



FQHC LOOK-ALIKE PROGRAM UPDATE

DATE: October 4, 2011

DOCUMENT TITLE: Federally Qualified Health Center Look-Alike Application Instructions for Calendar Year 2011/2012

TO: Federally Qualified Health Center Look-Alikes
Health Center Program Grantees
Primary Care Associations
Primary Care Organizations
National Cooperative Agreements

The Health Resources and Services Administration (HRSA) is committed to improving the health of underserved communities and vulnerable populations. The Federally Qualified Health Center (FQHC) Look-Alike Program maintains a critical role in supporting the delivery of comprehensive, culturally competent, quality primary health care services to low-income, underserved, and special populations.

In an effort to further strengthen the administration of the FQHC Look-Alike Program, HRSA is making changes to the requirements for securing and maintaining FQHC Look-Alike designation. Enclosed are the revised application instructions for the FQHC Look-Alike Program. This document supersedes Policy Information Notice (PIN) 2009-06, "Federally Qualified Health Center Look-Alike Guidelines and Application," dated September 22, 2009 and all corresponding amendments to PIN 2009-06, including PIN 2009-07, "Amendment to PIN 2009-06, Federally Qualified Health Center (FQHC) Look-Alike Guidelines and Application."

- **Effective Date for Calendar Year 2011/2012 Applications:** All applications submitted on or after October 3, 2011 are required to use the application instructions contained herein.
- **Application Submission Process:** Beginning October 3, 2011 all FQHC Look-Alike applications must be submitted electronically via HRSA's Electronic Handbooks (EHB).
- **Technical Assistance:** HRSA is committed to providing technical assistance in the preparation of applications. Organizations that seek technical assistance in preparing an FQHC Look-Alike application may submit questions in writing to HRSA's Bureau of Primary Health Care, Office of Policy and Program Development (OPPD) at FQHCLAL@hrsa.gov. Organizations may also contact OPPD at 301-594-4300 and their State Primary Care

Association (PCA) and/or Primary Care Office (PCO) for assistance in developing an application. Contact information for the State PCAs and PCOs are available on HRSA's Web site at <http://bphc.hrsa.gov/technicalassistance/>.

Questions regarding the FQHC Look-Alike Program should be directed to OPPD at 301-594-4300 or FQHCLAL@hrsa.gov.

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Attachments

Federally Qualified Health Center
Look-Alike Application Instructions
for Calendar Year 2011/2012



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I. PROGRAM DESCRIPTION AND GENERAL INFORMATION

This document provides information about the Federally Qualified Health Center (FQHC) Look-Alike Program, including an overview of program requirements and instructions for submitting applications for FQHC Look-Alike Initial Designation, Renewal of Designation, and Annual Certification.

A. Background

The Health Resources and Services Administration (HRSA) administers the FQHC Look-Alike Program. FQHC Look-Alikes improve the health of underserved communities and vulnerable populations by maintaining, expanding, and improving the availability and accessibility of essential high quality primary and preventive health care services, including oral health, mental health and substance abuse services. These services are provided to low income, medically underserved and vulnerable populations that have limited access to affordable services and face the greatest barriers to care. FQHC Look-Alikes provide a comprehensive system of care that is responsive to the community's identified health care needs and provide services to all persons residing in the health center's service area regardless of ability to pay.

In order to maximize access to care for the underserved populations and communities, the FQHC Look-Alike Program was established for entities that do not receive funding under section 330 of the Public Health Service (PHS) Act, but operate and provide services consistent with grant-funded programs. As such, FQHC Look-Alikes are expected to demonstrate a commitment to provide access to services for all populations residing in their respective medically underserved communities regardless of their ability to pay and they must meet all statutory, regulatory, and policy requirements that apply to section 330-funded health centers including: Community Health Center (CHC) (section 330(e)), Migrant Health Center (MHC) (section 330(g)), Health Care for the Homeless (HCH) (section 330(h)), and Public Housing Primary Care (PHPC) (section 330(i)) authorized under the PHS Act, as amended. For the purposes of this document, the term "health center" refers to the diverse types of health centers (i.e., CHC, MHC, HCH, and PHPC).

B. Legislative Authority

The Omnibus Budget Reconciliation Acts (OBRA) of 1989, 1990, and 1993 amended section 1905 of the Social Security Act (SSA) to create and define a category of facilities under Medicare and Medicaid known as FQHCs. One of the definitions of an FQHC as set forth in section 1861(aa)(4) and section 1905(l)(2)(B) of the SSA is an entity, which is determined by the delegated HHS authority to meet the requirements of the grant program authorized by section 330 of the Public Health Service (PHS) Act (the Health Center Program, 42 U.S.C. 254b), but does not receive a grant under section 330 of the PHS Act. This category of health centers has been labeled, "FQHC Look-Alikes." FQHC Look-Alikes do not receive section 330 grant funding; however, the FQHC designation authorizes eligibility for benefits such as (1) Medicaid and Medicare FQHC reimbursement; (2) participation in the 340B Federal Drug Pricing Program; and (3) automatic Health Professional Shortage Area (HPSA) designation. FQHC Look-Alikes are not eligible for Federal Tort Claims Act medical malpractice liability insurance coverage.

The Balanced Budget Act (BBA) of 1997 (P.L. 105-33) modified the definition under section 1905 of the SSA for an FQHC Look-Alike by adding the requirement that the “entity may not be owned, controlled or operated by another entity.” HRSA, in collaboration with the Centers for Medicare and Medicaid Services (CMS), issued PIN 1999-09, “Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Public Entities,” issued April 20, 1999, and PIN 1999-10, “Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Private Nonprofit Entities,” issued April 20, 1999, to implement the BBA requirements for public agencies and private nonprofit organizations. These documents describe the statutory limits on the involvement of “another entity” in the ownership, control and/or operation of a public or private nonprofit FQHC Look-Alike. Organizations are encouraged to work closely with HRSA if there are questions about the application of these policies.

C. Benefits of FQHC Look-Alike Designation

FQHC Look-Alikes are eligible to receive a number of benefits to support activities included in the approved scope of project, which defines five core elements of the FQHC Look-Alike including sites, services, providers, service area(s), and target population.¹ FQHC Look-Alikes are eligible for the following benefits:

- (a) Purchase of discounted drugs under the section 340B Federal Drug Pricing Program;
- (b) Cost-based reimbursement for services provided under Medicare;
- (c) Reimbursement under the Prospective Payment System (PPS) or other State-approved Alternative Payment Methodology (APM) for services provided under Medicaid (see HRSA Program Assistance Letter 2001-09 and section 1902(bb) of the SSA); and
- (d) Automatic HPSA Designation and access to National Health Service Corps providers.

It is important to note that the benefits of FQHC Look-Alike designation apply only to activities that are included in the approved scope of project. An FQHC Look-Alike’s approved scope of project may be part of a larger health care delivery system with other lines of business (e.g., day care center) that are not subject to section 330 requirements and, therefore, are not eligible for any FQHC Look-Alike benefits. Services that are within the approved scope of project but are not covered as an FQHC service by Medicaid or Medicare are not eligible for PPS or cost-based reimbursement.

¹ Refer to Policy Information Notice 2008-01, “Defining Scope of Project and Policy for Requesting Changes” available at <http://www.bphc.hrsa.gov/policiesregulations/policies/pin200801.html> which defines the scope of project.

II. ELIGIBILITY AND PROGRAM REQUIREMENTS

A. Eligibility Requirements

Organizations must meet the following eligibility requirements at the time the application is submitted for FQHC Look-Alike designation. Organizations that do not meet these requirements will be notified that the application is ineligible and offered the opportunity to submit a new application when the requirements are met. In order to be eligible to receive FQHC Look-Alike designation, the organization must:

- Be a public agency² or a private nonprofit entity, including tribal, faith-based and community-based organizations;
- Serve, in whole or in part, a federally-designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP).^{3, 4} (The list of MUAs and MUPs is available on the HRSA Web site at <http://bhpr.hrsa.gov/shortage/>); and
- Comply with section 1905(l)(2)(B) of the SSA, which requires that an FQHC Look-Alike may not be owned, controlled, or operated by another entity.⁵

B. Summary of Program Requirements

FQHC Look-Alikes are expected to demonstrate compliance with the applicable requirements of section 330 of the PHS Act, 42 Code of Federal Regulations (C.F.R.) Part 51c (Grants for Community Health Centers)⁶, and 42 C.F.R. Part 56 (Grants for Migrant Health Services and Migrant Health Centers)⁷, as applicable. Organizations are encouraged to review the Health Center Program requirements (available on HRSA's Web site at <http://www.bphc.hrsa.gov/about/requirements/index.html>), in addition to the applicable statutes, regulations, and policies prior to developing an application.

Organizations may be designated to serve the general medically underserved population and/or a special population authorized under section 330 of the PHS Act (i.e., migratory and seasonal farmworkers, homeless populations, and residents of public housing). There are specific requirements and expectations for organizations requesting designation under each type⁸ of

² See PIN 2010-01, "Confirming Public Agency Status under the Health Center Program and FQHC Look-Alike Program" (signed February 5, 2010) at <http://www.bphc.hrsa.gov/policiesregulations/policies/pin201001.html>

³ FQHC Look-Alike applicants do not have to be located in a MUA but must serve in whole or in part either an MUA or MUP.

⁴ Requested, not required for FQHC Look-Alikes exclusively serving migratory and seasonal farmworkers, homeless individuals, or residents of public housing.

⁵ See PIN 1999-09, "Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Public Entities" (dated April 20, 1999) at <http://www.bphc.hrsa.gov/policiesregulations/policies/pin199909.html>, "Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Private Non-Profit Entities" (dated April 20, 1999) at <http://www.bphc.hrsa.gov/policiesregulations/policies/pin199910.html>.

⁶ 42 C.F.R. Part 51c does not apply to FQHC Look-Alikes exclusively serving homeless individuals or residents of public housing.

⁷ 42 C.F.R. Part 56 only applies to FQHC Look-Alikes exclusively serving migratory and seasonal farmworkers.

⁸ The types of health centers authorized under section 330 of the PHS Act are: 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)).

health center authorized under section 330. Those requesting designation to exclusively serve a special population(s) may not have more than 25 percent of patients from the general underserved population.⁹ Specifics regarding program requirements for the different types of populations are detailed below.

C. Organizations Serving the General Medically Underserved Population

Organizations that receive FQHC Look-Alike designation to serve the general medically underserved population are expected to demonstrate compliance with section 330(e) (Community Health Center) statutory and regulatory program requirements and applicable policies. Organizations are expected to make services available to all residents of the service area (including migratory and seasonal farmworkers, homeless persons, and residents of public housing), to the extent possible using available resources.¹⁰ Organizations must ensure the availability and accessibility of required primary health care, preventive, and enabling services, including oral health, mental health, and substance abuse services, regardless of an individual’s ability to pay.

D. Organizations Serving a Special Population(s)

Organizations may be designated to serve the general medically underserved population and/or a special population authorized under section 330 of the PHS Act (i.e., migratory and seasonal farmworkers, homeless populations, and residents of public housing). Organizations that serve the general population (i.e., section 330(e)) in conjunction with a special population (i.e., section 330(g), (h), and/or (i)) must satisfy all section 330(e) program requirements as well as the section 330 program requirements of the specific special population.

Organizations that exclusively serve a special population(s) are not subject to the requirement to provide access to care for all residents of the service area; however, all FQHC Look-Alikes are expected to address the acute care needs of all who present for service regardless of residence and/or ability to pay. Organizations serving only a special population(s) may request a “good cause” exemption to waive the requirement that the center provide all required primary health services under section 330(b)(1) of the PHS Act.¹¹ Currently, HRSA will only consider waivers of the 51 percent consumer/patient majority governance requirement and the monthly meetings governance requirements.

Requests for waivers will not be granted for organizations that serve the general population or the general population in conjunction with a special population.

- i. Migratory and Seasonal Farmworkers (i.e., section 330(g)—Migrant Health Center)*
Organizations that serve migratory and seasonal farmworkers must comply with section 330(e) and section 330(g), and all applicable regulations and policies to be

⁹ Please Refer to PIN 2009-05, “[Policy for Special Populations-Only Grantees Requesting as Change in Scope to Add a New Target Population](#),” for HRSA’s policy on target populations.

¹⁰ Section 330(a)(1)(B) of the PHS Act.

¹¹ Section 330(k)(3)(H)(iii) of the PHS Act.

considered for FQHC Look-Alike designation. These organizations must: (1) ensure the availability and accessibility of required primary health care, preventive and enabling services, including oral health, mental health and substance abuse services, to migratory and seasonal farmworkers and their families in the area to be served; (2) explain how adjustments will be made for service delivery during peak and off-season cycles; and (3) discuss how the special environmental and occupational health concerns will be addressed. Organizations serving **only** migratory and seasonal farmworkers may request a “good cause” exemption to provide certain required primary health services only during certain periods of the year.¹²

ii. Homeless Populations (i.e., section 330(h)—Health Care for the Homeless)

Organizations that serve homeless populations must comply with section 330(e), section 330(h), and all applicable regulations and policies to be considered for FQHC Look-Alike designation. These organizations must: (1) ensure the availability and accessibility of required primary health care, preventive and enabling services, including oral health, mental health and substance abuse services, to homeless individuals and their families in the area to be served; and (2) provide a mechanism for delivering comprehensive substance abuse services to homeless populations (i.e., detoxification, risk reduction, outpatient treatment, residential treatment, and rehabilitation for substance abuse provided in settings other than hospitals).

iii. Residents of Public Housing (i.e., section 330(i)—Public Housing Primary Care)

Organizations that serve public housing residents must comply with section 330(e) and section 330(i), and all applicable regulations and policies to be considered for FQHC Look-Alike designation. These organizations must (1) ensure the availability and accessibility of required primary health care, preventive and enabling services, including oral health, mental health and substance abuse services, to residents of public housing in the area to be served, and (2) provide a mechanism for involving residents in the preparation of the application and in the on-going planning and administration of the program.

E. Public Centers¹³

Section 330 of the PHS Act and the implementing regulations permit any public agency to apply for FQHC Look-Alike designation. Public agencies must comply with the section 330 statutory and regulatory program requirements; however, recognizing that some public agencies may not be able to independently meet all health center requirements due to operational and/or legal constraints, public agencies may comply with these requirements through a “co-applicant” arrangement. In co-applicant arrangements, the public agency receives the FQHC Look-Alike designation and the co-applicant’s board serves as the health center’s governing board. The

¹² Section 330(b)(1)(B) of the PHS Act.

¹³ Please refer to <http://www.bphc.hrsa.gov/policiesregulations/policies/pin201001.html> for information on public entities and co-applicant arrangements.

public agency and the co-applicant are collectively referred to as the “health center” or “public center.”

In the co-applicant arrangement, the public agency is responsible for maintaining and demonstrating compliance with all program requirements. The public agency may retain the responsibility for establishing fiscal and personnel policies; however, the co-applicant governing board must meet all the size and composition requirements and perform and maintain all governance authorities, including: hold monthly meetings; select/dismiss/evaluate the Chief Executive Officer (CEO); approve the annual budget; select the services provided and hours of operation; and, establish general policies for the FQHC Look-Alike. HRSA recommends that the co-applicant governing board be formally incorporated to ensure maximum accountability.

The public agency and the co-applicant entity must have a co-applicant agreement that describes the delegation of authority and defines each party’s role, responsibilities, and authorities. The co-applicant agreement, governing board bylaws, and articles of incorporation must assure that the co-applicant governing board retains its full authorities, responsibilities, and functions, aside from those prescribed general policies that may be retained by the public agency.

Many organizations serve public interests by providing health care and other essential services to the underserved in their communities; however, not all can be classified as public agencies eligible for public center status under the FQHC Look-Alike Program. HRSA will use documentation of the following to assess whether an organization will qualify as a “public agency” for purposes of FQHC Look-Alike designation:

1. Internal Revenue Service (IRS) determination that the entity is a subdivision, municipality, or instrumentality of government that is exempt under Internal Revenue Code section 115 and the public agency has obtained a “letter ruling” (i.e., a positive written determination by the IRS of this status) by following the procedures specified in Revenue Procedure 2009-1 or its successor, as applicable. Evidence to support this determination may include an affirmation letter from the IRS or similar documentation.

OR

2. Public agency demonstration through supporting documentation that it meets the IRS standards that would determine that the public agency is a subdivision, municipality, or instrumentality of government that is exempt under Internal Revenue Code section 115.

OR

3. Formal documentation from a sovereign State’s taxing authority equivalent to the IRS or authority granting the entity one or more governmental powers.

The [IRS Federal, State & Local Governments \(FSLG\) Office](#) may provide more guidance. In addition, the IRS published an article on instrumentalities as part of its Exempt Organizations Continuing Professional Education (CPE) Technical Instruction Program for Fiscal Year 1990, which may provide more information on this topic. This article can be found at <http://www.irs.gov/pub/irs-tege/eotopice90.pdf>.

F. Service Area Overlap

HRSA is committed to increasing access to health care services to vulnerable and underserved populations including expanding and adding new sites and services in communities with high unmet health care needs. Organizations must demonstrate the need for health care services in the area to support the designation of a new FQHC Look-Alike. Organizations must demonstrate collaboration and coordination of health care services with other area health care providers including existing section 330 program grantees, FQHC Look-Alikes, hospitals, rural health clinics and health departments through letters of support, memorandums of agreement/understanding, and/or other formal documentation (see Program Assistance Letter 2011-02, "[Health Center Collaboration](#)"). For organizations that are serving the same, or a contiguous, area served by a section 330 program grantee or FQHC Look-Alike, HRSA will conduct an analysis to determine the level of unmet need in the area to determine the need for support of an additional FQHC. HRSA's policy and process for determining service area overlap is identified in PIN 2007-09, "[Service Area Overlap: Policy and Process](#)." Organizations are strongly encouraged to review this PIN and include appropriate documentation in its application to facilitate the review process.

III. APPLICATION REVIEW PROCESS

A. Roles of HRSA and CMS

HRSA and CMS collaboratively administer and monitor the FQHC Look-Alike Program. HRSA is responsible for reviewing all applications and ensuring that organizations are eligible and compliant with all program requirements. CMS has final authority to designate and recertify FQHC Look-Alikes and approve change in scope requests. The roles and responsibilities of each Agency are outlined below.

1. HRSA Review

Applications submitted to HRSA are reviewed for eligibility, completeness, and compliance based on the applicable requirements, statutes, and policies. Applications determined to be eligible and compliant with all program requirements are recommended to CMS for FQHC Look-Alike designation. Organizations that are determined to be ineligible will receive official notification detailing why the application is ineligible.

Organizations must demonstrate compliance with all requirements for HRSA to submit a recommendation for FQHC Look-Alike designation to CMS. Applications that are eligible for designation but are incomplete or non-compliant with program requirements will be provided technical assistance (e.g., feedback on areas of non compliance and how they may be addressed and consultation by phone if requested) to remedy the identified issues.

HRSA will provide the organization with an opportunity to respond to the identified areas of non-compliance and submit any additional documents necessary to complete their application and/or respond to issues of non-compliance. If the organization remains non-compliant with program requirements or the technical assistance response is incomplete, then HRSA will disapprove the application, and the organization can re-apply at a later date. If the organization demonstrates compliance with all program requirements, then HRSA will submit a recommendation to CMS for FQHC Look-Alike designation.

2. CMS Review

CMS is authorized to designate organizations as FQHC Look-Alikes based on a recommendation from HRSA. HRSA forwards to the CMS Central Office (CO) recommendations for approval regarding initial designation, continued designation (i.e., renewal of designation and annual certification), and change-in-scope requests; the CO then forwards a memorandum to the appropriate CMS Regional Office (RO); the RO forwards the request to the applicable State Medicaid Agency (SMA)/Office for review and comment. If no comments are provided, the recommendation will be approved and HRSA will notify the organization of the approval and the effective date.

In some cases, the SMA may request an extension to investigate any issues raised during the initial review and comment period. If the issues are not satisfactorily resolved within the extension period, the CMS CO will notify HRSA that the recommendation is not accepted. HRSA will then notify the organization of the disapproval. The organization may continue to work with the SMA to resolve any outstanding issues and resubmit an application when the issues have been resolved.

B. Review Time Frames by Application Type

The following chart identifies the maximum number of days allowed for the steps in the review of each type of FQHC Look-Alike application. HRSA’s intent is to have adequate time to comprehensively review each application type and provide substantive feedback to the organization if needed. The time frames may vary due to any extenuating issues raised during the review of an application.

Responsible Entity	Steps in Process	Initial Designation	Renewal of Designation	Annual Certification
Applicant	Time allowed for the submission of application once the application process has been initiated in the EHB.	90 days	90 days	60 days
HRSA	Time allowed for HRSA’s initial review of the application once received in EHB.	105 days	75 days	75 days

Responsible Entity	Steps in Process	Initial Designation	Renewal of Designation	Annual Certification
Applicant	Time allowed for applicant response to any follow-up information requested by HRSA.	30 days	30 days Unless otherwise specified by HRSA Project Officer	30 days Unless otherwise specified by HRSA Project Officer
HRSA	Time allowed for HRSA review of applicant response to requested follow-up information.	45 days	30 days	30 days
CMS	CMS review and approval process	30 days	30 days	30 days

IV. APPLICATION AND SUBMISSION REQUIREMENTS

All FQHC Look-Alike applicants must submit applications electronically through HRSA’s Electronic Handbooks (EHB). Refer to HRSA’s Electronic Submission User Guide, available online at <http://bphc.hrsa.gov/about/lookalike/index.html> for detailed EHB submission instructions.

This section details the requirements for preparing and submitting applications for the FQHC Look-Alike Program. Organizations are encouraged to review this document and contact HRSA with any questions prior to submitting an application. Refer to the FQHC Look-Alike Webpage available at <http://bphc.hrsa.gov/about/lookalike/index.html> for tips on how to develop a high quality application.

A. Types of Applications

There are three types of FQHC Look-Alike Program applications.

1. Initial Designation

This application type is for organizations that are seeking initial FQHC Look-Alike designation. The application must demonstrate eligibility and compliance with all applicable statutory, regulatory and policy requirements. Organizations are encouraged to collaborate with HRSA, their State Primary Care Association (PCA), and/or Primary Care Office (PCO), and other primary care providers in the community to prepare the application.

2. Renewal of Designation

FQHC Look-Alikes are assigned a designation period for which the FQHC Look-Alike designation is valid (two years for an initial designation and generally five years for existing FQHC Look-Alikes). FQHC Look-Alikes must submit a Renewal of Designation application at the end of the designation period in order to maintain the FQHC Look-Alike designation

status. The Renewal of Designation application must be submitted to HRSA at least 90 days prior to the end of the designation period. Failure to renew the FQHC Look-Alike designation may result in termination of the FQHC Look-Alike status and all corresponding benefits (e.g., Medicare and Medicaid FQHC reimbursement, 340B Drug Pricing Program benefits, etc.).

