U.S. Department of Health and Human Services

Bureau of Primary Health Care
Health Center Program

New Access Points

Funding Opportunity Number: HRSA-19-080
Funding Opportunity Type(s): New and Competing Supplement/Revision
Catalog of Federal Domestic Assistance (CFDA) Number: 93.224

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2019

Application Due Date in Grants.gov: March 12, 2019
Supplemental Information Due Date in HRSA EHBs: April 11, 2019

Ensure your SAM and Grants.gov registrations and passwords are current immediately!
HRSA will not approve deadline extensions for lack of registration.
Registration in all systems, including SAM.gov, Grants.gov and HRSA EHBs,
may take up to 1 month to complete.

Issuance Date: January 11, 2019

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

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA) is accepting applications for fiscal year (FY) 2019 Health Center Program New Access Points (NAP). The purpose of this funding is to provide operational support for new service delivery sites under the Health Center Program to improve the health of the nation's underserved communities and vulnerable populations by expanding access to affordable, accessible, quality, and cost effective primary health care services.

Funding Opportunity Title:	New Access Points (NAP)
Funding Opportunity Number:	HRSA-19-080
Due Date for Applications – **Grants.gov**:	March 12, 2019 (11:59 p.m. ET)
Due Date for Supplemental Information – **HRSA EHBs:**	April 11, 2019 (5 p.m. ET)
Anticipated Total Annual Available FY 2019 Funding:	$50,000,000
Estimated Number and Type of Awards:	Approximately 75 grants
Estimated Award Amount:	Up to $650,000 per year subject to the availability of appropriated funds
Cost Sharing/Match Required:	No
Project Period/Period of Performance:	September 1, 2019 through August 31, 2021 (up to 2 years)
Eligible Applicants:	Domestic public or private nonprofit entities, including tribal organizations. See Section III of this notice of funding opportunity (NOFO) 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.

Technical Assistance

HRSA will hold a pre-application technical assistance (TA) webinar for applicants seeking funding through this opportunity. The webinar will provide an overview of pertinent information in the NOFO and an opportunity for applicants to ask questions. Visit the NAP Technical Assistance website for webinar details, frequently asked questions, sample documents, and additional resources.

The HRSA Primary Health Care Digest is a weekly email newsletter containing information and updates pertaining to the Health Center Program, including 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 Primary Care Associations (PCAs), National Cooperative Agreement recipients (NCAs), and/or Primary Care Offices (PCOs) to prepare a responsive application. For a listing of HRSA-supported PCAs and NCAs, refer to HRSA's Strategic Partnerships website. For a list of PCO contacts, refer to https://bhw.hrsa.gov/shortage-designation/hpsa/primary-care-offices.

Summary of Key Changes since the FY 2017 NAP Funding Opportunity

- Health Center Program requirements are detailed in the Health Center Program Compliance Manual (Compliance Manual).
- The page limit has been reduced from 200 pages to 175 pages. See Section IV.2 for additional information.
- The Project Narrative has been streamlined to reduce applicant burden, simplify the collection of information, and more closely align with Health Center Program requirements as detailed in the Compliance Manual.
- In making funding decisions, HRSA may consider such factors as your current and proposed service area boundaries, the extent to which the proposed service area is currently served by the Health Center Program, unmet need, and collaboration. For example, if your proposed NAP site is within one-half mile of another health center service delivery site or if your proposed service area does not have relevant/rational boundaries, HRSA may opt not to award funds for your NAP application. See Section V.2 for additional information.
- NAP funding will not be awarded to a current Health Center Program award recipient that has 1 or more 60- or 30-day conditions on their award at the time that HRSA issues awards under this NOFO.
- The project director (PD)/chief executive officer (CEO) must be a direct employee of the health center.
- You must consult with appropriate State and local government agencies and health care providers regarding the need for services at the proposed NAP site and attest to this consultation on the Summary Page form.
- Form 1C: Documents on File has been streamlined and edited to align with Compliance Manual.
- The Need for Assistance Worksheet (Form 9) has been replaced by the Service Area Needs Assessment Methodology (SANAM) which will be used to calculate an Unmet Need Score (UNS) for each proposed service area. See the Funding Requirements section for more information.
- A question on the use of telehealth has been added to the Project Narrative RESOURCES/CAPABILITIES section.

- Scoring points have been adjusted from 5 to 10 for Evaluative Measures and from 10 to 5 for the Support Requested Review Criteria.
- The funding priority for unserved, high poverty populations has been replaced by a funding priority for locating proposed sites in “hot spot” zip codes, which are zip codes with high levels of unmet need. See Section V.2 for additional information.
- New applicants for NAP funding (but not look-alikes that have been found to be fully compliant with Health Center Program requirements) will be awarded a 1-year project period.
- If you are a new applicant or a look-alike with unresolved conditions on your Notice of Look-alike Designation related to Health Center Program requirements, you will be required to submit a Compliance Achievement Plan within 120 days of Notice of Award.

Other Federal Benefits

Receipt of Health Center Program funds, while a basis for eligibility, does not automatically confer such associated federal benefits as Federal Tort Claims Act (FTCA) coverage, 340B Drug Pricing Program participation, National Health Service Corps participation, or Federally Qualified Health Center (FQHC) reimbursement. Eligibility for such benefits depends upon compliance with applicable requirements in addition to the award of Health Center Program funding, including the submission and approval of separate applications to appropriate approval authorities. Please note, in this regard, that 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.

Table of Contents

I. Program Funding Opportunity Description

1. Purpose

This notice announces the opportunity to apply for Fiscal Year (FY) 2019 New Access Points (NAP) funding under the Health Center Program. The purpose of this funding is to provide operational support for new service delivery sites to improve the health of the nation's underserved communities and vulnerable populations by expanding access to affordable, accessible, quality, and cost effective primary health care services.

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

For the purposes of this document, the term "health center" refers to all health centers for which funding is awarded under the following PHS Act 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 Public Housing Primary Care (PHPC – section 330(i)). Applicants may request funding to serve one or multiple population types (i.e., CHC, MHC, HCH, PHPC) within a single application (e.g., if you propose to serve both the general community and homeless individuals, you can submit a NAP application requesting both CHC and HCH funding).

2. Background

This program is authorized by section 330 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254b, as amended).

Health Center Program funding targets the nation's high need geographic areas and populations by 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. In 2017, HRSA-funded health centers delivered accessible, affordable, quality primary health care services to more than 27 million people.

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

- A **NEW** applicant is an organization that is not currently a direct recipient of operational funding under the Health Center Program (authorized by section

330(e), (g), (h) and/or (i) of the PHS Act). A new application should address the entire scope of the project being proposed for NAP funding. A new applicant can be:

- A current Health Center Program look-alike;
- An organization that is operational at the time of application; or
- An organization that proposes to become operational within 120 days of the Notice of Award.

Health Center Program look-alikes can propose NAP sites that are currently in or out of scope, however, HRSA will not award funding that would result in "dual status" whereby the organization would become both a Federal awardee under section 330 and a look-alike designee. Therefore, look-alike applicants must include all currently-approved look-alike sites as part of their FY 2019 NAP application (i.e., list all sites on Form 5B: Service Delivery Sites).

- A **SATELLITE** applicant is an organization that is currently receiving direct operational funding under the Health Center Program (H80 grant funding).[1] A satellite application should address ONLY the proposed new access point (i.e., only the new site(s) and service area/target population proposed) in terms of need, population to be served, and the proposed health service delivery system.

Funding Requirements

Your application must document a high level of unmet need for primary health care services in the service area, with data to support the level of unmet need gathered through multiple sources including consultation with appropriate State and local government agencies and health care providers.

In recent past NAP funding opportunities, you were required to demonstrate a quantitative measure of need for primary health care services through the completion of the Need for Assistance Worksheet. For the FY 2019 NAP funding opportunity, HRSA will use the Service Area Needs Assessment Methodology (SANAM), a standardized assessment of need for primary care services, to automatically generate an unmet need score (UNS) for your NAP application. The SANAM leverages public data sources on critical health determinants and calculates an UNS for every zip code.[2] The UNS for each service area zip code proposed in the application (on Form 5B: Service Sites) is combined to establish the overall UNS for the application. The UNS accounts for up to 20 points in the NEED section of the application score and is a factor in one of the funding priorities. More information on SANAM and UNS can be found on the NAP Technical Assistance website. The UNS builds on the Medically Underserved Area and

[1] If any current Health Center Program award recipient incorrectly applies as a new applicant, the applicant type will be changed to satellite in the system, which may delay access to the application in HRSA EHBs.

[2] To calculate the UNS, HRSA uses Zip Code Tabulation Areas (ZCTAs). Each ZCTA is associated with one or more zip codes.

Medically Underserved Population designations as an objective assessment of unmet need.

In addition to the UNS, applicants have the opportunity to further describe the unique access issues experienced by their target population in the Project Narrative and propose a comprehensive plan to meet this need. You must also describe collaborative and coordinated delivery systems for the provision of quality health care to the underserved. In addition, you 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 demonstrate how your proposed service area has relevant and rational boundaries in relation to the existing service area (e.g., reasonable distance to other sites in scope, a size that ensures that services are accessible to the service area population, boundaries that conform to relevant boundaries of political subdivisions).

Your application must demonstrate compliance or plans to achieve compliance with Health Center Program requirements, as set forth in section 330 of the PHS Act and applicable program and grants regulations and as further detailed in the Compliance Manual. If funded, HRSA will assess your compliance during an Operational Site Visit conducted approximately 120 days after award for new applicants and mid-project period for satellite applicants. Failure to demonstrate compliance with Health Center Program requirements during the site visit will result in the placement of a condition of award, which provides a time-phased approach for resolution of an identified area of noncompliance.[3] See Project Period and Compliance Status in Section V.2 for information about the impact of conditions on funding decisions and/or project period.

In addition to the Health Center Program requirements, specific requirements for applicants requesting funding under each population 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 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 health care services to migratory and seasonal agricultural workers and their families in the service area, which includes:
  - Migratory agricultural workers who are individuals whose principal employment is in agriculture, and who have been so employed within the last 24 months, and who establish for the purposes of such employment a temporary abode;

[3] See Chapter 2: Health Center Program Oversight of the Compliance Manual.

- Seasonal agricultural workers who are individuals whose principal employment is in agriculture on a seasonal basis and who do not meet the definition of a migratory agricultural worker;
- Individuals who are no longer employed in migratory or seasonal agriculture because of age or disability who are within such catchment area; and/or
- Family members of the individuals described above.

Note: Agriculture refers to farming in all its branches, as defined by the 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 health care services to individuals:
  - Who lack housing (without regard to whether the individual is a member of a family);
  - Whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations;
  - Who reside in transitional housing;
  - Who reside in permanent supportive housing or other housing programs that are targeted to homeless populations; and/or
  - Who are children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness.
- Provide substance use disorder services.

PUBLIC HOUSING PRIMARY CARE APPLICANTS (PHPC):

- 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 health care services to residents of public housing and individuals living in areas immediately accessible to public housing. Public housing includes public housing agency-developed, owned, or assisted low-income housing, including mixed finance projects, but excluding housing units with no public housing agency support other than Section 8 housing vouchers.
- Consult with residents of the proposed public housing sites regarding the planning and administration of the program.

You must demonstrate readiness to initiate NAP site operations. Within 120 days of the Notice of Award, 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 target population as outlined in Attachment 12: Operational Plan. Failure to verify that all sites are operational within 120 days of the Notice of Award will result in the placement of a condition of award, which provides a time-phased approach for resolution. If you fail to successfully resolve

a site-related condition within the specified timeframes, HRSA may withdraw support through termination of all, or part, of the NAP award per 45 CFR § 75.371.

