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

Bureau of Primary Health Care
Health Center Program

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

Announcement Type: New, Competing Continuation, and Competing Supplement
Funding Opportunity Number: HRSA-17-096

Catalog of Federal Domestic Assistance (CFDA) No. 93.224

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2017

Application Due Date in Grants.gov: October 17, 2016
Supplemental Information Due Date in HRSA EHB: November 1, 2016

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

Issuance Date: August 16, 2016

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

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC) is accepting applications for the fiscal year (FY) 2017 Service Area Competition – Additional Area (SAC-AA) for Miles City, MT 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 comprehensive, culturally competent, quality primary health care services. Health Center Program funds support a variety of community-based and patient-directed public and private nonprofit organizations that provide primary and preventive health care services to the Nation's underserved.

Funding Opportunity Title:	Service Area Competition – Additional Area (SAC-AA) – Miles City, MT
Funding Opportunity Number:	HRSA-17-096
Due Date for Applications – Grants.gov:	October 17, 2016 (11:59 p.m. ET)
Due Date for Supplemental Information – EHB:	November 1, 2016 (5:00 p.m. ET)
Anticipated Total Annual Available Funding:	Approximately $250,000
Estimated Number and Type of Award(s):	1 grant
Estimated Award Amount:	$250,000
Cost Sharing/Match Required:	No
Project Period:	April 1, 2017 through March 31, 2020 (up to three years)
Eligible Applicants:	Public or nonprofit private entity, including tribal, faith-based, or community-based organizations that propose to provide comprehensive primary health care services to a service area and its associated population(s) and patients identified in Table 4. [See Section III-1 of this funding opportunity announcement (FOA) for complete eligibility information.]

Application Guide
You (the applicant organization/agency) are responsible for reading and complying with the instructions included in HRSA's *SF-424 Two-Tier Application Guide*, except where instructed in this funding opportunity announcement to do otherwise. A short video is available explaining the new *Application Guide*.

Technical Assistance
Application resources, including a webinar recording, form samples, and a frequently asked questions document are available at the SAC-AA Technical Assistance Web site.

Refer to How to Apply for a Grant for general (i.e., not SAC-AA specific) videos and slides on a variety of application and submission components.

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

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

Summary of Changes

- The instructions for the Application for Federal Assistance (SF-424) form (Section IV.2) provide information specific to this funding opportunity for select fields.
- In the Collaboration section of the Project Narrative, you are asked to describe collaboration with veterans and veteran-serving organizations as applicable.
- In the Evaluative Measures section of the Project Narrative, you are asked to describe the organization's certified Electronic Health Record (EHR) system.
- Ten Clinical Performance Measures have been revised. Details are provided in Appendix B and PAL 2016-02: Approved Uniform Data Systems Changes for Calendar Year 2016.
- Prior to making awards, HRSA is required to review and consider information about each applicant in the Federal Awardee Performance and Integrity Information System (FAPIIS).

Other Federal Benefits

You are reminded that receipt of Health Center Program funds, while a basis for eligibility, does not, of itself, confer such federal benefits as Federal Tort Claims Act (FTCA) coverage or FQHC reimbursement, both of which depend upon compliance with applicable requirements in addition to the award of Health Center Program funding. For more information about the FTCA Health Center Program and its requirements, refer to the FTCA Health Center Program Policy Manual (as updated).

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I. Program Funding Opportunity Description

1. Purpose

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

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

2. Background

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

The Health Center Program targets the Nation's neediest populations and geographic areas by currently funding nearly 1,400 health centers that operate more than 9,800 service delivery sites in every state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. More than 23 million patients, including medically underserved and uninsured patients, received comprehensive, culturally competent, quality primary health care services through the Health Center Program.

Only one award will be given for the announced service area.

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

You must demonstrate compliance with applicable Health Center Program requirements and corresponding regulations and policies, in accordance with section 330 of the PHS Act.

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

New and competing supplement applicants 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, 5B: Service Sites, and 5C: Other Activities/Locations, and in Attachment 13: Implementation Plan.[2]
- Within one year of receipt of the NoA, all proposed providers must be in place and all sites must be delivering services for the proposed hours of operation.

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

If you are funded, you must provide services to the number of unduplicated patients projected to be served by December 31, 2018, as indicated on Form 1A: General Information Worksheet.[3] **If a health center is unable to demonstrate that it is serving the cumulative total of projected patients by December 31, 2018 via the 2018 Uniform Data System (UDS) report, announced funding for the service area may be proportionally reduced.**

Failure to meet SAC-AA funding and Health Center Program requirements may jeopardize Health Center Program grant funding per Uniform Guidance 2 CFR part 200 as codified by HHS at 45 CFR part 75. HRSA will assess award recipients for program

[1] See PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes, which describes and defines the term "service sites."
[2] HRSA may issue Notices of Award up to 60 days prior to the project period start date.
[3] For this purpose, the term "patients" refers to individual patients and not patient visits; each individual patient counts as a single "patient," notwithstanding multiple encounters/visits.

compliance prior to and during the project period. When non-compliance is identified (e.g., an organization fails to become operational at all sites within 120 days, does not demonstrate compliance with Health Center Program requirements), HRSA will place a condition on the recipient's award, which follows the Progressive Action process. The Progressive Action process provides a time-phased approach to resolve compliance issues. If an organization fails to successfully resolve conditions via the Progressive Action process, HRSA may withdraw support through cancellation of all or part of the grant award. For more information, see Program Assistance Letter 2014-08: Health Center Program Requirements Oversight.

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

COMMUNITY HEALTH CENTER (CHC) APPLICANTS:

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

MIGRANT HEALTH CENTER (MHC) APPLICANTS:

- Ensure compliance with PHS Act section 330(g); and, as applicable, section 330(e), program regulations, requirements, and policies.
- Provide a plan that ensures the availability and accessibility of required primary and preventive health care services to migratory and seasonal agricultural workers and their families in the service area.
    - Migratory agricultural workers are individuals principally employed in agriculture and who establish temporary housing for the purpose of this work, including those individuals who have had such work as their principal employment within 24 months as well as their dependent family members. Agricultural workers who leave a community to work elsewhere are classified as migratory workers in both communities. Aged and disabled former agricultural workers should also be included in this group.
    - Seasonal agricultural workers are individuals employed in agriculture on a seasonal basis who do not establish a temporary home for purposes of employment, including their family members.
    - Agriculture means farming in all its branches, as defined by the OMB-developed North American Industry Classification System under codes 111, 112, 1151, and 1152 (48 CFR §219.303).[4]

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.

[4] For more information about the North American Industry Classification System, see https://www.census.gov/eos/www/naics/index.html.

- Provide a plan that ensures the availability and accessibility of required primary and preventive health care services to people experiencing homelessness, defined as patients who lack housing, including residents of permanent supportive housing, transitional housing, or other housing programs that are targeted to homeless populations, in the service area. This plan may also allow for the continuation of services for up to 12 months to individuals no longer homeless as a result of becoming a resident of permanent housing.
- Provide substance abuse services.

PUBLIC HOUSING PRIMARY CARE APPLICANTS:

- Ensure compliance with PHS Act section 330(i); and, as applicable, section 330(e), program regulations, requirements, and policies.
- Provide a plan that ensures the availability and accessibility of required primary and preventive health care services to residents of public housing and individuals living in areas immediately accessible to public housing. Public housing means public housing agency-developed, owned, or assisted low-income housing, including mixed finance projects. It does not mean public housing that is only subsidized through Section 8 housing vouchers.
- Consult with residents of the proposed public housing sites regarding the planning and administration of the program.

II. Award Information

1. Type of Application and Award

Types of applications sought:

- Competing continuation – A current Health Center Program award recipient 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 proposal of one or more new permanent delivery sites.

Funding will be provided in the form of a grant.

2. Summary of Funding

Approximately $250,000 is expected to be available annually to fund 1 recipient.

Award amounts will not exceed the total annual Health Center Program funding available for each service area (listed as Total Funding Table 4) in any budget year of the proposed three-year project period. Funding must be requested and will be

awarded proportionately for all population types within the service area as currently funded under the Health Center Program. No new population types may be added.

You must propose to serve at least 75 percent of the Patient Target in Table 4 by December 31, 2018. If you propose to serve fewer than the total number of patients indicated in Table 4, you must reduce your funding request according to the following table. If you propose to serve fewer than the total number of patients indicated in Table 4, but do not reduce the funding request, HRSA will reduce the award accordingly. A funding calculator is available to determine if a funding reduction is required.

Table 1: Funding Reduction by Patients Projected to Be Served

Patient Projections Compared to Table 4 Patient Target (%)	Funding Request Reduction (%)
95-100% of patients listed in Table 4	No reduction
90-94.9% of patients listed in Table 4	0.5% reduction
85-89.9% of patients listed in Table 4	1% reduction
80-84.9% of patients listed in Table 4	1.5% reduction
75-79.9% of patients listed in Table 4	2% reduction
< 75 % of patients listed in Table 4	Not eligible for funding

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

This program announcement is subject to the appropriation of funds and is a contingency action taken to ensure that, should funds become available for this purpose, applications can be processed and funds can be awarded in a timely manner. Funding beyond the first year of the three-year project period is dependent on the availability of appropriated funds for the Health Center Program in subsequent fiscal years, satisfactory recipient performance, and a decision that continued funding is in the best interest of the Federal Government.

Effective December 26, 2014, all administrative and audit requirements and the cost principles that govern federal monies associated with this award are subject to the Uniform Guidance 2 CFR part 200 as codified by HHS at 45 CFR part 75, which supersede the previous administrative and audit requirements and cost principles that govern the use of federal award monies.

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

III. Eligibility Information

You must meet all of the following eligibility requirements.

1. Eligible Applicants

1) You must be a public or nonprofit private entity, as demonstrated through the submission of the Evidence of Non-profit/Public Center Status outlined in Section IV.2.vi. Faith-based and community-based organizations, Tribes, and tribal organizations are eligible to apply.

2) You must propose to operate a health center that makes all required primary health care services, including preventive and enabling health care services, available and accessible in the service area, either directly or through established arrangements, without regard to ability to pay.[5] You may **not** propose to provide only a single type of service, such as dental, behavioral, or prenatal services.

3) You must provide continuity of services, ensuring availability and accessibility in the service area, by proposing to serve an announced service area and its patients identified in Table 4.

    a) The total unduplicated patients projected to be served by December 31, 2018, entered on Form 1A, must be at least 75 percent of the Patient Target in Table 4. See the Summary of Funding section above if your patient projection is less than the Patient Target in Table 4.
    b) Zip codes entered in the Service Area Zip Codes field on Form 5B: Service Sites for service delivery sites (administrative-only sites will not be considered) must be all of those listed in Table 4.[6]
    c) Through the request for federal funding on the SF-424A, you must propose to serve all currently targeted populations (i.e., CHC, MHC, HCH, PHPC) and maintain the current funding distribution (as identified in Table 4). Funding must be requested and will be made available proportionately for all population types within the service area as currently funded under the Health Center Program. No new population types may be added.