3. Annual Certification

During the approved designation period, FQHC Look-Alikes must submit an annual program update. The Annual Certification application must be submitted to HRSA at least 90 days prior to the end of the annual certification period. Failure to recertify may result in termination of the FQHC Look-Alike status and all corresponding benefits (e.g., Medicare and Medicaid FQHC reimbursement, 340B Drug Pricing Program benefits, etc.).

B. Application Submission

Initial Designation, Renewal of Designation, and Annual Certification applications must be submitted electronically to HRSA in accordance with the established time frames. Failure to submit the Renewal of Designation and/or Annual Certification application may result in a delay in designation or recertification and/or termination of the FQHC Look-Alike status.

Type of Application	When to Submit to HRSA
Initial Designation	Accepted on a rolling basis.
Renewal of Designation	At least 90 days prior to the end of the designation period.
Annual Certification	At least 90 days prior to the end of the annual certification period.

Refer to HRSA's *Electronic Submission User Guide*, available online at <http://bphc.hrsa.gov/about/lookalike/index.html>, for detailed application and submission instructions. Applicants must submit applications according to the instructions in this document and the User Guide.

C. Content and Form of Application Submission

This document contains separate instructions for each of the three types of FQHC Look-Alike applications: [Initial Designation](#), [Renewal of Designation](#), and [Annual Certification](#).

FQHC LOOK-ALIKE
INSTRUCTIONS FOR CALENDAR YEAR
2011/2012

INITIAL DESIGNATION APPLICATION

Technical Assistance Website:

<http://bphc.hrsa.gov/about/lookalike/index.html>

I. PURPOSE

An important element of the Health Resources and Services Administration's (HRSA) commitment to improving and expanding access to needed primary health care services is the support of the Federally Qualified Health Center (FQHC) Look-Alike Program for the delivery of primary health care services to underserved and vulnerable populations. FQHC Look-Alikes provide a comprehensive system of care that is responsive to the community's identified health care needs and provide services to all persons residing in the health center's service area regardless of ability to pay.

All applicants are expected to demonstrate compliance with the requirements of section 330 of the Public Health Service (PHS) Act, as amended and applicable regulations and policies. Applicants are encouraged to refer to <http://www.bphc.hrsa.gov/about/requirements/index.html> for additional information on key Health Center Program requirements.

II. GENERAL APPLICATION BACKGROUND/INFORMATION

An FQHC Look-Alike organization is a full-time service delivery site(s) for the provision of comprehensive primary and preventive health care services that will improve the health status and decrease health disparities of the medically underserved and vulnerable populations to be served. FQHC Look-Alike organizations will 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 Initial Designation application is expected to demonstrate compliance with the requirements of section 330 of the PHS Act, as amended and applicable regulations and policies. High quality Initial Designation applications will demonstrate a high level of need in their community/population, present a sound proposal to meet this need, demonstrate that the organization is already providing comprehensive health care services in the service area, 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 FQHC Look-Alike will provide access to comprehensive, culturally competent, quality primary health care services, including oral health, mental health, and substance abuse services, and improve the health status of underserved and vulnerable populations in the area to be served.

Applicants may request designation for one or multiple types of health centers (i.e., Community Health Center (CHC), Migrant Health Center (MHC), Health Care for the Homeless (HCH), and Public Housing Primary Care (PHPC)) within a single application based on the population(s) to be served (e.g., an applicant proposing to serve both the general community and migrant and seasonal farmworkers can submit an Initial Designation application requesting both the CHC

and MHC designation). Applicants must indicate on Form 1A – General Information Worksheet their request for FQHC Look-Alike designation.

A. School Based Health Centers

Applicants may propose to establish a school based health center site for the delivery of primary care services as an FQHC Look-Alike. To be eligible, an applicant must demonstrate that the school based site will provide, independently or in conjunction with another site(s), all required primary and preventive health care services to the students of the school as well as the general underserved population in the service area without regard for ability to pay.

B. Mobile Medical Vans

Mobile medical vans are an approved method for the delivery of primary care services for FQHC Look-Alike organizations if the organization is also proposing at least one permanent site to its scope of project. A mobile medical van cannot be the only site in the FQHC Look-Alike's scope of project. To be eligible as a service delivery method for an FQHC Look-Alike organization, the mobile medical van must be fully equipped and staffed by health center clinicians providing direct primary care services (e.g., primary medical or oral health services) at various locations. Mobile medical vans do not need to provide services on a regularly scheduled basis, although this is encouraged to provide continuity and access to care for the target population. Mobile medical vans that are not equipped or utilized for direct patient care are not considered service sites and therefore are not eligible to be included as part of an FQHC Look-Alike's scope of project.

III. EXPECTED RESULTS

Initial Designation applicants must demonstrate in their proposal a high level of need in their community/population, responsiveness to the health care environment in the area to be served, and that they are already providing comprehensive health care services in the service area.

More specifically, all successful Initial Designation applications will demonstrate:

- Compliance at the time of application with the requirements of section 330 of the PHS Act, as amended, and applicable regulations and policies. Program requirements are available at <http://www.bphc.hrsa.gov/about/requirements/index.html>.
- Evidence that the proposed FQHC Look-Alike site(s) will serve populations in **high need areas**. All Initial Designation applicants must submit a completed Need for Assistance (NFA) Worksheet (see instructions on page 48) as part of the application to demonstrate the relative need for additional primary health care services.
- Evidence of how the proposed project will **maintain or increase access to primary health care services, improve health outcomes and reduce health disparities** in the community/population to be served.

- Evidence that **all persons in the target population will have ready access to the full range of required primary, preventive, enabling and supplemental health care services, including oral health care, mental health care and substance abuse services**, either directly on-site or through established arrangements without regard to ability to pay.
- Responsiveness to its health care environment by documenting that it has developed **collaborative and coordinated delivery systems** for the provision of health care to the underserved in their communities. Successful applicants will demonstrate actual or proposed partnerships and collaborative activities with other FQHC Look-Alikes and section 330 grantees, rural health clinics, hospitals, State and local health departments, and other programs serving the same population(s).
- **A sound and complete plan** that is responsive 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 and accurate budget** (Form 3A – FQHC Look-Alike Budget Form) based on the activities proposed in the application.
- Their FQHC Look-Alike site(s) is already **operational and providing services** in the community/population. Successful Initial Designation applicants will demonstrate that: 1) the facility is operational and providing services to the proposed population/community; and 2) providers are serving the proposed FQHC Look-Alike site.

Throughout the application development and preparation process, applicants are highly encouraged to collaborate with the appropriate Primary Care Associations (PCAs), Primary Care Offices (PCOs), and/or National Cooperative Agreements (NCAs) in determining their readiness to develop an FQHC Look-Alike Initial Designation application. Refer to <http://www.bphc.hrsa.gov/technicalassistance/> for a complete listing of PCAs, PCOs, and NCAs.

IV. SPECIFIC PROGRAM REQUIREMENTS/EXPECTATIONS

All applicants are expected to demonstrate compliance with the applicable requirements of section 330 of the PHS Act, as amended, and corresponding program regulations and policies. There are specific requirements and expectations for applicants requesting designation under each type¹⁴ of health center authorized under section 330. Applicants requesting designation to support one or more health center types are expected to demonstrate compliance with the specific requirements of each type. Failure to document and demonstrate compliance in the application will significantly reduce the likelihood of designation.

¹⁴ The types of health centers authorized under section 330 of the PHS Act as amended are: 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)).

COMMUNITY HEALTH CENTER APPLICANTS

- Compliance with section 330(e) and program regulations; and
- A plan that ensures the availability and accessibility of required primary and preventive health services, including oral health, mental health, and substance abuse services, to all individuals in the service area.

MIGRANT HEALTH CENTER APPLICANTS

- Compliance with section 330(g) and, as applicable, section 330(e) and program regulations; and
- A plan that ensures: (1) the availability and accessibility of required primary and preventive health services, including oral health, mental health and substance abuse services, to migratory and seasonal farmworkers and their families in the area to be served; (2) how adjustments will be made for service delivery during peak and off-season cycles; and (3) how the special environmental and occupational health concerns will be addressed.

HEALTH CARE FOR THE HOMELESS APPLICANTS

- Compliance with section 330(h) and, as applicable, section 330(e) and program regulations;
- A plan that ensures the availability and accessibility of required primary and preventive health services, including oral health, mental health, and substance abuse services, to homeless individuals and families in the area to be served; and
- A mechanism for delivering comprehensive substance abuse services to homeless patients (i.e., detoxification, risk reduction, outpatient treatment, residential treatment, and rehabilitation for substance abuse provided in settings other than hospitals).

PUBLIC HOUSING PRIMARY CARE APPLICANTS

- Compliance with section 330(i) and, as applicable, section 330(e) and program regulations;
- A plan that ensures the availability and accessibility of required primary and preventive health services, including oral health, mental health, and substance abuse services, to residents of public housing primary care in the area to be served; and
- A mechanism for involving residents in the preparation of the application and in the ongoing planning and administration of the program.

V. ELIGIBILITY INFORMATION

An FQHC Look-Alike Initial Designation application will be considered eligible if it meets all of the applicable eligibility requirements listed below. **Applications that do not meet the eligibility requirements will be considered non-compliant and will not be considered for designation.**

1. Applicant is a public or private, nonprofit entity, including tribal, faith-based, and community-based organization.
2. Application requests FQHC Look-Alike designation for a site(s) that provides comprehensive primary, preventive, enabling, and additional health care services

including oral health care, mental health care, and substance abuse services, either directly on-site or through established arrangements without regard to ability to pay. An applicant may **not** propose to provide only a single service, such as dental, mental health, or prenatal services.

3. Application proposes access to services for all individuals in the targeted service area or population. In other words, applicant does not propose to exclusively serve a single age group (e.g., children), lifecycle (e.g., geriatric), or health issue/disease category (e.g., HIV/AIDS). In instances where a sub-population is being targeted within the service area or population (e.g., homeless children and adolescents/children in schools), the applicant must demonstrate how health care services will be made available to other persons in need of care who may seek services at the proposed site(s).
4. Application proposes to serve a defined geographic area that is federally-designated, in whole or in part, as a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP). [If the area is not currently federally-designated, in whole or in part as an MUA or MUP, the applicant must provide documentation that the request has been submitted in order for timely processing prior to a final HRSA designation decision on the Calendar Year (CY) 2011/2012 Initial Designation application]. **NOTE:** *If the applicant is requesting designation only for MHC, HCH, and/or PHPC, the applicant is not required to have an MUA/MUP designation for the proposed service area and/or target population.*

VI. SUBMISSION INFORMATION

HRSA **requires** applicants for this opportunity to apply electronically through the HRSA Electronic Handbooks (EHBs). All applicants **must** submit in this manner. Refer to HRSA's *Electronic Submission User Guide*, available online at <http://bphc.hrsa.gov/about/lookalike/index.html> for detailed application and submission instructions. HRSA will not accept FQHC Look-Alike Initial Designation applications in paper form.

Initial Designation applications are accepted on a rolling basis throughout the year. However, once the Initial Designation application process is started in the EHB system, it must be completed and submitted in a maximum of 90 calendar days. Applications will be considered having been formally submitted if the application has been successfully transmitted electronically by your organization's Authorizing Official (AO) through HRSA's EHB within 90 calendar days of the date of initiation of the application process in the HRSA EHB. If an application is not submitted in the EHB system within the 90 day period it will be considered ineligible and will be deleted from the EHB system.

It is incumbent on the applicant to ensure that the AO is available to submit the application before the 90 day application period has ended. HRSA will not accept submission or re-submission of incomplete, rejected or otherwise delayed applications after the 90 day

application period. Therefore, applicants are urged to submit applications in advance of the 90 day deadline.

A. Ineligible Applications

Applications that do not meet the eligibility criteria and/or are not submitted within the 90 day application period are considered ineligible and will not be considered for designation. However, applicants may reapply for initial designation at any time after their current application has either been returned by HRSA or deleted from the EHB system (after the 90 day application period has elapsed). Applicants can have only one Initial Designation application in the HRSA EHB system at any time.

B. Registering in the HRSA EHB

In order to submit the Initial Designation application in the HRSA EHB, the AO (and other application preparers) must register in the HRSA 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. Note that registration within the HRSA EHB is required only once for each user. HRSA's EHB allows a user to associate use his/her single username with more than one organization.

User registration within the HRSA EHB is a two-step process. In the first step, individuals who will participate in the organization's application process must create individual system accounts. In the second step, the users must associate themselves with the appropriate organization.

To complete the registration quickly and efficiently, HRSA recommends that applicants identify roles for all users in the application process. HRSA's EHB offers the following three functional roles for individuals from applicant organizations:

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

For more information on functional responsibilities, refer to the HRSA EHB online help. Once the registration is completed, all users from the organization must to go through an additional step to get access to the application in the HRSA EHB. This is required to ensure that appropriate individuals have access to the application.

For assistance in registering with the HRSA EHB or to access tutorials and Frequently Asked Questions (FAQs) please refer to the following:

- FQHC Look-Alike Technical Assistance webpage
<http://bphc.hrsa.gov/about/lookalike/index.html>
- 877-GO4-HRSA or 877-464-4772 (9:00 AM to 5:30 PM ET)
- TTY for hearing impaired 1-877-897-9910 (9:00 AM to 5:30 PM ET)
- Email callcenter@hrsa.gov.

VII. APPLICATION INSTRUCTIONS

A. Application Materials and Format Instructions

The following table details the documents required for the Initial Designation Application for CY 2011/2012. Organizations are encouraged to review this table prior to submitting an Initial Designation application to ensure that all required components are included. Failure to submit all required components as outlined may result in HRSA returning the application as incomplete.

“Forms” refer to documents that are completed online using HRSA’s EHB and that do not require downloading or uploading. “Documents” are requirements that must be downloaded in the template provided, completed, and then uploaded into the EHB system. ***For detailed instructions for all forms and documents, see Sections VII.B. and VII.C. below.***

Initial Designation Application Content	Form Type	Instructions
Cover Page	Form	Complete all portions of the form electronically online as presented.
Form 1A: General Information Worksheet	Form	Complete all portions of the form electronically online as presented.
Table of Contents	Document	The EHB will automatically generate a Table of Contents.
Project Abstract	Document	The project abstract should be single-spaced, limited to two pages in length. Please prepare the abstract so that it is clear, accurate, concise, and without reference to other parts of the application. The abstract narrative should include: <ul style="list-style-type: none"> – The population group(s) served. – Summary of the organizational structure. – A brief history of the organization, the community served and the target population(s). – A summary of the major health care needs and barriers to care. – A summary of services provided. – A summary of the number of providers, service delivery locations, services, and total number of patients and visits. – A brief description of any other relevant information.
Project Narrative	Document	Upload as instructed.
Clinical Performance Measures	Form	Complete all portions of the form electronically online as presented.
Financial Performance Measures	Form	Complete all portions of the form electronically online as presented.
Form 2: Staffing Profile	Form	Complete all portions of the form electronically online as presented.

FQHC Look-Alike Application Instructions CY 2011-2012

Initial Designation Application Content	Form Type	Instructions
Form 3: Income Analysis Form	Document	Complete all portions of the form electronically online as presented.
Form 3A:FQHC Look-Alike Budget	Form	Complete all portions of the form electronically online as presented.
Form 4: Community Characteristics	Form	Complete all portions of the form electronically online as presented.
Form 5A: Services Provided	Form	<p>Complete all portions of the form electronically online as presented.</p> <p>Applicants must identify what services are available and how these services will be provided. Only one form is required for all of the required and additional services provided by the applicant.</p> <p><i>If the application is approved, information presented on Form 5A in the FQHC Look-Alike application will be used by HRSA to determine the services included in the Scope of Project for the FQHC Look-Alike. Only those services that are included on Form 5A will be considered to be in the approved Scope of Project. Any services that are described or detailed in other portions of the application (e.g., narratives, attachments) will not be included in the organization's Scope of Project, even if the organization is designated.</i></p>
Form 5B: Service Sites	Form	<p>Complete all portions of the form electronically online as presented.</p> <p>Applicants must complete Form 5B for each site proposed as a FQHC Look-Alike site.</p> <p><i>If the application is approved, information presented on Form 5B in the FQHC Look-Alike application will be used by HRSA to determine the sites included in the Scope of Project for the FQHC Look-Alike. Only those sites that are included on Form 5B will be considered to be in the approved Scope of Project. Any sites that are described or detailed in other portions of the application (e.g., narratives, attachments) will not be included in the approved Scope of Project, even if the FQHC Look-Alike is designated.</i></p>
Form 5C: Other Activities/Locations (if applicable)	Form	Complete all portions of the form electronically online as presented.
Form 6A: Current Board Member Characteristics	Form	Complete all portions of the form electronically online as presented.
Form 6B: Request for Waiver of Governance Requirements	Form	Complete all portions of the form electronically online as presented. NOTE: Only organizations that request designation exclusively to serve a special population(s) authorized under section 330 of the PHS Act are eligible for a governance waiver.

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Initial Designation Application Content	Form Type	Instructions
Form 8: Health Center Agreements	Form	Complete all portions of the form electronically online as presented and attach related agreements as appropriate. NOTE: Form 8 is approved for the length of the designation period.
Form 9: Need for Assistance	Form	Complete all portions of the form electronically online as presented.
Form 10: Annual Emergency Preparedness and Management Report	Form	Complete all portions of the form electronically online as presented.
Form 12: Contacts Information	Form	Complete all portions of the form electronically online as presented.
Attachment 1: Patient Origin Study	Document	The patient origin study should identify the number of patients residing in each zip code served by the organization (e.g., ZIP Code 29999 = 48 patients; ZIP Code 29994 = 134 patients). Organizations may submit this information in a table format starting with the zip code with the greatest patients served.
Attachment 2: Service Area Map	Document	Provide a map that clearly identifies the areas served by the organization, all service delivery sites, the designated MUA/MUP areas, census tracts, zip codes, and the location of other primary care provider sites (e.g., section 330-funded health centers, FQHC Look-Alikes, hospitals, free-clinics, etc.). Organizations are encouraged to use HRSA's Geospatial Data Warehouse mapping feature to produce maps. This feature is available on HRSA's Web site at http://datawarehouse.hrsa.gov/hpsadetail.aspx .
Attachment 3: Current or Requested MUA/MUP Designation	Document	Provide a dated copy of the current or requested MUA/MUP designation. For inquiries regarding MUA/MUP, call 1-888-275-4772 (press option 1, then option 2); contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816; or obtain additional information on HRSA's Web site at http://bhpr.hrsa.gov/shortage/ . Organizations may submit as documentation of the MUA/MUP designation a confirmation page from HRSA's "Find Shortage Areas" Web site.
Attachment 4: Governing Board Bylaws	Document	Provide a signed and dated copy of the governing board bylaws. The bylaws must demonstrate compliance with the requirements of section 330 of the PHS Act, 42 C.F.R. 51c, and 42 C.F.R. 56 (as applicable).
Attachment 5: Governing Board Meeting Minutes	Document	Submit a copy of the governing board meeting minutes that document the governing board's involvement in the development and approval of the FQHC Look-Alike application. Also include minutes from all meetings held six months prior to the application or, if operational less than six months, for the period of time the board has been operational.

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Initial Designation Application Content	Form Type	Instructions
Attachment 6: Co-Applicant Agreement for Public Centers (if applicable)	Document	Public centers (also referred to as public entities or public agencies) with a co-applicant arrangement must provide a signed and dated copy of the written agreement between the two parties. The co-applicant agreement must identify the roles and responsibilities of both the public center and co-applicant, the delegation of authorities of both parties, and any shared roles and responsibilities in carrying out the governance functions.
Attachment 7: Affiliation, Contract, and/or Referral Agreements (if applicable)	Document	<p>Upload a BRIEF SUMMARY describing current or proposed contracts and agreements (e.g., contracted provider and/or staff, management services contracts, etc.). Applicants do not need to discuss contracts or agreements for such areas as janitorial services. The summary must address the following items for each contract or agreement:</p> <ul style="list-style-type: none"> – Name and contract 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 agreement/contract/affiliation. <p>If a contract or agreement will be attached to Form 8 (e.g., for a substantial portion of the proposed project), denote this with an asterisk (*).</p> <p>Organizations that do not have contractual agreements with another entity should clearly indicate so in the narrative. As a reminder, contracts must be in compliance with section 330 of the PHS Act and 42 C.F.R. 51c. In addition, the governing board must approve all contracts and retain authority over the organization’s policy and procedures, such as budget, hours, and services provided.</p>
Attachment 8: Articles of Incorporation	Document	Private, non-profit organizations must provide a copy of the Articles of Incorporation filed with the State or other evidence of non-profit status (e.g., a letter from the State or the Federal government or evidence that an application for non-profit status has been submitted). The seal page documenting the State acceptance of the articles must be included with the application.

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Initial Designation Application Content	Form Type	Instructions
Attachment 9: Evidence of Non-Profit or Public Agency Status	Document	<p>Private, non-profit organizations must provide evidence of current or pending tax exempt status. Public centers must provide evidence of the co-applicant governing board’s current or pending tax exempt status if the co-applicant is independently incorporated. Any of the following is acceptable evidence:</p> <ul style="list-style-type: none"> – 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 organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals. – A certified copy of the organization’s certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization. <p>Public Agency: Consistent with Policy Information Notice 2010-01, “Confirming Public Agency Status under the Health Center Program and FQHC Look-Alike Program,” applicants must provide documentation demonstrating the organization will qualify as a “public agency” for purposes of section 330 of the PHS Act, as amended. Any of the following is acceptable evidence:</p> <ol style="list-style-type: none"> 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; or 2. A determination letter issued by the IRS, providing evidence of a past positive letter ruling by the IRS, 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; or 3. Formal documentation from a sovereign State’s taxing authority equivalent to the IRS or authority granting the entity one or more governmental powers. <p><i>Please provide a detailed explanation if none of the above evidence is available, with supporting documentation, as relevant.</i></p>
Attachment 10: Medicare and Medicaid Provider Documentation	Document	<p>Submit a copy of the CMS notification that documents the organization is an approved Medicare and Medicaid provider and the provider numbers. Please note: Each permanent and seasonal site is required to have a unique Medicare Billing Number.</p>

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Initial Designation Application Content	Form Type	Instructions
Attachment 11: Organizational Chart	Document	Provide an organizational chart showing the organizational and management structure and lines of authority, key employee position titles, names, and Full Time Equivalents (FTEs). The governing board and individuals with the following responsibilities should be clearly identified: CEO/Executive Director, Chief Medical Officer (CMO)/Clinical Director, and Chief Financial Officer (CFO)/Financial Manager. The chart should demonstrate the governing board retains ultimate authority and leadership of the organization. Public centers with co-applicant arrangements should demonstrate the relationship between the two entities.
Attachment 12: Position Descriptions for Key Personnel	Document	Submit a copy of position descriptions for all key management positions. Indicate on the position descriptions if key management positions are combined and/or part-time (e.g., CFO and Chief Operation Officer (COO) roles are shared). At minimum, the position description should include the position title, description of duties and responsibilities, position qualifications, supervisory relationships, skills, knowledge and experience requirements, travel requirements, salary range and hours worked.
Attachment 13: Resumes for Key Personnel	Document	Provide resumes of key personnel for the organization. In the event that a resume is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the resume.
Attachment 14: Schedule of Discounts/Sliding Fee Scale	Document	Provide a schedule of charges with a corresponding schedule of discounts for which charges are adjusted on the basis of the patient's ability to pay. Organizations must show sliding fee scale discounts for persons with incomes between 200% and 100% of the most current annual Federal poverty guidelines (FPG) (see the most current annual FPG at http://aspe.hhs.gov/poverty/). Patients with incomes below 100 percent of the FPG may not be charged for services (nominal fees are acceptable if they do not serve as barriers to obtaining services). No discounts may be accorded to patients with incomes over 200% of the FPG.

