

- A public center with a co-applicant must upload the co-applicant's Articles of Incorporation signatory page, if incorporated.
- A Tribal organization must reference its designation in the Federally Recognized Indian Tribe List maintained by the Bureau of Indian Affairs.

Attachment 9: Collaboration Documentation (R)

Upload current dated documentation of collaboration activities to provide evidence of commitment to the project. See the COLLABORATION section of the Project Narrative for details on required documentation. Letters of support should be addressed to the organization's board, CEO, or other appropriate key management staff member (e.g., Clinical Director).

Note: Reviewers will only consider letters of support submitted with the application.

Attachment 10: Sliding Fee Discount Schedule(s) (R)
Upload the current 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 applicants: C) (competing continuation and competing supplement applicants: N/A)
If you are a new applicant, you 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 copy of your currently valid Internal Revenue Service (IRS) tax exemption letter/certificate.
- A statement from a state taxing body, state attorney general, or other appropriate state official certifying that your organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.
- A certified copy of your organization's certificate of incorporation or similar document (e.g., Articles of Incorporation) showing the state or tribal seal that clearly establishes the nonprofit status of the organization.
- Any of the above documentation for a state or local office of a national parent organization, and a statement signed by the parent organization that your organization is a local nonprofit affiliate.

Public Agency Organization: Public agency applicants must provide documentation demonstrating that the organization qualifies as a public agency (e.g., state or local health department) by submitting any of the following:

- A current dated letter affirming the organization's status as a State, territorial, county, city, or municipal government; a health department organized at the State, territory, county, city or municipal level; or a subdivision or municipality of a United States (U.S.) affiliated sovereign State (e.g., Republic of Palau).
- A copy of the law that created the organization and that grants one or more sovereign powers (e.g., the power to tax, eminent domain, police power) to the organization (e.g., a public hospital district).
- A ruling from the State Attorney General affirming the legal status of an entity as either a political subdivision or instrumentality of the State (e.g., a public university).

- A “letter ruling” which provides a positive written determination by the Internal Revenue Service of the organization’s exempt status as an instrumentality under Internal Revenue Code section 115.

Tribal or Urban Indian Organizations, as defined under the Indian Self-Determination Act or the Indian Health Care Improvement Act, must provide documentation of such status.

Attachment 12: Implementation Plan (new and competing supplement applicants: R) (competing continuation applicants: N/A)
If you are a new or competing supplement applicant, you must upload the Implementation Plan. Refer to Appendix C for detailed instructions and the SAC-AA Technical Assistance Web site for a sample.

Attachment 13: Other Relevant Documents (as applicable) (R)
Include other relevant documents to support the proposed project (e.g., indirect cost rate agreements, charts, organizational brochures, lease agreements). Maximum of two uploads. If you are a new or competing supplement applicant, you 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 (DUNS) Number and System for Award Management

You must obtain a valid DUNS number, also known as the Unique Entity Identifier, for your organization/agency and provide that number in the application. You 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 you have an active federal award or an application or plan under consideration by an agency (unless the applicant is an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110(b) or (c), or has an exception approved by the agency under 2 CFR § 25.110(d)).

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

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

The Grants.gov registration process requires information in three separate systems:
- Dun and Bradstreet (http://www.dnb.com/duns-number.html)
- System for Award Management (SAM) (https://www.sam.gov/portal/SAM/##11)

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

For further details, see Section 3.1 of HRSA's *SF-424 Two-Tier Application Guide*.

ALERT from SAM.gov: If you are registering a new entity in SAM.gov, you must now provide an original, signed notarized letter stating that you are the authorized Entity Administrator before your registration will be activated by SAM.gov. Please read these FAQs to learn more about this process change. Applicants registering as a new entity in SAM.gov should plan for additional time associated with submission and review of the notarized letter. This change is effective March 23, 2018. Entities already registered in SAM.gov are advised to log into SAM.gov and review their registration information, particularly their financial information.

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

4. Submission Dates and Times

Application Due Date

The due date for applications under this NOFO in Grants.gov (Phase 1) is *April 27, 2018 at 11:59 p.m. Eastern Time*. The due date to complete all other required information in HRSA EHB (Phase 2) is *May 11, 2018 at 5 p.m. Eastern Time*.

See Section 9.2.5 – Summary of emails from Grants.gov of HRSA's *SF-424 Two-Tier Application Guide* for additional information.

5. Intergovernmental Review

The Health Center Program is a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR part 100. See Executive Order 12372 in the HHS Grants Policy Statement.

See Section 5.1.ii of HRSA's *SF-424 Two-Tier Application Guide* for additional information.

6. Funding Restrictions

You may request funding for a project period of up to 3 years, at no more than the amount listed as Total Funding for the service area in the SAAT per year (inclusive of direct and indirect costs). 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 operations for the budget period 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 the fiscal year. Further, as stated in section 330 of the PHS Act, the federal cost principles apply only to federal funds.

Funds under this notice may not be used for the following purposes: fundraising or the construction of facilities. 45 CFR part 75 and the HHS Grants Policy Statement (HHS GPS) include 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 notice and is consistent with past practice and long-standing requirements applicable to awards to health centers.