Note*:* HRSA is committed to monitoring achievement of the SAC-AA application patient projection, as well as any additional patient projections through supplemental awards received during the project period. If you are unable to demonstrate that you are serving the cumulative total of projected patients by December 31, 2018, future funding for the service area may be proportionally reduced when it is announced in future SAC funding opportunities.

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

[5] Refer to the Service Descriptors for Form 5A: Services Provided for details regarding required comprehensive primary, preventive, and enabling health care services.
[6] HRSA considers service area overlap when making funding determinations for new and competing supplement applicants if zip codes are proposed on Form 5B: Service Sites beyond those listed in Table 4. For more information about service area overlap, refer to PIN 2007-09: Service Area Overlap: Policy and Process.

on Form 5B: Service Sites, with the exception of projects serving only migratory and seasonal agricultural workers, which may propose a full-time seasonal (rather than permanent) service delivery site.[7] You must provide a verifiable street address for each proposed site on Form 5B: Service Sites. A mobile medical van may be proposed only if at least one full-time (operational 40 hours or more per week) permanent (or seasonal for MHC-only applicants), fixed site is also proposed in the application.

5) You must propose to provide access to services for all individuals in the service area and target population, as defined in Table 4. In instances where a sub-population is targeted (e.g., homeless children; lesbian, gay, bisexual, and transgender individuals (LGBT)), you must ensure that health center services will be made available and accessible to others who seek services at the proposed site(s).

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

Note*:* If you are intending to apply to serve two different service areas announced under a single announcement number, you **must** contact the Office of Policy and Program Development at 301-594-4300 or BPHCSAC@hrsa.gov for guidance.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this funding opportunity.

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 catchment area.
- You will utilize, to the maximum extent feasible, other federal, state, local, and private resources available for support of the project.

3. Other

The Project Narrative must be organized by section headers with the requested information appearing in the appropriate section of the Project Narrative or the designated forms and attachments. An application that fails to address the required elements within each of the following five Project Narrative sections will be considered

[7] See PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes, which describes and defines the term “service sites.”

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

The annual funding request (as presented on the SF-424A and Budget Narrative) **must not** exceed the amount of Total Funding available in Table 4. Applications that exceed this amount will be considered non-responsive and will not be considered for funding under this announcement.

The application must include all forms and documents indicated as "required for completeness" in Section IV.2.iv, Section IV.2.v, and Section IV.2.vi based on your organization type.

You cannot apply on behalf of another organization. Your organization is expected to perform a substantive role in the project and meet the program requirements. For example, your organization as entered on the SF-424 must meet all eligibility criteria.

If you fail to satisfy the deadline requirements referenced in Section IV.4, your application will be considered non-responsive and will not be considered for funding under this announcement.

HRSA will only accept your first validated electronic submission, under the correct funding opportunity number, in Grants.gov.[8] Applications submitted after the first submission will be marked as duplicates and considered ineligible for review. If you want to change information submitted in the Grants.gov portion of the 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 in HRSA EHB. You must use a two-tier submission process associated with this FOA and follow the directions provided at Grants.gov and in HRSA EHB.

- **Phase 1 – Grants.gov** – Required information must be submitted and validated via Grants.gov with a due date of October 17, 2016 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 November 1, 2016 at 5:00 p.m. Eastern Time.

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

You may only submit the additional required information in HRSA EHB (Phase 2) if you successfully submit an application in Grants.gov (Phase 1) by the due date/time.

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 this FOA to do otherwise.

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
- Funding Opportunity-Specific Forms
- Attachments

See Section 9.5 of the *SF-424 Two-Tier 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 (unless otherwise noted), and letters of commitment and support. Standard OMB-approved forms that are included in the application package are NOT included in the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) will not be counted in the page limit. **We strongly urge you to take appropriate measures to ensure the 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 prior to the Grants.gov and HRSA EHB deadlines to be considered under this announcement.

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) Where the prospective recipient is unable to attest to any of the statements in this certification, such prospective recipient shall attach an explanation to this proposal.

See Section 5.1 viii of HRSA's *SF-424 Two-Tier Application Guide* for additional information on this and other 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), please include the following.

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

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

- *Box 2: Type of Applicant:* Incorrect selection may delay EHB access. Continuation – Current Health Center Program award recipients applying to continue serving its current service area: Select "Continuation" and include your H80 grant number in box 4.

  New – If you are not currently funded through the Health Center Program: Select "New" and leave box 4 blank.

  Revision – Current award recipient applying to serve a new service area: Select "Other" and type Supplemental and your H80 grant number in box 4.

- *Box 5a:* 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:* Your organization's DUNS number. *Note:* 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 FOA (Service Area Competition – Additional Area) and upload the project abstract. See instructions in Section IV.2.i. The abstract WILL count toward the page limit.
- *Box 17: Proposed Project Start and End Date:* Provide the start date (April 1, 2017) and end date (March 31, 2020) for the proposed three-year project period.

- *Box 18: Estimated Funding:* Complete the required information based on the funding request for the first year of the proposed project period. Refer to the Summary of Funding section for details.
- *Box 19: Review by State:* See Section IV.5 for guidance in determining applicability.

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

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

In addition to the information described in Section 5.1.vii of HRSA's *SF-424 Two-Tier Application Guide*, include the following at the top of the abstract*:*

- Project Title: Service Area Competition – Additional Area
- Congressional District(s) for your Organization and Proposed Service Area (if different)
- Identification (ID) number, city, and state of the service area proposed (available in Table 4)
- Type(s) of Section 330 Funding Requested (i.e., CHC, MHC, HCH, and/or PHPC)
- Current federal funding (including HRSA funding), if applicable

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

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

ii. Project Narrative *(Submitted in EHB)*

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

Reminder: An application that fails to address the required elements within each of the following five Project Narrative sections will be considered incomplete/non-responsive and will not be considered for funding: **Need, Response, Collaboration, Resources/Capabilities, and Governance**.

The Project Narrative must:

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

If you are a **competing continuation applicant**, you must ensure that the Project Narrative reflects the current approved scope of project. Any change in scope **must** be submitted separately through HRSA EHB.[9]

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

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

NEED *– Corresponds to Section V.1 Criterion 1: NEED (required for completeness)*

Information provided in the ***NEED*** section must serve as the basis for, and align with, the proposed activities and goals described throughout the application. Reference/cite data sources where appropriate. Describe how referenced/cited data and trends are reflective of the target population in the proposed service area.

1) Describe how the following **characteristics of the target population** affect access to primary health care, health care utilization, and health status, referencing/citing data sources.
   a) Percent of the target population that is uninsured.[10]
   b) Unemployment and educational attainment.
   c) Income and poverty level.
   d) Health disparities.

[9] Refer to the Scope of Project policy documents and resources for details pertaining to changes to the current services, providers, sites, service area zip codes, and target population(s).
[10] Refer to the Available Data Sources document on the SAC-AA Technical Assistance Web site for recommended data sources.

e) Unique characteristics not previously addressed (e.g., ethnicity, sexual orientation, gender identity, disability, health literacy, language, cultural attitudes and beliefs).

2) Describe how the following **characteristics of the service area** impact access to care for the target population, referencing/citing data sources:
   a) Geographical/transportation barriers to include the distance (miles) OR travel time to the nearest primary care provider accepting new Medicaid and uninsured patients (consistent with Attachment 1: Service Area Map and Table).[17]
   b) Other primary health care services available in the service area, including their location and accessibility by the target population.
   c) The number of individuals in the target population/service area for every one full-time equivalent (FTE) primary care physician as a ratio (i.e., number of patients: 1 FTE primary care physician).[17]

3) Describe the health care environment and its impact on your organization's current and future operations, including any recent or anticipated significant changes that affect the availability of health care services and patient characteristics in the service area, such as shifts in the number of patients served, including:
   a) Insurance coverage, including Medicaid, Medicare, and Children's Health Insurance Program (CHIP).
   b) State/local/private uncompensated care programs.
   c) Economic and demographic shifts (e.g., influx of immigrant/refugee populations; closing of local hospitals, ambulatory care sites, or major local employers).
   d) Natural disasters or emergencies (e.g., hurricanes, flooding, terrorism).
   e) Changes affecting specific populations (e.g., children experiencing homelessness, LGBT).

4) **Applicants requesting special population funding** to serve migratory and seasonal agricultural workers (MHC), people experiencing homelessness (HCH), and/or residents of public housing (PHPC):
   a) **MHC**: Describe the specific health care needs and access issues of migratory and seasonal agricultural workers, including the agricultural environment (e.g., crops and growing seasons, demand for labor, number of temporary workers); approximate migratory/seasonal residency period(s), including the availability of local providers to provide primary health care services during these times; occupational factors (e.g., working hours, housing, hazards, including pesticides and other chemical exposures); and significant increases or decreases in migratory and seasonal agricultural workers.
   b) **HCH**: Describe the specific health care needs and access issues of people experiencing homelessness, such as the number of providers treating people experiencing homelessness, availability of homeless shelters, and significant increases or decreases in people experiencing homelessness.

c) **PHPC**: Describe the specific health care needs and access issues of residents of public housing, such as the availability of public housing and its impact on the residents in the targeted public housing communities served, and significant increases or decreases in residents of public housing.

RESPONSE *– Corresponds to Section V.1 Criterion 2: RESPONSE (required for completeness)*

1) Describe the proposed service delivery sites and how they are appropriate for the needs of the service area and target population. Specifically address:
   a) Site(s)/location(s) where services will be provided (consistent with Attachment 1: Service Area Map and Table, and Forms 5B: Service Sites and 5C: Other Activities/Locations).
   b) How the type (e.g., fixed site, mobile van, school-based clinic), hours of operation, and location (e.g., proximity to public housing) of each proposed service delivery site (consistent with Form 5B: Service Sites) assures that services are, or will be, accessible and available at times that meet the needs of the target population (consistent with Form 5B: Service Sites and 5C: Other Activities/Locations).
   c) Capacity at the proposed service site(s) (consistent with Form 5B: Service Sites) to collectively achieve the projected number of patients and visits (consistent with Form 1A: General Information Worksheet).
   d) Professional coverage for medical emergencies during hours when service sites are closed and provisions for follow-up by the health center for patients accessing after hours coverage. Specifically, discuss how these arrangements are appropriate for the services proposed and the projected number of patients (consistent with Form 1A: General Information Worksheet).

   Note: New and competing supplement applicants must:
   - Propose at least one full-time (operational 40 hours or more per week) permanent, fixed building site on Form 5B: Service Sites, with the exception of projects serving only migratory and seasonal agricultural workers, which may propose a full-time, seasonal (rather than permanent) service delivery site. A mobile medical van may be proposed only if at least one full-time (operational 40 hours or more per week) permanent, fixed building site is also proposed in the application.
     Upload Floor Plans as Attachment 12 for all new sites proposed. If the site is/will be leased, you must include lease/intent to lease documentation in Attachment 14: Other Relevant Documents.

