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

Bureau of Primary Health Care
Health Center Program

Affordable Care Act New Access Point Grants

Announcement Type: New and Supplemental/Revision
Announcement Number: HRSA-13-228

Catalog of Federal Domestic Assistance (CFDA) No. 93.527

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2013

Application Due Date in Grants.gov:
February 27, 2013

Supplemental Information Due Date in EHB:
April 3, 2013

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

Release Date: January 16, 2013
Issuance Date: January 16, 2013

Modified on February 6, 2013- Eligibility criterion #6, page 7; CFDA number, page 23
Data Resource Guide Revisions: pages 12-13, 36, 40 posted on TA website below

Joanne Galindo
Public Health Analyst
Bureau of Primary Health Care
Office of Policy and Program Development
BPHCNAP@hrsa.gov
301-594-4300
http://www.hrsa.gov/grants/apply/assistance/NAP

Authority: Section 330 of the Public Health Service Act, as amended (42 U.S.C. 254b, as amended) and Section 10503 of The Patient Protection and Affordable Care Act (P.L. 111-148)

EXECUTIVE SUMMARY

Under this Funding Opportunity Announcement (FOA), the Health Resources and Services Administration (HRSA) is soliciting applications for New Access Point (NAP) grants under the Health Center Program, authorized by section 330 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254b). The FOA details the eligibility requirements, review criteria, and awarding factors for organizations seeking a grant in fiscal year (FY) 2013 for operational support under the Health Center Program.

An important element of HRSA's commitment to improving and expanding access to needed health care services is the support of NAPs for the delivery of primary health care services to underserved and vulnerable populations under the Health Center Program. Subject to the availability of appropriated funds, HRSA anticipates awarding approximately $19 million to support approximately 25 NAP grant awards in FY 2013. Pending the final Health Center Program appropriation funding level, HRSA may adjust the amount of funding and number of awards available under this funding opportunity announcement. This funding opportunity is supported under Section 10503 of The Patient Protection and Affordable Care Act (P.L. 111-148).

Competitive NAP applications will demonstrate a high level of need in their community/population, present a sound proposal to meet this need consistent with the requirements of the Health Center Program, show that the organization is ready to rapidly initiate the proposal, display responsiveness to the health care environment of the service area, and demonstrate collaborative and coordinated delivery systems for the provision of health care to the underserved. Further, applicants are expected to demonstrate that the new access point(s) will increase access to comprehensive, culturally competent, quality primary health care services, including oral and behavioral health, and improve the health status of underserved and vulnerable populations in the area to be served.

Eligible Applicants (Refer to Section III.1 for detailed information.)
Eligible applicants must be public or nonprofit private entities, including tribal, faith-based, and community-based organizations. Applications may be submitted from new organizations or organizations currently receiving operational grant funding under section 330.

Applicants must propose a new access point that:

a. Provides comprehensive primary medical care as its primary purpose.
b. Provides services, either directly onsite or through established arrangements, without regard to ability to pay.
c. Ensures access to services for all individuals in the targeted service area/population.
d. Provides services at one or more permanent service delivery sites.

Applicants must demonstrate compliance with the requirements of section 330 of the PHS Act, as amended, applicable regulations, and other program requirements. Program requirements are available in Appendix F and at http://bphc.hrsa.gov/about/requirements.

Summary of Changes
HRSA has revised the NAP FOA to streamline and clarify the application instructions. In addition, HRSA has revised sections addressing need based on an evaluation of the previous NAP FOA. Compared to the FY 2011 FOA, the following changes should be noted:

- The following sections have been revised: Eligibility Information, Application and Submission Information, Review Criteria, Review and Selection Process, instructions for the Program Specific Forms, instructions for the Program Specific Information, and Budget Presentation.

- In the Need for Assistance (NFA) Worksheet, the scoring for the Core Barriers has changed. Additionally, Core Barriers and Health Indicators have been modified, added, or removed to include the most relevant and current indicators of need for which data are available.

- New Clinical Performance Measures have been added.

- An Implementation Plan has been added, requiring applicants to demonstrate that the new access point(s) will be operational and compliant with Health Center Program Requirements within 120 days of award.

- The required attachment for the Service Area Map has changed to include a table listing map features and the use of UDS Mapper to create the map.

- Funding priorities have been changed.

- Applicants no longer need to request funding priorities. All applications will be assessed and assigned priority points as appropriate.

- Applicants are expected to provide plans for outreach and enrollment of health center patients that are eligible for either Medicaid expansion or Health Insurance Exchanges.

Application Submission
HRSA uses a two-tier submission process for NAP applications via Grants.gov and HRSA Electronic Handbooks (EHB). See Table 1 for detailed information on the application process.

> **Phase 1 – Grants.gov:** Must be completed and successfully submitted by 11:59 PM ET on February 27, 2013.
>
> **Phase 2 – HRSA EHB:** Must be completed and successfully submitted by 8:00 PM ET on April 3, 2013.

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

Phase 1 submission. Refer to http://www.hrsa.gov/grants/apply/userguide.pdf (HRSA Electronic Submission User Guide) for more details.

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

Per section 330(k)(3)(H) of the PHS Act, as amended (42 U.S.C. 254b, as amended), the health center governing board must approve the health center's annual budget and all grant applications. In addition, the applicant's authorized representative (most often the Executive Director, Program Director, or Board Chair), must electronically submit the SF-424 included in the application package. This form certifies that all application content is true and correct and that the application has been duly reviewed and authorized by the governing board. It also certifies that the applicant will comply with the assurances if a NAP grant is awarded.

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

Pre-Application Conference Call

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

Application Contacts

If you have questions regarding the FY 2013 NAP application and/or the review process described in this FOA, refer to Section VII to determine the appropriate agency contact.

Table of Contents

I. Funding Opportunity Description

1. Purpose

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

Health centers improve the health of the Nation's underserved communities and vulnerable populations by ensuring access to comprehensive, culturally competent, quality primary health care services. Health Center Program grants support a variety of community-based and patient-directed public and private nonprofit organizations that serve an increasing number of the Nation's underserved.

Individually, each health center plays an important role in the goal of ensuring access to services, and combined, they have had a critical impact on the health care status of medically underserved and vulnerable populations throughout the United States and its territories. Targeting the Nation's neediest populations and geographic areas, the Health Center Program currently funds 1,200 health centers that operate more than 8,500 service delivery sites in every state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. In 2011, more than 20 million patients, including medically underserved and uninsured patients, received comprehensive, culturally competent, quality primary health care services through the Health Center Program.

2. Background

This program is authorized by Section 330 of the Public Health Service Act, as amended, 42 U.S.C. 254b, as amended and Section 10503 of The Patient Protection and Affordable Care Act (P.L. 111-148).

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

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

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

Applications may be submitted for consideration from new organizations (new start applicants) or existing section 330 grantees currently receiving Health Center Program operational funding (satellite applicants):

- A **NEW START** applicant is an organization that is not currently a direct recipient of operational grant support under the Health Center Program (section 330(e), (g), (h) and/or (i) of the PHS Act). A new start application should address the entire scope of the project being proposed for NAP grant support.

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

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

Program Requirements

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

maximizes established collaborative and coordinated delivery systems for the provision of health care to the underserved.

All applicants are expected to demonstrate:

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

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

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

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

  Public Housing Primary Care (PHPC) Applicants:
  - Ensure compliance with section 330(i), section 330(e), and, as applicable, program regulations.
  - Provide a plan that ensures the availability and accessibility of required primary and preventive health services to residents of public housing and individuals

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

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

- Evidence of how the proposed project will **increase access to primary health care services, improve health outcomes, and reduce health disparities** in the community/population to be served. The applicant must demonstrate how section 330 funds will expand services and increase the number of people served through the establishment of a new permanent, full-time service delivery site or at an existing permanent, full-time site not currently within any section 330, HRSA-funded scope of project.

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

- Evidence of the development of **collaborative and coordinated delivery systems** for the provision of health care to the underserved through the demonstration of current or proposed partnerships and collaborative activities with health centers (section 330 grantees and look-alikes), rural health clinics, critical access hospitals, State and local health services delivery projects, and other programs serving the same population(s).

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

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

- **Readiness to initiate the proposed project plan.** Applicants are expected to demonstrate that the proposed new access point(s) will be operational and providing services in the community/population within 120 days of the Notice of Award. At a

minimum, within 120 days of the Notice of Award, (1) a facility will be operational and begin providing services for the proposed population/community, and (2) providers will be available to serve patients at the proposed new access point(s). It is expected that full operational capacity as outlined in the NAP application will be achieved within 2 years of receiving Federal section 330 grant support, including service to the number of patients projected in the NAP application.

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

II. Award Information

1. Type of Award

Funding will be provided in the form of a grant.

2. Summary of Funding

This program will provide funding for Federal fiscal years 2013-2014. Up to $19 million is expected to be available to fund approximately 25 grantees at a level not to exceed $650,000 per year. The project period is two years. Funding beyond the first year will be contingent upon the availability of appropriated funds, compliance with applicable statutory and regulatory requirements, demonstrated organizational capacity to accomplish the project's goals, and a determination that continued funding would be in the best interest of the Federal government. Although not applicable to FY 2013 funding at this time, previous NAP awards were subject to restrictions (e.g., salary limitation) based on appropriations provisions. Such determinations are made through the annual appropriations process, and HRSA cannot anticipate whether such limitations will be included in appropriations for FY 2013 or future funding years.

HRSA has established an **annual ceiling of $650,000** for section 330 funding for NAP grants. The ceiling is the **maximum amount of section 330 funding** that can be requested annually in a NAP grant application regardless of the number and/or type of new access points to be supported and/or populations to be served through the application. The total request for section 330 support MUST NOT exceed the established annual ceiling of $650,000 in Year 1 or Year 2. Applications that present a request for support in excess of the established annual ceiling in either year will be considered ineligible for review.

Of the $650,000, applicants may request Federal section 330 grant funding up to $150,000 in Year 1 only for one-time minor capital costs for equipment and/or minor alterations/renovations (see Appendix D).

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

III. Eligibility Information

1. Eligible Applicants

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

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

- New Start: An organization that does not currently receive Health Center Program section 330 operational grant funding. Select "New" on Application Form SF-424.
- Satellite: An organization that currently receives Health Center Program section 330 operational grant funding. Select "Revision" on Application Form SF-424 (see detailed instructions in Section IV.2.i.).

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

2. Applicant proposes a new access point that provides comprehensive primary medical care as its main purpose as documented on Form 1A: General Information Worksheet (projected patients).

3. Applicant proposes a new access point that provides services either directly onsite or through established arrangements without regard to ability to pay as documented on Form 5A: Services Provided.

4. Applicant ensures access to services for all individuals in the targeted service area or population. In other words, applicant does not propose a new access point to exclusively serve a single age group (e.g., children), lifecycle (e.g., geriatric), or health issue/disease category (e.g., HIV/AIDS).

5. Applicant proposes at least one new access point that is a permanent service delivery site operating for a minimum of 40 hours per week as documented on Form 5B: Service Sites.

6. Application proposes to establish a new access point which is not currently a site in the approved scope of project of any health center receiving section 330 grant support. In other words, the application **DOES NOT** propose:
   - funding to support the relocation of current sites,
   - the expansion of capacity (e.g., additional providers, additional patients, new services, new populations) at any site already in any Health Center Program grantee's approved scope of project, including those pending verification via Change in Scope or capital development grants (i.e., Capital Development, Building Capacity, or Facility Improvement Program), or
   - a site proposed through an active Change in Scope request or Health Center Program (H80) funding opportunity at the time of application.

7. Applicant requests annual Federal section 330 funding (as presented on the SF-424A) that **DOES NOT** exceed the established annual ceiling of $650,000 in Years 1 or 2.

8. Applicant adheres to the **200-page limit** on the length of the application when printed by HRSA. See Tables 2-5 for specific information regarding the documents included in the 200-page limit.

9. *NEW START APPLICANTS ONLY*: Applicant proposes to serve a defined geographic area that is federally-designated, in whole or in part, as a Medically Underserved Area (MUA) or Medically Underserved Population (MUP). If the area is not currently federally-designated as an MUA or MUP, the applicant must provide documentation that a request for designation has been submitted; designation must be received prior to a final HRSA FY 2013 NAP funding decision. *Note: If the applicant is requesting funding only for MHC, HCH, and/or PHPC, the applicant is not required to have a MUA/MUP designation for the proposed service area and/or target population. See Section I.3 for definitions of the MHC, HCH, and PHPC populations.*

***Note: SATELLITE APPLICANTS ONLY*: Organizations that received initial section 330 funding in FY 2011 or 2012 are not eligible to apply for New Access Point funding in FY 2013.**

2. Cost Sharing/Matching

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

3. Other

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

NOTE: Multiple applications from an organization are not allowable. If more than one NAP application is submitted for HRSA-13-238, HRSA will only accept the last application received in Grants.gov before the deadline and its corresponding application components submitted in HRSA EHB.

Maintenance of Effort
The awardee must agree to maintain non-Federal funding for activities described in the application at a level that is not less than the expenditures for the same activities for Healthcare for the Homeless and Public Housing Primary Care projects during the fiscal year prior to receiving the grant or cooperative agreement. Sections 330(h)(3) and 330(i)(2) of the Public Health Service Act describes the Maintenance of Effort provisions.

IV. Application and Submission Information

1. Address to Request Application Package

Application Materials and Required Electronic Submission Information
HRSA ***requires*** applicants for this funding opportunity announcement to apply electronically through Grants.gov. The registration and application process protects applicants against fraud and ensures that only authorized representatives from an organization can submit an application. Applicants are responsible for maintaining these registrations, which should be completed well in advance of submitting an application. All applicants ***must*** submit in this manner unless they obtain a written exemption from this requirement in advance of the deadline by the Director of HRSA's Division of Grants Policy. Applicants must request an exemption in writing from **DGPWaivers@hrsa.gov**, and provide details as to why they are technologically unable to submit electronically through the Grants.gov portal. If requesting a waiver, include the following in the e-mail request: the HRSA announcement number (HRSA-13-228); the organization's DUNS number; the name, address, and telephone number of the organization; the name and telephone number of the Project Director; the Grants.gov Tracking Number (GRANTXXXX) assigned to the submission (if any), and a copy of the "Rejected with Errors" notification as received from Grants.gov (if any). HRSA's Division of Grants Policy is the only office authorized to grant waivers. **HRSA and its Digital Services Operation (DSO) will only accept paper applications from applicants that received prior written approval.** However, the application must still be submitted by the deadline.