The General Provisions in Division H, of the Consolidated Appropriations Act, 2018 (P.L. 115-141), 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 restrictions will apply in FY 2019, as required by law.

You are required to have the necessary policies, procedures, and financial controls in place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding, including statutory restrictions on use of funds for lobbying, executive salaries, gun control, abortion, etc. Like those for all other applicable grants requirements, the effectiveness of these policies, procedures, and controls is subject to audit.

All program income generated as a result of awarded funds must be used for approved project-related activities. Post-award requirements for program income can be found at 45 CFR § 75.307.

V. Application Review Information

1. Review Criteria

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

These criteria are the basis upon which the reviewers will evaluate the merit of the application. The entire proposal will be considered during objective review. Information presented in the application will also affect the project period, if funding is awarded. See the Project Period Length Criteria section.

Review criteria are used to review and rank applications. The Service Area Competition-Additional Areas has seven review criteria:

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

- The extent to which the applicant describes the proposed service area and target population based on the applicant type.

- The extent to which the applicant demonstrates, through a needs assessment as well as other quantitative and qualitative data, an understanding of the health care needs in the service area/target population, including any targeted special populations.

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

- The extent to which the applicant demonstrates that the proposed services, sites, and clinical capacity will meet the needs of the target population, ensuring continuity, availability, and accessibility of care in a culturally sensitive manner, including the use of interpretation and translation services for patients with limited English proficiency.

- The extent to which the applicant establishes that the sliding fee discount program and schedules, including any nominal fees, ensure that services are available and accessible to all without regard for ability to pay; applies discounts based on a patient's income and family size; and is appropriately promoted.

- The extent to which the applicant describes how the unduplicated patient commitment (number of patients projected to be served in 2019) was determined and how it is achievable.

- **New or competing supplement applicants**: The extent to which the applicant provides a detailed implementation plan that ensures that within 120 days of the NoA, all proposed site(s) will be operating with necessary staff and providers in place to begin delivering health care services.

- **New or competing supplement applicants**: The extent to which the applicant demonstrates how 1) all providers will be in place to begin providing services at all sites for the targeted number of hours within one year of NoA; and 2) potential impacts of award recipient transition will be minimized for patients currently served.

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

- The extent to which the applicant describes and documents collaboration efforts with other primary care providers in the service area that serve similar patient populations, including
  - Other Health Center Program award recipients and look-alikes.
  - Health departments.
  - Local hospitals.
  - Rural health clinics.
  - Any additional organizations that support continuity of care and access to services beyond the scope or capacity of the health center.

- The extent to which the applicant describes formal and informal collaboration activities with other providers or programs in the service area, including private provider groups serving low income/uninsured patients.

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

- The extent to which the applicant describes how the QI/QA program systematically assesses health center services, including policies and procedures.

- The extent to which the applicant describes how the record system will optimize information technology, protect confidentiality, safeguard patient records, collect and organize data for required reporting, and monitor program compliance beyond required reporting.

- The extent to which the applicant establishes Clinical and Financial Performance Measure goals and plans for achieving such goals that are informed by documented contributing and restricting factors.

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

- The extent to which the applicant establishes that the organizational structure, management team, staffing plan, and procurement policies/procedures are appropriate for operation and oversight of the proposed project, including any contractors and subrecipients.

- The extent to which the applicant organization maintains written standards of conduct regarding conflicts of interest and governs the actions of employees that engage in the selection, award, or administration of contracts.

- The extent to which the applicant establishes that appropriate financial accounting and control systems, policies, and procedures are in place in accordance with GAAP noted in 45 CFR Part 75 Subpart F.

- The extent to which the applicant describes the billing and collections systems.

- The extent to which the applicant describes any national quality recognition the organization has received or is working towards.

- The extent to which the applicant describes the current status of or plans for participating in related federal benefits.

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

- The extent to which the applicant documents and demonstrates compliance with the governing board composition requirements, and requirements for board member selection and removal process, authorities, and responsibilities, including board representation that can communicate needs/concerns of targeted special populations.

- The extent to which the applicant describes how the governing board effectively operates within the organization's structure to ensure that the board maintains authority and oversight of the project.

- **Applicants targeting only special populations and requesting a waiver of the 51 percent patient majority board composition requirement**: The extent to which the applicant's waiver request provides 1) a reasonable statement of need for the request ("good cause"); and 2) a plan for appropriate alternative mechanisms for assuring patient participation in the direction and ongoing governance of the center.

- **Applicants requesting PHPC funding:** The extent to which the applicant documents that the service delivery plan was developed in consultation with residents of the targeted public housing and how residents of public housing will be involved in administration of the proposed project.

- **Indian applicants, to include tribal and urban groups:** The extent to which the applicant demonstrates that the governance structure will assure adequate input from the community/target population, as well as fiscal and programmatic oversight of the proposed project.

Criterion 7: SUPPORT REQUESTED (10 points) – *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 describes anticipated shifts in the payer mix, if any, and the potential impact on the overall budget, as well as mitigation plans for any adverse impacts.