2) Describe how the proposed primary health care services (consistent with Form 2: Staffing Profile and Form 5A: Services Provided) and other activities (consistent with Form 5C: Other Activities/Locations) are appropriate for the needs of the target population, including:

a) The provision of required and additional services, including whether these are provided directly or through formal written contracts/agreements or referral arrangements.[11]
b) How enabling services (e.g., case management, outreach and enrollment activities, transportation) are integrated into primary care. Describe any enabling services designed to increase access for targeted special populations or populations with identified unique health care needs, such as translation services for populations with limited English proficiency.

Note:

- Applicants requesting HCH funding must document how substance abuse services will be made available either directly, through formal written contracts/agreements, and/or via a formal written referral arrangement.
- Applicants requesting MHC funding must document how they will address any specific needs of this population (e.g., provide additional services such as environmental health).
- Applicants requesting PHPC funding must document that the service delivery plan was developed in consultation with residents of the targeted public housing and describe how residents of public housing will be involved in administration of the proposed project.

3) Describe plans to ensure continuity of care for health center patients, including:
   a) Arrangements for admitting privileges for health center physicians to ensure continuity of care for health center patients at one or more hospitals (consistent with Form 5C: Other Activities/Locations). In cases where hospital privileges are not possible, describe other established arrangements to ensure continuity of care (i.e., timely follow-up) for patient hospitalizations.
   b) How these arrangements ensure a continuum of care for health center patients, including discharge planning, post-hospitalization tracking, and patient tracking (e.g., interoperability of electronic health records (EHRs)).

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

[11]Refer to the Service Descriptors for Form 5A: Services Provided and to Form 5A Column Descriptors for details regarding required and additional services and service delivery methods.

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

5) Describe policies and procedures used to implement the sliding fee discount program (consistent with Attachment 10: Sliding Fee Discount Schedule), including how these specifically address the following:[12]
   a) Definitions of income and family size.
   b) Assessment of all patients for eligibility for sliding fee discounts based on income and family size only. *Note*: No other factors (e.g., insurance status) can be considered.
   c) Process for determining patient eligibility for sliding fee discounts, including frequency of re-evaluation of patient eligibility.
   d) Language and literacy level-appropriate methods used for making patients aware of the availability of sliding fee discounts (e.g., signs posted in accessible and visible locations, registration materials, brochures, verbal messages delivered by staff).
   e) How sliding fee discounts are applied to all services within the approved scope of project (i.e., required and additional services, consistent with the services and service delivery methods indicated on Form 5A: Services Provided, Columns I, II, or III).
   f) Method and frequency of evaluating the sliding fee discount program from the perspective of reducing patient barriers to care.

6) Describe the following aspects of the Sliding Fee Discount Schedule(s) (SFDS) (consistent with Attachment 10: Sliding Fee Discount Schedule):
   a) Annual updates to reflect the most recent Federal Poverty Guidelines (FPG).
   b) Adjustment of fees for individuals and families with incomes above 100 percent of FPG, and at or below 200 percent of the FPG, using at least three (3) discount pay classes.
   c) Provision of a full discount (or nominal charge) for individuals and families with annual incomes at or below 100 percent of the FPG.[13]
   d) If a nominal charge is applied for individuals and families with annual incomes at or below 100 percent of the FPG, how the charge is:
      - Determined to be nominal from the perspective of the patient (e.g., input from patient focus groups, patient surveys).
      - A fixed fee (not a percentage of the actual charge/cost) that does not reflect the true cost of the service(s) being provided.

[12] Refer to PIN 2014-02: Sliding Fee Discount and Related Billing and Collections Program Requirements for details on the Health Center Program sliding fee discount program and related billing and collections requirements.
[13] Sliding fee discounts may not be applied for individuals and families with annual incomes above 200 percent of the FPG.

- Not more than the fee paid by a patient in the first SFDS pay class above 100 percent of the FPG.

7) Describe the organization's quality improvement/quality assurance (QI/QA) and risk management plan(s) for systematically assuring and improving health care quality, including policies, procedures, and parties responsible for:
   a) Addressing patient grievances.
   b) Incident reporting and management.
   c) Patient records, including maintaining confidentiality of such records.
   d) Periodic assessment by physicians (or other licensed health care professionals under the supervision of a physician) of service utilization, quality of services delivered, and patient outcomes.
   e) Ensuring providers (e.g., employed, contracted, volunteers, locum tenens) are appropriately licensed, credentialed, and privileged to perform proposed health center services.
   f) Utilization of appropriate information systems (e.g., EHRs, practice management systems) for tracking, analyzing, and reporting key performance data, including 1) reporting required clinical and financial performance measures and 2) tracking diagnostic tests and other services provided to ensure appropriate patient record documentation and follow-up.
   g) Developing, updating, and implementing such policies and procedures.
   h) Communication to all project stakeholders and utilization of QI/QA results to improve performance.
   i) Accountability throughout the organization, specifically the role and responsibilities of the Clinical Director in providing oversight of the QI/QA program.

8) Describe plans for assisting individuals in determining their eligibility for and enrollment in affordable health insurance options available through the Marketplace, Medicaid and CHIP, including:
   a) How potentially eligible individuals (both current patients and other individuals in the service area) will be identified and informed of the available options.
   b) The type of assistance that will be provided for determining eligibility and completing the relevant enrollment process.

Note: If you are a new and competing supplement applicant, you must:

9) Upload a detailed implementation plan to Attachment 13: Implementation Plan (see Appendix C). The plan must include reasonable and time-framed activities that assure that, within 120 days of receipt of the NoA, **all proposed sites** (as noted on Form 5B: Service Sites) will 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.[14]

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

10) Describe plans to ensure that you will:
    a) Hire/contract with all providers (consistent with Form 2: Staffing Profile, Form 8: Health Center Agreements, and Attachment 7: Summary of Contracts and Agreements) and begin providing services at all sites for the targeted number of hours within one year of NoA.
    b) Minimize potential disruption for patients (as noted inTable 4) served by the current award recipient that may result from the transition of the award to a new recipient.[15]

COLLABORATION *– Corresponds to Section V.1 Criterion 3: COLLABORATION (required for completeness)*

1) Describe both formal and informal collaboration and coordination of services with the following community providers in the service area (consistent with Attachment 1: Service Area Map and Table for items a through e below), or explain if such community services are not available:[16]
    a) Existing health centers (Health Center Program award recipients and look-alikes).
    b) State and local health departments.
    c) Rural health clinics.
    d) Critical access hospitals.
    e) Free clinics.
    f) Other federally supported award recipients (e.g., Ryan White programs, Title V Maternal and Child Health programs).
    g) Private provider groups serving low income/uninsured patients.
    h) Evidence-based home visiting programs serving the same target population.[17]
    i) Additional programs serving the same target population (e.g., social services; job training; Women, Infants, and Children (WIC); coalitions; community groups; school districts).
    j) If applicable, organizations that provide services or support to the special population(s) for which funding is sought (e.g., Migrant Head Start, Public Housing Authority, homeless shelters).
    k) If applicable, veterans service organizations, U.S. Department of Veterans Affairs (VA), Veteran's Health Administration community based outpatient clinics, VA medical centers, and other local veteran-serving organizations.
    l) If applicable, neighborhood revitalization initiatives such as the Department of Housing and Urban Development's Choice Neighborhoods, the Department

[15] If a new organization is awarded a service area currently served by an existing Health Center Program award recipient, the sites and/or equipment of the current award recipient will not automatically transfer to the applicant selected for funding. Regulations concerning disposition and transfer of equipment are found at 45 CFR § 75.320(e), if applicable.
[16] Refer to PAL 2011-02: Health Center Collaboration for information on maximizing collaborative opportunities.
[17] Examples of evidence-based home visiting programs are available at the Maternal, Infant, and Early Childhood Home Visiting Program Web site.

of Education's Promise Neighborhoods, and/or the Department of Justice's Byrne Criminal Justice Innovation Program. If a neighborhood within your service area has been designated as a Promise Zone or named a Strong Cities, Strong Communities location, discuss how you will collaborate with these efforts (see http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/economicdevelopment/programs/pz and https://www.huduser.gov/portal/sc2/home.html).

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

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

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

3) **If you are proposing to serve special populations, you** must provide current dated letters of support that reference specific coordination or collaboration with community organizations that also serve the targeted special population(s) (e.g., Migrant Head Start, Public Housing Authority, homeless shelters).

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

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

1) Within the Clinical Performance Measures form (see detailed instructions in Appendix B), outline realistic goals that are responsive to clinical performance and identified needs. Goals should be informed by contributing and restricting factors affecting achievement.

2) Within the Financial Performance Measures form (see detailed instructions in Appendix B), outline realistic goals that are responsive to the organization's

financial performance. Goals should be informed by contributing and restricting factors affecting achievement.

3) Describe the organization's evaluation process for additional assessment of the health care needs of the target population, including:
   a) The frequency and when the last assessment occurred.
   b) Community engagement.
   c) Assessment tools/methods (e.g., written or verbal patient satisfaction surveys), and analysis, including cultural appropriateness.
   d) Dissemination of results to board members, health center staff, community stakeholders, project partners, and patients.

4) Describe how the organization's certified electronic health record (EHR) system will be used to optimize health information technology to achieve meaningful use and improve quality outcomes.[18,19] If you do not have an EHR system, or have an EHR system that is not yet functional or integrated into proposed sites, you should outline plans for full EHR implementation at all proposed sites (consistent with Form 5B: Service Sites) within one year of receipt of the NoA.

5) If any additional evaluation activities are planned for the project period, provide a brief description of the additional activities, including data collection tools.

RESOURCES/CAPABILITIES *– Corresponds to Section V.1 Criterion 5: RESOURCE/CAPABILITIES (required for completeness)*

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

2) Describe how your organization maintains appropriate oversight and authority over all proposed service sites, including contracted/sub-awarded sites, and services including (as applicable):
   a) Current or proposed contracts and agreements summarized in Attachment 7: Summary of Contracts and Agreements.

[18] Information about certified EHR systems is available at HealthIT.gov: ONC – Authorized Testing and Certification Body.
[19] Information about meaningful use is available at Centers for Medicare and Medicaid Services EHR Incentive Programs.

b) Subrecipient arrangements,[20] subawards, contracts, or parent/affiliate/subsidiary agreements uploaded in Form 8: Health Center Agreements. If you have proposed subrecipient arrangements, you must demonstrate that systems are in place to provide reasonable assurances that the subrecipient organization complies with – and will continue to comply with – all statutory and regulatory requirements throughout the period of award.

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

3) Describe how your organization's management team (CEO, CD, CFO, CIO, and COO, as applicable) is appropriate for the operational and oversight needs, scope, and complexity of the proposed project, including:
   a) Defined roles (consistent with Attachment 4: Position Descriptions for Key Management Staff), in particular the CEO's responsibilities for day-to-day program management of health center activities.
   b) Skills and experience for the defined roles (consistent with Attachment 5: Biographical Sketches for Key Management Staff).
   c) If applicable, shared key management positions (e.g., shared CFO/COO role) and time dedicated to health center activities (e.g., 0.5 FTE).
   d) If applicable, changes in key management staff in the last year or significant changes in roles and responsibilities.

