U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources & Services Administration

Bureau of Primary Health Care
Health Center Program

Service Area Competition

Funding Opportunity Number: HRSA-19-010
Funding Opportunity Types: Competing Continuation, Competing Supplement, and New
Catalog of Federal Domestic Assistance (CFDA) Number: 93.224

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2019

Application Due Date in Grants.gov: August 6, 2018
Supplemental Information Due Date in HRSA EHB: August 21, 2018

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

Issuance Date: June 7, 2018

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

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA) is accepting applications for fiscal year (FY) 2019 Service Area Competition (SAC) under the Health Center Program. The purpose of this grant program is to improve the health of the Nation's underserved communities and vulnerable populations by assuring continued access to affordable, quality primary health care services.

Funding Opportunity Title:	Service Area Competition (SAC)
Funding Opportunity Number:	HRSA-19-010
Due Date for Applications – **Grants.gov**:	August 6, 2018 (11:59 p.m. ET)
Due Date for Supplemental Information – **HRSA EHB**:	August 21, 2018 (5 p.m. ET)
Anticipated Total Annual Available Funding:	Approximately $409,300,000 million
Estimated Number and Type of Awards:	Up to 86 grants
Estimated Award Amount:	Varies and is dependent on the availability of funds
Cost Sharing/Match Required:	No
Project Period/Period of Performance:	January 1, 2019 through December 31, 2021 (up to 3 years)
Eligible Applicants:	Public or nonprofit private entities, including tribal, faith-based, or community-based organizations See Section III.1 of this notice of funding opportunity (NOFO).

Application Guide

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

Technical Assistance

Application resources, as well as form samples and a frequently asked questions document, are available at the SAC Technical Assistance website (http://bphc.hrsa.gov/programopportunities/fundingopportunities/SAC/index.html). Refer to "How to Apply for a Grant", available at http://www.hrsa.gov/grants/apply, for general (i.e., not SAC specific) videos and slides on a variety of application and submission components.

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

HRSA-supported Primary Care Associations (PCAs) and/or National Cooperative Agreements (NCAs) are available to assist applicants in preparing a quality, competitive application. For a listing of HRSA-supported PCAs and NCAs, refer to HRSA's Strategic Partnerships website.

Summary of Changes since the FY 2018 SAC Funding Opportunity

- You must use the Grants.gov Workspace to complete and submit your Grants.gov application package.
- Health Center Program requirements are detailed in the Health Center Program Compliance Manual (Compliance Manual).
- Project Narrative questions, forms, and attachments that will be assessed for determining your compliance with Health Center Program requirements are noted with a bolded, underlined asterisk (*****).
- The Project Narrative is now required for completeness.
- The project director (PD)/chief executive officer (CEO) must now be a direct employee of the health center. Form 8: Health Center Agreements has been updated accordingly.
- The term "substance use disorder services" has replaced "substance abuse services," both in this document and on Forms 1A: General Information Worksheet, 2: Staffing Profile, and 5A: Services Provided.
- Form 1C: Documents on File has been added to collect information in lieu of several policy and procedure-related items that have been removed from the Project Narrative, resulting in an overall reduction of burden.
- A question on the use of telehealth has been added to the Project Narrative: RESOURCES/CAPABILITIES section.
- The document outlining steps for having all proposed sites open and operational within 120 days is now called the Operational Plan. See Appendix C for details.
- Scoring points have been adjusted for some Review Criteria based on the quantity of responses required for each section.
- Competing continuation applicants will be awarded a 1-year project period if there are any Health Center Program requirements related conditions at the time of award. Such conditions may be placed on the award as a result of the SAC application review or carried over into the new project period because they have not yet been resolved.
- New applicants will be awarded a 1-year project period.
- Competing continuation applicants will not receive priority points if they currently have a 1-year project period or if there are any conditions related to Health Center Program requirements at the time of application.

- The Colorectal Cancer Screening performance measure has been revised to align with the Centers for Medicare & Medicaid Services (CMS) electronic-specified clinical quality measures (CMS eCQMs). Refer to Appendix B for details.
- Appendix B highlights HRSA priority clinical measures, with a corresponding question added to the Project Narrative: EVALUATIVE MEASURES section.
- Universal Data System (UDS) information for Form 1A: General Information Worksheet and the Clinical and Financial Performance Measures forms (refer to Appendix B) will be prepopulated for competing continuation applicants by mid-to-late June.
- Submit requests for information and technical assistance regarding the Health Center Program SAC through the BPHC Answers web portal (https://www.hrsa.gov/about/contact/bphc.aspx).

Other Federal Benefits

Receipt of Health Center Program funds, while a basis for eligibility, does not, of itself, confer such benefits as Federal Tort Claims Act (FTCA) coverage, 340B Drug Pricing Program participation, or Federally Qualified Health Center (FQHC) reimbursement. Such benefits depend upon compliance with applicable requirements in addition to the award of Health Center Program funding, including the completion of separate applications, as appropriate. The Centers for Medicare & Medicaid Services manages FQHC reimbursement (see https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html). More information about the FTCA Health Center Program and the 340B Drug Pricing Program is available in the Other Information section.

Table of Contents

I. Program Funding Opportunity Description

1. Purpose

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

This NOFO details the SAC eligibility requirements, review criteria, and awarding factors for organizations seeking funding for operational support to provide primary health care services to an announced service area. For the purposes of this document, the term "health center" encompasses Health Center Program award recipients funded under the following subsections: Community Health Center (CHC – section 330(e)), Migrant Health Center (MHC – section 330(g)), Health Care for the Homeless (HCH – section 330(h)), and/or Public Housing Primary Care (PHPC – section 330(i)).

2. Background

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

Health Center Program funding targets the Nation's high need geographic areas and populations by supporting nearly 1,400 health centers that operate more than 11,000 service delivery sites in every state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. In 2016, HRSA-funded health centers delivered accessible, affordable, quality primary health care services to nearly 26 million people.

Service areas and target populations listed in the Service Area Announcement Table (SAAT) are currently served by Health Center Program award recipients whose project periods are ending in FY 2019. You must demonstrate how you will make primary health care services accessible in the announced service area, including the provision of services to the same volume of patients. Only one award will be given for each announced service area.

Funding Requirements

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

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

Your application must also demonstrate compliance with Health Center Program requirements, as stated in section 330 of the PHS Act and corresponding regulations, and as detailed in the Compliance Manual. An applicant with one area of noncompliance (e.g., a progressive action condition on your current award or the assignment of a new condition based on the compliance assessment of your SAC application) will result in HRSA awarding a 1-year project period and may impact your ability to receive funding. See details in the Project Period Length Criteria section. Therefore, HRSA strongly encourages competing continuation and competing supplement applicants to maintain continuous compliance and to resolve any Health Center Program progressive action conditions as quickly as possible.

If you are a new or competing supplement applicant, you must demonstrate readiness to meet the following requirements:

- Within 120 days of receipt of the Notice of Award (NoA), all proposed sites (as noted on Form 5B: Service Sites and described in the Project Narrative) must have the necessary staff and providers in place to begin operating and delivering services to the proposed community and/or target population as described on Forms 5A: Services Provided and 5C: Other Activities/Locations, and in the Project Narrative and Attachment 12: Operational Plan.[1]
- Within 1 year of receipt of the NoA, all proposed providers must be delivering services and all sites must be open for the proposed hours of operation.

If a new or competing supplement applicant is awarded a service area currently served by an existing Health Center Program award recipient, HRSA may consider a request by the current award recipient for up to a 120-day project period extension, with an appropriate level of funding, to support the orderly phase-out of grant activities and, as appropriate, transition of patients to the new award recipient. Additionally, the sites of the current award recipient will not automatically transfer to the applicant selected for funding. Regulations concerning record-keeping and disposition and transfer of equipment are found at 45 CFR § 75.320(e).

You must provide services to the number of unduplicated patients projected to be served on Form 1A: General Information Worksheet in 2020. **If you do not serve the number of patients projected in 2020, announced funding for the service area may be reduced when it is next competed through SAC.**[2]

[1] HRSA may issue Notices of Award up to 60 days prior to the project period start date.
[2] If a health center is unable to meet the total unduplicated patient projection in 2020 (the patient projection from this application, plus other patient projections from funded supplemental applications for which the projections can be monitored in 2020), funding for the service area may be reduced when the service area is next competed through SAC (assuming a 3-year project period). For more information, visit the Patient Target FAQs.

HRSA assesses health centers for Health Center Program compliance on a regular basis, including via the SAC application review process. Failure to fulfill applicable SAC funding and Health Center Program requirements may jeopardize Health Center Program grant funding per Uniform Guidance 2 CFR part 200, as codified by the United States Department of Health and Human Services (HHS) at 45 CFR part 75.

If your SAC application is selected for Health Center Program funding, but you are determined to be noncompliant with any Health Center Program requirements (inclusive of the requirements of section 330(k)(3) of the PHS Act) at the time of the SAC award based on either unresolved prior conditions or via the SAC application review, HRSA may place one or more conditions, as applicable, on your award[3] and will award a 1-year project period. Additionally, per new statutory requirements, you must:

1) Attest on the Summary Page form that you will submit for HRSA approval an implementation plan within 120 days of receipt of the NoA to meet all Health Center Program requirements with which you are noncompliant; and
2) Submit an implementation plan for HRSA approval within 120 days of receipt of the NoA. The implementation plan must outline a plan to come into compliance with all Health Center Program requirements with which you are noncompliant within the timeframes specified in the conditions on your NoA.

If you do not provide the required attestation, grant funding will not be awarded. If you do not submit the required implementation plan within 120 days of receipt of the NoA, or if you fail to resolve conditions through the completed progressive action process outlined in Chapter 2: Health Center Program Oversight of the Compliance Manual, HRSA may withdraw support through termination of the award.

HRSA will not award funding for a third successive 1-year project period in the presence of continued noncompliance with the Health Center Program requirements under this NOFO (see the Project Period Length Criteria section for details).

All sites proposed on Form 5B of the approved SAC application must be open and operational within 120 days of award. Failure to verify that all sites are operational within 120 days of award will result in the placement of a condition of award that may include restricted drawdown of award funds. If the site is not operational within 120 days of the award, you must submit a justification of the delay and an operational plan within 14 days that indicates the revised date by which the site will become operational. If you fail to successfully resolve a site-related condition within the applicable time frame, HRSA may withdraw support through termination of all, or part, of the SAC grant award.