2. Review and Selection Process

The independent review process provides an objective evaluation to the individuals responsible for making award decisions. The highest ranked applications receive consideration for award within available funding ranges. In addition to the ranking based on merit criteria, HRSA approving officials may also apply other factors in award selection (e.g., geographical distribution), if specified below in this NOFO. HRSA may also consider assessment of risk and the other pre-award activities described in Section 3 below.

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

For this program, HRSA will use project period length criteria and a funding priority:

Project Period Length Criteria[23]
The length of an awarded project period is determined by a comprehensive evaluation of compliance with program requirements by HRSA. If you have one or more of the following characteristics, you will be awarded a one-year project period:[24]

- Ten or more Health Center Program requirement conditions.
- Three 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.

[23] See Chapter 2: Health Center Program Oversight of the Compliance Manual.
[24] *New applicants*: Conditions related to Health Center Program requirements to be placed on the award based on information included in this application and Assessment of Risk.
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 Assessment of Risk.

- One 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.

HRSA will not fund your application if you are a **competing continuation applicant** and have been awarded two consecutive one-year project periods in FY 2016 and FY 2017 and meet the criteria for a third consecutive one-year project period in FY 2018. If no other fundable applications were received, the service area will be re-competed.

HRSA will not fund your application if you are a **competing supplement applicant or a current look-alike** with conditions related to five or more Health Center Program requirements that are in the 60-day phase of Progressive Action or conditions related to one or more Health Center Program requirements that are in the 30-day phase of Progressive Action. If no other fundable applications were received, the service area will be re-competed.

Funding Priorities
This program includes a funding priority for competing continuation applicants. A funding priority is defined as the favorable adjustment of combined review scores of individually approved applications when applications meet specified criteria. An adjustment is made by a set, pre-determined number of points. **You do not need to request a funding priority.** Prior to final funding decisions, the funding factor will be determined by HRSA staff.

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.

- **Priority 1: Program Compliance (5 points)**: You will be granted a funding priority if you are a competing continuation applicant with no Health Center Program requirement conditions (see Chapter 2: Health Center Program Oversight of the Compliance Manual) in 60-day, 30-day, or default status phase of Progressive Action.

- **Priority 2: Patient Trend (5 points)**: You will be granted a funding priority if you are a competing continuation applicant that meets the criterion for Program Compliance above **and** you 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.**

Note: You may reference the applicable Health Center Profile, available at http://bphc.hrsa.gov/uds/datacenter.aspx?q=d, for point in time data.

3. Assessment of Risk and Other Pre-Award Activities

HRSA 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).

Applications receiving a favorable objective review are reviewed for other considerations that include past performance, as applicable, cost analysis of the project/program budget, assessment of management systems, ensuring continued applicant eligibility, and compliance with any public policy requirements, including those requiring just-in-time submissions. You may be asked to submit additional programmatic or administrative information (such as an updated budget or "other support" information) or to undertake certain activities (such as negotiation of an indirect cost rate) in anticipation of an award. However, even at this point in the process, such requests do not guarantee that an award will be made. Following review of all applicable information, HRSA's approving and business management officials will determine whether an award can be made, if special conditions are required, and what level of funding is appropriate. HRSA may conduct onsite visits and/or use the current compliance status to inform final funding decisions.

Award decisions, including funding level and project period length, are discretionary and are not subject to appeal to any HRSA or HHS official or board.

Effective January 1, 2016, HRSA is required to review and consider any information about your organization that is in the Federal Awardee Performance and Integrity Information System (FAPIIS). You may review and comment on any information about your organization that a federal awarding agency previously entered. HRSA will consider your comments, in addition to other information in FAPIIS in making a judgment about your organization's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed as described in 45 CFR § 75.205 HHS Awarding Agency Review of Risk Posed by Applicants.

A determination that an applicant is not qualified will be reported by HRSA to FAPIIS (45 CFR § 75.212).

4. Anticipated Announcement and Award Dates

HRSA anticipates issuing/announcing awards prior to the start date of August 1, 2018.

VI. Award Administration Information

1. Award Notices

HRSA will issue the Notice of Award prior to the start date of August 1, 2018. See Section 6.4 of HRSA's *SF-424 Two-Tier Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2.2 of HRSA's *SF-424 Two-Tier Application Guide*.

3. Reporting

Award recipients 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 accurate data on all health centers 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 UDS Universal Report and, if applicable, a UDS Grant Report annually, by the specified deadline. The Universal Report provides data on patients, services, staffing, and financing across all health centers. The Grant Report provides data on patients and services for special populations served.

2) **Progress Report** – The Budget Period Progress Report (BPR) non-competing continuation submission documents an award recipient's progress on program-specific goals and collects performance measure data to track progress. 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).

3) **Integrity and Performance Reporting** – The NoA will contain a provision for integrity and performance reporting in FAPIIS, as required in 2 CFR part 200 Appendix XII.