4) Describe your plan for recruiting and retaining key management staff and health care providers necessary for achieving the proposed staffing plan (consistent with Form 2: Staffing Profile).

5) Describe your organizational experience in the following areas:
   a) Serving the target population.
   b) Developing and implementing systems and services appropriate for addressing the target population's identified health care needs.

6) Describe your organization's ongoing strategic planning process, including:
   a) The roles of the governing board and key management staff.
   b) The frequency of strategic planning meetings.
   c) Strategic planning products (e.g., strategic plan, operational plan).
   d) Incorporation of needs assessment and program evaluation findings.

7) Describe any national quality recognition your organization has received or is in the process of achieving (e.g., Patient-Centered Medical Home, Accreditation

[20] A subrecipient is an organization that receives a subaward from a Health Center Program award recipient to carry out a portion of the grant-funded scope of project. Subrecipients must be compliant with all Health Center Program statutory and regulatory requirements, as well as applicable funding requirements specified in Uniform Guidance 2 CFR part 200 as codified by HHS at 45 CFR part 75. All subrecipient arrangements must be provided to HRSA as an attachment to Form 8.

Association for Ambulatory Health Care, Joint Commission, state-based or private payer initiatives).

8) Describe your current status or plans for participating in related federal benefits (e.g., Federal Tort Claim Act (FTCA) coverage, FQHC Medicare/Medicaid/CHIP reimbursement, 340 Drug Pricing Program, National Health Service Corps providers). If you do not have plans to seek FTCA coverage,[21] describe plans for malpractice insurance. Refer to Section VIII for details.

9) Describe your billing and collections policies and procedures, including:
   a) How the established schedule of charges for health center services (consistent with Form 5A: Services Provided) is consistent with locally prevailing rates and is designed to cover the reasonable cost of service operation.
   b) Efforts to collect appropriate reimbursement from Medicaid, Medicare, and other public and private insurance sources (e.g., CHIP, Marketplace qualified health plans) (consistent with Form 3: Income Analysis).[22]
   c) Efforts to secure payments owed by patients that do not create barriers to care.
   d) Criteria for waiving charges and staff authorized to approve such waivers.

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

11) Describe your organization's current financial status, including profitability (change in net income/total expenses), cash-on-hand (total unrestricted cash/daily expenses), and solvency (total liabilities/total net assets). You may upload source documents (e.g., current income statement and balance sheet) to Attachment 14: Other Relevant Documents, as desired.

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[21] Please note that FTCA coverage for the entities and its personnel requires the submission and approval by HRSA/BPHC of an application for deemed Public Health Service employment through a separate process that occurs subsequent to the award of funding under this FOA).

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

12) Describe your annual independent auditing process performed in accordance with federal audit requirements.[23] Explain any adverse audit findings (e.g., questioned costs, reportable conditions, cited material weaknesses) and corrective actions that have been implemented to address such findings.

13) Describe your status of emergency preparedness planning and development efforts, including plans to participate in state and local emergency planning. If applicable, explain negative responses on Form 10: Emergency Preparedness Report and plans for resolution.

GOVERNANCE[24] *– Corresponds to Section V.1 Criterion 6: GOVERNANCE (required for completeness)*

Note: Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups are required ONLY to respond to Item 7 below.

1) Describe how Attachments 2: Corporate Bylaws, 6: Co-Applicant Agreement, and 8: Articles of Incorporation demonstrate that your organization has an independent governing board that retains (i.e., does not delegate) the following unrestricted authorities, functions, and responsibilities:[25]
   a) Meets at least once a month.
   b) Ensures that minutes documenting the board's functioning are maintained.
   c) Determines executive committee function and composition.
   d) Selects the services to be provided.
   e) Determines the hours during which services will be provided.
   f) Measures and evaluates the organization's progress and develops a plan for the long-range viability of the organization through: strategic planning and periodic review of the organization's mission and bylaws; evaluating patient satisfaction; monitoring organizational performance; setting organizational priorities; and allocating assets and resources.
   g) Approves the health center's annual budget, federal applications for funding, and selection/dismissal/performance appraisal of the organization's CEO.
   h) Establishes general policies for the organization.

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

[23] Information about administrative and audit requirements, and the cost principles that govern federal funding under this announcement are available at Uniform Guidance 2 CFR part 200 as codified by HHS at 45 CFR part 75.
[24] Refer to PIN 2014-01: Health Center Program Governance for information on Governance requirements.
[25] In the case of public centers with co-applicant governing boards, the public center is permitted to retain authority for establishing general fiscal and personnel policies for the health center.

justify the need for a waiver in Form 6B: Request of Waiver of Board Member Requirements).

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

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

3) Document the effectiveness of the governing board by describing how the board:
   a) Operates, including the organization and responsibilities of board committees (e.g., Executive, Finance, QI/QA, Risk Management, Personnel, Planning).
   b) Monitors and evaluates its performance, inclusive of identifying training needs.
   c) Provides training, development, and orientation for **new members** to ensure that they have sufficient knowledge to make informed decisions regarding the strategic direction, general policies, and financial position of the organization.

4) **If you have a parent/affiliate/subsidiary** (consistent with Form 8: Health Center Agreements): Describe how this organizational structure/relationship does not impact or restrict your governing board composition and/or authorities (reference Attachment 2: Corporate Bylaws and other attachments as needed), including:
   a) Selection of the board chairperson, a majority of board members (both patient and non-patient), and, if applicable, Executive Committee members.
   b) Selection or dismissal of the CEO/Executive Director, including arrangements that combine this position with other key management positions.
   c) Ensuring that no outside entity has the authority to override board approval (e.g., dual or super-majority voting, prior approval process, veto power, final approval).

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

5) Document that your health center's bylaws (consistent with Attachment 2: Corporate Bylaws) and/or other board-approved policy document(s) and procedures include specific provisions that prohibit real or apparent conflict of interest by board members, employees, consultants, and others in the procurement of supplies, property (real or expendable), equipment, and other services procured with federal funds.

6) Describe how the composition of the governing board will be modified if changes occur in the demographics or needs of the target population and/or service area.

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

SUPPORT REQUESTED[26]*– Corresponds to Section V.1 Criterion 7: SUPPORT REQUESTED*

1) Provide a complete, consistent, and detailed budget presentation through the submission of the following: SF-424A, Budget Narrative, Form 2: Staffing Profile, and Form 3: Income Analysis.

2) Describe how your total budget is appropriate for the proposed project and the total number of **unduplicated patients projected to be served** (consistent with Form 1A: General Information Worksheet, Table 1: Funding Reduction by Patients Projected to Be Served, and the Summary Page).

3) Describe how the proportion of federal funds you requested in this application is appropriate given other sources of funding, including those specified in Form 3: Income Analysis (e.g., in-kind donations) and the Budget Narrative.

4) Describe expected shifts in your payer mix (consistent with payer categories listed on Form 3: Income Analysis) and the potential impact on the overall budget, including plans to mitigate any expected adverse impacts.

NARRATIVE GUIDANCE
In order to ensure that the Review Criteria are fully addressed, this table provides a crosswalk between the Project Narrative sections and where each section falls within the individual Review Criteria detailed in Section V.1.

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

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

iii. Budget *(Submitted in EHB)*

See Section 5.1 of HRSA's *SF-424 Two-Tier Application Guide*. Please note: The directions offered in the SF-424 Two-Tier Application Guide differ from those offered by Grants.gov. Follow the instructions included in the Application Guide and the additional budget instructions provided below. Funding must be requested and will be awarded proportionately for all population types within the service area as currently funded under the Health Center Program. No new population types may be added.

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) incurred by the 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.

Note: 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. As stated in section 330 of the PHS Act, as amended, the federal cost principles apply only to federal grant funds.

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

that the projected budget complies with all applicable HHS policies and other federal requirements.[27]

When completing the SF-424A:

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

The Consolidated Appropriations Act, 2016 Division H, § 202, (P.L. 114-113), 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." The Executive Level II salary of the Federal Executive Pay scale is $185,100. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to your organization. This salary limitation also applies to subawards/subcontracts under a HRSA grant or cooperative agreement. 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 2017, as required by law.

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

SAMPLE

Personnel Justification Table

Name	Position Title	% of FTE	Base Salary	Adjusted Annual Salary*	Federal Amount Requested
J. Smith	CEO	50	$255,000	$185,100	$92,550
C. Moore	Physician	50	$150,000	No adjustment needed	$75,000
R. Doe	Nurse Practitioner	100	$75,950	No adjustment needed	$75,950
M. Green	Dentist	100	$200,000	$185,100	$185,100
D. Jones	Data/AP Specialist	25	$33,000	No adjustment needed	$8,250
H. Black	Outreach Director	50	$65,000	No adjustment needed	$32,500
	TOTAL		$778,950		$469,350

*used only when salary is over limitation of $185,100

iv. Budget Narrative *(Submitted in EHB)*

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

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

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

All of the following forms, with the exception of Form 5C: Other Activities/Locations, are required. You must complete these OMB-approved forms in EHB, and you cannot upload them. Refer to Appendix A for Program Specific Forms instructions and Appendix B for Performance Measure Forms instructions. Samples are available at the SAC-AA Technical Assistance Web site.

Form 1A: General Information Worksheet
Form 1C: Documents on File
Form 2: Staffing Profile
Form 3: Income Analysis
Form 4: Community Characteristics
Form 5A: Services Provided
Form 5B: Service Sites
Form 5C: Other Activities/Locations (if applicable)
Form 6A: Current Board Member Characteristics
Form 6B: Request for Waiver of Board Member Requirements
Form 8: Health Center Agreements

Form 10: Emergency Preparedness Report
Form 12: Organization Contacts
Clinical Performance Measures
Financial Performance Measures
Summary Page

vi. Attachments *(Submitted in EHB)*

Provide the following items in the order specified below to complete the content of the application. **Unless otherwise noted, attachments count toward the application page limit.** Indirect cost rate agreements and proof of non-profit status (if applicable) will not count toward the page limit. You must clearly label each attachment.

Label each attachment according to the number provided (e.g., Attachment 2: Corporate Bylaws). Merge similar documents (e.g., letters of support) into a single file. Provide a table of contents for attachments with multiple components. Attachment-specific table of contents are not counted toward the page limit. Number the electronic pages sequentially, restarting at page 1 for each attachment. *NOTE*: The HRSA EHB will not accept file attachments with names that exceed 100 characters.

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

Attachment 1: Service Area Map and Table (R)

Upload a map of the service area for the proposed project, indicating the organization's proposed health center site(s) listed in Form 5B: Service Sites. The map must clearly indicate the proposed service area zip codes, any medically underserved areas (MUAs) and/or medically underserved populations (MUPs), and Health Center Program award recipients, look-alikes, and other health care providers serving the proposed zip codes. You should create the maps using UDS Mapper. You may need to manually place markers for the locations of other major private provider groups serving low income/uninsured patients.