Initial Designation Application Content	Form Type	Instructions
Attachment 15: Most Recent Independent Financial Audit	Document	Submit a complete copy of the organization’s most recent annual audit, including the auditor’s opinion statement (i.e., management letter). Audit information must include the balance sheet, profit and loss statement, audit findings, management letter and any noted exceptions. The audit must comply with generally accepted accounting principles (GAAP). In instances where the audit is not available at the time of application submission, identify the anticipated time frame for completion of the auditor report and submit a copy of the organization’s most recent six months of financial statements. 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 with no audit or financial statements must provide a detailed explanation of the situation, including supporting documentation as relevant (e.g., organization was formed for the purposes of this grant application).
Attachment 16: Letters of Support	Document	Organizations must collaborate with other primary care providers in the community. Submit copies of letters of support for the organization’s request for FQHC Look-Alike designation from the other primary care providers in the area, including other FQHC Look-Alikes, section 330 grantees, rural health clinics, hospitals, local health departments, and other programs serving the same population(s). If one or more letters from other local providers serving the same population are not provided, provide an explanation.
Attachment 17: Floor Plans	Document	Submit floor plans for all proposed FQHC Look-Alike sites.
Attachment 18: Other Information	Document	Organizations may include other relevant documents to support the proposed project plan such as charts and organizational brochures. Organizations should attach floor plans and lease/intent to lease documents for any facilities.

Applicants are reminded that failure to include all required documents as part of the application may result in an application being considered as incomplete or non-responsive. Incomplete applications may be returned to the applicant without further consideration.

B. Program Narrative Instructions

The Program Narrative provides a comprehensive description of the proposed FQHC Look-Alike project. It should provide a detailed picture of the community/target population served, the organizational structure, and how the organization is addressing the identified health care needs of the community.

Applicants should fully address ALL requirements within the narrative component of the application. All documents (i.e., Program Narrative, forms, documents, and attachments) are

evaluated individually and collectively. The Program Narrative should be succinct, self-explanatory and well-organized so that reviewers can fully understand the proposed project. Organizations must respond to all criteria and submit all applicable forms and attachments to demonstrate compliance with program requirements (<http://www.bphc.hrsa.gov/about/requirements/index.html>). Failure to include all required information could result in HRSA returning the application as incomplete.

The Program Narrative should be organized using the following framework and section headers. Applicants should ensure that all of the specific elements in the Program Narrative are completely addressed.

NEED

Information provided on need should serve as the basis for, and align with, the activities and goals described in the Clinical and Financial Performance Measures Forms and throughout the application.

1. Describe the unique characteristics of the target population, including those characteristics that impact access to primary health care, health care utilization, and/or health status. The response should describe additional aspects of need that are not captured by quantitative data. Reference Attachment 2: Service Area Map, if applicable.
2. Describe existing primary health care services (including mental health/substance abuse and oral health) currently available in the applicant's service area, including any gaps in services (e.g., provider shortages) and the role and location of any other providers who currently serve the target population.
3. Describe the health care environment and any significant changes that have affected the community's ability to provide services and/or have affected the applicant's fiscal stability, if applicable.
4. For applicants requesting designation to serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330 (h)), and/or residents of public housing (section 330(i)): describe the specific health care needs and access issues of the proposed special population.

RESPONSE

1. Describe the service delivery model(s) to serve the community/population health care needs identified in the Need section, including service delivery models to meet the specific needs of special populations if seeking designation under section 330(g), section 330(h), and/or section 330(i). All sites and activities described should be consistent with those listed in Forms 5B and 5C (Service Sites and Other Activities/Locations, respectively), including locations (reference Attachment 2: Service Area Map, if applicable), hours, and after-hours care.

NOTE: Public Housing Primary Care applicants ONLY (section 330(i)) should demonstrate that the service site(s) is (are) immediately accessible to the public housing community being targeted.

2. Describe how the primary health care services are appropriate for the needs of the target population and are available and accessible to all life cycles without regard to ability to pay. (Services discussed should be consistent with those listed in Form 5A – Services Provided and the form should be referenced as applicable.)

NOTE: Health Care for the Homeless applicants ONLY (section 330(h)) must demonstrate that substance abuse services will be made available as part of the required services.

3. Describe how the service delivery model(s) assures the integration of enabling services (e.g., outreach, transportation), continuity of care (e.g., admitting privileges), access to a continuum of care, and access to special care services (e.g., referral relationships).
4. Discuss the appropriateness of all current contracts for a substantial portion of the operation of the health center listed on Form 8 – Health Center Agreements and/or other agreements summarized in Attachment 7 (Affiliation, Contract, and/or Referral Agreements).

NOTE: All applicants must complete Form 8 – Health Center Agreements and reference it throughout the Response section as applicable. In addition, CHC and/or MHC applicants that respond “no” to any question in the Governance checklist section of Form 8 must clearly discuss the specific situation(s).

5. Describe the clinical team staffing plan, the projected number of patients, and how the organization provides the required, preventive, enabling, and additional health services as appropriate and necessary either directly or through established arrangements and referrals.

NOTE: The applicant should reference Form 2 and Form 5A (Staffing Profile and Services Provided, respectively) in their response as appropriate. If the clinical team staffing plan includes contracted providers, the applicant must include a summary of all such current or proposed contracts in Attachment 7.

6. Describe the system in place to determine eligibility for patient discounts adjusted on the basis of the patient’s ability to pay and demonstrate how the established schedule of charges is consistent with locally prevailing rates or charges. In addition, describe how the corresponding schedule of discounts/sliding fee scale ensures that no patient will be denied services due to their inability to pay. Reference the schedule of discounts/sliding fee scale in Attachment 14 in the response.

NOTE: Ability to pay is determined by a patient’s annual income and family size according to the most recent Federal Poverty Guidelines for the contiguous 48 states, Alaska and Hawaii (information available at <http://aspe.hhs.gov/poverty/>).

7. Describe the organization's ongoing quality improvement/quality assurance (QI/QA) and risk management plan(s) including management and staff roles in oversight and implementation and any previous significant adjustments in practice based on QI/QA findings. Additionally, describe any national quality recognition the organization has received.

NOTE: QI/QA may include but not be limited to clinical, financial, and administrative areas.

8. Describe the organization's appropriate and board-approved policies and procedures that support the QI/QA and risk management plan(s) including: current clinical standards of care, provider credentials and privileges, risk management procedures, patient grievance procedures, incident management, and confidentiality of patient records.

COLLABORATION

1. Describe both formal and informal collaboration and coordination of services¹⁵ with other health care providers. Specifically describe collaboration and coordination with existing section 330 grantees, FQHC Look-Alikes, rural health clinics, hospitals, State and local health departments, private providers and programs serving the same population(s) (e.g., social services; job training; Women, Infants and Children (WIC); coalitions; community groups).

Migrant Health Center (MHC), Health Care for the Homeless (HCH), and/or Public Housing Primary Care (PHPC) applicants must discuss formal agreements with other organizations that provide services or support to the special population(s) for which designation is sought.

NOTE: Formal collaboration (contracts, agreements, and/or arrangements) should also be summarized in Attachment 7.

2. Document collaborations by providing letters of support, commitment and/or investment that reference the specific collaboration and/or coordinated activities in support of the project's operation and provision of primary health care services (e.g., local school board, hospital, homeless shelters, advocacy groups, and other service providers).
3. Document support for the FQHC Look-Alike designation through current dated letters of support from all FQHCs (current section 330 grantees and FQHC Look-Alikes), health departments, rural health clinics, and/or hospitals in the service area. If such letters cannot be obtained, include documentation of efforts made to obtain the letters along with an explanation including documentation of efforts made to obtain the letter. All letters of support should be merged into one document and included in Attachment 16: Letters of Support, and referenced in the application as appropriate.

EVALUATIVE MEASURES

¹⁵ Review Program Assistance Letter 2011-02, Health Center Collaboration available at <http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html> for information on maximizing opportunities to collaborate with other health care safety net providers.

Information provided on need should serve as the basis for, and align with, the activities and goals described in the clinical and financial performance measures and throughout the application.

1. Outline within the Clinical Performance Measures Form, time-framed and realistic goals with baselines that are responsive to the health needs identified in the application. Specifically include:
 - (a) Goals for improving quality of care, health outcomes and eliminating disparities in the required areas. Applicants may (but are not required to) include goals that address any other key health needs within their community, target population(s) and/or for key life cycle groups (e.g., adolescents, elderly, etc.).
 - (b) **For applicants applying to serve migrant populations, people experiencing homelessness and/or residents of public housing under section 330(g), section 330(h), and/or section 330 (i) respectively**, include goals relevant to the needs of these populations. Applicants that currently or plan to serve one or more of these populations but are not a designated FQHC Look-Alike organization for these populations are also encouraged to include relevant goals and measures reflecting these needs.
 - (c) Corresponding measures for all goals and data collection methodology for measuring progress.
 - (d) A summary of the key factors anticipated to contribute to or restrict progress on the stated performance measure goals, and action steps planned for addressing described factors. **NOTE:** In discussing responses to anticipated contributing or restricting factors, applicants should discuss this area broadly and do not need to provide detail at an “action step” level.

2. Outline within the Financial Performance Measures Form, time-framed and realistic goals with baselines that are responsive to the strategic planning needs identified in the application. Specifically the applicant includes:
 - (a) Goals for improving the organization’s status in terms of costs and financial viability. Applicants may (but are not required to) include goals that address any other key financial viability and/or cost issues within their organization.
 - (b) Corresponding financial performance measures for all goals and related data collection methodology for measuring progress.
 - (c) A summary of the key factors anticipated to contribute to or restrict progress on the stated financial performance measures goals and action steps planned for addressing described factors. **NOTE:** In discussing responses to anticipated contributing or restricting factors, applicants should discuss this area broadly and do not need to provide detail at an “action step” level.

3. Provide a brief description of additional evaluation activities planned to assess progress throughout the designation period, if any, including tools utilized to collect and analyze relevant data.

RESOURCES/CAPABILITIES

1. Describe how the organizational structure is appropriate for the operational needs of the project, including how lines of authority are maintained from the governing board to the Chief Executive Officer (CEO)/Executive Director down through the management structure and are in accordance with Health Center Program Requirements (<http://www.bphc.hrsa.gov/about/requirements/index.html>). Reference Attachment 4: Governing Board Bylaws, Attachment 11: Organizational Chart, and, as applicable: Attachment 6: Co-Applicant Agreement for Public Centers (for Public Centers that have a co-applicant board),¹⁶ and Attachment 7: Affiliation, Contract, and/or Referral Agreements.
2. Describe how the organization maintains appropriate oversight and authority over all contracted services, including any affiliation arrangement(s) (as referenced in Program Specific Form 8 – Health Center Agreements), in accordance with Health Center Program requirements.¹⁷ Applicants must summarize all applicable current or proposed contracts and/or other agreements in Attachment 7. Applicants must reference Form 8 throughout the response as applicable.
3. Describe how the organization maintains a fully staffed management team (chief executive officer (CEO), chief clinical officer (CCO), chief financial officer (CFO), chief information officer (CIO), and chief operating officer (COO) as applicable), that is appropriate and adequate for the size, operational and oversight needs, and scope of the proposed project and is in accordance with Health Center Program requirements. Explain any management positions that are combined and/or part time (e.g., CFO and COO roles are shared). Also, describe the organizational and management structure and lines of authority, provide position descriptions that include the roles, responsibilities, and qualifications and resumes for the CEO, CCO, CFO, CIO, and COO as applicable. These should be included in Attachment 11: Organizational Chart, Attachment 12: Position Descriptions for Key Management Staff, and Attachment 13: Resumes for Key Personnel.
4. Describe the plan for recruiting and retaining key management staff and health care providers as appropriate for achieving the proposed staffing plan and discuss any key management staff changes in the last year, as applicable.
5. Describe how the service site(s) within the scope of project are appropriate for implementing the service delivery plan and reasonable in terms of the projected number of patients at full capacity. If facilities are not currently owned or under a lease agreement, provide a summary of the relevant contracts, MOUs (e.g., with homeless shelter, public

¹⁶ In cases where 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; and any shared roles and responsibilities of each party in carrying out the governance functions.

¹⁷ As stated in PIN 1997-27, Affiliation Agreements of Community and Migrant Health Centers, and/or PIN 1998-24, Amendment to PIN 1997-27, Regarding Affiliation Agreements of Community and Migrant Health Centers. Applicants are encouraged to review <http://bphc.hrsa.gov/about/requirements.htm> for additional information on program requirements and expectations.

housing authority, other partner organizations) describing how access to facilities and on-site space is assured, in Attachment 7. Floor plans and lease/intent to lease documents must be attached for all facilities in Attachment 17 (Floor Plans).

6. Describe expertise in working with the target population, including experience developing and implementing systems and services appropriate for addressing the target population's identified health care needs.

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

7. Describe the organization's strategic planning process and how the target population's health care needs and the related program evaluation objectives and data measures have been or will be incorporated into ongoing strategic planning.
8. Describe any current or planned acquisition/development and implementation of certified EHR technology systems used for tracking patient and clinical data to achieve meaningful use. Meaningful use encourages the use of Electronic Health Records (EHR) to improve the patient's experience of care and provider care coordination, reduce per capita health care costs, and increase population health. More information about meaningful use is available at http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp.
9. Describe financial information systems that are in place for collecting, organizing, and tracking key performance data for program reporting on the organization's financial status (e.g., revenue generation by source, aged accounts receivable by income source, debt to equity ratio, net assets to expenses, working capital to expenses, visits by payor category) and that support management decision making.
10. Describe systems that are in place to maximize collections and reimbursement for costs in providing health services, including written procedures for eligibility determination, as well as billing, credit and collection policies and procedures.
11. Describe financial management capability, accounting and control systems, and policies and procedures appropriate for the size and complexity of the organization, reflecting Generally Accepted Accounting Principles (GAAP) and how the organization maintains and separate functions appropriate to the organization's size to safeguard assets and maintain financial stability.
12. Describe the organization's annual independent auditing process performed in accordance with Federal audit requirements. Provide the most recent financial audit (performed in accordance with Federal audit requirements), and the management letter in Attachment 15. 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 or, if in

operation fewer than six months, the length of time the organization has been in operation, if available.

13. Discuss the status of emergency preparedness planning and development of emergency management plans, including participation or efforts to participate with State and local emergency planners. Any “No” response must be addressed in Form 10 – Annual Emergency Preparedness Report.
14. Provide a complete and detailed budget presentation (Form 2 – Staffing Profile, Form 3 – Income Analysis, and Form 3A – FQHC Look-Alike Budget).
15. Describe how the total budget is aligned and consistent with the proposed service delivery plan and number of patients to be served.

GOVERNANCE

NOTE: Health centers operated by Indian tribes or tribal, Indian or urban Indian groups should respond to ONLY Item 5 below.¹⁸ Such applicants should select N/A on Form 6B – Request for Waiver of Governance Requirements.

1. Discuss how the signed bylaws, and/or other relevant documents demonstrate compliance with the Health Center Program requirements.¹⁹ Specifically, describe how the bylaws (required, Attachment 4), Articles of Incorporation (required, Attachment 8), and/or Co-Applicant Agreement (Attachment 6)²⁰ document 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 and refer to [page 46](#) for instructions);
 - (b) Ensures that minutes are captured for all 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 long-range viability;
 - (f) Approves the health center’s annual budget;

¹⁸ Per section 330(k)(3)(H), of the PHS Act, 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.

¹⁹ Section 330(k)(3)(H) of the PHS Act as amended (42 U.S.C. 254b) and regulations (42 CFR 51c304 or 42 CFR 56.304, as applicable).

²⁰ 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 that stipulates roles, responsibilities, and the delegation of authorities, including and any shared roles and responsibilities of each party in carrying out the governance functions for the health center.

- (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 (only a public center may retain responsibility for establishing general fiscal and personnel policies); and
 - (j) Establishes policies that include provisions that prohibit conflict of interest.
2. Document that the structure of the board (co-applicant board for a public center) is appropriate in terms of size (i.e., number of board members), composition, and expertise (e.g., board members have a broad range of skills and perspectives in such areas as finance, legal affairs, business, health, social services). More specifically, document that:
- (a) The board is comprised of at least 51 percent of individuals who currently receive their primary health care from the organization (this requirement may be waived for eligible applicants; see Form 6B and refer to page 46 for instructions).
 - (b) As a group, board members represent the individuals served by the organization in terms of race, ethnicity, and gender. Reference Form 6A – Current Board Member Characteristics.²¹
 - (c) Non-patient members are representative of the community in which the center’s service area is located and are selected for their expertise.
 - (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 (50 percent) of the non-patient 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. (The CEO may serve only as a non-voting *ex officio* board member.)

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

3. Demonstrate the effectiveness of the governing board by describing how the board:
- (a) Operates, including the organization and responsibilities of board committees.
 - (b) Monitors and evaluates its (the board’s) performance.
 - (c) Provides board training, development, and orientation for **new members** to ensure that they have sufficient knowledge to make informed decisions.

²¹ Eligible applicants requesting a waiver of the 51 percent patient majority board composition requirement must list the applicant’s board members on Form 6A – Current Board Member Characteristics and NOT the members of any advisory councils.

NOTE: Only an applicant requesting targeted funding to serve special populations (MHC, HCH, and/or PHPC) that DOES NOT receive or IS NOT requesting CHC funding may request a waiver of the monthly meeting or 51 percent patient majority requirement. **An approved waiver does not relieve the governing board from fulfilling all other board authorities and responsibilities required by statute.**

An applicant that currently receives or is applying to receive CHC funding must indicate “Not Applicable” for Item 4 below.

4. An applicant requesting a waiver for one or both of the governance requirements must indicate such request on Form 6B – Request for Waiver of Governance Requirements and explain:
 - (a) Why the project cannot meet this requirement and describe in Form 6B the alternative mechanism(s) for gathering and utilizing patient input; and/or
 - (b) Why the project cannot meet the monthly meeting requirement and describe in Form 6B the alternative meeting schedule and how it will assure that the board will maintain appropriate oversight of the project.
5. **Indian Tribes or Tribal, Indian, or Urban Indian Groups Only:** Describe the 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 project.

C. Initial Application Form and Table Instructions

FQHC Look-Alike Program-Specific forms MUST be completed electronically in the HRSA EHB. “Forms” refer to those documents that are completed online in the system and do not require any downloading or uploading. “Documents” are those requirements that must be downloaded in the template provided, completed, and then uploaded into the system. Please complete each required form. Please note that only the forms available via the online application, approved by the U.S. Office of Management and Budget, should be submitted with the application.

Please also note the following:

- Any portions of the Program Specific Forms that are “blocked/grayed-out” are not required for the FQHC Look-Alike Initial Designation application and DO NOT need to be completed.
- The Clinical and Financial Performance Measures Forms are required for all applicants.

➤ **FORM 1A – GENERAL INFORMATION WORKSHEET**

Form 1A provides a summary of information related to the project at the time of application submission. The following instructions are intended to clarify the information to be reported in each section of the form.

1. Organization Information: Complete all information as requested.
2. Service Area
 - a. Service Area Designation: Select the designation(s) which best describes the proposed service area. Multiple selections are allowed. Identify the type of population served by the organization. For inquiries regarding Medically Underserved Areas or Medically Underserved Populations, call 1-888-275-4772. Press option 1, then option 2 or contact the Shortage Designation Branch via email sdb@hrsa.gov or 301-594-0816. For additional information, visit the HRSA Bureau of Health Professions Shortage Designation Web site at <http://bhpr.hrsa.gov/shortage/>.
 - b. Target Population Type: Classify target population type as Rural or Urban.
 - c. Target Population and Provider Information: For all portions of this section, organizations with more than one delivery site should report aggregate data for all of the sites included in the project.
 - **Service Area and Target Population:** Provide the estimated number of individuals composing the service area and target population currently and the estimated numbers proposed by end of a two-year initial designation period (“Projected at Full Capacity”).
 - **Provider FTEs by Type:**
 1. Identify a count of billable provider FTEs by type (i.e., medical providers, dental providers, behavioral health providers, and substance abuse services providers).
 2. “Projected at Full Capacity” refers to the number of FTEs anticipated by the organization by the end of the designation period (two years for Initial Designation applicants).
 3. Do not report provider FTEs outside the organization’s proposed scope of project or any volunteer providers.
 - **Total Unduplicated Patients and Visits by Service Type:**
 1. Identify the current number of unduplicated patients and visits for each service type and the projected number of patients and visits at full capacity. “Projected at Full Capacity” refers to the number of patients and/or visits anticipated to be served by the organization by the end of the designation period (2 years for Initial Designation applicants).
 2. Organizations are encouraged to sustain and/or increase patients and/or visits through the designation period.
 3. Do not report patients or visits for services outside the organization’s proposed scope of project.
 - **Unduplicated Patients and Visits by Population Type:** Identify the current number of patients and visits by population type. **NOTE:** When providing an unduplicated count of patients and visits please note the following guidelines:
 - Visits are defined as documented, face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services rendered must be documented in the patient’s record.

- Since patients must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.

➤ **FORM 2 - STAFFING PROFILE**

The Staffing Profile reports personnel salaries supported by the total budget for the first year of the proposed FQHC Look-Alike project.

- Salaries in categories representing multiple positions (e.g., LPN, RN) should be averaged.
- Do not report portions of salaries that support activities outside the proposed scope of project.

➤ **FORM 3 – INCOME ANALYSIS**

Each organization must complete the Income Analysis Form. The form projects program income, by source, for the first year of the designation period.

The Income Analysis Form provides a format for presenting the estimated non-Federal revenues and other sources of income for the organization. Any specific entries that require additional explanation should be addressed in the “Comments/Explanatory Notes” box at the bottom of page 2 of the form and if necessary, detailed in the Management and Finance Program Narrative. The worksheet must be based on the proposed project. It may not include any grant funds from any pending grants or other unapproved changes in sites, services or capacity. There are two major classifications of revenues, Program Income and Other Income.

