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

Bureau of Primary Health Care
Health Center Program

Affordable Care Act New Access Point Grants

Announcement Type: New and Supplemental/Revision
Announcement Number: HRSA-15-016

Catalog of Federal Domestic Assistance (CFDA) No. 93.527

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2015

Application Due Date in Grants.gov:
August 20, 2014

Supplemental Information Due Date in EHB:
October 7, 2014

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

Release Date: July 8, 2014
Issuance Date: July 8, 2014

August 13, 2014: Modification (pg. 66) includes clarification to "Note: Core Barrier D: Distance or Travel Time to Nearest Primary Care Provider Accepting New Medicaid and Uninsured Patients is not calculated based on population. For Core Barrier D, distance/time is measured from the proposed site to the nearest provider accepting new Medicaid and uninsured patients."

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

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

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Bureau of Primary Health Care, is accepting applications for fiscal year (FY) 2015 New Access Point (NAP) grants under the Health Center Program, authorized by section 330 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254b). The purpose of this grant program is to support new service delivery sites under the Health Center Program to provide comprehensive primary health care services to underserved and vulnerable populations. The source of funding for this opportunity is the Patient Protection and Affordable Care Act (P.L. 111-148), Section 10503.

Applications for NAP funding must demonstrate a high level of unmet need within their service area/target population, present a sound proposal to meet this need consistent with the requirements of the Health Center Program, and demonstrate collaborative and coordinated delivery systems for the provision of health care to the underserved. Further, applicants are expected to demonstrate that the NAPs will increase access to comprehensive, culturally competent, quality primary health care services and improve the health status of underserved and vulnerable populations in the area to be served.

Funding Opportunity Title:	Affordable Care Act New Access Point Grants
Funding Opportunity Number:	HRSA-15-016
Application Due Dates/Times:	In Grants.gov: August 20, 2014 by 11:59 PM ET In EHB: October 7, 2014 by 8:00 PM ET
Anticipated Total Annual Available Funding:	$100 million
Estimated Number and Type of Awards:	150 grants
Estimated Award Amount:	Up to $650,000 per year
Cost Sharing/Match Required:	No
Length of Project Period:	Two years
Project Start Date:	May 1, 2015
Eligible Applicants: (See Section III-1 of this FOA for complete eligibility information.)	Eligible applicants must be public or nonprofit private entities, including tribal, faith-based, and community-based organizations. Applications may be submitted by new organizations or organizations currently receiving operational grant funding under the Health Center Program. Applicants may not apply on behalf of another organization (i.e., the applicant on the SF-424 submitted in Grants.gov must be the organization that will carry out the proposed project). Applicants must propose a new access point that: a. Provides comprehensive primary medical care as its primary purpose. b. Provides services, either directly onsite or through established arrangements, without regard to ability to pay. c. Ensures access to services for all individuals in the service area/target population.

	d. Provides services at one or more permanent service delivery sites. Applicants must demonstrate compliance with the requirements of section 330 of the PHS Act, as amended and applicable regulations. Program requirements are available in Appendix F and at http://bphc.hrsa.gov/about/requirements.

Summary of Changes

HRSA has revised the NAP FOA to streamline and clarify the application instructions. Compared to the FY 2013 FOA, the following changes should be noted:

- Eligibility criterion clarified: An applicant may not apply on behalf of another organization.
- Organizations that received initial Health Center Program funding in FY 2013 or 2014 are eligible to apply for NAP funding if at least one site has been verified operational by the application submission date.
- Clarification that Health Center Program look-alikes can propose any/all of their existing sites as part of the NAP application.
- Minor enhancements to the Project Narrative and Review Criteria sections.
- Form 2: Staffing Plan has been updated to include a column to report staff expenses to be charged to the NAP grant (i.e., requested federal dollars).
- Form 3: Income Analysis has been revised to simplify the reporting of projected income.
- Form 6B: Request for Waiver of Governance Requirements has been removed from the application. If funded, grantees may request governance waiver(s) post-award.
- The prenatal and perinatal performance measures are now required for all applicants. See Appendix B for details.
- The childhood immunization and cancer screening performance measures have been updated per Program Assistance Letter 2013-02 available at http://bphc.hrsa.gov/policiesregulations/policies/pal201302.html.
- The Tobacco Use Assessment and Tobacco Cessation Counseling performance measures have been combined into one measure for Tobacco Use Screening and Cessation.
- New Clinical Performance Measures have been added for depression screening and HIV follow up.
- Addition of a checklist for noting compliance with Health Center Program requirements.
- The SF-424A Budget Categories form has been changed to capture details on the federal funding request and non-grant revenue supporting the project.
- The budget justification must explain the costs of each line item within each object class category based on the SF-424A Budget Categories form that details the federal section 330 funding request and non-federal funding separately. It must also provide information on each staff position to be supported with federal section 330-grant funding. See Appendix E for details.
- Addition of priority points for eligible applicants that are designated as Health Center Program look-alikes.
- Administrative and National Policy Requirements have been deleted and reference made to the *HRSA Electronic Submission User Guide* which describes the requirements.

Application Submission
HRSA uses a two-tier submission process for NAP applications via Grants.gov and HRSA Electronic Handbooks (EHB).

> **Step 1 – Grants.gov:** Must be completed and successfully submitted by 11:59 PM ET on August 20, 2014.
>
> **Step 2 – HRSA EHB:** Must be completed and successfully submitted by 8:00 PM ET on October 7, 2014.

Please Note: Applicants can only begin Step 2 in HRSA EHB after Step 1 in Grants.gov has been completed (no later than the due date) and HRSA has assigned the application a tracking number. Applicants will be notified by email when the application is ready within HRSA EHB for the completion of Step 2. This email notification will be sent within 7 business days of the Step 1 submission. Refer to http://www.hrsa.gov/grants/apply/userguide.pdf (HRSA Electronic Submission User Guide) for more details.

To ensure adequate time to successfully submit the application, HRSA recommends that applicants register immediately in Grants.gov and HRSA EHB. The Grants.gov registration process can take up to one month. For Grants.gov technical assistance, refer to http://www.grants.gov or call the Grants.gov Contact Center at 1-800-518-4726. For information on registering in HRSA EHB, refer to http://www.hrsa.gov/grants/apply/userguide.pdf or call the HRSA Contact Center at 1-877-464-4772. If these registration processes are not complete, you will be unable to submit an application. **HRSA recommends that applications be submitted in Grants.gov as soon as possible to ensure that maximum time is available for providing the extensive supplemental information required in HRSA EHB.**

Per section 330(k)(3)(H) of the PHS Act, as amended (42 U.S.C. 254b(k)(3)(H), as amended), the health center governing board must approve the health center's annual budget and all grant applications. In addition, the applicant's authorized representative (most often the Executive Director, Program Director, or Board Chair), must electronically submit the SF-424 included in the application package. This form certifies that:

- the application has been reviewed and authorized by the governing board,
- all application content, including the federal and non-federal budget presentation, accurately supports the project, and
- the applicant will comply with the required assurances and resulting terms if a NAP grant is awarded.

The electronic signature in Grants.gov (created when the Grants.gov forms are submitted) is the official signature when applying for a NAP grant and is considered binding. Selection of the responsible person must be consistent with responsibilities authorized by the organization's bylaws. **HRSA requires that for any authorized representative who submits an SF-424 electronically, a copy of the governing board's authorization permitting that individual to submit the application as an official representative must be on file in the applicant organization's office.**

Pre-Application Conference Call
HRSA will hold a pre-application conference call to provide an overview of this FOA and offer an opportunity for organizations to ask questions. For the date, time, dial-in number, and other information for the call, visit http://www.hrsa.gov/grants/apply/assistance/nap.

Application Contacts
If you have questions regarding the FY 2015 NAP application and/or the review process described in this FOA, refer to Section VII to determine the appropriate agency contact.

Table of Contents

I. Funding Opportunity Description

1. Purpose

This announcement solicits applications for New Access Point (NAP) grants under the Health Center Program. The FOA details the eligibility requirements, review criteria, and awarding factors for organizations seeking a grant for operational support under the Health Center Program.

The purpose of this Health Center Program grant is to support NAPs for the delivery of comprehensive primary health care services to underserved and vulnerable populations. NAPs will increase access to comprehensive, culturally competent, quality primary health care services and improve the health status of underserved and vulnerable populations in the area to be served.

Health Center Program grants support a variety of community-based and patient-directed public and private nonprofit organizations that serve an increasing number of the Nation's underserved. Individually, each health center plays an important role in the goal of ensuring access to services, and combined, they have had a critical impact on the health care status of medically underserved and vulnerable populations throughout the United States and its territories. Targeting the Nation's neediest populations and geographic areas, the Health Center Program currently funds 1,280 health centers that operate more than 9,300 service delivery sites in every state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. In 2012, more than 21 million patients, including medically underserved and uninsured patients, received comprehensive, culturally competent, quality primary health care services through the Health Center Program.

2. Background

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

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

For purposes of this FOA, a new access point is a new, full-time (operational a minimum of 40 hours per week), permanent (with the exception of Migrant Health Centers, which may be seasonally operated) service delivery site for the provision of comprehensive primary and preventive health care services. New access points improve the health status and decrease health disparities of the medically underserved and vulnerable populations and address the barriers to affordable and accessible primary health care services for the specific population and/or

community targeted by the application. Every NAP application must demonstrate compliance with the requirements of section 330 of the PHS Act, as amended, and applicable regulations (or have a thorough plan detailing necessary actions the applicant has committed to undertake to become compliant within 120 days of the Notice of Award). Applicants may submit a request for Federal support to establish a single new access point or multiple access points in a single NAP application.

Applications may be submitted for consideration from new organizations (new start applicants) or Health Center Program grantees currently receiving operational funding (satellite applicants):

- A **NEW START** applicant is an organization that is not currently a direct recipient of operational grant support under the Health Center Program (authorized by section 330(e), (g), (h) and/or (i) of the PHS Act). A new start application should address the entire scope of the project being proposed for NAP grant support. A new start can be operational at the time of application, or propose to become operational within 120 days of the Notice of Award.

- A **SATELLITE** applicant is an organization that is currently receiving direct operational grant support under the Health Center Program (authorized by section 330(e), (g), (h), and/or (i) of the PHS Act). Satellite applicants must propose to establish a *new* service site that is not listed in the applicant's approved scope of project under the Health Center Program at the time of application. Satellite applicants may not request funding to support the expansion or addition of services, programs, or staff at any site listed as being a part of their approved scope of project. A satellite application should address ONLY the service area and target population of the proposed new access point (i.e., only the new site and service area/target population proposed in the satellite application) in terms of need, population to be served, and the proposed new delivery system.

NAP applicants may propose to establish a school-based health center for the delivery of primary care services as long as it (a) is a permanent, full time site, or is in addition to a permanent, full time site proposed in the application, and (b) provides all required primary and preventive health care services to students of the school as well as the general underserved population in the service area without regard for ability to pay. Applicants may propose a mobile medical van as a new access point only if a permanent, full-time site is also proposed in the NAP application. A permanent site is a fixed building location. A mobile van must be affiliated with a location setting (i.e., a permanent or seasonal service site), and be fully equipped and staffed by health center clinicians providing direct primary care services. Proposals to expand the operation of an existing mobile van within the current scope of project (e.g., add new providers or services, expand hours of operation at current locations) are <u>NOT</u> eligible for consideration for NAP funding.

Program Requirements

Applicants must demonstrate that the new access point(s) will increase access to comprehensive, culturally competent, quality primary health care services and improve the health status of underserved and vulnerable populations in the service area. In addition, applicants must document a high level of need, a sound plan to meet this need, and readiness to implement the

proposed plan. Further, applicants must demonstrate that the plan maximizes established collaborative and coordinated delivery systems for the provision of health care to the underserved.

All applicants are expected to demonstrate:

- **Compliance** at the time of application with the requirements of section 330 of the PHS Act, as amended, and applicable regulations (or a detailed plan demonstrating the necessary actions to become compliant within 120 days of the Notice of Award – see Appendix C). See Appendix F for a summary of the Health Center Program requirements or visit http://bphc.hrsa.gov/about/requirements/index.html.

  Community Health Center (CHC) Applicants:
  - Ensure compliance with section 330(e) and program regulations.
  - Provide a plan that ensures the availability and accessibility of required primary and preventive health services to underserved populations in the service area.

  Migrant Health Center (MHC) Applicants:
  - Ensure compliance with section 330(g), section 330(e), and, as applicable, program regulations.
  - Provide a plan that ensures: (1) the availability and accessibility of required primary and preventive health services to migratory and seasonal agricultural workers and their families in the service area; with *migratory agricultural workers* meaning individuals principally employed in agriculture on a seasonal basis within the last 24 months who establish temporary housing for the purpose of this work; with *seasonal agricultural workers* meaning individuals employed in agriculture on a seasonal basis, who are not also migratory; and with *agriculture* meaning farming in all its branches, as defined by the OMB-developed North American Industry Classification System (NAICS) under the following codes and all sub-codes within – 111, 112, 1151, and 1152.

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

  Public Housing Primary Care (PHPC) Applicants:
  - Ensure compliance with section 330(i), section 330(e), and, as applicable, program regulations.

  - Provide a plan that ensures the availability and accessibility of required primary and preventive health services to residents of public housing and individuals living in areas immediately accessible to such public housing. Public housing means agency-developed, owned, or assisted low-income housing, including mixed finance projects, but excludes 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.

- Evidence that the proposed new access point(s) will serve populations in **high need areas**. Applicants must submit a completed Need for Assistance (NFA) Worksheet (see instructions in Appendix A for Form 9) to demonstrate the relative need for primary health care services.

- Evidence of how the proposed project will **increase access to primary health care services, improve health outcomes, and reduce health disparities** in the community/population to be served. The applicant must demonstrate how Health Center Program funds will expand services and increase the number of people served through the establishment of a permanent, full-time service delivery site (i.e., a site that is not currently part of any Health Center Program grantee's scope of project).

- Evidence that **all persons in the target population will have access to the full range of required primary, preventive, and enabling health care services, including oral and behavioral health care**, either directly onsite or through established arrangements without regard to ability to pay.

- Evidence of the development of **collaborative and coordinated delivery systems** for the provision of health care to the underserved through the demonstration of current or proposed partnerships and collaborative activities with health centers (Health Center Program grantees and look-alikes), rural health clinics, critical access hospitals, State and local health services delivery projects, and other programs serving the same population(s).

- **A sound and complete plan** that demonstrates responsiveness to the identified health care needs of the target population(s), appropriate short- and long-term strategic planning, coordination with other providers of care, organizational capability to manage the proposed project, and cost-effectiveness in addressing the health care needs of the target population.

- **A reasonable, appropriate budget** based on the activities proposed in the application and the number of new individuals to be served. The budget must demonstrate how section 330 funds will expand existing primary health care service capacity to currently underserved populations. (See Section IV and Appendix E for instructions on the presentation of the budget.)

- **Readiness to initiate the proposed project plan.** Applicants are expected to demonstrate that the proposed new access point(s) will be operational and providing services in the community/population within 120 days of the Notice of Award. At a minimum, within 120 days of the Notice of Award, (1) each proposed facility will be operational and begin providing services for the proposed population/community, (2) providers will be available to serve patients at each proposed new access point, and (3) the health center will be compliant with all Health Center Program requirements (see Appendix F). Full operational capacity as outlined in the NAP application, including service to the number of patients projected in the NAP application, must be achieved within the two-year project period.

Failure to meet these program requirements and expectations may jeopardize Health Center Program grant funding per 45 CFR 74.62(a). Grantees are routinely assessed for compliance with the program requirements. When an issue is identified (e.g., an organization fails to become operational in 120 days), a condition is placed on the award and the grant moves into progressive action. The progressive action process provides a time-phased approach for resolution of compliance issues. Failure to successfully resolve conditions via progressive action may result in the withdrawal of support through the cancellation of all or part of the grant award. See Program Assistance Letter 2014-08: Health Center Program Requirements Oversight.

II. Award Information

1. Type of Award

Funding will be provided in the form of a grant.

2. Summary of Funding

This program will provide funding for Federal fiscal years 2015-2016. Up to $100 million is expected to be available annually to fund approximately 150 grantees at a level not to exceed $650,000 per year. The project period is two years. Funding beyond the first year is dependent on the availability of appropriated funds in subsequent years, compliance with applicable statutory and regulatory requirements, demonstrated organizational capacity to accomplish the project's goals, and a determination that continued funding is in the best interest of the Federal government. NAP awards are subject to restrictions (e.g., salary limitation) based on appropriations provisions. Such determinations are made through the annual appropriations process.

HRSA has established an **annual ceiling of $650,000** for Health Center Program funding for NAP grants. The ceiling is the **maximum amount of funding** that can be requested annually in a NAP grant application regardless of the number and/or type of new access points to be supported and/or populations to be served through the application. The total request for Health Center Program grant support MUST NOT exceed the established annual ceiling of $650,000 in Year 1 or Year 2. Applications that present a request for support in excess of the established annual ceiling in either year will be considered ineligible for review.

Of the $650,000, applicants may request Health Center Program grant funding up to $150,000 in Year 1 only for one-time minor capital costs for equipment and/or minor alterations/renovations (see Appendix D).

It is possible that not all applicants approved and funded will receive the maximum grant support. Federal funding levels will be reviewed prior to a final funding decision and may be adjusted based on the organization's past performance and/or an analysis of experience related to patient projections, operating costs, utilization, provider staffing, and revenue generation. Federal funding levels may also be adjusted based on analysis of the budget and cost factors. See Appendix E for budget presentation instructions.

III. Eligibility Information

1. Eligible Applicants

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

Note: It is very important that applicants correctly identify their application type.

- New Start: An organization that does not currently receive Health Center Program operational grant funding. Select "New" on Application Form SF-424.
- Satellite: An organization that currently receives Health Center Program operational grant funding. Select "Revision" on Application Form SF-424 (see detailed instructions in Section IV.2.i).

1. Applicant is a public or nonprofit private entity, including tribal, faith-based, and community-based organizations. Applicant demonstrates current status by submitting:
   - Signed articles of incorporation (Attachment 9) AND
   - Proof of nonprofit status or proof of public agency status (Attachment 12).

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

3. Applicant proposes a new access point project (across all proposed sites) that:
   a) Provides comprehensive primary medical care as its main purpose as documented on Form 1A: General Information Worksheet (number of projected medical patients is greater than projected patients for other service types).
   b) Provides services without regard to ability to pay either directly onsite or through established arrangements as documented on Form 5A: Services Provided.

c) Ensures access to services for all individuals in the targeted service area or population (e.g., cannot exclusively serve a single age group (e.g., children or geriatric), racial/ethnic group, or health issue/disease category (e.g., HIV/AIDS)).

4. Applicant proposes at least one new access point that is a permanent service delivery site that provides comprehensive primary medical care as its main purpose and operates for a minimum of 40 hours per week as documented on Form 5B: Service Sites. A permanent site is a fixed building location. A mobile van is not considered a permanent site.