Suggestion: Submit the application to Grants.gov at least two days before the deadline to allow for unforeseen circumstances.

IMPORTANT NOTICE: CCR moved to SAM effective July 30, 2012

Central Contractor Registration (CCR) transitioned to the System for Award Management (SAM) on July 30, 2012. For any registrations in process during the transition period, data submitted to CCR will be migrated to SAM.

If a record was scheduled to expire between July 16, 2012 and October 15, 2012, CCR is extending the expiration date by 90 days. The registrant received an e-mail notification from CCR when the expiration date was extended. The registrant then will receive standard e-mail reminders to update their record based on the new expiration date. Those future e-mail notifications will come from SAM.

SAM will reduce the burden on those seeking to do business with the government. Organizations will be able to log into one system to manage their entity information in one record, with one expiration date, through one streamlined business process. Federal agencies will be able to look in one place for entity pre-award information. Everyone will have fewer passwords to remember and see the benefits of data reuse as information is entered into SAM once and reused throughout the system.

Active SAM registration is a pre-requisite to the successful submission of grant applications!

Items to consider are:

- When does the account expire?
- Does the organization need to complete the annual renewal of registration?
- Who is the eBiz POC? Is this person still with the organization?
- Does anything need to be updated?

To learn more about SAM, please visit https://www.sam.gov.

Note: SAM information must be updated at least every 12 months to remain active (for both grantees and sub-recipients).

Grants.gov will reject submissions from applicants with expired registrations. Do not wait until the last minute to register in SAM. According to the SAM Quick Guide for Grantees (https://www.sam.gov/sam/transcript/SAM_Quick_Guide_Grants_Registrations-v1.6.pdf), an entity's registration will become active after 3-5 days. Therefore, ***check for active registration well before the application deadline.***

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

Applicants are responsible for reading the instructions included in *HRSA Electronic Submission User Guide,* available online at http://www.hrsa.gov/grants/apply/userguide.pdf. This guide includes detailed application and submission instructions for both Grants.gov and HRSA Electronic Handbooks. Pay particular attention to Sections 2 and 5 that provide detailed information on the competitive application and submission process. According to the User Guide, applicants should submit single-spaced narrative documents with 12 point, easily readable font (e.g., Times New Roman, Ariel, Courier) and 1-inch margins. Smaller font (no less than 10 point) may be used for tables, charts, and footnotes.

Applicants are also responsible for reading the Grants.gov Applicant User Guide, available online at http://www.grants.gov/assets/GrantsGov_Applicant_UserGuide_v6.1.pdf. This guide includes detailed information about using the Grants.gov system and contains helpful hints for successful submission.

Applicants must submit proposals according to the instructions in these guides and this FOA, in conjunction with Application Form SF-424. The forms contain additional general information and instructions for applications. The forms and instructions may be obtained by:

(1) Downloading from http://www.grants.gov or

(2) Contacting HRSA Digital Services Operation (DSO) at HRSADSO@hrsa.gov

Each HRSA funding opportunity contains a unique set of forms, and only the specific forms package posted with an opportunity will be accepted. Specific instructions for preparing portions of the application that must accompany Application Form SF-424 appear in the "Application Format Requirements" section below.

2. Content and Form of Application Submission

Application Format Requirements
The total size of all uploaded files may not exceed the equivalent of 200 pages when printed by HRSA. The total file size may not exceed 25 MB. See Tables 2-5 for information about the application components included in the page limit. **Electronic submissions are subject to an automated page count, and those exceeding the limit in any way are automatically rejected.** Do not reduce the size of the fonts or margins to save space. See the formatting instructions in Section 5 of the *HRSA Electronic Submission User Guide* referenced above.

Applications must be complete, within the specified limits (200 pages, 25 MB), and submitted prior to the deadline to be considered under this announcement.

Application Format
The following tables detail the two-tier submission process for NAP applications via Grants.gov and HRSA EHB, the documents required, and the order in which they must be submitted. In the Form Type column of Tables 2-5, the word "Form" refers to a document that must be downloaded, completed in the template provided, and then uploaded. "E-Form" refers to forms that are completed online in EHB and therefore do not require downloading or uploading. "Document" refers to a document to be uploaded as an attachment.

In Tables 2-5, documents and forms marked "C" (required for completeness) will be used to determine if an application is complete. Applications that fail to include all forms and documents indicated as required for completeness will be considered incomplete or non-responsive and will not be considered for funding. Failure to include documents marked "R" (required for review) may negatively impact an application's objective review score.

Table 1: Summary of Two-Tiered Application Submission Process

Phase	Due Date	Helpful Hints
Phase 1 (Grants.gov): **Complete and submit the following by the Grants.gov deadline** (all forms are available in the Grants.gov application package): • SF-424 • Project Abstract (uploaded on line 15 of the SF-424) • SF-424B: Assurances – Non-Construction Programs • Project/Performance Site Location(s) Form • Grants.gov Lobbying Form • SF-LLL: Disclosure of Lobbying Activities (as applicable)	11:59 PM ET on February 27, 2013	**Complete Phase 1 as soon as possible. Phase 2 (HRSA EHB) may not begin until the successful submission of Phase 1.** Registration in Grants.gov is required. As registration may take up to a month, start the process as soon as possible. If the registration process is not complete, an application cannot be submitted. HRSA recommends that applications be submitted in Grants.gov as soon as possible to ensure that maximum time is available for providing the remainder of the application information in HRSA EHB. Refer to http://www.hrsa.gov/grants/apply for detailed application and submission instructions. **Before an applicant can register in Grants.gov, the organization must be registered in the System for Award Management (SAM) (formerly CCR). See Section IV of this document for SAM details.** The Grants.gov registration process involves three basic steps: A. Register your organization. B. Register yourself as an Authorized Organization Representative (AOR). C. Get authorized as an AOR by your organization. Applicants are strongly encouraged to register multiple authorized organization representatives. Visit http://www.grants.gov/applicants/get_registered.jsp or contact the Grants.gov Contact Center at 1-800-518-4726 or support@grants.gov for technical assistance on the registration process.

Phase	Due Date	Helpful Hints
Phase 2 (HRSA EHB): **Complete and submit the following by the HRSA EHB deadline:** • SF-424A: Budget Information – Non-Construction Programs • Project Narrative • Budget Justification • Program Specific Forms • Program Specific Information Forms • Attachments Referenced forms are available for preview at http://www.hrsa.gov/grants/apply/assistance/nap.	8:00 PM ET on April 3, 2013	**Phase 1 (Grants.gov) must be completed prior to starting Phase 2.** Registration in HRSA EHB is required. For information on registering in HRSA EHB, refer to http://www.hrsa.gov/grants/apply/userguide.pdf. Applicants will be able to access EHB (Phase 2) approximately seven business days following completion of the Grants.gov application components (Phase 1) and receipt of a Grants.gov tracking number. The Authorizing Official (AO) must complete submission of the application in Phase 2. Visit http://www.hrsa.gov/grants/apply or contact the HRSA Contact Center Monday through Friday, 9:00 a.m. to 5:30 p.m. ET (excluding Federal holidays) at 877-464-4772 or CallCenter@hrsa.gov for technical assistance on the registration process. For assistance with completing and submitting an application in HRSA EHB, contact the BPHC Helpline Monday through Friday, 8:30 a.m. to 5:30 p.m. ET (excluding Federal holidays) at 877-974-2742 or BPHCHelpline@hrsa.gov.

Table 2: Step 1–Submission through Grants.gov

http://www.grants.gov

- It is mandatory to follow the instructions provided in this section to ensure that your application can be printed efficiently and consistently for review.
- Failure to follow the instructions may make your application non-responsive. Non-responsive applications will not be considered under this funding opportunity announcement.
- Number the electronic attachment pages sequentially, resetting the numbering for each attachment (i.e., start at page 1 for each attachment). Do not attempt to number standard OMB approved form pages.
- For electronic submissions, no table of contents is required for the entire application. HRSA will construct an electronic table of contents in the order specified.
- Limit file attachment names to 50 characters or less. Do not use special characters (e.g., %, /, #) or spacing in the file name. An underscore (_) may be used to separate words in a file name. Attachments will be rejected by Grants.gov if special characters are included or if file names exceed 50 characters.
- The Other Attachments Form (listed as an Optional Document in Grants.gov) is not required and should NOT be submitted.

Application Section	Form Type	Instruction	Counted in Page Limit (Y/N)
Application for Federal Assistance (SF-424)	Form	Complete pages 1, 2, & 3 of the SF-424. See instructions in Section IV.2.i.	N
Project Summary/Abstract	Document (Attachment)	Type the title of the funding opportunity and upload the project abstract in Box 15 of the SF-424. See instructions in Section IV.2.viii.	Y
SF-424B: Assurances – Non-Construction Programs	Form	Complete the Assurances form.	N
Additional Congressional District(s) (as applicable)	Document (Attachment)	Upload a list of additional Congressional Districts served by the project if all districts served will not fit in 16b of the SF-424.	Y
Project Performance Site Location(s)	Form	Provide administrative site information AND information about all proposed NAP sites. A list of additional sites may be uploaded as necessary.	N
Grants.gov Lobbying Form	Form	Provide the requested contact information at the bottom of the form.	N
SF-LLL: Disclosure of Lobbying Activities (as applicable)	Form	Complete the form only if lobbying activities are conducted.	N

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

Table 3: Step 2–Submission through HRSA Electronic Handbooks (EHB)

https://grants.hrsa.gov/webexternal

- It is mandatory to follow the provided instructions to ensure that your application can be printed efficiently and consistently for review.
- Failure to follow the instructions may make your application non-responsive. Non-responsive applications will not be considered for funding.
- Number the electronic attachment pages sequentially, resetting the numbering for each attachment (i.e., start at page 1 for each attachment). Do not attempt to number standard OMB approved form pages.
- Limit file names for documents to 100 characters or less. Documents will be rejected by EHB if file names exceed 100 characters.

Application Section	Required for Completeness (C)/Review(R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Project Narrative	C	Document	Upload the Project Narrative. See instructions in Section IV.2.ix.	Y
SF-424A: Budget Information – Non-Construction Programs	C	E-Form	Complete Sections A, B, D, and E. Complete Section F if applicable. See instructions in Appendix E.	N
Budget Justification	C	Document	Upload the Budget Justification in the Budget Narrative Attachment Form field. See instructions in Appendix E.	Y
Attachments	Varies	Documents	See Table 4.	Varies
Program Specific Forms	R	Varies	See Table 5.	N
Program Specific Information	R	Varies	See Tables 5 and 6.	N

Table 4: Attachments Submission through HRSA EHB (Step 2 continued)

https://grants.hrsa.gov/webexternal

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

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

Attachment	Required for Completeness (C)/Review(R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Attachment 3: Applicant Organizational Chart	R	Document	Upload a one-page document that depicts the applicant's organizational structure, including the governing board, key personnel, staffing, and any sub-recipients or affiliated organizations.	Y
Attachment 4: Position Descriptions for Key Management Staff	R	Document	Upload position descriptions for key management staff: Chief Executive Officer (CEO), Chief Clinical Officer (CCO), Chief Financial Officer (CFO), Chief Information Officer (CIO), and Chief Operating Officer (COO). Indicate on the position descriptions if key management positions are combined and/or part time (e.g., CFO and COO roles are shared). Each position description should be limited to **one page** and must include, at a minimum, the position title; description of duties and responsibilities; position qualifications; supervisory relationships; skills, knowledge, and experience requirements; travel requirements; salary range; and work hours.	Y
Attachment 5: Biographical Sketches for Key Management Staff	R	Document	Upload biographical sketches/resumes for key management staff: CEO, CCO, CFO, CIO, and COO. Biographical sketches/resumes should not exceed **two** pages each. When applicable, biographical sketches/resumes must include training, language fluency, and experience working with the cultural and linguistically diverse populations to be served. If an identified individual is not yet hired, include a letter of commitment from that person with the biographical sketch/resume.	Y
Attachment 6: Co-Applicant Agreement (required for public center[1] applicants that have a co-applicant board)	C as applicable	Document	Public center applicants that have a co-applicant board must submit, in its entirety, the formal co-applicant agreement signed by both the co-applicant governing board and the public center. Note: Public centers that receive section 330 funding must comply with all applicable governance requirements and regulations. In cases where the public center's board cannot directly meet all applicable health center governance requirements, a separate co-	Y

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

Attachment	Required for Completeness (C)/Review(R)	Form Type	Instruction	Counted in Page Limit (Y/N)
			applicant health center governing board must be established that meets all the section 330 governance requirements. When a public center has a co-applicant board, the public center and co-applicant board must have a formal co-applicant agreement that stipulates roles, responsibilities, and the delegation of authorities of each party in the oversight and management of the public health center, detailing any shared roles and the responsibilities of each party in carrying out governance functions.	
Attachment 7: Summary of Contracts and Agreements	R as applicable	Document	Upload a BRIEF SUMMARY describing current or proposed patient service-related contracts and agreements. The summary must address the following items for each contract or agreement: • Name and contact information for each affiliated agency. • Type of contract or agreement (e.g., contract, affiliation agreement). • Brief description of the purpose and scope of each contract or agreement (i.e., type of services provided, how/where services are provided). • Timeframe for each contract or agreement. For required services provided by a formal written referral agreement/arrangement, explain how the services will be provided on a sliding fee scale that meets Health Center Program requirements and will be accessible regardless of ability to pay. If a contract or agreement will be attached to Form 8, denote this with an asterisk (*).	Y
Attachment 8: Independent Financial Audit	C	Document	Upload the most recent audit. The audit must include all balance sheets, profit and loss statements, audit findings, management letter (or a signed statement that no letter was issued with the audit), and noted exceptions. Organizations that have been operational less than one year and do not have an audit may submit monthly financial statements for the most recent six-month period. Organizations that are not yet operational and/or do not have an audit or financial statements must provide a detailed explanation of the situation, including supporting documentation.	N