- **Part 1: Program Income** includes fees, premiums and third party reimbursements and payments generated from the projected delivery of services. Program income is divided into two types: Fee for Service and Capitated Managed Care.
- **Part 2: Other Income** includes State, local or other Federal grants (e.g., Ryan White, HUD, Head Start, etc.) or contracts and local or private grants or other support not generated from charges for services delivered.

If the categories in the worksheet do not describe all possible categories of the organization’s Program or Other Income, such as “pharmacy,” organizations may add lines to account for additional income sources. Clarifications for these additions may be noted in the “Comments/Explanatory Notes” box at the bottom of page 2 of the form.

Part 1: Program Income

NOTE: This form reports only on those visits that are billable to first or third parties including income from individuals who, after the schedule of discounts/sliding fee scale, may pay little or none of the actual charge.

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 organization has a Blue Cross fee-for-service managed Medicaid contract, that information would be included on lines 1a.-1e., not on lines 3a.-3c. If the Child Health

Insurance Program (CHIP) is paid through Medicaid, it should be included in the appropriate category on lines 1a-1e. In addition, if the organization receives Medicaid reimbursement via a Primary Care Case Management (PCCM) model, this income should be included on line 1e. "Medicaid: Other Fee for Service."

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

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.

Column (b): Enter the average charge per visit by payor category. A sophisticated analysis of charges will generally reveal different average charges. For example, Medicare charges may be higher than average Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) charges. If this level of detail is not available, averages may be calculated more generally (e.g., at the payor, service type, or agency level).

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

Column (d): Enter the average adjustment to the average charge per visit in column (b).

A negative number reduces and a positive number increases the Net Charges calculated in column (e). (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. These are shown in columns f and g. Adjustments in column (d) include those related to:

- Projected contractual allowances or discounts to the average charge per visit.
- Sliding discounts given to low-income patients (with incomes 0 to 200% of the Federal poverty guidelines as applicable).
- Adjustments to bring the average charge up/down to the negotiated FQHC or PPS established reimbursement rate or the cost based reimbursement expected after completion of a cost reimbursement report.
- Any other applicable adjustments. (These should be discussed in the "Comments/Explanatory Notes" box at the bottom of page 2 of the form.)

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

Column (f): Based on previous experience, enter the estimated collection rate (%) by payor category. The collection rate is the amount projected to be collected divided by the amount actually billed. 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” section of the form. **NOTE:** Do not show sliding discount percentages here – they are included above in column (d); do show the collection rate for actual direct patient billings.

Column (g): Enter Projected income for each payor category calculated as: column (e) * column (f).

Column (h): Enter the actual accrued income by payor category for the most recent 12-month period for which data are available. Any significant variance between projected income (columns g) and actual accrued income (column h) should be explained in the management and finance program narrative portion of the application. If 12 months of data are not available, enter the amount available and indicate the time frame.

Projected Capitated Managed Care Income

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. Note also, that unlike the fee-for-service section of this form, organizations will group together all types of services on a single line for the type of payor. Thus, capitated Medicaid dental visits and capitated Medicaid medical visits are added together and reported on line 7a.

Number of Member Months (Column a): “Member months” is the number of member months for which the organization receives payment for each enrollee (e.g., 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 an even more unique mix of services. Unusual service mixes which provide for unusually high or low per-member per-month (PMPM) payments should be described in the notes section.

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 should be averaged together for a “blended rate” for the provider type.

Risk Pool Adjustment (Column c): This is an estimate of the total amount that will be earned from risk or performance pools. It includes any payment made by the HMO to the organization for effectively and efficiently managing the health care of the enrolled members. It is almost always for a prior period, but must be accounted for in the period in which it is received. Describe risk pools in the narrative. Risk pools may be estimated

by using the average risk pool receipt PMPM over an appropriate prior period selected by the organization.

FQHC and Other Adjustments (Column d): This is the total amount of payments made to the organization to cover the difference between the PMPM amount paid for Medicaid or Medicare managed care visits and the organization’s PPS/FQHC rate.

Projected Gross Income (Column e): Column e is calculated for each line as:
 $[\text{column (a)} * \text{column (b)}] + [\text{column c} + \text{column d}] = \text{e}.$

Actual Gross Income (Column f): Identify the actual gross income the organization accrued for the most recent 12-month period. Any significant variance between projected income (columns e) and actual accrued income (column f) should be explained in the management and finance program narrative portion of the application. If 12-months of data are not available, enter the amount available and indicate the time frame.

Part 2: Other Income

This category includes all other income not entered elsewhere on this table. 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, foundations, etc.

Line 9. “Applicant” refers to any income generated by the organization through the expenditure of its own assets such as income from reserves or realized sale of property.

Please note that in-kind donations should not be included in the Income Analysis; however organizations may discuss in-kind contributions as applicable, in the management and finance program narrative.

➤ **FORM 3A — FQHC LOOK-ALIKE BUDGET INFORMATION**

Each organization must complete the FQHC Look-Alike Budget Information Form. The form reports program budget, by program, function, and activity for the first year of the designation period.

The FQHC Look-Alike Budget Information Form provides a format for reporting the estimated expenses and revenue for the organization’s proposed project. There are two parts to this form, Expenses and Revenue.

- **Part 1: Expenses:** includes personnel, fringe benefits, travel, equipment, supplies, contractual, construction, and other. Indirect charges may also be included.
- **Part 2: Revenue:** includes funds supplied by the applicant and/or Federal, State, local, other sources.

Part 1: Expenses

For each of the expense categories enter the projected first year expenses for each of the Program(s), Function(s), or Activity(s) where applicable. If the categories in the form do not describe all possible expenses, organizations may enter expenses in the “Other” category. The total fields are calculated automatically as you move through the form.

Part 2: Revenue

For each of the revenue categories, enter the projected first year revenue from each of the Program(s), Functions(s), or Activity(s) where applicable. If revenue is collected from sources other than the listed sources, indicate those in the “Other” category. The total fields are calculated automatically as you move through the form.

➤ **FORM 4 — COMMUNITY CHARACTERISTICS**

The Community Characteristics form reports service area and target population data for the entire scope of the project (i.e., all sites) for the most recent period for which data are available. Service area data should be specific to the project. Target population data should reflect the total target population the organization serves. If information for the service area is not available, utilize data from U.S. Census Bureau, local planning agencies, health departments and other local, State, and national data sources. Estimates are acceptable.

When completing Form 4 – Community Characteristics, please note that all information provided regarding race and/or ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements. Data on race and/or ethnicity collected on this form will not be used as a factor for recommending FQHC Look-Alike designation.

Race:

In completing the form, organizations are required to report race for all individuals served; however, some patient registration systems are not configured to capture data for patients who were asked to report race or ethnicity. Organizations that are unable to distinguish a White Latino patient from a Black Latino patient (because the MIS only identifies patients as White, Black, or Latino), should report these patients as "unreported." In the table in Form 4, the total number of individuals in the “Hispanic or Latino Identity” total must equal the total number of individuals in the “Race” total.

- Report the number of individuals in each racial category.
- Classify all individuals in one of the racial categories (including “Unreported / refused to report”). This includes individuals who self-report to be “Latino” or “Hispanic.” If the organization’s MIS does not separately classify these individuals by race, then report “Latino” and “Hispanics” as “race unreported.”
- Further divide individuals on the Race table into separate ethnic categories:
 - 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, or other Pacific Islands.

- 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.
- Use the option of “More than one race” only if the individual has chosen two or more races.

Hispanic or Latino Identity (Ethnicity):

- Report on the “Hispanic or Latino” line persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- If the individual is not a member of one of the cultures or origins listed in the bullets above, then include the individual in the “All others including unreported” line.

➤ **FORM 5A – SERVICES PROVIDED**

Organizations must identify what services are available for the entire organization and how these services will be provided. Only one form is required for the services provided by the entire organization. Refer to PIN 2008-01, “[Defining Scope of Project and Policy for Requesting Changes](#),” for more information on defining services. Only those services identified on Form 5A will be documented as a part of the organization’s scope of project. Services that are identified elsewhere in the application (e.g., Program Narrative) and are not identified on Form 5A will not be considered to be in the approved scope of project.

NOTE: Organizations are required to have formal written referral arrangements/agreements for behavioral health and substance abuse services (Column III). If your organization also offers these services directly or has formal written contract(s)/agreement(s) with another provider to offer them, include them under “Services Provided – Additional Services” section of Form 5A.

➤ **FORM 5B – SERVICE SITES**

Organizations must identify the name and address of each service site that meets the definition of a site. Refer to PIN 2008-01, “[Defining Scope of Project and Policy for Requesting Changes](#),” for more information on defining sites and for special instructions for recording mobile, intermittent, or other site types. Only those sites identified on Form 5B will be documented as a part of the organization’s scope of project. Sites that are identified elsewhere in the application (e.g., Program Narrative) and are not identified on Form 5B will not be considered to be in the approved scope of project. **NOTE:** Only sites currently providing services can be included in the Initial Designation application. Once the organization is designated as an FQHC Look-Alike, additional sites can be added through the Change in Scope application process.

➤ **FORM 5C – OTHER ACTIVITIES/LOCATIONS (AS APPLICABLE)**

“Other activities/locations” are activities that: (1) are provided at locations that do not meet the definition of a service site; (2) are conducted on an irregular time frame/schedule; and/or (3) offer a limited activity from within the full complement of health center activities included within the scope of project. Organizations must identify all “other activities,” their locations, estimated frequency and a brief description of the activity using this form. For additional guidance on “other activities/locations,” refer to PIN 2008-01, “[Defining Scope of Project and Policy for Requesting Changes.](#)”

➤ **FORM 6A – CURRENT BOARD MEMBER CHARACTERISTICS**

- All applicants (with the exception of Tribal organizations) must complete the Board Member Characteristics form.
- Applicants must list all current board members, including *ex officio* members, and provide information on all characteristics as requested.
- Public entities with co-applicant health center governing boards should list the co-applicant board members on Form 6A.
- Applicants requesting a waiver of the 51 percent consumer majority composition requirement must list the health center’s board members on Form 6A, not the members of their advisory council(s) if they have one.

➤ **FORM 6B – REQUEST FOR WAIVER OF GOVERNANCE REQUIREMENTS (AS APPLICABLE)**

All applicants must complete Question 1A on Form 6B (at a minimum). Organizations requesting FQHC Look-Alike designation to serve a special population authorized under section 330 of the PHS Act (i.e., migratory and seasonal farmworkers (section 330(g)), homeless populations (section 330(h)) and/or residents of public housing (section 330(i)) must complete the entire form if requesting a waiver. Organizations that serve the general community (i.e., section 330(e)), or the general community in conjunction with a special population, are not eligible for a governance waiver.

- Tribal entities are exempt from Governance Requirements and should indicate “non-applicable” on Question 1A for Form 6B.
- An applicant that is applying to receive section 330(e) Community Health Center designation should indicate “no” on Question 1A for Form 6B.
- The remainder of Form 6B only needs to be completed by FQHC Look-Alike Initial Designation applicants requesting a governance waiver for 51% consumer/patient majority and/or monthly meetings.
- Only applicants requesting targeted designation to **solely** serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330 (h)) and/or residents of public housing (section 330(i)) and that are NOT requesting Community Health Center (section 330(e)) designation are eligible for a waiver request.

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

Applicants must clearly describe on Form 6B why the project cannot meet the statutory requirements for which a waiver is requested and detail the alternative strategies the program will employ to assure consumer/patient participation (if board is not 51 percent consumer/patients) and/or regular oversight (if no monthly meetings) in the direction and ongoing governance of the organization.

Waiver of Consumer/Patient Majority:

If the consumer/patient majority is requested to be waived, the applicant must briefly discuss why the project cannot meet this requirement and describe the alternative mechanism(s) for gathering consumer/patient input (e.g., separate advisory boards, patient surveys, focus groups). Areas of discussion should include:

- The specific type of consumer/patient input to be collected.
- Methods for documenting such input in writing.
- Process for formally communicating the input directly to the organization’s governing board (e.g., quarterly presentations of the advisory group to the full board, quarterly summary reports from consumer/patient surveys).
- How the consumer input will be used by the governing board in such areas 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 consumer input.

Waiver of Monthly Meetings

If monthly meetings are requested to be waived, the applicant must briefly discuss why the project cannot meet this requirement and detail the proposed alternative schedule of meetings and how the alternative schedule will assure that the board can still maintain appropriate oversight and operation of the project.

➤ **FORM 8 – HEALTH CENTER AGREEMENTS**

Complete Part I, indicating whether current or proposed agreements constitute a substantial portion of the proposed scope of project. 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 to determine if limits or compromises to the governing board’s authorities, functions, and responsibilities exist based on current or proposed agreements or arrangements. 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 in the appropriate field.

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 or (2) impacts the

governing board’s composition, authorities, functions, or responsibilities (as described in Part I and Part II). Upload **each** agreement/arrangement (up to 5 for each organization) in full. Agreements/arrangements that exceed these limits should be included in Attachment 18 (Other Information).

➤ **FORM 9 – NEED FOR ASSISTANCE (NFA) WORKSHEET**

1. GENERAL INSTRUCTIONS FOR COMPLETING FORM 9

All applicants must submit a completed NFA Worksheet (Form 9) as part of the application. Applicants must present data on the NFA Worksheet based on **the target population to be served within the proposed service area**, as appropriate. Only one NFA Worksheet will be submitted regardless of the number of FQHC Look-Alike sites proposed in the application.

- Applicants are expected to complete the NFA Worksheet based on the entire proposed scope of their project.
- If an applicant proposes to serve **multiple sites, populations and/or service areas**, the NFA Worksheet responses should represent the total targeted population within the proposed service area. **No more than one response should be submitted for any barrier or health indicator.**

Guidelines for Completing the NFA Worksheet:

- Responses cannot be expressed as ranges (e.g., 31-35).
- Responses must be expressed in the **same format/unit of analysis** identified in each barrier or health indicator (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
Percent	25% (25 percent of target population is uninsured)
Prevalence (expressed as percent or rate)	8.5% (8.5 percent of population has asthma) or 85 per 1,000 (85 asthma cases per 1,000 population)
Proportion	0.25 (25 out of 100 people, or 25% of all persons, are obese)
Rate	50 per 100,000 (50 hospital admissions for hypertension per 100,000 population)
Ratio	3000:1 (3000 people per every 1 primary care physician)

2. POPULATION TO BE SERVED

All responses must be based on data for the total target population within the proposed service area, as appropriate, per the following criteria:

- (a) Applicants requesting designation to serve the medically underserved population of a service area (**under section 330(e) ONLY**) must provide responses that reflect the health care needs of the target population for the application. When the service area is a sub-

county area (made up of groups of census tracts, other county divisions or zip codes), but data for a particular Barrier or Health indicator are not available at sub-county levels, applicants may use an extrapolation technique to appropriately modify the available county-level or other level (including if necessary, national) data to reflect the service area population.

- (b) Applicants requesting designation to serve **ONLY a homeless population (under section 330 (h)), a migrant/seasonal farmworkers population (under section 330(g)) or residents of public housing (under section 330(i)), or any combination of these special populations**, may use an extrapolation technique to appropriately modify available data for these special populations to reflect their specific population(s) within the proposed service area.
- (c) Applicants requesting designation to **serve a homeless population (under section 330 (h)), a migrant/seasonal farmworker population (under section 330(g)) or residents of public housing (under section 330(i)) IN COMBINATION WITH the medically underserved, general population of a service area (under section 330(e))**, must present responses that reflect the total population to be served. In calculating the response, applicants may use extrapolation techniques to appropriately modify available data to reflect the homeless, migrant/seasonal farmworker and/or public housing population within the service area (as in (b) above), then combine this with data about the general population within the defined the service area. As above, where sub-county data are not available, applicants may use an extrapolation technique to modify available county-level or other level data to reflect the service area population.

3. DATA

Please 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; and
- (b) Applicants must provide the following information for all data sources:
- Name of data source;
 - The year to which the data apply;
 - Description of the methodology utilized (e.g., extrapolation); and
 - Any additional information of relevance.

4. NFA WORKSHEET

SECTION 1: CORE BARRIERS

A response is required for **three (3) out of the four (4)** Core Barriers listed:

- Ratio of Population to One FTE Primary Care Physician
- Percent of Population at or Below 200 Percent of Poverty
- Percent of Population Uninsured
- Distance (miles) OR Travel Time (minutes) to Nearest Primary Care Provider Accepting New Medicaid Patients and/or Uninsured Patients

SECTION 2: CORE HEALTH INDICATORS

Applicant should provide a response to **one (1)** core health indicator **from within each of the six (6) categories**: Diabetes, Cardiovascular Disease, Cancer, Prenatal and Perinatal Health, Child Health, and Behavioral and Oral Health.

If an applicant believes that none of the specified indicators represent the applicant’s target population within the proposed service area, 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 used, and rationale for using this alternative indicator.

CORE HEALTH INDICATOR CATEGORIES	Format/Unit of Analysis
1. Diabetes	
1(a) Diabetes Short-term Complication Hospital Admission Rate	Number per 100,000
1(b) Diabetes Long-term Complication Hospital Admission Rate	Number per 100,000
1(c) Uncontrolled Diabetes Hospital Admission Rate	Number per 100,000
1(d) Rate of Lower-extremity Amputation Among Patients with Diabetes	Number per 100,000
1(e) Age Adjusted Diabetes Prevalence	Percent
1(f) Adult Obesity Prevalence	Percent
1(g) Diabetes Mortality Rate ²²	Number per 100,000
1(h) Other	Provided by Applicant
2. Cardiovascular Disease	
2(a) Hypertension Hospital Admission Rate	Number per 100,000
2(b) Congestive Heart Failure Hospital Admission Rate	Number per 100,000
2(c) Angina without Procedure Hospital Admission Rate	Number per 100,000
2(d) Mortality from Diseases of the Heart ²³	Number per 100,000
2(e) Proportion of Adults reporting diagnosis of high blood pressure	Percent
2(f) Other	Provided by Applicant
3. Cancer	
3(a) Cancer Screening – Percent of women 18 and older with No Pap test in past 3 years	Percent
3(b) Cancer Screening – Percent of women 40 and older with No Mammogram in past 3 years	Percent
3(c) Cancer Screening – Percent of adult 50 and older with No Fecal Occult Blood Test within the past 2 years	Percent
3(d) Other	Provided by Applicant
4. Prenatal and Perinatal Health	
4(a) Low Birth Weight Rate (5 year average)	Percent
4(b) Infant Mortality Rate (5 year average)	Number per 1000 births
4(c) Births to Teenage Mothers (ages 15-19; Percent of all births)	Percent
4(d) Late entry into prenatal care (entry after first trimester; Percent of all births)	Percent
4(e) Cigarette use during pregnancy (Percent of all pregnancies)	Percent
4(f) Other	Provided by Applicant

²²Number of deaths per 100,000 reported as due to diabetes as the underlying cause or as one of multiple causes of death (ICD-9 Code 250).

²³ Total number of deaths per 100,000 reported as due to heart disease (includes ICD-9 Codes I00-I09, I11, I13, and I20-I51).

CORE HEALTH INDICATOR CATEGORIES	Format/Unit of Analysis
5. Child Health	
5(a) Pediatric Asthma Hospital Admission Rate	Number per 100,000
5(b) Percent of Children tested for elevated blood lead levels by 36 months of age	Percent
5(c) Percent of children not receiving recommended immunizations: 4-3-1-3-3 ²⁴	Percent
5(d) Other	Provided by Applicant
6. Behavioral and Oral Health	
6(a) Depression Prevalence	Percent
6(b) Suicide Rate	Number per 100,000
6(c) Youth Suicide attempts requiring medical attention (Percent of all Youths)	Percent
6(d) Percent of Adults with Mental disorders not receiving treatment	Percent
6(e) Any Illicit Drug Use in the Past Month (Percent of all Adults)	Percent
6(f) Heavy alcohol use (Percent among population 12 and over)	Percent
6(g) Homeless with severe mental illness (Percent of all homeless)	Percent
6(h) Oral Health (Percent without dental visit in last year)	Percent
6(i) Other	Provided by Applicant

SECTION 3: OTHER HEALTH INDICATORS

Applicants must provide responses to **two (2) out of the twelve (12)** Other Health Indicators listed below. Alternatively, applicants can propose up to two (2) of the identified indicators using an “Other” indicator. For each “Other” indicator (up to two (2)), applicants must specify the indicator’s definition, data source used, and rationale for using this indicator in place of one of those specified.

OTHER HEALTH INDICATORS	Format/Unit of Analysis
(a) Age-Adjusted Death Rate	Number per 100,000
(b) HIV Infection Prevalence	Percent
(c) Percent Elderly (65 and older)	Percent
(d) Adult Asthma Hospital Admission Rate	Number per 100,000
(e) Chronic Obstructive Pulmonary Disease Hospital Admission Rate	Number per 100,000
(f) Bacterial Pneumonia Hospital Admission Rate	Number per 100,000
(g) Three Year Average Pneumonia Death Rate ²⁵	Number per 100,000
(h) Adult Current Asthma Prevalence	Percent
(i) Adult Ever Told Had Asthma (Percent of all adults)	Percent
(j) Unintentional Injury Deaths	Number per 100,000
(k) Percent of population linguistically isolated (percent of people 5 years and over who speak a language other than English at home)	Percent
(l) Waiting time for public housing where public housing exists	Months
(m) Other	Provided by Applicant
(n) Other	Provided by Applicant

²⁴ 4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B

²⁵ Three year average number of deaths per 100,000 due to pneumonia (includes ICD-9 Codes 480-486).

➤ **FORM 10 – ANNUAL EMERGENCY PREPAREDNESS (EP) REPORT**

The Annual Emergency Preparedness Report will be used to assess the status of emergency preparedness planning, progress towards developing and implementing an emergency management plan.

➤ **FORM 12 – CONTACT INFORMATION**

Form 12 captures the organizational contacts used for ongoing communication.

D. Instructions and Format for Initial Designation Clinical and Financial Performance Measures

The clinical and financial performance measures serve as ongoing monitoring and evaluation tool for FQHC Look-Alikes and HRSA. The performance measures should include time-framed and realistic goals and related performance measures (as referenced below) with baselines that are responsive to the identified primary health care needs of the community served and the strategic needs of the overall organization, including multiple sites and/or various activities at multiple sites. If baselines are not yet available, identify when the data will be available. If designated, FQHC Look-Alikes must report on the progress of achieving the goals and baselines during each Annual Certification application, as well as develop new goals and baselines for each Renewal of Designation application.

Performance Measures

Organizations are expected to respond to the health center performance measures within each Need/Focus Area identified below, as appropriate. The health center performance measures are accessible on HRSA's Web site at

<http://bphc.hrsa.gov/policiesregulations/performanceasures/>. Additional information on the Clinical Performance Measures can be found in the annual Uniform Data System Reporting Manual available at <http://bphc.hrsa.gov/uds/>. Additional technical assistance related to the clinical and financial performance measures is available through HRSA and the State PCA.