5. Application proposes to establish a new access point that is not currently a site in the approved scope of project of any Health Center Program grantee[1], based on Form 5B. In other words, the application **DOES NOT** propose:
   - funding to support the relocation or consolidation of currently approved sites,
   - the expansion of capacity (e.g., additional providers, additional patients, new services, new populations) at any site already in any Health Center Program grantee's approved scope of project, including those pending verification via Change in Scope or capital development grants (i.e., Capital Development or Building Capacity), or
   - a site proposed through an active Change in Scope request or Health Center Program (H80) funding opportunity at the time of application.

   Tools are available to assist applicants in determining current Health Center Program grantee sites and the location of safety-net service providers in their proposed service area, including the UDS Mapper (http://www.udsmapper.org) and Find a Health Center (http://findahealthcenter.hrsa.gov).

6. Applicant requests annual Health Center Program funding (as presented on the SF-424A) that **DOES NOT** exceed the established annual ceiling of $650,000 in Years 1 or 2.

7. Applicant adheres to the **200-page limit** on the length of the application when printed by HRSA. See Tables 1-5 for specific information regarding the documents included in the 200-page limit.

8. *NEW START APPLICANTS ONLY*: Applicant proposes to serve a defined geographic area that is federally-designated, in whole or in part, as a Medically Underserved Area (MUA) or Medically Underserved Population (MUP). If the area is not currently federally-designated as an MUA or MUP, the applicant must provide documentation that a request for designation has been submitted; designation must be received prior to a final HRSA FY 2015 NAP funding decision. *Note: If the applicant is requesting funding only for MHC, HCH, and/or PHPC, the applicant is not required to have a MUA/MUP designation for the proposed service area and/or target population. See Section I.3 for definitions of the MHC, HCH, and PHPC populations.*

[1] A current Health Center Program look-alike may propose the site(s) currently included in its Health Center Program look-alike scope of project, as well as new site(s), since look-alikes do not receive Health Center Program grant funding.

***Note: SATELLITE APPLICANTS ONLY*: Organizations that received initial Health Center Program funding in FY 2013 or 2014 are eligible to apply for New Access Point funding only if at least one proposed site has been verified operational by the application submission date.**

2. Cost Sharing/Matching

Cost sharing or matching is not a requirement for this funding opportunity. Under 42 CFR 51c.203, HRSA will take into consideration whether and to what extent an applicant plans to secure and maximize Federal, state, local, and private resources to support the proposed project. See Appendix E for guidelines pertaining to the budget presentation.

3. Other

Applications that exceed the page limit referenced in Section IV.2, exceed the ceiling amount, or fail to satisfy the deadline requirements referenced in Section IV.3 will be deemed non-responsive and will not be considered for funding.

NOTE: Multiple applications from an organization are not allowable. If more than one NAP application is submitted, HRSA will only accept the last application received in Grants.gov before the deadline and its corresponding application components submitted in HRSA EHB.

Supplement Not Supplant
Grants awarded for Health Care for the Homeless and Public Housing Primary Care projects must supplement and not supplant the expenditures of the health center and the value of in kind contributions for the delivery of services to these populations (see Sections 330(h)(3) and 330(i)(2) of the Public Health Service Act).

IV. Application and Submission Information

1. Address to Request Application Package

Application Materials and Required Electronic Submission Information
HRSA ***requires*** applicants for this funding opportunity announcement to apply electronically through Grants.gov and HRSA EHB. Applicants must download the SF-424 application package associated with this funding opportunity and follow the directions provided at Grants.gov and included in the *HRSA Electronic Submission User Guide*, available online at http://www.hrsa.gov/grants/apply/userguide.pdf.

Grants.gov
To submit an application electronically, use the APPLICANTS section at http://www.grants.gov. To download a copy of the application package and FOA, search grant opportunities using the funding opportunity number HRSA-15-016. Complete the application package off-line, and then upload and submit the application via Grants.gov. See Table 1 for the application components required to be submitted in Grants.gov.

It is essential that each organization ***immediately register*** in Grants.gov and become familiar with the Grants.gov application process. The registration process must be complete in order to submit an application. Applicants must first register in the System for Award Management (SAM) before registering in Grants.gov. **SAM registration must be updated every 12 months.** As registration may take up to one month, start the process as soon as possible. Instructions on how to register, tutorials, and FAQs are available on the Grants.gov Web site at http://www.grants.gov/web/grants/applicants.html. Assistance is also available from the Grants.gov Contact Center 24 hours a day, 7 days a week (excluding Federal holidays) at support@grants.gov or 1-800-518-4726.

2. Content and Form of Application Submission

HRSA uses a two-tier submission process for NAP applications via Grants.gov and HRSA Electronic Handbooks (EHB).

> **Step 1 – Grants.gov:** Must be completed and successfully submitted by 11:59 PM ET on August 20, 2014.
>
> **Step 2 – HRSA EHB:** Must be completed and successfully submitted by 8:00 PM ET on October 7, 2014.

Only applicants who successfully submit an application in Grants.Gov (Step 1) by the due date may submit the required additional information in HRSA EHB (Step 2). You must track your application using the Grants.gov tracking number (GRANTXXXXXXXX) provided in the confirmation email from Grants.gov. See http://www.grants.gov/web/grants/applicants/track-my-application.html. Be sure the application is validated by Grants.gov prior to the Grants.gov application deadline.

Note: Applicants can only begin Step 2 in HRSA EHB after Step 1 in Grants.gov has been completed (no later than the due date/time) and HRSA has assigned the application a tracking number. Applicants will be notified by email when the application is ready within HRSA EHB for the completion of Step 2. This email notification will be sent within 7 business days of the Step 1 submission.

The *HRSA Electronic Submission User Guide* provides general instructions for application submission. You must submit the information outlined in the Guide in addition to the program specific information below. All applicants are responsible for reading and complying with the instructions included in the *HRSA Electronic Submission User Guide* except where instructed in this funding opportunity announcement to do otherwise.

Application Page Limit
The total size of all uploaded files may not exceed the equivalent of 200 pages when printed by HRSA. See Tables 1-5 for information about the application components included in the page limit. **Electronic submissions are subject to an automated page count, and those exceeding the limit are automatically rejected.**

Applications must be complete, within the 200-page limit, and submitted prior to the deadline to be considered under this announcement.

HRSA EHB
To submit the application in HRSA EHB, the Authorizing Official (AO) and other application preparers must register in EHB at https://grants.hrsa.gov/webexternal/home.asp.

Once an individual is registered, the user can search for an existing organization using the **10-digit grant number** from the **Notice of Award** or the **EHB Tracking Number** provided via e-mail within seven business days of successful Grants.gov submission.

For more information on the EHB registration process, refer to the HRSA EHB online help feature available at https://grants.hrsa.gov/webexternal/help/hlpTOC.asp. Following registration, EHB users must complete a validation step before they can complete the application.

For assistance with HRSA EHB registration, refer to http://www.hrsa.gov/grants/manage/ehbregistration.pdf or contact the HRSA Contact Center Monday through Friday, 9:00 a.m. to 5:30 p.m. ET (excluding Federal holidays) at:

- 877-464-4772
- TTY for hearing impaired: 877-897-9910
- CallCenter@hrsa.gov

For assistance with completing and submitting an application in HRSA EHB, contact the BPHC Helpline Monday through Friday, 8:30 a.m. to 5:30 p.m. ET (excluding Federal holidays) at:

- 877-974-2742
- BPHCHelpline@hrsa.gov

Application Format
The following tables detail the two-tier submission process for NAP applications via Grants.gov and HRSA EHB. Table 1 includes the components required to complete Step 1 of the application process through Grants.gov. Tables 2 through 5 list the components that are submitted through EHB to complete Step 2 of the application process.

In the Form Type column of Tables 1-5, the word "Form" refers to a document that must be downloaded, completed in the template provided, and then uploaded. "E-Form" refers to forms that are completed online in EHB and therefore do not require downloading or uploading. "Document" refers to a document to be uploaded as an attachment.

In Tables 2-3, documents and forms marked “C” (required for completeness) will be used to determine if an application is complete. Applications that fail to include all forms and documents indicated as required for completeness will be considered incomplete or non-responsive and will not be considered for funding. Failure to include documents marked “R” (required for review) may negatively impact an application’s objective review score.

Table 1: Step 1 – Submission through Grants.gov

http://www.grants.gov

- Complete and submit the following application components by the Grants.gov deadline. These forms are available in the Grants.gov application package.
- It is mandatory to follow the instructions provided in this section to ensure that your application can be printed efficiently and consistently for review.
- Failure to follow the instructions may make your application non-responsive. Non-responsive applications will not be considered under this funding opportunity announcement.
- For electronic submissions, no table of contents is required for the entire application. HRSA will construct an electronic table of contents in the order specified.
- Limit file attachment names to 50 characters or less. Do not use special characters (e.g., %, /, #) or spacing in the file name. An underscore (_) may be used to separate words in a file name. Attachments will be rejected by Grants.gov if special characters are included or if file names exceed 50 characters.

Application Component	Form Type	Instruction	Counted in Page Limit (Y/N)
Application for Federal Assistance (SF-424)	Form	Prepare according to instructions provided in the form itself (mouse over fields for specific instructions) and the following guidelines: • *Box 2: Type of Applicant:* **Incorrect selection may delay EHB access.** ▪ NEW STARTS select New (new applicants) ▪ SATELLITES select Revision, then choose Other and type Supplement and your H80 grant number (current grantees) • *Boxes 4 and 5a:* Leave blank. • *Box 5b: Federal Award Identifier:* 10-digit grant number (H80…) found in box 4b from the most recent Notice of Award for current section 330 grantees. New applicants should leave this blank. • *Box 8c: Organizational DUNS:* Applicant organization's DUNS number. See http://www.whitehouse.gov/omb/grants/duns_num_guide.pdf. • *Box 8f: Name and Contact Information of Person to be Contacted on Matters Involving this Application:* Provide the Project Director's name and contact information. ***Note:*** If, for any reason, the Project Director will be out of the office between the Grants.gov submission date and the project period start date, ensure that the email Out of Office Assistant is set so HRSA will be aware of whom to contact if	N

Application Component	Form Type	Instruction	Counted in Page Limit (Y/N)
		issues arise with the application and a timely response is required. • *Box 11: Catalog of Federal Domestic Assistance Number:* 93.527 • *Box 14: Areas Affected by Project:* Provide a summary of the areas to be served (e.g., if entire counties are served, cities do not need to be listed) and upload it as a Word document. • *Box 15: Descriptive Title of Applicant's Project:* Type the title of the FOA (New Access Point) and upload the project abstract. The abstract WILL count toward the page limit. • *Box 16: Congressional Districts:* Provide the congressional district where the administrative office is located in 16a and the congressional districts to be served by the proposed project in 16b. If information will not fit in the boxes provided, attach a Word document. • *Box 17: Proposed Project Start and End Date:* Provide the start date (May 1, 2015) and end date (April 30, 2017) for the proposed two-year project period. • *Box 18: Estimated Funding:* Complete the required information based on the funding request for the **first year** of the proposed project period. • *Box 19: Review by State:* See Section IV.4 for guidance in determining applicability. • *Box 21: Authorized Representative:* The electronic signature in Grants.gov (created when the Grants.gov forms are submitted) is the official signature when applying for a NAP grant. The form should NOT be printed, signed, and mailed to HRSA.	
Project Summary/Abstract	Document (Attachment)	Type the title of the funding opportunity and upload the project abstract in Box 15 of the SF-424. See instructions in Section IV.2.i.	Y
SF-424B: Assurances – Non-Construction Programs	Form	Complete the Assurances form.	N
Additional Congressional District(s) (as applicable)	Document (Attachment)	Upload a list of additional Congressional Districts served by the project if all districts served will not fit in 16b of the SF-424.	Y
Project Performance Site Location(s)	Form	Provide administrative site information AND information about all proposed NAP sites. A list of additional sites may be uploaded as necessary.	N

Application Component	Form Type	Instruction	Counted in Page Limit (Y/N)
Grants.gov Lobbying Form	Form	Provide the requested contact information at the bottom of the form.	N
SF-LLL: Disclosure of Lobbying Activities (as applicable)	Form	Complete the form only if lobbying activities are conducted.	N

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

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

https://grants.hrsa.gov/webexternal

- Complete and submit the following application components in EHB.
- It is mandatory to follow the provided instructions to ensure that your application can be printed efficiently and consistently for review.
- Failure to follow the instructions may make your application non-responsive. Non-responsive applications will not be considered for funding.
- Limit file names for documents to 100 characters or less. Documents will be rejected by EHB if file names exceed 100 characters.

Application Component	Required for Completeness (C)/Review(R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Project Narrative	C	Document	Upload the Project Narrative. See instructions in Section IV.2.ix.	Y
SF-424A: Budget Information – Non-Construction Programs	C	E-Form	Complete Sections A, B, C, and E. Complete Section F if applicable. See instructions in Appendix E.	N
Budget Justification	C	Document	Upload the Budget Justification in the Budget Narrative Attachment Form field. See instructions in Appendix E.	Y
Attachments	Varies	Documents	See Table 3.	Varies
Program Specific Forms	R	Varies	See Table 4.	N
Program Specific Information	R	Varies	See Tables 4 and 5.	N

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

- To ensure that attachments are organized and printed in a consistent manner, follow the order provided below.
- Number the electronic attachment pages sequentially, resetting the numbering for each attachment (i.e., start at page 1 for each attachment).
- Merge similar documents (e.g., Letters of Support) into a single document. Add a table of contents page specific to the attachment.
- Limit file names for documents to 100 characters or less. Documents will be rejected by EHB if file names exceed 100 characters.
- If the attachments marked "required for completeness" are not uploaded, the application will be considered incomplete and non-responsive, thereby making it ineligible. Ineligible applications will not proceed to Objective Review.
- If the attachments marked "required for review" are not uploaded, the application's Objective Review score may be negatively impacted.

Attachment	**Required for Completeness (C)/Review(R)**	Form Type	Instruction	**Counted in Page Limit (Y/N)**
Attachment 1: Service Area Map and Table	R	Document	Upload a map of the service area for the proposed project, indicating the organization's proposed new access point(s) listed in Form 5B and any current sites (as applicable). The map must clearly indicate the proposed service area zip codes, any medically underserved areas (MUAs) and/or medically underserved populations (MUPs), and Health Center Program grantees, look-alikes, and other health care providers serving the proposed zip codes. Maps should be created using UDS Mapper (http://www.udsmapper.org). Include a corresponding table that lists each zip code tabulation area (ZCTA) in the service area, the number of Health Center Program grantees serving each ZCTA, the dominant grantee serving the ZCTA and its share of Health Center Program patients, total population, total low-income population, total Health Center Program grantee patients, and patient penetration levels for each ZCTA and for the overall proposed service area. This table will be automatically created in UDS Mapper when the map is created. See http://www.hrsa.gov/grants/apply/assistance/nap for samples. For a tutorial on how to create a map, see How To's: Create a Service Area Map and Data Table at http://www.udsmapper.org/tutorials.cfm.	Y
Attachment 2: Implementation Plan	C	Document	Upload the NAP Implementation Plan. Refer to Appendix C for detailed instructions and see http://www.hrsa.gov/grants/apply/assistance/nap for a sample.	Y

Attachment	**Required for Completeness (C)/Review(R)**	Form Type	Instruction	**Counted in Page Limit (Y/N)**
Attachment 3: Applicant Organizational Chart	R	Document	Upload a one-page document that depicts the applicant's organizational structure, including the governing board, key personnel, staffing, and any sub-recipients or affiliated organizations.	Y
Attachment 4: Position Descriptions for Key Management Staff	R	Document	Upload position descriptions for key management staff: Chief Executive Officer (CEO), Chief Clinical Officer (CCO), Chief Financial Officer (CFO), Chief Information Officer (CIO), Chief Operating Officer (COO), and Project Director (PD). Indicate on the position descriptions if key management positions are combined and/or part time (e.g., CFO and COO roles are shared). Each position description should be limited to **one page** and must include, at a minimum, the position title; description of duties and responsibilities; position qualifications; supervisory relationships; skills, knowledge, and experience requirements; travel requirements; salary range; and work hours.	Y
Attachment 5: Biographical Sketches for Key Management Staff	R	Document	Upload biographical sketches/resumes for key management staff: CEO, CCO, CFO, CIO, COO, and PD. Biographical sketches/resumes should not exceed **two** pages each. When applicable, biographical sketches/resumes must include training, language fluency, and experience working with the cultural and linguistically diverse populations to be served. If an identified individual is not yet hired, include a letter of commitment from that person with the biographical sketch/resume.	Y

Attachment	Required for Completeness (C)/Review(R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Attachment 6: Co-Applicant Agreement (required for public center applicants that have a co-applicant board) Note: Public centers were referred to as "public entities" in the past.	C as applicable	Document	Public center applicants that have a co-applicant board must submit, in its entirety, the formal co-applicant agreement signed by both the co-applicant governing board and the public center. Note: Public centers that receive section 330 funding must comply with all applicable governance requirements and regulations. In cases where the public center's board cannot directly meet all applicable health center governance requirements, a separate co-applicant health center governing board must be established that meets all the section 330 governance requirements. When a public center has a co-applicant board, the public center and co-applicant board must have a formal co-applicant agreement that stipulates roles, responsibilities, and the delegation of authorities of each party in the oversight and management of the public health center, detailing any shared roles and the responsibilities of each party in carrying out governance functions.	Y
Attachment 7: Summary of Contracts and Agreements	R as applicable	Document	Upload a BRIEF SUMMARY describing **all** current or proposed patient service-related contracts and agreements supporting the proposed project. The summary must address the following items for each contract or agreement: • Name and contact information for each affiliated agency. • Type of contract or agreement (e.g., contract, affiliation agreement). • Brief description of the purpose and scope of each contract or agreement (i.e., type of services provided, how/where services are provided). • Timeframe for each contract or agreement. For required services provided by a formal written referral agreement/arrangement, explain how the services will be provided on a sliding fee scale that meets Health Center Program requirements and will be accessible regardless of ability to pay. If a contract or agreement will be attached to Form 8, denote this with an asterisk (*).	Y

Attachment	Required for Completeness (C)/Review(R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Attachment 8: Independent Financial Audit	C	Document	Upload the applicant organization's most recent audit. The audit must include all balance sheets, profit and loss statements, audit findings, management letter (or a signed statement that no letter was issued with the audit), and noted exceptions. Organizations that have been operational less than one year and do not have an audit may submit monthly financial statements for the most recent six-month period. Organizations that are not yet operational and/or do not have an audit or financial statements must provide a detailed explanation of the situation, including supporting documentation.	N
Attachment 9: Articles of Incorporation (required for nonprofit organizations)	R	Document	Upload the official signatory page (including state seal) of the applicant organization's Articles of Incorporation. Public centers with a co-applicant, upload the co-applicant's Articles of Incorporation.	Y
Attachment 10: Letters of Support	R	Document	Upload current dated letters of support addressed to the appropriate organizational contact (e.g., board, CEO) to document commitment to the project. See the *COLLABORATION* section of the Project Narrative for details on required letters of support. As necessary, applicants may provide a list of additional letters that are available onsite. Letters of support that are not submitted with the application will not be considered by reviewers.	Y
Attachment 11: Sliding Fee Discount Schedule(s)	R	Document	Upload the current or proposed sliding fee discount schedule(s). The scale(s) must correspond to a schedule of charges for which discounts are adjusted based on the patient's ability to pay and apply only to persons with incomes between 100-200 percent of the Federal poverty level (see the Federal poverty guidelines at http://aspe.hhs.gov/poverty). The discount schedule must provide a full discount to individuals with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged).	Y
Attachment 12: Evidence of Nonprofit or Public Center Status	C for NEW START	Document	Upload the applicant organization's evidence of nonprofit or public center status. Private Nonprofit: A private, nonprofit organization must submit any	Y