You must provide a realistic and achievable number of unduplicated patients projected to be served in 2020 on Form 1A: General Information Worksheet. If you do not serve at least the number of patients projected to be served in 2020, funding for the service area may be reduced when it is next competed through a Service Area Competition.[4]

II. Award Information

1) Type of Application and Award

Types of applications sought:

- New
- Competing Supplement/Revision (i.e., satellite)

HRSA will provide funding in the form of a grant.

2) Summary of Funding

HRSA expects approximately $50,000,000 to be available annually to fund 75 recipients. Of this total, approximately:

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

You may apply for a ceiling amount of up to $650,000 total costs (includes both direct and indirect costs) per year. Of the $650,000, you may request Health Center Program funding up to $150,000 in Year 1 only for one-time minor capital costs for equipment and/or minor alteration/renovation (see Appendix D). This funding opportunity does not support construction costs.

The project period is September 1, 2019 through August 31, 2021 (2 years). New applicants for NAP funding (but not look-alikes that have been found to be fully compliant with Health Center Program requirements) will be awarded a 1-year project period. See Project Period and Compliance Status in Section V.2 for more information.

Funding beyond the first year is subject to 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.

[4] If a health center is unable to meet the total unduplicated patient projection in calendar year 2020 (the patient projection from this application, in addition to other patient projections from funded supplemental applications), funding for the service area may be reduced when the service area is next competed through Service Area Competition. Therefore, your 2020 patient projection must be realistic and achievable. For more information, see the Patient Target FAQs.

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

III. Eligibility Information

1. Eligible Applicants

1) Your organization must be a domestic public[5] or private, nonprofit entity, as demonstrated in Attachment 11: Evidence of Nonprofit or Public Center Status. Tribes, tribal organizations, faith-based organizations, and community-based organizations are eligible to apply.[6]

2) Your organization must provide health services to medically underserved populations, as defined in section 330 of the PHS Act. You may not propose to serve **ONLY** a single age group, address a single health issue/disease category, or provide any subset of the required primary health care services.[7] You must propose a new access point project (across all proposed sites) that provides comprehensive primary medical care as its main purpose as documented on:
   a) Form 1A: General Information Worksheet (number of projected medical patients is greater than projected patients for other service types, e.g., mental health, dental) and
   b) Form 5A: Services Provided (General Primary Medical Care is provided directly (Column I) and/or through formal written contractual agreements in which the health center pays for the service (Column II)).

3) You must ensure the required primary health care services will be available and accessible in the service area. As such, you must propose at least one permanent service delivery site[8] that provides comprehensive primary medical care as its main purpose and operates for a minimum of 40 hours per week, as documented on Form 5B: Service Sites. If you propose to serve only migratory and seasonal agricultural workers, you may propose a full-time seasonal (rather than permanent) service delivery site.
   a) A permanent site is a fixed building location that operates year-round.

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[5] Only public agency health centers can have a co-applicant. A co-applicant is the established body, identified as such in the NAP application, that provides and functions as the health center's governing board when the public agency determines that it cannot meet the Health Center Program governing board requirements directly (Section 330(r)(2)(A) of the Public Health Service Act). However, this status does not confer any right to receive grant funding or any other grant-associated federal benefits upon the co-applicant organization.

[6] Refer to Chapter 1: Health Center Program Eligibility of the Compliance Manual.

[7] Refer to the Service Descriptors for Form 5A: Services Provided, available at https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/scope/form5aservicedescriptors.pdf, for details regarding required primary health care services.

[8] 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."

b) You must provide a verifiable street address for each proposed site on Form 5B: Service Sites.
c) You may propose a mobile medical unit only if you also propose at least one full-time, fixed site in the application and on Form 5B: Service Sites.
d) You may propose a school-based service delivery site if the site is a permanent, full time site or if you propose it in addition to a permanent, full time site, **and** you demonstrate in the RESPONSE section of the Project Narrative how the health center will ensure that the entire underserved population in the service area has access to all required services.

4) Your proposed service delivery site(s), based on Form 5B: Service Sites, must be located in an area with a shortage of health services. All proposed NAP sites must:
a) Not be located in the same building as any site already in the approved scope of project of any Health Center Program award recipient or look-alike,[9]
- With the exception of look-alike applicants that include their own look-alike sites as part of their FY 2019 NAP application,[10]
- Including those sites pending verification via Change in Scope or capital development awards (e.g., Capital Development, Building Capacity, Health Infrastructure Investment Program);

b) Not represent the relocation or consolidation of currently approved sites; and
c) Not be proposed through an active Change in Scope request or Health Center Program (H80) funding opportunity application at the time of application.

5) *NEW APPLICANTS ONLY:* You must propose to serve a defined geographic area that is federally-designated, in whole or in part, as a Medically Underserved Area (MUA) or Medically Underserved Population (MUP).[11] If the area is not currently federally-designated as an MUA or MUP, you must provide documentation that a request for designation has been submitted **and** designation must be received prior to award. Note: If you are requesting funding only for MHC, HCH, and/or PHPC, you are not required to have a MUA/MUP designation for the proposed service area and/or target population. See Section I.1 for definitions of the MHC, HCH, and PHPC populations.

6) *PUBLIC HOUSING PRIMARY CARE APPLICANTS ONLY:* If you are applying for 330(i) funding, you must demonstrate that you have consulted with the public housing residents in the preparation of the NAP application and will ensure ongoing consultation with the residents regarding the planning and administration of the health center, as documented in the GOVERNANCE section of the Project Narrative.

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[9] Tools are available to assist you in determining current Health Center Program service sites in your proposed service area, including the UDS Mapper (http://www.udsmapper.org) and Find a Health Center (http://findahealthcenter.hrsa.gov).
[10] A current Health Center Program look-alike may propose a new site(s) in addition to their current site(s) in scope, as desired.
[11] To find out if all or part of your service area is located in a designated MUA/MUP, see https://data.hrsa.gov/tools/shortage-area/mua-find.

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

HRSA will consider any application that exceeds the ceiling amount of $650,000 on the SF-424A non-responsive and will not consider it for funding under this notice.

HRSA will consider any application that fails to satisfy the deadline requirements referenced in Section IV.4 non-responsive and will not consider it 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 will be considered non-responsive and will not be considered for funding under this notice.[12]

If you do not include all documents indicated as "required for completeness" in Section IV.2.ii and Section IV.2.vi in your application, HRSA will consider your application to be non-responsive and will not consider it for funding under this notice. This includes the Project Narrative, as well as Attachments 2: Bylaws, 6: Co-Applicant Agreement, 10: Articles of Incorporation, and 11: Evidence of Nonprofit or Public Center Status.

NOTE: Multiple applications from an organization are not allowable.

HRSA will only accept your first validated electronic submission, under the correct funding opportunity number, in Grants.gov.[13] 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 EHBs) application phase.

[12] Applications in which the applicant organization proposes to perform a substantive role in the project in addition to conducting a portion of the project through a subrecipient arrangement are allowable.
[13] Grants.gov has compatibility issues with Adobe Reader DC. Direct questions pertaining to software compatibility to Grants.gov. See Section VII for contact information.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** you to apply electronically through Grants.gov and the HRSA EHBs. You must use a two-phase submission process associated with this NOFO and follow the directions provided at http://www.grants.gov/applicants/apply-for-grants.html **and** in HRSA EHBs.

- **Phase 1 – Grants.gov** – Required information must be submitted and validated via Grants.gov with a due date of March 12, 2019 at 11:59 p.m. Eastern Time; **and**
- **Phase 2 – HRSA EHBs** – Supplemental information must be submitted via HRSA EHBs with a due date of April 11, 2019 at 5 p.m. Eastern Time.

Only applicants who successfully submit the workspace application package associated with this NOFO in Grants.Gov (Phase 1) by the due date may submit the required additional information in HRSA EHBs (Phase 2).

The NOFO is also known as "Instructions" on Grants.gov. If you provide your email address when reviewing or preparing the workspace application package, you will automatically be notified in the event HRSA changes and/or republishes the NOFO 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 For Applicants 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. You must submit the application in English and in the terms of U.S. dollars (45 CFR § 75.111(a)). You must submit the following application components 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

You must submit the following application components in HRSA EHBs:

- 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 **175 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 workspace application package do not count in the page limit. Indirect Cost Rate Agreement and proof of nonprofit status (if applicable) do not count 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 EHBs 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 14: 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), include the following:

Application for Federal Assistance SF-424 (Submit in Grants.gov)
In addition to the specific fields below, see Section 3.2 of HRSA's *SF-424 Two-Tier Application Guide*.

- *Box 2: Type of Applicant:* Incorrect selection may delay HRSA EHBs access.
  - New – Organization not currently funded through the Health Center Program: Select "New" and leave box 4 blank.
  - Satellite – Current Health Center Program award recipient applying to serve a new service area: Check the "Revision" box, select "Other" and type "Supplement" and your H80 grant number in box 4.
- *Box 5b: Federal Award Identifier:* 10-digit number starting with H80 or LAL for current health centers. New applicants should leave this blank.

i. Project Abstract (Submit in Grants.gov)

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

In addition, the abstract must provide:

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

*ii. Project Narrative *(Submit in HRSA EHBs – required for completeness)*

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

The Project Narrative must:

- 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 EHBs submission.
- Where applicable, demonstrate compliance with Health Center Program requirements, as detailed in the Compliance Manual.
- Reflect the NAP proposed scope of project (proposed services, providers, sites, service area zip codes, and target population). If you are a **satellite applicant**, you may refer to current services, policies, procedures, and capacity as they relate to the new access point project (e.g., transferrable experience, procedures, resources).

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

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 your proposed service area (consistent with Attachment 1: Service Area Map and Table), including:
   a) The service area boundaries, including how they conform to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs. If your proposed service area does not contain contiguous zip codes, or is not contiguous with your current health center service area (if applicable), explain why.
   b) How the service area reflects where the proposed patients reside (e.g., service area zip codes listed on Form 5B: Service Sites represent those where 75 percent of proposed patients reside).
   c) The extent to which the service area is currently served by the Health Center Program (reference the Health Center Program penetration percentages on the table provided in Attachment 1: Service Area Map and Table), including health center locations, proximity to your proposed service delivery site(s),[14] and accessibility. If the proposed NAP site(s) serves an area already served in part by another health center, explain the remaining unmet need.

2) Describe, citing relevant data and their sources, the current unmet health care needs in the service area/target population, specifically addressing items a-e below. If you are requesting funding for one or more special populations (MHC, HCH, and/or PHPC),[15] include the specific needs of **each** targeted special population. In your description of need for services in the proposed service area, you must include data informed by or gathered through consultation with appropriate State and local government agencies (e.g., health department, state Medicaid agency, state Primary Care Office) and data informed by or gathered through consultation with other health care providers.
   a) The extent to which your target population is currently served by other primary health care providers (e.g., rural health clinics, critical access hospitals, private providers serving Medicaid patients) and the remaining unmet need.
   b) Factors associated with access to care and health care utilization (e.g., geography, transportation, occupation, unemployment, income level, educational attainment, transient populations).

[14] If your proposed NAP site is within one-half mile of another health center service delivery site, HRSA may opt not to award funds for your NAP application. See Section V.2 for additional information.
[15] Special populations by type of health center are MHC – Migratory and Seasonal Agricultural Workers and Families, HCH – People Experiencing Homelessness, or PHPC – Residents of Public Housing.

c) Most significant causes of morbidity and mortality (e.g., diabetes, cardiovascular disease, cancer, low birth weight, mental health and/or substance use disorder).
d) Health disparities.
e) 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) On Form 1A: General Information Worksheet, under Unduplicated Patients and Visits by Population Type, provide goals for the estimated new patients you project to serve in 2020 at your proposed NAP site(s). In the narrative, describe:
   a) How you determined the projected number of patients, based on unmet need.
   b) How the projected number of patients is achievable given any recent or anticipated changes in the local health care landscape, organizational structure, and/or workforce capacity.
   c) The current number of patients and the increase in patients served, if the proposed NAP site(s) is currently operational (including Health Center Program look-alikes).