- Please note that only applicants that provide or assume primary responsibility for some or all of a patient's prenatal care services, whether or not the applicant does the delivery, are required to include prenatal performance measures, including the required measures: Percentage of pregnant women beginning prenatal care in the first trimester and Percentage of births less than 2,500 grams to health center patients.
- If the applicant is applying for FQHC Look-Alike designation to target special populations (e.g., migrant/seasonal farmworkers, residents of public housing, homeless persons), they are encouraged to include additional goals and related performance measures that address the unique health care needs of these populations, as appropriate.
- If the applicant has identified other unique populations, life-cycles, health issues, risk management efforts, etc. in the narrative Need section, they are encouraged to include additional goals and related performance measures as appropriate.

- Any additional narrative regarding the clinical and financial performance measures should be included in the Evaluative Measures section of the Program Narrative, as appropriate.

Applicants are expected to address the performance measures provided by HRSA, as applicable. All applicants are expected to also include one Behavioral Health (e.g., Mental Health or Substance Abuse) and one Oral Health performance measure of their choice in the clinical performance measures.

Applicants may also wish to consider utilizing Healthy People 2020 goals and performance measures when developing their clinical and financial performance measures. Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The program consists of 41 focus areas and more than 1,400 objectives. Further information on Healthy People 2020 goals may be downloaded at <http://www.healthypeople.gov/document/>.

Initial Designation applicants should include goals and baselines that can be achieved in a two-year period, starting January 1 and ending December 31. Use the sample Initial Designation application clinical and financial performance measures formats provided below.

Need Addressed/Focus Area

This is a concise categorization of the major need or focus area to be addressed by the applicant for their service area, target population, and/or organization (Diabetes; Cardiovascular; Costs, Productivity; etc.). Applicants are expected to address each required performance measurement area as well as any other key needs of their target population or organization as identified in the application narrative.

Designation Period Goal(s) with Baseline

Goals relating to the Need/Focus Area should be listed in this section. Applicants should provide goals for the required performance measures listed above as well as other goals, which can be accomplished by the end of the two-year designation period. The goals should be reasonable, measurable, and reflect an anticipated impact upon the specified need or focus area. The applicant must also provide baseline data to indicate their status at or prior to the beginning of the designation period. Baseline data provides a basis for quantifying the amount of progress/improvement to be accomplished in the designation period. If applicants choose to establish a baseline for any of the new clinical performance measures, they are encouraged to utilize current data. Applicants are expected to track performance against these goals throughout the entire approved designation period and to report interim progress achieved on the goal in subsequent Annual Certification applications.

Performance Measure(s)

Applicants must make use of the required performance measures listed above when setting goals in the Designation Period Goal(s) with Baseline section (also noted in the sample

performance measures). Applicants may also include additional performance measures. Additional measures chosen by the applicant should also define the numerator and denominator that will be used to determine the level of progress/improvement achieved on each goal (e.g., Numerator: One or more screenings for colorectal cancer. Denominator: All patients age 51-80 years during the measurement year).

Data Source & Methodology

The source of performance measure data, method of collection and analysis (e.g., electronic health records, disease registries, chart audits/sampling) should be noted by the applicant. Data should be valid and reliable and derived from currently established management information systems, where possible.

Key Factors

This is a brief description of the key factors (up to 3) that may impact (positively or negatively) on the applicant's progress on each of the clinical and financial performance measures.

Major Planned Actions

This is a brief description of the major planned actions (up to 2) to be completed in response to the key factors identified in the Key Factors section impacting performance on the clinical and financial performance measures.

Comments/Notes

Supplementary information, notes, context for related entries in the plan may be provided, as applicable.

SAMPLE MEASURES

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE CLINICAL PERFORMANCE MEASURE	FOR HRSA USE ONLY		
	Organization Name	Application Tracking Number	
	XYZ Health Center	00000	
	Designation Period Date	01/01/2011 - 12/31/2013	
Focus Area: Diabetes			
Performance Measure: Percentage of diabetic patients whose HbA1c levels are less than or equal to 9 percent			
Is this Performance Measure Applicable to your Organization?	Yes		
Target Goal Description	By the end of the Designation Period, increase the % of adult patients with type 1 or 2 diabetes whose most recent hemoglobin A1c (HbA1c) is ≤ 9% (under control) up to 65%		
Numerator Description	Number of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator.		
Denominator Description	Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria		
Baseline Data	Baseline Year: 2009 Measure Type: Percentage Numerator: 2200 Denominator: 4000	Projected Data (by End of Designation Period)	65%
Data Source & Methodology	Representative sample of patient records. (Data run on 1/10/2010)		
Key Factor and Major Planned Action #1	Key Factor Type: <input checked="" type="checkbox"/> Contributing <input type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable Key Factor Description: XYZ offers a variety of pharmaceutical assistance programs, including the provision of free, discounted, or generic medications as well as medications through its 340B Federal Drug Pricing arrangement. At least 70% of diabetic patients are on 3 to 8 medications because of co-morbidity complications that occur. Major Planned Action Description: Increase education and outreach efforts to diabetic patients on the importance of daily testing and the availability of free/discounted glucometers and test strips available through XYZ.		
Key Factor and Major Planned Action #2	Key Factor Type: <input checked="" type="checkbox"/> Contributing <input type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable Key Factor Description: XYZ has an agency-wide, multidisciplinary team that includes physicians, nurses, medical assistants, a quality management coordinator and a data specialist. The team works with each site to analyze and improve the internal processes to achieve effective diabetes care delivery. Major Planned Action Description: At each site, XYZ will identify a physician champion who will be allotted administrative time to work with fellow staff to test and implement changes. The agency-wide and site-specific teams will form a collaborative infrastructure that provides diabetic patients with the necessary tools and support to successfully manage their disease.		

FQHC Look-Alike Application Instructions CY 2011-2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE CLINICAL PERFORMANCE MEASURE	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	XYZ Health Center	00000
	Designation Period Date	01/01/2011 - 12/31/2013
Key Factor and Major Planned Action #3	Key Factor Type: <input type="checkbox"/> Contributing <input checked="" type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable Key Factor Description: Time management becomes problematic when XYZ staff juggles regular work with Diabetes Collaborative tasks. The agency-wide team would like to meet more frequently, but providers are pressed for administrative time given their full clinical schedules. Any type of backlog or deficiency adds system stress to a provider or staff member's work schedule that negatively affects patient care management. Major Planned Action Description: Hire an additional clinical staff person to provide additional "non-clinical" review time for the agency-wide team members.	
Comments		

FQHC Look-Alike Application Instructions CY 2011-2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration		FOR HRSA USE ONLY	
		Organization Name	Application Tracking Number
SAMPLE FINANCIAL PERFORMANCE MEASURE		XYZ	00001
		Designation Period Date	01/01/2011 - 12/31/2013
Focus Area: Costs			
Performance Measure: Medical Cost per Medical Visit			
Is this Performance Measure Applicable to your Organization?	Yes		
Target Goal Description	By the end of the Designation Period, maintain rate of increase not exceeding 5% per year, such that medical cost per medical visit is less than or equal to 164.83.		
Numerator Description	Total accrued medical staff and medical other cost after allocation of overhead (excludes lab and x-ray costs)		
Denominator Description	Non-nursing medical visits (excludes nursing (RN) and psychiatrist visits)		
Baseline Data	Baseline Year: 2009 Measure Type: Ratio Numerator: 492000 Denominator: 4000	Projected Data (by End of Designation Period)	164.83
Data Source & Methodology	UDS		
Key Factor and Major Planned Action #1	<p>Key Factor Type: <input checked="" type="checkbox"/> Contributing <input type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable</p> <p>Key Factor Description: Recent addition of nurse practitioner providers increased XYZ encounters.</p> <p>Major Planned Action Description: Continue assessing current patient/provider mix to best utilize resources.</p>		
Key Factor and Major Planned Action #2	<p>Key Factor Type: <input type="checkbox"/> Contributing <input checked="" type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable</p> <p>Key Factor Description: Recently lost our pediatrician to a local competitor, therefore child visits are down.</p> <p>Major Planned Action Description: We are beginning efforts to recruit a NHSC loan repayer to address the shortage.</p>		
Key Factor and Major Planned Action #3	<p>Key Factor Type: <input type="checkbox"/> Contributing <input type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable</p> <p>Key Factor Description:</p> <p>Major Planned Action Description:</p>		
Comments			

E. Agency Contacts

Additional information related to the overall program issues and/or technical assistance regarding the Initial Designation application may be obtained by contacting:

FQHC Look-Alike Program
Office of Policy and Program Development
HRSA, Bureau of Primary Health Care
5600 Fishers Lane
Parklawn Building, Room 17C-26
Rockville, MD 20857
Telephone: 301-594-4300
Fax: 301-594-4997
Email: FQHCLAL@hrsa.gov
Technical Assistance Resources: <http://bphc.hrsa.gov/about/lookalike/index.html>

For Assistance with Application Submission and the HRSA electronic Handbooks (EHB):

Applicants who need assistance preparing and submitting their application electronically through HRSA's EHB can contact the HRSA Call Center, Monday – Friday, 9:00 AM to 5:30 PM ET:

HRSA Call Center
Phone: 877-Go4-HRSA or 877-464-4772
TTY: 877-897-9910
Fax: 301-998-7377
Email: CallCenter@hrsa.gov

**FQHC LOOK-ALIKE
INSTRUCTIONS FOR CALENDAR YEAR
2011/2012**

RENEWAL OF DESIGNATION APPLICATION

Technical Assistance Website:

<http://bphc.hrsa.gov/about/lookalike/index.html>

I. PURPOSE

Renewal of Designation applications will demonstrate a high level of need in their community/population, present a sound proposal to meet this need, show that the organization displays responsiveness to the health care environment of the service area and demonstrates collaborative and coordinated delivery systems for the provision of health care to the underserved. Further, applicants are expected to demonstrate that the FQHC Look-Alike organization: 1) provides access to comprehensive, culturally competent, quality primary health care services, including oral health, mental health, and substance abuse services, and 2) improves the health status of underserved and vulnerable populations in the area to be served.

All applicants are expected to demonstrate compliance with the requirements of section 330 of the Public Health Service (PHS) Act, as amended and applicable regulations. Applicants are encouraged to refer to <http://www.bphc.hrsa.gov/about/requirements/index.html> for additional information on key health center program requirements.

II. EXPECTED RESULTS

All successful Renewal of Designation applications will demonstrate:

- Compliance at the time of application with the requirements of section 330 of the PHS Act, as amended, and applicable regulations and policies. Program requirements are available at <http://www.bphc.hrsa.gov/about/requirements/index.html>.
- Evidence that the FQHC Look-Alike site(s) serves populations in **high need areas**. All applicants must submit a completed Need for Assistance (NFA) Worksheet (see instructions on page 88) as part of the application to demonstrate the relative need for additional primary health care services.
- Evidence of how the FQHC Look-Alike organization **maintains or increases access to primary health care services, improves health outcomes and reduces health disparities** in the community/population to be served.
- Evidence that **all persons in the target population have ready access to the full range of required primary, preventive, enabling and supplemental health care services, including oral health care, mental health care and substance abuse services**, either directly on-site or through established arrangements without regard to ability to pay.
- Responsiveness to its health care environment by documenting that it has developed **collaborative and coordinated delivery systems** for the provision of health care to the underserved in their communities. Successful applicants will demonstrate actual or proposed partnerships and collaborative activities with other FQHC Look-Alikes and section 330 grantees, rural health clinics, hospitals, State and local health departments, and other programs serving the same population(s).

- **A sound and complete plan** that is responsive 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 and accurate budget** (Form 3A – FQHC Look-Alike Budget Form) based on the activities proposed in the application.

Throughout the application development and preparation process, applicants are highly encouraged to collaborate with the appropriate Primary Care Associations (PCAs), Primary Care Offices (PCOs) and/or National Cooperative Agreements (NCAs) in determining their readiness to develop an FQHC Look-Alike Renewal of Designation application. Refer to <http://www.bphc.hrsa.gov/technicalassistance/> for a complete listing of PCAs, PCOs, and NCAs.

III. SPECIFIC PROGRAM REQUIREMENTS/EXPECTATIONS

All applicants are expected to demonstrate compliance with the applicable requirements of section 330 of the PHS Act, as amended, and corresponding program regulations and policies. There are specific requirements and expectations for applicants requesting designation under each type²⁶ of health center authorized under section 330. Applicants requesting designation to support one or more health center types are expected to demonstrate compliance with the specific requirements of each type. Failure to document and demonstrate compliance in the application will significantly reduce the likelihood renewal of designation.

COMMUNITY HEALTH CENTER APPLICANTS

- Compliance with section 330(e) and program regulations; and
- A plan that ensures the availability and accessibility of required primary and preventive health services, including oral health, mental health and substance abuse services, to all individuals in the service area.

MIGRANT HEALTH CENTER APPLICANTS

- Compliance with section 330(g) and, as applicable, section 330(e) and program regulations; and
- A plan that ensures: (1) the availability and accessibility of required primary and preventive health services, including oral health, mental health and substance abuse services, to migratory and seasonal farmworkers and their families in the area to be served; (2) how adjustments will be made for service delivery during peak and off-season cycles; and (3) how the special environmental and occupational health concerns will be addressed.

²⁶ The types of health centers authorized under section 330 of the PHS Act as amended are: 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)).

HEALTH CARE FOR THE HOMELESS APPLICANTS

- Compliance with section 330(h) and, as applicable, section 330(e) and program regulations;
- A plan that ensures the availability and accessibility of required primary and preventive health services, including oral health, mental health, and substance abuse services to homeless individuals and families in the area to be served; and
- A mechanism for delivering comprehensive substance abuse services to homeless patients (i.e., detoxification, risk reduction, outpatient treatment, residential treatment, and rehabilitation for substance abuse provided in settings other than hospitals).

PUBLIC HOUSING PRIMARY CARE APPLICANTS

- Compliance with section 330(i) and, as applicable, section 330(e) and program regulations;
- A plan that ensures the availability and accessibility of required primary and preventive health services, including oral health, mental health and substance abuse services, to residents of public housing primary care in the area to be served; and
- A mechanism for involving residents in the preparation of the application and in the ongoing planning and administration of the program.

IV. ELIGIBILITY INFORMATION

An FQHC Look-Alike Renewal of Designation application must meet all of the applicable eligibility requirements listed below. **Applications that do not meet the eligibility requirements will be considered non-responsive and will not be considered for renewal of designation.**

1. Applicant is a public or private, nonprofit entity, including tribal, faith-based, and community-based organization.
2. Applicant requests renewal of FQHC Look-Alike designation for a site(s) that provides comprehensive primary, preventive, enabling and additional health care services including oral health care, mental health care and substance abuse services, either directly on-site or through established arrangements without regard to ability to pay. An applicant may **not** propose to provide only a single service, such as dental, mental health or prenatal services.
3. Applicant proposes to provide access to services for all individuals in the targeted service area or population. In other words, applicant does not propose to exclusively serve a single age group (e.g., children), lifecycle (e.g., geriatric), or health issue/disease category (e.g., HIV/AIDS). In instances where a sub-population is being targeted within the service area or population (e.g., homeless children and adolescents/children in schools), the applicant must demonstrate how health care services will be made available to other persons in need of care who may seek services at the proposed site(s).
4. Applicant proposes to serve a defined geographic area that is federally-designated, in whole or in part, as a Medically Underserved Area (MUA) or a Medically Underserved

Population (MUP). **NOTE:** *If the applicant is requesting designation only for MHC, HCH, and/or PHPC, the applicant is not required to have an MUA/MUP designation for the proposed service area and/or target population.*

V. SUBMISSION INFORMATION

HRSA **requires** applicants for this opportunity to apply electronically through the HRSA Electronic Handbooks (EHBs). All applicants **must** submit in this manner. Refer to HRSA's *Electronic Submission User Guide*, available online at <http://bphc.hrsa.gov/about/lookalike/index.html> for detailed application and submission instructions. HRSA will not accept FQHC Look-Alike Renewal of Designation applications in paper form.

Renewal of Designation applications are due 90 days prior to the end of the designation period. The EHB system will send electronic email reminders to the organization's contacts identified in the EHB system 180 days prior to the end of the designation period to inform them when the application is due and that it is accessible in the EHB system. **Failure to submit the Renewal of Designation application could result in termination of the FQHC Look-Alike designation and all corresponding benefits (e.g., Medicare and Medicaid FQHC reimbursement, 340B Drug Pricing Program benefits, etc.).**

Once the Renewal of Designation application process is started in the EHB system, applicants have a maximum of 90 calendar days to complete and submit the entire application. Applications will be considered having been formally submitted if the application has been successfully transmitted electronically by the organization's Authorizing Official (AO) through HRSA's EHB within the 90 days following notification of the availability of the application in the HRSA EHB. If an application is not submitted in the EHB system within the 90 day period, it will be considered ineligible and deleted from the EHB system.

It is incumbent on the applicant to ensure that the AO is available to submit the application within the 90 day application period. HRSA will not accept submission or re-submission of incomplete, rejected, or otherwise delayed applications after the 90 day application period. Therefore, applicants are urged to submit applications in advance of the 90 day deadline. If the application is rejected by HRSA's EHB due to errors, the application must be corrected by the applicant and resubmitted to the EHB before the application deadline.

VI. APPLICATION INSTRUCTIONS

A. Application Materials and Format Instructions

The following table details the documents required for the Renewal of Designation application for Calendar Year 2011/2012. Organizations are encouraged to review this table prior to submitting a Renewal of Designation application to ensure that all required components are included. Failure to submit all required components as outlined may result in a delay of HRSA's application review.

“Forms” refer to those documents that are completed online using HRSA’s EHB and that do not require any downloading or uploading. “Documents” are those requirements that must be downloaded in the template provided, completed, and then uploaded into the EHB system. ***For detailed instructions for all Forms and Documents, see Sections VI.B. and VI.C. below.***

Renewal of Designation Application Content	Form Type	Instructions
Cover Page	Form	Complete all portions of the form electronically online as presented.
Form 1A: General Information Worksheet	Form	Complete all portions of the form electronically online as presented.
Table of Contents	Document	The EHB will automatically generate a Table of Contents.
Project Abstract	Document	The project abstract should be single-spaced, limited to two pages in length. Please prepare the abstract so that it is clear, accurate, concise, and without reference to other parts of the application. The abstract narrative should include: <ul style="list-style-type: none"> – The population group(s) served. – Summary of the organizational structure. – A brief history of the organization, the community served and the target population(s). – A summary of the major health care needs and barriers to care. – A summary of services provided. – A summary of the number of providers, service delivery locations, services, and total number of patients and visits.
Project Narrative	Document	Upload as instructed.
Clinical Performance Measures	Form	Complete all portions of the form electronically online as presented.
Financial Performance Measures	Form	Complete all portions of the form electronically online as presented.
Form 2: Staffing Profile	Form	Complete all portions of the form electronically online as presented.
Form 3: Income Analysis Form	Document	Complete all portions of the form electronically online as presented.
Form 3A:FQHC Look-Alike Budget	Form	Complete all portions of the form electronically online as presented.
Form 4: Community Characteristics	Form	Complete all portions of the form electronically online as presented.
Form 5A: Services Provided	Form	This form is pre-populated with the services in the current approved scope of project. This is a read-only form and may not be modified. NOTE: Only existing services in the approved scope of project will be pre-populated in the application in the EHB (excluding pending applications for change in scope to add a service). Only one form is required for the all of the required and additional services provided by the FQHC Look-Alike organization.

FQHC Look-Alike Application Instructions CY 2011-2012

Renewal of Designation Application Content	Form Type	Instructions
Form 5B: Service Sites	Form	This form is pre-populated with the sites in the current approved scope of project. Essential attributes are read-only and may not be modified in this form. Other attributes in this form are modifiable. NOTE: Only existing service sites in the approved scope of project will be pre-populated in the application in EHB (excluding pending applications for change in scope to add a site).
Form 5C: Other Activities/Locations (if applicable)	Form	This form is pre-populated with the other activities in the current approved scope of project. This is a read-only form and may not be modified.
Form 6A: Current Board Member Characteristics	Form	Complete all portions of the form electronically online as presented.
Form 6B: Request for Waiver of Governance Requirements	Form	Complete all portions of the form electronically online as presented.. NOTE: Only organizations that request designation exclusively to serve a special population authorized under section 330 of the PHS Act are eligible for a governance waiver. FQHC Look-Alikes with an approved waiver must request to maintain the waiver in the Renewal of Designation application.
Form 8: Health Center Agreements	Form	Complete all portions of the form electronically online as presented and attach agreements as appropriate. NOTE: Form 8 is approved for the length of the designation period.
Form 9: Need for Assistance	Form	Complete all portions of the form electronically online as presented.
Form 10: Annual Emergency Preparedness and Management Report	Form	Complete all portions of the form electronically online as presented.
Form 12: Contacts Information	Form	Complete all portions of the form electronically online as presented.
Attachment 1: Service Area Map	Document	Provide a map that clearly identifies the areas served by the organization, all service delivery sites, the designated MUA/MUP areas, census tracts, zip codes, and the location of other primary care provider sites (e.g., section 330-funded health centers, FQHC Look-Alikes, hospitals, free-clinics, etc.). Organizations are encouraged to use HRSA's Geospatial Data Warehouse mapping feature to produce maps. This feature is available on HRSA's Web site at http://datawarehouse.hrsa.gov/hpsadetail.aspx .
Attachment 2: Current or Requested MUA/MUP Designation	Document	Provide a dated copy of the current or requested MUA/MUP designation. For inquiries regarding MUA/MUP, call 1-888-275-4772 (press option 1, then option 2); contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816; or obtain additional information on HRSA's Web site at http://bhpr.hrsa.gov/shortage/ . Organizations may submit as documentation of the MUA/MUP designation a confirmation page from HRSA's "Find Shortage Areas" Web site.

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Renewal of Designation Application Content	Form Type	Instructions
Attachment 3: Governing Board Bylaws	Document	Provide a signed and dated copy of the governing board bylaws. The bylaws must demonstrate compliance with the requirements of section 330 of the PHS Act, 42 C.F.R. 51c, and 42 C.F.R. 56 (as applicable).
Attachment 4: Co-Applicant Agreement for Public Centers (if applicable)	Document	Public centers (also referred to as public entities or public agencies) with a co-applicant arrangement must provide a signed and dated copy of the written agreement between the two parties. The co-applicant agreement must identify the roles and responsibilities of both the public center and co-applicant, the delegation of authorities of both parties, and any shared roles and responsibilities in carrying out the governance functions.
Attachment 5: Affiliation, Contract, and/or Referral Agreements (if applicable)	Document	<p>Upload a BRIEF SUMMARY describing current or proposed contracts and agreements (e.g., contracted provider and/or staff, management services contracts, etc.). Applicants do not need to discuss contracts or agreements for such areas as janitorial services. The summary must address the following items for each contract or agreement:</p> <ul style="list-style-type: none"> – Name and contract 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 agreement/contract/affiliation. <p>If a contract or agreement will be attached to Form 8 (e.g., for a substantial portion of the proposed project), denote this with an asterisk (*).</p> <p>Organizations that do not have contractual agreements with another entity should clearly indicate so in the narrative. As a reminder, contracts must be in compliance with section 330 of the PHS Act and 42 C.F.R. 51c. In addition, the governing board must approve all contracts and retain authority over the organization’s policy and procedures, such as budget, hours, and services provided.</p>
Attachment 6: Articles of Incorporation	Document	Private, non-profit organizations must provide a copy of the Articles of Incorporation filed with the State or other evidence of non-profit status (e.g., a letter from the State or the Federal government or evidence that an application for non-profit status has been submitted). The seal page documenting the State acceptance of the articles must be included with the application.