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

Attachment 2: Corporate Bylaws (C)
Upload (in its entirety) 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 more 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: Chief Executive Officer (CEO), Clinical Director (CD), Chief Financial Officer (CFO), Chief Information Officer (CIO), Chief Operating Officer (COO), and Project Director (PD). Indicate on the position descriptions if key management positions are combined and/or part time (e.g., CFO and COO roles are shared). Limit each position description to **one page** and include, at a minimum, the position title; description of duties and responsibilities; position qualifications; supervisory relationships; skills, knowledge, and experience requirements; travel requirements; salary range; and work hours.

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

Attachment 6: Co-Applicant Agreement (as applicable) (new applicants: C) (competing continuation and competing supplement applicants: R)
Public center applicants that have a co-applicant board must submit, in its entirety, the formal co-applicant agreement signed by both the co-applicant governing board and the public center.[28] See the *RESOURCES/CAPABILITIES* and *GOVERNANCE* sections of the Project Narrative for more details.

Attachment 7: Summary of Contracts and Agreements (as applicable) (R)
Upload a brief summary describing all current or proposed patient service-related contracts and agreements, consistent with Form 5A: Services Provided, columns II and III, respectively. The summary must address the following items for each contract or agreement:

- Name of contract/referral organization.
- Type of contract or agreement (e.g., contract, referral agreement, Memorandum of Understanding or Agreement).
- Brief description of the type of services provided and how/where services are provided.

[28] Public centers were referred to as "public entities" in the past.

- 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: C) (competing continuation and competing supplement applicants: N/A)
If you are a new applicant, you must upload the official signatory page (seal page) of the organization's Articles of Incorporation. A public center with a co-applicant will upload the co-applicant's Articles of Incorporation signatory page, if incorporated. Tribal organizations, reference your designation in the Federally Recognized Indian Tribe List maintained by the Bureau of Indian Affairs.

Attachment 9: Letters of Support (R)
Upload current dated letters of support to document commitment to the project. See the *COLLABORATION* section of the Project Narrative for details on required letters of support. Letters of support should be addressed to the organization's board, CEO, or other appropriate key management staff member (e.g., Clinical Director).

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

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

Attachment 11: Evidence of Nonprofit or Public Center Status (as applicable) (new applicants: C) (competing continuation and competing supplement applicants: N/A)
If you are a new applicant, you must upload evidence of nonprofit or public center status. This attachment does not count toward the page limit.

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

- A copy of a 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.
- A certified copy of the organization's certificate of incorporation or similar document **if it clearly establishes the nonprofit status of the organization**.
- Any of the above documentation for a state or national parent organization, and a statement signed by the parent organization that your organization is a local nonprofit affiliate.

Public Center: Consistent with PIN 2010-01: Confirming Public Agency Status Under the Health Center Program & FQHC Look-Alike Program, public center applicants must provide documentation demonstrating that the organization qualifies as a public agency (e.g., health department) for the purposes of section 330 of the PHS Act, as amended. Any of the following is acceptable:

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

Attachment 12: Floor Plans (new and competing supplement applicants: R) (competing continuation applicants: N/A)
New and competing supplement applicants must provide copies of floor plans for all sites within the proposed scope of project. Competing continuation applicants should only provide floor plans for approved sites in the currently funded Health Center Program scope of project if there has been a change in site layout.

Attachment 13: Implementation Plan (new and competing supplement applicants: C) (competing continuation applicants: N/A)
New and competing supplement applicants must upload the Implementation Plan. Refer to Appendix C for detailed instructions and the SAC-AA Technical Assistance Web site for a sample.

Attachment 14: Other Relevant Documents (as applicable) (R)
If desired, include other relevant documents to support the proposed project (e.g., indirect cost rate agreements, charts, organizational brochures, lease agreements). Maximum of two uploads.

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

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

Your organization must obtain a valid DUNS number, also known as the Unique Entity Identifier, and provide that number in your application. Each applicant must also register with the System for Award Management (SAM) and continue to maintain active SAM registration with current information at all times during which it has an active federal award or an application under consideration by an agency (unless you are 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 until you have 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 you are not qualified to receive an award and use that determination as the basis for making an award to another applicant.

If your organization has already completed Grants.gov registration for HRSA or another federal agency, confirm that it is still active and that the Authorized Organization Representative (AOR) has been approved.
The Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet
- System for Award Management
- Grants.gov

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

4. Submission Dates and Times

Application Due Date
The due date for applications under HRSA-17-096 in Grants.gov (Phase 1) is *October 17, 2016 at 11:59 p.m. Eastern Time*. The due date to complete all other required information in the HRSA EHB (Phase 2) is *November 1, 2016 at 5:00 p.m. Eastern Time*.

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

5. Intergovernmental Review

State System Reporting Requirements

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

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

6. Funding Restrictions

You may request funding for a project period of up to three years, at no more than the amount listed as Total Funding for the service area in Table 4. Awards to support

projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

The amount of funds awarded in any fiscal year may not exceed the costs of health center operation in such fiscal year less the total of state, local, and other operational funding provided to the center and the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in such fiscal year. In other words, Health Center Program funds are to be used for authorized health center operations and may not be used for profit. Further, as stated in section 330 of the PHS Act, the federal cost principles apply only to federal funds. All program income generated as a result of awarded funds must be used for approved project-related activities.

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

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

The General Provisions in Division H, of the Consolidated Appropriations Act, 2016 (P.L. 114-113), apply to this program. Please see Section 5.1 of the HRSA *SF-424 Two-Tier Application Guide* for additional information. Note that these or other provisions will apply in FY 2017, 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 federal funding requirements and prohibitions such as lobbying, gun control, abortion, etc. The effectiveness of these policies, procedures and controls is subject to audit.

V. Application Review Information

1. Review Criteria

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

Review criteria are outlined below with specific detail and scoring points. Reviewers will use the HRSA Scoring Rubric when assigning scores to each criterion.

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

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

Review criteria are used to review and rank each application that undergoes an objective review. The Service Area Competition – Additional Area has seven review criteria:

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

- The extent to which the applicant demonstrates, through quantitative and qualitative data, an understanding of the need for the proposed project by detailing significant health care needs in the service area/target population, including any targeted special populations.

- The extent to which the applicant clearly describes the existing primary health care services, service gaps, and access indicators; factors affecting the broader health care environment; and the role that the applicant organization currently plays or will play in the local health care landscape.

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

- The extent to which the applicant demonstrates that the proposed services, sites, and clinical staffing plan will meet the needs of the target population, provide continuity of care, incorporate enabling services, and ensure that the target population's continuum of health care needs are met.

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

- The extent to which the applicant establishes that the QI/QA and risk management plans are or will be integrated into the health center's routine

management efforts and will be utilized to ensure ongoing improvement of services and practices.
- The extent to which the applicant describes plans for assisting individuals with affordable health insurance options.

- Applicants requesting funds to serve special populations: The extent to which the applicant demonstrates compliance with requirements for targeted special populations, including demonstrating that services targeting residents of public housing: 1) are immediately accessible, and 2) were developed and will be administered in consultation with the targeted public housing communities; and that services targeting people experiencing homelessness will include the provision of substance abuse services (either directly or through referral).

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

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

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

- The extent to which the applicant establishes that other providers in the service area support the proposed project through detailed descriptions of specific commitment or collaboration. Descriptions should be supported by the specific letters of support from, at a minimum, the organizations listed in Item 2 of the *COLLABORATION* section of the Project Narrative and other community organizations that also serve the targeted special population(s) (e.g., Migrant Head Start, Public Housing Authority, homeless shelters).

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

- The extent to which the applicant establishes Clinical and Financial Performance Measure goals and plans for achieving such goals that are informed by documented contributing and restricting factors and any additional unique special population needs identified in the *NEED* section.

- The extent to which the applicant establishes that the needs of the target population are routinely assessed and that any additional planned evaluation activities are methodologically sound.

- The extent to which the applicant describes current or planned acquisition/development, implementation, and/or enhancement of certified EHR systems.

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

- The extent to which the applicant establishes that the proposed organizational structure, management staff, and policies/procedures are appropriate for operation and oversight of the proposed project, including any contractors and subrecipients, or parent, affiliate, or subsidiary arrangements.

- The extent to which the applicant establishes its experience and expertise working with and addressing the target population's health care needs.

- The extent to which the applicant establishes a commitment to sustainability by documenting: 1) plans to recruit and retain key management staff and health care providers; 2) policies and procedures for maximizing collection of payments and reimbursement for costs; 3) participation in FQHC-related benefits; 4) emergency planning; and 5) a strategic planning process that incorporates the target population's needs and related performance measure goals.

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

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

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

- The extent to which the applicant establishes that the governing board is appropriate in terms of size, composition, expertise, and unrestricted authority (i.e., operates independently, without conflicts of interests) and establishes and reviews policies and procedures to oversee the proposed project's: 1) compliance with Health Center Program requirements, and 2) effective operations.

- **Applicants targeting only special populations and requesting a waiver of the 51% patient majority board composition requirement**: The extent to which the applicant's waiver request provides 1) a reasonable statement of need for the request ("good cause") supporting why the applicant cannot meet the

patient majority board composition requirement; and 2) a plan for appropriate alternative mechanisms for assuring patient participation in the direction and ongoing governance of the center.

- **Indian tribe or tribal, Indian, or urban Indian group applicants**: The extent to which the applicant demonstrates that: 1) policy documents specifically prohibit real or apparent conflict of interest and 2) the governance structure will assure adequate input from the community/target population as well as fiscal and programmatic oversight of the proposed project.

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

- The extent to which the applicant provides a detailed and reasonable budget presentation that supports the proposed project, including planned service delivery.

- The extent to which the applicant establishes that the federal request for funds is appropriate considering other sources of project income and the total number of unduplicated patients projected to be served.

- The extent to which the applicant anticipates and describes expected shifts in payer mix and potential impact on the overall budget as well as mitigation plans for any adverse impacts.

2. Review and Selection Process

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

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

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

Additional Review Information
As part of HRSA's required review of risk posed by applicants for this program, as described in 45 CFR § 75.205 (HHS Review of Risk Posed by Applicants), when selecting applications for funding and, if applicable, determining project period length (see Project Period Length Criteria section),[29] HRSA will consider additional factors.

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

These factors include, but are not limited to, past performance, including unsuccessful Progressive Action condition resolution and current compliance with Health Center Program requirements and regulations, and the results of HRSA's assessment of the financial stability of your organization. HRSA reserves the right to conduct onsite visits and/or use the current compliance status to inform final funding decisions.

Project Period Length Criteria

The length of an awarded project period is determined by a comprehensive evaluation of compliance with program requirements by HRSA. If you have one or more of the following characteristics, you will be awarded a one-year project period: [30]

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

If a competing continuation applicant has been awarded two consecutive one-year project periods in FY 2015 and FY 2016 and meets the criteria for a third consecutive one-year project period in FY 2017, the application will not be funded and the service area will be re-competed if no other fundable applications were received.

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

Funding Priorities

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

To minimize potential service disruptions and maximize the effective use of federal dollars, HRSA will award priority points to competing continuation applicants according to the criteria below.