Attachment	Required for Completeness (C)/Review(R)	Form Type	Instruction	Counted in Page Limit (Y/N)
	Applicants Only		one of the following as evidence of its nonprofit status: • A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code. • A copy of a currently valid IRS tax exemption certificate. • A statement from a state taxing body, state Attorney General, or other appropriate state official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals. • A certified copy of the organization's certificate of incorporation or similar document **if it clearly establishes the nonprofit status of the organization**. • Any of the above proof for a state or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate. Public Center: Consistent with Policy Information Notice 2010-10 (http://bphc.hrsa.gov/policiesregulations/policies/pin201001.html), applicants must provide documentation demonstrating that the organization qualifies as a public agency (e.g., health department, university health system) for the purposes of section 330 of the PHS Act, as amended. Any of the following are acceptable: 1. Affirm Instrumentality Letter (4076C) from the IRS or a letter of authority from the Federal, state, or local government granting the entity one or more sovereign powers. 2. A determination letter issued by the IRS providing evidence of a past positive IRS ruling or other documentation demonstrating that the organization is an instrumentality of government, such as documentation of the law that created the organization or documentation showing that the state or a political subdivision of the state controls the organization. 3. Formal documentation from a sovereign state's taxing authority	

Attachment	Required for Completeness (C)/Review(R)	Form Type	Instruction	Counted in Page Limit (Y/N)
			equivalent to the IRS granting the entity one or more governmental powers.	
Attachment 13: Floor Plans	R	Document	Provide floor plans of the proposed new access point(s), including proposed exam rooms and waiting area(s).	Y
Attachment 14: Corporate Bylaws	C	Document	Upload (in entirety) the applicant organization's most recent bylaws. Bylaws must be signed and dated by the appropriate individual indicating review and approval by the governing board.	Y
Attachment 15: Other Relevant Documents	R	Document	If desired, include other relevant documents to support the proposed project (e.g., charts, organizational brochures, lease agreements). If the site is/will be leased, lease/intent to lease documents must be included in this attachment.	Y

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

https://grants.hrsa.gov/webexternal

- With the exception of Form 3, all Program Specific Forms will be completed online in HRSA EHB. Refer to Appendix A for instructions.
- The Clinical and Financial Performance Measures Forms will be completed online in HRSA EHB. Refer to Appendix B for instructions.
- The Program Specific Forms and Program Specific Information forms DO NOT count against the page limit.

Program Specific Form/Information	Form Type	Instruction
Form 1A: General Information Worksheet	E-Form	Required
Form 1B: BPHC Funding Request Summary	E-Form	Required
Form 1C: Documents on File	E-Form	Required
Form 2: Staffing Profile	E-Form	Required for Year 1 and Year 2
Form 3: Income Analysis	Form	Required for Year 1 and Year 2
Form 4: Community Characteristics	E-Form	Required
Form 5A: Services Provided	E-Form	Required
Form 5B: Service Sites	E-Form	Required
Form 5C: Other Activities/Locations	E-Form	If applicable
Form 6A: Current Board Member Characteristics	E-Form	Required
Form 8: Health Center Agreements	E-Form	Required
Form 9: Need for Assistance Worksheet	E-Form	Required
Form 10: Annual Emergency Preparedness Report	E-Form	Required
Form 12: Organization Contacts	E-Form	Required
Summary Page	E-Form	Required
Clinical and Financial Performance Measures	E-Forms	Required

Table 5: Program Specific Information for One-Time Funding Submission through HRSA EHB (Step 2 continued)

- Items in this table are required, unless otherwise noted, for applicants requesting one-time funds for minor alteration/renovation with or without equipment.
- Refer to Appendix D for detailed instructions for the Program Specific Information for One-Time Funding.
- The Program Specific Information for One-Time Funding forms DO NOT count against the page limit.

Program Specific Information	Form Type	Instruction
Equipment List	E-Form	Required for applicants that are requesting one-time funds for equipment
Alteration/Renovation (A/R) Project Cover Page	E-Form	Required for applicants that are requesting one-time funds for minor alteration/renovation with or without equipment
Other Requirements for Sites	E-Form	Required for applicants that are requesting one-time funds for minor alteration/renovation with or without equipment
Environmental Information and Documentation (EID)	Form	Required for applicants that are requesting one-time funds for minor alteration/renovation with or without equipment
A/R Budget Justification	Document	Required for applicants that are requesting one-time funds for minor alteration/renovation with or without equipment
Schematic Drawings	Document	Required for applicants that are requesting one-time funds for minor alteration/renovation with or without equipment
Landlord Letter of Consent	Document	If applicable

Failure to include all forms and documents indicated as "required for completeness" will result in an application being considered incomplete or non-responsive. Failure to include documents indicated as "required for review" may negatively impact an application's objective review score.

Application Preparation
The NAP technical assistance Web site (http://www.hrsa.gov/grants/apply/assistance/nap) provides essential resources for application preparation. Throughout the application development and preparation process, applicants are encouraged to work with the appropriate Primary Care Associations (PCAs), Primary Care Offices (PCOs), and/or National Cooperative Agreements (NCAs) in determining their readiness to develop a quality, competitive NAP application. For a complete listing of PCAs, PCOs, and NCAs, refer to http://www.bphc.hrsa.gov/technicalassistance/partnerlinks. General application resources can also be accessed online at http://www.hrsa.gov/grants/apply/index.html.

Only materials included with an application submitted by the announced deadlines will be considered. Supplemental materials submitted after the application deadlines, and letters of support sent directly to HHS, HRSA, or BPHC will **not** be added to an application for consideration by the Objective Review Committee.

Program-Specific Instructions

i. ***Project Abstract***
In Grants.gov, upload a single-spaced, one-page summary of the application in Box 15 of the SF-424. Because the abstract is often distributed to provide information to the public and Congress, ensure that it is clear, accurate, concise, and without reference to other parts of the application.

Place the following at the top of the abstract:
- Project Title: New Access Point
- Applicant Name
- Address
- Project Director Name
- Phone Numbers (voice, fax)
- E-Mail Address
- Web Site Address (if applicable)
- Congressional District(s) for the Applicant Organization and Proposed Service Area
- Amount and Types of Health Center Program Funding Requested in this Application (i.e., CHC, MHC, HCH, and/or PHPC)
- Current Federal Funding Received (including HRSA funding)

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

ii. *Project Narrative*

In HRSA EHB, upload a Project Narrative that provides a comprehensive description of all aspects of the proposed NAP project. The Project Narrative must be succinct, consistent with other application components, and well organized so that reviewers can fully understand the proposed project. The Project Narrative should:

- Demonstrate the applicant's compliance with Health Center Program requirements (see Appendix F).
- Address the specific Review Criteria (see Section V) in the areas specified (i.e., Project Narrative, form, or attachment). Unless specified, attachments should not be used to extend the Project Narrative.
- Reference attachments and forms as needed to clarify information about patients, sites, geographic boundaries, demographic data, and proposed key management staff. Referenced items must be part of the HRSA EHB submission.

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

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

The Project Narrative must be organized using the following section headers (***NEED***, ***RESPONSE***, ***COLLABORATION***, ***EVALUATIVE MEASURES***, ***RESOURCES/CAPABILITIES***, ***GOVERNANCE***, ***SUPPORT REQUESTED***). The following framework indicates where the requested information should appear in the appropriate section of the Project Narrative, forms, and attachments.

NEED

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

1) Using current, relevant data, describe the characteristics of the target population within the proposed service area by:
   - Completing Form 9: Need for Assistance Worksheet (see Appendix A) that quantitatively compares target population health care needs to national median and severe benchmark data.
   - Describing the following factors in narrative format and how they impact access to primary health care, health care utilization, and health status, citing data resources, including local target population needs assessments when available:
     a) Geographical/transportation barriers (consistent with Attachment 1).
     b) Unemployment, income level, and/or literacy.
     c) Lack of insurance coverage.
     d) Health disparities.

e) Any unique health care needs of the target population (e.g., black lung disease, lyme disease).
f) Cultural/ethnic factors, including language barriers (consistent with Form 4).

2) **Applicants requesting special population funding** (see Section I.3 for definitions of MHC, HCH, and PHPC) to serve migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing: Describe the specific health care needs and access issues of the proposed special population(s), using data **specific to the proposed service area and target population**.
   a) Migratory and Seasonal Agricultural Workers needs/access issues, including agricultural environment (e.g., crops and growing seasons, demand for labor, number of temporary workers), approximate period(s) of residence of migratory workers and their families, availability of local providers to provide primary care services during these times, and occupation-related factors (e.g., working hours, housing, hazards including pesticides and other chemical exposures).
   b) People Experiencing Homelessness needs/access issues, such as the number of providers treating people experiencing homelessness and availability of homeless shelters and affordable housing.
   c) Residents of Public Housing needs/access issues, such as the availability of public housing and the availability of accessible providers for residents in the targeted public housing communities.

3) Describe other primary health care services currently available in the service area (consistent with Attachment 1) including whether they also serve the applicant's target population. Specifically list existing Health Center Program grantees, look-alikes, rural health clinics, critical access hospitals, and other major primary care providers serving the proposed zip codes, including the location and proximity to the proposed new access point(s), referencing Attachment 1. Justify the need for Health Center Program support by highlighting service gaps that the proposed new access point(s) will fill.

4) Describe the health care environment and any significant changes that have affected the availability of health care services, including:
   a) Changes in insurance coverage, including Medicaid, Medicare, and Children's Health Insurance Program (CHIP). Specifically discuss changes that have resulted from Affordable Care Act implementation.
   b) Changes in state/local/private uncompensated care programs.
   c) Economic or demographic shifts (e.g., influx of immigrant/refugee population; closing of local hospitals, community health care providers, or major local employers).
   d) Natural disasters or emergencies (e.g., hurricanes, flooding).
   e) Changes affecting special populations.

RESPONSE

1) Within Attachment 2 (see Appendix C), outline a plan for ensuring full program compliance[2] within 120 days of the Notice of Award by:
    - Detailing the action steps the applicant will take to ensure that within 120 days of the Notice of Award, all proposed site(s) on Form 5B will:
        a) Be open and operational.[3]
        b) Have appropriate staff and providers in place.
        c) Begin to deliver services as proposed (consistent with Form 5A and 5C) to the target population.
    - Describing appropriate and reasonable time-framed tasks (i.e., developing operational policies/procedures; applying for billing numbers; formalizing referral agreements; provider/staff recruitment and retention; facility development/operational planning; information system acquisition/integration; risk management/quality assurance procedures; governance) that ensure compliance with Health Center Program requirements (see Appendix F). Reference relevant documentation (e.g., renovation plans, provider contracts and/or agreements, provider commitment letters) as needed.

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

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

[3] The requirement to be open and operational within 120 days is not the same as the requirement to achieve full operational capacity. Open and operational means that services/providers are available for the proposed patients/population at the new access point(s). Full operational capacity is defined as achieving the goals proposed in the NAP application and is expected within two years of award. Full operational capacity is determined by progress toward the projected provider and patient numbers when providing all of the services in the manner proposed in the application

Program Requirement	Currently Compliant (Indicate Where in Application Compliance is Described)	Planned Actions to Become Compliant Included in Implementation Plan
1. Needs Assessment		
2. Required and Additional Services		
3. Staffing for Health Services		
4. Accessible Hours of Operation/Locations		
5. After Hours Coverage		
6. Hospital Admitting Privileges and Continuum of Care		
7. Sliding Fee Discounts		
8. Quality Improvement/Assurance Plan		
9. Key Management Staff		
10. Contractual/Affiliation Agreements		
11. Collaborative Relationships		
12. Financial Management and Control Policies		
13. Billing and Collections		
14. Budget		
15. Program Data Reporting Systems		
16. Scope of Project		
17. Board Authority		
18. Board Composition		
19. Conflict of Interest Policy		

2) Describe the service delivery model(s) proposed to address health care needs identified in ***NEED*** section and how these model(s) are appropriate and responsive to identified health care needs, including specific needs of any special populations for which funding is sought (migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing). The description must address the following:
   a) Site(s)/location(s) and service area where services will be provided (consistent with Attachment 1, Form 5B, and Form 5C).
   b) Service site type (e.g., permanent, seasonal) for each site (consistent with Form 5B).
   c) Hours of operation, including how scheduled hours will assure services are accessible and available at times that meet target population's needs, with at least one delivery site operating 40 or more hours per week (consistent with Forms 5B and 5C).
   d) Professional after-hours care/coverage during hours when service sites or locations are closed.
   e) For all proposed NAP sites that are currently operational, including Health Center Program look-alike sites, provide the current number of patients and describe how NAP funding and related benefits, such as medical malpractice insurance through the Federal

Tort Claims Act (FTCA) will allow the organization to increase the number of patients served.

3) Describe how proposed primary health care services (consistent with Form 5A) and other activities (consistent with Form 5C) are appropriate for the target population's needs. Description must include:
   a) Provision of required and additional clinical and non-clinical services, including whether these are provided directly or through established written arrangements and referrals (consistent with Attachment 7).
   b) How services will be culturally and linguistically appropriate.
   c) Method by which enabling services such as case management, outreach, and transportation are integrated into the primary health care delivery system, as well as any translation services for serving limited English proficiency population(s). Highlight enabling services designed to increase access for targeted special populations, if any.

   Note: Health Care for the Homeless (HCH) applicants must document how substance abuse services will be made available either directly or via a formal written referral arrangement. Migrant Health Center (MHC) applicants must document how they will address any occupational health or environmental health hazards or conditions identified in the ***NEED*** section. Public Housing Primary Care (PHPC) applicants must document that the service plan was developed in consultation with residents of the targeted public housing.

4) Describe how the service delivery model(s) assures continuity of care and access to a continuum of care. The description must address:
   a) Continuity of care, including arrangements for admitting privileges for health center physicians at one or more hospitals (consistent with Form 5C). In cases where hospital privileges are not possible, include formal arrangement(s) with one or more hospitals to ensure continuity of care (consistent with Attachment 7).
   b) A seamless continuum of care, including discharge planning, post-hospitalization tracking, patient tracking (e.g., shared electronic health records), and referral relationships for specialty care (including relationships with one or more hospitals), with an emphasis on working collaboratively to meet local needs.

5) Describe the proposed clinical team staffing plan (consistent with Form 2), include the mix of provider types and support staff necessary for:
   a) Providing services for the projected number of patients (consistent with Form 1A).
   b) Assuring appropriate linguistic and cultural competence (e.g., bilingual/multicultural staff, training opportunities).
   c) Carrying out required and additional health care services (as appropriate and necessary), either directly or through established written arrangements and referrals (consistent with Form 5A and Attachment 7).

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

6) Describe how the established schedule of charges is board-approved, consistent with locally prevailing rates, and designed to cover the reasonable cost of service operation (consistent with Form 5A).

7) Describe the sliding fee discount schedule(s) (consistent with Attachment 11 and Attachment 7), including:
   a) The process utilized to develop the sliding fee discount schedule(s).
   b) Policies and procedures used to implement the sliding fee discount schedule(s), including provisions that assure that no patient will be denied service based on an inability to pay.
   c) How the sliding fee discount schedule(s):
      - Are applied only for individuals and families with an annual income at or below 200 percent of the poverty rate according to the most current Federal Poverty Guidelines (available at http://aspe.hhs.gov/poverty).
      - Provide a full discount (no charge) or only a nominal charge for individuals and families with an annual income at or below 100 percent of the poverty rate.
   d) How any nominal charges are determined. (Nominal charges may be collected from patients at and below 100 percent of the poverty rate only if a nominal charge is consistent with project goals and **does not** pose a barrier to receiving care.)
   e) How often the governing board reviews and updates the sliding fee discount schedule(s) to reflect most recent Federal Poverty Guidelines.
   f) How often the governing board evaluates and updates policies and procedures supporting implementation of the sliding fee discount schedule(s).
   g) How patients are made aware of available discounts (e.g., signs posted in accessible and visible locations, registration materials, brochures, verbal messages delivered by staff).
   h) How the applicant ensures that services that are provided by a formal written contract/agreement (where the applicant will pay for the service) will be included under the applicant's sliding fee discount schedule(s)
   i) How the applicant ensures that services that are provided by a formal written referral arrangement/agreement are included under a sliding fee discount schedule that meets health center program requirements (items (b), (c), (d), and (g)).

8) Describe the organization's quality improvement/quality assurance (QI/QA) and risk management plan(s) including:
   a) Accountability and communication throughout the organization for systematically improving the provision of quality health care, including a clinical director whose responsibilities clearly include oversight of the QI/QA program.
   b) The process and parties responsible for developing, getting board approval and updating policies and procedures that support the QI/QA and risk management plan(s).
   c) The process and parties responsible for provider licensure, credentials, and privileges – ensuring that all providers (e.g., employed, contracted, volunteers, locum tenens) are appropriately licensed, credentialed, and privileged to perform proposed services (consistent with Form 5A) at proposed sites/locations (consistent with Forms 5B and 5C).
   d) Risk management procedures, including those related to patient grievance procedures and incident reporting and management.

e) Monitoring the impact of the provision and efficiency of clinical services on the assessed health needs of the target population (e.g., clinical and financial performance measures).
f) Maintenance of confidentiality of patient records throughout the continuum of care.
g) Periodic assessment on the appropriateness of service utilization, quality of services delivered, and patient outcomes, conducted by physicians or other licensed health professionals under the supervision of physician, including peer review and systematic evaluation of patient records to identify areas for improvement in documentation of services provided either directly or through referral.
h) Utilization of appropriate information systems (e.g., electronic health records, payment management systems) for tracking, analyzing, and reporting key performance data, including data necessary for 1) required performance measures and 2) tracking of diagnostic tests and other services provided to health center patients to ensure appropriate follow up and documentation in patient record.
i) Utilization of QI results to improve performance.

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

9) Describe current or proposed efforts to ensure access to health care including:
   a) Integration with the state health care delivery plan with respect to outreach, enrollment, and delivery system reform.
   b) Facilitation of enrollment in new affordable health insurance options, including the Marketplace, Medicaid, and CHIP. Specifically describe how potentially-eligible individuals will be identified and informed of the new options; what type of assistance will be provided for determining eligibility; and what type of assistance will be provided to facilitate the relevant enrollment process.