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Renewal of Designation Application Content	Form Type	Instructions
Attachment 7: Evidence of Non-Profit or Public Agency Status	Document	<p>Private, non-profit organizations must provide evidence of current or pending tax exempt status. Public centers must provide evidence of the co-applicant governing board’s current or pending tax exempt status if the co-applicant is independently incorporated. Any of the following is acceptable evidence:</p> <ul style="list-style-type: none"> – 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 organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals. – A certified copy of the organization’s certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization. <p>Public Agency: Consistent with Policy Information Notice 2010-10, “Confirming Public Agency Status under the Health Center Program and FQHC Look-Alike Program,” applicants must provide documentation demonstrating the organization will qualify as a “public agency” for purposes of section 330 of the PHS Act, as amended. Any of the following is acceptable evidence:</p> <ul style="list-style-type: none"> – “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; or – A determination letter issued by the IRS, providing evidence of a past positive letter ruling by the IRS, 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; or – Formal documentation from a sovereign State’s taxing authority equivalent to the IRS or authority granting the entity one or more governmental powers. <p><i>Please provide a detailed explanation if none of the above evidence is available, with supporting documentation, as relevant.</i></p> <p>For additional information, refer to Confirming Public Agency Status PIN at http://www.bphc.hrsa.gov/policiesregulations/policies/pin201001.html</p>
Attachment 8: Medicare and Medicaid Provider Documentation	Document	<p>Submit a copy of the CMS notification that documents the organization is an approved Medicare and Medicaid provider and the provider numbers. Please note: Each permanent and seasonal site is required to have a unique Medicare Billing Number.</p>

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Renewal of Designation Application Content	Form Type	Instructions
Attachment 9: Organizational Chart	Document	Provide an organizational chart showing the organizational and management structure and lines of authority, key employee position titles, names, and Full Time Equivalents (FTEs). The governing board and individuals with the following responsibilities should be clearly identified: CEO/Executive Director, Chief Medical Officer (CMO)/Clinical Director, and Chief Financial Officer (CFO)/Financial Manager. The chart should demonstrate the governing board retains ultimate authority and leadership of the organization. Public centers with co-applicant arrangements should demonstrate the relationship between the two entities.
Attachment 10: Position Descriptions for Key Personnel	Document	Submit a copy of position descriptions for all key management positions. Indicate on the position descriptions if key management positions are combined and/or part-time (e.g., CFO and Chief Operation Officer (COO) roles are shared). At minimum, the position description should include the position title, description of duties and responsibilities, position qualifications, supervisory relationships, skills, knowledge and experience requirements, travel requirements, salary range and hours worked.
Attachment 11: Resumes for Key Personnel	Document	Provide resumes of key personnel for the organization. In the event that a resume is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the resume.
Attachment 12: Schedule of Discounts/Sliding Fee Scale	Document	Provide a schedule of charges/sliding fee scale with a corresponding schedule of discounts for which charges are adjusted on the basis of the patient's ability to pay. Organizations must show sliding fee scale discounts for persons with incomes between 200% and 100% of the most current annual Federal poverty guidelines (FPG) (see the most current annual FPG at http://aspe.hhs.gov/poverty/). Patients with incomes below 100 percent of the FPG may not be charged for services (nominal fees are acceptable if they do not serve as barriers to obtaining services). No discounts may be accorded to patients with incomes over 200% of the FPG.
Attachment 13: Most Recent Independent Financial Audit	Document	Submit a complete copy of the organization's most recent annual audit, including the auditor's opinion statement (i.e., management letter). Audit information will be considered complete when it includes the balance sheet, profit and loss statement, audit findings, management letter, and any noted exceptions. The audit must comply with generally accepted accounting principles (GAAP). In instances where the audit is not available at the time of application submission, identify the anticipated time frame for completion of the auditor report and submit a copy of the organization's most recent six months of financial statements.

Renewal of Designation Application Content	Form Type	Instructions
Attachment 14: Letters of Support	Document	Organizations must collaborate with other primary care providers in the community. Include a copy of any letters from the other primary care providers in the area including other FQHC Look-Alikes, section 330 grantees, rural health clinics, hospitals, local health departments, and other programs serving the same population(s) that supports the organization’s request for FQHC Look-Alike designation or an explanation of why the organization was unable to obtain the support letter.
Attachment 15: Floor Plans	Document	Organizations must attach floor plans for any sites that have been added since their last FQHC Look-Alike application.
Attachment 16: Other Information	Document	Organizations may include other relevant documents to support the proposed project plan such as charts, organizational brochures, lease/intent to lease documents, etc.

Failure to include all required documents as part of the application may result in an application being considered incomplete or non-responsive. Incomplete applications may be returned to the applicant without further consideration.

B. Program Narrative Instructions

The Program Narrative provides a comprehensive description of the proposed FQHC Look-Alike project. It should be succinct, self-explanatory, and well-organized so that reviewers can fully understand the proposed project. It should provide a detailed picture of the community/target population(s) being served, the applicant organization, and the organization’s plan for addressing the identified health care needs/issues of the community/target population(s).

Applicants should fully address ALL requirements within the narrative component of the application. All documents (i.e., Program Narrative, forms, documents and attachments) are evaluated individually and collectively. The Program Narrative should be succinct, self-explanatory and well-organized so that reviewers can fully understand the proposed project. Organizations must respond to all criteria and submit all applicable forms and attachments to demonstrate compliance with program requirements <http://www.bphc.hrsa.gov/about/requirements/index.html>. Failure to include all required information could result in HRSA returning the application as incomplete.

The Program Narrative should be consistent with the clinical and financial performance measures as well as all other Program Specific Forms and attachments. The attachments should not be used to extend the Program Narrative. The following provides a framework for the Program Narrative. Applicants should ensure that all of the specific elements in the Program Narrative are completely addressed.

NEED

Information provided on need should serve as the basis for, and align with, the proposed activities and goals described in the Clinical and Financial Performance Measures Forms and throughout the application.

1. Describe the unique characteristics of the target population, including those characteristics that impact access to primary health care, health care utilization and/or health status. The response should describe additional aspects of need that are not captured by quantitative data. Reference Attachment 1: Service Area Map, if applicable.
2. Describe other existing primary health care services (including mental health/substance abuse and oral health) currently available in the applicant's service area including any gaps in service (e.g., provider shortages) and the role and location of any other providers who currently serve the target population.
3. Describe the health care environment and any significant changes that have affected the community's ability to provide services and/or have affected the applicant's fiscal stability, if applicable.
4. For applicants requesting designation to serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330 (h)), and/or residents of public housing (section 330(i)): describe the specific health care needs and access issues of the proposed special population.

RESPONSE

1. Describe the service delivery model(s) to serve the community/population health care needs identified in the Need section, including service delivery models to meet the specific needs of special populations if seeking renewal of designation under section 330(g), section 330(h) and/or section 330(i). All sites and activities described should be consistent with those listed in Forms 5B and 5C (Service Sites and Other Activities/Locations, respectively), including locations (reference Attachment 1: Service Area Map, if applicable), hours, and after-hours care.

NOTE: Public Housing Primary Care applicants ONLY (section 330(i)) should demonstrate that the service site(s) is (are) immediately accessible to the public housing community being targeted.

2. Describe how the primary health care services are appropriate for the needs of the target population and are available and accessible to all life cycles without regard to ability to pay. (Services discussed should be consistent with those listed in Form 5A – Services Provided and the form should be referenced as applicable.)²⁷

²⁷ Applicants currently designated as an FQHC Look-Alike and applying to serve their current service area who are changing the delivery manner of services resulting in a service being added (e.g., directly providing or paying for a

NOTE: Health Care for the Homeless applicants ONLY (section 330(h)) must demonstrate that substance abuse services will be made available as part of the required services.

3. Describe how the service delivery model(s) assures the integration of enabling services (e.g., outreach, transportation), continuity of care (e.g., admitting privileges), access to a continuum of care, and access to special care services (e.g., referral relationships).
4. Discuss the appropriateness of all current contracts for a substantial portion of the operation of the health center listed on Form 8 – Health Center Agreements and/or other agreements summarized in Attachment 5 (Affiliation, Contract, and/or Referral Agreements).

NOTE: All applicants must complete Form 8 – Health Center Agreements and reference it throughout the Response section as applicable. In addition, CHC and/or MHC applicants that respond “no” to any question in the Governance checklist section of Form 8 must clearly discuss the specific situation(s).

5. Describe the clinical team staffing plan, the projected number of patients, and how the organization is providing the required, preventive, enabling, and additional health services as appropriate and necessary either directly or through established arrangements and referrals.

NOTE: The applicant should reference Form 2 and Form 5A (Staffing Profile and Services Provided, respectively) in their response as appropriate. If the clinical team staffing plan includes contracted providers, the applicant must include a summary of all such current contracts in Attachment 5.

6. Describe the system in place to determine eligibility for patient discounts adjusted on the basis of the patient’s ability to pay and demonstrate how the established schedule of discounts/sliding fee scale is consistent with locally prevailing rates or charges. In addition, describe how the corresponding schedule of discounts (often referred to as a sliding fee scale) ensures that no patient will be denied services due to their inability to pay. Reference the schedule of discounts in Attachment 12 in the response.

NOTE: Ability to pay is determined by a patient’s annual income and family size according to the most recent Federal Poverty Guidelines for the contiguous 48 states, Alaska, and Hawaii (information available at <http://aspe.hhs.gov/poverty/>).

service that was previously provided by referral without payment) or deleted (e.g., providing a service by referral without payment that was previously directly provided or paid for by the applicant) must submit a change in scope request for prior approval. The change in scope application must be submitted through HRSA’s Electronic Handbooks (EHBs).

7. Describe the organization's ongoing quality improvement/quality assurance (QI/QA) and risk management plan(s), including management and staff roles in oversight and implementation and any previous significant adjustments in practice based on QI/QA findings. Additionally, describe any national quality recognition the organization has received.

NOTE: QI/QA may include but not be limited to clinical, financial, and administrative areas.

8. Describe the organization's appropriate and board-approved policies and procedures that support the QI/QA and risk management plan(s).including: current clinical standards of care, provider credentials and privileges, risk management procedures, patient grievance procedures, incident management, and confidentiality of patient records.

COLLABORATION

1. Describe both formal and informal collaboration and coordination of services²⁸ with other health care providers. Specifically, describe collaboration and coordination with existing section 330 grantees, FQHC Look-Alikes, rural health clinics, hospitals, State and local health departments, private providers and programs serving the same population(s) (e.g., social services; job training; Women, Infants and Children (WIC); coalitions; community groups).

Migrant Health Center (MHC), Health Care for the Homeless (HCH), and/or Public Housing Primary Care (PHPC) applicants must discuss formal agreements with other organizations that provide services or support to the special population(s) for which designation is sought.

NOTE: Formal collaboration (contracts, agreements, and/or arrangements) should also be summarized in Attachment 5.

2. Document collaborations by providing letters of support, commitment and/or investment that reference the specific collaboration and/or coordinated activities in support of the project's operation and provision of primary health care services (e.g., local school board, hospital, homeless shelters, advocacy groups, and other service providers).
3. Document support for the renewal of designation through current dated letters of support from all FQHCs (current section 330 grantees, and FQHC Look-Alikes), health departments, rural health clinics, and/or hospitals in the service area. If such letters cannot be obtained, include documentation of efforts made to obtain the letters along with an explanation including documentation of efforts made to obtain the letter. All letters of support should be merged into one document and included in Attachment 14: Letters of Support, and referenced in the application as appropriate.

²⁸ Review Program Assistance Letter 2011-02, Health Center Collaboration available at <http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html> for information on maximizing opportunities to collaborate with other health care safety net providers.

EVALUATIVE MEASURES

Information provided on need should serve as the basis for, and align with, the activities and goals described in the clinical and financial performance measures and throughout the application.

1. Outline within the Clinical Performance Measures Form, time-framed and realistic goals with baselines that are responsive to the health needs identified in the application. More specifically include:
 - (a) Goals for improving quality of care, health outcomes and eliminating disparities in the required areas. Applicants may (but are not required to) include goals that address any other key health needs within their community, target population(s) and/or for key life cycle groups (e.g., adolescents, elderly, etc.).
 - (b) **For applicants applying to serve migrant populations, people experiencing homelessness and/or residents of public housing under section 330(g), section 330(h) and/or section 330 (i) respectively**, include goals relevant to the needs of these populations. Applicants that currently serve or plan to serve but are not a designated FQHC Look-Alike organization for these populations are also encouraged to include relevant goals and measures reflecting these needs.
 - (c) Corresponding measures for all goals and data collection methodology for measuring progress.
 - (d) A summary of the key factors anticipated to contribute to or restrict progress on the stated performance measure goals, and action steps planned for addressing described factors. **NOTE:** In discussing responses to anticipated contributing or restricting factors, applicants should discuss this area broadly. It is not necessary to provide detail at an “action step” level.

2. Outline within the Financial Performance Measures Form, time-framed and realistic goals with baselines that are responsive to the strategic planning needs identified in the application. Specifically the applicant must include:
 - (a) Goals for improving the organization’s status in terms of costs and financial viability. Applicants may (but are not required to) include goals that address any other key financial viability and/or cost issues within their organization.
 - (b) Corresponding financial performance measures for all goals and related data collection methodology for measuring progress.
 - (c) A summary of the key factors anticipated to contribute to or restrict progress on the stated financial performance measures goals and action steps planned for addressing described factors. **NOTE:** Applicants should discuss this area broadly. It is not necessary to provide detail at an “action step” level.

3. Provide a brief description of additional evaluation activities planned to assess progress throughout the designation period, if any, including tools utilized to collect and analyze relevant data.

RESOURCES/CAPABILITIES

1. Describe how the organizational structure is appropriate for the operational needs of the project, including how lines of authority are maintained from the governing board to the Chief Executive Officer (CEO)/Executive Director down through the management structure and are in accordance with Health Center Program Requirements (<http://www.bphc.hrsa.gov/about/requirements/index.html>). Reference Attachment 3: Governing Board Bylaws, Attachment 9: Organizational Chart, and, as applicable: Attachment 4: Co-Applicant Agreement (for Public Centers that have a co-applicant board),²⁹ and Attachment 5: Affiliation, Contract, and/or Referral Agreements.
2. Describe how the organization maintains appropriate oversight and authority over all contracted services and/or affiliation arrangement(s) (as referenced in Program Specific Form 8 – Health Center Agreements), in accordance with Health Center Program requirements.³⁰ Applicant must summarize all applicable current contracts and/or other agreements in Attachment 5. Applicants must reference Form 8 (Health Center Affiliation/Checklist) throughout the response as applicable.
3. Discuss how the organization maintains a fully staffed management team (chief executive officer (CEO), chief clinical officer (CCO), chief financial officer (CFO), chief information officer (CIO), and chief operating officer (COO) as applicable), that is appropriate and adequate for the size, operational and oversight needs and scope of the proposed project and is in accordance with Health Center Program requirements. Explain any positions that are combined and/or part time (e.g., CFO and COO roles are shared). Also, explain the organizational and management structure and lines of authority, provide position descriptions that include the roles, responsibilities, and qualifications as well as resumes for the CEO, CCO, CFO, CIO, and COO as applicable. These should be included in Attachment 9: Project Organizational Chart, Attachment 10: Position Descriptions for Key Management Staff and Attachment 11: Resumes for Key Personnel.
4. Describe the plan for recruiting and retaining key management staff and health care providers as appropriate for achieving the proposed staffing plan and discuss any key management staff changes in the last year, as applicable.
5. Describe how the service site(s) within the current scope of project are appropriate for implementing the service delivery plan and reasonable in terms of the projected number of patients. If facilities are not currently owned or under a lease agreement, provide the relevant contracts, MOUs (e.g., with homeless shelter, public housing authority, other

²⁹ In cases where 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; and any shared roles and responsibilities of each party in carrying out the governance functions.

³⁰ As stated in PIN 1997-27, Affiliation Agreements of Community and Migrant Health Centers, and/or PIN 1998-24, Amendment to PIN 1997-27, Regarding Affiliation Agreements of Community and Migrant Health Centers. Applicants are encouraged to review <http://bphc.hrsa.gov/about/requirements.htm> for additional information on program requirements and expectations.

partner organizations) describing how access to facilities and on-site space is assured, in Attachment 5. Floor plans and lease/intent to lease documents must be attached for any facilities in Attachment 15: Floor Plans.

6. Describe expertise in working with the target population, describing experience developing and implementing systems and services appropriate for addressing the target population's identified health care needs.

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

7. Describe the organization's strategic planning process and how the target population's health care needs and the related program evaluation objectives and data measures have been or will be incorporated into ongoing strategic planning.
8. Describe any current or planned acquisition/development and implementation of certified EHR technology systems used for tracking patient and clinical data to achieve meaningful use. Meaningful use encourages the use of Electronic Health Records (EHR) to improve the patient's experience of care and provider care coordination, reduce per capita health care costs, and increase population health. More information about meaningful use is available at http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp.
9. Describe financial information systems that are in place for collecting, organizing, and tracking key performance data for program reporting on the organization's financial status (e.g., revenue generation by source, aged accounts receivable by income source, debt to equity ratio, net assets to expenses, working capital to expenses, visits by payor category) and that support management decision making.
10. Demonstrate that systems are in place to maximize collections and reimbursement for costs in providing health services including written procedures for eligibility determination, as well as billing, credit and collection policies and procedures.
11. Demonstrate financial management capability, accounting and control systems, and policies and procedures appropriate for the size and complexity of the organization, reflecting Generally Accepted Accounting Principles (GAAP) and how the organization maintains separate functions appropriate to the organization's size to safeguard assets and maintain financial stability.
12. Provide an annual independent financial audit that is performed in accordance with Federal audit requirements. The most recent financial audit and management letter must be referenced and must be included in Attachment 13, as applicable.

13. Discuss the status of emergency preparedness planning and development of emergency management plans, including participation or efforts to participate with State and local emergency planners. Any “No” response must be addressed in Form 10: Annual Emergency Preparedness Report.
14. Provide a complete and detailed budget presentation (Form 2: Staffing Profile, Form 3: Income Analysis, and Form 3A: FQHC Look-Alike Budget).
15. Describe how the total budget is aligned and consistent with the proposed service delivery plan and number of patients to be served.

GOVERNANCE

NOTE: Health centers operated by Indian tribes or tribal, Indian or urban Indian groups should respond to ONLY Item 5 below.³¹ Such applicants should select N/A on Form 6B: Request for Waiver of Governance Requirements.

1. Discuss how the signed bylaws and/or other relevant documents demonstrate compliance with the Health Center Program requirements.³² Specifically, describe how the bylaws (Attachment 3), Articles of Incorporation (see Attachment 6) or Co-Applicant Agreement (if applicable, see Attachment 4)³³ demonstrate that the organization has an independent governing board that has the following authorities:
 - (a) Meets at least once a month (this requirement may be waived for eligible applicants: see Form 6B and refer to page 86 for specific instructions);
 - (b) Ensures that minutes are captured for all 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 long-range viability;
 - (f) Approves the health center’s annual budget;
 - (g) Approves the health center’s grant applications;

³¹ Per section 330(k)(3)(H), of the PHS Act, 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.

³² Section 330(k)(3)(H) of the PHS Act as amended (42 U.S.C. 254b) and regulations (42 CFR 51c304 or 42 CFR 56.304, as applicable).

³³ Applicants that are public centers 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 collectively are referred to as the “health center.”

The co-applicant board members should be identified and documented in the center’s application (using Form 6A: Board Member Characteristics). The public center and health center board must have a formal co-applicant agreement that stipulates: roles, responsibilities and the delegation of authorities; and any shared roles and responsibilities of each party in carrying out the governance functions.

- (h) Approves the selection/dismissal and conducts the performance evaluation of the organization's Executive Director/CEO;
 - (i) Establishes general policies for the organization(only a public center may retain responsibility for establishing general fiscal and personnel policies); and
 - (j) Establishes policies that include provisions that prohibit conflict of interest.
2. Demonstrate that the structure of the board (co-applicant board for a public center) is appropriate in terms of size (i.e., number of board members), composition and expertise (e.g., board members have a broad range of skills and perspectives in such areas as finance, legal affairs, business, health, social services). More specifically document that:
- (a) The board is comprised of at least 51 percent of board members must be individuals who are or will receive their primary health care from the organization (this requirement may be waived for eligible applicants; see Form 6B and refer to page 86 for instructions).
 - (b) As a group, board members represent the individuals served by the organization in terms of race, ethnicity, and gender. Reference Form 6A: Current Board Member Characteristics.³⁴
 - (c) Non-patient members are representative of the community in which the center's service area is located and are selected for their expertise.
 - (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 (50 percent) of the non-patient 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. (The CEO may serve only as a non-voting *ex officio* board member.)

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

3. Discuss the effectiveness of the governing board by describing how the board:
- (a) Operates, including the organization and responsibilities of board committees.
 - (b) Monitors and evaluates its (the board's) performance.
 - (c) Provides board training, development and orientation for new members to ensure that they have sufficient knowledge to make informed decisions.

³⁴ 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 and NOT the members of any advisory councils.

NOTE: Only an applicant requesting targeted funding to serve special populations (MHC, HCH, and/or PHPC) that DOES NOT receive or IS NOT requesting CHC funding may request a waiver of the monthly meeting or 51 percent patient majority requirement. **An approved waiver does not relieve the governing board from fulfilling all other board authorities and responsibilities required by statute.**

An applicant that currently receives or is applying to receive CHC funding must indicate “Not Applicable” for Item 4 below.

4. An applicant requesting a waiver for one or both of the governance requirements must indicate such request on Form 6B: Request for Waiver of Governance Requirements and explain:
 - (a) Why the project cannot meet this requirement and describe in Form 6B the alternative mechanism(s) for gathering and utilizing patient input.
 - (b) Why the project cannot meet this requirement and describe in Form 6B the alternative meeting schedule and how it will assure that the board will maintain appropriate oversight of the project.

5. **INDIAN TRIBES OR TRIBAL, INDIAN, OR URBAN INDIAN GROUPS ONLY:** Describe the 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 project.