2) Describe how you will ensure access to all required services[16] and any additional services (consistent with Form 5A: Services Provided) to meet identified unmet needs, including:
   a) The method of provision of services, including whether services will be provided directly (Form 5A, Column I), through contracts or agreements for which the health center pays (Form 5A, Column II), or through formal referral arrangements (Form 5A, Column III) (consistent with Attachment 7: Summary of Contracts and Agreements).
   b) How you will document services provided through contractual agreements (Form 5A, Column II) in the patient's health center record, and how the health center will pay for the services.
   c) How you will manage services provided through formal referral arrangements (Form 5A, Column III), and how you will establish a process for tracking and referring patients back to the health center for appropriate follow-up care.
   d) How your enabling services (e.g., case management, outreach, eligibility assistance, health education, transportation, translation) will increase access to

[16] Refer to Scope of Project, including the Column Descriptors for Form 5A: Services Provided.

care, particularly for the barriers to care identified in the NEED section and any targeted special populations.

e) How you will ensure that the entire underserved population (all individuals and age groups) in the service area will have access to all required services.

f) **If you are requesting HCH funding**: Document how substance use disorder services will be made available (consistent with Form 5A).

3) Describe plans to hire, contract, and/or establish formal referral arrangements with all providers and begin providing services at all sites (consistent with Forms 5A: Services Provided and 5B: Service Sites) within 120 days of award.

4) Upload a detailed operational plan as Attachment 12: Operational Plan (see Appendix C). The plan must include reasonable and time-framed activities which demonstrate that, within 120 days of award, **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. In addition, the plan must demonstrate that the health center will be compliant with Health Center Program requirements within 120 days of award.

5) Describe the proposed service delivery sites[17] and how the sites ensure 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 residents of public housing). Specifically address:

a) Site address(es) and location(s) where services are being/will be provided (consistent with Forms 5B: Service Sites and 5C: Other Activities/Locations and Attachment 1: Service Area Map and Table). If the site is leased, include relevant portions of the lease or intent to lease documentation in Attachment 14: Other Relevant Documents.

b) How you will minimize access barriers, including barriers related to the area's physical characteristics, residential patterns, or economic and social groupings.

c) Distance and duration for patients to travel to or between service sites to access the full range of services proposed.

d) How the total number and type (e.g., fixed site, mobile unit, school-based clinic), hours of operation, number of exam rooms, and location of service delivery sites facilitate scheduling appointments and accessing services. Attach floor plans for all proposed sites in Attachment 13.

6) Describe how you will promptly respond to patient medical emergencies during and after regularly scheduled hours, including:

[17] You must propose a number of sites that is realistic and achievable because you must verify that all proposed sites are operational within 120 days of Notice of Award.

a) How you ensure that at least one staff member certified in basic life support skills is present at each service delivery site (consistent with Form 5B: Service Sites) during regularly scheduled hours of operation.
b) How you ensure after-hours coverage that:
   - Is provided via telephone or face-to-face by an individual with the qualifications and training necessary to exercise professional judgment in assessing the need for emergency care.
   - Includes the ability to refer patients either to a licensed independent practitioner for further consultation or to locations, such as emergency rooms or urgent care facilities, for further assessment or immediate care, as needed.
c) How you inform patients of after-hours coverage, including those with limited English proficiency (i.e., language(s), literacy levels, and formats of information).

7) Describe how you address the following related to continuity of care:
   a) Hospital admitting privileges, such as provider(s) with admitting privileges at one or more hospitals and/or formal arrangements with one or more hospitals or entities (e.g., hospitalists, obstetrics hospitalist practices).
   b) How you receive and record medical information from non-health center providers/entities for patients who are hospitalized or visit a hospital's emergency department (e.g., hospital or emergency department discharge follow-up instructions; laboratory, radiology, or other results).
   c) Health center staff follow-up, when appropriate, for patients who are hospitalized or visit a hospital's emergency department.

8) Describe your sliding fee discount program, (consistent with Attachment 8: Sliding Fee Discount Schedule).[18] Specifically address how you:
   a) Define income and family size.
   b) Assess the eligibility of **all** patients for sliding fee discounts based **only** on income and family size.
   c) Apply sliding fee discounts to all required and additional services (Form 5A: Services Provided).
   d) Establish a nominal charge, if applicable, for patients at or below 100 percent of the Federal Poverty Guidelines (FPG), available at https://aspe.hhs.gov/poverty-guidelines. **Note**: The nominal fee must be a flat charge that is considered nominal from the perspective of the patient. It cannot reflect the actual cost of the service provided.
   e) Determine the number and income ranges of sliding fee discount pay classes. In Attachment 8: Sliding Fee Discount Schedule, document how the Sliding Fee Discount Schedule(s) (SFDS) is structured to provide:
      - A full discount 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

[18] A health center's sliding fee discount program includes both the schedule of discounts that adjusts fees based on the patient's ability to pay and the related policies and procedures for determining sliding fee eligibility and applying sliding fee discounts. For more information, see Chapter 9: Sliding Fee Discount Program of the Compliance Manual.

a nominal charge, it is a flat fee and less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.
- Partial discounts for individuals and families with incomes above 100 percent of the FPG, and at or below 200 percent of the FPG, that adjust based on income using a minimum of three discount pay classes.
- No discounts to individuals and families with annual incomes above 200 percent of the FPG.
- Discounts based on the most current FPG.

f) Inform patients of the availability of sliding fee discounts (e.g., language and literacy-level appropriate materials and signage, intake process, website).
g) Evaluate the sliding fee discount program to ensure its effectiveness in reducing financial barriers to care.

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

Information provided in the COLLABORATION section must:
- Demonstrate compliance with the Collaborative Relationships Health Center Program requirement described in Chapter 14 of the Compliance Manual.
- Be supported by documents provided in Attachment 9: Collaboration Documentation.

1) Describe your efforts to coordinate and integrate activities with other health care providers (consistent with Attachment 1: Service Area Map and Table) and programs in the service area, including, but not limited to, local hospitals (including critical access hospitals), specialty providers, home visiting programs and state and local tuberculosis programs, and those that serve targeted special populations, to support:
   - Continuity of care across community providers.
   - Access to other health or community services not available through the health center that impact the patient population (e.g., inpatient care, specialty services).
   - A reduction in non-urgent use of hospital emergency departments.

2) In Attachment 9: Collaboration Documentation, document collaboration[19] with primary health care and other providers serving similar patient populations in the service area (consistent with Attachment 1: Service Area Map and Table), including at a minimum:
   - Health Center Program award recipients and look-alikes.
   - Health departments.
   - Local hospitals, including critical access hospitals.
   - Rural health clinics.
   - Other primary care providers (e.g., clinics supported by the Indian Health Service).

[19] If your proposed service area has a Health Center Program penetration level of the low-income population that is 75 percent or greater, and you do not sufficiently document both collaboration and unmet need within the service area, HRSA may not fund your NAP application.

- Community organizations (e.g., social service organizations, schools, homeless shelters, veterans service organizations), as applicable.

If any of the above providers/organizations do not exist in the service area, state this. If you do not provide documentation of collaboration with one or more of the entities above, you must provide evidence of your request to collaborate and explain why you could not obtain such documentation.

3) If you do not provide documentation of collaboration with one or more of the entities above, describe your plans to ensure that proposed primary care services complement other health services in the community, particularly critical access hospitals and rural health clinics.

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

Information provided 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
- Chapter 18: Program Monitoring and Data Reporting Systems

1) Describe how your Quality Improvement/Assurance (QI/QA) program addresses:
   a) Adherence to current clinical guidelines and standards of care in the provision of services.
   b) Identification and analysis of patient safety and adverse events, including implementation of follow-up actions, as necessary.
   c) Assessment of patient satisfaction, including hearing and resolving patient grievances.
   d) Completion of quarterly (or more frequent) QI/QA assessments to inform modifications to the provision of services.
   e) Production and sharing of QI/QA reports to support oversight and decision-making regarding the provision of services by key management staff and the governing board.

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

3) 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 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.

4) Describe how your health record system (e.g., electronic health record (EHR) system) will:
   a) Optimize health information technology.
   b) Protect the confidentiality of patient information and safeguard it against loss, destruction, or unauthorized use, consistent with federal and state requirements.
   c) Facilitate the collection and organization of data for the purpose of monitoring program performance.

5) On the Clinical and Financial Performance Measures forms (see instructions in Appendix B), establish realistic goals that are responsive to clinical and financial performance and associated needs.

6) Describe how you will focus efforts on the following HRSA clinical priorities to improve the health status of the patient population and achieve goals cited in the Clinical Performance Measures form, as applicable:
   a) Diabetes.
   b) Depression Screening and Follow-Up.
   c) Child Weight Assessment and Counseling.
   d) Body Mass Index.
   e) Combating the Opioid Crisis

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

Information provided 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 your 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 your staffing plan (consistent with Form 2: Staffing Profile):

a) How you ensure that clinical staff, contracts, or formal referral arrangements with other providers/organizations will be in place to carry out all required and additional services (consistent with Form 5A: Services Provided).
b) How you considered size, demographics, and health care needs of the service area/patient population when determining the number and mix of clinical support staff.
c) How credentialing and privileging are implemented for all health center employees, individual contractors, and volunteers who provide clinical services, including:
    - Clinical staff (licensed independent practitioners (LIPs)), addressing provider categories separately (e.g., physicians, dentists, physician assistants, nurse practitioners).
    - Other licensed or certified practitioners (OLCPs), addressing provider categories separately (e.g., registered nurses, licensed practical nurses, registered dietitians, certified medical assistants).
    - Other clinical staff providing services on behalf of the health center, addressing provider categories separately (e.g., medical assistants or community health workers in states, territories or jurisdictions that do not require licensure or certification).

Note: Indicate contracted providers on Form 2: Staffing Profile and in Attachment 7: Summary of Contracts and Agreements. If you will secure a majority of core primary health care services via contract, include the contract/agreement as an attachment to Form 8: Health Center Agreements.

3) Describe your management team (e.g., project director (PD)/chief executive officer (CEO), clinical director (CD), chief financial officer (CFO), chief information officer (CIO), chief operating officer (COO)), including:
    a) How it supports the operation and oversight of the proposed project, consistent with scope and complexity.
    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 (e.g., CFO and COO combined role).
    d) Employment arrangement of the CEO (consistent with Form 2: Staffing Profile).[20]
    e) Responsibilities of the CEO for reporting to the governing board and overseeing other key management staff in carrying out the day-to-day activities of the proposed project.
    f) The process for filling vacant key management staff positions.

[20] Per Section 330(k)(3)(H)(ii), the project director (PD)/chief executive officer (CEO) must be a direct employee of the health center.

4) If applicable, describe how you will maintain appropriate oversight and authority over all contracts and subawards for services, sites, and substantive programmatic work[21] (consistent with Forms 5A: Services Provided, 5B: Service Sites, and 8: Health Center Agreements, and Attachment 7: Summary of Contracts and Agreements), including provisions that address the following:
   a) The specific activities or services to be performed.
   b) Ensuring the contractor/subrecipient 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.[22]

   Note: Upon award, your organization will be the legal entity held accountable for carrying out the approved Health Center Program scope of project, including the portion of these activities that may be carried out by contractors or subrecipients.

5) Describe provisions that are in place to prohibit real or apparent conflict of interest by board members, employees, consultants, and others in the procurement of supplies, property, equipment, and services.