COLLABORATION

1) Describe both formal and informal collaboration and coordination of services[4] with other health care providers and community organizations. Specifically describe collaboration and coordination with the following:
   a) Existing health centers (Health Center Program grantees and look-alikes)
   b) Rural health clinics
   c) Critical access hospitals
   d) Other federally-supported grantees (e.g., Ryan White programs, Title V Maternal and Child Health programs)
   e) Health departments
   f) Private primary care providers
   g) Programs serving the same target population (e.g., social services; job training; Women, Infants, and Children (WIC); community groups; school districts) and, if applicable,

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

special population(s) for which funding is sought (e.g., Public Housing Authority, homeless shelters).

h) If applicable, neighborhood revitalization initiatives such as the Department of Housing and Urban Development's Choice Neighborhoods, the Department of Education's Promise Neighborhoods, and/or the Department of Justice's Byrne Criminal Justice Innovation Program. If a neighborhood within your service area has been designated as a Promise Zone, discuss how you will collaborate with this effort (see http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/economicdevelopment/programs/pz).

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

2) Document support for the proposed project through current dated letters of support[5] that reference specific coordination or collaboration from all of the following in the service area or within close proximity of the proposed new access point site(s):
   a) Health centers (Health Center Program grantees and look-alikes)
   b) Rural health clinics
   c) Critical access hospitals
   d) Health departments
   e) Private primary care provider groups serving low income and/or uninsured populations
   f) Other community organizations (e.g., social service organization, school, homeless shelter)

   If such providers/organizations do not exist in the service area, state this. If such letters cannot be obtained from providers/organizations in the service area, include documentation of efforts made to obtain the letters along with an explanation for why such letters could not be obtained. Letters of support should be consistent with providers shown on Attachment 1.

3) Document support for the proposed project through a current dated letter of support from relevant State public agencies:
   a) State Health Departments/State Primary Care Offices
   b) State Medicaid agencies

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

Note: Merge all letters of support into a single document and submit it as Attachment 10.

[5] Letters of support should be addressed to the organization's board, CEO, or other appropriate key management staff member (e.g., Medical Director), not HRSA staff. Letters of support that are not submitted with the application will not be considered by reviewers.

EVALUATIVE MEASURES

1) Within the Clinical Performance Measures form (see detailed instructions in Appendix B), outline time-framed and realistic goals that are responsive to the needs identified in the ***NEED*** section. ***NOTE:*** *If baselines are not yet available, state when data will be available.* Goals should be limited to the proposed two-year project period. Specifically include:
   a) Goals for improving quality of care and health outcomes in the areas of Diabetes, Cardiovascular Disease, Cancer, Prenatal Health, Perinatal Health, Child Health, Weight Assessment and Counseling for Children and Adolescents, Adult Weight Screening and Follow-Up, Tobacco Use Screening and Cessation, Asthma – Pharmacological Therapy, Coronary Artery Disease (CAD) – Lipid Therapy, Ischemic Vascular Disease (IVD) – Aspirin Therapy, Colorectal Cancer Screening, New HIV Cases With Timely Follow Up, Depression Screening and Follow Up, and Oral Health.
   b) Goals relevant to the needs of migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing for applicants seeking targeted special population funding. An applicant that is not requesting targeted funding but currently serves or plans to serve special population(s) is encouraged to include relevant goals reflecting the needs of these populations.
   c) Measures (numerator and denominator) and data collection methodology for all goals.
   d) A summary of at least one key factor anticipated to contribute to and one key factor anticipated to restrict progress toward the stated performance measure goals, and action steps planned for addressing described factors.

2) Within the Financial Performance Measures form (see detailed instructions in Appendix B), outline time-framed and realistic goals that are responsive to the organization's financial needs. ***NOTE:*** *If baselines are not yet available, state when data will be available.* Goals should be limited to the two-year proposed project period. Specifically include:
   a) Goals for improving the organization's status in terms of costs and financial viability.
   b) Measures (numerator and denominator) and data collection methodology for all goals.
   c) A summary of at least one key factor anticipated to contribute to and one key factor anticipated to restrict progress toward the stated performance measure goals, and action steps planned for addressing described factors.

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

4) Describe the experience and skills of evaluation staff, in addition to the amount of time and effort proposed for staff to perform project evaluation activities.

5) Describe any established certified EHR system or any planned acquisition/development and implementation of certified EHR systems (including the number of sites) to be used for tracking patient and clinical data to achieve meaningful use and improve quality outcomes. Information about meaningful use is available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html.

RESOURCES/CAPABILITIES

1) Describe how the organizational structure (including any sub-recipients) is appropriate for the operational needs of the NAP project (consistent with Attachments 2 and 3, and, as applicable, Attachments 6[6] and 7), including how lines of authority are maintained from the governing board to the CEO/Executive Director down through the management structure.

2) Describe how the organization maintains appropriate oversight and authority in accordance with Health Center Program requirements over all contracted services, including (as applicable):
   a) Current or proposed contracts and agreements summarized in Attachment 7.
   b) Sub-recipient arrangements[7] referenced in Form 8 (any "No" response to the Governance Checklist in Form 8 must be explained).

3) Describe how the organization's management team (CEO, CCO, CFO, CIO, and COO, as applicable):
   a) Is appropriate and adequate for the scope of the proposed project, including operational and program oversight needs.
   b) Has appropriately defined roles as outlined in Attachment 4.
   c) Possesses necessary skills and experience for the defined roles as demonstrated in Attachment 5.

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

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

[7] A sub-recipient is an organization that receives a subaward from a Health Center Program grantee to carry out a portion of the grant-funded scope of project. Sub-recipients must be compliant with all Health Center Program statutory and regulatory requirements, as well as applicable grant requirements specified in 45 CFR Part 74 or 45 CFR Part 92, as applicable. As a sub-recipient of section 330 funding, such organizations are eligible to receive FQHC benefits, including enhanced reimbursement as an FQHC, 340B drug discount pricing, and FTCA coverage. All sub-recipient arrangements must be documented through a formal written contract/agreement, and a copy must be provided to HRSA as an attachment to Form 8. The grantee must demonstrate that it has systems in place to provide reasonable assurances that the sub-recipient organization complies with—and will continue to comply with—all statutory and regulatory requirements throughout the period of award.

5) Describe how the proposed service site(s) (consistent with Form 5B) are appropriate for implementing the service delivery plan in terms of the projected number of patients and visits (consistent with Form 1A). Attach floor plans for all proposed sites in Attachment 13. If the site is leased, include lease/intent to lease documents in Attachment 15.

6) Describe expertise in the following areas:
   a) Working with the NAP target population.
   b) Developing and implementing systems and services appropriate for addressing the NAP target population's identified health care needs (consistent with Attachment 2).

   Note: Public Housing Primary Care (PHPC) applicants must specifically describe how residents of public housing were involved in the development of the NAP application and will be involved in administration of the proposed project.

7) Describe the processes in place to maximize collection of payments and reimbursement for services, including written policies and procedures for billing, credit, and collection.

8) Describe how the financial accounting and control systems, as well as related policies and procedures:
   a) Are appropriate for the size and complexity of the organization.
   b) Reflect Generally Accepted Accounting Principles (GAAP).
   c) Separate functions/duties appropriate to the organization's size to safeguard assets and maintain financial stability.
   d) Enable the collection and reporting of the organization's financial status as well as tracking of key financial performance data (e.g., visits, revenue generation, aged accounts receivable by income source or payor type, aged accounts payable, lines of credit, debt to equity ratio, net assets to expenses, working capital to expenses).
   e) Support management decision making.

9) Describe the organization's annual independent auditing process performed in accordance with Federal audit requirements and submit the most recent financial audit and management letter (or a signed statement that no letter was issued with the audit) as Attachment 8.[8] Organizations that have been operational for less than one year and do not have an audit may submit monthly financial statements for the most recent six-month period. Organizations that are not yet operational and do not have audit or financial information must provide a detailed explanation of the situation, including supporting documentation.

10) Describe the status of emergency preparedness planning and development of emergency management plan(s), including efforts to participate in state and local emergency planning. Any "No" response on Form 10 must be addressed.

[8] Grantees are reminded that the annual audit must also be provided to the Federal Audit Clearinghouse and submitted via EHB. For more information, see http://bphc.hrsa.gov/policiesregulations/policies/pal200906.html.

GOVERNANCE[9]

Note: Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups should respond ONLY to Item 5 below.[10]

1) Describe how the Corporate Bylaws (Attachment 14), Articles of Incorporation (Attachment 9), and/or Co-Applicant Agreement (Attachment 6)[11] demonstrate that the organization has an independent governing board that meets the following criteria:
   a) Meets at least once a month.
   b) Ensures that written minutes are recorded for all meetings (i.e., full board and subcommittee meetings).
   c) Selects the services to be provided.
   d) Determines the hours during which services will be provided.
   e) Measures and evaluates the organization's progress and develops a plan for the long-range viability of the organization through strategic planning, ongoing review of the organization's mission and bylaws, evaluation of patient satisfaction, and monitoring of organizational performance and assets.
   f) Approves the health center's annual budget, including the use of grant and non-grant funds.
   g) Approves the health center's grant applications.
   h) Approves the selection/dismissal and conducts the performance evaluation of the organization's Executive Director/CEO.
   i) Establishes general policies for the organization. ***Note:*** In the case of public centers with co-applicant governing boards, the public center is permitted to retain authority for establishing general fiscal and personnel policies for the health center.
   j) Establishes policies to prohibit conflict of interest by board members, employees, consultants, and those who furnish goods or services to the health center.

   Note: Only public center applicants are permitted to establish a separate co-applicant health center governing board that meets all Health Center Program requirements.

2) Document that the structure of the board (co-applicant board for a public center) is appropriate in terms of size, composition, and expertise by describing how the following criteria are met:
   a) At least 51 percent of board members are individuals who are/will be patients of the health center (this requirement may be waived for eligible applicants[12]).

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[9] For detailed information regarding Health Center Program governance requirements, see Policy Information Notice 2014-01 at http://bphc.hrsa.gov/policiesregulations/policies/pin201401.html.

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

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

b) As a group, the patient board members reasonably represent the individuals served by the organization in terms of race, ethnicity, and gender (consistent with Forms 4 and 6A).
c) Non-patient board members are representative of the service area and selected for their expertise in any of the following areas: community affairs; local government; finance and banking; legal affairs; trade unions and related organizations; and/or social services.
d) Board has a minimum of nine but no more than 25 members, as appropriate for the complexity of the organization.
e) No more than half of the non-patient board members derive more than 10 percent of their annual income from the health care industry.
f) No board member is an employee of the health center or an immediate family member of an employee.

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

3) **Applicants requesting a waiver of the 51 percent patient majority governance requirement ONLY** (only applicants **not** currently receiving or applying for general community (CHC) funding are eligible to request a waiver – see Policy Information Notice 2014-01): Justify the need for a waiver by explaining why the applicant cannot meet this requirement and describing the alternative mechanism(s) for gathering consumer/patient input (e.g., separate advisory boards, patient surveys, focus groups). Discuss:
   a) Specific types of patient input to be collected.
   b) Methods for documenting input in writing.
   c) Process for formally communicating the input directly to the organization's governing board.
   d) How the patient input will be used by the governing board in areas such as: 1) selecting services; 2) setting operating hours; 3) defining strategic priorities; 4) evaluating the organization's progress in meeting goals, including patient satisfaction; and 5) other relevant areas of governance that require and benefit from patient input.

Note: If funded, post-award actions will be required to finalize waiver approval. An approved waiver does not absolve the organization's governing board from fulfilling all other statutory board responsibilities and requirements.

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

4) Document the effectiveness of the governing board by describing how the board:
   a) Operates, including the organization and responsibilities of board committees (e.g., Executive, Finance, Quality Improvement/Assurance, Risk Management, Personnel, Planning).
   b) Monitors and evaluates its own (the board's) performance (e.g., identifies and develops processes for assessing and addressing board weaknesses, challenges, training needs).
   c) Provides board training, development, and orientation for new board members to ensure that they have sufficient knowledge to make informed decisions regarding the strategic direction, general policies, and financial position of the organization. ***Note:*** In the case of a public center with a co-applicant governing board, the public center is permitted to retain authority for establishing general fiscal and personnel policies for the health center.

5) **Indian Tribes or Tribal, Indian, or Urban Indian Applicants ONLY:** Describe the applicant organization's governance structure and how it will assure adequate (1) input from the community/target population on health center priorities and (2) fiscal and programmatic oversight of the proposed project.

SUPPORT REQUESTED

1) Provide a complete, consistent, and detailed budget presentation through the submission of the following: SF-424A (Budget Information), budget justification, Form 2, and Form 3. See Appendix E for budget presentation instructions and Appendix A for details on completing the referenced forms.

2) Describe how the proportion of requested Federal grant funds is appropriate given other sources of income specified in Form 3 and the budget justification.

3) Describe how the total budget is aligned and consistent with the proposed service delivery plan and number of patients to be served (consistent with the ***RESPONSE*** section of the Project Narrative, Attachment 2, and Form 1A).

4) Provide the total cost per patient and Federal cost per patient for the proposed NAP broken out by funding population type (i.e., CHC, MHC, HCH, PHPC) and explain why the costs are appropriate and reasonable for the proposed NAP. The Federal dollars per patient at the end of the project period will be calculated automatically when Program Specific Forms 1A and 1B are complete. The Forms Summary Page will show this number, broken out by funding population type.

iii. ***Program Specific Forms and Information***

See Appendix A for Program Specific Forms instructions. See Appendix B for Program Specific Information instructions and Appendix D for instructions for completing Program Specific Information for One-Time Funding.

iv. *Attachments*

Attachments are not intended to be a continuation of the Project Narrative. Attachments must be clearly labeled and uploaded in the appropriate place within HRSA EHB. See Table 2 for a complete listing of required attachments, including instructions for completing them.

3. Submission Dates and Times

Application Due Dates

The Grants.gov deadline for applications under HRSA-15-016 is **11:59 p.m. ET on August 20, 2014** and the deadline to complete all required information in HRSA EHB is **8:00 p.m. ET on October 7, 2014.** Applications completed online are considered formally submitted when: (1) the application has been successfully transmitted electronically by the Authorized Organization Representative (AOR) through Grants.gov to the correct funding opportunity number and has been validated by Grants.gov on or before the Grants.gov deadline date and time; and (2) the Authorizing Official (AO) has submitted the additional information in HRSA EHB on or before the EHB deadline date and time.

Receipt Acknowledgement

Upon receipt of an application, Grants.gov will send a series of email messages regarding the progress of the application through the system. The applicant will receive an "Application successfully transmitted to HRSA" message in HRSA EHB upon successful application submission within the EHB system. For more details regarding application submission and receipt acknowledement, refer to the *HRSA Electronic Submission User Guide*.

Late Applications

Applications that do not meet the deadline criteria above are considered late applications and will not be considered for NAP funding.

4. Intergovernmental Review

State System Reporting Requirements

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

All applicants other than federally recognized Native American Tribal Groups must contact their SPOCs as early as possible to alert them to the prospective applications and receive any necessary instructions on the process used under this Executive Order. For proposed projects serving more than one state, the applicant is advised to contact the SPOC of each affected state.

Letters from the SPOC in response to Executive Order 12372 are due 60 days after the application due date. Letters should be sent electronically to the points of contact listed in section VII *Agency Contacts*.

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

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

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

Applicants should contact their SPOC to determine how and where to submit the PHSIS (see contact information above).

5. Funding Restrictions

Funds must be requested and utilized by the applicant organization identified on the SF-424 submitted in Grants.gov. Applicants are expected to perform the activities indicated in the NAP application and may not apply on behalf of another organization.

Funds under this announcement may not be used for fundraising or major alteration and renovation or construction/expansion of facilities. Funds may be used for minor capital costs, including equipment and/or minor alteration and renovation of proposed new access point facilities. Applicants may request to use up to $150,000 of Federal funds in Year 1 ONLY for such minor capital costs (see Appendix D for more information). HRSA grant awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS); for more information on allowable costs and other grant requirements see the HHS GPS at http://www.hrsa.gov/grants/hhsgrantspolicy.pdf. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award).

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

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of grant applications have been instituted to provide an objective review of applications and assist applicants in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information and provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points. Reviewers will reference the Health Center Program requirements in Appendix F to assess the applicant's compliance and readiness to implement a NAP. Reviewers will also use the HRSA Scoring Rubric as a guideline when assigning scores for each criterion. The HRSA Scoring Rubric may be found at http://www.hrsa.gov/grants/apply/assistance/NAP.

As a reminder, the application must be limited to the scope of the proposed NAP project. Specifically**:**

- A **NEW START** applicant should include information on the entire scope of the proposed NAP project.
- A **SATELLITE** applicant should address **only** the proposed new access point(s), not the scope of the entire organization.

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

Criterion 1: NEED (30 Points of which 20 points are determined by the NFA Worksheet calculations and 10 points are determined by the objective review process)

Note: 20 of the 30 available points in this section will be awarded based on the Need for Assistance (NFA) Score (see Form 9). The NFA score will be calculated automatically by the HRSA EHB system. Although reviewers do not score the NFA, they will look for consistency between the NFA and other parts of the application. The remaining 10 points will be based on the criteria outlined below.

1. How well the applicant demonstrates the current health care needs in the service area/target population (including any targeted special populations) described in Item 1 of the ***NEED*** section of the Project Narrative, consistent with the quantitative and qualitative data provided in the Need for Assistance Worksheet (Form 9), and Form 4.

2. For applicants requesting funding to serve migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing, (as indicated on Form 1A), how well the applicant demonstrates, with consistent and complete information, the specific health care needs and access issues of each proposed special population as documented by quantitative and qualitative data, using data sources with the greatest specificity available for the proposed service area and target population of the NAP,

provided in the Need for Assistance Worksheet (Form 9), and listed in Item 2 of the ***NEED*** section of the Project Narrative.

3. How well the applicant describes, with consistent and complete information, existing primary health care services and service gaps in the service area, as well as factors affecting the broader health care environment, as documented in Items 3 and 4 of the ***NEED*** section of the Project Narrative.

Criterion 2: RESPONSE (20 Points)

1. How well the Implementation Plan (Attachment 2) identifies appropriate, realistic, and achievable action steps necessary to ensure that the new access point(s) will be open, operational, and compliant within 120 days of award with appropriate staff and providers in place to deliver services to the proposed service area and how well the applicant ensures compliance with Health Center Program requirements as outlined in Item 1 of the ***RESPONSE*** section of the Project Narrative (consistent with the Implementation Plan).

2. How well the applicant demonstrates, with consistent and complete information, that the proposed service delivery model(s), sites, services, staffing plan, and coordination with other providers/institutions in the community will provide continuity of care while ensuring that the target population's continuum of health care needs outlined in the ***NEED*** section and related application materials are met, as documented by quantitative and qualitative descriptions provided in Attachment 1, Attachment 7, Forms 5A, 5B, and 5C, and Items 2, 3, 4, and 5 of the ***RESPONSE*** section of the Project Narrative.

3. For applicants requesting funding to serve migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing (as indicated on Form 1A), how well the applicant demonstrates, with consistent and complete information, compliance with requirements for targeted special populations, as documented in Forms 5A, 5B, and 5C, Attachment 7, and Items 2 and 3 of the ***RESPONSE*** section of the Project Narrative. In particular, services targeting people experiencing homelessness will include provision of substance abuse services (either directly or through referral); services targeting migratory and seasonal agricultural workers will address environmental health needs and hazards; and services targeting public housing residents will be informed by consultation with public housing residents.