Attachment	Required for Completeness (C)/Review(R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Attachment 9: Articles of Incorporation (required for nonprofit organizations)	R	Document	Upload the official signatory page (seal page) of the organization's Articles of Incorporation. Public centers with a co-applicant, upload the co-applicant's Articles of Incorporation.	Y
Attachment 10: Letters of Support	R	Document	Upload current dated letters of support addressed to the appropriate organization contact (e.g., board, CEO) to document commitment to the project. See the *COLLABORATION* section of the Project Narrative for details on required letters of support. As necessary, applicants may provide a list of additional letters that are available onsite. Letters of support that are not submitted with the application will not be considered by reviewers	Y
Attachment 11: Sliding Fee Discount Schedule(s)	R	Document	Upload the current or proposed sliding fee discount schedule(s). The scale(s) must correspond to a schedule of charges for which discounts are adjusted based on the patient's ability to pay and apply only to persons with incomes between 100-200 percent of the Federal poverty level (see the Federal poverty guidelines at http://aspe.hhs.gov/poverty). The discount schedule must provide a full discount to individuals with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged).	Y
Attachment 12: Evidence of Nonprofit or Public Center Status	C for NEW START Applicants	Document	Upload evidence of nonprofit or public center status **only if evidence is not already on file** with HRSA. Private Nonprofit: A private, nonprofit organization must submit any one of the following as evidence of its nonprofit status: • A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code. • A copy of a currently valid IRS tax exemption certificate. • A statement from a state taxing body, state Attorney General, or other appropriate state official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or	Y

Attachment	Required for Completeness (C)/Review(R)	Form Type	Instruction	Counted in Page Limit (Y/N)
			individuals. • A certified copy of the organization's certificate of incorporation or similar document **if it clearly establishes the nonprofit status of the organization**. • Any of the above proof for a state or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate. Public Center: Consistent with Policy Information Notice 2010-10 (http://bphc.hrsa.gov/policiesregulations/policies/pin201001.html), applicants must provide documentation demonstrating that the organization qualifies as a public agency (e.g., health department, university health system) for the purposes of section 330 of the PHS Act, as amended. Any of the following are acceptable: 1. Affirm Instrumentality Letter (4076C) from the IRS or a letter of authority from the Federal, state, or local government granting the entity one or more sovereign powers. 2. A determination letter issued by the IRS providing evidence of a past positive IRS ruling or other documentation demonstrating that the organization is an instrumentality of government, such as documentation of the law that created the organization or documentation showing that the state or a political subdivision of the state controls the organization. 3. Formal documentation from a sovereign state's taxing authority equivalent to the IRS granting the entity one or more governmental powers.	
Attachment 13: Floor Plans	R	Document	Provide floor plans of the proposed new access point(s), including proposed exam rooms and waiting area(s).	Y
Attachment 14: Corporate Bylaws	C	Document	Upload (in entirety) the applicant organization's most recent bylaws. Bylaws must be signed and dated by the appropriate individual indicating review and approval by the governing board.	Y

Attachment	**Required for Completeness (C)/Review(R)**	Form Type	Instruction	**Counted in Page Limit (Y/N)**
Attachment 15: Other Relevant Documents	R	Document	If desired, include other relevant documents to support the proposed project (e.g., charts, organizational brochures, lease agreements).	Y

Table 5: Program Specific Forms and Information Submission through HRSA EHB (Step 2 continued)

https://grants.hrsa.gov/webexternal

- With the exception of Form 3, all Program Specific Forms will be completed online in HRSA EHB. Refer to Appendix A for instructions.
- Limit the file name for Form 3 to 100 characters or less. Attachments will be rejected by EHB if file names exceed 100 characters.
- The Clinical and Financial Performance Measures Forms are required and will be completed online in HRSA EHB. Refer to Appendix B for instructions.
- The Program Specific Forms and Program Specific Information forms DO NOT count against the page limit.

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

Table 6: Program Specific Information for One-Time Funding Submission through HRSA EHB (Step 2 continued)
https://grants.hrsa.gov/webexternal

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

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

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

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

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

Application Format

i. ***Application for Federal Assistance (SF-424)***
In Grants.gov, complete Application Form SF-424 provided with the application package. Prepare according to instructions provided in the form itself (mouse over fields for specific instructions) and the following guidelines:

- *Box 2: Type of Applicant:* **Incorrect selection may delay EHB access.**
  - NEW STARTS only select New (new applicants)
  - SATELLITES only select Revision, then choose Other and type Supplement and your H80 grant number (current grantees)
- *Box 4: Applicant Identifier:* Leave blank.
- *Box 5a: Federal Entity Identifier:* Leave blank.
- *Box 5b: Federal Award Identifier:* 10-digit grant number (H80…) found in box 4b from the most recent Notice of Award for current section 330 grantees. New applicants should leave this blank.
- *Box 8c: Organizational DUNS:* Applicant organization's DUNS number (see below).
- *Box 8f: Name and Contact Information of Person to be Contacted on Matters Involving this Application:* Provide the Project Director's name and contact information.
  Note: If, for any reason, the Project Director will be out of the office between the Grants.gov submission date and the project period start date, ensure that the email Out of Office Assistant is set so HRSA will be aware of whom to contact if issues arise with the application and a timely response is required.
- *Box 11: Catalog of Federal Domestic Assistance Number:* 93.527
- *Box 14: Areas Affected by Project:* Provide a summary of the areas to be served (e.g., if entire counties are served, cities do not need to be listed) and upload it as a Word document.
- *Box 15: Descriptive Title of Applicant's Project:* Type the title of the FOA (New Access Point) and upload the project abstract. The abstract WILL count toward the page limit.
- *Box 16: Congressional Districts:* Provide the congressional district where the administrative office is located in 16a and the congressional districts to be served by the proposed project in 16b. If information will not fit in the boxes provided, attach a Word document.

- *Box 17: Proposed Project Start and End Date:* Provide the start date (September 1, 2013) and end date (August 31, 2015) for the proposed two-year project period.
- *Box 18: Estimated Funding:* Complete the required information based on the funding request for the **first year** of the proposed project period.
- *Box 19: Review by State:* See Section IV.4 for guidance in determining applicability.
- *Box 21: Authorized Representative:* The electronic signature in Grants.gov (created when the Grants.gov forms are submitted) is the official signature when applying for a NAP grant. The form should NOT be printed, signed, and mailed to HRSA.

DUNS Number
All applicant organizations (and sub-recipients of HRSA award funds) are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant from the Federal government. The DUNS number is a unique nine-character identification number provided by the commercial company Dun and Bradstreet. There is no charge to obtain a DUNS number. Information about obtaining a DUNS number can be found by visiting http://fedgov.dnb.com/webform or calling 1-866-705-5711. Applications ***will not*** be reviewed without a DUNS number.

Note: A missing or incorrect DUNS number is the number one reason for applications being "Rejected for Errors" by Grants.gov. HRSA will not extend the deadline for applications with a missing or incorrect DUNS number. Applicants should take care in entering the DUNS number in the application.

Additionally, applicant organizations (and sub-recipients of HRSA award funds) are required to register annually with the System for Award Management (SAM) in order to conduct electronic business with the Federal government. SAM registration must be maintained with current, accurate information at all times during which an entity has an active award from or an application under consideration by HRSA. It is extremely important to verify that the applicant organization's SAM registration is active and the Marketing Partner ID Number (MPIN) is current. Information about registering with SAM can be found at https://www.sam.gov. Please see Section IV of this funding opportunity announcement for SAM registration requirements.

ii. *Table of Contents*
The application components should be submitted in the order presented in Tables 2-5. For electronic applications, no table of contents is necessary as it will be generated by the EHB system. ***Note:*** The table of contents will not count in the page limit.

iii. *Budget*
In HRSA EHB, complete Application Form SF-424A: Budget Information – Non-Construction Programs. Complete Sections A, B, and D for the first year of the proposed project period, and complete Section E for year two. Complete section F only if applicable. See Appendix E for detailed instructions.

iv. *Budget Justification*
Provide a justification in HRSA EHB that provides a line-item budget for each year of the proposed project period and explains in line-item format the amounts requested for each object

class category in the budget (SF-424A, Section B). **The budget justification must clearly describe how each cost element contributes to meeting the project's objectives/goals.** The budget period is one year. However, the applicant **must** submit one-year budget justifications for each budget period within the proposed two-year project period. For the second budget year, the justification narrative should highlight the changes from Year 1, including the projected impact of the Affordable Care Act (ACA) implementation with respect to increased insurance coverage. While HRSA is not requesting that applicants provide a detailed analysis on the projected impact of the ACA implementation in the second year budget justification, applicants will need to begin collecting such information/data so that they will be able to provide such an analysis for the Year 2 budget, if their application is awarded funding in FY 2013. See Appendix E for a detailed explanation of object class categories to be included in the budget justification.

Budget for Multi-Year Award
This announcement is inviting applications for project periods up to two years. Awards, on a competitive basis, will be for a one-year budget period; although the project period may be up to two years. Submission and HRSA approval of the Progress Report and any other required submissions are the basis for the budget period renewal and release of subsequent year funds. Funding beyond the one-year budget period but within the two-year project period is subject to availability of funds, satisfactory progress, and a determination that continued funding would be in the best interest of the Federal government.

v. *Staffing Plan and Personnel Requirements*
In HRSA EHB, staffing and personnel information will be provided through Form 1A: General Information Worksheet, Form 2: Staffing Profile, Attachment 3: Organizational Chart, Attachment 4: Position Descriptions, and Attachment 5: Biographical Sketches. As applicable, ensure consistency of the staffing information provided across these application components. Position descriptions must include the roles, responsibilities, and qualifications of proposed project staff. When applicable, biographical sketches should include training, language fluency, and experience working with the cultural and linguistically diverse populations served.

vi. *Assurances*
In Grants.gov, complete Application Form SF-424B: Assurances – Non-Construction Programs.

vii. *Certifications*
In Grants.gov, complete the Certification Regarding Lobbying. Complete the SF-LLL: Disclosure of Lobbying Activities in Grants.gov only if the organization engages in lobbying.

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

Place the following at the top of the abstract:

- Project Title: New Access Point

- Applicant Name
- Address
- Project Director Name
- Phone Numbers (voice, fax)
- E-Mail Address
- Web Site Address (if applicable)
- Congressional District(s) for the Applicant Organization and Proposed Service Area
- Types of Section 330 Funding Requested (i.e., CHC, MHC, HCH, and/or PHPC)
- Current Federal Funding Received (including HRSA funding)

Include the following in the body of the abstract:

- A brief overview 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 if applicable (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 proposed new patients, visits, and providers; service delivery sites and locations; and services to be provided.

ix. ***Project Narrative***

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

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

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

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

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

NEED

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

1) Describe the characteristics of the target population within the proposed service area by:
   - Completing Form 9: Need for Assistance Worksheet (see Appendix A) that quantitatively compares target population health care needs to national median and severe benchmark data.
   - Describing the following factors in narrative format and how they impact access to primary health care, health care utilization, and health status, citing data resources, including local target population needs assessments when available:
     a) Geographical/transportation barriers (consistent with Attachment 1).
     b) Unemployment, income level, and/or educational attainment.
     c) Health disparities.
     d) Unique health care needs of the target population not previously addressed.
     e) Cultural/ethnic factors (consistent with Form 4).

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

Applicants not requesting special population funding but that currently serve or may serve these populations in the future: Describe the current or future planned services for and specific health care needs and access issues of the targeted special populations (i.e., migratory and seasonal agricultural workers (MHC), people experiencing homelessness (HCH), and/or residents of public housing (PHPC)).

3) Describe other primary health care services currently available in the service area (consistent with Attachment 1) including whether they also serve the applicant's target population. Specifically list existing section 330 grantees, look-alikes, rural health clinics, critical access hospitals, and other major providers serving the proposed zip codes, including the location and proximity to proposed new access point(s), referencing Attachment 1. Justify the need for Health Center Program support by highlighting service gaps that the proposed new access point(s) will fill.

4) Describe the health care environment and its impact on the applicant organization's operations, including any significant changes that affect the availability of health care services. Include external factors within the service area and internal factors specific to the applicant's fiscal stability, including:
   a) Changes in insurance coverage, including Medicaid, Medicare, and Children's Health Insurance Program (CHIP). Specifically discuss changes that could result from the Affordable Care Act implementation during Year 2 of the project.
   b) Changes in state/local/private uncompensated care programs.
   c) Economic or demographic shifts (e.g., influx of immigrant/refugee population; closing of local hospitals, community health care providers, or major local employers).
   d) Natural disasters or emergencies (e.g., hurricanes, flooding).
   e) Changes affecting special populations.

RESPONSE

1) Describe the service delivery model(s) proposed to address health care needs identified in ***NEED*** section and how these model(s) are appropriate and responsive to identified health care needs, including specific needs of any special populations for which funding is sought (MHC, HCH, and/or PHPC). The description must address the following:
   a) Site(s)/location(s) where services will be provided (consistent with Attachment 1, Form 5B, and Form 5C).
   b) Service site type (e.g., permanent, seasonal) for each site (consistent with Form 5B).
   c) Hours of operation, including how scheduled hours will assure services are accessible and available at times that meet target population's needs, with at least one delivery site operating 40 or more hours per week (consistent with Forms 5B and 5C).
   d) Professional after-hours care/coverage during hours when service sites or locations are closed.

2) Describe how proposed primary health care services (consistent with Form 5A) and other activities (consistent with Form 5C) are appropriate for the target population's needs. Description must include:

a) Provision of required and additional clinical and non-clinical services, including whether these are provided directly or through established written arrangements and referrals (consistent with Attachment 7).
b) How services will be culturally and linguistically appropriate.
c) Method by which enabling services such as case management, outreach, and transportation are integrated into the primary health care delivery system. Highlight enabling services designed to increase access for targeted special populations, if any.