6) Describe how your written policies and procedures and financial accounting and internal control systems ensure:
   a) Effective control over, and accountability for, all funds, property, and other assets associated with the health center.
   b) 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.
   c) The capacity to account for all federal award(s) in order to identify the source (receipt) and application (expenditure) of funds for federally-funded activities.
   d) Assurance that expenditures of the federal award funds will be allowable in accordance with the terms and conditions of the federal award and Federal Cost Principles.[23]

[21] For the purposes of the Health Center Program, contracting for substantive programmatic work does not include the acquisition of supplies, material, equipment, or general support services. However, it does apply to contracting for the majority of health care providers with a single entity.
[22] For regulations and further guidance on these requirements, please see 45 CFR § 75.352 and the HHS Grants Policy Statement, at https://www.hrsa.gov/grants/hhsgrantspolicy.pdf.
[23] See 45 CFR 75 Subpart E: Cost Principles and Legislative Mandates in Grants Management for Fiscal Year 2019.

7) Describe how you conduct billing and collections, 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, 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.

8) Describe how you use or plan to use telehealth[24] to increase access to required primary health care services and additional health services, as applicable.

9) Describe any national quality recognition your organization has received or is in the process of achieving (e.g., HRSA National Quality Leader, HRSA Health Center Quality Leader, Patient-Centered Medical Home, Accreditation Association for Ambulatory Health Care, Joint Commission, state-based or private payer initiatives).

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

Information provided 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 organizations are ONLY required to respond to Item 4 below.

1) Describe where in Attachment 2: Bylaws you document meeting the following board composition requirements (consistent with compliance demonstrated on Form 6A: Board Member Characteristics):
   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.[25]
   b) At least 51 percent of board members must be patients served by the health center.[26]

[24] Telehealth is defined as the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications. See https://www.hrsa.gov/rural-health/telehealth/index.html for telehealth resources.
[25] For the purposes of the Health Center Program, the term 'board member" refers only to voting members of the board.
[26] If you are targeting only special populations (MHC, HCH, and/or PHPC), you may request a waiver of the 51 percent patient majority board composition requirement by showing good cause on Form 6B: Request for Waiver of Board Member Requirements (as applicable). A waiver of the 51 percent patient majority governance requirement is not available for entities requesting CHC funding.

c) Patient members of the board, as a group, must reasonably represent the patient population in terms of demographic factors (e.g., gender, race, ethnicity) (consistent with Form 4: Community Characteristics).[27]
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 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).
f) No more than one-half of non-patient board members earn more than 10 percent of their annual income from the health care industry.
g) Health center employees, contractors, and immediate family members of employees may not be health center board members.[28]
h) If you are **requesting funding to target any special populations**, you must have at least one representative on the board from/for each special population 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 where in Attachment 2: Bylaws you document meeting the following board authority requirements:
   a) Board meetings occur monthly.
   b) Approving the selection and dismissal or termination of the Project Director/CEO.
   c) 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, including revenue.
   d) Approving proposed sites, hours of operation, and services.
   e) Evaluating the performance of the health center.
   f) Establishing or adopting policy related to the operations of the health center.
   g) Assuring the health center operates in compliance with applicable federal, State, and local laws and regulations.

3) Describe how your governing board maintains authority and oversight over the proposed project, as outlined in Attachments 2: Bylaws, 3: Project Organizational Chart, and if applicable, 6: Co-Applicant Agreement. Specifically address the following requirements:
   a) No individual, entity, or committee (including, but not limited to, an executive committee authorized by the board) reserves or has approval/veto power over the board with regard to the required authorities and functions.

[27] 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 current/proposed scope of project.
[28] 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).

b) Collaboration or agreements with other entities do not restrict or infringe upon the board's required authorities and functions.
c) **Public agency applicants with a co-applicant board**: Attachment 6: Co-Applicant Agreement delegates the required authorities and functions to the co-applicant board and delineates the respective roles and responsibilities of the public agency and the co-applicant in carrying out the project.[29]
d) **Applicants requesting PHPC Funding**: The service delivery plan was developed in consultation with residents of the targeted public housing and residents of public housing will be involved in administration of the proposed project.

4) **INDIAN TRIBES OR TRIBAL, INDIAN, OR URBAN INDIAN ORGANIZATIONS 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 *– Corresponds to Section V.1 Review Criterion 7: SUPPORT REQUESTED*

Information provided in the SUPPORT REQUESTED section must demonstrate compliance with the Budget Health Center Program requirement described in Chapter 17 of the Compliance Manual.

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 (see Form 3: Income Analysis for details regarding revenue sources).

2) Describe how you have considered and planned for mitigating the adverse impacts of financial or workforce-related challenges (e.g., payer mix changes, workforce recruitment or retention challenges).

3) Provide the total cost per patient and federal cost per patient for the proposed NAP project broken out by funding population type (i.e., CHC, MHC, HCH, PHPC) and explain why the costs are appropriate and reasonable. The federal dollars per patient will be calculated automatically on the Summary Page form after Forms 1A: General Information Worksheet and 1B: BPHC Funding Request Summary are complete.

[29] Only public agency applicants may establish a separate co-applicant health center governing board to meet all Health Center Program requirements. Refer to Chapter 19: Board Authority of the Compliance Manual.

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. You should use both the Project Narrative and Review Criteria sections as you develop your application. Reviewers will use both when scoring your application.

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 *(Submit in HRSA EHBs)*

See Section 5.1.iv of HRSA's *SF-424 Two-Tier Application Guide*. 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 HRSA selects the application 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 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.

You must present the total budget for the proposed NAP project, which includes the NAP federal request for funding and all non-NAP 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, other federal, and non-federal sources. Health centers have discretion regarding how they propose to allocate the total budget between NAP grant funds and other funding that

supports the project, provided that the projected budget complies with all applicable HHS policies and other federal requirements.[30]

When completing the SF-424A: Budget Information Form:

- In Section A, Budget Summary, enter the budget on separate rows for each population type (CHC, MHC, HCH, PHPC) for which you are requesting funding. The federal amount refers to only the NAP funding requested, not all federal funding that you receive. Estimated Unobligated Funds are not applicable for this NOFO.
- In Section A and B, enter only the federal NAP funding requested in the Federal columns.
- In Section B, Budget Categories, enter an object class category (line item) budget for Year 1. The amounts for each category in the federal and nonfederal columns, as well as the totals, should align with the Budget Narrative.
- In Year 1 only, up to $150,000 may be requested for equipment (enter on the Equipment row in Section B) and/or minor alteration/renovation (enter on the Construction row in Section B). The SF-424A is the official budget request. If a NAP grant is awarded, the maximum amount of one-time funding HRSA will award is the amount indicated on the SF-424A. The one-time funding information entered on Form 1B: BPHC Funding Request Summary must be consistent with the request on the SF-424A. See Appendix D for one-time funding instructions.
- In Section C, when providing Non-Federal Resources by funding source, include non-NAP federal funds supporting the proposed project in the "other" category. Program Income must be consistent with the Total Program Income (patient service revenue) presented on Form 3: Income Analysis.
- In Section E, provide the federal funds requested for Year 2 in the First column, entered on separate rows for each proposed type of Health Center Program funding (CHC, MHC, HCH, and/or PHPC). The maximum amount that may be requested cannot exceed $650,000. The Second, Third, and Fourth columns must remain $0.

The Consolidated Appropriations Act, 2018 (P.L. 115-245), 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 Two-Tier Application Guide* for additional information. Note that these or other salary limitations may apply in FY 2019, as required by law.

*iv. **Budget Narrative** (Submit in HRSA EHBs)*

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

[30] The federal cost principles apply to the federal grant funds only. Refer to Chapter 17: Budget of the Compliance Manual for additional information on applicable HHS policies and other federal requirements.

In addition, the NAP program requires a 2-year budget narrative that outlines federal and non-federal costs (including program income, if any) for year 1 (9/1/2019 to 8/31/2020) and year 2 (9/1/2020 to 8/31/2021) separately.[31] Refer to the sample budget narrative available on the NAP Technical Assistance website.

Your budget narrative must:

- Clearly detail calculations for each line item on the SF-424A Budget Information Form, including cost per unit.
- Explain how each cost contributes to meeting your stated NAP project goals to enable HRSA to determine if costs are allowed.[32]
- Include a Personnel Justification Table for year 1 and for year 2. Include the following information for all direct hire staff and contractors you propose to support with NAP funding: name, position, percent of FTE, base salary, adjusted annual salary based on salary limitation requirements, and the amount of federal funding requested.
- If applicable, include one-time costs such as equipment (consistent with the Equipment List Form) and minor A/R (consistent with the Budget Justification attached in the A/R Project Cover Page). See Appendix D for more information.

v. *Program-Specific Forms* *(Submit in HRSA EHBs)*

You must complete the required OMB-approved forms directly in HRSA EHBs. Where applicable, the forms should demonstrate compliance with Health Center Program requirements, as detailed in the Compliance Manual. Forms collect important data that contribute to a full picture of the proposed project, including performance goals. Data provided in the forms must be consistent with information provided in the Project Narrative and other parts of the application.

Refer to Appendix A for a list of required Program-Specific Forms, Appendix B for Performance Measure Forms instructions, and Appendix D for one-time funding instructions. Detailed instructions and samples are available at the NAP Technical Assistance website.

vi. *Attachments (Submit in HRSA EHBs)*

Provide the following items in the order specified below. Where applicable, the attachments should demonstrate compliance with Health Center Program requirements, as detailed in the Compliance Manual.

Unless otherwise noted, attachments count toward the application page limit. Indirect cost rate agreements and proof of nonprofit status (if applicable) will not count toward the page limit. **You must clearly label each attachment** according to the number and title below (e.g., Attachment 2: Bylaws). Merge similar documents (e.g., collaboration documentation) into a single file.

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[31] Submit a 2-year budget narrative regardless of the applicant type to enable HRSA to assess and plan for ongoing funding to be approved in the Service Area Competition or Budget Period Progress Report.
[32] Refer to the cost principles embedded in 45 CFR part 75, see http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75 for details on allowable costs.

If you do not include attachments marked "C" (required for completeness) in your application, HRSA will consider your application to be non-responsive and will not consider it for funding. If you fail to include attachments marked "R" (required for review), that may negatively affect your objective review score.

Attachment 1: Service Area Map and Table (R)
Upload a map of the service area for the proposed project, indicating the proposed NAP site(s) listed on Form 5B: Service Sites and any current sites (as applicable). The map must clearly indicate the proposed service area zip codes, medically underserved areas (MUAs) and/or medically underserved populations (MUPs), and Health Center Program award recipients, look-alikes, and other health care providers serving the proposed zip codes, as described in the COLLABORATION section of the Project Narrative. Create the map 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 individuals.

Include the corresponding data table created 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 health center serving each ZCTA.
- Total population and low-income population for each ZCTA.
- Total Health Center Program patients.
- Low-income population and total population Health Center Program penetration levels for each ZCTA and for the overall proposed service area.

See the NAP Technical Assistance website 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 (C)
Upload a complete copy of your organization's most recent bylaws. Bylaws must demonstrate compliance with Health Center Program governance requirements as detailed in Chapters 19: Board Authority and 20: Board Composition of the Compliance Manual. Additionally, bylaws must be signed and dated, indicating review and approval by the governing board. Public agencies 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: PD/CEO, CD, CFO, CIO, and COO. Indicate on the position descriptions if key management positions are combined and/or part time (e.g., CFO and COO roles are shared). For each position description, 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: PD/CEO, CD, CFO, CIO, and COO. Biographical sketches should not exceed **two pages** each. Biographical sketches must include training, language fluency, and experience working in community-based organziations and with cultural and linguistically diverse patient populations, as applicable.