4. How well the applicant demonstrates, with consistent and complete information, that the schedule of charges is board-approved, reasonable, and consistent with local rates; the sliding fee discount schedule(s), including any justified nominal charges, ensure services (regardless if they are provided directly, through a formal written contract/agreement, or by formal written referral arrangement/agreement) are available and accessible to all without regard to ability to pay; the system in place for determining eligibility for and application of discounts is based on a patient's income, family size, and current Federal Poverty Guidelines; and a system is in place to ensure patients are made aware of the availability of the sliding fee discounts, as reflected in Attachment 11, Attachment 7 (as applicable), and Items 6 and 7 of the ***RESPONSE*** section of the Project Narrative.

5. How well the applicant demonstrates, with consistent and complete information: good accountability and communication within the organization to include all staff in QI/QA activities; that its QI committee/workgroup is led by a qualified leader; that its proposed focus, goals, performance measures, methodology, and evaluation plans are based on an assessment of its current service performance and analysis of current and potential risks incurred in the implementation of all services; and that key management obtained the board's input and approval on the QI/QA plan as described in Item 8 of the ***RESPONSE*** section of the Project Narrative, Clinical Performance Measures, and Attachment 2 (as applicable).

6. For applicants requesting funding for a sub-recipient or contracted service site (see Form 5B and Form 8), how well the applicant demonstrates that the proposed sub-recipient or contractor site meets the *RESPONSE* sub-criteria 1-5 above as documented by consistent and complete information in the ***RESPONSE*** section of the Project Narrative, Form 8, sub-recipient agreement/contract attached to Form 8, Attachment 2, and any other relevant attachments.

7. How well the applicant identifies appropriate, realistic, and achievable plans to ensure access to health care through integration with the state health care delivery plan and facilitation of enrollment in new affordable health insurance options as described in Item 9 of the ***RESPONSE*** section of the Project Narrative.

Criterion 3: COLLABORATION (10 points)

1. How well the applicant demonstrates, with consistent and complete information, that other primary health care providers and community organizations in the proposed service area and within close proximity (as identified by the UDS Mapper tool) support the proposed project through detailed descriptions of collaboration and coordination as documented in Attachment 1, Attachment 7 (as applicable), Attachment 10, and Items 1 and 2 of the ***COLLABORATION*** section of the Project Narrative.

2. How well the letters of support (Attachment 10) demonstrate that Health Center Program grantees and look-alikes, rural health clinics, critical access hospitals, health departments, private primary care provider groups serving low income and/or uninsured populations, at least one community organization in the service area, and relevant State public agencies support the proposed project through detailed descriptions of collaboration and coordination. **The letters of support must be specific to the nature of the support and the NAP project**. If letter(s) are not included from all required organizations (e.g., those identified on the service area map), how well the applicant justifies why such letter(s) could not be obtained, including documentation of efforts made to obtain the letter(s).

Criterion 4: EVALUATIVE MEASURES (5 points)

1. How well the applicant establishes Clinical and Financial Performance Measures (goals) appropriate to the proposed project and two-year project period, including realistic contributing and restricting factors, effective plans for addressing such factors, as well as

unique special population measures corresponding to the identified special population needs, as evidenced in the Clinical and Financial Performance Measures forms, and consistent with the ***NEED*** section of the Project Narrative and Form 9.

2. How well the applicant demonstrates, with consistent and complete information, the organization's strategic planning process and how strategic planning will be used to continually evaluate and improve the NAP project as described in Item 3 of the ***EVALUATIVE MEASURES*** section of the Project Narrative.

3. How well the applicant demonstrates that the proposed evaluation staff possess the appropriate experience and skills to perform the proposed project evaluation activities, including allotment of adequate time for activity completion as described in Item 4 of the ***EVALUATIVE MEASURES*** section of the Project Narrative.

4. How well the applicant demonstrates that the established or planned implementation of certified EHR systems will appropriately track patient/clinical data and be used to improve clinical outcomes as described in Item 5 of the ***EVALUATIVE MEASURES*** section of the Project Narrative.

Criterion 5: RESOURCES/CAPABILITIES (15 points)

1. How well the applicant demonstrates, with consistent and complete information, that the sites, organizational structure, proposed management staff, staffing plan, and policies/procedures are appropriate for implementing the proposed new access point(s) and for meeting the Health Center Program requirements (see Appendix F), including oversight and authority over all agreements, contracts, contractors, and sub-recipients through information provided in Items 1, 2, 3, 4, and 5 of the ***RESOURCES/CAPABILITIES*** section of the Project Narrative, Attachment 2, Attachment 3, Attachment 7, Attachment 13, Attachment 14, Form 2, and Form 8.

2. How well the applicant establishes, with consistent and complete information, that its experience and expertise working with and addressing needs of the target population(s) have positioned the applicant organization to successfully implement the proposed project in the proposed timeframe, with a particular focus on experience and expertise regarding addressing primary and preventive health care needs through information provided in Items 2, 3, and 6 of the ***RESOURCES/CAPABILITIES*** section of the Project Narrative, Attachment 3, Attachment 4, Attachment 5, Attachment 7, and Form 8, as applicable.

3. How well the applicant demonstrates, with consistent and complete information, sound financial management, financial stability, and compliance with Federal laws and regulations, as supported through audit and financial information, billing and collections details, and appropriate financial accounting and control systems, information systems, policies, and procedures to enable data tracking and reporting of the organization's financial status in accordance with Generally Accepted Accounting Principles (GAAP) and to support management decision making.

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

4. How well the applicant establishes a commitment to sustainability by documenting in detail: plans to effectively recruit and retain key management staff and health care providers; policies and procedures for maximizing collection of payments and reimbursement for costs while ensuring access to health care without regard to ability to pay; and plans for emergencies in Items 4, 7, and 10 of the ***RESOURCES/CAPABILITIES*** section of the Project Narrative.

5. How well the Implementation Plan (Attachment 2) identifies appropriate, realistic, and achievable action steps that ensure the organization has the resources and capability to open and operate the compliant new access point(s) within 120 days of award (e.g., lease arrangements, staffing, policies). See Health Center Program requirements in Appendix F.

Criterion 6: GOVERNANCE (10 points)

1. How well the applicant demonstrates, with consistent and complete information, that the independent governing board appropriately oversees the proposed project through: compliance with Health Center Program requirements (specifically see Program Requirements 17, 18, and 19 in Appendix F), including the quality and appropriateness of the governing board in terms of size, composition, and expertise; effective operations; and establishment and review of policies and procedures as documented in Items 1, 2, and 4 of the ***GOVERNANCE*** section of the Project Narrative, Attachment 3, Attachment 6 (if applicable), Attachment 9, Attachment 14, and Form 8.

2. **Public center applicants with a co-applicant governance structure ONLY**: How well the applicant demonstrates that the co-applicant's patient/community-based governing board meets the statutory requirements for board composition (e.g., size, expertise, member selection) and appropriate implementation of all board authorities, including setting health center policy (with the exception of general fiscal and personnel policies) as evidenced in Items 1, 2, and 4 of the ***GOVERNANCE*** section of the Project Narrative, Attachment 2 (if applicable), Attachment 3, Attachment 6, Attachment 14, and Form 8. See Appendix F for more information on required governance composition and authorities.

3. How well the applicant demonstrates, with consistent and complete information, that the project has an independent, patient/community-driven governing board that assumes full authority and responsibility for the health center, is responsive to the needs of patients, and ensures patient participation in the organization, direction, and ongoing governance of the center as documented in Item 2 of the ***GOVERNANCE*** section of the Project Narrative, Attachment 6 (if applicable), Attachment 14, and Form 8.

4. If the governing board is not currently operational and/or appropriate in any element, the quality of the applicant's plan (Attachment 2) for ensuring that the governing board becomes operational and compliant with the Health Center Program requirements within 120 days.

5. **Applicants targeting only special populations and planning to request a waiver of the 51 percent patient majority requirement ONLY**: the degree to which the applicant demonstrates the need for a waiver and the quality of the current/planned alternative procedures for ensuring patient participation in governance as documented in Item 3 of the ***GOVERNANCE*** section of the Project Narrative.

6. **Indian tribe or tribal, Indian, or urban Indian applicants ONLY**: How well the applicant demonstrates, with consistent and complete information, that the governance structure will ensure input from the community/target population on health center priorities, as well as the quality of the governing board's fiscal and programmatic oversight of the proposed project in Item 5 of the ***GOVERNANCE*** section of the Project Narrative, Attachment 2 (if applicable), and Attachment 14.

Criterion 7: SUPPORT REQUESTED (10 points)

1. How well the applicant demonstrates, with consistent and complete information, a detailed and appropriate budget presentation that supports the proposed project, including planned service delivery and patient projections, as documented in Items 1 and 2 of the ***SUPPORT REQUESTED*** section of the Project Narrative, SF-424A, budget justification, Form 1B, and Form 3, consistent with Form 1A, Form 2, and the ***RESPONSE*** section of the Project Narrative. If applicable, how well the applicant requesting MHC, HCH, and/or PHPC funding reflects the special population focus in the budget presentation.

2. How well the applicant demonstrates that the budget is realistic, and aligned and consistent with, the proposed service delivery plan and number of patients to be served through Item 3 of the ***SUPPORT REQUESTED*** section of the Project Narrative, budget justification, and SF-424A, consistent with Form 1A, Form 1B, and Form 3.

3. How well the applicant demonstrates that the total cost per patient and Federal cost per patient is appropriate and reasonable for the proposed NAP, considering the information provided in Item 4 of the ***SUPPORT REQUESTED*** section of the Project Narrative, the Forms Summary Page, and the Financial Performance Measure related to cost per patient.

2. Review and Selection Process

The Division of Independent Review is responsible for managing objective reviews within HRSA. Applicants competing for Federal funds receive an objective and independent review performed by a committee of experts qualified by training and experience in particular fields or disciplines related to the program being reviewed. In selecting review committee members, other factors in addition to training and experience may be considered to improve the balance of the committee (e.g., geographic distribution). Each reviewer is screened to avoid conflicts of interest and is responsible for providing an objective, unbiased evaluation based on the review

criteria noted in Section V.1 and the guidelines included in the HRSA Scoring Rubric located at http://www.hrsa.gov/grants/apply/assistance/NAP. The committee provides expert advice on the merits of each application to program officials responsible for final award selections.

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

Applications that pass the initial HRSA completeness and eligibility screening will be reviewed and rated by a panel of experts based on the program elements and review criteria presented in relevant sections of this funding opportunity announcement. The review criteria are designed to enable the review panel to assess the quality of a proposed project and determine the likelihood of its success. The criteria are closely related to each other and are considered as a whole in judging the overall quality of an application.

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

HRSA reserves the right to review fundable applicants for compliance with HRSA program requirements through reviews of site visits, audit data, Uniform Data System (UDS) or similar reports, Medicare/Medicaid cost reports, external accreditation, and other performance reports, as applicable. The results of this review may impact final funding decisions. For example, based on review of applicants by the Division of Financial Integrity, applicants with serious financial sustainability concerns will not receive a NAP award.

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

- Have three or more active 60 day health center program requirement conditions on current grant award;
- Have one or more 30 day health center program requirement condition(s) on current grant award; or
- Received initial Health Center Program funding in FY 2013 or FY 2014 and did not verify a site operational.

Following the objective review, all applications within the fundable range will be assessed by HRSA for an adjustment to the overall application score based on the funding priorities detailed below.

Funding Priorities

A funding priority is defined as the favorable adjustment of review scores when applications meet specified criteria. **Applicants do not need to request funding priorities.** Prior to final funding decisions, HRSA will assess all NAP applications within the fundable range for eligibility to receive priority point adjustment(s). The FY 2015 NAP funding opportunity has three funding priorities:

- ***Unserved, High Poverty Population (0-15 points):*** HRSA will assess the current Health Center Program penetration in the applicant's service area (defined by all the service area zip codes for all sites listed on Form 5B) along with the number of unserved, low-income individuals in the service area. For priority points to be awarded, the service area must meet two criteria:
  1) The proposed service area must have a Health Center Program (grantees and look-alikes) penetration rate for the low-income (below 200% of the poverty limit[13]) population at or below 25% (i.e., 75% or more of the proposed service area's low-income population is not being served under the Health Center Program); AND
  2) The number of low income residents not currently served under the Health Center Program must be at least 150% of the proposed patients to be served by the NAP site(s) as identified on Form 1A. For example, if the application proposes to serve 1,000 individuals, there must be at least 1,500 low-income residents in the proposed service area that are not being served under the Health Center Program.

  Applicants meeting the two criteria above will receive 3-15 points based on the table below. HRSA will utilize 2013 UDS data (2012 UDS data is currently available via UDS Mapper located at http://www.udsmapper.org) to complete this assessment.

Percent of High Poverty Unserved Residents Compared to Proposed Patients	Percent Penetration of the Low Income Population	Priority Points
150% or more	25% to 20.1%	3
150% or more	20% to 15.1%	6
150% or more	15% to 10.1%	9
150% or more	10% to 5.1%	12
150% or more	5% to 0%	15

- ***Sparsely Populated Area (5 points)*:** For applicants requesting funding to serve the general community (section 330(e) – CHC) alone or in combination with special populations funding (section 330(g) - MHC, 330(h) – HCH, and/or 330(i) – PHPC), HRSA will assess whether the entire proposed service area (defined by all the service area zip codes for all sites listed on Form 5B) has seven or fewer people per square mile. Applicants requesting funding ONLY under MHC, HCH, and/or PHPC are not eligible for this priority. Applicants with a service area of seven or fewer people per

[13] Since publically available income data (American Community Survey) are reported for "below 200% poverty of the FPL", data analyses (i.e., funding priorities, NFA worksheet) must be based on the population below 200%. However, sliding fee discounts must apply to individuals with incomes at or below 200% of the FPL.

square mile, will receive 5 points. HRSA will utilize US Census data to complete this assessment.

- ***Health Center Program Look-Alikes (5 points)*:** Health Center Program look-alikes are health centers that operate and provide services consistent with all statutory, regulatory, and policy requirements that apply to Health Center Program grantees, but do not receive funding under section 330. Based on this HRSA designation, applicants that were designated as Health Center Program look-alikes prior to October 1, 2013 are eligible to receive five priority points if the following conditions are met:

  1) The NAP application must include all current sites in the applicant's Health Center Program look-alike scope of project at the time of application (i.e., all sites listed on the look-alike Form 5B must be listed as sites on the NAP application Form 5B). Applicants may propose additional sites.
  2) The NAP application must include the service area zip codes on Form 5B in which at least 75% of current patients reside (based on the look-alike 2013 UDS report). Applicants may propose to serve additional service area zip codes.
  3) Complete 2013 patient data must have been reported in the Uniform Data System (UDS).
  4) The total unduplicated patient projection by December 31, 2016 on Form 1A must be greater than the total unduplicated patients included in the 2013 UDS report.
  5) The organization cannot have three or more Health Center Program requirement-related conditions at the time of application.

Special Funding Considerations

Other factors such as geographic distribution, past performance, and compliance with Health Center Program requirements and applicable regulations may be considered as part of the selection of applications for funding. Additionally, HRSA will consider the following factors in making FY 2015 NAP awards:

- *RURAL/URBAN DISTRIBUTION OF AWARDS:* Aggregate awards in FY 2015 will be made to ensure that no more than 60 percent and no fewer than 40 percent of health centers serve people from urban areas and no more than 60 percent and no fewer than 40 percent serve people from rural areas. In order to ensure this distribution, HRSA may award grants to applications out of rank order.

- *PROPORTIONATE DISTRIBUTION:* Aggregate awards in FY 2015 to support the various types of health centers will be made to ensure continued proportionate distribution of funds across the Health Center Program as set forth in section 330(r)(2)(B) of the PHS Act. In order to meet this distribution, HRSA may award grants to applications out of rank order.

- *GEOGRAPHIC CONSIDERATION:* The intent of this funding opportunity is to expand the current safety net on a national basis by creating new access points in areas not currently served by federally funded health centers. In order to meet this intent, HRSA

will consider geographic distribution and the extent to which an area may currently be served by Health Center Program grantee(s) when deciding which applications to fund.

3. Anticipated Announcement and Award Dates

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

VI. Award Administration Information

1. Award Notices

Each applicant will receive written notification of the outcome of the objective review process, including a summary of the objective review committee's assessment of the application's strengths and weaknesses, and whether the application was selected for funding. Applicants who are selected for funding may be required to respond in a satisfactory manner to conditions placed on their award before funding can proceed. Letters of notification do not provide authorization to begin performance.

The Notice of Award, the only authorizing document, will be sent prior to the project period start date. See Section 5.4 of the *HRSA Electronic Submission User Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2 of the *HRSA Electronic Submission User Guide*.

3. Reporting

Successful applicants under this FOA must comply with Section 6 of the *HRSA Electronic Submission User Guide* and the following reporting and review activities:

a. **Uniform Data System (UDS) Report –** The UDS is an integrated reporting system used to collect data on all health center programs to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments. All grantees are required to submit a Universal Report and, if applicable, a Grant Report annually. The Universal Report provides data on patients, services, staffing, and financing across all Health Center Program grantees. The Grant Report provides data on patients and services for special populations served (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing) by grantees.

b. **Progress Report –** A progress report must be submitted to HRSA on an annual basis. Submission and HRSA approval of the Budget Period Progress Report (BPR) non-competing continuation application will trigger the budget period renewal and release of each subsequent year of funding. The BPR documents progress on program-specific goals and collects core performance measurement data to track the progress and impact

of the project. Grantees will receive an email message via HRSA EHB when it is time to begin working on the progress report.

VII. Agency Contacts

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

Angela Wade
Division of Grants Management Operations
HRSA Office of Federal Assistance Management
5600 Fishers Lane
Rockville, MD 20857
301-594-5296
awade@hrsa.gov

Information related to overall program issues and/or technical assistance regarding this FOA may be obtained by contacting:

Joanne Galindo
Office of Policy and Program Development
HRSA Bureau of Primary Health Care
5600 Fishers Lane, Room 17C-05
Rockville, MD 20857
301-594-4300
BPHCNAP@hrsa.gov

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

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

Grants.gov Contact Center
Telephone: 1-800-518-4726
E-mail: support@grants.gov
iPortal: http://grants.gov/iportal

Note: Applicants should always obtain a case number when calling Grants.gov for support.

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

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

VIII. Other Information

Technical Assistance Page
A technical assistance Web site has been established to provide applicants with copies of forms, FAQs, and other resources that will help organizations submit competitive applications. To review available resources, visit http://www.hrsa.gov/grants/apply/assistance/NAP.

Federal Tort Claims Act Coverage/Medical Malpractice Insurance
Organizations that receive operational grants under the Health Center Program (sections 330(e), (g), (h), and/or (i)) are eligible for protection from claims or suits alleging medical malpractice through the Federally Supported Health Centers Assistance Act of 1992 (Act). The Act provides that health center employees may be deemed as Public Health Service (PHS) employees and thereby afforded protections of the Federal Tort Claims Act (FTCA) for the performance of medical, dental, surgical, and related functions.