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

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

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

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

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

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

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

8) Describe the organization's quality improvement/quality assurance (QI/QA) and risk management plan(s) including:
   a) Accountability and communication throughout the organization for systematically improving the provision of quality health care, including a clinical director whose responsibilities clearly include oversight of the QI/QA program.
   b) The process and parties responsible for developing, getting board approval and updating policies and procedures that support the QI/QA and risk management plan(s).
   c) The process and parties responsible for provider licensure, credentials, and privileges – ensuring that all providers (e.g., employed, contracted, volunteers, locum tenens) are appropriately licensed, credentialed, and privileged to perform proposed services (consistent with Form 5A) at proposed sites/locations (consistent with Forms 5B and 5C).
   d) Risk management procedures, including those related to patient grievance procedures and incident reporting and management.
   e) Monitoring the impact of the provision and efficiency of clinical services on the assessed health needs of the target population (e.g., clinical and financial performance measures).
   f) Maintenance of confidentiality of patient records throughout the continuum of care.
   g) Periodic assessment of appropriateness of service utilization, quality of services delivered, and patient outcomes, conducted by physicians or other licensed health professionals under the supervision of physician, including peer review and systematic evaluation of patient records to identify areas for improvement in documentation of services provided either directly or through referral.
   h) Utilization of appropriate information systems for tracking, analyzing, and reporting key performance data, including data necessary for 1) required performance measures (e.g., electronic health records, payment management systems) and 2) tracking of diagnostic tests and other services provided to health center patients to ensure appropriate follow up and documentation in patient record.
   i) Utilization of QI results to improve performance.

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

9) Describe how the health center will assist individuals in determining their eligibility for, and enrolling in, health insurance options that will be available starting in January 2014 as a result of the Affordable Care Act (e.g., Medicaid coverage for individuals up to 133% of the FPL in states choosing to provide this coverage; the ability to purchase insurance through an Exchange; the availability of Advanced Premium Tax Credits for insurance purchased through an Exchange for individuals with incomes up to 400% FPL; and the availability of Cost-Sharing Reductions for insurance purchased through an Exchange for persons up to 250% FPL). Specifically describe how potentially-eligible individuals will be identified and informed of the new options; what type of assistance will be provided for determining eligibility; and what type of assistance will be provided for completion of the relevant enrollment process.

COLLABORATION

1) Describe both formal and informal collaboration and coordination of services[2] with other health care providers. Specifically describe collaboration and coordination with the following:
   a) Existing health centers (Health Center Program section 330 grantees and look-alikes)
   b) Rural health clinics
   c) Critical access hospitals
   d) Other federally-supported grantees (e.g., Ryan White programs, Title V Maternal and Child Health programs)
   e) State and local health departments
   f) Private providers
   g) Programs serving the same target population (e.g., social services; job training; Women, Infants, and Children (WIC); community groups; school districts) and, if applicable, special population(s) for which funding is sought (e.g., Public Housing Authority, homeless shelters).
   h) If applicable, neighborhood revitalization initiatives such as the Department of Housing and Urban Development's Choice Neighborhoods, the Department of Education's Promise Neighborhoods, and/or the Department of Justice's Byrne Criminal Justice Innovation Program.

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

2) Document support for the proposed project through current dated letters of support[3] that reference specific coordination or collaboration from all of the following in the service area or within close proximity of the proposed new access point site(s):
   a) Health centers (section 330 grantees and look-alikes)
   b) Rural health clinics
   c) Critical access hospitals
   d) Health departments
   e) Major private provider groups serving low income and/or uninsured populations

   If such organizations do not exist in the service area state this. 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. Letters of support should be consistent with Attachment 1, except for other major provider groups that are not required to be shown on the service area map.

[2] Refer to http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html for information on maximizing collaborative opportunities.
[3] Letters of support should be addressed to the organization's board, CEO, or other appropriate key management staff member (e.g., Medical Director), not HRSA staff. Letters of support that are not submitted with the application will not be considered by reviewers.

3) Provide current dated letters of support that reference **specific commitment, collaboration, and/or coordinated activities** with community organizations in support of the proposed project beyond those required in Item 2 above (e.g., service providers, school districts, homeless shelters).

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

EVALUATIVE MEASURES

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

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

3) Describe the organization's ongoing strategic planning process, including:
   a) The role of the governing board in strategic planning
   b) The role of key management staff and any other relevant individuals in strategic planning
   c) The frequency of strategic planning meetings (e.g., annually, bi-annually)
   d) Strategic planning products (e.g., strategic plan, operational plan)
   e) How often and when health care needs of the target population were last assessed

f) How the target population's health care needs and the related program evaluation results have been or will be incorporated into the organization's ongoing strategic planning process
g) How the strategic planning process relates to the QI/QA plans
h) How the applicant organization's financial needs/performance are addressed

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

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

RESOURCES/CAPABILITIES

1) Describe how the organizational structure (including any sub-recipients) is appropriate for the operational needs of the project (consistent with Attachments 2 and 3, and, as applicable, Attachments 6[4] and 7), including how lines of authority are maintained from the governing board to the CEO/Executive Director down through the management structure.

2) Describe how the organization maintains appropriate oversight and authority in accordance with Health Center Program requirements over all contracted services, including (as applicable):
a) Current or proposed contracts and agreements summarized in Attachment 7.
b) Sub-recipient arrangements[5] referenced in Form 8 (any "No" response to the Governance Checklist in Form 8 must be explained).

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

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

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

c) Possesses needed skills and experience for the defined roles as demonstrated in Attachment 5.

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

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

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

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

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

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

9) Describe the organization's annual independent auditing process performed in accordance with Federal audit requirements and submit the most recent financial audit and management letter (or a signed statement that no letter was issued with the audit) as Attachment 8.[6] Organizations that have been operational for less than one year and do not have an audit may submit monthly financial statements for the most recent six-month period. Organizations that are not yet operational and do not have audit or financial information must provide a detailed explanation of the situation, including supporting documentation.

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

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

11) Describe current or proposed efforts to integrate with the state health care delivery plan for ensuring access to health care including outreach, enrollment, and delivery system reform.

GOVERNANCE

Note: Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups should respond ONLY to Item 5 below.[7]

1) Describe how the Corporate Bylaws (Attachment 14), Articles of Incorporation (Attachment 9), and/or Co-Applicant Agreement (Attachment 6)[8] demonstrate that the organization has an independent governing board that meets the following criteria:
   a) Meets at least once a month (this requirement may be waived for eligible applicants; see Form 6B).
   b) Ensures that written minutes are recorded for all meetings (i.e., full board and subcommittee meetings).
   c) Selects the services to be provided.
   d) Determines the hours during which services will be provided.
   e) Measures and evaluates the organization's progress and develops a plan for the long-range viability of the organization through strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational performance and assets.
   f) Approves the health center's annual budget.
   g) Approves the health center's grant applications.
   h) Approves the selection/dismissal and conducts the performance evaluation of the organization's Executive Director/CEO.
   i) Establishes general policies for the organization. ***Note:*** In the case of public centers with co-applicant governing boards, the public center is permitted to retain authority for establishing general fiscal and personnel policies for the health center.
   j) Establishes policies to prohibit conflict of interest by board members, employees, consultants, and those who furnish goods or services to the health center.

   Note*:* Only public center applicants are permitted to establish a separate co-applicant health center governing board that meets all section 330 requirements.

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

[8] Public center applicants whose board cannot directly meet health center governance requirements are permitted to establish a separate co-applicant health center governing board that meets all the section 330 governance requirements. In the co-applicant arrangement, the public center receives the section 330 grant and the co-applicant board serves as the health center board. Together, the two are collectively referred to as the health center. The public center and health center board must have a formal co-applicant agreement in place.

2) Document that the structure of the board (co-applicant board for a public center) is appropriate in terms of size, composition, and expertise by describing how the following criteria are met:
   a) At least 51 percent of board members are individuals who are/will be patients of the health center (this requirement may be waived for eligible applicants[9]; see Form 6B).
   b) As a group, the patient board members reasonably represent the individuals served by the organization in terms of race, ethnicity, and gender (consistent with Forms 4 and 6A).
   c) Non-patient board members are representative of the service area and selected for their expertise in any of the following areas: community affairs; local government; finance and banking; legal affairs; trade unions and related organizations; and/or social services.
   d) Board has a minimum of nine but no more than 25 members, as appropriate for the complexity of the organization.
   e) No more than half of the non-patient board members derive more than 10 percent of their annual income from the health care industry.
   f) No board member is an employee of the health center or an immediate family member of an employee.

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

3) **Applicants requesting a waiver of governance requirements ONLY** (only applicants not currently receiving or applying for CHC funding are eligible to request a waiver): Justify the need for a waiver of the governance requirements of patient majority board composition and/or monthly meetings, consistent with Form 6B.
   a) If the 51% patient majority board composition is requested to be waived, justify why the applicant cannot meet this requirement and describe the alternative mechanism(s) for gathering consumer/patient input (e.g., separate advisory boards, patient surveys, focus groups). Discuss:
      - Specific types of patient input to be collected.
      - Methods for documenting input in writing.
      - Process for formally communicating the input directly to the organization's governing board.
      - How the patient input will be used by the governing board in areas such as: 1) selecting services; 2) setting operating hours; 3) defining strategic priorities; 4) evaluating the organization's progress in meeting goals, including patient satisfaction; and 5) other relevant areas of governance that require and benefit from patient input.

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

b) If monthly meetings are requested to be waived, justify why the applicant cannot meet this requirement, describe the proposed alternative meeting schedule, and detail how the alternative schedule will assure that the board will maintain appropriate oversight.

Note: An approved waiver does not absolve the organization's governing board from fulfilling all other statutory board responsibilities and requirements.

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

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

SUPPORT REQUESTED

1) Provide a complete, consistent, and detailed budget presentation through the submission of the following: SF-424A, budget justification, Form 2, and Form 3.

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

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

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

x. ***Program Specific Forms***

See Appendix A for Program Specific Forms instructions.

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

xii. *Attachments*
Attachments are supplementary in nature and are not intended to be a continuation of the Project Narrative. Attachments must be clearly labeled and uploaded in the appropriate place within HRSA EHB. See Table 4 for a complete listing of required attachments, including instructions for completing them.

3. Submission Dates and Times

Application Due Date
The Grants.gov deadline for applications under HRSA-13-238 is **11:59 p.m. ET on February 27, 2013** and the deadline to complete all required information in HRSA EHB is **8:00 p.m. ET on April 3, 2013.** Applications completed online are considered formally submitted when: (1) the application has been successfully transmitted electronically by the Authorized Organization Representative (AOR) through Grants.gov to the correct funding opportunity number and has been validated by Grants.gov on or before the Grants.gov deadline date and time; and (2) the Authorizing Official (AO) has submitted the additional information in HRSA EHB on or before the EHB deadline date and time.

Receipt Acknowledgement
Upon receipt of an application, Grants.gov will send a series of email messages regarding the progress of the application through the system.

1. The first will confirm receipt in the system.
2. The second will indicate whether the application has been successfully validated or has been rejected due to errors.
3. The third will be sent when the application has been successfully downloaded at HRSA.
4. The fourth will notify the applicant of the Agency Tracking Number assigned to the application.

The applicant will receive an "Application successfully transmitted to HRSA" message in HRSA EHB upon successful application submission within the EHB system.

The Chief Grants Management Officer (CGMO) or designee may authorize an extension of published deadlines when justified by circumstances such as natural disasters (e.g., floods, hurricanes) or other service disruptions such as prolonged blackout. The CGMO or designee will determine the affected geographic area(s). For more details, refer to HRSA Electronic Submission User Guide at http://www.hrsa.gov/grants/apply/userguide.pdf.

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

4. Intergovernmental Review

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

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

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

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

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

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

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

5. Funding Restrictions

Funds under this announcement may not be used for fundraising or major alteration and renovation or construction/expansion of facilities. Funds may be used for minor capital costs, including equipment and/or minor alteration and renovation of proposed new access point facilities. Applicants may request to use up to $150,000 of Federal funds in Year 1 ONLY for such minor capital costs (see Appendix D for more information). HRSA grant awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS); for more information on allowable costs and other grant requirements see the HHS GPS at http://www.hrsa.gov/grants/apply/writestrong/index.html.

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

6. Other Submission Requirements

As stated in Section IV.1, except in very rare cases, HRSA will no longer accept applications in paper form. Applicants are ***required*** to submit ***electronically*** through Grants.gov and HRSA EHB.

Grants.gov
To submit an application electronically, use the APPLY FOR GRANTS section at http://www.grants.gov. When using Grants.gov, download a copy of the application package, complete it off-line, and then upload and submit the application via Grants.gov.

It is essential that each organization ***immediately register*** in Grants.gov and become familiar with the Grants.gov application process. The registration process must be complete in order to submit an application. The registration process can take up to one month. To successfully register in Grants.gov, complete all of the following required actions:

- Obtain an organizational Data Universal Number System (DUNS) number
- Register the organization with the System for Award Management (SAM) – see Section IV.1 for SAM details
- Identify the organization's E-Business Point of Contact (E-Biz POC)
- Confirm the organization's SAM Marketing Partner ID Number (M-PIN) password
- Register and approve at least one Authorized Organization Representative (AOR)—HRSA recommends registering multiple AORs
- Obtain a username and password from the Grants.gov Credential Provider

Instructions on how to register, tutorials, and FAQs are available on the Grants.gov Web site at http://www.grants.gov/applicants/app_help_reso.jsp. Assistance is also available from the Grants.gov Contact Center 24 hours a day, 7 days a week (excluding Federal holidays) at support@grants.gov or 1-800-518-4726. Applicants must ensure that all passwords and registrations are current well in advance of the deadline.

HRSA EHB
To submit the application in HRSA EHB, the Authorizing Official (AO) and other application preparers must register in EHB. The purpose of the registration process is to collect consistent information from all users, avoid collection of redundant information, and allow for the unique identification of each system user. Registration within HRSA EHB is required only once for each user.

Registration within HRSA EHB is a two-step process:

1. Individuals who participate in the grants process create individual system accounts.
2. Individual users associate themselves with the appropriate grantee organization.

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

To complete the registration quickly and efficiently, HRSA recommends that applicants identify EHB roles for all participants in the grants management process. HRSA EHB offers three functional roles for individuals from applicant organizations:

- Authorizing Official (AO)
- Business Official (BO)
- Other Employee (for project directors, assistant staff, AO designees, and others)

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

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

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

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

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

Note: The BPHC Helpline will remain open until 8:00 p.m. ET on the EHB application due date.