VII. AGENCY CONTACTS

You may request additional information regarding business, administrative, or fiscal issues related to this NOFO by contacting:

Donna M. Marx
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Room 10SWH03
Rockville, MD 20857
Telephone: (301) 594-4245
Email: dmarx@hrsa.gov

You may request additional information regarding the overall program issues and/or technical assistance related to this NOFO by contacting:

Dave Butterworth
Public Health Analyst
Office of Policy and Program Development
Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration
5600 Fishers Lane, Room 16N09
Rockville, MD 20857
Telephone: (301) 594-4300
Contact: https://www.hrsa.gov/about/contact/bphc.aspx
SAC-AA Technical Assistance Web site

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

Grants.gov Contact Center
Telephone: 1-800-518-4726, (International Callers, please dial 606-545-5035)
Email: support@grants.gov
Self-Service Knowledge Base: https://grants-portal.psc.gov/

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

BPHC Helpline
Telephone: 1-877-974-2742, select option 3
Web: https://www.hrsa.gov/about/contact/bphc.aspx (select Grant Application as the Issue Type)

VIII. Other Information

Technical Assistance
A technical assistance Web site has been established to provide you with copies of forms, FAQs, and other resources that will help you submit a competitive application. To review available resources, visit the SAC-AA Technical Assistance Web site.
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BPHC Primary Health Care Digest
The BPHC Primary Health Care Digest is a weekly email newsletter containing information and updates pertaining to the Health Center Program, including release of all competitive funding opportunities. Organizations interested in seeking funding under the Health Center Program are encouraged to subscribe several staff.

Federal Tort Claims Act Coverage/Medical Malpractice Insurance
Organizations that receive operational funds under the Health Center Program are eligible for liability protection from certain claims or suits through the Federally Supported Health Centers Assistance Acts of 1992 and 1995 (Act) (42 U.S.C. 233(g)-(n)). The Act provides that health centers and any associated statutorily eligible personnel 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, surgical, dental, or related functions within the scope of their deemed employment. The 21st Century Cures Act amends the Public Health Service Act (42 U.S.C. 233) to include liability protections for health professional volunteers.[25]

Once funded, you can apply annually through HRSA EHB to become deemed PHS employees for purposes of FTCA coverage as described above; however, you must maintain private malpractice coverage until the effective date of such coverage (and may maintain private gap insurance for health-related activities not covered by FTCA after the effective date of FTCA coverage). The search for malpractice insurance, if necessary, should begin as soon as possible. The costs associated with this private insurance may be included in your budget request.

Deemed PHS employee status with resulting **FTCA coverage is not guaranteed**. If you are interested in FTCA protection, you will need to submit and receive approval for a new FTCA application annually. The Notice of Deeming Action (NDA) for an individual health center provides documentation of HRSA's deeming determination and

[25] Information on the 21st Century Cures Act can be found at https://www.congress.gov/bill/114th-congress/house-bill/34/text.

will be issued only after approval of a deeming application. You are encouraged to review the requirements outlined in the FTCA Health Center Policy Manual and the most current FTCA Deeming Application Program Assistance Letter (search for keyword FTCA). Contact the BPHC Helpline at 877-974-BPHC for additional information.

340B Drug Pricing Program

The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, codified as Section 340B of the Public Health Service Act, as amended, available at http://www.hrsa.gov/opa/programrequirements/phsactsection340b.pdf. The program limits the cost of covered outpatient drugs for certain federal award recipients and Health Center Program look-alikes. If you are interested in 340B Program participation, you must register and be enrolled and comply with all 340B Program requirements. Covered entities may realize a cost savings of 20-50 percent on outpatient drug purchases through participation in the 340B Prime Vendor Program (PVP). 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, visit the Office of Pharmacy Affairs Web site at http://www.hrsa.gov/opa.

IX. Tips for Writing a Strong Application

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

Appendix A: Program-Specific Forms Instructions

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

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Note: If you are a competing supplement applicant, you must utilize the Program-Specific Forms to describe ONLY the proposed project in the new service area.

Form 1A: General Information Worksheet

1. Applicant Information

- Complete all relevant information that is not pre-populated.
- Use the Fiscal Year End Date field to note the month and day in which your organization's fiscal year ends (e.g., January 31) to help HRSA know when to expect the audit submission in the Federal Audit Clearinghouse, available at https://harvester.census.gov/facweb/default.aspx/.
- You may check only one category in the Business Entity section. If you are a Tribal or Urban Indian entity and meet the definition for a public or private entity, select the Tribal or Urban Indian category.
- You may select one or more categories for the Organization Type section.

2. Proposed Service Area

2a. Service Area Designation

- If you are applying for CHC funding, you 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 at http://www.hrsa.gov/shortage or email sdb@hrsa.gov.

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 at http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html.

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 face-to-face interaction between a patient and a licensed or credentialed 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 your organization (Form 5A: Services Provided, Columns I and/or II) and documented in the patient's health center chart.

- A patient is an individual who had at least one visit in 2016 (current data) or is projected to have at least one visit in 2019 (projected data).
- Since a patient must have at least one documented visit, the number of patients cannot exceed the number of visits.
- If you have more than one service site, report aggregate data for all sites in the proposed project.
- Baseline patient data will pre-populate from the most recent UDS report for competing continuation applicants.
- If you are a new or competing supplement applicant, report annualized baseline values based on services your organization is currently providing in the proposed service area. If your organization is not currently operational in the proposed service area, report baseline values as zero.