Once funded, new grantees can apply through EHB to become deemed PHS employees for purposes of FTCA coverage as described above; however, they must maintain private malpractice coverage until the effective date of such coverage. **Deemed PHS employee status with resulting FTCA coverage is not guaranteed.** The Notice of Deeming Action (NDA) for an individual health center provides documentation of HRSA's deeming determination. Funded health centers that do not have or seek FTCA coverage must maintain private medical malpractice insurance coverage at all times. Applicants are encouraged to review the FTCA Health Center Policy Manual available at http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin201101manual.pdf or contact the BPHC Helpline at BPHCHelpline@hrsa.gov or 1-877-974-2742 for additional information.

340B Drug Pricing Program
The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, codified as Section 340B of the Public Health Service Act, as amended (see http://www.hrsa.gov/opa/programrequirements/phsactsection340b.pdf). The program limits the cost of covered outpatient drugs for certain Federal grantees, look-alikes, and qualified disproportionate share hospitals. Covered entities may realize a cost savings of 20-50 percent on outpatient drug purchases and additional savings on other value-added services through participation in the 340B Prime Vendor Program (PVP). Pharmacy related technical assistance is available at 866-PharmTA (866-742-7682). There is no cost to participate in the 340B program or the 340B Prime Vendor Program, and eligible entities are not required to have an established in-house pharmacy to participate. For additional information, please contact the Office of Pharmacy Affairs (OPA) at 800-628-6297 or visit the OPA Web site at http://www.hrsa.gov/opa/index.html.

Appendix A: Program Specific Forms Instructions

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

FORM 1A – GENERAL INFORMATION WORKSHEET (REQUIRED)
Form 1A provides a summary of information related to the proposed NAP project.

1. APPLICANT INFORMATION

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

2. PROPOSED SERVICE AREA

2a. Target Population and Service Area Designation

- Population Types: The type of funding requested (i.e., section 330(e)-CHC, section 330(g)-MHC, section 330(h)-HCH, and/or section 330(i)-PHPC) will be pre-populated from the Budget Summary form. Refer to Section I.3 for definitions of the MHC, HCH, and PHPC populations. To change the population type, go to the Budget Summary page of the standard forms and click on Change Sub-Program.
- Service Area Designation: Applicants seeking section 330(e) funding for Community Health Centers (CHC) MUST serve a Medically Underserved Area (MUA) and/or Medically Underserved Population (MUP). Select the MUA and/or MUP designations for the proposed service area and enter the identification number. For information regarding MUAs or MUPs, visit the Shortage Designation Web site at http://www.hrsa.gov/shortage, call 1-888-275-4772 (option 1 then option 2), or contact the Shortage Designation Branch at SDB@hrsa.gov or 301-594-0816.

2b. Service Area Type

- Select the type (Urban, Rural, or Sparsely Populated) that describes the majority of the service area. To be determined sparsely populated, the entire proposed service area must have seven or fewer people per square mile. For information about rural populations, visit the Office of Rural Health Policy's Web site at http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html.

2c. Target Population Information:

- Applicants with more than one proposed new access point should report aggregate data for all of the sites included in the NAP application.
- New start applicants should report combined data for all of the sites to be included under the scope of project.
- Satellite applicants should report data for the proposed new access point(s) ONLY.

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

Projecting Patients and Visits:
When providing the count of patients and visits, ensure that the projections are realistic and appropriate based on the proposed NAP project. If funded, grantees will be held accountable for meeting these patient projections in future continuation applications. Note the following definitions and guidelines (see the UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics/reporting for detailed information):

- A visit is a documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services must be documented in the patient's record. Such contacts provided by contractors and paid for by the applicant are considered to be visits.
- A patient is an individual who had at least one visit in the previous year.
- Since a patient must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.
- Do not report patients and visits for services outside the organization's proposed scope of project. Specifically, the scope of project defines the service sites, services, providers, service area, and target population for which Health Center Program grant funds may be used. For more information, see PIN 2008-01 available at http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin2008-01.pdf.
- Do not report patients and visits for pharmacy services.

Patients and Visits by Service Type:

- Project the number of patients and visits anticipated within each service type category across all proposed NAP sites by December 31, 2016. Within each service type category (medical, dental, mental health, substance abuse, and enabling services), an individual can only be counted once as a patient. An individual who receives multiple types of services should be counted once for each service type (e.g., once for medical and once for dental).
- Because a new access point's main purpose must be the provision of comprehensive primary medical care, the number of projected medical patients must be equal to or greater than the number of projected patients within each of the other service types.

Unduplicated Patients and Visits by Population Type:

- Project the number of patients and visits anticipated within each population type category across all proposed NAP sites by December 31, 2016.
- Data reported for patients and visits should not be duplicated within or across the four target population categories (i.e., General Community, Migratory and Seasonal Agricultural Workers, Public Housing Residents, Homeless Persons). Note that Population Type in this table refers to the population being served, not the funding type (i.e., section 330(g), section 330(h), section 330(i)). For example, an applicant applying for only CHC funding (general underserved community – section 330(e)) may still have patients/visits reported in the other population type categories.

- The number of patients to be served by December 31, 2016 will be used to calculate the Unserved, High Poverty Priority Points and will be the number of patients grantees will be held accountable for serving by December 31, 2016 as reported in UDS.

FORM 1B – BPHC FUNDING REQUEST SUMMARY (REQUIRED)
Form 1B collects the funding request for the NAP application. The maximum amount of funding in Year 1 is $650,000; any one-time funding requested for equipment or minor alteration and renovation (up to $150,000) is included in this amount. Applicants can request up to $650,000 for operations in Year 2. Before completing Form 1B, the SF-424A: Budget Information form must be completed. See Appendix E for instructions on completing the SF-424A.

For the Year 1 operational funding column, enter operational budget information by funding category (CHC, MHC, HCH, and/or PHPC) and then enter any one-time funds requested for minor alteration/renovation, which may also include equipment. No more than $150,000 can be requested for one-time funds for minor alteration/renovation and/or equipment. Only the types of health center programs selected in the Budget Summary (Section A) of the SF-424A will be available in Form 1B. The budget for Year 2 on Form 1B will be pre-populated from data provided by the applicant in Federal Resources (Section E) of the SF-424A.

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

Applicants requesting one-time funding for equipment and/or minor alteration/renovation must indicate if the one-time funds are for: 1) equipment only; 2) minor alteration/renovation with equipment; or 3) minor alteration/renovation without equipment. Applicants requesting one-time funding for equipment only or minor alteration/renovation with equipment must complete an equipment list. Equipment is considered to be loose, moveable items that have a useful life of more than one year. See Appendix D for detailed instructions on equipment requirements.

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

FORM 1C – DOCUMENTS ON FILE (REQUIRED)
Provide the date that each document listed was last reviewed and, if appropriate, revised. Form 1C provides a summary of documents that support the implementation of Health Center Program requirements and key areas of health center operations. The form lists the corresponding Health Center Program requirements found in Appendix F and at http://bphc.hrsa.gov/about/requirements. Reference this list for more detailed information about each requirement.

All documents noted on Form 1C should be maintained and updated by key management staff and, as appropriate, approved and monitored by the health center's governing board. **Any document on Form 1C that is not in place or current should be included on the Implementation Plan (Attachment 2) to ensure compliance with Health Center Program requirements within 120 days of the Notice of Award.**

Keep these documents on file, making them available to HRSA **upon request** within 3-5 business days. DO NOT submit these documents with the application. Please note that Form 1C is not intended to provide an exhaustive list of all types of health center documents (e.g., policies and procedures, protocols, legal documents).

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

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

FORM 2 – STAFFING PROFILE (REQUIRED)

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

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

The Staffing Profile should be consistent with the amounts for personnel costs included in the budget justification. However, the amount for total salaries (this figure will auto-calculate in EHB) may not match the amount allocated for the Personnel cost category of the Budget Summary Form due to the inclusion of salaries charged to indirect costs on the Staffing Profile.

FORM 3 – INCOME ANALYSIS (REQUIRED)
Complete Form 3 to show the projected patient services and projected income from all sources (other than the Health Center Program grant), for each year of the proposed NAP project period. Form 3 must be based ONLY on the proposed NAP project. Form 3 income is divided into two parts: (1) program income (known as patient service revenue) and (2) all other income.

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

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

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

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

Patient service revenue associated with sites or services not in the NAP scope of project is to be excluded.

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

- A crossover patient with Medicare & 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.

Column (b): Billable Visits: These include all billable/reimbursable visits.[14] There may be other exclusions or additions which, if significant, should be noted in the Comments/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column (see ancillary instructions under the payer categories below).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Note: DO NOT include in-kind donations on the Income Analysis form. However, applicants may discuss in-kind contributions in Item 2 of the *SUPPORT REQUESTED* section of the Project Narrative. Additionally, such donations may be included on the SF-424A (Section A: Budget Summary—Non-Federal Resources under New or Revised Budget).

FORM 4 – COMMUNITY CHARACTERISTICS (REQUIRED)
Report service area and target population data for the entire scope of the project (i.e., all proposed NAP sites) for which data are available. Information provided regarding race and ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements and will not be used as an awarding factor.

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

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

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

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

Guidelines for Reporting Race
All individuals must be classified in one of the racial categories, including individuals who also consider themselves Hispanic or Latino. If the data source does not separately classify Hispanic or Latino individuals by race, report them as Unreported/Declined to Report. Utilize the following race definitions:

- Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
- Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, Palau, Tonga, Chuuk, Yap, or other Pacific Islands in Micronesia, Melanesia, or Polynesia.
- Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

- American Indian/Alaska Native – Persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- More Than One Race – Persons who identify with two or more races.

Guidelines for Reporting Hispanic or Latino Ethnicity

- If ethnicity is unknown, report individuals as Unreported/Declined to Report.
- 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.

Note: Applicants compiling data from multiple data sources may find that the total numbers vary across sources. Such applicants should make adjustments as needed to ensure that the total numbers for the first four sections of this form match.

Guidelines for Reporting Special Populations

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

FORM 5A – SERVICES PROVIDED (REQUIRED)

Identify the services that will be available through the proposed new access point(s) and how the services will be provided (i.e., Direct by Health Center, Formal Written Agreement (Health Center Pays for Service), Formal Written Referral Arrangement). The new access point(s) must provide the required services either directly onsite or through established agreements/ arrangements without regard to ability to pay and on a sliding fee discount schedule. Established agreements must be summarized in Attachment 7 and, if they constitute a significant portion of the applicants scope of project, agreements/contracts must be noted on Form 8.

Information presented on Form 5A will be used by HRSA to determine the scope of project for the NAP grant. Only the services included on Form 5A will be considered to be in the approved scope of project. Services described or detailed in other portions of the application (e.g., narratives, attachments) are not considered to be included in the approved scope of project if the application is funded. Refer to the Scope of Project policy documents available at http://bphc.hrsa.gov/about/requirements/scope for more information on services and modes of service delivery.

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

FORM 5B – SERVICE SITES (REQUIRED)
Identify the NAP site(s).[15] Applicants must certify on the Summary Page Form that all sites included on Form 5B will be open and operational within 120 days of Notice of Award. Provide the required data for each proposed new access point that meets the definition of a service site. Refer to PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes available at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html for more information on defining service sites and for special instructions for recording mobile, intermittent, or other site types. Information presented on Form 5B will be used by HRSA to determine the scope of project for the NAP grant. Only the service sites included on Form 5B will be considered to be in the approved scope of project. Service sites described or detailed in other portions of the application (e.g., narratives, attachments) are not considered to be included in the approved scope of project if the application is funded. On each Form 5B, applicants should include the zip codes for the area served by the site. The zip code of the site address must be listed in the service area zip codes on Form 5B. The applicant's entire service area (as described on Form 4) should be represented by the consolidation of all zip codes across all proposed service sites (all 5B forms). The zip codes listed on Form 5B will be used to calculate the Unserved, High Poverty and Sparsely Populated Priority Points.

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

NOTE: In HRSA EHB, applicants will have to state if the proposed site is a Domestic Violence site (e.g., emergency shelter). If so, applicants will not provide a street address to protect the confidentiality of the precise location.

FORM 5C – OTHER ACTIVITIES/LOCATIONS (AS APPLICABLE)
Provide requested data for other activities/locations (e.g., home visits, health fairs). List only the activities/locations that: 1) do not meet the definition of a service site; 2) are conducted on an irregular timeframe/schedule; and/or 3) offer a limited activity from within the full complement of health center activities included within the scope of project. NAP service site(s) should not be listed. Refer to PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes (available at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html) for more details.

Information presented on Form 5C will be used by HRSA to determine the scope of project for the NAP grant. Note that Form 5C will only add activities/locations to the scope of the project that meet the criteria listed above. Any additional activities/locations described or detailed in other portions of the application (e.g., narratives, attachments) that are not listed on Form 5C are not considered to be included in the approved scope of project if the application is funded.

[15] A current Health Center Program look-alike may propose the site(s) currently included in its Health Center Program look-alike scope of project, as well as new site(s), as long as those sites are not included in any Health Center Program grantee's scope of project.

FORM 6A – CURRENT BOARD MEMBER CHARACTERISTICS (REQUIRED)
List all current board members and provide the requested details. For more information regarding board requirements, refer to the Health Center Program Governance policy available at http://www.bphc.hrsa.gov/policiesregulations/policies/pin201401.html.

- Public entities with co-applicant health center governing boards must list the co-applicant board members.
- Applicants planning to request a waiver of the 51% patient majority requirement must list the health center's board members, not the members of any advisory councils.
- List the current board office position held for each board member, if applicable (e.g., Chair, Treasurer).
- List each board member's 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. Patient board members must be a current registered patient of the health center and must have accessed the health center in the past 24 months to receive at least one service (in scope) that generated a health center visit. (Refer to Form 1A instructions above for the definition of a visit).
- Indicate if each board member lives and/or works in the service area. Note: This is not a requirement to serve on a health center board, but assists with assessing how representative the board is of the community being served.
- List how long each individual has served on the board.
- Indicate if each board member is a representative of/for a special population (i.e., persons experiencing homelessness, migratory and seasonal agricultural workers, residents of public housing).
- Indicate gender, ethnicity, and race of board members who are patients of the health center.

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

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

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

Complete Part II, Governance Checklist. If the response to any of the Governance Checklist items is **No**, the response to the question regarding agreements/arrangements affecting the governing board's composition, authorities, functions, or responsibilities must be **Yes**, and the

number of such agreements/arrangements must be indicated. Additionally, **No** responses for the Governance Checklist must be explained in Item 2 of the *RESOURCES/CAPABILITIES* section of the Project Narrative. Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups may select **Yes** for all items on the Governance Checklist.

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

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

FORM 9 – NEED FOR ASSISTANCE (NFA) WORKSHEET (REQUIRED)

The worksheet is presented in three sections: Core Barriers, Core Health Indicators, and Other Health and Access Indicators. Refer to the Data Resource Guide (available at http://www.hrsa.gov/grants/apply/assistance/NAP) for recommended data sources and methodology. To ensure data consistency and validity, applicants must adhere to the following instructions when completing the form. Applicants will be asked to verify the validity of NFA data on the Summary Page Form.

GENERAL INSTRUCTIONS

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

- **New start applicants** must complete the NFA Worksheet based on the entire proposed scope of project.
- **Satellite applicants** must complete the NFA Worksheet based on the **proposed new access point(s) ONLY.**

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

Guidelines for Completing the NFA Worksheet:

- If no response is provided for a particular barrier or health indicator, or if the data source and date for the response are not provided, no points will be awarded for that barrier or health indicator.
- All responses must be expressed as a finite number (e.g., 212.5) and cannot be presented as a range (e.g., 31-35).

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

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

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

POPULATION BASIS FOR DATA

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

Data Reporting Guidelines Table

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

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

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

Extrapolation

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

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

The following scenarios assume that data is available according to differentiating demographics, and that the applicant can describe the target area or subpopulation to be served according to the demographics.

Scenario 1: Extrapolation to a Service Area from a larger area

Data are available at the county level but the applicant's service area includes only certain Census tracts within that county. The applicant would follow instructions in the Data Resource Guide for how to extrapolate data from the larger geographic area to the service area.

Scenario 2: Extrapolation to a Target Population from the Service Area population
Data are available at a geographic level that matches the service area, but the applicant is serving a specific target population within that area. The applicant would follow instructions in the Data Resource Guide for how to extrapolate data from the service area to the target population.

Scenario 3: Extrapolation to a Service Area and Target Population from the total population in a larger area
Data are available at the county level. The applicant's target population is the low-income population in a service area comprised of certain Census tracts within that county. The applicant would follow instructions in the Data Resource Guide for how to extrapolate data from the county to the service area and the target population within that area.

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

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

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

(b) Applicants must provide the following information:

- **Data Response—**The data reported for each indicator on which the NFA score will be based.
- **Year to which Data Apply—**Provide the year of the data source. If the data apply to a period of more than one year, provide the most recent year for the data reported.
- **Data Source/Description**—If a data source other than what is included in the Data Resource Guide is utilized, name the data source and provide a rationale (e.g., more current, more geographically specific, more population specific). For example, if a county-level survey which meets all the required criteria was used, name that survey and provide a rationale for using it.
- **Methodology Utilized/Extrapolation Method**—Provide the following information:
    - Extrapolation methodology used – State whether extrapolation was from one geographic area to another, one population to another, both, or none.
    - Differentiating factor used – Describe the demographic factor upon which the extrapolation was based (e.g., rates by age, gender) and data source.

- Level of geography – State geographic basis for the data (e.g., the data source may be a national survey, but the geographic basis for extrapolation was at the county level).

- **Identify Geographic Service Area or Target Population for Data**—Define the service area and/or target population used (e.g., zip codes, Census tracts, MUA or MUP designation, population type).

NFA WORKSHEET SCORING (Maximum 100 points to be converted to a 20-point scale)
The NFA Worksheet will be scored out of a total possible 100 points. If no response or data source is provided for a Barrier or Indicator, **no** points will be awarded for that indicator.