Formal Submission of the Electronic Application

It is incumbent on applicants to ensure that the AOR is available to submit the application in Grants.gov and the AO is available to submit the application in HRSA EHB by the published due dates and times. HRSA will not accept submission or resubmission of incomplete, rejected, or otherwise delayed applications after the deadlines. Therefore, an organization is urged to submit an application in advance of the deadlines. If an application is rejected by Grants.gov due to errors, the application must be corrected and resubmitted to Grants.gov before the deadline date and time. Deadline extensions will **not** be provided to applicants who do not correct errors and resubmit before the posted deadlines. Please note that unlike Grants.gov, which allows for revision resubmission before the Grants.gov deadline, applicants will **not** be allowed to correct and resubmit applications in HRSA EHB.

If, for any reason, an application is submitted more than once prior to the application due dates, HRSA will only accept the applicant's last validated application submitted to Grants.gov prior to the Grants.gov due date and time, and the corresponding HRSA EHB submission (submitted prior to the EHB application due date and time), as the final and only acceptable application.

Tracking an application: It is incumbent on the applicant to track the application using the Grants.gov tracking number (GRANTXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking an application can be found at https://apply07.grants.gov/apply/checkApplStatus.faces. **Be sure the application is validated by Grants.gov prior to the application deadline.**

V. Application Review Information

1. Review Criteria

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

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

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

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

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

Note: 20 of the 30 available points in this section will be awarded based on the Need for Assistance (NFA) Score (see Form 9). The NFA score will be calculated automatically by the HRSA EHB system. The remaining 10 points will be based on the criteria outlined below.

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

2. For applicants requesting funding to serve migratory and seasonal agricultural workers (section 330(g)), people experiencing homelessness (section 330(h)) and/or residents of public housing (section 330(i)), how well the applicant demonstrates, with consistent and complete information, the specific health care needs and access issues of each proposed special population as documented by quantitative and qualitative data, using data sources with the greatest specificity available for the proposed service area and target population of the NAP, provided in the Need for Assistance Worksheet (Form 9) and listed in Item 2 of the ***NEED*** section of the Project Narrative.

3. How well the applicant describes, with consistent and complete information, existing primary health care services and service gaps in the service area, factors affecting the broader health care environment, and the role the applicant organization currently plays or will play in the local health care landscape through NAP grant support as documented in Items 3 and 4 of the ***NEED*** section of the Project Narrative.

Criterion 2: RESPONSE (20 Points)

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

2. For applicants requesting funding to serve migratory and seasonal agricultural workers (section 330(g)), people experiencing homelessness (section 330(h)) and/or residents of public housing (section 330(i)), how well the applicant demonstrates, with consistent and complete information, compliance with requirements for targeted special populations; services targeting people experiencing homelessness (HCH) will include provision of substance abuse services (either directly or through referral); and/or services targeting migratory and seasonal agricultural workers (MHC) address environmental health needs and hazards, as documented in Forms 5A, 5B, and 5C, Attachment 7, and Items 1 and 2 of the ***RESPONSE*** section of the Project Narrative.

3. How well the applicant demonstrates, with consistent and complete information, that the schedule of charges is board-approved, reasonable, and consistent with local rates; the sliding fee discount schedule(s), including any justified nominal charges, ensure services (regardless if they are provided directly, through a formal written contract/agreement, or by formal written referral arrangement/agreement) are available and accessible to all without regard to

ability to pay; the system in place for determining eligibility for and application of discounts is based on a patient's income, family size, and current Federal Poverty Guidelines; and a system is in place to ensure patients are made aware of the availability of the sliding fee discounts, as reflected in Attachment 11, Attachment 7 (as applicable), and Items 5 and 6 of the ***RESPONSE*** section of the Project Narrative.

4. How well the Implementation Plan (Attachment 2) identifies appropriate, realistic, and achievable action steps necessary to ensure that the new access point(s) will be open, operational, and compliant within 120 days of award with appropriate staff and providers in place to deliver services to the entire proposed service area as outlined in Item 7 of the ***RESPONSE*** section of the Project Narrative.

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

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

7. How well the applicant identifies appropriate, realistic, and achievable plans to ensure assistance for individuals in determining their eligibility for, and enrolling in, new health insurance options that will be available starting in January 2014 as a result of the Affordable Care Act as described in Item 9 of the ***RESPONSE*** section of the Project Narrative.

Criterion 3: COLLABORATION (10 points)

1. How well the applicant demonstrates, with consistent and complete information, that health centers (Health Center Program section 330 grantees and look-alikes), rural health clinics, critical access hospitals, health departments, and major private provider groups serving low income and/or uninsured populations in the proposed service area and within close proximity (as identified by the UDS Mapper tool) support the proposed project through detailed descriptions of collaboration and coordination supported by specific letters of support as documented in Attachment 1, Attachment 7 (as applicable), Attachment 10, and Items 1 and 2 of the ***COLLABORATION*** section of the Project Narrative. The letters of support must be specific to the nature of the support. If letter(s) are not included, whether the applicant provides an adequate justification as to why such letter(s) could not be obtained, including documentation of efforts made to obtain the letter(s).

2. How well the applicant demonstrates, with consistent and complete information, that other health care providers and social service providers in the service area and within close proximity support the proposed project through detailed descriptions of collaboration and coordination in Item 3 of the ***COLLABORATION*** section of the Project Narrative and specific, current letters of support in Attachment 10.

Criterion 4: EVALUATIVE MEASURES (5 points)

1. How well the applicant establishes Clinical and Financial Performance Measures (goals) appropriate to the proposed project and two-year project period, including realistic contributing and restricting factors, effective plans for addressing such factors, as well as unique special population measures corresponding to the identified special population needs consistent with the ***NEED*** section and Items 1 and 2 of the ***EVALUATIVE MEASURES*** section of the Project Narrative, as well as Form 9, as evidenced in the Clinical and Financial Performance Measures forms.

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

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

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

Criterion 5: RESOURCES/CAPABILITIES (15 points)

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

2. How well the applicant establishes, with consistent and complete information, that its experience and expertise working with and addressing needs of the target population(s) have positioned the applicant organization to successfully implement the proposed project in the proposed timeframe, with a particular focus on experience and expertise regarding meeting primary and preventive health care needs through information provided in Items 2, 3, and 6

of the ***RESOURCES/CAPABILITIES*** section of the Project Narrative, Attachment 3, Attachment 4, Attachment 5, Attachment 7, and Form 8, as applicable.

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

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

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

5. How well the applicant describes current or proposed efforts to integrate with the state health care delivery plan to ensure access to health care.

6. How well the Implementation Plan (Attachment 2) identifies appropriate, realistic, and achievable action steps that ensure the organization has the resources and capability to open and operate the compliant new access point(s) within 120 days of award. See Program Requirements in Appendix F.

Criterion 6: GOVERNANCE (10 points)

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

2. **Public center applicants with a co-applicant governance structure ONLY**: How well the applicant demonstrates that the co-applicant's patient/community-based governing board

meets the statutory requirements for board composition (e.g., size, expertise, member selection) and appropriate implementation of all board authorities, including setting health center policy (with the exception of general fiscal and personnel policies) as evidenced in Items 1, 2, and 4 of the ***GOVERNANCE*** section of the Project Narrative, Attachment 2 (if applicable), Attachment 3, Attachment 6, Attachment 14, and Form 8. See Appendix F for more information on required governance composition and authorities.

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

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

5. **Applicants targeting only special populations and requesting a waiver in Form 6B ONLY**: the degree to which the applicant demonstrates the need for a waiver and the quality of the current/planned alternative procedures for ensuring patient participation in governance (if applying for a waiver of the 51% majority) or regular oversight (if applying for a waiver of the monthly meeting requirement) as documented in Item 3 of the ***GOVERNANCE*** section of the Project Narrative and Form 6B.

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

Criterion 7: SUPPORT REQUESTED (10 points)

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

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

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

2. Review and Selection Process

The Division of Independent Review is responsible for managing objective reviews within HRSA. Applicants competing for Federal funds receive an objective and independent review performed by a committee of experts qualified by training and experience in particular fields or disciplines related to the program being reviewed. In selecting review committee members, other factors in addition to training and experience may be considered to improve the balance of the committee (e.g., geographic distribution). Each reviewer is screened to avoid conflicts of interest and is responsible for providing an objective, unbiased evaluation based on the review criteria noted in Section V.1 and the guidelines included in the HRSA Scoring Rubric located at http://www.hrsa.gov/grants/apply/assistance/NAP. The committee provides expert advice on the merits of each application to program officials responsible for final award selections.

All applications will be reviewed initially for eligibility (see Section III), completeness (see Section IV.2), and responsiveness. **Applications determined to be ineligible, incomplete, or non-responsive to this FOA and/or section 330 program requirements will not be considered for funding.**

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

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

The review criteria are designed to enable the review panel to assess the quality of a proposed project and determine the likelihood of its success. The criteria are closely related to each other and are considered as a whole in judging the overall quality of an application.

HRSA reserves the right to review fundable applicants for compliance with HRSA program requirements through reviews of site visits, audit data, Uniform Data System (UDS) or similar reports, Medicare/Medicaid cost reports, external accreditation, and other performance reports,

as applicable. The results of this review may impact final funding decisions. For example, based on review of applicants by the Division of Financial Integrity, applicants with serious financial sustainability concerns will not receive a NAP award.

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

- One-year or two-year project period for current grant award
- Five or more active health center program requirement conditions on current grant award
- One or more 30 day progressive action condition(s) on current grant award

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

Funding Priorities
A funding priority is defined as the favorable adjustment of review scores when applications meet specified criteria. **Applicants do not need to request funding priorities.** Prior to final funding decisions, HRSA will assess all NAP applications within the fundable range for eligibility to receive priority point adjustment(s). The FY 2013 NAP funding opportunity has two funding priorities:

- ***Unserved, High Poverty Population (3-15 points):*** HRSA will assess the current Health Center Program penetration in the applicant's service area (defined by the service area zip codes listed on Form 5B) along with the number of unserved, low-income individuals in the service area. For priority points to be awarded, the service area must meet two criteria:
  1) The proposed service area must have a Health Center Program (grantees and look-alikes) penetration rate for the low-income (below 200% of the poverty limit[10]) population at or below 25% (i.e., 75% or more of the proposed service area's low-income population is not being served under the Health Center Program); AND
  2) The number of low income residents not currently served under the Health Center Program must be at least 150% of the proposed patients to be served by the NAP site(s) as identified on Form 1A. For example, if the application proposes to serve 1,000 individuals, there must be at least 1,500 low-income residents in the proposed service area that are not being served under the Health Center Program.

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

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

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

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

Special Funding Considerations

Other factors such as geographic distribution, past performance, and compliance with section 330 program requirements and applicable regulations may be considered as part of the selection of applications for funding. Additionally, HRSA will consider the following factors in making FY 2013 NAP awards:

- *RURAL/URBAN DISTRIBUTION OF AWARDS:* Aggregate awards in FY 2013 will be made to ensure that no more than 60 percent and no fewer than 40 percent of centers serve people from urban areas and no more than 60 percent and no fewer than 40 percent serve people from rural areas. In order to ensure this distribution, HRSA may award grants to applications out of rank order.

- *PROPORTIONATE DISTRIBUTION:* Aggregate awards in FY 2013 to support the various types of health centers will be made to ensure continued proportionate distribution of funds across the Health Center Program as set forth in section 330(r)(2)(B) of the PHS Act. In order to meet this distribution, HRSA may award grants to applications out of rank order.

- *GEOGRAPHIC CONSIDERATION:* The intent of this funding opportunity is to expand the current safety net on a national basis by creating new access points in areas not currently served by federally funded health centers. In order to meet this intent, HRSA will consider geographic distribution and the extent to which an area may currently be served by another section 330-funded health center when deciding which applications to fund.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of September 1, 2013.

VI. Award Administration Information

1. Award Notices

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

The NoA sets forth the amount of funds granted, the terms and conditions of the grant, the effective date of the grant, the budget period for which initial support will be given, the non-Federal funding (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant's Authorized Organization Representative and reflects the only authorizing document. It will be sent prior to the project period start date.

2. Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations or 45 CFR Part 92 Uniform Administrative Requirements For Grants And Cooperative Agreements to State, Local, and Tribal Governments, as appropriate.

HRSA grant and cooperative agreement awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable based on recipient type and purpose of award. This includes any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at http://www.hrsa.gov/grants/hhsgrantspolicy.pdf. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the NoA).

Non-Discrimination Requirements
To serve persons most in need and to comply with Federal law, services must be widely accessible. Services must not discriminate on the basis of age, disability, sex, race, color, national origin, or religion. The HHS Office for Civil Rights provides guidance to grant recipients on complying with civil rights laws that prohibit discrimination on these bases. Please see http://www.hhs.gov/ocr/civilrights/understanding/index.html. HHS also provides specific guidance for recipients on meeting their legal obligation under Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin in programs and activities that receive Federal financial assistance (P.L. 88-352, as amended and 45 CFR Part

80). Please see http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html to learn more about the Title VI requirement to take reasonable steps to provide meaningful access to persons with limited English proficiency.

Trafficking in Persons
Awards issued under this funding opportunity announcement are subject to the requirements of Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to http://www.hrsa.gov/grants/trafficking.html.

Smoke-Free Workplace
The Public Health Service strongly encourages all award recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. Further, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children.

Cultural and Linguistic Competence
HRSA programs serve culturally and linguistically diverse communities. Although race and ethnicity are often thought to be dominant elements of culture, HRSA-funded programs embrace a broader definition to incorporate diversity within specific cultural groups, including but not limited to, cultural uniqueness within Native American populations; Native Hawaiian, Pacific Islanders, and other ethnic groups; language; gender; socio-economic status; sexual orientation and gender identity; physical and mental capacity; age; religion; housing status; and regional differences. Organizational behaviors, practices, attitudes, and policies across all HRSA-supported entities respect and respond to the cultural diversity of communities, clients, and students served. HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, and materials delivered by competent providers in a manner that factors in the language needs, cultural richness, and diversity of populations served. Quality also means that, where appropriate, data collection instruments used should adhere to culturally competent and linguistically appropriate norms. For additional information and guidance, refer to the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) published by HHS and available online at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15. Additional cultural competency and health literacy tools, resources, and definitions are available online at http://www.hrsa.gov/culturalcompetence and http://www.hrsa.gov/healthliteracy.