Attachment 6: Co-Applicant Agreement (as applicable) (new applicants: C) (satellite applicants: R)
Only public agency health centers can have a co-applicant. A co-applicant is the established body that serves as the health center's governing board when the public agency cannot meet the Health Center Program governing board requirements directly. Public agency 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 agency that delegates the required authorities and functions to the co-applicant board and delineates the roles and responsibilities of the public agency and the co-applicant in carrying out the Health Center Program project.[33] 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.[34] Also summarize agreements for a substantial portion of the project, as attached to Form 8: Health Center Agreements and indicate with an asterisk (*). 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.

[33] Refer to Chapter 19: Board Authority of the Compliance Manual.
[34] Refer to the Scope of Project policy documents, including the Column Descriptors for Form 5A: Services Provided, for the requirements for providing services via formal written contract/agreement and formal written referral arrangement.

Attachment 8: Sliding Fee Discount Schedule(s) (R)
Upload your sliding fee discount schedule(s). For details, see the RESPONSE section of the Project Narrative and Chapter 9: Sliding Fee Discount Program of the Compliance Manual.

Attachment 9: Collaboration Documentation (R)
Upload current dated letters of support and other documentation that provide evidence of collaboration specific to the NAP project. See the COLLABORATION section of the Project Narrative for details on required documentation. Letters of support should be addressed to the applicant 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: Articles of Incorporation (new applicants: C) (satellite applicants: N/A)
New applicants: Upload your Articles of Incorporation official signatory page (including state seal or stamp) that documents nonprofit status.

- Public agency applicants with a co-applicant: Upload the co-applicant's Articles of Incorporation signatory page, if incorporated.
- Tribal organizations: Reference designation in the Federally Recognized Indian Tribe List maintained by the Bureau of Indian Affairs.

Attachment 11: Evidence of Nonprofit or Public Center Status (new applicants: C) (satellite applicants: N/A)
New applicants: Upload evidence of nonprofit or public center status. This attachment does not count toward the page limit.

Private, Nonprofit Organization: Upload one of the following as evidence of nonprofit status:

- A copy of your currently valid Internal Revenue Service (IRS) tax exemption certificate/letter.
- 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: Upload one of the following as evidence of public agency status:

- 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 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 IRS of the organization's exempt status as an instrumentality under Internal Revenue Code section 115.

Tribal or Urban Indian Organization: Upload documentation of such status as applicable to the nonprofit or public agency sections above and as defined under the Indian Self-Determination Act or the Indian Health Care Improvement Act. Documentation should include a certified copy of the organization's official certificate of incorporation or similar document showing the state or tribal seal that clearly establishes nonprofit status.

Attachment 12: Operational Plan (R)
As noted in Item 4 of the RESPONSE section of the Project Narrative, upload an Operational Plan detailing the steps you will take to ensure that your organization will be compliant with Health Center Program requirements and will have the necessary staff and providers in place to begin operating and delivering services at **all proposed sites** within 120 days of award. Refer to Appendix C for detailed instructions and the NAP Technical Assistance website for a sample.

Attachment 13: Floor Plans (R)
Upload floor plans of the proposed new access point(s), including proposed exam rooms and waiting area(s). Indicate the area of the building to be used (e.g., suites, floors) and the address.

Attachment 14: 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.

3. Dun and Bradstreet Data 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)
- Grants.gov (http://www.grants.gov/)

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

UPDATED SAM.GOV ALERT: For your SAM.gov registration, you must submit a notarized letter appointing the authorized Entity Administrator. The review process changed for the Federal Assistance community on June 11, 2018. Read the updated FAQs to learn more.

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 March 12, 2019 *at 11:59 p.m. Eastern Time*. The due date to complete all other required information in HRSA EHBs (Phase 2) is April 11, 2019 *at 5 p.m. Eastern Time*. HRSA suggests submitting applications to Grants.gov at least **3 days before the deadlines** to allow for any unforeseen circumstances.

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 subject to the provisions of Executive Order 12372, as implemented by 45 CFR part 100.

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 2 years, at no more than $650,000 per year (inclusive of direct **and** indirect costs). If you request one-time funding for equipment and/or minor alteration/renovation, it must be requested only in Year 1 and may not exceed $150,000 of the $650,000 maximum (see Appendix D for more information).

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. If funded, HRSA will assess compliance with Health Center Program requirements during an Operational Site Visit conducted approximately 120 days after award for new award recipients and mid-project period for satellites. Failure to demonstrate compliance with Health Center Program requirements during the Operational Site Visit will result in the placement of a condition of award, which provides a time-phased approach for resolution of an identified area of noncompliance.

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.

The General Provisions in Division H, of the Consolidated Appropriations Act, 2018 (P.L. 115-245), 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.

45 CFR part 75 and the HHS Grants Policy Statement (HHS GPS) include information about allowable expenses. Please note that funds under this notice may not be used for:

- Fundraising
- Lobbying
- New construction activities, including additions or expansions
- Major alteration/renovation in excess of $500,000 in total federal and non-federal costs (excluding the cost of allowable moveable equipment)
- Installation of trailers and pre-fabricated modular units
- Facility or land purchases

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.

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. In accordance with Sections 330(e)(5)(D) and 330(k)(3)(D) of the PHS Act, the health center must use any non-grant funds as permitted under section 330, and may use such funds for such other purposes as are not specifically prohibited under section 330, if such use furthers the objectives of the health center project.

V. Application Review Information

1. Review Criteria

HRSA has procedures for assessing the technical merit of applications to provide for an objective review of applications and to assist you in understanding the standards against which your application will be reviewed. HRSA has critical indicators 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.

These criteria are the basis upon which the reviewers will evaluate and score the merit of the application. Reviewers will use both the Project Narrative and Review Criteria section to assess your application. The entire proposal will be considered during objective review.

Review criteria are used to review and rank applications. The NAP application has seven review criteria, with a maximum objective review score of 80 points, as outlined below. HRSA will determine the remaining 20 points of the score using the Unmet Need Score (UNS). The UNS leverages standardized public data sources on critical health determinants to calculate a score that represents the aggregate unmet need across all proposed zip codes. More information on the UNS is available on the NAP Technical Assistance website.

See the review criteria outlined below with specific details and scoring points.

Criterion 1: NEED (10 Points determined by the objective review process; UNS accounts for an additional 20 points) – *Corresponds to Section IV.2.ii NEED*

1) The extent to which the applicant describes the proposed service area (consistent with Attachment 1: Service Area Map and Table), including the reasonableness of service area boundaries, how well the service area reflects where proposed patients

reside, and the extent to which the Health Center Program current services do not address all unmet need.

2) The strength of the documented unmet health care needs in the service area/target population.

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

1) The extent to which the unduplicated patient projection (indicated on Form 1A: General Information Worksheet) was logically developed and is realistic and achievable during calendar year 2020.

2) The extent to which the applicant ensures:
   - Access to, documentation of, and follow-up for all required services to meet identified unmet needs, including how the services will be provided (consistent with Form 5A: Services Provided).
   - That enabling services increase access to care.
   - That the entire underserved population in the service area has access to all required services.
   - That substance use disorder services will be available, if HCH funding is requested.

3) The strength of the applicant's plans to hire, contract, and/or establish formal referral arrangements with providers and begin providing services at all sites within 120 days of award.

4) The extent to which the Operational Plan demonstrates that within 120 days of award, all proposed sites will have the necessary staff and providers in place to begin operating and delivering services and the health center will be compliant with Health Center Program requirements.

5) The extent to which the proposed service delivery sites (consistent with Form 5B: Service Sites) ensure availability, prompt accessibility, and continuity of services within the proposed service area relative to where the target population lives and works.

6) The extent to which the applicant ensures prompt and appropriate response to patient medical emergencies during and after regularly scheduled hours.

7) The extent to which the applicant ensures continuity of care.

8) The extent to which the sliding fee discount program and schedules (consistent with Attachment 8: Sliding Fee Discount Schedule) address the following:
   - Discounts based on defined income and family size only.
   - Discounts are applied to all required and additional services.

- Individuals and families with incomes at or below 100 percent of the current FPG, receive a full discount, unless there is a nominal charge which is considered nominal from the perspective of the patient.
- Partial discounts for individuals and families with incomes above 100 percent of the FPG, and at or below 200 percent of the FPG.
- How patients are informed of sliding fee discounts.
- Evaluating the sliding fee discount program to ensure its effectiveness in reducing financial barriers.

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

1) The extent to which the applicant coordinates and integrates activities with other providers or programs in the service area to support continuity of care, access to other services, and a reduction in non-urgent use of hospital emergency departments.

2) The extent to which the applicant documents in Attachment 9: Collaboration Documentation collaboration efforts with other providers that serve similar patient populations in the service area, including:
   - Health Center Program award recipients and look-alikes.
   - Health departments.
   - Local hospitals.
   - Rural health clinics.
   - Other primary care providers.
   - Community organizations, as applicable.

3) If collaboration documentation with one or more of the entities above is not provided, the extent to which the applicant demonstrates that proposed primary care services will complement other health services in the community.

Criterion 4: EVALUATIVE MEASURES (10 points) – *Corresponds to Section IV.2.ii EVALUATIVE MEASURES*

1) The strength of the applicant's QI/QA program, including standards of care, patient safety, patient satisfaction, QI/QA assessments, and QI/QA reports.

2) The extent to which the applicant describes the responsibilities of the individual designated to oversee the implementation and monitoring of the QI/QA program.

3) The extent to which the health center's physicians or other licensed health care professionals conduct QI/QA assessments to ensure adherence to clinical guidelines and identification of patient safety and adverse events.

4) The extent to which the applicant's health record system will optimize health information technology, protect confidentiality, and collect and organize data for monitoring.
5) The reasonableness of Clinical and Financial Performance Measure goals and plans for achieving such goals in the Clinical and Financial Performance Measures Forms.

6) The extent to which the applicant will focus efforts on the following HRSA clinical priorities to improve the health status of the patient population: Diabetes, Depression Screening and Follow-Up, Child Weight Assessment and Counseling, Body Mass Index, and Combatting the Opioid Crisis.

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

1) The extent to which the applicant's organizational structure 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 and Form 8: Health Center Agreements).

2) The extent to which the staffing plan (consistent with Form 2: Staffing Profile) ensures that:
   - Clinical staff, contracts, or formal referral arrangements with other providers/organizations will be in place to carry out all required and additional services.
   - The number and mix of clinical support staff meet the health care needs of the service area/patient population.
   - Credentialing and privileging are implemented appropriately for all health center employees, individual contractors, and volunteers who provide clinical services.

3) The capabilities of the management team, including:
   - How it supports operations and oversight consistent with the scope of the NAP project.
   - Qualifications documented in Attachment 4: Position Descriptions for Key Management Staff and Attachment 5: Biographical Sketches for Key Management Staff.
   - Employment arrangement and responsibilities of the CEO.
   - The process for filling vacant key management staff positions.

4) The extent to which the applicant demonstrates appropriate oversight and authority over all contracts and subawards for services, sites, and substantive programmatic work.

5) The extent to which the applicant demonstrates appropriate conflict of interest provisions.

6) The extent to which the applicant demonstrates appropriate financial accounting and internal control systems.

7) The extent to which the applicant demonstrates appropriate billing and collections, including:
   - Ensuring that no patient is denied service based on inability to pay.
   - Education for patients on insurance options.
   - Timely billing.

8) The extent to which the applicant describes use of telehealth to increase access to required primary health care services and additional health services, as applicable.

9) The extent to which the applicant describes any national quality recognition the organization has received or is in the process of achieving.

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

1) The extent to which the applicant describes, and Attachment 2: Bylaws and Form 6A: Board Member Characteristics demonstrate, compliant board composition, including:
   - Board size between 9 and 25 members.
   - At least 51 percent patient board members.
   - Patient board members reasonably represent the patient population.
   - Non-patient members represent the community in which the health center is located, provide relevant expertise, and no more than half earn more than 10 percent of their annual income from the health care industry.
   - Health center employees, contractors, and immediate family members of employees may not be health center board members.
   - **Applicants requesting funding to target any special populations** have at least one representative on the board from/for each special population.