SECTION I: CORE BARRIERS (Maximum 60 points)
A response is required for **3 of the 4 Core Barriers**. The points awarded for each Barrier response will be calculated using the point distributions provided below.

a. Population to One FTE Primary Care Physician

Population to One FTE Primary Care Physician	
Scaling	**Points**
< 1641	0
1641 to <1979	1
1979 to <2318	2
2318 to <2656	3
2656 to <2995	4
2995 to <3333	5
3333 to <3672	6
3672 to <4010	7
4010 to <4348	8
4348 to <4687	9
4687 to <5025	10
5025 to <5364	11
5364 to <5702	12
5702 to <6040	13
6040 to <6379	14
6379 to <6717	15
6717 to <7056	16
7056 to <7394	17
7394 to <7733	18
7733 to <8071	19
≥ 8071	20

b. Percent of Population Below 200 Percent of Poverty[16]

Percent of Population Below 200% of Poverty	
Scaling	**Points**
< 36.6%	0
36.6% to <38.2%	1
38.2% to <39.8%	2
39.8% to <41.5%	3
41.5% to <43.1%	4
43.1% to <44.7%	5
44.7% to <46.3%	6
46.3% to <47.9%	7
47.9% to <49.6%	8
49.6% to <51.2%	9
51.2% to <52.8%	10
52.8% to <54.4%	11
54.4% to <56.1%	12
56.1% to <57.7%	13
57.7% to <59.3%	14
59.3% to <60.9%	15
60.9% to <62.5%	16
62.5% to <64.2%	17
64.2% to <65.8%	18
65.8% to <67.4%	19
≥ 67.4%	20

[16] Data must be submitted for the proposed service area (not the target population), unless serving special population(s) ONLY.

c. Percent of Population Uninsured[17]

Percent of Population Uninsured	
Scaling	Points
< 14.1%	0
14.1% to <14.9%	1
14.9% to <15.8%	2
15.8% to <16.6%	3
16.6% to <17.5%	4
17.5% to <18.3%	5
18.3% to <19.2%	6
19.2% to <20.0%	7
20.0% to <20.9%	8
20.9% to <21.7%	9
21.7% to <22.6%	10
22.6% to <23.4%	11
23.4% to <24.3%	12
24.3% to <25.1%	13
25.1% to <26.0%	14
26.0% to <26.8%	15
26.8% to <27.7%	16
27.7% to <28.5%	17
28.5% to <29.4%	18
29.4% to <30.2%	19
≥ 30.2%	20

d. Distance (miles) OR travel time (minutes) to nearest primary care provider accepting new Medicaid and uninsured patients

Distance (in miles)	Driving time (in minutes)	
Scaling	Scaling	Points
< 7	< 13	0
7 to <10	13 to <17	1
10 to <12	17 to <20	2
12 to <14	20 to <23	3
14 to <16	23 to <26	4
16 to <18	26 to <29	5
18 to <20	29 to <33	6
20 to <22	33 to <36	7
22 to <25	36 to <39	8
25 to <27	39 to <42	9
27 to <29	42 to <45	10
29 to <31	45 to <49	11
31 to <33	49 to <52	12
33 to <35	52 to <55	13
35 to <37	55 to <58	14
37 to <40	58 to <62	15
40 to <42	62 to <65	16
42 to <44	65 to <68	17
44 to <46	68 to <71	18
46 to <48	71 to <74	19
≥ 48	≥ 74	20

SECTION II: CORE HEALTH INDICATORS (Maximum 30 points)

Applicant must provide a response to **1 core health indicator from each of the 6 categories**: Diabetes, Cardiovascular Disease, Cancer, Prenatal and Perinatal Health, Child Health, and Behavioral Health. The table below provides the national median (50th percentile) benchmark and, where applicable, the severe (75th percentile) benchmark for each indicator within the six categories. Benchmarks are based on national public data sources such as the Centers for Disease Control, Substance Abuse and Mental Health Services Administration, Agency for Healthcare Research and Quality, HRSA, and the Census.

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

[17] Data must be submitted for the proposed service area (not the target population), unless serving special population(s) ONLY.

If an applicant determines that none of the specified indicators represent the applicant's service area or target population, the applicant may propose to use an "Other" alternative for that core health indicator category. In such a case, the applicant must specify the indicator's definition, data source, benchmark, source of the benchmark, and rationale for using the alternative indicator. However, the applicant will **NOT** be eligible for additional points for exceeding a severe benchmark (four points maximum for each "Other" indicator). See the Data Resource Guide for detailed instructions on providing documentation for an "Other" indicator.

SECTION II: CORE HEALTH INDICATOR CATEGORIES	**National Median Benchmark (4 Points if Exceeded)**	**Severe Benchmark (1 Additional Point if Exceeded)**
1. Diabetes		
1(a) Age-adjusted diabetes prevalence	8.1%	9.2%
1(b) Adult obesity prevalence	27.6%	30.2%
1(c) Age-adjusted diabetes mortality[18] rate (per 100,000)	22.5	24.8
1(d) Percent of diabetic Medicare enrollees not receiving a hemoglobin A1c (HbA1c) test	18.0%	20.4%
1(e) Percent of adults (18 years and older) with no physical activity in the past month	24.0%	26.6%
1(f) Other	*Provided by Applicant*	*N/A*
2. Cardiovascular Disease		
2(a) Hypertension hospital admission rate (18 years and older; per 100,000)	61.4	66.3
2(b) Congestive heart failure hospital admission rate (18 years and older; per 100,000)	361.7	378.3
2(c) Age-adjusted mortality from diseases of the heart[19] (per 100,000)	179.4	203.2
2(d) Proportion of adults reporting diagnosis of high blood pressure	28.7%	31.4%
2(e) Percent of adults who have not had their blood cholesterol checked within the last 5 years	23.1%	25.7%
2(f) Age-adjusted cerebrovascular disease mortality (per 100,000)	41.4	46.3
2(g) Other	*Provided by Applicant*	*N/A*
3. Cancer		
3(a) Cancer screening – percent of women 18 years and older with no Pap test in past 3 years	18.4%	20.1%
3(b) Cancer screening – percent of women 50 years and older with no mammogram in past 2 years	22.2%	25.8%
3(c) Cancer screening – percent of adults 50 years and older with no fecal occult blood test (FOBT) within the past 2 years	83.3%	85.0%

[18] Number of deaths per 100,000 reported as due to diabetes as the underlying cause or as one of multiple causes of death (ICD-10 codes E10-E14).
[19] Total number of deaths per 100,000 reported as due to heart disease (includes ICD-10 codes I00-I09, I11, I13, and I20-I51).

SECTION II: CORE HEALTH INDICATOR CATEGORIES	National Median Benchmark (4 Points if Exceeded)	Severe Benchmark (1 Additional Point if Exceeded)
3(d) Percent of adults who currently smoke cigarettes	17.3%	20.3%
3(e) Age-adjusted colorectal cancer mortality (per 100,000)	14.0	15.2
3(f) Age-adjusted breast cancer mortality (per 100,000) among females	22.1	23.8
3(g) Other	*Provided by Applicant*	*N/A*
4. Prenatal and Perinatal Health		
4(a) Low birth weight (<2500 grams) rate (5 year average)	7.9%	9.4%
4(b) Infant mortality rate (5 year average; per 1,000)	6.6	7.9
4(c) Births to teenage mothers (ages 15-19; percent of all births)	8.4%	10.0%
4(d) Late entry into prenatal care (entry after first trimester; percent of all births)	16.4%	21.1%
4(e) Cigarette use during pregnancy (percent of all pregnancies)	14.1%	18.2%
4(f) Percent of births that are preterm (<37 weeks gestational age)	12.0%	13.0%
4(g) Other	*Provided by Applicant*	*N/A*
5. Child Health		
5(a) Percent of children (19-35 months) not receiving recommended immunizations: 4-3-1-3-3-1-4[20]	30.0%	34.6%
5(b) Percent of children not tested for elevated blood lead levels by 72 months of age	84.1%	89.3%
5(c) Pediatric asthma hospital admission rate (2-17 year olds; per 100,000)	116.0	148.3
5(d) Percent of children (10-17 years) who are obese	15%	18.1%
5(e) Other	*Provided by Applicant*	*N/A*
6. Behavioral Health		
6(a) Percent of adults with at least one major depressive episode in the past year	6.6%	7.3%
6(b) Suicide rate (per 100,000)	13.5	15.2
6(c) Binge alcohol use in the past month (percent of population 12 years and older)	24.1%	26.1%
6(d) Age-adjusted drug poisoning (i.e., overdose) mortality rate per 100,000 population	12.3	14.8
6(e) Other	*Provided by Applicant*	*N/A*

[20] 4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B, 1 varicella, and 4 Pneumococcal conjugate.

SECTION III: OTHER HEALTH AND ACCESS INDICATORS (Maximum 10 points)
Applicants must provide responses to **2 of the 13** Other Health and Access Indicators. Applicants will receive 5 points for each response that **exceeds** the corresponding national median benchmark provided in the table below.

OTHER HEALTH AND ACCESS INDICATORS	National Median Benchmark (5 Points if Exceeded)
(a) Age-adjusted death rate (per 100,000)	764.8
(b) HIV infection prevalence	0.2%
(c) Percent elderly (65 and older)	15.2%
(d) Adult asthma hospital admission rate (18 years and older; per 100,000)	130.7
(e) Chronic Obstructive Pulmonary Disease hospital admission rate (18 years and older; per 100,000)	227.2
(f) Influenza and pneumonia death[21] rate (3 year average; per 100,000)	18.6
(g) Adult current asthma prevalence	9.0%
(h) Age-adjusted unintentional injury deaths (per 100,000)	40.0
(i) Percent of population linguistically isolated (people 5 years and over who speak a language other than English at home)	10.3%
(j) Percent of adults (18+ years old) that could not see a doctor in the past year due to cost	13.4%
(k) Percentage of adults 65 years and older who have not had a flu shot in the past year	32.6%
(l) Chlamydia (sexually transmitted infection) rate (per 100,000)	389.5
(m) Percent of adults without a visit to a dentist or dental clinic in the past year for any reason	30.4%

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

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

NFA WORKSHEET TO APPLICATION SCORE CONVERSION TABLE

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

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

FORM 12 – ORGANIZATION CONTACTS (REQUIRED)
Provide the requested contact information. For the Contact Person field, provide an individual who can represent the organization in communication regarding the application.

SUMMARY PAGE – (REQUIRED)
This form will enable applicants to verify key application data utilized 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) have been entered correctly. Reference will be provided regarding where to make corrections if needed.

Note that the population funding percentages (i.e., percentage of funding requested for CHC, MHC, HCH, and/or PHPC) will be based on operational funds requested for Year 2 and will therefore not include any one-time funding requested. The population funding percentages and Federal dollars per patient will be automatically calculated. The Federal dollars per patient will be calculated by dividing the Federal dollar amount requested by the projected number of patients at the end of the project period by population type entered on Form 1A.

This form will be certified by checking a box at the bottom to signify that the applicant has double-checked all information provided to ensure accuracy. Funded applicants will be held accountable for:

- having **all proposed sites** (from Form 5B) open and operational within 120 days of Notice of Award, and
- meeting the **unduplicated patient projection** (from Form 1A), defined as full operational capacity, by December 31, 2016.

Appendix B: Program Specific Information Instructions

CLINICAL AND FINANCIAL PERFORMANCE MEASURES

The Clinical and Financial Performance Measures set the clinical and financial goals for the two-year project period (enter 2/1/15 – 1/31/2017). The goals and performance measures should be responsive to the proposed target population, identified community health and organizational needs, and key service delivery activities discussed in the project narrative. For more information on the Clinical and Financial Performance Measures, see http://bphc.hrsa.gov/policiesregulations/performancemeasures/ and http://www.hrsa.gov/data-statistics/health-center-data/reporting (refer to the UDS Reporting Manual for specific measurement details such as exclusionary criteria). Sample forms can be found at http://www.hrsa.gov/grants/apply/assistance/nap.

Required Clinical Performance Measures

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

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

Required Financial Performance Measures

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

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

Important Details about the Performance Measures Forms

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

- Satellite applicants are expected to complete the Clinical and Financial Performance Measures based on their proposed new access point(s) ONLY.

- If applying for funds to target one or more special populations (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing) in addition to the general community, applicants *must include* at least one additional Clinical Performance Measure that addresses the unique health care needs of each of the special populations. In providing additional performance measures specific to a special population, applicants must reference the target group in the performance measure. For example, if an applicant seeks funds to serve migratory and seasonal agricultural workers, then the applicant must propose to measure *"the percentage of migratory and seasonal agricultural workers who…"* ***rather than*** simply *"the percentage of patients who…"*

- If applicants have identified unique health issues or described populations/lifestages targeted for services in the ***NEED*** section of the project narrative, they are encouraged to include additional related performance measures. To add a performance measure of your choice, click on "Add Other Performance Measure" in EHB.

Baselines for performance measures should be developed from data that are valid, reliable, and whenever possible, derived from currently established management information systems. If baselines are not yet available, state in the comments field when data will be available.

Special Instructions for the Clinical Performance Measures

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

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

The **Child Health Performance Measure** includes the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumococcal conjugate vaccines by age 3.

The **Cancer Screening Performance Measure** has been modified to include the following: Number of female patients age 21 - 64 years of age who received one or more documented Pap tests during the measurement year or during the two years prior to the measurement year OR, for women age 30 - 64 who received a Pap test accompanied with an HPV test done during the measurement year or the four years prior who had at least one medical visit during the reporting year.

The **Tobacco Use Screening and Cessation Performance Measure** combines Tobacco Use Assessment and Tobacco Cessation Counseling into one performance measure.

New Clinical Performance Measures have been added for **New HIV Cases With Timely Follow Up** and **Depression Screening and Follow Up**. Refer to Program Assistance Letter 2014-01 located at http://bphc.hrsa.gov/policiesregulations/policies/pal201401.pdf for more information.

Table 6: Overview of Performance Measures Form Fields

Field Name	Notes
Focus Area	This field contains the content area description for each required performance measure. Applicants must specify focus areas for Oral Health and Other performance measures.
Performance Measure	This field defines each performance measure. Applicants may specify this field for Oral Health and Other performance measures.
Performance Measure Applicability	Audit-related Financial Performance Measures (Change in Net Assets to Expense Ratio, Working Capital to Monthly Expense Ratio, and Long Term Debt to Equity Ratio) may be marked *Not Applicable* ONLY by tribal and public center applicants. As desired, these applicants may choose to include substitute measures.
Target Goal Description	This field provides a description of the target goal. Applicants must specify this field for all measures.
Numerator Description	In the case of the Clinical Performance Measures, the numerator is the number of patients that meet the criteria identified by the measure (e.g., patients in a specified age range that received a specified service). In the Financial Performance Measures, the numerator field must be specific to the organizational measure. Applicants must specify a numerator for Oral Health and Other performance measures. The numerator for all other measures can be found at http://bphc.hrsa.gov/policiesregulations/performancemeasures.
Denominator Description	In the case of the Clinical Performance Measures, the denominator is all patients to whom the measure applies (e.g., patients in a specified age range, regardless of whether they received a specified service). In the Financial Performance Measures, the denominator field must be specific to the organizational measure. Applicants must specify a denominator for Oral Health and Other performance measures. The denominator for all other measures can be found at http://bphc.hrsa.gov/policiesregulations/performancemeasures.
Baseline Data Baseline Year Measure Type Numerator Denominator	This field contains subfields that provide information regarding the initial threshold used to measure progress over the course of the 2-year project period. The Baseline Year subfield identifies the initial data reference point. The Measure Type subfield provides the unit of measure (e.g., percentage, ratio). The Numerator and Denominator subfields specify patient or organizational characteristics (see above).
Projected Data	This field provides the goal for the end of the 2-year project period.
Data Source and Methodology	This field provides information about the data sources used to develop the performance measures. Applicants are required to identify data sources and discuss the methodology used to collect and analyze data (e.g., electronic health records (EHR), disease registries). Data must be valid, reliable, and derived from established management information systems. For Clinical Performance Measures, applicants must select the data source—EHR, Chart Audit, or Other (please specify)—before describing the methodology. For Financial Performance Measures, note if data are based on the most recent audit.

Field Name	Notes
Key Factors and Major Planned Actions Key Factor Type Key Factor Description Major Planned Action Description	The Key Factor Type subfield requires applicants to select Contributing and/or Restricting factor categories. Contributing factors are those that are predicted to positively impact goal attainment, while restricting factors are those predicted to negatively impact goal attainment. Applicants must specify at least one key factor of each type. In the Key Factor Description subfield, applicants provide a narrative description of the factors predicted to contribute to and restrict progress toward stated goals. In the Major Planned Action Description subfield, applicants provide a description of the major actions planned for addressing the identified key factors. Applicants must use this subfield to outline major action steps and strategies for achieving each performance measure. This field has a 1,000-character limit.
Comments	This open text field, limited to 1,500 characters, enables applicants to provide additional information. Information exceeding the character limit should be placed in the *EVALUATIVE MEASURES* section of the Project Narrative.

Resources for the Development of Performance Measures

- Examine the performance measures of other health centers that serve similar target populations.
- Consider state and national performance UDS benchmarks and comparison data (available at http://bphc.hrsa.gov/healthcenterdatastatistics/index.html).
- Note that many UDS clinical performance measures are aligned with the meaningful use measures specified at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_MeasuresTable_Posting_CQMs.pdf.
- Use the Healthy People 2020 goals as a guide when developing performance measures. Healthy People 2020 objectives are available at http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf. Several of these objectives can be compared directly to UDS clinical performance measures (high blood pressure under control, diabetes HbA1c readings less than or equal to nine, cervical cancer screening, low birth weight infants, access to prenatal care in the first trimester, and colorectal cancer screening). A table outlining the Healthy People 2020 objectives related to these performance measures can be found at http://www.hrsa.gov/grants/apply/assistance/nap.

Appendix C: Implementation Plan

Applicants are expected to demonstrate that they will be operational and compliant with Health Center Program requirements (see Appendix F) within 120 days of award. The Implementation Plan (as noted in the ***RESPONSE*** section of the Project Narrative) is the applicant's opportunity to outline the action steps necessary to ensure that the new access point(s) will be open, operational, and compliant within the 120-day timeframe. Instructions for developing the Implementation Plan are provided below. A sample Implementation Plan is provided on the NAP technical assistance Web site at http://www.hrsa.gov/grants/apply/assistance/nap.

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

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

The Implementation Plan must be specific to the proposed NAP project and should include operational, administrative, governance, and program policy activities (e.g., EHR implementation, staffing, reimbursement enrollment, board composition) to be undertaken as appropriate. Applicants may choose any of the following from the below list of focus areas and goals, or may include other focus areas and goals as desired. The Implementation Plan will be reviewed in conjunction with the Project Narrative, Program Specific Forms, and required attachments to evaluate the application. For NAP applicants proposing site(s) that are currently operational and compliant with Health Center Program requirements, the Implementation Plan should demonstrate compliance and highlight proposed changes in access to care, such as planned service expansion and outreach activities, new collaborations/partnerships, and any other changes that would occur within 120 days of the Notice of Award as a result of the NAP funding.

Focus Area: Operational Service Delivery Program

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

Focus Area: Functioning Key Management Staff/Systems/Arrangements

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

Focus Area: Operational NAP Site(s) within 120 Days

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

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

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

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

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

Focus Area: Governing Board

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

Key Elements of the Project Work Plan

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

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

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

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

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

6) **Comments:** Provide supplementary information as desired.

Appendix D: One-Time Funding Request Information

Within the maximum amount of $650,000, applicants may request to use up to $150,000 in Federal section 330 grant funding in Year 1 only for one-time minor capital costs for equipment and/or minor alterations/renovations. Applicants are required to enter budget information for this one-time funding in Form 1B.