Healthy People 2020
Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The initiative has four overarching goals: (1) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote quality of life, healthy development, and healthy behaviors across all life stages. The program consists of over 40 topic areas, containing measurable objectives. HRSA has actively participated in the work groups of all the topic areas and is committed to the achievement of the Healthy People 2020 goals. More information about Healthy People 2020 may be found online at http://www.healthypeople.gov/.

National HIV/AIDS Strategy (NHAS)
The National HIV/AIDS Strategy (NHAS) has three primary goals: (1) reducing the number of people who become infected with HIV; (2) increasing access to care and optimizing health outcomes for people living with HIV; and (3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of early entrance into care for people living with HIV to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention, care, and treatment services, and as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to identify people who are HIV-positive but do not know their serostatus and reduce stigma and discrimination against people living with HIV.

To the extent possible, program activities should strive to support the three primary goals of the NHAS. As encouraged by the NHAS, programs should seek opportunities to increase collaboration, efficiency, and innovation in the development of program activities to ensure success of the NHAS. Programs providing direct services should comply with federally-approved guidelines for HIV Prevention and Treatment (see http://www.aidsinfo.nih.gov/Guidelines/Default.aspx as a reliable source for current guidelines). More information can also be found at http://www.whitehouse.gov/administration/eop/onap/nhas.

Health IT
Health information technology (Health IT) provides the basis for improving the overall quality, safety, and efficiency of the health delivery system. HRSA endorses the widespread and consistent use of health IT, which is a promising tool for making health care services more accessible, efficient and cost effective for all Americans.

Related Health IT Resources:
- Health Information Technology (HHS)
- What is Health Care Quality and Who Decides? (AHRQ)

3. Reporting

Successful applicants under this FOA must comply with the following reporting and review activities:

a. Audit Requirements
Comply with audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found at http://www.whitehouse.gov/omb/circulars_default. Organizations should refer to the submission process described in Program Assistance Letter 2009-06: New Electronic Process for Submitting Required Annual Financial Audits located at http://bphc.hrsa.gov/policiesregulations/policies/pal200906.html.

b. Payment Management Requirements

Submit a quarterly electronic Federal Financial Report (FFR) Cash Transaction Report via the Payment Management System. The report identifies cash expenditures against the authorized grant funds. The FFR Cash Transaction Reports must be filed within 30 days of the end of each calendar quarter. Failure to submit the report may result in the inability to access award funds. Go to http://www.dpm.psc.gov for additional information.

c. Status Reports

1) **Federal Financial Report** – The Federal Financial Report (SF-425) is required according to the following schedule: http://www.hrsa.gov/grants/manage/technicalassistance/federalfinancialreport/ffrschedule.pdf. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through HRSA EHB. More information will be included in the NoA.

2) **Uniform Data System (UDS) Report –** The UDS is an integrated reporting system used to collect data on all health center programs to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments. All grantees are required to submit a Universal Report and, if applicable, a Grant Report annually. The Universal Report provides data on patients, services, staffing, and financing across all section 330 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).

3) **Progress Report –** A progress report must be submitted to HRSA on an annual basis. Submission and HRSA approval of the Budget Period Progress Report (BPR) non-competing continuation application will trigger the budget period renewal and release of each subsequent year of funding. The BPR documents progress on program-specific goals and collects core performance measurement data to track the progress and impact of the project. Grantees will receive an email message via HRSA EHB when it is time to begin working on the progress report.

   ***Note:* A detailed analysis of the projected impact of the ACA implementation will be required as part of the BPR.**

4) **Tangible Personal Property Report.** If applicable, the Tangible Personal Property Report (SF-428) and related forms must be submitted within 90 days after the project period ends. Awardees are required to report all federally-owned property and acquired equipment with an acquisition cost of $5,000 or more per unit. Tangible personal property includes equipment and supplies. Property may be provided by HRSA or acquired by the recipient with award funds. Federally-owned property consists of items that were furnished by the Federal Government. Tangible personal property reports must be submitted electronically through EHB. More information will be included in the NoA.

d. Transparency Act Reporting Requirements

New awards ("Type 1" / NEW STARTS) issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252, and implemented by 2 CFR Part 170. Grant recipients must report information for each first-tier subaward of $25,000 or more in Federal funds and executive total compensation for the recipient's and sub-recipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (FFATA details are available online at http://www.hrsa.gov/grants/ffata.html). Satellite grantees may be subject to this requirement and will be so notified in the NoA.

VII. Agency Contacts

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

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

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

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

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

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

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

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

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

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

Note: The BPHC Helpline will remain open until 8:00 p.m. ET on the EHB application due date.

VIII. Other Information

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

Federal Tort Claims Act Coverage/Medical Malpractice Insurance
Organizations that receive grant funds under section 330 are eligible for protection from suits alleging medical malpractice through the Federally Supported Health Centers Assistance Act of 1992 (Act). The Act provides that health center employees may be deemed Federal employees and afforded the protections of the Federal Tort Claims Act (FTCA).

Organizations must be aware that **participation in the FTCA program is not guaranteed**. If an applicant is not absolutely certain it can meet the requirements of the Act, the costs associated with the purchase of malpractice insurance must be included in the proposed budget. The search for malpractice insurance, if necessary, should begin as soon as possible. All applicants interested in FTCA will need to submit a new application annually. Applicants are encouraged to review the Federal Tort Claims Act (FTCA) Health Center Policy Manual available at http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin201101manual.pdf and contact 866-FTCA-HELP (866-382-2435) for additional information.

340B Drug Pricing Program
The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, codified as Section 340B of the Public Health Service Act, as amended (see http://www.hrsa.gov/opa/programrequirements/phsactsection340b.pdf). The program limits the cost of covered outpatient drugs for certain Federal grantees, FQHC Look-Alikes, and qualified disproportionate share hospitals. Covered entities may realize a cost savings of 20-50 percent on outpatient drug purchases and additional savings on other value-added services

through participation in the 340B Prime Vendor Program (PVP). Pharmacy related technical assistance is available at 866-PharmTA (866-742-7682). There is no cost to participate in the 340B program or the 340B Prime Vendor Program, and eligible entities are not required to have an established in-house pharmacy to participate. For additional information, please contact the Office of Pharmacy Affairs (OPA) at 800-628-6297 or visit the OPA Web site at http://www.hrsa.gov/opa/index.html.

IX. Tips for Writing a Strong Application

HRSA has designed a technical assistance Web site to assist applicants in preparing applications. Resources include help with system registration, finding and applying for funding opportunities, writing strong applications, understanding the review process, and many other topics which applicants will find relevant. The Web site can be accessed online at: http://www.hrsa.gov/grants/apply/index.html.

In addition, a concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at: http://dhhs.gov/asfr/ogapa/grantinformation/apptips.html.

Appendix A: Program Specific Forms Instructions

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

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

1. APPLICANT INFORMATION

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

2. PROPOSED SERVICE AREA

2a. Target Population and Service Area Designation

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

2b. Service Area Type

- Classify the proposed target population type as Urban, Rural, or Sparsely Populated. To be determined sparsely populated, the entire proposed service area must have seven or fewer people per square mile. Visit the Office of Rural Health Policy's Web site at http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html for information about rural populations.

2c. Target Population Information:

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

- Provide the number of individuals currently composing the service area and target populations.

When providing the count of patients and visits, note the following guidelines (see the 2011 UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics/reporting for detailed information):

- A visit is a documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services must be documented in the patient's record. Such contacts provided by contractors and paid for by the applicant are considered to be visits.
- A patient is an individual who had at least one visit in the previous year.
- Since a patient must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.
- Do not report patients and visits for services outside the organization's proposed scope of project. Specifically, the scope of project defines the service sites, services, providers, service area, and target population for which section 330 grant funds may be used. For more information, see PIN 2008-01 available at http://www.bphc.hrsa.gov/policy/pin0801/.
- Do not report patients and visits for vision services.

Patients and Visits by Service Type:

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

Unduplicated Patients and Visits by Population Type:

- Project the number of patients and visits anticipated within each population type category across all proposed NAP sites by the end of the two-year project period.
- Data reported for patients and visits should not be duplicated within or across the four target population categories (i.e., General Community, Migratory and Seasonal Agricultural Workers, Public Housing Residents, Homeless Persons). Note that Population Type in this table refers to the population being served, not the funding type (i.e., section 330(g), section 330(h), section 330(i)).
- The number of patients to be served at the end of the two-year project period will be used to calculate the Unserved, High Poverty Priority Points.

FORM 1B – BPHC FUNDING REQUEST SUMMARY (REQUIRED)

Form 1B collects the funding request for the NAP application. The maximum amount of funding in Year 1 is $650,000; any one-time funding requested for equipment or minor

alteration/renovation (up to $150,000) is included in this amount. Applicants can request up to $650,000 for operations in Year 2.

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

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

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

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

FORM 1C – DOCUMENTS ON FILE (REQUIRED)

Provide the date that each document listed was last reviewed and, if appropriate, revised. Form 1C provides a summary of documents that support the implementation of Health Center Program Requirements and key areas of health center operations. The requirement numbers listed on the form correspond to the list of Health Center Program requirements in Appendix F and found at http://bphc.hrsa.gov/about/requirements. Reference this list for more detailed information about each requirement.

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

Keep these documents on file, making them available to HRSA **upon request** within 3-5 business days. DO NOT submit these documents with the application. Please note that Form 1C is not

intended to provide an exhaustive list of all types of health center documents (e.g., policies and procedures, protocols, legal documents).

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

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

FORM 2 – STAFFING PROFILE (REQUIRED)

The Staffing Profile reports personnel salaries supported by the total budget for each year of the proposed project, including those that are part of an indirect cost rate. Include salaried staff for the entire scope of the NAP project. Anticipated staff changes within the proposed project period must be addressed in Item 4 of the *RESOURCES/CAPABILITIES* section of the Project Narrative.

- Salaries in categories representing multiple positions (e.g., LPN, RN) must be averaged. To calculate the average annual salary, sum the salaries within the category and divide that amount by the total number of FTEs.
- Report ONLY portions of salaries that support activities within the proposed NAP scope of project.
- Do not include contracted staff on this form.

The Staffing Profile should be consistent with the amounts for personnel costs included in the budget justification. However, the amount for total salaries (this figure will auto-calculate in EHB) may not match the amount allocated for the Personnel cost category of the SF-424A due to the inclusion of salaries charged to indirect costs on the Staffing Profile.

FORM 3 – INCOME ANALYSIS (REQUIRED)

Project the program income, by source, for each year of the proposed NAP project period by presenting the estimated non-Federal revenues **(all sources of income ASIDE FROM the section 330 grant funds)** for the requested budget (Year 1 and Year 2). Anticipated changes within the proposed project period must be addressed in the budget justification. Entries that require additional explanation (e.g., projections that include reimbursement for billable events that UDS does not count as visits) must be discussed in the Comments/Explanatory Notes box and, if necessary, detailed in the budget justification. Form 3 must be based ONLY on the proposed NAP project.

The two major classifications of revenues are as follows:

- **Program Income (Part 1)** includes fees, premiums, third party reimbursements, and payments generated from the projected delivery of services. Program income is divided

into Fee for Service and Capitated Managed Care. **All service-related income must be reported in this section of the form.**

- **Other Income (Part 2)** includes state, local, other Federal grants or contracts (e.g., Ryan White, HUD, Head Start), and local or private support that is not generated from charges for services delivered.

If the categories in the worksheet do not describe all possible categories of Program Income or Other Income (e.g., laboratory, imaging, pharmacy, other professional services), applicants may add lines for additional income sources. Explanations for such additions must be noted in the Comments/Explanatory Notes box.

Note: *Not all visits reported on this form are reported in UDS, and similarly, not all visits reported in UDS are included on this form. This form reports only visits that are billable to first or third parties, including individuals who, after the sliding fee discount schedule, may pay little or none of the actual charge. (See Column (a) instructions below for additional details.)*

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

PART 1: PROGRAM INCOME

All service-related income must be reported in this section of the form.

Projected Fee For Service Income

Lines 1a.-1e. and 2a.-2b. (Medicaid and Medicare): Show income from Medicaid and Medicare *regardless of whether there is another intermediary involved*. For example, if the applicant has a Blue Cross fee-for-service managed Medicaid contract, the information would be included on lines 1a.-1e., not on lines 3a.-3d. If CHIP is paid through Medicaid, it must be included in the appropriate category on lines 1a-1e. In addition, if the applicant receives Medicaid reimbursement via a Primary Care Case Management (PCCM) model, this income must be included on line 1e.—Medicaid: Other Fee for Service.

Line 5 (Other Public): Include CHIP **not** paid through Medicaid as well as any other state or local programs that pay for visits (e.g., Title X family planning visits, CDC's Breast and Cervical Cancer Early Detection Program, Title I and II Ryan White visits).

Column (a): Enter the number of billable visits that will be covered by each category and payment source: Medicaid, Medicare, other third-party payors, and uninsured self-pay patients. **Do not calculate visits for laboratory, imaging, pharmacy, or other professional services.**

Column (b): Enter the average charge per visit by payor category. An analysis of charges will generally reveal different average charges (e.g., average Medicare charges may be higher than average Medicaid Early and Periodic Screening, Diagnostic, and Treatment

(EPSDT) charges). If this level of detail is not available, calculate averages on a more general level (i.e., at the payor, service type, or agency level).

Column (c): Enter Gross Charges before any discount or allowance for each payment category calculated as [columns (a)*(b)].

Column (d): Enter the adjustment rate (percentage) to the average charge per visit listed in column (b). In actual operation, adjustments may be taken either before or after the bill is submitted to a first or third party. Adjustments reported here do NOT include adjustments for bad debts which are shown in columns (f) and (g). Adjustments in column (d) include those related to:

1. Projected contractual allowances or discounts to the average charge per visit.
2. Sliding discounts given to self-pay patients (with incomes 0-200% of the FPL).
3. Adjustments to bring the average charge/reimbursement up or down to the:
    a. Negotiated Federally Qualified Health Center (FQHC) reimbursement rate
    b. Established Prospective Payment System reimbursement rate
    c. Cost based reimbursement expected <u>after</u> completion of a cost reimbursement report
4. Any other applicable adjustments. These must be discussed in the Comments/Explanatory Notes box.