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

COMMUNITY HEALTH CENTER (CHC) APPLICANTS:

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

- Ensure compliance with PHS Act section 330(e) and program regulations, requirements, and policies.
- Provide a plan that ensures the availability and accessibility of required primary health care services to underserved populations in the service area.

MIGRANT HEALTH CENTER (MHC) APPLICANTS:

- Ensure compliance with PHS Act section 330(g); and, as applicable, section 330(e), program regulations, requirements, and policies.
- Provide a plan that ensures the availability and accessibility of required primary health care services to migratory and seasonal agricultural workers and their families in the service area, which includes:
  - Migratory agricultural workers who are individuals whose principal employment is in agriculture, and who have been so employed within the last 24 months, and who establish for the purposes of such employment a temporary abode;
  - Seasonal agricultural workers who are individuals whose principal employment is in agriculture on a seasonal basis and who do not meet the definition of a migratory agricultural worker;
  - Individuals who are no longer employed in migratory or seasonal agriculture because of age or disability who are within such catchment area; and/or
  - Family members of the individuals described above.
  - Agriculture refers to farming in all its branches, as defined by the North American Industry Classification System under codes 111, 112, 1151, and 1152 (48 CFR § 219.303).

HEALTH CARE FOR THE HOMELESS (HCH) APPLICANTS:

- Ensure compliance with PHS Act section 330(h); and, as applicable, section 330(e), program regulations, requirements, and policies.
- Provide a plan that ensures the availability and accessibility of required primary health care services to individuals:
  - Who lack housing (without regard to whether the individual is a member of a family);
  - Whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations;
  - Who reside in transitional housing;
  - Who reside in permanent supportive housing or other housing programs that are targeted to homeless populations; and/or
  - Who are children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness.
- Provide substance use disorder services.

PUBLIC HOUSING PRIMARY CARE APPLICANTS:

- Ensure compliance with PHS Act section 330(i); and, as applicable, section 330(e), program regulations, requirements, and policies.
- Provide a plan that ensures the availability and accessibility of required primary health care services to residents of public housing and individuals living in areas immediately accessible to public housing. Public housing includes public

housing agency-developed, owned, or assisted low-income housing, including mixed finance projects, but 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.

II. Award Information

1. Type of Application and Award

Types of applications sought:
- Competing continuation – A current Health Center Program award recipient whose project period ends December 31, 2018 and that seeks to continue serving its current service area.
- New – A health center not currently funded through the Health Center Program that seeks to serve an announced service area through the proposal of one or more permanent service delivery sites.
- Competing supplement – A current Health Center Program award recipient that seeks to serve an announced service area, in addition to its current service area, through the addition of one or more new permanent service delivery sites.

HRSA will provide funding in the form of a grant.

2. Summary of Funding

HRSA expects approximately $409,300,000 million to be available annually to fund 86 recipients. You may apply for a ceiling amount of up to the Total Funding listed in the SAAT for the proposed service area in total cost (includes both direct and indirect costs) per year. The actual amount available will not be determined until enactment of the final FY 2019 federal appropriation.

This program notice is subject to the appropriation of funds and is a contingency action taken to ensure that, should funds become available for this purpose, HRSA can process applications and award funds in a timely manner. The project period is January 1, 2019 through December 31, 2021 (3 years). Funding beyond the first year is dependent on the availability of appropriated funds for the Health Center Program in subsequent fiscal years, satisfactory recipient performance, and a decision that continued funding is in the best interest of the Federal Government.

Funding must be requested and will be awarded proportionately for all currently targeted population types, as indicated in the SAAT. No new population types may be added.

You must propose to serve at least 75 percent of the SAAT Patient Target in 2020 (January 1 through December 31, 2020). Applications that propose to serve less than 75 percent of the patient target will be deemed ineligible. If you propose to serve fewer

than the total number of patients indicated in the SAAT, the federal request for funding on the SF-424A and Budget Narrative must reflect the required reductions noted below. If you propose to serve fewer than the total number of patients indicated in the SAAT, but do not reduce the funding request, HRSA will reduce the award accordingly. A funding calculator is available at https://bphc.hrsa.gov/programopportunities/fundingopportunities/sac/patientbudgetcalculator.html to help you determine if a funding reduction is required.

Table 1: Funding Reduction by Patients Projected to Be Served

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

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

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

III. Eligibility Information

1. Eligible Applicants

1) You must be a domestic public or nonprofit private entity, as demonstrated through the submission of the Evidence of Non-profit/Public Center Status (Attachment 11), outlined in Section IV.2.vi.[4] Domestic faith-based and community-based organizations, Tribes, and tribal organizations are also eligible to apply.[5]

[4] Only public agency health centers can have a co-applicant. A co-applicant is the established body that serves as the health center's governing board when the public agency cannot meet the Health Center Program governing board requirements directly (Section 330(r)(2)(A) of the Public Health Service Act). However, this does not confer any grant rights to the co-applicant organization.
[5] Refer to Chapter 1: Health Center Program Eligibility of the Compliance Manual.

2) You must propose in the RESPONSE section of the Project Narrative to operate a health center that makes all required primary health care services[6] available and accessible in the service area, either directly or through established arrangements, without regard for ability to pay. You may **not** propose to provide **ONLY** a single service or any subset of the required primary health care services.

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

   a) The total number of unduplicated patients projected to be served in 2020 (January 1 through December 31, 2020) entered on Form 1A: General Information Worksheet must be at least 75 percent of the SAAT Patient Target. See the Summary of Funding section above if your patient projection is less than the SAAT Patient Target.
   b) If you are a **new or competing supplement applicant**, unduplicated zip codes entered in the Service Area Zip Codes field on Form 5B: Service Sites for service delivery sites (administrative-only sites will not be considered) must:[7]
      - Include a combination of SAAT Service Area Zip Codes where zip code patient percentages total at least 75 percent of the current patients served; or
      - Include all SAAT Service Area Zip Codes for the proposed service area, if the sum of all zip code patient percentages is less than 75 percent of the current patients served.
   c) You must propose to serve all currently targeted population types (i.e., CHC, MHC, HCH, and/or PHPC) and maintain the current funding distribution from the SAAT in the federal funding request on the SF-424A. Funding must be requested and will be awarded proportionately for all currently funded population types, as indicated in the SAAT. You may not add new population types (those noted in the SAAT with $0 in funding).

Note*:* HRSA will monitor your achievement of the patient commitment (SAC application patient projection as well as any additional patients projected from supplemental awards). If you are unable to demonstrate via your 2020 Uniform Data System (UDS) Report that you served the cumulative projected patients in 2020, funding for the service area may be reduced when it is next competed through SAC.

4) If you are a **new and competing supplement applicant** , you must propose at least one new full-time (operational 40 hours or more per week) permanent, fixed building site on Form 5B: Service Sites. If you propose to serve only migratory and seasonal agricultural workers, you may propose a full-time seasonal (rather than permanent)

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

[7] HRSA considers service area overlap when making funding determinations for new and competing supplement applicants if zip codes are proposed on Form 5B: Service Sites beyond those listed in the SAAT. For more information about service area overlap, refer to Policy Information Notice 2007-09, available at http://bphc.hrsa.gov/programrequirements/policies/pin200709.html.

service delivery site.[8] You may propose a mobile medical van only if you also propose at least one full-time, fixed site in the application. You must provide a verifiable street address for each proposed site on Form 5B: Service Sites, including mobile vans.

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

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

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

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

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

3. Other

HRSA will consider any application that exceeds the ceiling amount (the amount of Total Funding available in the SAAT) on the SF-424A and Budget Narrative non-responsive and will not consider it for funding under this notice.

Applications that do not include all documents indicated as "required for completeness" in Section IV.2.ii and Section IV.2.vi will be considered non-responsive and will not be considered for funding under this notice. This includes the Project Narrative, as well as Attachments 6: Co-Applicant Agreement and 11: Evidence of Nonprofit or Public Center Status.

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

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

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

Note: Multiple applications from an organization with the same DUNS number are allowable only if the applications propose to serve different service areas. If you plan to apply to serve two or more different service areas announced under this NOFO, you **must** contact the Office of Policy and Program Development at https://www.hrsa.gov/about/contact/bphc.aspx for guidance.

HRSA will only accept your first validated electronic submission, under the correct funding opportunity number, in Grants.gov.[9] Applications submitted after the first submission will be marked as duplicates and considered ineligible for review. If you want to change information submitted in a Grants.gov application, you may do so in the HRSA Electronic Handbooks (HRSA EHB) application phase.

IV. Application and Submission Information

1. Address to Request Application Package

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

- **Phase 1 – Grants.gov** – Required information must be submitted and validated via Grants.gov with a due date of August 6, 2018 at 11:59 p.m. Eastern Time; **and**

- **Phase 2 – HRSA EHB** – Supplemental information must be submitted via HRSA EHB with a due date of August 21, 2018 at 5 p.m. Eastern Time.

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

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

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

2. Content and Form of Application Submission

Application Format Requirements
Section 5 of HRSA's *SF-424 Two-Tier Application Guide* provides instructions for the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the Application Guide in addition to the program-specific information below. You are responsible for reading and complying with the instructions included in HRSA's *SF-424 Two-Tier Application Guide* except where instructed in the NOFO to do otherwise. You must submit the application in English and in the terms of U.S. dollars (45 CFR § 75.111(a)).

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

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

The following application components must be submitted in HRSA EHB:

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

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

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

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

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

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

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

Program-Specific Instructions

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

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

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

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

- *Box 15: Descriptive Title of Applicant's Project:* Type the title of the NOFO (Service Area Competition) and upload the project abstract. See instructions in Section IV.2.i. The abstract WILL count toward the page limit.
- *Box 17: Proposed Project Start Date and End Date:* Provide the start date (January 1, 2019) and end date (December 31, 2021) for the proposed 3-year project period.
- *Box 18: Estimated Funding:* Complete the required information based on the funding request for the first year of the proposed project period. Refer to the Summary of Funding section for details.
- *Box 19: Review by State:* See Section IV.5 for guidance in determining applicability.

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

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

Additionally, include the proposed service area identification number (ID), city, and state (available in the SAAT); and total number of unduplicated patients projected to be served in 2020 (January 1 through December 31, 2020).

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

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

The specified items that HRSA will utilize, in whole or in part, in its assessment of compliance are noted with a bolded, underlined asterisk (*****). Other items contribute to HRSA having a full picture of the proposed project and are assessed for compliance, as appropriate, through other oversight processes (e.g., site visits, audit reviews) or on timelines that do not align with the SAC application.