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

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

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

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

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

Equipment Purchases

Applicants requesting one-time funding for equipment purchases (with or without minor alteration/renovation), as indicated on Form 1B, must submit a complete list of the requested equipment in EHB. For each item on the equipment list, the following fields must be completed:

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

Any equipment purchased with grant funds must be pertinent to health center operations. Further, equipment purchased with grant funds must be procured through a competitive process (see 45 CFR 74.43) and maintained, tracked, and disposed of in accordance with 45 CFR Parts 74.34 and 92.32.

An allowable equipment-only project is limited to moveable items that are non-expendable, tangible personal property having a useful life of more than one year and an 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. Furniture, administrative equipment (i.e., computers, servers, telephones, fax machines, copying machines, software), and special purpose equipment used for medical activities (e.g., stethoscopes, blood pressure monitors, scales, electronic thermometers) with a useful life of one year or more and a unit cost of less than $5,000 may also be included. Moveable equipment can be readily shifted from place to place without requiring a change in the utilities or structural characteristics of the space. Moveable equipment is usually purchased outside of any construction contract. Dental chairs and radiographic equipment, including CAT scanners and MRIs, are considered moveable equipment.

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

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

Minor Alteration/Renovation

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

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

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

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

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

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

3. Project Management/Resources/Capabilities – Explain the administrative structure and oversight for the project, including the roles and responsibilities of the health center's key management staff as well as oversight by the governing board. Identify the Project Manager and the individuals who will comprise the Project Team responsible for managing the minor alteration/renovation project. Describe how the Project Team has the expertise and experience necessary to successfully manage and complete the project within the 120-day timeline and achieve the goals and objectives established for this project. This field has a maximum of 4,000 characters, including spaces.

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

Project Budget Justification
Applicants requesting one-time funding for minor alteration/renovation must attach a project budget justification. Describe in detail each cost element and explain how the costs contribute to meeting the project's objectives/goals. Clearly identify other funding sources needed to support

the minor alteration/renovation project and indicate whether these funds are secured or not. See http://www.hrsa.gov/grants/apply/assistance/nap for a sample A/R budget justification.

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

	ALLOWABLE	UNALLOWABLE
Administrative and legal expenses	▪ Salary of applicant's staff and consultant fees that are **directly** related to the administration of the technical aspects of the proposed project. Generally, administrative and legal expenses should be less than 10% of total project costs ▪ Costs of obtaining required data for the environmental analysis report ▪ Performance/Payment bonds and insurance costs	▪ Bonus payments to contractors ▪ Costs of groundbreaking and dedication ceremonies and items such as plaques ▪ Indirect costs ▪ General department operations and maintenance
Architectural and engineering fees	▪ Fees associated with architectural and engineering professional services ▪ Expenses for preparation of specifications and reproduction of design documents ▪ Costs incurred no more than 90 days before the Notice of Award for architect's fees and consultant's fees necessary to the planning and design of the project (if the project is approved and funded)	▪ Architectural and engineering fees for work not within the scope of the approved project ▪ Costs of abandoned designs (designs that will not be used in the minor alteration/renovation project) ▪ Elaborate or extravagant designs, materials, or projects that are above the known local costs for comparable buildings
Other architectural and engineering fees	▪ Other architectural and engineering services such as surveys and tests ▪ Preliminary expenses associated with the approved award	
Project inspection fees	▪ Clerk-of-the-works, inspection fees	▪ Fees not associated with the requested project
Site work	▪ See Alteration and renovation	▪ Fees not associated with the requested project
Demolition and removal	▪ Costs of demolition or removal for improvements such as wall finishings and fixtures. Reduce the costs on this line by the amount of expected proceeds from the sale of salvage.	▪ Costs of hazard material abatement and remediation ▪ Costs not associated with the requested award
Alteration and renovation	▪ Costs of fixed equipment necessary for the functioning of the facility. FIXED EQUIPMENT is equipment that requires modification of the facility for its satisfactory installation or removal and is included in the construction contract. Examples include fume hoods, linear accelerator, laboratory casework, sinks, fixed shelving, built-in sterilizers, built-in refrigerators, and drinking fountains. ▪ Costs for remodeling and alteration of existing buildings which will be used for the program ▪ Installation of fixed items such as windows, HVAC, and generators ▪ Costs of connecting to existing central utility distribution systems contiguous to the site, such as steam and chilled water that service a campus	▪ Relocation of utilities ▪ Prorated cost of existing central utility plant and distribution systems, which serve the proposed facility ▪ Sanitary sewer, storm sewer, and portable water connections, providing that such municipal utilities are located in streets, roads, and alleys contiguous to the site ▪ Works of art ▪ Otherwise allowable costs incurred beyond 90 days prior to the Notice of Award

	ALLOWABLE	UNALLOWABLE
	from centrally located boiler and refrigeration plants ▪ Prorated costs for new boilers and chillers ▪ Resurfacing of existing parking areas located onsite and deemed essential for the use and operation of an approved project ▪ Special features for earthquake resistance code requirements (use nationally recognized codes adopted by authorities having jurisdiction) ▪ Costs of eliminating architectural barriers to the handicapped ▪ Costs of pollution-control equipment for the facility's boilers, incinerators, waste water treatment, etc., which may be required by local, State, or Federal regulations	
Equipment	▪ Moveable equipment ▪ The cost to train individuals to operate the equipment, if included in the purchase contract ▪ Fixed equipment if it is not part of the construction contract ▪ Sales tax (unless the applicant is otherwise exempt) and shipping costs on equipment ▪ Service contract costs if it is included in the purchase contract	▪ Equipment that does not meet the moveable equipment definition ▪ Donated equipment, leased equipment, or equipment purchased through a conditional sales contract (lease purchasing)

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

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

The National Environmental Policy Act of 1969 (NEPA) (P.L. 91-190; 42 U.SC 4321 et.seq.), the National Historic Preservation Act (NHPA) (P.L. 89-665; 16 U.S.C. 470 *et seq.*), and other associated laws require, among other things, that HRSA consider the environmental impacts and potential effects on historical and archeological resources of any Federal action, including minor alteration and renovation projects supported in whole or in part through Federal grants. In order to initiate reviews under NEPA and NHPA, applicants must submit a completed EID Checklist (OMB Form No. 0915-0324) **for <u>each proposed NAP site</u> for which any Federal funds are being requested for minor alteration/renovation**. Applicants are required to explain each response of "yes" on the EID Checklist. If funded, grantees must receive HRSA approval prior to beginning any projects involving minor alteration/renovation.

Following the review of the EID Checklist and the project proposal, HRSA will determine if the potential exists for the project to have a significant impact on the environment. If HRSA determines additional reviews or compliance requirements are necessary, HRSA will contact the

applicant and require documentation such as a hazardous materials survey, abatement plans, or initiating Section 106 consultation. It is advised that if the applicant does not possess in-house expertise in environmental and historic preservation compliance, that the services of a consultant with the appropriate background be secured.

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

Floor Plans/Schematic Drawings

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

Other Requirements for Sites

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

1. Site Control and Federal Interest

1a. Identify the current status of the property site – If the site is owned by the applicant organization, select "owned." If the site is not owned by the applicant organization, regardless of whether the applicant organization will pay a recurring fee to use the property, select "leased." If the site is leased, applicants must certify that:

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

2. Cultural Resource Assessment and Historic Preservation Considerations

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

2a. Was the project facility constructed prior to 1975?

2b. Is the project facility 50 years or older?

2c. Does any element of the overall work at the project site include: 1) any renovation/modification to the exterior of the facility (e.g., roof, HVAC, windows, siding,

signage, exterior painting, generators) or 2) ground disturbance activity (e.g., expansion of building footprint, parking lot, sidewalks, utilities)?

2d. Does the project involve renovation to a facility that is, or near a facility that is, architecturally, historically, or culturally significant; or is the site located on or near Native American, Alaskan Native, Native Hawaiian, or equivalent culturally significant lands?

Landlord Letter of Consent

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

Appendix E: Budget Presentation Instructions

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

Applicants must present the total budget for the NAP project, which includes section 330 grant funds and all non-grant funds, including both program income and all other non-grant funding sources that support of the health center scope of project. For new start applicants, the budget will encompass the total proposed health center scope of project. For satellite applicants, the budget will be based on the proposed New Access Point(s) only. The total budget represents projected operational costs for the health center scope of project where all proposed expenditures directly relate to and support in-scope activities. The total budget is inclusive of section 330 grant funds and non-grant funds, which includes both program income and all other non-grant funding sources. Therefore, the total budget must reflect projections from all anticipated revenue sources from program income (e.g., fees, premiums, third party reimbursements, and payments) that is generated from the delivery of services, and from "other non-section 330 grant sources" such as state, local, or other federal grants or contracts, private contributions, and income generated from fundraising. See Policy Information Notice 2013-01 for additional information on health center budgeting. Health centers have discretion regarding how they propose to allocate the total budget between section 330 grant funds and non-grant funds, provided that the projected budget complies with all applicable DHHS policies and other federal requirements.

STANDARD FORM 424A

Complete Sections A, B, C, E, and F (if F is applicable) of the SF-424A: Budget Information. The budget must clearly indicate the projected revenue and expense for the first **12-month period**. The maximum amount that may be requested in each year cannot exceed $650,000.

Use the following guidelines to complete the SF-424A: Budget Information. Budget amounts must be rounded to the nearest whole dollar. In addition, please review the sample SF-424A located on the NAP technical assistance Web site at http://www.hrsa.gov/grants/apply/assistance/nap.

Section A – Budget Summary

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

non-section 330 revenue for each sub-program. Estimated Unobligated Funds are not applicable for this funding opportunity.

Section B – Budget Categories
Update the budget for the first 12-month budget period. Enter the budget amount for each object class category with the federal section 330 funding request and the non-federal (non-section 330) funding in separate columns. Each line represents a distinct object class category that must be addressed in the budget justification. Applicants may request federal section 330 grant funding up to $150,000 in Year 1 only for one-time minor capital costs for equipment and/or minor alterations/renovations (see Appendix D).

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

Section D – Forecasted Cash Needs (optional)
Enter the amount of cash needed by quarter during the first year for both the Federal request and all other sources, if desired.

Section E – Budget Estimates of Federal Funds Needed For the Balance of the Project
Enter the Federal funds requested for Year two in the First column broken down by each proposed section 330 program type (CHC, MHC, HCH, and/or PHPC). The maximum amount that may be requested cannot exceed $650,000. The Second, Third, and Fourth year columns must remain $0.

Section F – Other Budget Information (if applicable)
Direct Charges: Explain amounts for individual direct object class categories that may appear to be out of the ordinary.
Indirect Charges: Enter the type of indirect rate (provisional, predetermined, final, or fixed) that will be in effect during the project period, the estimated amount of the base to which the rate is applied, and the total indirect expense.
Remarks: Provide other explanations as necessary.

BUDGET JUSTIFICATION
A detailed budget justification in line-item format with accompanying narrative must be provided for **each 12-month period** of the two-year project period. For the second budget year, the justification narrative should highlight the changes from Year 1.

Attach the budget justification in the Budget Narrative Attachment Form section in EHB. If using Excel or other spreadsheet documents, be aware that reviewers will only see information that is set in the "Print Area" of the document. The budget justification must be concise and should not be used to expand the Project Narrative. See http://www.hrsa.gov/grants/apply/assistance/nap for a sample budget justification.

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

New for FY 2015: The budget justification must detail the costs of each line item within each object class category based on the Budget Categories form (federal section 330 request and non-federal (non-section 330) funding). The budget justification must contain sufficient detail to enable HRSA to determine if costs are allowable.

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

Personnel Costs: Personnel costs must be explained by listing the exact amount requested each year. Reference Form 2: Staffing Profile as justification for dollar figures, noting that the total dollar figures will not match if any salaries are charged as indirect costs.

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

Table 7: Budget Justification Sample for Staff

Name	Position Title	% of FTE	Base Salary	Federal Amount Requested
J. Smith	Physician	50	$225,000	$112,500
R. Doe	Nurse Practitioner	100	$ 75,950	$75,950
D. Jones	Data/AP Specialist	25	$ 33,000	$ 8,250

Fringe Benefits: List the components of the fringe benefit rate (e.g., health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement). Fringe benefits must be directly proportional to the portion of personnel costs allocated for the project.

Travel: List travel costs categorized by local and long distance travel. Detail the mileage rate, number of miles, reason for travel, and staff members/patients/board members completing the travel. The budget must also reflect travel expenses associated with participating in proposed meetings, trainings, or workshops.

Equipment: Identify the cost per item and justify the need for each piece of equipment to carry out the proposed project. Equipment includes moveable items that are non-expendable, tangible personal property having a useful life of more than 1 year and an acquisition cost that equals or exceeds $5,000. See Appendix D for information on one-time funding for equipment-only projects or minor alteration/renovation projects with equipment.

Supplies: List the items necessary for implementing the proposed project, separating items into three categories: office supplies (e.g., paper, pencils), medical supplies (e.g., syringes, blood tubes, gloves), and educational supplies (e.g., brochures, videos).

Contractual: Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. List both patient care (e.g., laboratory) and non-patient care (e.g., janitorial) contracts. Each applicant is responsible for ensuring that its organization/institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring contracts. Explain contracts and sub-recipient agreements including any salaries supported in whole or in part with federal section 330 grant funds. See Table 9 above for the information that must be included for each staff position. Reminder: Recipients must notify potential sub-recipients that entities receiving subawards must be registered in SAM and provide the recipient with their DUNS number.

Construction: For the purposes of this funding opportunity announcement, the construction line item is intended to include ONLY costs related to minor alteration/renovation. If one-time funding is requested for minor alteration/renovation, provide a summary of the A/R project costs. The construction line item should be consistent with the A/R budget justification submitted with the minor A/R Project Cover Page. See Appendix D for information on one-time funding for minor alteration/renovation projects.

Other: Include all costs that do not fit into any other category and provide an explanation of each cost (e.g., EHR provider licenses, audit, legal counsel). In some cases, rent, utilities, organizational membership fees, and insurance fall under this category if they are not included in an approved indirect cost rate. This category can also include the cost of access accommodations, including sign language interpreters, plain language materials, health-related print materials in alternate formats (e.g., Braille, large print), and cultural/linguistic competence modifications (e.g., use of cultural brokers, translation, or interpretation services at meetings, clinical visits, and conferences).

Indirect Charges: Costs incurred for common or joint objectives that cannot be readily identified but are necessary to organizational operation (e.g., facility operation and maintenance, depreciation, administrative salaries). If an organization does not have an

indirect cost rate, the applicant may wish to obtain one through the HHS Division of Cost Allocation (DCA). Visit https://rates.psc.gov/ to learn more about rate agreements, including the process for applying for them.

If an organization does not have a Federally Negotiated Indirect Costs (IDC) Rate Agreement, all costs will be considered direct costs until a rate agreement is negotiated with a Federal cognizant agency and provided to HRSA as part of the budget request. If the application is funded, HRSA will reallocate any amount identified under the Indirect Charges cost category to the Other cost category. If the grantee can provide an approved IDC Rate Agreement within 90 days of award, the funds can be moved back to the Indirect Charges cost category. **Organizations with previously negotiated Federal indirect cost rates must provide the current Federal indirect cost rate agreement in Attachment 15.**

Appendix F: Health Center Program Requirements

A summary of the key health center program requirements is provided below. For additional information on these requirements, please review:

- Health Center Program Statute: Section 330 of the Public Health Service Act, as amended (42 U.S.C. §254b, as amended)
- Program Regulations (42 CFR Part 51c and 42 CFR Parts 56.201-56.604 for Community and Migrant Health Centers)
- Grants Regulations (45 CFR Part 74, and 45 CFR Part 92, as applicable)

	NEED
1.	**Needs Assessment:** Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)
	SERVICES
2.	**Required and Additional Services:** Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. (Section 330(a) of the PHS Act) **Note:** Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services (Section 330(h)(2) of the PHS Act)
3.	**Staffing Requirement:** Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed and privileged. (Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act)
4.	**Accessible Hours of Operation/Locations:** Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. (Section 330(k)(3)(A) of the PHS Act)
5.	**After Hours Coverage:** Health center provides professional coverage for medical emergencies during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act and 42 CFR Part 51c.102(h)(4))
6.	**Hospital Admitting Privileges and Continuum of Care:** Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. (Section 330(k)(3)(L) of the PHS Act)
7.	**Sliding Fee Discounts:** Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. • This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.* • No discounts may be provided to patients with incomes over 200 % of the Federal poverty guidelines.* • No patient will be denied health care services due to an individual's inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived. (Section 330(k)(3)(G) of the PHS Act, 42 CFR Part 51c.303(f)), and 42 CFR Part 51c.303(u))

8.	**Quality Improvement/Assurance Plan:** Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include: • a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;* • periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall: * o be conducted by physicians or by other licensed health professionals under the supervision of physicians;* o be based on the systematic collection and evaluation of patient records;* and o identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.* (Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2), (3) and 42 CFR Part 51c.303(c)(1-2))
MANAGEMENT AND FINANCE	
9.	**Key Management Staff:** Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director/Executive Director/CEO position is required. (Section 330(k)(3)(I) of the PHS Act, 42 CFR Part 51c.303(p) and 45 CFR Part 74.25(c)(2),(3))
10.	**Contractual/Affiliation Agreements:** Health center exercises appropriate oversight and authority over all contracted services, including assuring that any sub-recipient(s) meets Health Center program requirements. (Section 330(k)(3)(I)(ii), 42 CFR Part 51c.303(n), (t)), Section 1861(aa)(4) and Section 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a) (2))
11.	**Collaborative Relationships:** Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers (section 330 grantees and FQHC Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained. (Section 330(k)(3)(B) of the PHS Act and 42 CFR Part 51c.303(n))
12.	**Financial Management and Control Policies:** Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. (Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26)
13.	**Billing and Collections:** Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures. (Section 330(k)(3)(F) and (G) of the PHS Act)
14.	**Budget:** Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served. (Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 74.25)
15.	**Program Data Reporting Systems:** Health center has systems which accurately collect and organize data for program reporting and which support management decision making. (Section 330(k)(3)(I)(ii) of the PHS Act)
16.	**Scope of Project:** Health center maintains its funded scope of project (sites, services, service area, target population and providers), including any increases based on recent grant awards. (45 CFR Part 74.25)

GOVERNANCE	
17.	**Board Authority:** Health center governing board maintains appropriate authority to oversee the operations of the center, including: • holding monthly meetings; • approval of the health center grant application and budget; • selection/dismissal and performance evaluation of the health center CEO; • selection of services to be provided and the health center hours of operations; • measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and • establishment of general policies for the health center. (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304) **Note:** In the case of public centers (also referred to as public entities) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center (Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304(d)(iii) and (iv)). **Note:** Upon a showing of good cause the Secretary may waive, for the length of the project period, the monthly meeting requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (Section 330(k)(3)(H) of the PHS Act)
18.	**Board Composition:** The health center governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically: • Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.* • The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community. * • No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry. * **Note:** Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)
19.	**Conflict of Interest Policy:** Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center. • No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as a non-voting ex-officio member of the board.* (45 CFR Part 74.42 and 42 CFR Part 51c.304(b))
NOTE: Portions of program requirements notated by an asterisk **"*"** indicate regulatory requirements that are recommended ***but not required*** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.	