Note: An adjustment rate that has the effect of increasing charges is expressed as a negative.

Column (e): Enter the total Net Charges by payment source calculated as [column (c)*(100 - column (d))]. Net charges are gross charges less adjustments described in column (d).

Column (f): Enter the estimated collection rate by payor category. The collection rate is the amount projected to be collected divided by the net charges. As a rule, collection rates will not exceed 100%, and may be less than 100% due to factors such as bad debts (especially for self pay), billing errors, or denied claims not re-billable to another source. Explain any rate greater than 100% using the Comments/Explanatory Notes box.
Note: Do not show sliding discount percentages here; they are included in column (d). Show the collection rate for actual direct patient billings.

Column (g): Enter Projected Income for each payor category calculated as [columns (e)*(f)].

<u>Projected Capitated Managed Care Income</u>
This section applies only to capitated programs. Visits provided under a fee-for-service managed care contract are included in the fee-for-service section of this form.

Lines 7a.-7d. (Type of Payor): Group all capitated managed care income types of service by payor on a single line. Thus, capitated Medicaid dental visits and capitated Medicaid medical visits are added together and reported on line 7a.

Number of Member Months (Column a): The number of member months for which payment is received. One person enrolled for one month is one member month; a family of five enrolled for six months is 30 member months. A member month may cover just medical

services, or medical and dental, or a unique mix of services. Unusual service mixes that provide for unusually high or low per member per month (PMPM) payments must be described in the Comments/Explanatory Notes box.

Rate per Member Month (Column b): Also referred to as PMPM rate, this is the average payment across all managed care contracts for one member. PMPM rates may be based on multiple age/gender specific rates or on service specific plans, but all these must be averaged together for a "blended rate" for the provider type.

Risk Pool and Other Adjustments (Column c): This is an *estimate* of the *total* amount that will be earned from risk or performance pools, including any payment made by a Health Maintenance Organization (HMO) to the applicant for effectively and efficiently managing the health care of enrolled members. The estimate is usually for a prior period, but must be accounted for in the period it is received. Describe risk pools and other adjustments in the Comments/Explanatory Notes box. Risk pools may be estimated using the average risk pool receipt PMPM over an appropriate prior period selected by the applicant.

FQHC Cost Settlement and Wrap Adjustments (Column d): This is the *total* amount of payments made to the applicant to cover the difference between the PMPM amount paid for Medicaid or Medicare managed care visits and the applicant's PPS/FQHC rate.

Projected Gross Income (Column e): Calculate this for each line as [columns (a)*(b)] + [columns (c)+(d)] = column (e).

PART 2: OTHER INCOME

This section includes **all non-section 330 income not entered elsewhere** on this form. It includes grants for services, construction, equipment, or other activities that support the project, where the revenue is **not** generated from services provided or visit charges. It also includes income generated from fundraising and contributions.

Line 10: Enter the amount of funds applied from the applicant's retained earnings, reserves, and/or assets needed to achieve a breakeven budget. Please explain the reason for and source of amounts entered on this line in the Comments/Explanatory Notes box.

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

FORM 4 – COMMUNITY CHARACTERISTICS (REQUIRED)

Report service area and target population data for the entire scope of the project (i.e., all proposed NAP sites) for which data are available. Information provided regarding race and ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements.

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

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

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

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

Guidelines for Reporting Race

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

- Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
- Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, Palau, Chuuk, Yap, or other Pacific Islands in Micronesia, Melanesia, or Polynesia.
- Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- American Indian/Alaska Native – Persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- More Than One Race – Persons who identify with two or more races.

Guidelines for Reporting Hispanic or Latino Identity

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

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

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

FORM 5A – SERVICES PROVIDED (REQUIRED)
Identify the services that will be available through the proposed new access point(s) and how the services will be provided (i.e., Applicant, Formal Written Contract/Agreement (Applicant Pays for Service), Formal Written Referral Arrangement/Agreement). The new access point(s) must provide the required services either directly onsite or through established agreements/arrangements without regard to ability to pay and on a sliding fee discount schedule. Established agreements must be summarized in Attachment 7 and, if they constitute a significant portion of the applicants scope of project, agreements/contracts must be noted on Form 8.

Information presented on Form 5A will be used by HRSA to determine the scope of project for the NAP grant. Only the services included on Form 5A will be considered to be in the approved scope of project. Services described or detailed in other portions of the application (e.g., narratives, attachments) are not considered to be included in the approved scope of project if the application is funded.

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

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

NOTE: At least one proposed service site must be a full-time (operational 40 hours or more per week), permanent service delivery site (with the exception of proposed NAP projects serving only migratory and seasonal agricultural workers, which may propose a full-time, seasonal service delivery site). Subsequent service sites may be administrative, part-time, seasonal, etc.

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

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

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

FORM 6A – CURRENT BOARD MEMBER CHARACTERISTICS (REQUIRED)
List all current board members and provide the requested details.

- Public entities with co-applicant health center governing boards must list the co-applicant board members.
- Applicants requesting a waiver of the 51% patient majority requirement must list the health center's board members, not the members of any advisory councils.
- List the current board office held for each board member, if applicable (e.g., Chair, Treasurer).
- List each board member's area of expertise (e.g., finance, education, nursing).
- Indicate if each board member is a health center patient.
- Indicate if each board member lives and/or works in the service area.
- List how long each individual has been on the board.
- Indicate if each board member is a representative of a special population (i.e., homeless, agricultural, public housing).

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

FORM 6B – REQUEST FOR WAIVER OF GOVERNANCE REQUIREMENTS
Only applicants requesting funding to ***ONLY*** serve migratory and seasonal agricultural workers (section 330(g)), people experiencing homelessness (section 330 (h)), and/or residents of public housing (section 330(i)) are eligible to request a waiver.

- An applicant that currently receives or is applying to receive CHC (section 330(e)) funding is not eligible for a waiver. Form 6B will not permit the applicant to enter information on this form.
- Indian tribes or tribal, Indian, or urban Indian groups are not required to complete this form. Form 6B will not permit the applicant to enter information on this form.
- Current health center program grantees with an existing waiver must reapply for governance waiver approval as part of the NAP application.

Eligible applicants may request a waiver of the patient majority board composition and/or board monthly meetings. When completing Form 6B, applicants requesting a waiver must briefly justify why the applicant cannot meet the statutory requirements requested to be waived and summarize the alternative strategies that will assure consumer/patient participation/input (if board is not 51 percent consumers/patients) and/or regular oversight in the direction and ongoing governance of the organization (if no monthly meetings). The text boxes are limited to 500 characters in this section.

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

Complete the Governance Checklist. If the response to any of the Governance Checklist items is **No**, the response to the question regarding agreements/arrangements affecting the governing board's composition, authorities, functions, or responsibilities must be **Yes**, and the number of such agreements/arrangements must be indicated. Additionally, **No** responses for the Governance Checklist must be explained in Item 2 of the *RESOURCES/CAPABILITIES* section of the Project Narrative.

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

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

FORM 9 – NEED FOR ASSISTANCE (NFA) WORKSHEET (REQUIRED)
The worksheet is presented in three sections: Core Barriers, Core Health Indicators, and Other Health and Access Indicators.

Please note that the following changes have been made to the worksheet since the FY 2011 NAP FOA:

- Core Barrier, "Percent of Population below 200 Percent Federal Poverty Level (FPL)": Applicants are required to report the percentage of the **service area** population below 200 percent of the FPL. Only applicants applying to serve special populations exclusively (MHC, HCH, and/or PHPC) may use this barrier to report the percentage of the target population in poverty. See the Data Reporting Guidelines Table for additional clarification.

- Core Barrier, "Percent of Population Uninsured": Applicants are required to report the percentage of the **service area** population that is uninsured. Only applicants applying to serve special populations exclusively (MHC, HCH, and/or PHPC) may use this barrier to report the percentage of the target population that is uninsured. See the Data Reporting Guidelines Table for additional clarification.

- The scaling of the core barriers has been changed so that points are awarded only for indicators for which the applicant scores higher than the national median.

- Indicators in Section 2: "Core Health Indicators" and Section 3: "Other Health and Access Indicators" have been added, removed, or modified to include the most current indicators for which data are readily available at the sub-state level. In addition, corresponding benchmarks for each indicator have been updated.

To ensure data consistency and validity, applicants must adhere to the following instructions when completing the form. Applicants will be asked to verify the validity of NFA data on the Forms Summary Page.

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

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

If an applicant proposes **multiple sites, populations, and/or service areas**, the NFA Worksheet responses should represent the total combined population for all sites. Data values for different sites/populations/service areas should be combined using population weighting described below and in the Data Resource Guide located at http://www.hrsa.gov/grants/apply/assistance/NAP. **Only one response may be submitted for each barrier or health indicator.**

Guidelines for Completing the NFA Worksheet:

- If no response is provided for a particular barrier or health indicator, or if the data source and date for the response are not provided, no points will be awarded for that barrier or health indicator.
- All responses must be expressed as a finite number (e.g., 212.5) and cannot be presented as a range (e.g., 31-35).
- The data sources used should be those identified in the Data Resource Guide. Alternative sources must have the same parameters for each indicator as the source in the Data Resource Guide. For example, any source used for diabetes prevalence must provide age-adjusted rates. See the Data Resource Guide for more information.
- Responses to all indicators must be expressed in the same format/unit of analysis identified on the worksheet (e.g., a mortality ratio cannot be used to provide a response to age-adjusted death rate). The following table provides examples of the unit and format of responses:

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

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

POPULATION BASIS FOR DATA

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

Data Reporting Guidelines Table

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

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

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

Extrapolation

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

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

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

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

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

Scenario 2: Extrapolation to a Target Population from the Service Area population

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

Scenario 3: Extrapolation to a Service Area and Target Population from the total population in a larger area

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

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

DATA RESPONSE AND SOURCES

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

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

(b) Applicants must provide the following information:

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

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

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

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

SECTION 1: CORE BARRIERS (Maximum 60 points)
A response is required for **3 of the 4 Core Barriers**. The points awarded for each Barrier response will be calculated using the point distributions provided below.

a. Population to One FTE Primary Care Physician

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

b. Percent of Population Below 200 Percent of Poverty[11].

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

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

c. Percent of Population Uninsured[12]

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

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

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

SECTION 2: CORE HEALTH INDICATORS (Maximum 30 points)

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

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

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

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

SECTION 2: CORE HEALTH INDICATOR CATEGORIES	**National Median Benchmark (4 Points if Exceeded)**	**Severe Benchmark (1 Additional Point if Exceeded)**
1. Diabetes		
1(a) Age-adjusted diabetes prevalence	8.1%	9.2%
1(b) Adult obesity prevalence	27.6%	30.2%
1(c) Age-adjusted diabetes mortality[13] rate (per 100,000)	22.5	24.8
1(d) Percent of diabetic Medicare enrollees not receiving a hemoglobin A1c (HbA1c) test	18.0%	20.4%
1(e) Percent of adults (18 years and older) with no physical activity in the past month	24.0%	26.6%
1(f) Other	*Provided by Applicant*	*N/A*
2. Cardiovascular Disease		
2(a) Hypertension hospital admission rate (18 years and older; per 100,000)	61.4	66.3
2(b) Congestive heart failure hospital admission rate (18 years and older; per 100,000)	361.7	378.3
2(c) Age-adjusted mortality from diseases of the heart[14] (per 100,000)	179.4	203.2
2(d) Proportion of adults reporting diagnosis of high blood pressure	28.7%	31.4%
2(e) Percent of adults who have not had their blood cholesterol checked within the last 5 years	23.1%	25.7%
2(f) Age-adjusted cerebrovascular disease mortality (per 100,000)	41.4	46.3
2(g) Other	*Provided by Applicant*	*N/A*
3. Cancer		
3(a) Cancer screening – percent of women 18 years and older with no Pap test in past 3 years	18.4%	20.1%
3(b) Cancer screening – percent of women 50 years and older with no mammogram in past 2 years	22.2%	25.8%
3(c) Cancer screening – percent of adults 50 years and older with no fecal occult blood test (FOBT) within the past 2 years	83.3%	85.0%

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

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

[15] 4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B, 1 varicella, and 4 Pneumococcal conjugate.

SECTION 3: OTHER HEALTH AND ACCESS INDICATORS (Maximum 10 points)
Applicants must provide responses to **2 of the 13** Other Health and Access Indicators. Applicants will receive 5 points for each response that **exceeds** the corresponding national median benchmark provided in the table below.

OTHER HEALTH AND ACCESS INDICATORS	National Median Benchmark (5 Points if Exceeded)
(a) Age-adjusted death rate (per 100,000)	764.8
(b) HIV infection prevalence	0.2%
(c) Percent elderly (65 and older)	15.2%
(d) Adult asthma hospital admission rate (18 years and older; per 100,000)	130.7
(e) Chronic Obstructive Pulmonary Disease hospital admission rate (18 years and older; per 100,000)	227.2
(f) Influenza and pneumonia death[16] rate (3 year average; per 100,000)	18.6
(g) Adult current asthma prevalence	9.0%
(h) Age-adjusted unintentional injury deaths (per 100,000)	40.0
(i) Percent of population linguistically isolated (people 5 years and over who speak a language other than English at home)	10.3%
(j) Percent of adults (18+ years old) that could not see a doctor in the past year due to cost	13.4%
(k) Percentage of adults 65 years and older who have not had a flu shot in the past year	32.6%
(l) Chlamydia (sexually transmitted infection) rate (per 100,000)	389.5
(m) Percent of adults without a visit to a dentist or dental clinic in the past year for any reason	30.4%

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

CONVERSION OF NFA WORKSHEET SCORE TO APPLICATION SCORE

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

NFA WORKSHEET TO APPLICATION SCORE CONVERSION TABLE

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

FORM 10 – ANNUAL EMERGENCY PREPAREDNESS REPORT (REQUIRED)

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

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

SUMMARY PAGE – (REQUIRED)
This form will enable applicants to verify key application data utilized by HRSA when reviewing the NAP applications. Content will be pre-populated from the Program Specific Forms. If the pre-populated data appear incorrect, verify that the pertinent data provided in the Program Specific Forms (1A, 1B, 2, and 5B) have been entered correctly. Reference will be provided regarding where to make corrections if needed.