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

The Project Narrative must:

- Address the specific Project Narrative elements below, with the requested information appearing under the appropriate Project Narrative section header or the designated forms and attachments.
- Reference attachments and forms as needed. Referenced items must be part of the HRSA EHB submission.
- Where applicable, demonstrate compliance with Health Center Program requirements, as detailed in the Compliance Manual.

If you are a **competing continuation applicant**, ensure that the Project Narrative reflects your approved scope of project. Any change in scope **must** be submitted separately through HRSA EHB.[10]

If you are a **new applicant**, ensure that the Project Narrative reflects the entire scope of the proposed project for the service area proposed in this application (proposed services, providers, sites, service area zip codes, and target population), inclusive of at least one full-time (operational 40 hours or more per week) permanent service delivery site.[11]

If you are a **competing supplement applicant**, ensure that the Project Narrative reflects only the proposed scope of project for the service area proposed in this application, inclusive of at least one new (not in your current Health Center Program scope of project) full-time (operational 40 hours or more per week) permanent service delivery site.[10] Current sites in scope may also be selected for this project to the extent that they will provide services to the proposed new patients. Reference may be made in the Project Narrative to current services, policies, procedures, and capacity as they relate to the new service area (e.g., experience, transferrable procedures, resources).

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

Information provided in the NEED section must:

- Serve as the basis for, and align with, the activities and goals described throughout the application.
- Be utilized to inform and improve the delivery of health center services.

For information on how to demonstrate compliance, where applicable, reference Chapter 3 of the Compliance Manual.

1) _*****_ Describe the proposed service area (consistent with Attachment 1: Service Area Map and Table), including:
   a) The service area boundaries.
   b) If you are a **new or competing supplement applicant**: How you determined your service area based on where the proposed patients reside.

      If you are a **competing continuation applicant**: How you annually review and determine your service area based on where patients reside, as reported in the 2017 UDS[12] and identified in the SAAT (i.e., service area zip codes listed on

[10] Refer to the Scope of Project policy documents and resources, available at https://bphc.hrsa.gov/programrequirements/scope.html, for details pertaining to changes to the current services, providers, sites, service area zip codes, and target population(s).
[11] Projects that will serve only migratory and seasonal agricultural workers may propose a full-time seasonal (rather than permanent) service delivery site.
[12] Refer to the 2017 UDS Manual, available at https://bphc.hrsa.gov/datareporting/reporting/index.html.

Form 5B: Service Sites represent those where 75 percent of current patients reside).

2) _*****_ Citing data sources and the frequency of assessments, describe the service area/target population and the current health care needs, specifically addressing items a-d below. This description must include the unique needs of **each** special population, as identified in the SAAT with a funding amount greater than $0 (MHC, HCH, PHPC).[13]
   a) Factors associated with access to care and health care utilization (e.g., geography, transportation, occupation, unemployment, income level, educational attainment, transient populations).
   b) Most significant causes of morbidity and mortality (e.g., diabetes, cardiovascular disease, cancer, low birth weight, mental health and/or substance use disorder).
   c) Health disparities.
   d) Unique health care needs or characteristics that impact health, access to care, or health care utilization (e.g., social factors, environmental factors, occupational factors, cultural/ethnic factors, language needs, housing status).

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

For more information on how to demonstrate compliance, where applicable, reference the following chapters of the Compliance Manual:

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

1) Describe how you will ensure access to all required and additional services (consistent with Form 5A: Services Provided) and other activities, as applicable, (consistent with Form 5C: Other Activities/Locations) to meet the identified needs, including:
   a) The method of provision of services (Form 5A: Services Provided).
   b) How services provided through contractual agreements (Form 5A: Services Provided, Column II) will be documented in the patient's health center record, and how the health center will pay for the services.
   c) How services provided through referral arrangements (Form 5A: Services Provided, Column III) will be managed, and the process for tracking and referring patients back to the health center for appropriate follow-up care.
   d) How you make arrangements and provide resources that address health care access and utilization barriers (e.g., transportation, transience, unemployment, income level, educational attainment) and other factors that impact health status (e.g., social factors, the physical environment, cultural/ethnic factors, housing status). Additionally, describe such services for any targeted special populations.

[13] Special populations by type of health center are MHC – Migratory and Seasonal Agricultural Workers and Families, HCH – People Experiencing Homelessness, or PHPC – Residents of Public Housing.

e) **If HCH funding is requested**: Document how substance use disorder services will be made available (consistent with Form 5A: Services Provided).

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

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

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

5) Describe the sliding fee discount program, (consistent with Attachment 10: Sliding Fee Discount Schedule).[14] Specifically address how you:
   a) Define income and family size.
   b) Assess the eligibility of all patients for sliding fee discounts based only on income and family size.
   c) Apply sliding fee discounts to all required and additional services (Form 5A: Services Provided).
   d) Determine the number and income ranges of sliding fee discount pay classes.
   e) Establish a nominal charge, if applicable, for patients at or below 100 percent of the Federal Poverty Guidelines (FPG), available at https://aspe.hhs.gov/poverty-guidelines.
      Note: The nominal fee must be a flat charge considered nominal from the perspective of the patient. It cannot reflect the actual cost of the service provided.
   f) Inform patients of the availability of sliding fee discounts (e.g., language and literacy-level appropriate materials, intake process, health center's website).
   g) Evaluate the sliding fee discount program to ensure its effectiveness in reducing financial barriers to care.

6) _*_ In Attachment 10: Sliding Fee Discount Schedule, document how the Sliding Fee Discount Schedule(s) (SFDS) is structured to provide:
   a) A full discount for individuals and families with annual incomes at or below 100 percent of the current FPG, unless there is a nominal charge. If there is a nominal charge, it is a flat fee and less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.
   b) Partial discounts for individuals and families with incomes above 100 percent of the FPG, and at or below 200 percent of the FPG, that adjust in accordance with income using a minimum of three discount pay classes.
   c) No discounts to individuals and families with annual incomes above 200 percent of the FPG.
   d) Discounts based on the most current FPG.

7) Describe the unduplicated patient commitment (number of patients projected to be served in 2020 as documented on Form 1A: General Information Worksheet), including how it was determined and how it is achievable given any recent or anticipated changes in the local health care landscape, organizational structure, and/or workforce capacity.

Only new and competing supplement applicants should address items 8 and 9 below.

8) Upload a detailed operational plan to Attachment 12: Operational Plan (see Appendix C). The plan must include reasonable and time-framed activities which assure that, within 120 days of receipt of the NoA, **all proposed sites** noted on Form 5B: Service Sites will have the necessary staff and providers in place to begin

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

operating and delivering services as described on Forms 5A: Services Provided and 5C: Other Activities/Locations.[15]

9) Describe plans to:
   a) Hire, contract, and/or establish formal written referral arrangements with all providers (consistent with Forms 2: Staffing Profile, 5A: Services Provided and 8: Health Center Agreements, and Attachment 7: Summary of Contracts and Agreements) and begin providing services at all sites for the stated number of hours (consistent with Form 5B: Service Sites) within 1 year of receipt the NoA.
   b) Minimize potential disruption for patients served by the current award recipient (as noted in the SAAT) that may result from transition of the award to a new recipient.[16]

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

For more information on how to demonstrate compliance, where applicable, reference Chapter 14 of the Compliance Manual.

1) _*****_ Describe efforts to coordinate and integrate activities with other providers[17] (consistent with Attachment 1: Service Area Map and Table) and programs in the service area, including those that serve targeted special populations, to support:
   - Continuity of care across community providers.
   - Access to other health or community services not available through the health center that impact the patient population.
   - A reduction in non-urgent use of hospital emergency departments.

2) _*****_ In Attachment 9: Collaboration Documentation, document collaboration with primary care[18] and other providers serving similar patient populations in the service area (consistent with Attachment 1: Service Area Map and Table), including:
   - Other Health Center Program award recipients and look-alikes.
   - Health departments.
   - Local hospitals.
   - Rural health clinics.

   If documentation of collaboration with one or more of the entities above is not provided in Attachment 9: Collaboration Documentation, explain why it could not be obtained and provide documentation of the request.

[15] HRSA may issue Notices of Award up to 60 days prior to the project period start date.
[16] See details regarding the current award recipient's site(s) and equipment in the Funding Requirements section.
[17] Including, but not limited to, local hospitals and specialty providers.
[18] At a minimum, you must establish and maintain relationships with other Health Center Program award recipients and look-alikes in the service area.

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

For more information on how to demonstrate compliance, where applicable, reference the following chapters of the Compliance Manual:

- Chapter 10: Quality Improvement/Assurance (QI/QA)
- Chapter 18: Program Monitoring and Data Reporting Systems

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

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

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

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

5) On the Clinical Performance Measures form only (see detailed instructions in Appendix B), establish realistic goals that are responsive to clinical performance and

associated needs. Goals should be measure-specific and informed by contributing and restricting factors affecting achievement.

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

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

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

For more information on how to demonstrate compliance, where applicable, reference the following chapters of the Compliance Manual:

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

1) Describe how the organizational structure (including any subrecipients/contractors) is appropriate to implement the proposed project (consistent with Attachments 2: Bylaws and 3: Project Organizational Chart, and, as applicable, Attachments 6: Co-Applicant Agreement and 7: Summary of Contracts and Agreements), including whether your organization is part of a parent, affiliate, or subsidiary organization (consistent with Form 8: Health Center Agreements).

2) Describe the following related to the staffing plan (consistent with Form 2: Staffing Profile):
   a) _***** How it ensures that clinical staff, contracts, or formal referral arrangements with other providers/provider organizations, will be in place to carry out all required and additional services (consistent with Form 5A: Services Provided)
   b) How the size, demographics, and health care needs of the service area/patient population were considered when determining the number and mix of clinical support staff.
   c) How credentialing and privileging are implemented for all health center employees, individual contractors, and volunteers who provide clinical services, including:

- Clinical staff members (licensed independent practitioners (LIPs)), addressing provider categories separately (e.g., physicians, dentists, physician assistants, nurse practitioners).
- Other licensed or certified practitioners (OLCPs), addressing provider categories separately (e.g., registered nurses, licensed practical nurses, registered dietitians, certified medical assistants).
- Other clinical staff providing services on behalf of the health center, addressing provider categories separately (e.g., medical assistants, community health workers).