2) The extent to which Attachment 2: Bylaws documents the following required authorities and responsibilities of the governing board:
   - Monthly board meetings.
   - Approving the selection and dismissal or termination of the Project Director/CEO.
   - Approving applications related to the health center project.
   - Approving proposed sites, hours of operation, and services.
   - Evaluating the performance of the health center.
   - Establishing or adopting policy related to the operations of the health center.
   - Assuring compliance with applicable federal, State, and local laws and regulations.

3) The extent to which the applicant describes how the governing board maintains authority and oversight over the proposed project (consistent with Attachments 2:

Bylaws, 3: Project Organizational Chart, and, if applicable, 6: Co-Applicant Agreement).

4) **Public agency applicants with a co-applicant board**: The extent to which Attachment 6: Co-Applicant Agreement delegates the required authorities and functions to the co-applicant board and delineates the respective roles and responsibilities of the public agency and the co-applicant.

5) **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.

6) **Indian Tribes or Tribal, Indian, or Urban Indian Organizations Only**: The extent to which the organization's governance structure and processes assure adequate input from the community/target population, as well as fiscal and programmatic oversight of the proposed project.

Criterion 7: SUPPORT REQUESTED (5 points) – *Corresponds to Section IV.2.ii SUPPORT REQUESTED*

1) The strength of the budget presentation (i.e., SF-424A, Budget Narrative, Form 2: Staffing Profile, and Form 3: Income Analysis), including reasonableness and alignment with the proposed project.

2) The strength of plans to mitigate adverse impacts of financial or workforce-related challenges.

3) The reasonableness of the total cost per patient and federal cost per patient for the proposed NAP project (consistent with the Summary Page form).

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. HRSA may also consider assessment of risk and the other pre-award activities described in Section 3 below. In addition to the ranking based on merit criteria, HRSA approving officials will apply other factors below in award selection (e.g., geographical distribution).

See section 6.3 of HRSA's *SF-424 Two-Tier Application Guide* for more details.

For this program, HRSA will use funding priorities, distribution criteria, and compliance status.

Funding Priorities
This program includes funding priorities, as authorized by section 330 of the PHS Act. A funding priority is the favorable adjustment of combined review scores of individually approved applications when applications meet specified criteria. For applications that score within the fundable range for eligibility, HRSA staff adjusts the score by a set, pre-determined number of points. Applicants for NAP funding may be eligible to receive points for up to three funding priorities:

- ***High Unmet Need Area (5 points):*** The UNS is a standardized unmet need score for every zip code. A "hot spot" zip code has high unmet need, indicated by:
    1) An UNS of 35 or greater, denoting need in the area based on the SANAM;
    2) A Health Center Program penetration of the low-income population of 5% or less, indicating the need in the area is not being met by health centers; and
    3) No current health center service delivery sites (including your current health center sites, if applicable).

  If your proposed NAP full-time service site (as indicated by the site address zip code on Form 5B), is located in a hot spot zip code, HRSA will add 5 points to your application score. See the NAP Technical Assistance website for detailed information about UNS and hot spot zip codes.

- ***Sparsely Populated Area (5 points)*:** If any of your proposed NAP service sites[35] (as indicated by the site address zip code on Form 5B), is located in a "sparsely populated" zip code where no other current health center service delivery sites are located, HRSA will add 5 points to your application score. For the 50 U.S. States and Puerto Rico, a sparsely populated zip code is designated as a Level 4 frontier and remote (FAR) area[36] characterized by a combination of low population size and high geographic remoteness. To find out if your site address zip code is located in a FAR area, see https://www.ruralhealthinfo.org/am-i-rural. For the U.S. Territories and Compact of Free Association states (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau), a sparsely populated zip code is an area that has seven or fewer people per square mile. HRSA will calculate the population density by dividing the population in the area by the landmass.

- ***Health Center Program Look-Alikes (10 points)*:** Health Center Program look-alikes are health centers that operate and provide services consistent with all statutory, regulatory, and policy requirements that apply to Health Center Program award recipients, but do not receive Health Center Program funding. You will receive 10 priority points if HRSA designated your organization as a

[35] To qualify for sparsely populated priority points, the proposed NAP service site must operate for 20 hours per week or more.
[36] See https://www.ers.usda.gov/data-products/frontier-and-remote-area-codes/ for more information about FAR areas.

Health Center Program look-alike prior to October 1, 2018 and all of the following conditions are met:

1) The NAP application includes all current sites in the applicant's Health Center Program look-alike scope of project at the time of application (i.e., all sites listed on the look-alike Form 5B must be listed as sites on the NAP application Form 5B). Applicants may but are not required to propose additional sites.
2) The NAP application includes the service area zip codes on Form 5B in which at least 75% of current patients reside (based on the look-alike 2018 UDS report). Applicants may propose to serve additional service area zip codes.
3) The applicant organization has reported patient data in the 2018 Uniform Data System (UDS).
4) The total unduplicated patient projection by December 31, 2020 on Form 1A is greater than the total unduplicated patients included in the 2018 UDS report.
5) The organization does not have an active 60-day or 30-day Health Center Program requirement condition at the time of application.

Distribution of Awards

- *RURAL/URBAN DISTRIBUTION OF AWARDS:* Aggregate awards in FY 2019 will be made to ensure that the ratio of rural to urban target populations is not less than two to three or greater than three to two as set forth in section 330(e)(6)(A) of the PHS Act. In order to ensure this distribution, HRSA may award funds to applications out of rank order.
- *PROPORTIONATE DISTRIBUTION:* Aggregate awards in FY 2019 to support the various types of health centers (i.e., CHC, MHC, HCH, PHPC) will be made to ensure proportionate distribution across the Health Center Program as set forth in section 330(r)(2)(B) of the PHS Act. In order to meet this intended distribution, HRSA may award funding to applications out of rank order.
- *GEOGRAPHIC CONSIDERATION OF NEED:* HRSA may consider the extent to which an area may currently be served by the Health Center Program when deciding which applications to fund. If your proposed NAP site is within one-half mile of another Health Center Program award recipient or look-alike site, HRSA may not fund your NAP application. Additionally, if your proposed service area has a Health Center Program penetration level of the low-income population that is 75 percent or greater (per UDS Mapper), and you do not sufficiently document both collaboration (e.g., letters of support from health centers that serve a significant number of patients in the area) and unmet need within the service area, HRSA may not fund your NAP application.
- *SERVICE AREA EXPANSION:* HRSA may consider your service area boundaries, including how they conform to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs. If your proposed service area does not have relevant/rational boundaries by itself and in relation to your existing service area (e.g., reasonable distance to your other sites in scope), HRSA may not fund your NAP application.

Project Period and Compliance Status[37]

The length of the project period will be dependent on the type of application and compliance status:

- For new award recipients and look-alikes with conditions related to Health Center Program requirements on the Notice of Look-alike Designation at the time of award, the project period will be September 1, 2019 through August 31, 2020 (1 year). Within 120 days of the Notice of Award, you must submit for HRSA approval a Compliance Achievement Plan, which outlines steps you will take to meet the Health Center Program requirements.
- For look-alikes that are fully compliant with Health Center Program requirements at the time of award, the project period is September 1, 2019 through August 31, 2021 (2 years).
- For satellite award recipients, HRSA will align the NAP award with your existing Health Center Program project period. Health Center Program compliance will be assessed through the Service Area Competition application and Operational Site Visit.

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

SATELLITE APPLICANTS: You will **not** receive NAP funding if you have an active 60-day or 30-day Health Center Program requirement condition on your award at the time HRSA makes final NAP funding decisions.

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).

HRSA reviews applications receiving a favorable objective review for other considerations that include past performance, as applicable, cost analysis of the project/program budget, assessment of your management systems, ensuring continued applicant eligibility, and compliance with any public policy requirements, including those requiring just-in-time submissions. HRSA may ask you 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 HRSA will make an award. Following review of all applicable information, HRSA's approving and business management officials will

[37] See the Health Center Program Compliance Manual, Chapter 2: Health Center Program Oversight at https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-2.html.

determine whether HRSA can make an award if special conditions are required, and what level of funding is appropriate.

Award decisions 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 any of 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.

HRSA will report to FAPIIS a determination that an applicant is not qualified (45 CFR § 75.212).

4. Anticipated Announcement and Award Dates

HRSA anticipates issuing/announcing awards prior to the start date of September 1, 2019.

VI. Award Administration Information

1. Award Notices

HRSA will issue the Notice of Award prior to the start date of September 1, 2019. See Section 6.4 of HRSA's *SF-424 Two-Tier Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2.1 of HRSA's *SF-424 Two-Tier Application Guide*.

Requirements of Subawards
The terms and conditions in the Notice of Award (NoA) apply directly to the recipient of HRSA funds. The recipient is accountable for the performance of the project, program, or activity; the appropriate expenditure of funds under the award by all parties; and all other obligations of the recipient, as cited in the NoA. In general, the requirements that apply to the recipient, including public policy requirements, also apply to subrecipients under awards. See 45 CFR § 75.101 Applicability for more details.

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 data on all health centers to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments. 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 progress on program-specific goals and performance measures 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 45 CFR part 75 Appendix XII.

VII. Agency Contacts

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

Terry Hatchett and Brian Feldman
Grants Management Specialists
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10SWH03
Rockville, MD 20857
Telephone: Terry Hatchett (301) 443-7525, Brian Feldman (301) 443-3190
Email: THatchett@hrsa.gov, BFeldman@hrsa.gov

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

Allison Arnone
Public Health Analyst
Office of Policy and Program Development
Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration
5600 Fishers Lane, Room 16N-09
Rockville, MD 20857
Telephone: (301) 594-4300
Contact: https://www.hrsa.gov/about/contact/bphc.aspx

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, 7 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 EHBs. Always obtain a case number when calling for support. For assistance with submitting the remaining information in HRSA EHBs, contact Health Center Program Support, Monday-Friday, 8:30 a.m. to 5:30 p.m. ET, excluding federal holidays at:

Health Center Program Support
Telephone: 1-877-464-4772
Web: https://www.hrsa.gov/about/contact/bphc.aspx

VIII. Other Information

Technical Assistance
HRSA will hold a pre-application technical assistance (TA) webinar for applicants seeking funding through this opportunity. Visit the NAP Technical Assistance website for webinar details, frequently asked questions, sample documents, and additional resources.

Federal Tort Claims Act Coverage/Medical Malpractice Insurance
Organizations that receive operational funds under the Health Center Program are eligible for liability protection for certain claims or suits under the Federally Supported Health Centers Assistance Acts of 1992 and 1995 (42 U.S.C. 233(g)-(n)) (FSHCAA) and volunteer health professionals of such organizations are also eligible for such protection under the 21st Century Cures Act (42 U.S.C. 233(q)) (Cures Act). Under FSHCAA, 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. Under the Cures Act, volunteer health professionals sponsored by a deemed health center may become deemed PHS employees as well.

Once funded, your health center can apply annually through HRSA EHBs to become a deemed PHS employee 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.

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 will be issued only after approval of a deeming application. You are encouraged to review the deeming requirements outlined in the Compliance Manual and the most current FTCA Deeming Application Program Assistance Letter (search for keyword FTCA). Information on deeming requirements for health center volunteer health professionals can be found at https://bphc.hrsa.gov/ftca/about/health-center-volunteers.html. Contact Health Center Program Support 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 Program. There is no cost to participate in the 340B 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 website at http://www.hrsa.gov/opa or contact the 340B Program at 888-340-2787 or ApexusAnswers@340bpvp.com.