Unduplicated Patients and Visits by Population Type:
The population types in this section do NOT refer only to the requested funding categories in Section A of the SF-424A: Budget Information Worksheet. If you are applying for only CHC funding (General Underserved Community), you 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 and Families, Public Housing Residents, or the People Experiencing Homelessness categories must be included in the General Underserved Community category.**

1. Project the number of unduplicated patients to be served in 2019 (January 1 through December 31, 2019). This value will pre-populate in the corresponding cell within the table below.

   HRSA will use the number of unduplicated patients projected to be served in 2019 (January 1 through December 31, 2019) to determine compliance with Eligibility Requirement 3a, which requires the patient projection to be at least 75 percent of the SAAT Patient Target. If a health center is unable to meet the total unduplicated patient commitment in 2019 (the patient projection from this application, plus other patient projections from funded supplemental applications for which the projections can be monitored in 2019), funding for the service area may be reduced when the service area is next competed through SAC (assuming a 3-year project period).

2. If you are a new or competing supplement applicant: Provide the number of current unduplicated patients and visits for each population type category to establish a baseline. **Across all population type categories, an individual can only be counted once as a patient.**

   If you are a competing continuation applicant, provide the number of visits across the population type categories to establish a baseline; current patients will pre-populate from the 2016 UDS data. To maintain consistency with the patients and

visits reported in UDS, do not include patients and visits for pharmacy services or other services outside the proposed scope of project. Refer to the Scope of Project policy documents.

3. The total number of unduplicated patients projected in 2019 (January 1 through December 31, 2019) will pre-populate from Item 1 above. Project the **total** number of visits in 2019 (January 1 through December 31, 2019). Then categorize these projected numbers for each population type category. **Across all population type categories, an individual can only be counted once as a patient.**

Patients and Visits by Service Type:

1. If you are a new or competing supplement applicant: Provide the number of current patients and visits within each service type category to establish a baseline. **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).

   If you are a competing continuation applicant: Current patients and visits for each service type category will pre-populate from the 2016 UDS data.

2. Project the number of patients and visits anticipated within each service type category in 2019 (January 1 through December 31, 2019).

   If you are a competing supplement applicant, you should include only the new patients you propose to serve via the proposed project.

3. To maintain consistency with the patients and visits reported in UDS, do not report patients and visits for vision or pharmacy services or other services outside the proposed scope of project.

   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 single patient should be counted as a patient for each service type received).

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 FTEs 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., clinical director 0.3 (30%) FTE and family physician 0.7 (70%) FTE). Do not exceed 1.0 (100%) FTE for any individual. For position descriptions, refer to the UDS Manual.

- Volunteers must be recorded in the Direct Hire FTEs column.
- For health centers that provide services through formal written contracts/agreements (Form 5A, Column II), select Yes for contracted staff.
- Contracted staff are indicated by answering Yes or No only. **Do not quantify contracted staff in the Direct Hire column.**

Form 3: Income Analysis

Form 3 collects 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, 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 Manual. All patient service revenue is reported in this section of the form.

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.

Only include patient service revenue associated with sites or services in the approved scope of project. Do not include patient service revenue for sites or services not in the approved scope of project or pending HRSA approval.

Patients by Primary Medical Insurance - Column (a): The projected number of unduplicated patients classified by payer based upon the patient's primary medical insurance (payer billed first). The patients are classified in the same way as in the UDS Manual, Table 4, lines 7 – 12. Do 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): Includes all billable/reimbursable visits.[26] The value is typically based on assumptions about the amount of available clinician time, average visit time (based on complexity of patient conditions and use of team provider arrangements), and types of billable visits by payer. 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).

Note: The patient service income budget is primarily based upon income per visit estimates. However, some forms of patient service income do not generate reportable visits, such as income from laboratory or pharmacy services, capitated-managed care, performance incentives, wrap payments, and cost report settlements. You may choose to include some or all of this income in the income per visit assumption, basing it on historical experience. You may also choose to separately budget for some or all of these sources of patient service income.

Income per Visit – Column (c): Calculated by dividing projected income in Column (d) by billable visits in Column (b).

Projected Income – Column (d): Projected accrued net revenue, including an allowance for bad debt, from all patient services for each pay grouping. Pharmacy income may be estimated using historical data to determine the number of prescriptions per medical visit and the average income per prescription. All separate projections of income are consolidated and reported here.

Prior FY Income – Column (e): The income data from the health center's most recent fiscal year, which will be either interim statement data or audit data.

Alternative Instructions for Capitated Managed Care:
Health centers may use their own methods for budgeting patient service income other than those noted above, but must report the consolidated result in Projected Income Column (d), along with the related data requested in Columns (a) through (e). Income for each service may be estimated by multiplying the projected visits by assumed income per visit. For example, capitated managed care income may be based upon member-month enrollment projections and estimated capitation rates for each plan, grouped by payer and added to the projected income. The estimated visits associated with these managed care plans are entered in Column (b).