Note: Contracted providers should be indicated on Form 2: Staffing Profile and the summary of current or proposed contracts/agreements in Attachment 7: Summary of Contracts and Agreements. If a majority of core primary health care services will be secured via contract, include the contract/agreement as an attachment to Form 8: Health Center Agreements.

3) _*****_ Describe the management team (e.g., project director (PD)/chief executive officer (CEO), clinical director (CD), chief financial officer (CFO), chief information officer (CIO), chief operating officer (COO)), including:
   a) How it supports the operation and oversight of the proposed project, consistent with scope and complexity.
   b) Training, experience, skills, and qualifications necessary to execute each defined role (demonstrated in Attachment 4: Position Descriptions for Key Management Staff), as well as the amount of time that each will dedicate to Health Center Program activities (consistent with Form 2: Staffing Profile).
   c) Identification of individuals who will serve in the defined roles (demonstrated in Attachment 5: Biographical Sketches for Key Management Staff). If applicable, identify individuals that will fill more than one key management position, including the positions (e.g., CFO and COO combined role), and describe any changes in key management staff in the last year or significant changes in their roles.
   d) Employment arrangement of the CEO (consistent with Form 2: Staffing Profile).[19]
   e) Responsibilities of the CEO for and reporting to the governing board and overseeing other key management staff in carrying out the day-to-day activities of the proposed project.

4) _*****_ If applicable, describe how you will maintain appropriate oversight and authority over all contracts for substantive programmatic work and all subawards services and sites (consistent with Forms 5A: Services Provided, 5B: Service Sites, and 8: Health Center Agreements, and Attachment 7: Summary of Contracts and Agreements), including:[20]
   a) The structure of the agreement (i.e., contract or subaward).

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

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

b) Ensuring the contractor/subrecipient performs in accordance, with all applicable award terms, conditions, and requirements, including those found in section 330 of the PHS Act, implementing program regulations, and grants regulations in 45 CFR Part 75.
c) Mechanisms to monitor contractor or subrecipient performance.
d) Requirements for the contractor or subrecipient to provide data necessary for you to meet applicable federal financial and programmatic reporting requirements, as well as provisions addressing record retention and access, audit, and property management.[21]

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

5) Describe how your financial accounting and internal control systems will:
   a) Have the capacity to account for all federal award(s) in order to identify the source (receipt) and application (expenditure) of funds for federally-funded activities in whole or in part, including maintaining related source documentation pertaining to authorizations, obligations, unobligated balances, assets, expenditures, income, and interest under the federal award(s).
   b) Assure that expenditures of the federal award funds will be allowable in accordance with the terms and conditions of the Federal Award and Federal Cost Principles.[22]

6) Describe how you conduct billing and collections, including:
   a) Requesting applicable payments from patients, while ensuring that no patient is denied service based on inability to pay.
   b) Educating patients on insurance and, if applicable, third-party coverage options available to them.
   c) _*****_ Billing Medicare, Medicaid, Children's Health Insurance Program (CHIP), and other public and private assistance programs or insurance in a timely manner, as applicable.

7) Describe how you use or plan to use telehealth[23] for the following, as applicable:
   a) Facilitating access to required primary and additional (including specialty) services.
   b) Providing long-distance primary and additional health services to health center patients.
   c) Providing health education to health center patients.
   d) Facilitating professional education.

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[21] For further guidance on these requirements, please see the HHS Grants Policy Statement, at https://www.hrsa.gov/grants/hhsgrantspolicy.pdf and 45 CFR § 75.352.
[22] See 45 CFR 75 Subpart E: Cost Principles.
[23] Telehealth is defined as the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include video conferencing, the internet , store-and-forward imaging, streaming media, and terrestrial and wireless communications.

e) Promoting public health.

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

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

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

For more information on how to demonstrate compliance, where applicable, reference the following chapters of the Compliance Manual:

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

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

1) Describe where in Attachment 2: Bylaws and other components of this application you document meeting the Health Center Program board composition and authority requirements, as follows:[24]
   a) _*****_ Board size is at least 9 and no more than 25 members, with either a specific number or range of board members prescribed (compliance demonstrated on Form 6A: Board Member Characteristics).
   b) _*****_ At least 51 percent of board members are patients served by the health center (compliance demonstrated on Form 6A: Board Member Characteristics).[25, 26]

      Note: You may request a waiver of this requirement on Form 6B: Request for Waiver of Board Member Requirements if you are requesting funding to serve only special populations (e.g., if you are not requesting CHC funding).
   c) _*****_ Patient members of the board, as a group, reasonably represent the patient population in terms of demographic factors (e.g., gender, race, ethnicity) (compliance demonstrated on Form 6A: Board Member Characteristics, consistent with Form 4: Community Characteristics).

[24] The health center must maintain documentation of adherence to requirements outlined in the bylaws.
[25] For the purposes of the Health Center Program, the term "board member" refers only to voting members of the board.
[26] For the purposes of board composition, a patient is an individual who has received at least one service in the past 24 months that generated a health center visit, where both the service and the site where the service was received are within the current/proposed scope of project.

d) _*_ Non-patient members are representative of the community in which the health center is located, either by living or working in the community or by having a demonstrable connection to the community.
e) _*_ Non-patient members provide relevant expertise and skills (e.g., community affairs, local government, finance and banking, legal affairs, trade unions and other commercial and industrial concerns, social services) (compliance demonstrated on Form 6A: Board Member Characteristics).
f) _*_ No more than one-half of non-patient board members may earn more than 10 percent of their annual income from the health care industry (compliance demonstrated on Form 6A: Board Member Characteristics).
g) _*_ Health center employees, contractors, and immediate family members of employees may not be health center board members.[27]
h) _*_ Board meetings occur monthly.
i) _*_ Approving the selection and dismissal or termination of the project director/CEO.
j) _*_ Approving applications related to the health center project, including approving the annual budget, which outlines the proposed uses of both federal Health Center Program award and non-federal resources, including revenue.
k) _*_ Approving proposed sites, hours of operation, and services.
l) _*_ Evaluating the performance of the health center.
m) _*_ Establishing or adopting policy related to the operations of the health center.
n) _*_ Assuring the health center operates in compliance with applicable federal, state, and local laws and regulations.
o) _*_ If you are **requesting funding to target any special populations**, you have at least one representative on the board from/for each special population who can clearly communicate the special population's needs/concerns (e.g., migratory and seasonal agricultural workers advocate, former or current homeless individual, current resident of public housing).

2) Describe how your governing board (consistent with Attachment 3: Project Organizational Chart) maintains authority and oversight over the proposed project, as outlined in Attachments 2: Bylaws, 6: Co-Applicant Agreement, and 8: Articles of Incorporation. Specifically affirm that:
a) _*_ No individual, entity, or committee (including, but not limited to, an executive committee authorized by the board) reserves or has approval/veto power over the board with regard to the required authorities and functions.
b) _*_ Collaboration or agreements with other entities do not restrict or infringe upon the board's required authorities and functions.
c) _*_ **New public agency applicants with a co-applicant board**: Attachment 6: Co-Applicant Agreement delegates the required authorities and functions to the co-applicant board and delineates the respective roles and responsibilities of the public agency and the co-applicant in carrying out the project.

[27] In the case of public agencies with co-applicant boards, this includes employees or immediate family members of either the co-applicant organization or of the public agency component in which the health center project is located (for example, employees within the same department, division, or agency).

d) **Applicants requesting PHPC Funding**: The service delivery plan was developed in consultation with residents of the targeted public housing and describe how residents of public housing will be involved in administration of the proposed project.

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

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

For information on how to demonstrate compliance, where applicable, reference Chapter 17 of the Compliance Manual.

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

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

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

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

iii. Budget *(Submit in HRSA EHB)*
See Section 5.1.iv of HRSA's *SF-424 Two-Tier Application Guide*. Follow the instructions included in the Application Guide and the additional budget instructions provided below. A budget that follows the Application Guide will ensure that, if HRSA

selects the application for funding, you will have a well-organized plan and by carefully following the approved plan can avoid audit issues during the implementation phase.

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

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

You must present the total budget for the proposed SAC project, which includes the SAC federal request for funding and all non-SAC grant funds that support the health center scope of project. The total budget represents projected operational costs for the proposed scope of project where all proposed expenditures directly relate to and support in-scope activities. Therefore, the total budget must reflect projections from **all** anticipated revenue sources from program income (e.g., fees, premiums, third party reimbursements, and payments) that is generated from the delivery of services, and from "other non-Health Center Program grant sources" such as state, local, other federal, and non-federal sources. Health centers have discretion regarding how they propose to allocate the total budget between SAC grant funds and other funding that supports the project, provided that the projected budget complies with all applicable HHS policies and other federal requirements.[28]

When completing the SF-424A:

- In Section A, Budget Summary, enter the budget on separate rows for each population type (CHC, MHC, HCH, PHPC) for which you are requesting funding. The federal amount refers to only the SAC funding requested, not all federal funding that you receive. Estimated Unobligated Funds are not applicable for this NOFO. **Funding must be requested and will be awarded consistent with the distribution of funds across population types**, as indicated in the SAAT.
- In Section B, Budget Categories, enter an object class category (line item) budget for Year 1 of the 3-year project period. The amounts for each category in the federal and nonfederal columns, as well as the totals, should align with the Budget Narrative.
- In Section C, when providing Non-Federal Resources by funding source, include non-SAC federal funds supporting the proposed project in the "other" category.

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

Program Income must be consistent with the Total Program Income (patient service revenue) presented on Form 3: Income Analysis.

- In Section E, provide the federal funds requested for Year 2 in the First column and Year 3 in the Second column, entered on separate rows for each proposed type of Health Center Program funding (CHC, MHC, HCH, and/or PHPC). The Third and Fourth columns must remain $0.

The Consolidated Appropriations Act, 2018 (P.L. 115-141), Division H, § 202, states "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II." See Section 5.1.iv Budget – Salary Limitation of HRSA's *SF-424 Two-Tier Application Guide* for additional information. *Note* that these or other salary limitations will apply in FY 2019, as required by law.

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

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

In addition, the Service Area Competition NOFO requires a detailed budget narrative for **each requested 12-month period** (budget year) of the 3-year project period (1-year project period for new applicants). Classify Year 1 of the budget narrative into federal and non-federal resources, and provide a table of personnel to be paid with federal funds. For subsequent budget years, the narrative should highlight the changes from Year 1 or clearly indicate that there are no substantive changes during the project period. See the SAC Technical Assistance website for a sample Budget Narrative.