C. Renewal Of Designation Form and Table Instructions

FQHC Look-Alike Program Specific Forms MUST be completed electronically in the HRSA EHB. “Forms” refer to those documents that are completed online in the system and do not require any downloading or uploading. “Documents” are those requirements that must be downloaded in the template provided, completed, and then uploaded into the system. Please complete each required form. Please note that only these forms available via the online application, approved by the U.S. Office of Management and Budget, should be submitted with the application.

Please note the following:

- Any portions of the Program Specific Forms that are “blocked/grayed-out” are not required for the FQHC Look-Alike Renewal of Designation application and DO NOT need to be completed.
- The Clinical and Financial Performance Measures Forms are required for all applicants.

➤ **FORM 1A – GENERAL INFORMATION WORKSHEET**

Form 1A provides a summary of information related to the project at the time of application submission. The following instructions are intended to clarify the information to be reported in each section of the form.

1. Organization Information: Complete all information as requested.
2. Service Area
 - (a) Service Area Designation: Select the designation(s) which best describe the proposed service area. Multiple selections are allowed. Identify the type of population served by the organization. For inquiries regarding Medically Underserved Areas or Medically Underserved Populations, call 1-888-275-4772. Press option 1, then option 2 or contact the Shortage Designation Branch via email sdb@hrsa.gov or 301-594-0816. For additional information, visit the HRSA Bureau of Health Professions Shortage Designation Web site at <http://bhpr.hrsa.gov/shortage/>.
 - (b) Target Population Type: Classify target population type as Rural or Urban.
 - (c) Target Population and Provider Information: For all portions of this section, organizations with more than one delivery site should report aggregate data for all of the sites included in the project.
 - **Service Area and Target Population:** Provide the estimated number of individuals composing the service area and target population currently and the estimated numbers proposed by end of the designation period (“Projected at Full Capacity”).
 - **Provider FTEs by Type:**
 1. Identify a count of billable provider FTEs by type (i.e., medical providers, dental providers, behavioral health providers, and substance abuse services providers).
 2. “Projected at Full Capacity” refers to the number of FTEs anticipated by the organization by the end of the designation period.
 3. Do not report provider FTEs outside the organization’s proposed scope of project or any volunteer providers.
 - **Total Unduplicated Patients and Visits by Service Type:**
 1. Identify the current number of unduplicated patients and visits for each service type and the projected number of patients and visits at full capacity. “Projected at Full Capacity” refers to the number of patients and/or visits anticipated to be served by the organization by the end of the designation period (up to five years).
 2. Organizations are encouraged to sustain and/or increase patients and/or visits through the designation period. Organizations should explain any declines in the number of patients and/or visits over the designation period in the Program Narrative.
 3. Do not report patients or visits for services outside the organization’s approved scope of project.
 - **Unduplicated Patients and Visits by Population Type:** Identify the current number of patients and visits by population type. **NOTE:** When providing an unduplicated count of patients and visits please note the following guidelines:
 - Visits are defined as documented, face-to-face contact between a patient and a provider who exercises independent judgment in the

provision of services to the individual. To be included as a visit, services rendered must be documented in the patient’s record.

- Since patients must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.

➤ **FORM 2 – STAFFING PROFILE**

Report personnel salaries supported by the total budget for the **first year** of the proposed five-year designation period, including those that are part of an indirect cost rate. Include staff for the entire scope of project (i.e., all sites, include volunteer providers). Anticipated staff changes within the proposed designation period must be addressed in the Program 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.
- Do not report portions of salaries that support activities outside the proposed scope of project.

➤ **FORM 3 – INCOME ANALYSIS**

Each organization must complete the Income Analysis Form. The form projects program income, by source, for the first year of the designation period.

The Income Analysis Form provides a format for presenting the estimated non-Federal revenues and other sources of income for the organization. Any specific entries that require additional explanation should be addressed in the “Comments/Explanatory Notes” box at the bottom of page 2 of the form and if necessary, detailed in the management and finance program narrative. The worksheet must be based on the proposed project. It may not include any grant funds from any pending grants or other unapproved changes in sites, services or capacity. There are two major classifications of revenues, Program Income and Other Income.

- **Part 1: Program Income** includes fees, premiums and third party reimbursements and payments generated from the projected delivery of services. Program income is divided into two types of income: Fee for Service and Capitated Managed Care.
- **Part 2: Other Income** includes State, local or other Federal grants (e.g., Ryan White, HUD, Head Start, etc.) or contracts and local or private grants support that is not generated from charges for services delivered.

If the categories in the worksheet do not describe all categories of the organization’s Program or Other Income, such as “pharmacy” organizations may add lines to account for any additional income source if necessary. Clarifications for these additions may be noted in the “Comments/Explanatory Notes” box at the bottom of page 2 of the form.

Part 1: Program Income

NOTE: This form reports only on those visits that are billable to first or third parties including income from individuals who, after the schedule of discounts/sliding fee scale, may pay little or none of the actual charge.

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 organization has a Blue Cross fee-for-service managed Medicaid contract, that information would be included on lines 1a.-1e., not on lines 3a.-3c. If the Child Health Insurance Program (CHIP) is paid through Medicaid, it should be included in the appropriate category on lines 1a-1e. In addition, if the organization receives Medicaid reimbursement via a Primary Care Case Management (PCCM) model, this income should be included on line 1e. "Medicaid: Other Fee for Service."

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

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.

Column (b): Enter the average charge per visit by payor category. A sophisticated analysis of charges will generally reveal different average charges. For example, Medicare charges may be higher than average Medicaid EPSDT charges. If this level of detail is not available, averages may be calculated more generally (e.g., at the payor, service type, or agency level).

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

Column (d): Enter the average adjustment to the average charge per visit in column (b). A negative number reduces and a positive number increases the Net Charges calculated in column (e). (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. These are shown in columns f and g. Adjustments in column (d) include those related to:

- Projected contractual allowances or discounts to the average charge per visit.
- Sliding discounts given to low-income patients (with incomes 0 to 200% of the Federal poverty guidelines as applicable).

- Adjustments to bring the average charge up/down to the negotiated FQHC or PPS established reimbursement rate or the cost based reimbursement expected after completion of a cost reimbursement report.
- Any other applicable adjustments. (These should be discussed in the “Comments/Explanatory Notes” box at the bottom of page 2 of the form.)

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

Column (f): Based on previous experience, enter the estimated collection rate (%) by payor category. The collection rate is the amount projected to be collected divided by the amount actually billed. 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” section of the form. **NOTE:** Do not show sliding discount percentages here – they are included above in column (d); do show the collection rate for actual direct patient billings.

Column (g): Enter Projected income for each payor category calculated as: column (e) * column (f).

Column (h): Enter the actual accrued income by payor category for the most recent 12-month period for which data are available. Any significant variance between projected income (columns g) and actual accrued income (column h) should be explained in the management and finance program narrative portion of the application. If 12-months of data are not available, enter the amount available and indicate the time frame.

Projected Capitated Managed Care Income

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. Note also, that unlike the fee-for-service section of this form, organizations will group together all types of services on a single line for the type of payor. Thus, capitated Medicaid dental visits and capitated Medicaid medical visits are added together and reported on line 7a.

Number of Member Months (Column a): “Member months” is the number of member months for which the organization receives payment for each enrollee (e.g., 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 an even more unique mix of services. Unusual service mixes which provide for unusually high or low per-member per-month (PMPM) payments should be described in the notes section.

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 should be averaged for a “blended rate” for the provider type.

Risk Pool Adjustment (Column c): This is an estimate of the total amount that will be earned from risk or performance pools. It includes any payment made by the HMO to the organization for effectively and efficiently managing the health care of the enrolled members. It is almost always for a prior period, but must be accounted for in the period for which it is received. Describe risk pools in the narrative. Risk pools may be estimated by using the average risk pool receipt PMPM over an appropriate prior period selected by the organization.

FQHC and Other Adjustments (Column d): This is the total amount of payments made to the organization to cover the difference between the PMPM amount paid for Medicaid or Medicare managed care visits and the organization’s PPS/FQHC rate.

Projected Gross Income (Column e): Column e is calculated for each line as:
 $[\text{column (a)} * \text{column (b)}] + [\text{column c} + \text{column d}] = \text{e}.$

Actual Gross Income (Column f): Identify the actual gross income the organization accrued for the most recent 12-month period. Any significant variance between projected income (columns e) and actual accrued income (column f) should be explained in the management and finance program narrative portion of the application. If 12-months of data are not available, enter the amount available and indicate the time frame.

Part 2: Other Income

This category includes all other income not entered elsewhere on this table. 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, foundations, etc.

Line 9. “Applicant” refers to any income generated by the organization through the expenditure of its own assets such as income from reserves or realized sale of property.

Please note that in-kind donations should not be included in the Income Analysis; however organizations may discuss in-kind contributions as applicable, in the management and finance program narrative.

➤ **FORM 3A — FQHC LOOK-ALIKE BUDGET INFORMATION**

Each organization must complete the FQHC Look-Alike Budget Information Form. The form reports program budget, by program, function, and activity for the first year of the designation period.

The FQHC Look-Alike Budget Information Form provides a format for reporting the estimated expenses and revenue for the organization’s proposed project. There are two parts to this form, Expenses and Revenue.

- **Part 1: Expenses:** Includes personnel, fringe benefits, travel, equipment, supplies, contractual, construction, and other. Indirect charges may also be included.
- **Part 2: Revenue:** Includes funds supplied by the applicant and/or Federal, State, local, other sources.

Part 1: Expenses

For each of the expense categories enter the projected first year expenses for each of the Program(s), Function(s), or Activity(s) where applicable. If the categories in the form do not describe all possible expenses, organizations may enter expenses in the “Other” category. The total fields are calculated automatically as you move through the form.

Part 2: Revenue

For each of the revenue categories, enter the projected first year revenue from each of the Program(s), Functions(s), or Activity(s) where applicable. If revenue is collected from sources other than the listed sources, indicate those in the “Other” category. The total fields are calculated automatically as you move through the form.

➤ **FORM 4 — COMMUNITY CHARACTERISTICS**

The Community Characteristics form reports service area and target population data for the entire scope of the project (i.e., all sites) for the most recent period for which data are available. Service area data should be specific to the project. Target population data should reflect the total target population the organization serves. If information for the service area is not available, utilize data from U.S. Census Bureau, local planning agencies, health departments and other local, State, and national data sources. Estimates are acceptable.

When completing Form 4 – Community Characteristics, please note that all information provided regarding race and/or ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements. Data on race and/or ethnicity collected on this form will not be used as a factor for recommending FQHC Look-Alike designation.

Race

In completing the form, organizations are required to report race for all individuals served; however, some patient registration systems are configured not to capture data for patients who were asked to report race or ethnicity. Organizations that are unable to distinguish a White Latino patient from a Black Latino patient (because the MIS only identifies patients as White, Black, or Latino), should report these patients as “unreported.” In the table in Form 4, the total number of individuals in the “Hispanic or Latino Identity” total must equal the total number of individuals in the “Race” total.

- Report the number of individuals in each racial category.
- Classify individuals in one of the racial categories (including “Unreported / refused to report”). This includes individuals who self-report to be “Latino” or “Hispanic.” If the organization’s MIS does not separately classify these individuals by race, then report “Latino” and “Hispanics” as “race unreported.”
- Further divide Individuals on the Race table into separate ethnic categories:
 - 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, or other Pacific Islands.
 - 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.
 - Note the addition of “More than one race.” Use this line only if the individual has chosen two or more races.

Hispanic or Latino Identity (Ethnicity)

- Report on the “Hispanic or Latino” line persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- If the individual is not a member of one of the cultures or origins listed in the bullets above then include the individual in the “All others including unreported” line.

➤ **FORM 5A – SERVICES PROVIDED**

Data will be pre-populated from the FQHC Look-Alike’s official scope of project and **CANNOT** be modified. Any change in scope or self-update will **NOT** be allowed at the time of the Renewal of Designation submission.

Only services included on Form 5A are considered to be in a FQHC Look-Alike’s approved scope of project. Services that are identified elsewhere in the application (e.g., Program Narrative) and are not identified on Form 5A will not be considered to be in the approved scope of project.

NOTE: If your organization has a pending Change in Scope application to add a service, it cannot be included in Form 5A until the Change in Scope has been approved.

➤ **FORM 5B – SERVICE SITES**

Data will be pre-populated from the FQHC Look-Alike’s official scope of project. Essential attributes are read-only and may not be modified in this form. Other attributes in this form are modifiable. Any change in scope or self-update will **NOT** be allowed at the time of the Renewal of Designation submission.

Only service sites included on Form 5B are considered to be in a FQHC Look-Alike's approved scope of project. Sites that are identified elsewhere in the application (e.g., Program Narrative) are not identified on Form 5B will not be considered to be in the approved scope of project.

NOTE: If your organization has a pending Change In Scope application to add a site, it cannot be included in Form 5B until the Change In Scope has been approved.

➤ **FORM 5C – OTHER ACTIVITIES/LOCATIONS (AS APPLICABLE)**

Data will be pre-populated from the FQHC Look-Alike's official scope of project and **CANNOT** be modified. Any change in scope or self-update will **NOT** be allowed at the time of the Renewal of Designation submission. Only Other Activities/Locations included on Form 5C (e.g., home visits, health fairs) are considered to be in a FQHC Look-Alike's approved scope of project.

➤ **FORM 6A – CURRENT BOARD MEMBER CHARACTERISTICS**

- All applicants (with the exception of Tribal organizations) must complete the Board Member Characteristics form.
- Applicants must list all current board members, including *ex officio* members, and provide information on all characteristics as requested.
- Public entities with co-applicant health center governing boards should list the co-applicant board members on Form 6A.
- Applicants requesting a waiver of the 51 percent consumer majority composition requirement must list the health center's board members on Form 6A, not the members of their advisory council(s) if they have one.

➤ **FORM 6B – REQUEST FOR WAIVER OF GOVERNANCE REQUIREMENTS (AS APPLICABLE)**

All applicants must complete Question 1A on Form 6B (at a minimum). Organizations requesting FQHC Look-Alike designation to serve a special population authorized under section 330 of the PHS Act (i.e., migratory and seasonal farmworkers (section 330(g)), homeless populations (section 330(h)) and/or residents of public housing (section 330(i)) must complete the entire form if requesting a waiver. Organizations that serve the general community (i.e., section 330(e)), or the general community in conjunction with a special population, are not eligible for a governance waiver.

- Tribal entities are exempt from Governance Requirements and should indicate "non-applicable" on Question 1A for Form 6B.
- An applicant that is applying to receive section 330(e) Community Health Center designation should indicate "no" on Question 1A for Form 6B.
- The remainder of Form 6B only needs to be completed by FQHC Look-Alike Initial Designation applicants requesting a governance waiver for 51% consumer/patient majority and/or monthly meetings.
- Only applicants requesting targeted designation to **solely** serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330 (h))

and/or residents of public housing (section 330(i)) and that are NOT requesting Community Health Center (section 330(e)) designation are eligible for a waiver request.

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

Applicants must clearly describe on Form 6B why the project cannot meet the statutory requirements for which a waiver is requested and detail the alternative strategies the program will employ to assure consumer/patient participation (if board is not 51 percent consumer/patients) and/or regular oversight (if no monthly meetings) in the direction and ongoing governance of the organization.

Waiver of Consumer/Patient Majority:

If the consumer/patient majority is requested to be waived, the applicant must briefly discuss why the project cannot meet this requirement and describe the alternative mechanism(s) for gathering consumer/patient input (e.g., separate advisory boards, patient surveys, focus groups). Areas of discussion should include:

- The specific type of consumer/patient input to be collected.
- Methods for documenting such input in writing.
- Process for formally communicating the input directly to the organization’s governing board (e.g., quarterly presentations of the advisory group to the full board, quarterly summary reports from consumer/patient surveys).
- How the consumer input will be used by the governing board in such areas 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 consumer input.

Waiver of Monthly Meetings

If monthly meetings are requested to be waived, the applicant must briefly discuss why the project cannot meet this requirement and detail the proposed alternative schedule of meeting and how the alternative schedule will assure that the board can still maintain appropriate oversight and operation of the project.

➤ **FORM 8 – HEALTH CENTER AGREEMENTS**

Complete Part I, indicating whether current or proposed agreements constitute a substantial portion of the proposed scope of project. 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 to determine if limits or compromises to the governing board’s authorities, functions, and responsibilities exist based on current or proposed agreements or arrangements. 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 in the appropriate field.

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 or (2) impacts the governing board’s composition, authorities, functions, or responsibilities (as described in Part I and Part II). Upload **each** agreement/arrangement (up to 5 for each organization) in full. Agreements/arrangements that exceed these limits should be included in Attachment 16 (Other Information).

➤ **FORM 9 - NEED FOR ASSISTANCE (NFA) WORKSHEET**

1. GENERAL INSTRUCTIONS FOR COMPLETING FORM 9

All applicants must submit a completed NFA Worksheet (Form 9) as part of the application. Applicants must present data on the NFA Worksheet based on ***the target population to be served within the proposed service area***, as appropriate. Only one NFA Worksheet will be submitted regardless of the number of FQHC Look-Alike sites proposed in the application.

- Applicants are expected to complete the NFA Worksheet based on the entire proposed scope of their project.
- If an applicant proposes to serve **multiple sites, populations and/or service areas**, the NFA Worksheet responses should represent the total targeted population within the proposed service area. **No more than one response should be submitted for any barrier or health indicator.**

Guidelines for Completing the NFA Worksheet

- Responses cannot be expressed as ranges (e.g., 31-35).
- Responses must be expressed in the **same format/unit of analysis** identified in each barrier or health indicator (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
Percent	25% (25 percent of target population is uninsured)
Prevalence (expressed as percent or rate)	8.5% (8.5 percent of population has asthma) or 85 per 1,000 (85 asthma cases per 1,000 population)
Proportion	0.25 (25 out of 100 people, or 25% of all persons, are obese)
Rate	50 per 100,000 (50 hospital admissions for hypertension per 100,000 population)
Ratio	3000:1 (3000 people per every 1 primary care physician)

2. POPULATION TO BE SERVED

All responses must be based on data for the total target population within the proposed service area, as appropriate, per the following criteria:

- (a) Applicants requesting designation to serve the medically underserved population of a service area (**under section 330(e) ONLY**) must provide responses that reflect the health care needs of the target population for the application. When the service area is a sub-county area (made up of groups of census tracts, other county divisions or zip codes), but data for a particular Barrier or Health indicator are not available at sub-county levels, applicants may use an extrapolation technique to appropriately modify the available county-level or other level (including if necessary, national) data to reflect the service area population.
- (b) Applicants requesting designation to serve **ONLY a homeless population (under section 330 (h)), a migrant/seasonal farmworkers population (under section 330(g)) or residents of public housing (under section 330(i)), or any combination of these special populations**, may use an extrapolation technique to appropriately modify available data for these special populations to reflect their specific population(s) within the proposed service area.
- (c) Applicants requesting designation to **serve a homeless population (under section 330 (h)), a migrant/seasonal farmworkers population (under section 330(g)) or residents of public housing (under section 330(i)) IN COMBINATION WITH the medically underserved, general population of a service area (under section 330(e))**, must present responses that reflect the total population to be served. In calculating the response, applicants may use extrapolation techniques to appropriately modify available data to reflect the homeless, migrant/seasonal farmworkers and/or public housing population within the service area (as in (b) above), then combine this with data about the general population within the defined the service area. As above, where sub-county data are not available, applicants may use an extrapolation technique to modify available county-level or other level data to reflect the service area population.

3. DATA

Please 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; and
- (b) Applicants must provide the following information for all data sources:
 - Name of data source;
 - The year to which the data apply;
 - Description of the methodology utilized (e.g., extrapolation); and
 - Any additional information of relevance.

4. NFA WORKSHEET

SECTION 1: CORE BARRIERS

A response is required for **three (3) out of the four (4) Core** Barriers listed:

- Ratio of Population to One FTE Primary Care Physician
- Percent of Population at or Below 200 Percent of Poverty
- Percent of Population Uninsured
- Distance (miles) OR Travel Time (minutes) to Nearest Primary Care Provider Accepting New Medicaid Patients and/or Uninsured Patients

SECTION 2: CORE HEALTH INDICATORS

Applicant should provide a response to **one (1)** core health indicator **from within each of the six (6) categories**: Diabetes, Cardiovascular Disease, Cancer, Prenatal and Perinatal Health, Child Health, and Behavioral and Oral Health.

If an applicant believes that none of the specified indicators represent the applicant’s target population within the service area, 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 used, and rationale for using this alternative indicator.

CORE HEALTH INDICATOR CATEGORIES	Format/Unit of Analysis
1. Diabetes	
1(a) Diabetes Short-term Complication Hospital Admission Rate	Number per 100,000
1(b) Diabetes Long-term Complication Hospital Admission Rate	Number per 100,000
1(c) Uncontrolled Diabetes Hospital Admission Rate	Number per 100,000
1(d) Rate of Lower-extremity Amputation Among Patients with Diabetes	Number per 100,000
1(e) Age Adjusted Diabetes Prevalence	Percent
1(f) Adult Obesity Prevalence	Percent
1(g) Diabetes Mortality Rate ³⁵	Number per 100,000
1(h) Other	Provided by Applicant
2. Cardiovascular Disease	
2(a) Hypertension Hospital Admission Rate	Number per 100,000
2(b) Congestive Heart Failure Hospital Admission Rate	Number per 100,000
2(c) Angina without Procedure Hospital Admission Rate	Number per 100,000
2(d) Mortality from Diseases of the Heart ³⁶	Number per 100,000
2(e) Proportion of Adults reporting diagnosis of high blood pressure	Percent
2(f) Other	Provided by Applicant
3. Cancer	
3(a) Cancer Screening – Percent of women 18 and older with No Pap test in past 3	Percent
3(b) Cancer Screening – Percent of women 40 and older with No Mammogram in	Percent
3(c) Cancer Screening – Percent of adult 50 and older with No Fecal Occult Blood Test within the past 2 years	Percent
3(d) Other	Provided by Applicant
4. Prenatal and Perinatal Health	
4(a) Low Birth Weight Rate (5 year average)	Percent
4(b) Infant Mortality Rate (5 year average)	Number per 1000 births
4(c) Births to Teenage Mothers (ages 15-19; Percent of all births)	Percent

³⁵ Number of deaths per 100,000 reported as due to diabetes as the underlying cause or as one of multiple causes of death (ICD-9 Code 250).

³⁶ Total number of deaths per 100,000 reported as due to heart disease (includes ICD-9 Codes I00-I09, I11, I13, and I20-I51).