[26] These visits will correspond closely with the visits reported on the UDS 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 in UDS. The UDS Manual includes definitions for each payer category.

Visits are reported on the line of the primary payer (payer billed first). Income is classified by the payer groupings where the income is earned. When a single visit involves more than one payer, attribute each 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, report that income on the self-pay line. If the co-payment is to be paid by another payer, report that income on the other payer's line. It is acceptable if you cannot accurately associate the income to secondary and subsequent sources.

Ancillary Instructions: All service income is to be classified by payer, including pharmacy and other ancillary service revenue. If you do not normally classify the projected ancillary or other service revenue by payer category, allocate the projected income by payer group using a reasonable 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): 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): 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 case management fee income.

Other Public (Line 3): Income not reported elsewhere from federal, state, or local government programs earned for providing services. A CHIP operated independently from the Medicaid program is an example of other public insurance. Other Public income also includes income from categorical grant programs when the grant income is earned by providing services. An example of this includes the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program.

Private (Line 4): Income from private insurance plans, managed care plans, and other private contracts for service. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, service contracts with employers, and Veterans

Health Administration Community Based Outpatient Clinic (CBOC) contracts. Income from health benefit plans that 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): 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): 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 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.

Other Federal (Line 7): Income from direct federal funds (where your organization is the recipient of an NoA from a federal agency). It does not include this Health Center Program funding request or federal funds awarded through intermediaries (see Line 9 below). It includes funds from federal sources such as the CDC, Housing and Urban Development (HUD), Centers for Medicare and Medicaid Services (CMS), and Department of Health and Human Service funding under the Ryan White HIV/AIDS Program Part C. The CMS Medicare and Medicaid EHR incentive program income is reported here in order to be consistent with the UDS Manual.

State Government (Line 8): 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): 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): Income from private sources, such as foundations, non-profits, 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): Income from private entities and individual donors that may be the result of fund raising.

Other (Line 12): Incidental income not reported elsewhere, including 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): The amount of funds needed from your organization'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): The sum of lines 7 – 13.

Total Non-Federal (Line 15): The sum of Lines 6 and 14 (the total income aside from this Health Center Program grant).

Note*:* In-kind donations are not included as income on Form 3. You 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. If you compile data from multiple data sources, the total numbers may vary across sources. If this is the case, make adjustments as needed to ensure that the total numbers for the first four sections of this form match. Adjustments must be explained in the NEED section of the Project Narrative.

Service area data must be specific to the proposed project and include the total number of individuals for each characteristic (percentages will automatically calculate in HRSA 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 are most often a subset of service area data. Report the number of individuals for each characteristic (percentages will automatically calculate in HRSA EHB). Estimates are acceptable. **Patient data should not be used to report target population data since patients are typically a subset of all individuals targeted for service.**

If the target population includes a large number of transient individuals 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 **must match**.

Guidelines for Reporting Race

- Classify all individuals 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. 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.
- Utilize the following race definitions:
  - 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.
  - 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, Saipan, Kosrae, Ebeye, Pohnpei, or other Pacific Islands in Micronesia, Melanesia, or Polynesia.
  - 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 – Person who chooses two 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 and Select Population Characteristics

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

- **Competing continuation applicants**: These forms will be pre-populated and cannot be modified to ensure that they reflect the current scope of project. Changes in services, sites, and other activities/locations require prior approval through a Change in Scope request submitted in HRSA EHB. If the pre-populated data do not reflect recently approved scope changes, click the **Refresh from Scope** button in HRSA EHB to display the latest scope of project.

Note: In order for forms to accurately pre-populate, if you are a competing continuation applicant, you must correctly complete the SF-424 in Grants.gov by selecting **Continuation** for Box 2 and providing the grant number for Box 4. **Failure to apply in this manner may result in delayed HRSA EHB application access.**

- **If you are a new or competing supplement applicant,** complete these forms based only on the scope of project for the proposed service area.

- If the application 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 elsewhere in the application.

- Refer to the Scope of Project 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 additional services[27] will be provided. Only one form is required regardless of the number of sites proposed. All referral arrangements/agreements for services noted on Form 5A as provided via Column I and/or II must be formal written arrangements/agreements.

If you are a competing supplement applicant:

- All services in your current scope of project must be accessible to patients from the newly proposed service area.

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

- If new services are proposed on Form 5A and this application is funded, these services must be accessible to all patients (both current and proposed patients).

Form 5B: Service Sites

Provide requested data for each proposed service site.

If you are a new or competing supplement applicant, you must propose **at least one new** full-time permanent service delivery, or administrative/service delivery site, located in the new service area.[28] **You must provide a verifiable street address for each proposed site on Form 5B: Service Sites.** If you are a competing supplement applicant, current sites in scope may also be selected for this project to the extent that they will provide services to the proposed new patients.

Zip codes entered in the Service Area Zip Codes field for service sites and administrative/service delivery sites[29] will **determine compliance with Eligibility Requirement 3b** and therefore must be those where at least 75 percent of the current patients within the service area reside. Zip codes entered for administrative-only sites will not be considered when determining eligibility. Refer to the SAAT to determine the zip codes where the majority of patients reside.