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

All of the following forms, with the exception of Form 5C: Other Activities/Locations, are required. You must complete these OMB-approved forms directly in HRSA EHB. Where applicable, the forms should demonstrate compliance with Health Center Program requirements, as detailed in the Compliance Manual. The forms that HRSA will utilize, in part or in full, in its assessment of compliance are noted with a bolded, underlined asterisk (*****). Other forms contribute to HRSA having a full picture of the proposed project, including performance goals.

Refer to Appendix A for Program-Specific Forms instructions and Appendix B for Performance Measure Forms instructions. Samples are available at the SAC Technical Assistance website.

***** Form 1A: General Information Worksheet
***** Form 1C: Documents on File
***** Form 2: Staffing Profile
***** Form 3: Income Analysis
***** Form 4: Community Characteristics
***** Form 5A: Services Provided
***** Form 5B: Service Sites
Form 5C: Other Activities/Locations (if applicable)

__*__ Form 6A: Current Board Member Characteristics
__*__ Form 6B: Request for Waiver of Board Member Requirements
__*__ Form 8: Health Center Agreements
Form 10: Emergency Preparedness Report
Form 12: Organization Contacts
Clinical Performance Measures
Financial Performance Measures
__*__ Summary Page

vi. Attachments *(Submit in HRSA EHB)*

Provide the following items in the order specified below. Where applicable, the attachments should demonstrate compliance with Health Center Program requirements, as detailed in the Compliance Manual. The attachments that HRSA will utilize, in part or in full, in its assessment of compliance are noted with a bolded, underlined asterisk (**__*__**). Other attachments contribute to HRSA having a full picture of the proposed project and are assessed for compliance, as appropriate, through other oversight processes (e.g., site visits, audit reviews) or on timelines that do not align with the SAC application.

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

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

__*__ *Attachment 1: Service Area Map and Table (R)*

Upload a map of the service area for the proposed project, indicating the proposed health center site(s) listed on Form 5B: Service Sites. The map must clearly indicate the proposed service area zip codes, any medically underserved areas (MUAs) and/or medically underserved populations (MUPs), and Health Center Program award recipients, look-alikes, and other health care providers serving the proposed zip codes, as described in the COLLABORATION section of the Project Narrative. Create the map using UDS Mapper, available at http://www.udsmapper.org/. You may need to manually place markers for the locations of other major private provider groups serving low income/uninsured patients.

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

- Each zip code tabulation area (ZCTA) in the service area.
- The number of Health Center Program award recipients and look-alikes serving each ZCTA.
- The dominant award recipient serving each ZCTA.

- Total population for each ZCTA.
- Low-income population for each ZCTA.
- Total Health Center Program award recipient patients, low-income population, and total population penetration levels for each ZCTA and for the overall proposed service area.

See the SAC Technical Assistance website for samples and instructions on creating maps using UDS Mapper. For a tutorial, see Specific Use Cases: Create a Service Area Map and Data Table, available at http://www.udsmapper.org/tutorials.cfm.

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

_**_ *Attachment 3: Project Organizational Chart (R)*
Upload a one-page document that depicts your current organizational structure, including the governing board, key personnel, staffing, and any subrecipients or affiliated organizations.

_**_ *Attachment 4: Position Descriptions for Key Management Staff (R)*
Upload current position descriptions for key management staff: PD/CEO, CD, CFO, CIO, and COO. Indicate on the position descriptions if key management positions are combined and/or part time (e.g., CFO and COO roles are shared). Limit each position description to **one page** and include, at a minimum, the role, responsibilities, and qualifications.

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

_**_ *Attachment 6: Co-Applicant Agreement (as applicable) (new applicants: C) (competing continuation and competing supplement applicants: R)*
Public center applicants that have a co-applicant board **must** submit a complete copy of the formal co-applicant agreement signed by both the co-applicant governing board and the public center.[29] See the RESOURCES/CAPABILITIES and GOVERNANCE sections of the Project Narrative for more details.

Attachment 7: Summary of Contracts and Agreements (as applicable) (R)
Upload a brief summary describing all current or proposed patient service-related contracts and agreements, consistent with Form 5A: Services Provided, columns II and

[29] See the definition of a co-applicant in the Eligible Applicants footnotes for details.

III, respectively. The summary must address the following items for each contract or agreement:

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

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

_***_** *Attachment 8: Articles of Incorporation (as applicable) (new applicants: R) (competing continuation and competing supplement applicants: N/A)*
New applicants: Upload the official signatory page (seal page) of the organization's Articles of Incorporation.

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

_***_** *Attachment 9: Collaboration Documentation (R)*
Upload current dated documentation of collaboration activities to provide evidence of commitment to the project. See the COLLABORATION section of the Project Narrative for details on required documentation. Letters of support should be addressed to the organization's board, CEO, or other appropriate key management staff member (e.g., clinical director).

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

_***_** *Attachment 10: Sliding Fee Discount Schedule(s) (R)*
Upload the current sliding fee discount schedule(s). See the RESPONSE section of the Project Narrative for details.

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

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

- A copy of your currently valid Internal Revenue Service (IRS) tax exemption letter/certificate.

- A statement from a state taxing body, state attorney general, or other appropriate state official certifying that your organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.
- A certified copy of your organization's certificate of incorporation or similar document (e.g., Articles of Incorporation) showing the state or tribal seal that clearly establishes the nonprofit status of the organization.
- Any of the above documentation for a state or local office of a national parent organization, and a statement signed by the parent organization that your organization is a local nonprofit affiliate.

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

- A current dated letter affirming the organization's status as a state, territorial, county, city, or municipal government; a health department organized at the state, territory, county, city, or municipal level; or a subdivision or municipality of a United States (U.S.) affiliated sovereign State (e.g., Republic of Palau).
- A copy of the law that created the organization and that grants one or more sovereign powers (e.g., the power to tax, eminent domain, police power) to the organization (e.g., a public hospital district).
- A ruling from the State Attorney General affirming the legal status of an entity as either a political subdivision or instrumentality of the state (e.g., a public university).
- A "letter ruling" which provides a positive written determination by the Internal Revenue Service of the organization's exempt status as an instrumentality under Internal Revenue Code section 115.

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

Attachment 12: Operational Plan (new and competing supplement applicants: R) (competing continuation applicants: N/A)
New or competing supplement applicants: Upload the Operational Plan. Refer to Appendix C for detailed instructions and the SAC Technical Assistance website for a sample.

Attachment 13: Other Relevant Documents (as applicable) (R)
Include other relevant documents to support the proposed project (e.g., indirect cost rate agreements, charts, organizational brochures, lease agreements). Maximum of two uploads.
New or competing supplement applicants: Lease/intent to lease documentation must be included in this attachment if a proposed site is or will be leased.

3. Dun and Bradstreet Universal Numbering System (DUNS) Number and System for Award Management

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

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

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

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

- Dun and Bradstreet (http://www.dnb.com/duns-number.html)
- System for Award Management (SAM) (https://www.sam.gov/portal/SAM/##11)
- Grants.gov (http://www.grants.gov/)

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

ALERT from SAM.gov: You must now provide an original, signed notarized letter stating that you are the authorized Entity Administrator before your registration will be activated by SAM.gov. Please read these FAQs to learn more about this process change. Plan for additional time associated with submission and review of the notarized letter. This requirement is effective March 22, 2018 for **new** entities registering in SAM. This requirement is effective April 27, 2018 for **existing** registrations being updated or renewed. Entities already registered in SAM.gov are advised to log into SAM.gov and review their registration information, particularly their financial information.

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

4. Submission Dates and Times

Application Due Date
The due date for applications under this NOFO in Grants.gov (Phase 1) is *August 6, 2018 at 11:59 p.m. Eastern Time*. The due date to complete all other required information in HRSA EHB (Phase 2) is *August 21, 2018 at 5 p.m. Eastern Time*. HRSA suggests submitting applications to Grants.gov at least **3 days before the deadlines** to allow for any unforeseen circumstances.

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

5. Intergovernmental Review

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

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

6. Funding Restrictions

You may request funding for a project period of up to 3 years, at no more than the amount listed as Total Funding for the service area in the SAAT per year (inclusive of direct and indirect costs). Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government. HRSA will not award funding to a competing continuation applicant for a third successive 1-year project period (see the Project Period Length Criteria section for details).

The amount of funds awarded in any fiscal year may not exceed the costs of health center operations for the budget period less the total of state, local, and other operational funding provided to the center and the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in the fiscal year. Further, as stated in section 330 of the PHS Act, the federal cost principles apply only to federal funds.

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

Pursuant to existing law and consistent with Executive Order 13535 (75 FR 15599), health centers are prohibited from using federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered).

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

The General Provisions in Division H, of the Consolidated Appropriations Act, 2018 (P.L. 115-141), apply to this program. Please see Section 5.1 of the HRSA *SF-424 Two-Tier Application Guide* for additional information. Note that these or other restrictions will apply in FY 2019, as required by law.

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

All program income generated as a result of awarded funds must be used for approved project-related activities. Post-award requirements for program income can be found at 45 CFR § 75.307. In accordance with Sections 330(e)(5)(D) and 330(k)(3)(D) the health center must use any non-grant funds as permitted under section 330, and may use such funds for such other purposes as are not specifically prohibited under section 330, if such use furthers the objectives of the health center project.

V. Application Review Information

1. Review Criteria

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

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

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

Criterion 1: NEED (10 Points) – *Corresponds to Section IV.2.ii NEED*

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

- The extent to which the applicant demonstrates an understanding of the health care needs in the service area/target population, including any targeted special populations.

Criterion 2: RESPONSE (25 Points) – *Corresponds to Section IV.2.ii RESPONSE*

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

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

- The extent to which the applicant describes how the unduplicated patient projection (number of patients projected to be served in 2020), was determined and how it is achievable.

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

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

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

- The extent to which the applicant collaborates on activities with other providers or programs in the service area, including those that serve targeted special populations to support continuity of care, access to other non-health center health or community services, and reduce non-urgent use of hospital emergency

departments.

- The extent to which the applicant describes and documents collaboration efforts with other primary care providers in the service area that serve similar patient populations, including:
  - Other Health Center Program award recipients and look-alikes.
  - Health departments.
  - Local hospitals.
  - Rural health clinics.

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

- The extent to which the applicant describes the QI/QA program, including patient satisfaction and grievance processes, and patient safety, including adverse events.