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

- **Program Compliance**: HRSA will award 5 points if you are a competing continuation applicant applying to continue serving your current service area **and** with no Health Center Program requirement conditions (see PAL 2014-08: Health Center Program Requirements Oversight) in 60-day, 30-day, or default status phase of Progressive Action.

- **Patient Trend**: HRSA will award an additional 5 points if you are a competing continuation applicant applying to continue serving your current service area, if you meet the criterion for Program Compliance above AND you have a positive or neutral 3-year patient growth trend (+/- 5 percent). **Patient trend points will not be awarded if the Program Compliance criterion is not met.**[31]

Note: You may reference the applicable Health Center Profile for point in time data.

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

- *RURAL/URBAN DISTRIBUTION OF AWARDS:* Aggregate awards in FY 2017 will be made to ensure that no more than 60 percent and no fewer than 40 percent of centers serve people from either rural or urban areas.

- *PROPORTIONATE DISTRIBUTION:* Aggregate awards in FY 2017 to support the various types of health centers (CHC, MHC, HCH, and/or PHPC) will be made to ensure continued proportionate distribution of funds across the Health Center Program as set forth in section 330(r)(2)(B) of the PHS Act.

3. **Assessment of Risk and Other Pre-Award Activities**

The Health Resources and Services Administration may elect not to fund you if you have management or financial instability that directly relates to your organization's ability to implement statutory, regulatory or other requirements (45 CFR § 75.205).

Applications receiving a favorable objective review that HRSA is considering for funding are reviewed for other considerations. These include, as applicable, cost analysis of the project/program budget, assessment of the applicant's management systems, ensuring continued applicant eligibility, and compliance with any public policy requirements,

[31] To calculate the patient growth trend, access the Health Center Data Profile of the current Health Center Program awardee, if known (HRSA does not disclose the current awardee), serving the proposed area. **U**nder the Age and Race/Ethnicity heading, pull the 2013 and 2015 Total Patients figures. The calculation is as follows: [(2015 Total Patients – 2013 Total Patients)/2013 Total Patients] x 100 = patient growth trend percent. If the number of patients served in 2015 is less than the number served in 2013, the patient growth trend will be negative.

including those requiring just-in-time submissions. You may be asked to submit additional programmatic or grants information (such as an updated budget or "other support" information) or to undertake certain activities (such as negotiation of an indirect cost rate) in anticipation of an award. However, even at this point in the process, such requests do not guarantee that an award will be made. Following review of all applicable information, the HRSA approving and business management officials will determine whether an award can be made, if special conditions are required, and what level of funding is appropriate.

Award decisions are discretionary and are not subject to appeal to any HRSA or HHS official or board.

Effective January 1, 2016, HRSA is required to review and consider any information about you that is in the Federal Awardee Performance and Integrity Information System (FAPIIS). You may review and comment on any information about your organization that a federal awarding agency previously entered. HRSA will consider any comments by you, in addition to other information in FAPIIS in making a judgment about your integrity, business ethics, and record of performance under federal awards when completing the review of risk posed by applicants as described in § 200.205 Federal Awarding Agency Review of Risk Posed by Applicants.

The decision not to make an award, to make an award at a particular funding level, or to make an award with a shortened project period length is discretionary and is not subject to appeal to any HHS Operating Division or HHS official or board.

4. Anticipated Announcement and Award Dates

HRSA anticipates issuing/announcing awards prior to the start date of April 1, 2017.

VI. Award Administration Information

1. Award Notices

The Notice of Award will be sent prior to the start date of April 1, 2017. See Section 6.4 of HRSA's *SF-424 Two-Tier Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2 of HRSA's *SF-424 Two-Tier Application Guide*.

3. Reporting

If you are successful under this funding opportunity announcement, you 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. All award recipients are required to submit a UDS Universal Report and, if applicable, a UDS Grant Report annually, by the specified deadline. The Universal Report provides data on patients, services, staffing, and financing across all health centers. The Grant Report provides data on patients and services for special populations served (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing).

2) **Progress Report** – The Budget Period Progress Report (BPR) non-competing continuation application documents an award recipient's progress on program-specific goals, and collects core performance measurement data to track the progress and impact of the project. Submission and HRSA approval of a BPR will trigger the budget period renewal and release of each subsequent year of funding (dependent upon Congressional appropriation, program compliance, organizational capacity, and a determination that continued funding would be in the best interest of the Federal Government). Award recipients will receive an email message via HRSA EHB when it is time to begin working on their progress reports.

3) **Prevention and Public Health Fund Reporting Requirements.**
Division H, Title II, section 221 of the Consolidated Appropriations Act, 2016 (P.L. 114-113) requires that recipients awarded a grant, cooperative agreement, or contract from such funds with a value of $25,000 or more shall produce reports on a semi-annual basis. The reporting cycle is January 1 – June 30 and July 1 – December 31; e-mail such reports (in 508 compliant format) to the HHS grants management official assigned to the grant or cooperative agreement no later than 20 calendar days after the end of each reporting period (i.e. July 20 and January 20, respectively). Recipient reports shall reference the NoA number and title of the grant or cooperative agreement, and include a summary of the activities undertaken and identify any sub-grants or sub-contracts awarded (including the purpose of the award and the identity of the subrecipient).

4) **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 obtain additional information regarding business, administrative, or fiscal issues related to this FOA by contacting:

Donna M. Marx
Grants Management Specialist
Division of Grants Management Operations
Office of Federal Assistance Management
Health Resources and Services Administration
5600 Fishers Lane 10SWH03
Rockville, MD 20857
301-594-4245
dmarx@hrsa.gov

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

David Butterworth
Public Health Analyst
Office of Policy and Program Development
Bureau of Primary Health Care
Health Resources and Services Administration
5600 Fishers Lane, Room 16N09
Rockville, MD 20857
301-594-4300
BPHCSAC@hrsa.gov
SAC-AA Technical Assistance Web site

Additional technical assistance regarding this FOA may be obtained by contacting the appropriate PCAs, PCOs, or NCAs. For a list of contacts, see Strategic Partnerships.

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

Grants.gov Contact Center
1-800-518-4726, (International Callers, please dial 606-545-5035)
support@grants.gov
Self-Service Knowledge Base

You may need assistance when working online to submit the remainder of your information electronically through HRSA EHB. For assistance with submitting the application 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
1-877-974-2742, select option 3
Web: www.hrsa.gov/about/contact/bphc.aspx (select Grant Application as the Issue Type)

VIII. Other Information

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

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

Federal Tort Claims Act Coverage/Medical Malpractice Insurance
Organizations that receive operational funds under the Health Center Program (sections 330(e), (g), (h), and/or (i)) 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.

Once funded, you can apply through 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. Deemed PHS employee status with resulting FTCA coverage is not guaranteed. The Notice of Deeming Action (NDA) for an individual health center provides documentation of HRSA's deeming determination and will be issued only after approval of an application. Funded health centers have the option of applying for liability protection as described above through FTCA or purchasing a private medical malpractice insurance policy. You may also elect to seek gap insurance to supplement FTCA coverage (i.e., private insurance for health-related activities not covered by FTCA). You are encouraged to review the FTCA Health Center Policy Manual and contact the BPHC Help Line at 877-974-BPHC for additional information.

You must be aware that **participation in the FTCA program is not guaranteed**. You are encouraged to review the requirements that are outlined in the FTCA Health Center Policy Manual and the most current FTCA Deeming Application Program Assistance Letter (search for keyword FTCA). If you are not currently deemed, the costs

associated with the purchase of malpractice insurance would be included in your proposed health center budget. The search for malpractice insurance, if necessary, should begin as soon as possible. If you are interested in FTCA protection, you will need to submit and receive approval for a new application annually.

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

Health Centers Hire Veterans Challenge
HRSA encourages health centers to consider hiring qualified veterans for positions supported by federal funding.

IX. Tips for Writing a Strong Application

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

Appendix A: Program Specific Forms Instructions

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

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

Form 1A: General Information Worksheet

1. Applicant Information

- Complete all relevant information that is not pre-populated.
- Grant numbers will pre-populate for competing continuation applicants.
- Use the Fiscal Year End Date field to note the month and day in which your organization's fiscal year ends (e.g., December 31) to help HRSA know when to expect the audit submission in the Federal Audit Clearinghouse.
- You may check only one category in the Business Entity section. If you are a Tribal or Urban Indian entity and meet the definition for a public or private entity, you should select the Tribal or Urban Indian category.
- You may select one or more categories for the Organization Type section.

2. Proposed Service Area

2a. Service Area Designation

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

2b. Service Area Type

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

2c. Patients and Visits

General Guidance for Patient and Visit Numbers:

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

- A visit is a documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services rendered must be paid for by your organization and documented in the patient's record.

- A patient is an individual who had (current data) or is projected to have (projected data) at least one visit in 2018 (January 1 through December 31, 2018).
- Since a patient must have at least one documented visit, the number of patients cannot exceed the number of visits.
- If you have more than one service site, you must report aggregate data for all sites in the proposed project.
- Baseline patient data will pre-populate from the most recent UDS report for competing continuation applicants. If UDS data does not accurately reflect current numbers (e.g., due to additional funding received, change in scope, or shifting service area characteristics such as influx of new populations), indicate the accurate current data and describe the discrepancy between UDS and current data in Item 3 of the *NEED* section of the Project Narrative.
- If you are a new or competing supplement applicant, you should report baseline values based on services your organization is currently providing in the proposed service area (report annualized data) or, if not currently operational in the service area, report baseline values as zero.

  Note: If you are a competing supplement applicant, you should only include in the baseline values patients/visits occurring in the proposed service area that are **not** included in your most recent UDS report.

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 (i.e., CHC, MHC, HCH, and/or PHPC). If you are applying for only CHC funding (General Underserved Community), you may still have patients/visits reported in the other population type categories. **All patients/visits that do not fall within the Migratory and Seasonal Agricultural Workers and Families, Public Housing Residents, or the People Experiencing Homelessness categories must be included in the General Underserved Community category**.

1. Project the number of unduplicated patients to be served by December 31, 2018 (January 1 – December 31, 2018). 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 by December 31, 2018 (January 1 – December 31, 2018) to determine compliance with Eligibility Requirement 3a, which requires the patient projection to be at least 75 percent of the Patient Target in Table 4. If a health center is unable to meet the total unduplicated patient projection (along with other patient projections for supplemental funding awarded during the project period) by December 31, 2018, funding for the service area may be reduced when the service area is next competed through SAC in three years.

2. New or competing supplement applicants: Provide the number of current unduplicated patients and visits for each population type category to establish a

baseline. **Across all population type categories, an individual can only be counted once as a patient.**

If you are a competing continuation applicant: Provide the number of visits across the population type categories to establish a baseline; current patients will pre-populate from the 2015 UDS data. To maintain consistency with the patients and visits reported in UDS, do not include patients and visits for pharmacy services or services outside the proposed scope of project. Refer to the Scope of Project policy documents.