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.[30]

Form 6A: Current Board Member Characteristics

The list of board members will be pre-populated for competing continuation and competing supplement applicants. **Update pre-populated information as appropriate.**[31] Public centers with co-applicant health center governing boards must list the co-applicant board members.

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[28] MHC-only applicants may propose at least one full-time seasonal rather than permanent site to meet this criterion.
[29] 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 the SAAT. For more information about service area overlap, refer to Policy Information Notice 2007-09.
[30] Refer to Scope of Project for more information.
[31] Refer to Chapter 20: Board Composition of the Compliance Manual.

Complete or update the following information:

- List all current board members along with the current board office, if applicable (e.g., Chair, Treasurer), and area of expertise (e.g., finance, education, nursing). Do not list non-voting board members (e.g., PD, advisory board members).
- 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. For the purposes of board composition only, a patient is an individual who has received at least one service in the past 24 months that generated a health center visit, where both the service and the site where the service was received are within the HRSA-approved (or proposed in this application) scope of project.
- Indicate if the board member lives and/or works in the service area.
- Indicate if the board member is a representative of a special population (i.e., individuals experiencing homelessness, migratory and seasonal agricultural workers and families, residents of public housing).
- Indicate the total gender, ethnicity, and race of board members who are patients of the health center. 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.

Note:

- Indian tribes or tribal, Indian, or urban Indian organizations are not required to complete this form, but may do so if desired.
- If you are requesting a waiver of the 51 percent patient majority board composition requirement (see below), you must list your board members, NOT the members of any advisory council.

Form 6B: Request for Waiver of Board Member Requirements

- If you currently receive or are applying to receive CHC funding, you are 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.
- If you are a competing continuation applicant that wishes to continue an existing waiver, you must complete this form.
- When requesting a waiver, present a “good cause” justification describing the need for a waiver of the patient majority board composition requirement, including:
    - The unique characteristics of the special population (migratory and seasonal agricultural workers advocate, former homeless individual, current resident of public housing) or service area that create an undue hardship in recruiting a patient majority.
    - Attempts to recruit a majority of special population board members within the last 3 years and why these attempts have not been successful.
    - Strategies that will ensure patient participation and input in the direction and ongoing governance of the organization by addressing the following:

- Collection and documentation of input from the special population(s).
- Communication of special population(s) input directly to the health center governing board.
- Incorporation of special population(s) input into key areas, including but not limited to: selecting health center services; setting hours of operation of health center sites; defining budget priorities; evaluating the organization's progress in meeting goals, including patient satisfaction; and assessing the effectiveness of the sliding fee discount program.

Form 8 – Health Center Agreements

Complete Part I, by selecting **Yes** if you have 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 part 200 as codified by HHS at 45 CFR part 75 for the definition of "substantial" and characteristics of a subrecipient or contractor agreement. You must determine whether an individual agreement that will result in disbursement of federal funds will be carried out through a contract or a subaward and structure the agreement accordingly. If there are current/proposed agreements that will constitute a substantial portion[32] of the project, indicate the number of each type in the appropriate field and attach the complete agreements in Part II.

If either of questions 1 or 2 were answered, "Yes" in Part I, you must upload associated 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 13: Other Relevant Documents.

Note: Items attached to Form 8 will **not** count against the page limit; however, documents included in Attachment 13 **will** count against the page limit.

Form 10: Emergency Preparedness Report

Select the appropriate responses regarding emergency preparedness.

Form 12: Organization Contacts

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

[32] Per 45 CFR 75.351(c), please note that the "substance of the relationship is more important than the form of the agreement. All of the characteristics listed may not be present in all cases, and the pass-through entity [Health Center Program award recipient] must use judgment in classifying each agreement as a subaward or a procurement contract."

If you are a new applicant, 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 enables you to verify key application data. If pre-populated data appear incorrect, verify that the pertinent data in the SF-424A and Forms 1A: General Information Worksheet and 5B: Service Sites was entered correctly.

Service Area
Enter the identification number, City, and State of the proposed service area, as indicated in the SAAT.

Patient Projection
The total number of unduplicated patients projected to be served in 2019 (January 1 through December 31, 2019) will pre-populate from Form 1A: General Information Worksheet. Enter the Patient Target for the proposed service area from the SAAT. The percentage of patients to be served in 2019 will auto-calculate. **Applications with an auto-calculated percentage below 75 percent will be deemed ineligible.**[33]

Federal Request for Health Center Program Funding
To ensure eligibility, the total Health Center Program funding request must not exceed the Total Funding available in the SAAT for the proposed service area. Additionally, ensure that the funding requested for each population aligns with the values in the SAAT. If the unduplicated patient projection on Form 1A General Information Worksheet is less than 95 percent of the SAAT Patient Target, ensure the annual Health Center Program funding request is adjusted based on the auto-calculated percentage of patients to be served in 2019 (January 1 through December 31, 2019) from the Patient Projection section of this form, if necessary. If the total Health Center Program funding request is reduced, funding requested for each targeted population (e.g., CHC, MHC) must maintain the same distribution as in the SAAT.