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

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

- The extent to which the applicant describes how efforts will be focused to improve the health status of the patient population through achievement of the goals for the following HRSA clinical priorities: Diabetes, Depression Screening and Follow-Up, Child Weight Assessment and Counseling, and Body Mass Index.

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

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

- The extent to which the staffing plan ensures that all providers, including contract and referral arrangements, will be credentialed and privileged, and in place to carry out required and additional services for the service area described.

- The extent to which the applicant establishes that appropriate financial accounting and control systems will have the capacity to account for all federal

award(s) and assure that expenditures of the federal award funds will be allowable in accordance with Federal Award and Cost Principles.

- The extent to which the applicant describes how it conducts billing and collections, including educating patients on public and private insurance and third-party coverage options.

- The extent to which the applicant describes current and planned uses of telehealth to address multiple needs, as applicable.

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

- The extent to which the applicant describes the current status of or plans for participating in Health Center Program-related federal benefits (e.g., Federal Tort Claims Act (FTCA) coverage).

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

- The extent to which the applicant documents the governing board composition, including board representation that can communicate needs/concerns of targeted special populations.

- The extent to which the applicant documents requirements for board member selection and removal and board authorities and responsibilities.

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

- **Public agency applicants with a co-applicant board**: The extent to which the applicant documents, in Attachment 6: Co-Applicant Agreement, delegation of the required authorities and functions to the co-applicant board and delineation of the respective roles and responsibilities of the public agency and the co-applicant.

- **Applicants targeting only special populations and requesting a waiver of the 51 percent patient majority board composition requirement**: The extent to which Form 6B: Request for Waiver of Board Member Requirements provides 1) a reasonable statement of need for the request ("good cause"); and 2) a plan for appropriate alternative mechanisms for assuring patient participation in the direction and ongoing governance of the center.

- **Applicants requesting PHPC funding**: The extent to which the applicant documents that the service delivery plan was developed in consultation with

residents of the targeted public housing and how residents of public housing will be involved in administration of the proposed project.

- **Indian Tribes or Tribal, Indian, or Urban Indian Groups Only**: The extent to which the applicant demonstrates that the governance structure will assure adequate input from the community/target population, as well as fiscal and programmatic oversight of the proposed project.

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

- The extent to which the applicant provides a detailed budget presentation that aligns with the proposed project (e.g., services, sites, staffing).

- The extent to which the applicant describes how the organization will respond to financial changes or challenges to mitigate adverse impacts.

2. Review and Selection Process

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

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

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

Project Period Length Criteria[30]
The length of an awarded project period is determined by a comprehensive evaluation of compliance with program requirements by HRSA.

- If you are a competing continuation applicant and have any conditions related to Health Center Program requirements[31] at the time of award:
    - You will not receive an FY 2019 SAC award if you had consecutive 1-year project periods in FY 2017 and FY 2018.[32]
    - You will be awarded a 1-year project period if you did NOT have consecutive 1-year project periods in FY 2017 and FY 2018.

[30] See Chapter 2: Health Center Program Oversight of the Compliance Manual.
[31] Current unresolved conditions related to Health Center Program requirements carried over into the new project period or new conditions related to Health Center Program requirements to be placed on the award based on information included in this application and Assessment of Risk.
[32] If no other fundable applications were received, the service area will be re-competed.

- If you are a new applicant, you will be awarded a 1-year project period[33] and will receive an operational site visit (OSV) within 2-4 months of your project period start date.

Funding Priority
To minimize potential service disruptions and maximize the effective use of federal dollars, this program includes a funding priority for competing continuation applicants. A funding priority is the favorable adjustment of combined review scores of individually approved applications when applications meet specified criteria. The Objective Review Committee/HRSA Staff adjusts the score by a set, pre-determined number of points. **You do not need to request a funding priority.** Prior to final funding decisions, the funding priority will be determined by HRSA staff.

HRSA will award priority points to competing continuation applicants according to the criteria below.

- **Program Compliance (5 points)**: You will be granted a funding priority if you are a competing continuation applicant and do not have:
  - A current 1-year project period or
  - An active condition related to Health Center Program requirements **at the time of application** (see Chapter 2: Health Center Program Oversight of the Compliance Manual).

- **Patient Trend (5 points)**: You will be granted a funding priority if you are a competing continuation applicant that meets the criterion for Program Compliance above **and** you have a positive or neutral 3-year patient growth trend (+/- 5 percent).[34] **Patient trend points will not be awarded if the Program Compliance criterion is not met.**

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

3. Assessment of Risk and Other Pre-Award Activities

HRSA may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory, or other requirements (45 CFR § 75.205).

[33] Regardless of the presence or absence of conditions related to Health Center Program requirements to be placed on the award based on information included in this application and Assessment of Risk.
[34] Based on the availability of only two years of UDS data, new applicants that received an FY 2016 Service Area Competition (SAC) or SAC-Additional Areas award are eligible for the Patient Trend priority points if they have a positive or neutral 2-year patient growth trend (+/- 5 percent).

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

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

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

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

4. Anticipated Announcement and Award Dates

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

VI. Award Administration Information

1. Award Notices

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

2. Administrative and National Policy Requirements

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

Requirements under Subawards and Contracts under Grants

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

3. Reporting

Award recipients must comply with Section 7 of HRSA's *SF-424 Two-Tier Application Guide* **and** the following reporting and review activities:

1) **Uniform Data System (UDS) Report** – The UDS is an integrated reporting system used to collect data on all health centers to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments. Award recipients are required to submit a UDS Universal Report and, if applicable, a UDS Grant Report annually, by the specified deadline. The Universal Report provides data on patients, services, staffing, and financing across all health centers. The Grant Report provides data on patients and services for special populations served.

2) **Progress Report** – The Budget Period Progress Report (BPR) non-competing continuation submission documents progress on program-specific goals and performance measures to track progress. Submission and HRSA approval of a BPR will trigger the budget period renewal and release of each subsequent year of funding (dependent upon Congressional appropriation, program compliance, organizational capacity, and a determination that continued funding would be in the best interest of the Federal Government).

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

VII. AGENCY CONTACTS

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

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

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

Beth Hartmayer
Public Health Analyst
Office of Policy and Program Development
Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration
5600 Fishers Lane, Room 16N09
Rockville, MD 20857
Telephone: (301) 594-4300
Contact: https://www.hrsa.gov/about/contact/bphc.aspx (select **Applicant** as the Requestor Type; **Application/Progress Report: Instructions/Requirements Questions** as the Issue Type; and **SAC** as the Application Issue Subcategory)
SAC Technical Assistance website

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

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

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

BPHC Helpline
Telephone: 1-877-974-2742, select option 3

Web: https://www.hrsa.gov/about/contact/bphc.aspx (select **Applicant** as the Requestor Type and **Application/Progress Report: EHB System Questions** as the Issue Type)

VIII. Other Information

Technical Assistance
A technical assistance website has been established to provide you with copies of forms, FAQs, and other resources that will help you submit a competitive application. To review available resources, visit the SAC Technical Assistance website.

BPHC Primary Health Care Digest
The BPHC Primary Health Care Digest is a weekly email newsletter containing information and updates pertaining to the Health Center Program, including release of all competitive funding opportunities. You are encouraged to subscribe several staff.

Federal Tort Claims Act Coverage/Medical Malpractice Insurance
Organizations that receive operational funds under the Health Center Program are eligible for liability protection from certain claims or suits through the Federally Supported Health Centers Assistance Acts of 1992 and 1995 (Act) (42 U.S.C. 233(g)-(n)). The Act provides that health centers and any associated statutorily eligible personnel may be deemed as Public Health Service (PHS) employees and thereby afforded protections of the Federal Tort Claims Act (FTCA) for the performance of medical, surgical, dental, or related functions within the scope of their deemed employment. The 21st Century Cures Act amends the Public Health Service Act (42 U.S.C. 233(q)) to include liability protections for volunteer health professional.[35]

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

Deemed PHS employee status with resulting **FTCA coverage is not guaranteed**. If you are interested in FTCA protection, you will need to submit and receive approval for a new FTCA application annually. The Notice of Deeming Action (NDA) for an individual health center provides documentation of HRSA's deeming determination and will be issued only after approval of a deeming application. You are encouraged to review the deeming requirements outlined in the Compliance Manual and the most current FTCA Deeming Application Program Assistance Letter (search for keyword FTCA). Contact the BPHC Helpline at 877-974-BPHC for additional information.

[35] Information on deeming requirements for health center volunteer health professionals can be found at https://bphc.hrsa.gov/ftca/about/health-center-volunteers.html.

340B Drug Pricing Program
The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, codified as Section 340B of the Public Health Service Act, as amended, available at http://www.hrsa.gov/opa/programrequirements/phsactsection340b.pdf. The program limits the cost of covered outpatient drugs for certain federal award recipients and Health Center Program look-alikes. If you are interested in 340B Program participation, you must register and be enrolled and comply with all 340B Program requirements. Covered entities may realize a cost savings of 20-50 percent on outpatient drug purchases through participation in the 340B Prime Vendor Program (PVP). There is no cost to participate in the 340B Drug Pricing Program or the 340B Prime Vendor Program, and eligible entities are not required to have an established in-house pharmacy to participate. For additional information, visit the Office of Pharmacy Affairs website at http://www.hrsa.gov/opa.

Tips for Writing a Strong Application

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

Appendix A: Program-Specific Forms Instructions

Program-Specific Forms must be completed electronically in HRSA EHB. All forms are required, except Form 5C: Other Activities/Locations. The forms that HRSA will utilize, in part or in full, in its assessment of compliance are noted with a bolded, underlined asterisk (**_*_**). Sample forms are available at the SAC Technical Assistance website.

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

_*_ Form 1A: General Information Worksheet

1. Applicant Information

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

2. Proposed Service Area

2a. Service Area Designation

- If you are applying for CHC funding, you MUST serve at least one Medically Underserved Area (MUA) or Medically Underserved Population (MUP).
- Select the MUA and/or MUP designations for the proposed service area and enter the identification number(s).
- For inquiries regarding MUAs or MUPs, visit the Shortage Designation website at https://bhw.hrsa.gov/shortage-designation or email sdb@hrsa.gov.

2b. Service Area Type

- Select the type (urban or rural) that describes the majority of the service area. If rural is selected, you may further choose sparsely populated, if applicable, and provide the number of people per square mile (values must range from .01 to 7). For information about rural populations, visit the Office of Rural Health Policy's website at http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html.