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 EHBs. All forms are required, except Form 5C: Other Activities/Locations. Sample forms are available at the NAP Technical Assistance website. Data provided in the forms must be consistent with information provided in the Project Narrative and other parts of the application.

Form 1A: General Information Worksheet

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/.
- 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). If you are requesting funding for special populations only (e.g., MHC, HCH, and/or PHPC), this is not required.
- Select the MUA and/or MUP designation(s) for the proposed service area and enter the identification number(s).
- To find out if all or part of your service area is located in a designated MUA or MUP, see https://data.hrsa.gov/tools/shortage-area/mua-find.
- For more information regarding MUAs or MUPs, visit the Shortage Designation website at https://bhw.hrsa.gov/shortage-designation/what-is-shortage-designation or email sdb@hrsa.gov.

2b. Service Area Type

- Select the type (urban or rural) that describes the majority of the service area. If rural is selected, you may further choose sparsely populated, if applicable, and provide the number of people per square mile (values must range from .01 to 7). Sparsely populated is an optional field and will not be used to calculate priority

points. For information about rural populations, visit the Office of Rural Health Policy's website at http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html.

2c. Patients and Visits

Ensure that patient and visit projections are:

- Realistic and appropriate based on the proposed NAP project.
- Consistent with the RESPONSE section of the Project Narrative and other parts of the application.

When determining patient and visit projections, note the following definitions and guidelines (see the UDS Manual for detailed information):

- Base your patient projections on the proposed NAP site(s) only (i.e., do not include sites outside the proposed scope of project). Report aggregate data for all service sites in the proposed project.
- A visit is a face-to-face contact between a patient and a licensed or credentialed provider who exercises independent judgment in providing services. To be counted as a visit, services must be paid for by your organization (Form 5A: Services Provided, Columns I and/or II) and documented in a chart that stays in the possession of the health center.
- Baseline values for patients and visits are prepopulated as N/A.
- For purposes of your NAP patient projection, a patient is an individual who is projected to have at least one visit in 2020 (projected data).
- Since a patient must have at least one documented visit, the number of patients cannot exceed the number of visits.

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 Form. For example, 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, Residents of Public Housing, 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 2020 (January 1 through December 31, 2020). This value will pre-populate in the corresponding cell within the table below. 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.

   New patient projections should be reasonable and achievable since, if funded, HRSA will hold you accountable for serving the projected number of patients in 2020. If you are a new applicant, this number becomes the Health Center Program (H80) grant patient target. If you are a satellite applicant, HRSA will add this number to your current patient target. Failure to achieve this projection by

December 31, 2020 may result in a funding reduction when your service area is next competed through SAC. See the Patient Target FAQs for more information.

2. The total number of unduplicated patients projected in 2020 (January 1 through December 31, 2020) will pre-populate from Item 1 above. Project the corresponding **total** number of visits in 2020 (January 1 through December 31, 2020). 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. Project the number of patients and visits anticipated within each service type category in 2020 (January 1 through December 31, 2020). If you are a satellite applicant, include only the new patients you propose to serve via the proposed NAP project.

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

3. Because the main purpose of the NAP project must be the provision of comprehensive primary medical care, the number of projected medical patients must be greater than the number of projected patients within each of the other service types.

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 1B: BPHC Funding Request Summary

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

For the Year 1 operational funding column, enter operational budget information by funding category (CHC, MHC, HCH, and/or PHPC). Only the types of health center programs selected in the Budget Summary (Section A) of the SF-424A will be available

in Form 1B. Next, enter any one-time funds requested for minor alteration/renovation and/or equipment (up to $150,000). The one-time funding request on Form 1B must be consistent with the federal request for equipment and/or construction in Section B on the SF-424A. The budget for Year 2 on Form 1B will be pre-populated from data that you entered in the Federal Resources (Section E) of the SF-424A.

You cannot modify the pre-populated data on this form. If changes are required, go to the appropriate section of the SF-424A to make changes. A link to the SF-424A is provided for navigation to the appropriate budget sections.

If you are requesting one-time funding for equipment and/or minor A/R, indicate if the one-time funds are for: 1) equipment only; 2) minor A/R with equipment; or 3) minor A/R without equipment. See Appendix D for detailed instructions on equipment and minor A/R requirements.

Form 1C: Documents on File

This form provides a summary of documents that support the implementation of Health Center Program requirements, as outlined in the Health Center Program Compliance Manual. It does not provide an exhaustive list of all types of health center documents (e.g., policies and procedures, protocols, legal documents). Provide the date that each document was last reviewed and, if appropriate, revised. Any document on Form 1C that is not in place or current should be included on the Operational Plan (Attachment 12) to ensure compliance with Health Center Program requirements. See Appendix C for more information on the Operational Plan.

The policies related to your Sliding Fee Discount Program, Quality Improvement/Assurance, and Billing and Collections – noted in the form with an asterisk (*) – must be evaluated by the health center board at least once every 3 years. For more information, review element d of Chapter 19: Board Authority of the Compliance Manual.

DO NOT submit these documents with the application. HRSA will review these documents as part of an Operational Site Visit and/or may request these for review post-award**.**

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

Form 2: Staffing Profile

Report personnel for the **first 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.
- Record volunteers in the Direct Hire FTEs column.
- If you propose to 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 include a number in the Direct Hire FTEs column for contracted staff.** Contracted staff should be summarized in Attachment 7: Summary of Contracts and Agreements.

Form 3: Income Analysis

Form 3 collects the projected patient services and other income from all sources (other than the Health Center Program grant funds) for the **first year** of the proposed project. Base Form 3 income on the proposed NAP site(s) only (i.e., do not include income from sites outside the proposed scope of project). Form 3 income is divided into two parts: (1) Patient Service Revenue - Program Income and (2) Other Income - Other Federal, State, Local, and Other Income.

Part 1: Patient Service Revenue – Program Income

Patient service revenue is income directly tied to the provision of services to health center 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. If you do not have an FQHC reimbursement rate for services provided to Medicaid and Medicare beneficiaries, you may contact your PCA to inquire about FQHC rates for service delivery programs that are similar in size.[38]

[38] For a listing of HRSA-supported PCAs, refer to HRSA's Strategic Partnerships website.

Only include patient service revenue associated with sites or services proposed in this application.

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. To determine where to count patients, note these examples:

- 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): All billable/reimbursable visits.[39] The value is typically based on assumptions about the amount of available clinician time, clinician productivity (visits per unit of time), and mix of billable visits by payer. Do not include billable services related to laboratory, pharmacy, imaging, and other ancillary services in this column. (See Ancillary Instructions under Payer Categories below.) Note other significant exclusions or additions in the Comment/Explanatory Notes box at the bottom of the form.

Note: The patient service income budget is primarily based on 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. Based on historical experience, you may choose to include some or all of this income in the income per visit assumption. 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, when available.

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

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 the Projected Income Column (d), along with the related data requested in Columns (a) through (e). You may estimate income for each service by multiplying the projected visits by assumed income per visit. For example, capitated managed care income may be based on member-month enrollment projections and estimated capitation rates for each plan, grouped by payer and added to the projected income. Enter the estimated visits associated with these managed care plans in Column (b).

Payer Categories (Lines 1 – 5): The five payer categories (Medicaid, Medicare, Other Public, Private, and Self-Pay) reflect 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, which is the 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-around payments, incentives, pharmaceutical reimbursements, 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, pharmaceutical reimbursements, and case management fee income.

Other Public (Line 3): Income not reported elsewhere from federal, state, or local government programs earned for providing services or pharmaceuticals. 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 services or pharmaceuticals. 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 (not including the NAP funding request). It includes other federal, state, local, and other income. It is income that is earned but not directly tied to visits, procedures, or other specific services. Income is to be classified based on the source of the revenue. 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 NAP 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, Facility Investment Program grants and others. The CMS 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; Special Supplemental Nutrition Program for 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:

- If you contract with the local Department of Health to provide services to the Department's patients, report all income earned under this contract on this line.
- 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 received directly from the municipality would be shown on this line.

Private Grants/Contracts (Line 10): Income from private sources, such as foundations, nonprofits, hospitals, nursing homes, drug companies, employers, other health centers, and similar entities. For example, if you operate a 340B pharmacy in part for your own patients and in part as a contractor to another health center, report the pharmacy income for your own patients in Part 1 under the appropriate payer categories 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 fundraising.

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 retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why your organization's funds (retained earnings) are needed to achieve a breakeven budget. Amounts from non-federal sources, combined with the Health Center Program funds, should typically be adequate to support 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 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 population and target population data for the entire scope of the project (i.e., all proposed NAP sites). All information provided regarding race and/or ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements. Data on race and/or ethnicity collected on this form will **not** be used as an awarding factor. 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.

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

If the target population includes a large number of transient individuals that are not included in the data set used for service area population data (e.g., census data), adjust the service area population numbers accordingly to ensure that the target population numbers are always less than or equal to the service area numbers. Explain significant adjustments in the NEED section of the Project Narrative.

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

Guidelines for Reporting Race

- 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.

- 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 – Persons who are choosing 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.

Form 5A: Services Provided

Identify how the required and any additional health services will be provided at the proposed NAP sites (i.e., direct by health center, formal written contract (health center pays for service), formal written referral arrangement). You must provide all required services either directly and/or through established contracts or referral arrangements without regard to ability to pay and on a sliding fee discount schedule. Additional services are not required. However, in order to be considered in-scope services, additional services must be provided in compliance with section 330 (e.g., provided without regard to ability to pay and on a sliding fee discount schedule). For more information, refer to Chapter 4: Required and Additional Health Services of the Compliance Manual.

Because comprehensive primary medical care is the main purpose of the NAP project, you must provide General Primary Medical Care either directly by the health center (Column I) and/or through formal written contractual agreements in which the health center pays for the service (Column II). You cannot provide General Primary Medical Care solely by referral (Column III) for the NAP project. This is an eligibility criterion.

Refer to the Service Descriptors for Form 5A: Services Provided for descriptions of the general elements for all required and additional services. Also see the Column Descriptors for Form 5A: Services Provided for descriptions of the three service delivery methods used by health centers and the specific requirements for using them. All contracts and referral arrangements for services noted on Form 5A as provided via Column II and/or III must be formal written contracts and arrangements, summarized in Attachment 7.

If the NAP project is funded, only the services included on Form 5A will be considered to be in the approved scope of project, regardless of what is described or detailed elsewhere in the application. Refer to the Scope of Project policy documents and resources for more information on services and modes of service delivery.

You cannot add specialty services to your scope of project at the time of NAP submission. However, after NAP funding has been awarded, you may request to add specialty services to the scope of project through the Change in Scope process.[40]

Note: All services must be accessible to all patients in the service area, though the mode of service delivery may be different across sites.

Form 5B: Service Sites

Complete Form 5B for each proposed NAP site[41] and provide the following required data:

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

You must propose **at least one** full-time (40 hours or more per week), permanent service delivery site that provides comprehensive primary medical care as its main purpose.[42] A permanent site is a fixed building location that provides services year-round. Subsequent service sites may be part-time, seasonal, etc.

If you are proposing to serve only migratory and seasonal agricultural workers, you may propose a full-time seasonal (instead of permanent) service delivery site that operates

[40] See PIN 2009-02: Specialty Services and Health Centers' Scope of Project.
[41] Proposed service sites must meet the definition of a service site according to PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes.
[42] Current Health Center Program look-alikes must add all sites into H80 scope within 120 days through a change in scope request if all sites are not added through the FY19 NAP application.

at least 40 hours per week and provides comprehensive primary medical care as its main purpose.

Proposed NAP sites must not be located in the same building as any site already in the approved scope of project of any Health Center Program award recipient or look-alike.[43] This is an eligibility criterion.