3. The total number of unduplicated patients projected by December 31, 2018 (January 1 – December 31, 2018) will pre-populate from Item 1 above. Project the **total** number of visits by December 31, 2018 (January 1 – December 31, 2018). 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.**

   Note: HRSA will add new patient commitments from supplemental awards issued after June 1, 2016 (e.g., FY 2016 Oral Health Service Expansion, FY 2017 NAP) to the FY 2017 SAC-AA patient projection. To avoid double counting of patients, your FY 2017 SAC-AA application patient projection must **not** include new patient projections from these applications/awards, if applicable.

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 2015 UDS data.

2. Project the number of patients and visits anticipated within each service type category by December 31, 2018 (January 1 – December 31, 2018). In general, HRSA does not expect the number of patients and visits to decline over time.

   If you are a competing supplement applicant, you should not include patients served through current Health Center Program funding.

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

Note: The Patients and Visits by Service Type section does not have a row for total numbers since an individual patient may be included in multiple service type categories (i.e., a 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 listed Health Center Program requirements and key areas of health center operations. It does not provide an exhaustive list of all types of health center documents (e.g., policies and procedures, protocols, legal documents). Provide the date that each document was last reviewed and, if appropriate, revised. Reference the Health Center Program requirements for detailed information about each requirement.

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

Under Malpractice Coverage Plan listed in the Services section, you should indicate when malpractice coverage would be in effect. Once funded, you can apply for FTCA coverage upon meeting the FTCA eligibility requirements; however, FTCA participation is not guaranteed. Health centers that have chosen not to apply for, or have terminated FTCA coverage, may use federal grant funds for the purchase of private malpractice insurance. See Section VIII for more information about FTCA.

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 FTE column by function among the staff positions listed. An individual's full-time equivalent (FTE) should not be duplicated across positions. For example, a provider serving as a part-time family physician and a part-time Clinical Director should be listed in each respective category with the FTE percentage allocated to each position (e.g., Clinical Director 0.3 (30%) FTE and family physician 0.7 (70%) FTE). Do not exceed 1.0 (100%) FTE for any individual. For position descriptions, refer to the UDS Manual.
- Volunteers must be recorded in the Direct Hire FTEs column.
- For health centers that provide services through formal written contracts/agreements (Form 5A, Column II), Select Yes for contracted staff summarized in Attachment 7: Summary of Contracts and Agreements and/or included in contracts uploaded to Form 8: Health Center Agreements, as needed.

- Contracted staff are indicated by answering Yes or No only. **Do not quantify contracted staff in the Direct Hire column of this form.**

Form 3: Income Analysis

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

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

The program income section groups billable visits and income into the same five payer groupings used in the UDS Manual. All patient service revenue is reported in this section of the form. This includes all income from medical, dental, mental health, substance abuse, other professional, vision, and other clinical services, as well as income from ancillary services such as laboratory, pharmacy, and imaging services.

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

Patient service revenue associated with sites or services not in the approved scope of project, including those pending approval, must be excluded.

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

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

Billable Visits - Column (b): This includes all billable/reimbursable visits.[32] The value is typically based on assumptions about consolidated individual clinician time, productivity, and visits by payer. There may be other exclusions or additions, which, if significant, should be noted in the Comment/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column (See ancillary instructions below.)

Note: The patient service income budget is primarily based upon income per visit estimates. However, there are some forms of patient service income which do not generate reportable visits in UDS or on Form 3, such as income from laboratory or pharmacy services; capitated managed care; performance incentives; wrap payments; and cost report settlements. You may choose to include some or all of this income in the income per visit assumption, basing it on historical experience. You may also choose to separately budget for some or all of these sources of patient service income.

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

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

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

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

Payer Categories (Lines 1 – 5): There are five payer categories including Medicaid, Medicare, Other Public, Private, and Self-Pay, reflecting the five payer groupings in UDS. The UDS Manual must be used to define each payer category.

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

Visits are reported on the line of the primary payer (payer billed first). Income is classified by the payer groupings where the income is earned. When a single visit involves more than one payer, attribute that portion of the visit income to the payer group from which it is earned. In cases where there are deductibles and co-payments to be paid by the patient, that income is to be shown on the self-pay line. If the co-payment is to be paid by another payer, that income should be shown on the other payer's line. It is acceptable if 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. In the event you do not normally classify the projected ancillary or other service revenue by payer category, the projected income is to be allocated by payer group using a reasonable allocation method, such as the proportion of medical visits or charges. The method used should be noted in the Comments/Explanatory Notes section at the bottom of the form.

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

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

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

Private (Line 4): This includes income from private insurance plans, managed care plans, insurance plans from the ACA marketplaces/exchanges, and other private contracts for service. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, service contracts with employers, and Veteran's Administration Community Based Outpatient Clinic (CBOC) contracts. Income from

health benefit plans which are earned by government employees, veterans, retirees, and dependents, such as TRICARE, the federal employee health benefits program, state employee health insurance benefit programs, teacher health insurance, and similar plans are to be classified as private insurance. Private insurance is earned or paid for by the beneficiary and other public insurance is unearned or based upon meeting the plan's eligibility criteria.

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

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

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

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

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

Local Government (Line 9): This is income from local government grants, contracts, and programs, including local indigent care income, community development block grants, capital improvement project funding, and similar awards. For example: (1) a

health center that contracts with the local Department of Health to provide services to the Department's patients is to report all the income earned under this contract on this line, and (2) Ryan White Part A funds are federal funds awarded to municipalities who in turn make awards to provider organizations, so Ryan White Part A funding would be classified as income earned from a local government and be shown on this line.

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

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

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

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

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

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

Note*:* In-kind donations are not included as income on Form 3. 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. Information provided regarding race and ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements and will not be used as an awarding factor. If you compile data from multiple data sources, you may find that the total numbers vary across sources. If this is the case, you should make adjustments as needed to ensure that the total numbers for the first four sections of this form match. Adjustments must be explained in Item 1 of the *NEED* section of the Project Narrative.

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

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

If the target population includes a large number of transient individuals (e.g., the county has an influx of migratory and seasonal agricultural workers and families during the summer months) that are not included in the dataset used for service area data (e.g., census data), adjust the service area numbers accordingly to ensure that the target population numbers are always less than or equal to the service area numbers.
Note*:* The total numbers for the first four sections of this form (i.e., Race, Hispanic or Latino Ethnicity, Income as a Percent of Poverty Level, and Primary Third Party Payment Source) **must match**.

Guidelines for Reporting Race

- All individuals must be classified in one of the racial categories, including individuals who also consider themselves Hispanic or Latino. If the data source does not separately classify Hispanic or Latino individuals by race, report them as Unreported/Declined to Report.
- Utilize the following race definitions:
  - 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, or other Pacific Islands in Micronesia, Melanesia, or Polynesia.
  - American Indian/Alaska Native – Persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
  - More Than One Race – Person who chooses two or more races.

Guidelines for Reporting Hispanic or Latino Ethnicity

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

Guidelines for Reporting Special Populations
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**: The application should reflect only the current scope of project. Therefore, these forms will be pre-populated and cannot be modified. Changes in services, sites, and other activities/locations require prior approval through a Change in Scope request submitted in EHB. If the pre-populated data do not reflect recently approved scope changes, click the **Refresh from Scope** button in the EHB to display the latest scope of project.

Note: In order for forms to accurately pre-populate, if you are a competing continuation applicant, you must select **Continuation** for Box 2 and provide the grant number for Box 4 on the SF-424. **Failure to apply in this manner will result in delayed EHB application access.**

- **If you are a new and competing supplement applicant,** you must complete Forms 5A: Services Provided and 5B: Service Sites. Form 5C: Other Activities/Locations may be completed, as applicable. Complete these forms based only on the scope of project for the proposed service area.

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

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

Form 5A: Services Provided

Identify how the required and any optional additional services will be provided. Only one form is required regardless of the number of sites proposed. All referral arrangements/agreements for required services must be formal written arrangements/agreements.[33]

If you are a competing supplement applicant:

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

- All services in your current scope of project must be accessible to patients from the newly proposed service area, through one or more modes of service delivery (Column I, II, or III).
- If new services are proposed on Form 5A of this application and this application is funded, these services must be consistent with the proposed project for the new service area and must be accessible to patients, through one or more modes of service delivery (Column I, II, or III).

Form 5B: Service Sites

Provide requested data for each proposed service site.

If you are a new and competing supplement applicant, you must propose **at least one new** full-time, permanent service delivery or administrative/service delivery site located in the new service area.[34] You must provide a verifiable street address for each proposed site on Form 5B: Service Sites. Competing supplement applicants may select sites from their current scope, to the extent that these sites have the capacity to serve new patients from the proposed service area, but must also propose a new service delivery site that meets the previously stated parameters.

Zip codes entered in the Service Area Zip Codes field for service sites and administrative/service delivery sites (administrative-only sites will not be considered) must be all of those listed in Table 4.[35] **Zip codes entered in this field will determine compliance with Eligibility Requirement 3b.**

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

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

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

Form 6A: Current Board Member Characteristics

[34] MHC-only applicants may propose at least one full-time seasonal rather than permanent site to meet this criterion.
[35] 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 Table 4. For more information about service area overlap, refer to PIN 2007-09: Service Area Overlap: Policy and Process.

The list of board members will be pre-populated for competing continuation and competing supplement applicants. **You must update pre-populated information as appropriate.**[36] Public centers with co-applicant health center governing boards must list the co-applicant board members.
Complete or update the following information:

- List all current board members; current board office held for each board member, if applicable (e.g., Chair, Treasurer); and each board member's area of expertise (e.g., finance, education, nursing). Do not list the CEO or other health center employees.[37]
- Indicate if the board member derives more than 10 percent of income from the health care industry.
- Indicate if the board member is a health center patient. A patient board member must be a currently registered patient of the health center and must have accessed the health center in the past 24 months to receive at least one in-scope service that generated a documented health center visit.
- Indicate if the board member lives and/or works in the service area.
- Indicate if the board member is a representative of/for a special population (i.e., persons 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 include information, as desired.
- If you are requesting a waiver of the 51% patient majority board composition requirement (see below), you must list your board members, NOT the members of any advisory council.

Form 6B: Request for Waiver of Board Member Requirements

- If you currently receive or are applying to receive CHC (section 330(e)) funding, you are not eligible for a waiver and cannot enter information.
- Indian tribes or tribal, Indian, or urban Indian groups are not required to complete this form and cannot enter information.
- If you are a competing continuation applicant that wishes to continue an existing waiver, you must complete this form.
- When requesting a waiver, briefly demonstrate good cause as to why the patient majority board composition requirement cannot be met, and present a plan for ensuring patient input and participation in the organization, direction, and ongoing governance of the health center. The plan must provide all of the following:

[36] Refer to PIN 2014-01: Health Center Program Governance for information on Governance requirements.
[37] The CEO may serve only as a non-voting, ex-officio board member and is generally only a member by virtue of being CEO of the health center.