2c. Patients and Visits

General Guidance for Patient and Visit Numbers:

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

- A visit is a face-to-face contact between a patient and a licensed or credentialed provider who exercises independent judgment in providing services. To be included as a visit, services must be paid for by your organization (Form 5A: Services Provided, Columns I and/or II) and documented in a chart that stays in the possession of the health center.
- A patient is an individual who had at least one visit in 2017 (current data) or is projected to have at least one visit in 2020 (projected data).
- Since a patient must have at least one documented visit, the number of patients cannot exceed the number of visits.
- Report aggregate data for all service sites in the proposed project.
- If you are a new or competing supplement applicant, report annualized baseline values for services your organization is currently providing in the proposed service area. If your organization is not currently operational in the proposed service area, report baseline values as zero.

Unduplicated Patients and Visits by Population Type:
The population types in this section do NOT refer only to the requested funding categories in Section A of the SF-424A: Budget Information Worksheet. For example, if you are applying for only CHC funding (General Underserved Community), you may still have patients/visits reported in the other population type categories. **All patients/visits that do not fall within the Migratory and Seasonal Agricultural Workers and Families, Residents of Public Housing, or the People Experiencing Homelessness categories must be included in the General Underserved Community category.**

1. Project the number of unduplicated patients to be served in 2020 (January 1 through December 31, 2020). This value will pre-populate in the corresponding cell within the table below.

   HRSA will use the number of unduplicated patients projected to be served in 2020 (January 1 through December 31, 2020) to determine compliance with Eligibility Requirement 3a, which requires the patient projection to be at least 75 percent of the SAAT Patient Target. If a health center is unable to meet the total unduplicated patient commitment in 2020 (the patient projection from this application, plus other patient projections from funded supplemental applications for which the projections can be monitored in 2020), funding for the service area may be reduced when the service area is next competed through SAC (assuming a 3-year project period).

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

   If you are a competing continuation applicant, current patients will pre-populate from the 2017 UDS data in EHB by mid-to-late June. Provide the number of visits across the population type categories to establish a baseline. To maintain

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

3. The total number of unduplicated patients projected in 2020 (January 1 through December 31, 2020) will pre-populate from Item 1 above. Project the **total** number of visits in 2020 (January 1 through December 31, 2020). Then categorize these projected numbers for each population type category. **Across all population type categories, an individual can only be counted once as a patient.** Refer to the Scope of Project policy documents.

Patients and Visits by Service Type:

1. If you are a new or competing supplement applicant: Provide the number of current patients and visits within each service type category to establish a baseline. **An individual who receives multiple types of services should be counted once for each service type** (e.g., an individual who receives both medical and dental services should be counted once for medical and once for dental).

   If you are a competing continuation applicant: Current patients and visits for each service type category will pre-populate from the 2017 UDS data, appearing in EHB in mid-June.

2. Project the number of patients and visits anticipated within each service type category in 2020 (January 1 through December 31, 2020).

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

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

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

*** Form 1C: Documents on File**

This form provides a summary of documents that support the implementation of Health Center Program requirements, as outlined in the Health Center Program Compliance Manual. It does not provide an exhaustive list of all types of health center documents (e.g., policies and procedures, protocols, legal documents). Provide the date that each document was last reviewed and, if appropriate, revised.

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

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

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

* Form 2: Staffing Profile

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

- Allocate staff time in the Direct Hire FTEs column by function among the staff positions listed. An individual's full-time equivalent (FTE) should not be duplicated across positions. For example, a provider serving as a part-time family physician and a part-time Clinical Director should be listed in each respective category with the FTE percentage allocated to each position (e.g., clinical director 0.3 (30%) FTE and family physician 0.7 (70%) FTE). Do not exceed 1.0 (100%) FTE for any individual. For position descriptions, refer to the UDS Manual.
- Record volunteers in the Direct Hire FTEs column.
- If you propose to provide services through formal written contracts/agreements (Form 5A, Column II), select Yes for contracted staff.
- Contracted staff are indicated by answering Yes or No only. **Do not quantify contracted staff in the Direct Hire column.**

* Form 3: Income Analysis

Form 3 collects the projected patient services and other income from all sources (other than the Health Center Program grant funds) for the **first year** of the proposed project period. Form 3 income is divided into two parts: (1) Patient Service Revenue - Program Income and (2) Other Income - Other Federal, State, Local, and Other Income.

Part 1: Patient Service Revenue – Program Income
Patient service revenue is income directly tied to the provision of services to health center patients. Services to patients that are reimbursed by health insurance plans, managed care organizations, categorical grant programs (e.g., breast and cervical cancer screening), employers, and health provider organizations are classified as patient service revenue. Reimbursements may be based upon visits, procedures,

member months, enrollees, achievement of performance goals, or other service related measures.

The program income section groups billable visits and income into the same five payer groupings used in the UDS Manual. All patient service revenue is reported in this section of the form.

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

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

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

- A crossover patient with Medicare and Medicaid coverage is to be classified as a Medicare patient on line 2.
- A Medicaid patient with no dental coverage who is only seen for dental services is to be classified as a Medicaid patient on line 1 with a self-pay visit on line 5.

Billable Visits – Column (b): Includes all billable/reimbursable visits.[36] The value is typically based on assumptions about the amount of available clinician time, clinician productivity (visits per unit of time), and mix of billable visits by payer. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column. (See Ancillary Instructions below.) Note other significant exclusions or additions in the Comment/Explanatory Notes box at the bottom of the form.

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

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

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

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

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

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

Payer Categories (Lines 1 – 5): The five payer categories (Medicaid, Medicare, Other Public, Private, and Self-Pay) reflect the five payer groupings in UDS. The UDS Manual includes definitions for each payer category.

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

Ancillary Instructions: All service income is to be classified by payer, including pharmacy and other ancillary service revenue. If you do not normally classify the projected ancillary or other service revenue by payer category, allocate the projected income by payer group using a reasonable method, such as the proportion of medical visits or charges. The method used should be noted in the Comments/Explanatory Notes section at the bottom of the form.

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

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

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

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

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

Total (Line 6): Sum of lines 1-5.

Part 2: Other Income – Other Federal, State, Local, and Other Income
This section includes all income other than the patient service revenue shown in Part 1 (exclusive of this Health Center Program funding request). It includes other federal, state, local, and other income. It is income that is earned but not directly tied to visits, procedures, or other specific services. Income is to be classified based on the source of the revenue. Income from services provided to non-health center patients either in-house or under contract with another entity such as a hospital, nursing home, or other health center is to be reported in Part 2: Other Income (see examples below). This would include income from in-house retail pharmacy sales to individuals who are not patients of the health center.

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

State Government (Line 8): Income from state government funding, contracts, and programs, including uncompensated care funding; state indigent care income; emergency preparedness funding; mortgage assistance; capital improvement funding; school health funding; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); immunization funding; and similar awards.

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

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

Contributions (Line 11): Income from private entities and individual donors that may be the result of fundraising.

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

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

Total Other (Line 14): The sum of lines 7 – 13.

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

Note*:* In-kind donations are not included on Form 3. You may discuss in-kind donations in the SUPPORT REQUESTED section of the Project Narrative. Additionally, such donations may be included on the SF-424A (Section A: Budget Summary—Non-Federal Resources under New or Revised Budget).

_*_ Form 4: Community Characteristics

Report current service area and target population data. If you compile data from multiple data sources, the total numbers may vary across sources. If this is the case, make adjustments as needed to ensure that the total numbers for the first four sections of this form match. Adjustments must be explained in the NEED section of the Project Narrative.

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

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

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

Note*:* The total numbers for the first four sections of this form **must match**.

Guidelines for Reporting Race

- Classify all individuals in one of the racial categories, including individuals who also consider themselves Hispanic or Latino. If the data source does not separately classify Hispanic or Latino individuals by race, report them as Unreported/Declined to Report.
- Utilize the following race definitions:
  - Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Indonesia, Thailand, and Vietnam.

- Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
- Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, Tonga, Palau, Truk, Yap, Saipan, Kosrae, Ebeye, Pohnpei, or other Pacific Islands in Micronesia, Melanesia, or Polynesia.
- American Indian/Alaska Native – Persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- More Than One Race – Persons who are choosing two or more races.

Guidelines for Reporting Hispanic or Latino Ethnicity

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

Guidelines for Reporting Special Populations and Select Population Characteristics

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

Forms 5A, 5B, and 5C

General Notes

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

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

- **New or competing supplement applicants**: Complete these forms based only on the scope of project included in this application for the proposed service area.

- If the application is funded, only the services, sites, and other activities/locations listed on these forms will be in the approved scope of project, regardless of what is described elsewhere in the application.

- Refer to the Scope of Project documents and resources for details pertaining to defining and changing scope (i.e., services, sites, service area zip codes, target population).

_*_ Form 5A: Services Provided

Identify how the required and additional services[37] will be provided. Only one form is required regardless of the number of sites proposed. All referral arrangements/agreements for services noted on Form 5A as provided via Column II and/or III must be formal written arrangements/agreements.

Competing supplement applicants:

- All services in your current scope of project must be accessible to patients in the newly proposed service area.
- If new services are proposed on Form 5A and this application is funded, these services must be accessible to all patients (both current and proposed patients).

_*_ Form 5B: Service Sites

Provide requested data for each proposed service site. **Provide a verifiable street address for each proposed site on Form 5B: Service Sites.**

New or competing supplement applicants: You must propose **at least one new** full-time permanent service delivery, or administrative/service delivery site, located in the new service area. [38]

Competing supplement applicants: Current sites in scope may be selected for this project to the extent that they will provide services to the proposed new patients.

Zip codes entered in the Service Area Zip Codes field for service sites and administrative/service delivery sites[39] will **determine compliance with Eligibility Requirement 3b** and therefore must be: 1) those where at least 75 percent of the current patients within the service area reside, based on the SAAT, or 2) all SAAT zip codes for the proposed service area, if the sum of all zip code percentages is less than 75 percent of the current patients served. Zip codes entered for administrative-only sites will not be considered when determining eligibility.

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

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

[38] MHC-only applicants may propose at least one full-time seasonal rather than permanent site.

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

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

Provide requested data for other activities/locations (e.g., home visits, health fairs). List only activities/locations that 1) do not meet the definition of a service site, 2) are conducted on an irregular timeframe/schedule, and/or 3) offer a limited activity from within the full complement of health center activities in the scope of project.[40]

* Form 6A: Current Board Member Characteristics

The list of board members will be pre-populated for competing continuation and competing supplement applicants. **Update pre-populated information as appropriate.**[41] Public centers with co-applicant health center governing boards must list the co-applicant board members.