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

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

Appendix B: Program Specific Information Instructions

CLINICAL AND FINANCIAL PERFORMANCE MEASURES

The Clinical and Financial Performance Measures set the clinical and financial goals for the two-year project period (enter 9/1/2013 – 8/31/2015). The goals and performance measures should be responsive to the proposed target population, identified community health and organizational needs, and key service delivery activities discussed in the project narrative. For more information on the Clinical and Financial Performance Measures, see http://www.hrsa.gov/grants/apply/assistance/nap and http://bphc.hrsa.gov/policiesregulations/performancemeasures/.

Important Details about the Performance Measures Forms

- Applicants ***must include*** one **behavioral health** (e.g., mental health/substance abuse screening, treatment, or referral) and one **oral health** (e.g., screenings and exams, referrals, dental caries) Clinical Performance Measure of their choice.

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

- If applicants have identified unique health issues or described populations/life cycles targeted for services in the ***NEED*** section of the project narrative, they are encouraged to include additional related performance measures.

The Clinical and Financial Performance Measures should address ONLY the service area and target population of the proposed new access point(s).

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

Special Instructions for the Clinical Performance Measures

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

- Report adult patients with HbA1c levels ≤ 9 percent in the Baseline Data (numerator and denominator subfields) and Projected Data fields.
- If desired, report the additional measurement thresholds (i.e., < 7 percent, < 8 percent, > 9 percent) in the Comments field.

The **Child Health Performance Measure** includes the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 2 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumococcal conjugate vaccines.

Overview of the Performance Measures Form Fields

Table 8: Overview of Measures Form Fields

Field Name	Notes
Focus Area	This field contains the content area description for each required performance measure. Applicants must specify focus areas for Oral Health and Behavioral Health measures and when adding non-required Other performance measures.
Performance Measure	This field defines each performance measure. Applicants may specify this field for Oral Health, Behavioral Health, and Other performance measures.
Performance Measure Applicability	The Prenatal Health and Perinatal Health Clinical Performance Measures can be marked Not Applicable by applicants who do not provide or pay for such services (those who have selected only the third column on Form 5A for these services). Such designation requires justification in the Comments field regarding referral and tracking practices. Audit-related Financial Performance Measures (Change in Net Assets to Expense Ratio, Working Capital to Monthly Expense Ratio, and Long Term Debt to Equity Ratio) may be marked *Not Applicable* ONLY by tribal and public center applicants. As desired, these applicants may choose to include substitute measures.
Target Goal Description	This field provides a description of the target goal. Applicants must specify this field for all measures.
Numerator Description	In the case of the Clinical Performance Measures, the numerator is the number of patients that meet the criteria identified by the measure (e.g., patients in a specified age range that received a specified service). In the Financial Performance Measures, the numerator field must be specific to the organizational measure. Applicants must specify a numerator for Oral Health, Behavioral Health, and Other performance measures. The numerator for all other measures can be found at http://bphc.hrsa.gov/policiesregulations/performancemeasures.
Denominator Description	In the case of the Clinical Performance Measures, the denominator is all patients to whom the measure applies (e.g., patients in a specified age range, regardless of whether they received a specified service). In the Financial Performance Measures, the denominator field must be specific to the organizational measure. Applicants must specify a denominator for Oral Health, Behavioral Health, and Other performance measures. The denominator for all other measures can be found at http://bphc.hrsa.gov/policiesregulations/performancemeasures.
Baseline Data Baseline Year Measure Type Numerator Denominator	This field contains subfields that provide information regarding the initial threshold used to measure progress over the course of the 2-year project period. The Baseline Year subfield identifies the initial data reference point. The Measure Type subfield provides the unit of measure (e.g., percentage, ratio). The Numerator and Denominator subfields specify patient or organizational characteristics (see above).
Projected Data	This field provides the goal for the end of the 2-year project period.
Data Source and Methodology	This field provides information about the data sources used to develop the performance measures. Applicants are required to identify data sources and discuss the methodology used to collect and analyze data (e.g., electronic

Field Name	Notes
	health records (EHR), disease registries). Data must be valid, reliable, and derived from established management information systems. For Clinical Performance Measures, applicants must select the data source—EHR, Chart Audit, or Other (please specify)—before describing the methodology. For Financial Performance Measures, note if data are based on the most recent audit.
Key Factors and Major Planned Actions Key Factor Type Key Factor Description Major Planned Action Description	The Key Factor Type subfield requires applicants to select Contributing and/or Restricting factor categories. Contributing factors are those that are predicted to positively impact goal attainment, while restricting factors are those predicted to negatively impact goal attainment. Applicants must specify at least one key factor of each type. In the Key Factor Description subfield, applicants provide a narrative description of the factors predicted to contribute to and restrict progress toward stated goals. In the Major Planned Action Description subfield, applicants provide a description of the major actions planned for addressing the identified key factors. Applicants must use this subfield to outline major action steps and strategies for achieving each performance measure. This field has a 1,000-character limit.
Comments	This open text field, limited to 1,000 characters, enables applicants to provide additional information. Information exceeding the character limit should be placed in the *EVALUATIVE MEASURES* section of the Project Narrative.

Resources for the Development of Performance Measures

- Examine the performance measures of other health centers that serve similar target populations.
- Consider state and national performance UDS benchmarks and comparison reports (available http://www.hrsa.gov/data-statistics/health-center-data/reporting).
- Use the Healthy People 2020 goals as a guide when developing performance measures. Healthy People 2020 objectives are available at http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf. Several of these objectives can be compared directly to UDS clinical performance measures (high blood pressure under control, diabetes HbA1c readings less than or equal to nine, pap test performance rate, low birth weight infants, access to prenatal care in the first trimester, childhood immunization, tobacco use assessment, and tobacco cessation counseling). A table outlining the Healthy People 2020 objectives related to these performance measures can be found at http://www.hrsa.gov/grants/apply/assistance/nap.

Appendix C: Implementation Plan

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

In the Implementation Plan, outline goals and action steps necessary to ensure that within 120 days of the Notice of Award, all proposed site(s) will:

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

The Implementation Plan must be specific to the proposed NAP project. Applicants may choose from the following list of focus areas and goals within each area, or may include other goals as desired. The Implementation Plan will be reviewed in conjunction with the Project Narrative, Program Specific Forms, and required attachments to evaluate the application.

Focus Area: Operational Service Delivery Program

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

Focus Area: Functioning Key Management Staff/Systems/Arrangements

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

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

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

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

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

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

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

Focus Area: Governing Board

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

Key Elements of the Project Work Plan

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

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

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

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

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

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

Appendix D: One-Time Funding Request Information

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

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

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

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

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

Requests for equipment-only projects or minor alteration/renovation with moveable equipment are required to submit an equipment list. Applicants requesting one-time funding for minor alteration/renovation (with or without moveable equipment) must complete additional forms in EHB. After completing Form 5B, which collects information about the new access point site, applicants will indicate whether one-time funding will be used for alteration/renovation at that site. If yes, applicants must complete the Alteration/Renovation (A/R) Project Cover Page and Other Requirements for Sites forms and attach the A/R project information, as specified below and in Table 6.

Equipment List

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

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

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

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

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

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

Minor Alteration/Renovation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Following the review of the EID Checklist and the project proposal, HRSA will determine if the potential exists for the project to have a significant impact on the environment. If HRSA determines additional reviews or compliance requirements are necessary, HRSA will contact the applicant and require documentation such as a hazardous materials survey, abatement plans, or

initiating Section 106 consultation. It is advised that if the applicant does not possess in-house expertise in environmental and historic preservation compliance, that the services of a consultant with the appropriate background be secured.

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

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

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

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

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

2. Cultural Resource Assessment and Historic Preservation Considerations
Applicants are required to respond to the following questions by indicating yes or no:

2a. Was the project facility constructed prior to 1975?
2b. Is the project facility 50 years or older?
2c. Does any element of the overall work at the project site include: 1) any renovation/modification to the exterior of the facility (e.g., roof, HVAC, windows, siding, signage, exterior painting, generators) or 2) ground disturbance activity (e.g., expansion of building footprint, parking lot, sidewalks, utilities)?

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

Landlord Letter of Consent

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

Appendix E: Budget Presentation Instructions

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

STANDARD FORM 424A
Complete Sections A, B, D, E, and F (if F is applicable) of the SF-424A: Budget Information – Non-Construction Programs. The budget must be entered separately for each type of Health Center Program (CHC, MHC, HCH, and/or PHPC). The budget must clearly indicate the cost for each program and must provide detailed information on the first **12-month period**. The maximum amount that may be requested in each year cannot exceed $650,000.

Use the following guidelines to complete the SF-424A. Budget amounts must be rounded to the nearest whole dollar. In addition, please review the sample SF-424A located in this appendix.

Section A – Budget Summary
Under New or Revised Budget, provide the proposed budget (Federal and non-Federal) for the first 12-month budget period broken down by each section 330 program for which funding is requested (CHC, MHC, HCH, and/or PHPC). The Federal amount refers to only the Federal section 330 grant funding requested, not all Federal grant funding that an applicant receives. Provide non-Federal Resources by funding source. Program Income must be consistent with the Total Program Income presented in Form 3: Income Analysis. If the applicant is a state agency, state funding should be included in the applicant field. As a reminder, matching funds are not required for this grant program.

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

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

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

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

BUDGET JUSTIFICATION
A detailed budget justification in line-item format must be provided for **each 12-month period** of the two-year project period. For the second budget year, the justification narrative should highlight the changes from Year 1, including the projected impact of ACA implementation with respect to increased insurance coverage.

Attach the budget justification in the Budget Narrative Attachment Form section in EHB. Please be aware that Excel or other spreadsheet documents with multiple pages (sheets) may not print out in their entirety. The budget justification must be concise and should not be used to expand the Project Narrative.

The budget justification must detail the costs of each line item within each object class category from the SF-424A. It is important to **ensure that the budget justification contains detailed calculations explaining how each line-item expense is derived** (e.g., number of visits, cost per unit). Refer to the HHS Grants Policy Statement available at http://www.hrsa.gov/grants for information on allowable costs. If there are budget items for which costs are shared with other programs (e.g., other HRSA programs), the basis for the allocation of costs between the programs must be explained.

Include the following in the budget justification:

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

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

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

Equipment: Identify the cost per item and justify the need for each piece of equipment to carry out the proposed project. Equipment includes moveable items that are non-expendable, tangible personal property having a useful life of more than 1 year and an acquisition cost that equals or exceeds the lesser of (a) the capitalization level established by the applicant for its financial statement purposes, or (b) $5,000. Furniture, administrative equipment (i.e., computers, servers, telephones, fax machines, copying machines, software) and special purpose equipment used for medical activities (e.g., stethoscopes, blood pressure monitors, scales, electronic thermometers) with a useful life of one year or greater and a unit cost of less than $5,000 may also be included. See Appendix D for information on one-time funding for equipment-only projects or minor alteration/renovation projects with equipment.

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

Contractual: Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. List both patient care (e.g., laboratory) and non-patient care (e.g., janitorial) contracts. Each applicant is responsible for ensuring that its organization/institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring contracts. Reminder: Recipients must notify potential sub-recipients that entities receiving subawards must be registered in SAM and provide the recipient with their DUNS number.

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

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

Indirect Charges: Costs incurred for common or joint objectives that cannot be readily identified but are necessary to organizational operation (e.g., facility operation and maintenance, depreciation, administrative salaries). If an organization does not have an indirect cost rate, the applicant may wish to obtain one through the HHS Division of Cost Allocation (DCA). Visit http://rates.psc.gov to learn more about rate agreements, including the process for applying for them.

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

SAMPLE SF-424A FOR NEW ACCESS POINTS (First Page Only)

BUDGET INFORMATION – Non-Construction Programs

SECTION A – BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Fed Domestic Assist No. (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. **Community Health Centers - 330(e)**	93.224			$325,000	$599,486	$924,486
2. **Health Care for the Homeless - 330(h)**	93.224			$325,000	$452,704	$777,704
3.						
4.						
5. TOTALS				$650,000	$1,052,190	$1,702,190

SECTION B - BUDGET CATEGORIES

6. Object Class Category	Grant Program Function or Activity					Total (5)
	(1) **Community**	(2) **Homeless**				
a. Personnel	$504,580	$437,060				$941,640
b. Fringe Benefits	$108,424	$93,842				$202,266
c. Travel	$9,276	$7,924				$17,200
d. Equipment	$20,000	$50,000				$70,000
e. Supplies	$67,374	$50,728				$118,102
f. Contractual	$47,169	$50,000				$97,169
g. Construction	$80,000	$0				$80,000
h. Other	$87,663	$88,150				$175,813
i. Total Direct Charges (sum of 6a-6h)	$924,486	$777,704				$1,702,190
j. Indirect Charges	$0	$0				$0
k. TOTALS (sum of 6i and 6j)	$924,486	$777,704				$1,702,190
7. Program Income						$1,052,190

Standard Form 424A (7-97)
Prescribed by OMB Circular A-102

Appendix F: Health Center Program Requirements

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

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

	NEED
1.	**Needs Assessment:** Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)
	SERVICES
2.	**Required and Additional Services:** Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. (Section 330(a) of the PHS Act) **Note:** Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services (Section 330(h)(2) of the PHS Act)
3.	**Staffing Requirement:** Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed and privileged. (Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act)
4.	**Accessible Hours of Operation/Locations:** Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. (Section 330(k)(3)(A) of the PHS Act)
5.	**After Hours Coverage:** Health center provides professional coverage for medical emergencies during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act and 42 CFR Part 51c.102(h)(4))
6.	**Hospital Admitting Privileges and Continuum of Care:** Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. (Section 330(k)(3)(L) of the PHS Act)
7.	**Sliding Fee Discounts:** Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. • This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.* • No discounts may be provided to patients with incomes over 200 % of the Federal poverty guidelines.* • No patient will be denied health care services due to an individual's inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived. (Section 330(k)(3)(G) of the PHS Act, 42 CFR Part 51c.303(f)), and 42 CFR Part 51c.303(u))
8.	

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

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