Include the zip codes for the area served by the site on each Form 5B. The zip code of the site address must be included in the service area zip codes on Form 5B. Your entire service area for the NAP project (as described on Form 4 and in the Project Narrative) should be represented by the consolidation of all zip codes across all proposed service sites (all 5B forms). The zip codes listed in the Service Area Zip Codes field for service and administrative/service delivery sites on Form 5B will be used to determine the NAP service area, UNS, and priority points. See Section V.2 for more information about priority points.

If the NAP project is funded, only the site information included on Form 5B will be considered to be in the approved scope of project, regardless of what is described or detailed elsewhere in the application.

For additional instructions for each field of Form 5B, see the NAP Technical Assistance website. In the Site Qualification Criteria, indicate if the site is a Domestic Violence site (e.g., emergency shelter). Select "yes" for this question only if the site serves victims of domestic violence and the street address cannot be published to protect the confidentiality of the precise location.

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

Form 5C: Other Activities/Locations (as applicable)

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

- Do not meet the definition of a service site;[44]
- Are conducted on an irregular timeframe/schedule; and/or
- Offer a limited activity from within the full complement of health center activities in the scope of project.[45]

[43] A current Health Center Program look-alike may propose the site(s) currently included in its Health Center Program look-alike scope of project, as well as new site(s).
[44] See PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes.
[45] Refer to the Scope of Project technical assistance page for more information.

Form 6A: Current Board Member Characteristics

The list of board members will be pre-populated for satellite applicants. **Update pre-populated information as appropriate.**[46] Public agencies with co-applicant health center governing boards must list the co-applicant board members.

Complete or update the following information:

- List all current board members (minimum of nine; maximum of 25). Do not list non-voting board members (e.g., PD/CEO, advisory board members).
- List each board member's board office position held, if applicable (e.g., Chair, Treasurer) and area of expertise (e.g., finance, education, nursing).
- Indicate if each board member derives more than 10 percent of income from the health care industry.
- Indicate if each board member is a health center patient. 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 each board member lives and/or works in the service area.
- Indicate if each board member is a representative from/for a special population (i.e., people experiencing homelessness, migratory and seasonal agricultural workers and families, residents of public housing).
- Indicate gender, ethnicity, and race of board members who are patients of the health center.

Note:

- Indian tribes or tribal, Indian, or urban Indian organizations are not required to complete this form, but may 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

This form is only applicable if you are proposing to serve **only** special populations (i.e., HCH, MHC, and/or PHCP). 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 satellite applicant that wishes to continue an existing waiver, or a new applicant that wishes to request a waiver of the 51 percent patient majority board composition requirement, you must complete this form. Present a "good cause"

[46] Refer to Chapter 20: Board Composition of the Compliance Manual.

justification describing the need for a waiver of the patient majority board composition requirement, including:

- The unique characteristics of the special population or service area that create an undue hardship in recruiting a patient majority.
- Attempts to recruit a majority of special population board members and why these attempts have not been successful.
- Strategies that will ensure patient participation and input in the direction and ongoing governance of the health center 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 progress in meeting goals and 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 a) subrecipient agreements or b) agreement for the majority of health care providers.

Subrecipient agreements must require compliance with section 330 program requirements in order for the services and/or the site to be considered within the scope of the 330 project.

Refer to Uniform Guidance 2 CFR part 200 as codified by HHS at 45 CFR part 75 for more information on the characteristics of a subaward.[47] Under 45 CFR 75.2, "a subaward may be provided through any form of legal agreement, including an agreement that the pass-through entity considers a contract."

If either question 1 or 2 are answered "Yes" in Part I, you must upload the associated agreement(s) in Part II. Ensure all agreements uploaded provide the required details as listed in Chapter 12: Contracts and Subawards, Demonstrating Compliance Elements f and h of the Compliance Manual.

[47] For purposes of the Health Center Program, contracting for substantive programmatic work does not include the acquisition of supplies, material, equipment, or general support services. However, it does apply to contracting for the entire key management team or the majority of health care providers with a single entity.

Form 10: Emergency Preparedness Report

Select the appropriate responses regarding emergency preparedness.

Form 12: Organization Contacts

Data will pre-populate for satellite applicants to revise as necessary. 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

The Summary Page is used to verify key application data used by HRSA when reviewing the NAP applications. Content will be pre-populated from the Program Specific Forms. If the pre-populated data appear incorrect, verify that the pertinent data provided in the Program Specific Forms (1A, 1B, 2, and 5B) were entered correctly.

Proposed NAP site(s) and service area zip codes will pre-populate from Form 5B: Service Sites. If funded, you will be held accountable for verifying ALL proposed sites are open and operational within 120 days of Notice of Award. Use this section of the form to verify that the correct sites have been proposed, the correct service area zip codes have been proposed, and all proposed sites have street addresses. The zip codes listed on Form 5B (service and administrative/service delivery sites only) will be used to determine the NAP service area, UNS, and priority points. Zip codes entered for administrative-only sites will not be considered when determining the UNS and priority points.

The UNS automatically calculates a standardized unmet need score that represents the aggregate unmet need across all proposed service area zip codes. The UNS is worth up to 20 points in your overall application score. Carefully review your service area zip codes and corresponding UNS for accuracy. More information on UNS can be found on the NAP Technical Assistance website.

The total number of unduplicated patients projected to be served in 2020 (January 1 – December 31, 2020) will be pre-populated from Form 1A: General Information Worksheet. If funded, you will be held accountable for meeting the **unduplicated** patient projection (from the Total line under Unduplicated Patients and Visits by Population Type on Form 1A: General Information Worksheet) and any future or other supplemental funding patient commitments by December 31, 2020. HRSA will use 2020 UDS data to assess achievement of your patient target. Use this section of the form to verify that the total number of unduplicated patients projected to be served is realistic and appropriate based on the proposed NAP project.

Note that the population funding percentages (i.e., percentage of funding requested for CHC, MHC, HCH, and/or PHPC) will be based on operational funds requested for Year

2 and will therefore not include any one-time funding requested. The system will automatically calculate the population funding percentages and federal dollars per patient. The federal dollars per patient is calculated by dividing the federal dollar amount requested by the projected number of unduplicated patients projected to be served in 2020 by population type entered on Form 1A. Use this section of the form to verify that each year of the NAP funding request is appropriately budgeted by population type and reasonable for the number of patients projected to be served.

You must certify that:

- You have double-checked all information provided to ensure accuracy, including the UNS.
- The main purpose of your NAP project is to provide comprehensive primary medical care for all underserved individuals in the targeted service area or population.
- You have consulted with appropriate State and local government agencies and health care providers regarding the need for the health services to be provided at the proposed NAP site(s).

You will be held accountable for:

- Having **all proposed sites** (from Form 5B) open and operational within 120 days of Notice of Award.
- Meeting the calendar year 2020 **unduplicated patient projection** (from Form 1A) by December 31, 2020.
- Submitting a Compliance Achievement Plan within 120 days of Notice of Award which outlines steps you will take to meet the Health Center Program requirements (if you are a new applicant or a look-alike with unresolved conditions on your Notice Look-alike Designation related to Health Center Program requirements).

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. Goals should be measure-specific and informed by contributing and restricting factors affecting achievement. 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 NAP Technical Assistance website, including the Performance Measure Crosswalk and Clinical Performance Measure Form Field Guide and Sample. Refer to the UDS Manual for specific measurement details such as exclusionary criteria.

Required Clinical Performance Measures

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

Required Financial Performance Measures

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

Important Details about the Performance Measures Forms

- The Clinical and Financial Performance Measures should address ONLY the service area and target population of the proposed new access point(s).
    - If you are a new applicant, complete the performance measures based on the entire proposed scope of your NAP project.
    - If you are a satellite applicant, complete the performance measures based on your proposed new access point(s) only.

- If you only provide preventive dental services via a formal referral arrangement (Form 5A, Column III), you may set the goal for the Dental Sealants for Children performance measure as 0 and track at least one self-defined Oral Health performance measure. Refer to the Frequently Asked Questions on the NAP Technical Assistance website for recommended self-defined measures.

- Develop baselines for performance measures from data that are valid, reliable, and whenever possible, derived from current information management systems. If baselines are not yet available, enter 0 for the numerator and denominator and state in the comments field the date when baseline data will be available.

- If you are applying for funds to serve special populations (i.e., MHC, HCH, PHPC), you **must include** additional clinical performance measures that address the unique health care needs of these populations. 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…"*

- 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 and progress must be tracked over time.

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 the NAP Technical Assistance website.
- Consider your UDS Health Center Trend Report and/or Summary Report if you are a satellite applicant. For help with accessing reports in HRSA EHBs, contact Health Center Program Support at https://www.hrsa.gov/about/contact/bphc.aspx.

Appendix C: Operational Plan

As noted in Item 4 of the RESPONSE section of the Project Narrative, the Operational Plan outlines the steps you will take to ensure that **all proposed sites** will begin operating and delivering services within 120 days of award and your health center will be compliant with Health Center Program requirements within 120 days of award. Your plan must be specific to the proposed NAP project, with appropriate and reasonable time-framed goals and action steps necessary to achieve the following within 120 days of the Notice of Award:

1. 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, as described on Forms 5A: Services Provided and 5C: Other Activities/Locations. If required services are provided by contract or referral, specify action steps and timeframes for the development of these formal arrangements.

2. Your health center must be compliant with all Health Center Program requirements detailed in the Compliance Manual. If funded, HRSA will assess your compliance during an Operational Site Visit.

Key Elements of the Operational Plan

Element	Description
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 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.

In your Operational Plan, include activities for the Focus Areas subcomponents listed on the sample Operational Plan, or develop your own, as appropriate. If you are currently operational and compliant with Health Center Program requirements, demonstrate your compliance in the Operational Plan and highlight proposed changes in access to care, such as planned service expansion and outreach activities, new collaborations or partnerships, and any other changes that would occur as a result of the NAP funding.

A sample Operational Plan is provided on the NAP Technical Assistance website. Use the Compliance Manual and Site Visit Protocol to assess your compliance with Health Center Program requirements.

Appendix D: One-Time Funding Request Information

Within the maximum annual amount of $650,000, you may request to use up to $150,000 in funding in Year 1 for one-time costs for equipment and/or minor alteration/renovation (A/R). If requesting one-time funding, you must enter the amount on the SF-424A Budget Information Form in the Equipment and/or Construction object class categories and on Form 1B.

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

One-time funding cannot be used for new construction activities (e.g., additions or expansions, work that requires ground disturbance such as new parking surfaces or expansion of a building footprint), the installation of trailers/pre-fabricated modular units, or major A/R. For a minor A/R activity, the total federal and non-federal cost of the project cannot exceed $500,000, excluding the cost of moveable equipment.

Equipment includes moveable items that are non-expendable, tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of (a) the capitalization level established by the applicant for its financial statement purposes, or (b) $5,000. Moveable equipment can be readily shifted from place to place without requiring a change in the utilities or structural characteristics of the space. Dental chairs and radiographic equipment are considered moveable equipment.

Permanently affixed equipment (e.g., heating, ventilation, and air conditioning (HVAC), generators, signs in or on the existing building, and lighting) is considered fixed equipment and is categorized as minor A/R (not equipment).

An allowable minor A/R project must be a stand-alone project consisting of work in an existing facility required to:

- Install fixed equipment;
- Modernize, improve, and/or reconfigure the interior arrangements or other physical characteristics of a facility;
- Repair and/or replace the exterior envelope;
- Improve accessibility such as curb cuts, ramps, or widening doorways; and/or
- Address life safety requirements.

If you are requesting one-time funding, you must complete the Equipment List Form (if proposing equipment), and the A/R Project Cover Page and Other Requirements for Sites forms (if proposing minor A/R). See the One-Time Funding section of the NAP Technical Assistance website for detailed instructions for the required forms and attachments.