Complete or update the following information:

- List all current board members along with the current board office, if applicable (e.g., Chair, Treasurer), and area of expertise (e.g., finance, education, nursing). Do not list non-voting board members (e.g., PD, advisory board members).
- Indicate if each board member derives more than 10 percent of income from the health care industry.
- Indicate if each board member is a health center patient. For the purposes of board composition only, a patient is an individual who has received at least one service in the past 24 months that generated a health center visit, where both the service and the site where the service was received are within the HRSA-approved (or proposed in this application) scope of project.
- Indicate if each board member lives and/or works in the service area.
- Indicate if each board member is a representative from/for a special population (i.e., people experiencing homelessness, migratory and seasonal agricultural workers and families, residents of public housing).
- Indicate the total gender, ethnicity, and race of board members who are patients of the health center.

Note:

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

[40] Refer to Scope of Project for more information.
[41] Refer to Chapter 20: Board Composition of the Compliance Manual.

* Form 6B: Request for Waiver of Board Member Requirements

- If you currently receive or are applying to receive CHC funding, you are not eligible for a waiver and cannot enter information.
- Indian tribes or tribal, Indian, or urban Indian groups are not required to complete this form and cannot enter information.
- If you are a competing continuation applicant that wishes to continue an existing waiver, you must complete this form.
- Present a "good cause" justification describing the need for a waiver of the patient majority board composition requirement, including:
  - The unique characteristics of the special population (migratory and seasonal agricultural workers advocate, former homeless individual, current resident of public housing) or service area that create an undue hardship in recruiting a patient majority.
  - Attempts to recruit a majority of special population board members within the last 3 years.
  - Strategies that will ensure patient participation and input in the direction and ongoing governance of the organization by addressing the following:
    - Collection and documentation of input from the special population(s).
    - Communication of special population(s) input directly to the health center governing board.
    - Incorporation of special population(s) input into key areas, including but not limited to: selecting health center services; setting hours of operation of health center sites; defining budget priorities; evaluating the organization's progress in meeting goals, including patient satisfaction; and assessing the effectiveness of the sliding fee discount program.

* Form 8 – Health Center Agreements

Complete Part I, by selecting **Yes** if you have 1) a parent, affiliate, or subsidiary organization; and/or 2) any current or proposed agreements that will constitute a substantial portion of the proposed scope of project, including a proposed site to be operated by a subrecipient or contractor, as identified on Form 5B: Service Sites.

Refer to Uniform Guidance 2 CFR part 200 as codified by HHS at 45 CFR part 75 for more information on the characteristics of a subrecipient or contractor agreement.[42] You must determine whether an individual agreement that will result in disbursement of federal funds will be carried out through a contract or a subaward and structure the agreement accordingly.

If either question 1 or 2 are answered "Yes" in Part I, you must upload associated agreements in Part II. Part II will accept a maximum of 10 Affiliate/Contract/Subaward

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

Organizations with five document uploads for each. Additional documentation that exceeds this limit should be included in Attachment 13: Other Relevant Documents.

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

Form 10: Emergency Preparedness Report

Select the appropriate responses regarding emergency preparedness.

Form 12: Organization Contacts

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

If you are a new applicant, provide the requested contact information. For the Contact Person field, provide an individual who can represent the organization in communication regarding the application.

*** Summary Page**

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

Service Area
Enter the proposed service area identification number (ID), city, and State, as indicated in the SAAT.

Patient Projection
The total number of unduplicated patients projected to be served in 2020 (January 1 through December 31, 2020) will pre-populate from Form 1A: General Information Worksheet. Enter the Patient Target for the proposed service area from the SAAT. The percentage of patients to be served in 2020 will auto-calculate. **Applications with an auto-calculated percentage below 75 percent will be deemed ineligible.**

Federal Request for Health Center Program Funding
To ensure eligibility, the total Health Center Program funding request must not exceed the Total Funding available in the SAAT for the proposed service area. Additionally, ensure that the funding requested for each population aligns with the values in the SAAT. If the unduplicated patient projection on Form 1A General Information Worksheet is less than 95 percent of the SAAT Patient Target, ensure the annual Health Center Program funding request is adjusted based on the auto-calculated percentage of patients to be served in 2020 (January 1 through December 31, 2020) from the Patient Projection section of this form. If the total Health Center Program

funding request is reduced, funding requested for each targeted population (e.g., CHC, MHC) must maintain the same distribution as in the SAAT.

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

Scope of Project: Sites and Services
New or competing supplement applicants: To ensure continuity of services in areas already being served by the Health Center Program, you must certify that **all sites** described in the application are included on Form 5B: Service Sites and will be open and operational within 120 days of receipt of the NoA.
Competing continuation applicants: To ensure an accurate scope of project, certify that:

- Form 5A: Services Provided accurately reflects all services and service delivery methods included in the current scope of project OR Form 5A: Services Provided requires changes that **you have already submitted** through the change in scope process.
- Form 5B: Service Sites accurately reflects all sites included in the current scope of project OR Form 5B: Service Sites requires changes that **you have already submitted** through the change in scope process.

120 Day Implementation Plan Certification
Certify that if your organization is funded and is noncompliant with any Health Center Program requirements, within 120 days of receipt of your NoA, you will submit for HRSA approval an implementation plan which outlines a plan to meet the Health Center Program requirements within the timeframes required by the conditions on your NoA.

Appendix B: Performance Measures Instructions

CLINICAL AND FINANCIAL PERFORMANCE MEASURES

The Clinical and Financial Performance Measures forms record the proposed project's clinical and financial goals. The goals must be responsive to identified community health and organizational needs and correspond to proposed service delivery activities and organizational capacity discussed in the Project Narrative. Further detail and sample forms are available at the SAC Technical Assistance website. Refer to the UDS Manual for specific measurement details such as exclusionary criteria.

Required Clinical Performance Measures

1. Diabetes: Hemoglobin A1c Poor Control
2. Screening for Clinical Depression and Follow-up Plan
3. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
4. Body Mass Index (BMI) Screening and Follow-up
5. Controlling High Blood Pressure
6. Cervical Cancer Screening
7. Early Entry into Prenatal Care
8. Low Birth Weight
9. Childhood Immunization Status (CIS)
10. Dental Sealants for Children Between 6-9 Years
11. Tobacco Use: Screening and Cessation Intervention
12. Use of Appropriate Medications for Asthma
13. Coronary Artery Disease: Lipid Therapy
14. Ischemic Vascular Disease: Use of Aspirin or Another Antiplatelet
15. Colorectal Cancer Screening (revised) [43]
16. HIV Linkage to Care

Required Financial Performance Measures

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

Important Details about the Performance Measures Forms

- Analysis of current health center and national data has resulted in the prioritization of the following Health Center Program clinical priorities: Diabetes, Depression Screening and Follow-up, Child Weight Assessment and Counseling, and Body Mass Index.

- If you only provide preventive dental services via a formal referral (Form 5A, Column III), you may set the goal for the Dental Sealants for Children performance measure as 0 and track at least one self-defined Oral Health

[43] Refer to Program Assistance Letter 2017-08: Approved Uniform Data System Changes for Calendar Year 2018 for details about new and updated performance measures.

performance measure. Refer to the Frequently Asked Questions on the SAC Technical Assistance website for recommended self-defined measures.

- You should develop baselines for performance measures from data that are valid, reliable, and whenever possible, derived from current information management systems. If baselines are not yet available, enter 0 and provide a date by which baseline data will be available.

- If you are applying for funds to serve special populations (i.e., MHC, HCH, PHPC), you **must include** additional clinical performance measures that address the unique health care needs of these populations. For example, if you are seeking funds to serve people experiencing homelessness, then you must propose to measure *"the percentage of people experiencing homelessness who…"*

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

Additional Performance Measures
In addition to the required Clinical and Financial Performance Measures, you may identify other measures relevant to your target population and/or health center. Each additional measure must be defined by a numerator and denominator, and progress must be tracked over time.

Competing continuation applicants: If you no longer track a previously self-defined measure in the Additional Performance Measures section, note this by marking the measure *Not Applicable* and including a justification in the Comments field as to why reporting is no longer possible and/or relevant.

Overview of the Performance Measures Form Fields
If you are a competing continuation applicant, pre-populated baseline data will be sourced from the 2017 UDS report for measures that have not been revised and will appear in the EHB application mid-June. Refer to the Clinical Performance Measure Form Field Guide and Sample, and the Performance Measure Crosswalk at the SAC Technical Assistance website.

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

- Examine the performance measures of other health centers that serve similar target populations.
- Consider state and national performance UDS benchmarks and comparison data (available at Health Center Data).
- Use the Healthy People 2020 goals, available at http://www.healthypeople.gov/2020/topicsobjectives2020/default, as a guide when developing performance measures. Several of these objectives can be compared

directly to UDS Clinical Performance. A table outlining the Healthy People 2020 objectives related to applicable performance measures is available at http://bphc.hrsa.gov/programopportunities/fundingopportunities/sac/healthypeopleandmeasures.pdf.

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

Appendix C: Operational Plan

New or competing supplement applicants: You must outline a plan, specific to the proposed project, with appropriate and reasonable time-framed goals and action steps necessary to achieve the following:

1. Within 120 days of receipt of the NoA, [44] all proposed sites (as noted on Form 5B: Service Sites) must have the necessary staff and providers in place to begin operating and delivering services to the proposed community and/or target population, as described on Forms 5A: Services Provided and 5C: Other Activities/Locations.
2. Within 1 year of receipt of the NoA, all proposed providers must be delivering services and all sites must be open for the proposed hours of operation.

Table 2: Key Elements of the Operational Plan

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

A sample Operational Plan is provided on the SAC Technical Assistance website.

Optional Focus Areas

Operational Service Delivery
- A.1. Provision of Required & Additional Services (Form 5A: Services Provided)
- A.2. Professional Coverage for After Hours Care
- A.3. Admitting Privileges
- A.4. Readiness to Serve the Target Population

Functioning Key Management Staff/Systems/Arrangements
- B.1. Documented Contractual/Affiliation Agreements
- B.2. Data Reporting System

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

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

C.1. Sliding Fee Discount Program
C.2. Billing and Collections System
C.3. Implementation of a Compliant Sliding Fee Scale

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

D.1. Leadership and Accountability
D.2. QI/QA Plan and Process to Evaluate Performance

Governing Board

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