- Clear description of the alternative mechanism(s) for gathering patient input. If advisory councils or patient representatives are proposed, include a list of the members in Attachment 14: Other Relevant Documents that identifies these individuals and their reasons/qualifications for participation on the advisory council or as governing board representatives.
- Specifics on the type of patient input to be collected.
- Methods for collecting and documenting such input.
- Process for formally communicating the input directly to the health center governing board (e.g., monthly presentations of the advisory group to the full board, monthly summary reports from patient surveys).
- Specifics on how the patient input will be used by the governing board for: 1) selecting health center services; 2) setting health center operating hours; 3) defining budget priorities; 4) evaluating the organization's progress in meeting goals, including patient satisfaction; and 5) other relevant areas of governance that require and benefit from patient input.

Form 8 – Health Center Agreements

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

Refer to Uniform Guidance 2 CFR part 200 as codified by HHS at 45 CFR part 75 for the definition of "substantial" and characteristics of a subrecipient or contractor agreement. You must use judgment in classifying each agreement as a subaward or a procurement contract, based on the substance of the relationship. If there are current/proposed agreements that will constitute a substantial portion of the project, indicate the number of each type in the appropriate field and attach the complete agreements in Part II.

If either of questions 1 or 2 were answered, "Yes" in Part I, you must upload associated agreements in Part II. Part II will accept a maximum of 10 Affiliate/Contract/Subaward Organizations with five document uploads for each. Additional documentation that exceeds this limit should be included in Attachment 14: Other Relevant Documents.

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

Form 10: Emergency Preparedness Report

Select the appropriate responses regarding emergency preparedness. If any answer is no, explain the response in *Item 13 of the RESOURCES/CAPABILITIES* section of the Project Narrative.

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, you must provide the requested contact information. For the Contact Person field, provide an individual who can represent the organization in communication regarding the application.

Summary Page

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

Service Area

Enter the identification number, City, and State of the service area that you are proposing to serve, as indicated in Table 4.

Patient Projection

The total number of unduplicated patients projected to be served by December 31, 2018 (January 1 – December 31, 2018) will pre-populate from Form 1A: General Information Worksheet. Enter the Patient Target for the proposed service area from Table 4. The percentage of patients to be served by December 31, 2018 will auto-calculate. **The auto-calculated percentage must be 75 percent or greater to ensure eligibility.** HRSA is committed to monitoring achievement of the SAC-AA application patient projection, as well as any additional patient projections through supplemental awards received during the project period by December 31, 2018.

Federal Request for Health Center Program Funding

To ensure eligibility, the total Health Center Program funding requested must not exceed the Total Funding available in Table 4 for the proposed service area.[38] Additionally, ensure that the funding requested for each population type does not exceed the values in Table 4. If the unduplicated patient projection on Form 1A General Information Worksheet is less than 95 percent of the Patient Target in Table 4, ensure the annual Health Center Program funding request is adjusted based on the auto-calculated percentage of patients to be served by December 31, 2018 from the Patient Projection section of this form, if necessary.

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

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

To ensure an accurate scope of project, if you are a competing continuation applicant, you must certify that:

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

Appendix B: Performance Measures Instructions

CLINICAL AND FINANCIAL PERFORMANCE MEASURES

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

Required Clinical Performance Measures

1. Diabetes (updated)
2. Hypertension: Controlling High Blood Pressure (updated)
3. Cervical Cancer Screening (updated)
4. Prenatal care
5. Low Birth Weight
6. Childhood Immunization Status (updated)
7. Oral Health (updated)
8. Adolescent Weight Screening and Follow-Up
9. Adult Weight Screening and Follow-Up (updated)
10. Tobacco Use Screening and Cessation (updated)
11. Asthma: Use of Appropriate Medications (updated)
12. Coronary Artery Disease: Lipid Therapy
13. Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic
14. Colorectal Cancer Screening (updated)
15. HIV Linkage to Care
16. Screening for Clinical Depression and Follow-Up Plan (updated)

Required Financial Performance Measures

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

New and Updated Performance Measures

- Ten required Clinical Performance Measures have been revised and are noted above. [39]

Important Details about the Performance Measures Forms

- The Oral Health Clinical Performance Measure for sealants is currently only applicable to health centers that provide preventive dental services directly or by a formal arrangement in which the health center pays for the service (Form 5A,

[39] Refer to PAL 2016-02: Approved Uniform Data System Changes for Calendar Year 2016 for details about new and updated performance measures.

Columns I and II). A health center that only provides preventive dental services via a formal referral (Form 5A, Column III) may set the goal for the Oral Health performance measure as zero. If the goal for the Oral Health performance measure for sealants will be set to 0, at least one self-defined Oral Health performance measure must be tracked under the Additional Clinical Performance Measures section.

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

- If you are applying for funds to serve special populations (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing), you **must include** additional clinical performance measures that address the health care needs of these populations. Additional performance measures specific to special populations may not replace the required measures listed above. In providing additional performance measures specific to a special population, you must reference the target group in the performance measure. For example, if you are seeking funds to serve migratory and seasonal agricultural workers and their families, then you must propose to measure *"the percentage of migratory and seasonal agricultural workers* and their families *who…" **rather than*** simply *"the percentage of patients who…"*

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

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

Overview of the Performance Measures Form Fields
Pre-populated baseline data will be sourced from the 2015 UDS report for competing continuation applicants for measures that have not significantly changed.[40] If you are a competing continuation applicant that did not submit a 2015 UDS report, such information will be pre-populated where possible from the latest SAC/NAP/BPR submission.

[40] Refer to the 2016 Clinical Performance Measure Form Field Guide and Sample at the SAC-AA Technical Assistance Web site.

Table 2: Overview of Measures Form Fields

Field Name	Pre-Populated	Editable	Notes
Focus Area	YES	NO	This field contains the content area description for each required performance measure. You will specify focus areas when adding performance measures in the Additional Performance Measures section.
Performance Measure	YES	NO	This field defines each performance measure and is editable for performance measures in the Additional Performance Measures section. Edits must be explained in the Comments field.
Additional Performance Measures: Is this Performance Measure applicable to your organization?	NO	YES	This field is editable for previously self-defined performance measures. If "No" is selected, provide justification in the Comments field and the measure will no longer be tracked.
Target Goal Description	NO	YES	This field provides a description of the target goal.
Numerator Description	YES	NO	In the Clinical Performance Measures, the numerator is the number of patients that meet the criteria identified by the measure (e.g., patients in a specified age range that received a specified service). In the Financial Performance Measures, the numerator field is specific to the organizational measure. This field can be edited for any previously self-defined Additional Performance Measure. All edits require justification in the Comments field.

Denominator Description	YES	NO	In the Clinical Performance Measures, the denominator is all patients to whom the measure applies (e.g., patients in a specified age range, regardless of whether they received a specified service). In the Financial Performance Measures, the denominator field must be specific to the organizational measure. This field can be edited for any previously self-defined Additional Performance Measure. All edits require justification in the Comments field.
Baseline Data			The Baseline Data comprises the subfields below (i.e., Baseline Year, Measure Type, Numerator, and Denominator) that provide information regarding the initial threshold used to measure progress over the course of the project. If you are a competing continuation applicant: These fields will be blank and editable for the updated Clinical Performance Measures, since no UDS data are available. Otherwise, data pre-populate from the 2015 UDS report and are not editable. For pre-populated, non-editable data, to report more current data, include information in the Comments field. If you are a new and competing supplement applicant: These fields will be blank and editable, For previously self-defined Additional Performance Measures, pre-populated information can be edited. Justification is required in the Comments field.
Baseline Year	Varies	Varies	The Baseline Year subfield identifies the initial data reference point. If it is blank and editable, provide the baseline reference year.

Measure Type	YES	NO	The Measure Type subfield provides the unit of measure (e.g., percentage, ratio).
Numerator	Varies	Varies	The Numerator subfield specifies a quantitative value in reference to the Numerator Description above.
Denominator	Varies	Varies	The Denominator subfield specifies a quantitative value in reference to the Denominator Description above.
Progress Field	NO	YES	If you are a competing continuation applicant, you MUST use this field to provide information regarding progress for required measures since the application that initiated the budget period (e.g., FY 2016 Budget Period Progress Report (BPR)). State if progress cannot be reported due to the measure being updated. This field is not applicable if you are a new and competing supplement applicant. Limit to 1,500 characters.
Projected Data	NO	YES	This field provides the goal to be met by December 31, 2018.
Data Source and Methodology	NO	YES	This field provides information about the data source used to develop each performance measure. You are first required to identify a data source. For Clinical Performance Measures, select from EHR, Chart Audit, or Other (please specify). You must then discuss the methodology used to collect and analyze data. Data must be valid, reliable, and derived from established information management systems. Limit to 500 characters.
Key Factors and Major Planned Actions			This field contains subfields that provide information regarding the factors that must be minimized or maximized to ensure goal achievement.

Key Factor Type	NO	YES	The Key Factor Type subfield requires you to select Contributing and/or Restricting factor categories. You must specify at least one key factor of each type.
Key Factor Description	NO	YES	The Key Factor Description subfield provides a description of the factors predicted to contribute to and/or restrict progress toward stated goals.
Major Planned Action Description	NO	YES	The Major Planned Action Description subfield provides a description of the major actions planned for addressing key factors. You must use this subfield to provide planned overarching action steps and strategies for achieving each performance measure. Limit to 1,500 characters.
Comments	NO	YES	Provide justifications required from changes made to other form fields as well as any additional information desired. Information exceeding the character limit should be placed in the *EVALUATIVE MEASURES* section of the Project Narrative. Limit to 1,500 characters.

Resources for the Development of Performance Measures
If you are a competing continuation applicant, you are encouraged to use your UDS Health Center Trend Report and/or Summary Report available in EHB when considering how improvements to past performance can be achieved for performance measures that have not been updated. For help with accessing reports in EHB, contact the BPHC Helpline by submitting a request through the Web portal or call 877-974-2742. You may also find it useful to do the following:

- Recognize that many UDS Clinical Performance Measures are aligned with the meaningful use measures.
- Examine the performance measures of other health centers that serve similar target populations.
- Consider state and national performance UDS benchmarks and comparison data (available at Health Center Data).

- Use the Healthy People 2020 goals as a guide when developing performance measures. Several of these objectives can be compared directly to UDS Clinical Performance. A table outlining the Healthy People 2020 objectives related to applicable performance measures is available at Healthy People 2020/Health Center Program Measures.

Appendix C: Implementation Plan

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

1. Within 120 days of receipt of the NoA [41] 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.
2. Within one year of receipt of the NoA, all proposed providers must be in place and all sites must be delivering services for the proposed hours of operation.

Table 3: Key Elements of the Implementation Plan

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

A sample Implementation Plan is provided on the SAC-AA Technical Assistance Web site.

Optional Focus Areas

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

Functioning Key Management Staff/Systems/Arrangements
- B.1. Management Team Recruitment
- B.2. Documented Contractual/Affiliation Agreements

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

B.3. Financial Management and Control Policies
B.4. Data Reporting System

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

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

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

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

Governing Board

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

Appendix D: Service Area Details

Table 4: Service Area Details

For the service area listed below, the following apply:

- Project Period Start Date: April 1, 2017
- Grants.gov deadline: October 17, 2016 at 11:59 PM ET
- HRSA EHB deadline: November 1, 2016 at 5:00 PM ET

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