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
If you are a new or competing supplement applicant, to ensure continuity of services in areas already being served by the Health Center Program, you 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 NoA.

[33] If a health center is unable to meet the total unduplicated patient commitment in 2019 (the patient projection from this application, plus other patient projections from funded supplemental applications for which the projections can be monitored in 2019), funding for the service area may be reduced when the service area is next competed through SAC (assuming a 3-year project period).

If you are a competing continuation applicant, to ensure an accurate scope of project, you 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 **you have 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 **you have 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 proposed project's clinical and financial goals. The goals must be responsive to identified community health and organizational needs and correspond to proposed service delivery activities and organizational capacity discussed in the Project Narrative. Further detail and sample forms are available at the SAC-AA Technical Assistance Web site. Refer to the UDS Manual for specific measurement details such as exclusionary criteria.

Required Clinical Performance Measures

1. Diabetes: Hemoglobin A1c Poor Control
2. Controlling High Blood Pressure
3. Cervical Cancer Screening (revised)
4. Early Entry into Prenatal Care (formerly Prenatal Care)
5. Low Birth Weight
6. Childhood Immunization Status (CIS)
7. Dental Sealants for Children Between 6-9 Years (formerly Oral Health)
8. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (formerly Adolescent Weight Screening and Follow-Up)
9. Body Mass Index (BMI) Screening and Follow-up (formerly Adult Weight Screening and Follow-Up)
10. Tobacco Use: Screening and Cessation Intervention
11. Use of Appropriate Medications for Asthma
12. Coronary Artery Disease: Lipid Therapy
13. Ischemic Vascular Disease: Use of Aspirin or Another Antiplatelet (revised)
14. Colorectal Cancer Screening
15. HIV Linkage to Care
16. Screening for Clinical Depression and Follow-Up Plan

Required Financial Performance Measures

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

New and Updated Performance Measures

- Two required Clinical Performance Measures have been revised and four have been renamed, as noted above.[34]

Important Details about the Performance Measures Forms

- The Dental Sealants for Children between 6-9 Years Clinical Performance Measure is currently only applicable to health centers that provide preventive

[34] Refer to Program Assistance Letter 2017-02: Approved Uniform Data System Changes for Calendar Year 2017 for details about new and updated performance measures.

dental services directly or by a formal arrangement in which the health center pays for the service (Form 5A, Columns I and II). A health center that only provides preventive dental services via a formal referral (Form 5A, Column III) may set the goal for this performance measure as zero. If the goal for the Dental Sealants for Children between 6-9 Years performance measure will be set to 0, at least one self-defined Oral Health performance measure must be tracked under the Additional Clinical Performance Measures section.[35]

- 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.

- If you are applying for funds to serve special populations (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing), you **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, you must reference the target group in the performance measure. For example, if you are seeking funds to serve people experiencing homelessness, then you must propose to measure *"the percentage of people experiencing homelessness who…"* ***rather than*** simply *"the percentage of patients who…"*

- If you have identified unique issues (e.g., populations, age groups, health issues, risk management efforts) in the NEED section of the Project Narrative, you are encouraged to include additional related performance measures.

Additional Performance Measures
In addition to the required Clinical and Financial Performance Measures, you may identify other measures relevant to your 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 you are a competing continuation applicant who no longer tracks a previously self-defined measure in the Additional Performance Measures section, 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
If you are a competing continuation applicant, pre-populated baseline data will be sourced from the 2016 UDS report for measures that have not been revised. Refer to the 2017 Clinical Performance Measure Form Field Guide and Sample at the SAC-AA Technical Assistance Web site.

[35] Refer to sample additional Oral Health performance measures in the FAQs at the SAC-AA Technical Assistance Web site.

Resources for the Development of Performance Measures
You may find it useful to:

- 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, available at http://www.healthypeople.gov/2020/topicsobjectives2020/default, as a guide when developing performance measures. Several of these objectives can be compared directly to UDS Clinical Performance. A table outlining the Healthy People 2020 objectives related to applicable performance measures is available at http://bphc.hrsa.gov/programopportunities/fundingopportunities/sac/healthypeopleandmeasures.pdf.

If you are a competing continuation applicant, you are encouraged to use your UDS Health Center Trend Report and/or Summary Report available in HRSA EHB when considering how improvements to past performance can be achieved. For help with accessing reports in HRSA EHB, contact the BPHC Helpline by submitting a request through the Web portal (https://www.hrsa.gov/about/contact/bphc.aspx) or calling 877-974-2742.

Appendix C: Implementation Plan

If you are a new or competing supplement applicant, you must outline a plan, specific to the proposed project, with appropriate and reasonable time-framed goals and action steps necessary to achieve the following:

1. Within 120 days of receipt of the NoA, [36] 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.
2. Within one year of receipt of the NoA, all proposed providers must be in place and all sites must be delivering services for the proposed hours of operation.

Table 2: Key Elements of the Implementation Plan

Element	Implementation
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
- 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

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

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. SFDP Policies and Procedures
C.2. Billing and Collections Policy and Procedure
C.3. Implementation of a Compliant Sliding Fee Scale

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