CORE HEALTH INDICATOR CATEGORIES	Format/Unit of Analysis
4(d) Late entry into prenatal care (entry after first trimester; Percent of all births)	Percent
4(e) Cigarette use during pregnancy (Percent of all pregnancies)	Percent
4(f) Other	Provided by Applicant
5. Child Health	
5(a) Pediatric Asthma Hospital Admission Rate	Number per 100,000
5(b) Percent of Children tested for elevated blood lead levels by 36 months of age	Percent
5(c) Percent of children not receiving recommended immunizations: 4-3-1-3-3 ³⁷	Percent
5(d) Other	Provided by Applicant
6. Behavioral and Oral Health	
6(a) Depression Prevalence	Percent
6(b) Suicide Rate	Number per 100,000
6(c) Youth Suicide attempts requiring medical attention	Percent
6(d) Percent of Adults with Mental disorders not receiving treatment	Percent
6(e) Any Illicit Drug Use in the Past Month (Percent of all Adults)	Percent
6(f) Heavy alcohol use (Percent among population 12 and over)	Percent
6(g) Homeless with severe mental illness (Percent of all homeless)	Percent
6(h) Oral Health (Percent without dental visit in last year)	Percent
6(i) Other	Provided by Applicant

SECTION 3: OTHER HEALTH INDICATORS

Applicants must provide responses to **two (2) out of the twelve (12)** Other Health Indicators listed below. Alternatively, applicants can propose up to two (2) of the identified indicators using an “Other” indicator. For each “Other” indicator (up to two (2)), applicants must specify the indicator’s definition, data source used, and rationale for using this indicator in place of one of those specified.

OTHER HEALTH INDICATORS	Format/Unit of Analysis
(a) Age-Adjusted Death Rate	Number per 100,000
(b) HIV Infection Prevalence	Percent
(c) Percent Elderly (65 and older)	Percent
(d) Adult Asthma Hospital Admission Rate	Number per 100,000
(e) Chronic Obstructive Pulmonary Disease Hospital Admission Rate	Number per 100,000
(f) Bacterial Pneumonia Hospital Admission Rate	Number per 100,000
(g) Three Year Average Pneumonia Death Rate ³⁸	Number per 100,000
(h) Adult Current Asthma Prevalence	Percent
(i) Adult Ever Told Had Asthma (Percent of all adults)	Percent
(j) Unintentional Injury Deaths	Number per 100,000
(k) Percent of population linguistically isolated (percent of people 5 years and over who speak a language other than English at home)	Percent
(l) Waiting time for public housing where public housing exists	Months
(m) Other	Provided by Applicant
(n) Other	Provided by Applicant

³⁷ 4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B

³⁸ Three year average number of deaths per 100,000 due to pneumonia (includes ICD-9 Codes 480-486).

➤ **FORM 10 – ANNUAL EMERGENCY PREPAREDNESS (EP) REPORT**

The Annual Emergency Preparedness Report will be used to assess the status of emergency preparedness planning, progress towards developing and implementing an emergency management plan.

➤ **FORM 12 – CONTACT INFORMATION**

Form 12 captures the organizational contacts used for ongoing communication.

D. Instructions and Format for Renewal Of Designation Clinical and Financial Performance Measures

The clinical and financial performance measures serve as an ongoing monitoring and evaluation tool for FQHC Look-Alikes and HRSA. The performance measures should include time-framed and realistic goals and related performance measures (as referenced below) with baselines that are responsive to the identified primary health care needs of the community served and the strategic needs of the overall organization, including multiple sites and/or various activities at multiple sites. FQHC Look-Alikes must report on the progress of achieving the goals and baselines during each Annual Certification application, as well as develop new goals and baselines for each Renewal of Designation application.

Performance Measures

Organizations are expected to respond to the health center performance measures within each Need/Focus Area identified below, as appropriate. The Health Center performance measures are assessable on HRSA's Web site at <http://bphc.hrsa.gov/policiesregulations/performanceasures/>. Additional information on the clinical performance measures can be found in the annual Uniform Data System Reporting Manual available at <http://bphc.hrsa.gov/uds/>. Additional technical assistance related to the clinical and financial performance measures is available through HRSA and the State PCA.

- Please note that only applicants that provide or assume primary responsibility for some or all of a patient's prenatal care services, whether or not the applicant does the delivery, are required to include prenatal performance measures, including the required measures: Percentage of pregnant women beginning prenatal care in the first trimester and Percentage of births less than 2,500 grams to health center patients.
- If the applicant is applying for FQHC Look-Alike designation to target special populations (e.g., migrant/seasonal farmworkers, residents of public housing, homeless persons), they are encouraged to include additional goals and related performance measures that address the unique health care needs of these populations, as appropriate.
- If the applicant has identified other unique populations, life-cycles, health issues, risk management efforts, etc. in the narrative Need section, they are encouraged to include additional goals and related performance measures as appropriate.

- Any additional narrative regarding the clinical and financial performance measures should be included in the Evaluative Measures section of the Program Narrative, as appropriate.

Applicants are expected to address the performance measures provided by HRSA, as applicable. All applicants are expected to also include one Behavioral Health (e.g., Mental Health or Substance Abuse) and one Oral Health performance measure of their choice in the clinical performance measures.

Applicants may also wish to consider utilizing Healthy People 2020 goals and performance measures when developing their clinical and financial performance measures. Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The program consists of 41 focus areas and more than 1,400 objectives. Further information on Healthy People 2020 goals may be downloaded at <http://www.healthypeople.gov/>.

Applications for renewal of designation must integrate the required clinical and financial performance measures into their Clinical and Financial Performance Measures Forms, and are expected to develop goals and baselines that can be achieved in a five-year period, starting January 1 and ending December 31. Use the sample Renewal of Designation application clinical and financial performance measures formats provided below.

Need Addressed/Focus Area

This is a concise categorization of the major need or focus area to be addressed by the applicant for their service area, target population and/or organization (Diabetes; Cardiovascular; Costs, Productivity; etc.). Applicants are expected to address each required performance measurement area as well as any other key needs of their target population or organization as identified in the application narrative.

Designation Period Goal(s) with Baseline

Goals relating to the Need/Focus Area should be listed in this section. Applicants should provide goals for the required performance measures listed above as well as other goals, which can be accomplished by the end of the designation period (usually a five-year period). The goals should be reasonable, measurable, and reflect an anticipated impact upon the specified need or focus area. The applicant must also provide baseline data to indicate their status at or prior to the beginning of the designation period. Baseline data provides a basis for quantifying the amount of progress/improvement to be accomplished in the designation period. If applicants choose to establish a baseline for any of the new measures they are encouraged to utilize current data. Applicants are expected to track performance against these goals throughout the entire approved designation period and to report interim progress achieved on the goal in subsequent Annual Certification applications.

Performance Measure(s)

Applicants must make use of the required performance measures listed above when setting goals in the Designation Period Goal(s) with Baseline section (also noted in the sample

performance measures). Applicants may also include additional performance measures. Additional measures chosen by the applicant should also define the numerator and denominator that will be used to determine the level of progress/improvement achieved on each goal (e.g., Numerator: One or more screenings for colorectal cancer. Denominator: All patients age 51-80 years during the measurement year).

Data Source & Methodology

The source of performance measure data, method of collection and analysis (e.g., electronic health records, disease registries, chart audits/sampling) should be noted by the applicant. Data should be valid and reliable and derived from currently established management information systems, where possible.

Key Factors

This is a brief description of the key factors (up to 3) that may impact (positively or negatively) on the applicant’s progress on each of the clinical and financial performance measures.

Major Planned Actions

This is a brief description of the major planned actions (up to 2) to be completed in response to the key factors identified in the Key Factors section impacting performance on the clinical and financial performance measures.

Comments/Notes

Supplementary information, notes, context for related entries in the plan may be provided, as applicable.

SAMPLE MEASURES

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	XYZ Health Center	00000
SAMPLE CLINICAL PERFORMANCE MEASURE	Designation Period Date	01/01/2011 - 12/31/2013
Focus Area: Diabetes		
Performance Measure: Percentage of diabetic patients whose HbA1c levels are less than or equal to 9 percent		
Is this Performance Measure Applicable to your Organization?	Yes	
Target Goal Description	By the end of the Designation Period, increase the % of adult patients with type 1 or 2 diabetes whose most recent hemoglobin A1c (HbA1c) is ≤ 9% (under control) up to 65%	
Numerator Description	Number of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator.	
Denominator Description	Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria	

FQHC Look-Alike Application Instructions CY 2011-2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE CLINICAL PERFORMANCE MEASURE	FOR HRSA USE ONLY		
	Organization Name	Application Tracking Number	
	XYZ Health Center	00000	
	Designation Period Date	01/01/2011 - 12/31/2013	
Baseline Data	Baseline Year: 2009 Measure Type: Percentage Numerator: 2200 Denominator: 4000	Projected Data (by End of Designation Period)	65%
Data Source & Methodology	Representative sample of patient records. (Data run on 1/10/2010)		
Key Factor and Major Planned Action #1	Key Factor Type: <input checked="" type="checkbox"/> Contributing <input type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable Key Factor Description: XYZ offers a variety of pharmaceutical assistance programs, including the provision of free, discounted, or generic medications as well as medications through its 340B Federal Drug Pricing arrangement. At least 70% of diabetic patients are on 3 to 8 medications because of co-morbidity complications that occur. Major Planned Action Description: Increase education and outreach efforts to diabetic patients on the importance of daily testing and the availability of free/discounted glucometers and test strips available through XYZ.		
Key Factor and Major Planned Action #2	Key Factor Type: <input checked="" type="checkbox"/> Contributing <input type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable Key Factor Description: XYZ has an agency-wide, multidisciplinary team that includes physicians, nurses, medical assistants, a quality management coordinator and a data specialist. The team works with each site to analyze and improve the internal processes to achieve effective diabetes care delivery. Major Planned Action Description: At each site, XYZ will identify a physician champion who will be allotted administrative time to work with fellow staff to test and implement changes. The agency-wide and site-specific teams will form a collaborative infrastructure that provides diabetic patients with the necessary tools and support to successfully manage their disease.		
Key Factor and Major Planned Action #3	Key Factor Type: <input type="checkbox"/> Contributing <input checked="" type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable Key Factor Description: Time management becomes problematic when XYZ staff juggles regular work with Diabetes Collaborative tasks. The agency-wide team would like to meet more frequently, but providers are pressed for administrative time given their full clinical schedules. Any type of backlog or deficiency adds system stress to a provider or staff member's work schedule that negatively affects patient care management. Major Planned Action Description: Hire an additional clinical staff person to provide additional "non-clinical" review time for the agency-wide team members.		
Comments			

FQHC Look-Alike Application Instructions CY 2011-2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE FINANCIAL PERFORMANCE MEASURE		FOR HRSA USE ONLY	
		Organization Name	Application Tracking Number
		XYZ	00001
		Designation Period Date	01/01/2011 - 12/31/2013
Focus Area: Costs			
Performance Measure: Medical Cost per Medical Visit			
Is this Performance Measure Applicable to your Organization?	Yes		
Target Goal Description	By the end of the Designation Period, maintain rate of increase not exceeding 5% per year, such that medical cost per medical visit is less than or equal to 164.83.		
Numerator Description	Total accrued medical staff and medical other cost after allocation of overhead (excludes lab and x-ray costs)		
Denominator Description	Non-nursing medical visits (excludes nursing (RN) and psychiatrist visits)		
Baseline Data	Baseline Year: 2009 Measure Type: Ratio Numerator: 492000 Denominator: 4000	Projected Data (by End of Designation Period)	164.83
Data Source & Methodology	UDS		
Key Factor and Major Planned Action #1	<p>Key Factor Type: <input checked="" type="checkbox"/> Contributing <input type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable</p> <p>Key Factor Description: Recent addition of nurse practitioner providers increased XYZ encounters.</p> <p>Major Planned Action Description: Continue assessing current patient/provider mix to best utilize resources.</p>		
Key Factor and Major Planned Action #2	<p>Key Factor Type: <input type="checkbox"/> Contributing <input checked="" type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable</p> <p>Key Factor Description: Recently lost our pediatrician to a local competitor, therefore child visits are down.</p> <p>Major Planned Action Description: We are beginning efforts to recruit a NHSC loan repayer to address the shortage.</p>		
Key Factor and Major Planned Action #3	<p>Key Factor Type: <input type="checkbox"/> Contributing <input type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable</p> <p>Key Factor Description:</p> <p>Major Planned Action Description:</p>		
Comments			

E. Agency Contacts

Additional information related to the overall program issues and/or technical assistance regarding the Renewal of Designation application may be obtained by contacting:

FQHC Look-Alike Program

Office of Policy and Program Development

HRSA, Bureau of Primary Health Care

5600 Fishers Lane

Parklawn Building, Room 17C-26

Rockville, MD 20857

Telephone: 301-594-4300

Fax: 301-594-4997

Email: FQHCLAL@hrsa.gov

Technical Assistance Resources: <http://bphc.hrsa.gov/about/lookalike/index.html>

For Assistance with Application Submission and the HRSA electronic Handbooks (EHB):

Applicants who need assistance preparing and submitting their application electronically through HRSA's EHB can contact the HRSA Call Center, Monday – Friday, 9:00 AM to 5:30 PM ET:

HRSA Call Center

Phone: 877-Go4-HRSA or 877-464-4772

TTY: 877-897-9910

Fax: 301-998-7377

Email: CallCenter@hrsa.gov

**FQHC LOOK-ALIKE
INSTRUCTIONS FOR CALENDAR YEAR
2011/2012**

ANNUAL CERTIFICATION APPLICATION

Technical Assistance Website:

<http://bphc.hrsa.gov/about/lookalike/index.html>

I. PURPOSE

The Health Resources and Services Administration (HRSA) has streamlined the process for Federally Qualified Health Center FQHC Look-Alike organizations applying for annual certification (formerly known as annual recertification). Under the new streamlined process, FQHC Look-Alike organizations are required to submit an abbreviated version of the full designation application. This process will alleviate the burden on FQHC Look-Alike organizations and allow for a more efficient method of providing HRSA with progress on the approved FQHC Look-Alike.

The Annual Certification application will be used by HRSA to assess progress, as well as any significant change(s) to an FQHC Look-Alike organization's approved Health Center Program designated activities. The continuation of FQHC Look-Alike designation will be based on compliance with applicable statutory and regulatory requirements, including the timely submission of the Annual Certification application through the HRSA Electronic Handbook (EHB), demonstrated organizational capacity to accomplish the project's goals, and a determination that continued designation would be in the best interest of the government.

All applicants are expected to demonstrate compliance with the requirements of section 330 of the Public Health Service (PHS) Act, as amended and applicable regulations. Applicants are encouraged to refer to <http://www.bphc.hrsa.gov/about/requirements/index.html> for additional information on key Health Center Program requirements.

II. APPLICATION FORMS AND DOCUMENTS

The Annual Certification application is a progress update and cannot be used to make any changes in the scope of the approved project. These changes can be made anytime during the year, using the current prior approval requests process within EHB.

The forms and documents identified in the following table are required submissions (unless noted otherwise) for the Calendar Year 2011/2012 Annual Certification applications. In the "Form Type" column of the table, the word "Form" refers to those documents that are completed in the online system and that DO NOT require any downloading or uploading. The word "Document" refers to required Annual Certification materials that must be downloaded in the template provided, completed, and then uploaded into the system.

Organizations are encouraged to review this table prior to submitting an Annual Certification application to ensure that all required components are included. Failure to submit all required components as outlined may result in a delay of HRSA's application review.

FQHC Look-Alike Application Instructions CY 2011-2012

Annual Certification Application Content	Form Type	Instructions
Cover Page (Required)	Form	Complete all portions of the form electronically online as presented.
Project Abstract (Required)	Document	<p>The project abstract should be single-spaced, limited to two pages in length. Please prepare the abstract so that it is clear, accurate, concise, and without reference to other parts of the application.</p> <p>The abstract narrative should include:</p> <ul style="list-style-type: none"> – The population group(s) served. – Summary of the organizational structure. – A brief history of the organization, the community served and the target population(s). – A summary of the major health care needs and barriers to care. – A summary of services provided. – A summary of the number of providers, service delivery locations, services, and total number of patients and visits.
Project Narrative (Required)	Document	Upload as instructed.
Clinical Performance Measures (Required)	Form	Complete all portions of the form electronically online as presented.
Financial Performance Measures (Required)	Form	Complete all portions of the form electronically online as presented.
Form 1A: General Information Worksheet (Required)	Form	Complete all portions of the form electronically online as presented.
Form 2: Staffing Profile (Required)	Form	Complete all portions of the form electronically online as presented.
Form 3: Income Analysis Form (Required)	Document	Complete all portions of the form electronically online as presented.
Form 3A: FQHC Look-Alike Budget (Required)	Form	Complete all portions of the form electronically online as presented.
Form 5A: Services Provided (Read Only)	Form	<p>This form is pre-populated with the services in the current approved scope of project. This is a read-only form and may not be modified. NOTE: Only existing services in the approved scope of project will be pre-populated in the application in the EHB (excluding pending applications for change in scope to add a service).</p> <p>Only one form is required for the all of the required and additional services provided by the FQHC Look-Alike organization.</p>

FQHC Look-Alike Application Instructions CY 2011-2012

Annual Certification Application Content	Form Type	Instructions
Form 5B: Service Sites (Read Only)	Form	This form is pre-populated with the sites in the current approved scope of project. Essential attributes are read-only and may not be modified in this form. Other attributes in this form are modifiable. NOTE: Only existing service sites in the approved scope of project will be pre-populated in the application in EHB (excluding pending applications for change in scope to add a site).
Form 5C: Other Activities/Locations (Read Only)	Form	This form is pre-populated with the other activities in the current approved scope of project. This is a read-only form and may not be modified.
Form 6A: Current Board Member Characteristics (Required)	Form	Complete all portions of the form electronically online as presented.
Form 8: Health Center Agreements (<i>as applicable</i>)	Form	Complete all portions of the form electronically online and attach all appropriate documents only if there have been changes.
Form 10: Annual Emergency and Management Preparedness Report (Required)	Form	Complete all portions of the form electronically online as presented.
Form 12: Contacts Information (Required)	Form	Complete all portions of the form electronically online as presented.
Attachment 1: Service Area Map	Document	Upload a map that clearly identifies the areas served by the organization, all service delivery sites, the designated MUA/MUP areas, census tracts, zip codes, and the location of other primary care provider sites (e.g., section 330-funded health centers, FQHC Look-Alikes, hospitals, free-clinics, etc.). Organizations are encouraged to use HRSA's Geospatial Data Warehouse mapping feature to produce maps. This feature is available on HRSA's Web site at http://datawarehouse.hrsa.gov/hpsadetail.aspx .
Attachment 2: Governing Board Bylaws (<i>as applicable</i>)	Document	Upload a copy of the bylaws only if there have been any amendments.
Attachment 3: Affiliation, Contract, and/or Referral Agreements (<i>as applicable</i>)	Document	Upload a summary describing any new or revised contracts and/or agreements. Do not discuss contracts and/or agreements for such areas as janitorial services. The summary must address the following items for each contract and/or agreement: <ul style="list-style-type: none"> – Name and contact information for each affiliated agency. – Type of contract and/or agreement (e.g., contract, MOU). – Brief description of the purpose and scope of the contract and/or agreement (i.e., type of services provided through the agreement, how/where services are provided). – Timeframe for the contract and/or agreement.

Annual Certification Application Content	Form Type	Instructions
Attachment 4: Organizational Chart (<i>as applicable</i>)	Document	Upload a copy of the organizational chart only if there have been changes since the most recent application (Initial, Renewal or Annual Certification).
Attachment 5: Position Descriptions for Key Personnel (<i>as applicable</i>)	Document	Upload position descriptions for any VACANT key management staff positions or if the descriptions have changed since the most recent application (Initial, Renewal or Annual Certification).
Attachment 6: Resumes for Key Personnel (<i>as applicable</i>)	Document	Upload biographical sketches for any new key management staff hired since the submission of the most recent application (Initial, Renewal, or Annual Certification).
Attachment 7: Other Information (<i>as applicable</i>)	Document	Organizations may include other relevant documents to support the program updates in the Annual Certification submission. Other documents may include floor plans of the facilities, charts, and organizational brochures. Merge all additional documents into a single document and upload as one document.

III. SUBMISSION INFORMATION

Annual Certification applications are due 90 days prior to the end of the certification period. The EHB system will send out electronic email reminders to the organization’s contacts identified in the EHB system 150 days prior to the end of the certification period to inform them of when the application is due and that it is accessible in the EHB system. Once notified that the application is available within the EHB, applicants will have 60 days to complete and submit the Annual Certification application in the EHB system. **Failure to submit the Annual Certification application could result in termination of the FQHC Look-Alike designation and all corresponding benefits (e.g., Medicare and Medicaid FQHC reimbursement, 340B Drug Pricing Program benefits, etc.).**

All applications **MUST** be submitted electronically through the HRSA EHB system. Applications will be considered having been formally submitted if the application has been successfully transmitted electronically by your organization’s AO through HRSA’s EHB. If an application is not submitted in the EHB system within the 60 day period it will be considered ineligible and deleted from the EHB system.

It is incumbent on the applicant to ensure that the AO is available to submit the application before the 60 day application period has ended. HRSA will not accept submission or re-submission of incomplete, rejected, or otherwise delayed applications after the 60 day application period. Therefore, applicants are urged to submit applications in advance of the 60 day deadline. If the application is rejected by HRSA’s EHB due to errors, the application must be corrected by the applicant and resubmitted to the EHB before the 60 day application deadline.

IV. APPLICATION NARRATIVE

Applications for annual certification must include all required information as identified in the previous table. The specific responses to the Program Narrative are identified below.

A. Program Narrative

The Program Narrative update should address broad issues and changes that have impacted the community/target population(s) served and the organization, the extent to which the organization's project plan continues to address the specific program requirements, and the organization's progress in meeting the goals of the project plan as stated in the most recently approved FQHC Look-Alike Initial Designation or Renewal of Designation application.

FQHC Look-Alikes should ensure that an update is provided for any changes to the elements presented in the criteria, including all appropriate health center type-specific elements. Failure to clearly address the requested information could result in a delay of HRSA's review.

FQHC Look-Alikes **must** use the Program Narrative to discuss the extent to which program specific requirements continue to be met. FQHC Look-Alikes are encouraged to review <http://www.bphc.hrsa.gov/about/requirements/index.html> for information on key health center program requirements.

The Program Narrative update must be consistent with the information presented in the Clinical and Financial Performance Measures Forms as well as all of the Program Specific forms and attachments. Throughout the Program Narrative reference may be made to required attachments and forms, as needed, to reflect information about multiple sites and/or geographic or demographic data. **The attachments must augment, not replace, required narrative.** The Program Narrative should be organized using the section headers listed below. In addition, the Program Narrative Update must address ***broad issues and changes/progress*** in the following areas:

NEED

1. Highlight the **CURRENT STATUS** and describe any **CHANGES** since the last application (Initial, Renewal of Designation, or Annual Certification) in the target population and service area that affect access to primary health care, health care utilization, and health status. FQHC Look-Alikes that are not designated to serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330(h)), and/or residents of public housing (section 330 (i)), but currently serve or may serve these populations in the future, are encouraged to discuss the unique health care needs of these populations.
2. For FQHC Look-Alikes that are designated to serve special populations, highlight the **CURRENT STATUS** and describe any **CHANGES** in the following areas, including increases or decreases in the special populations in the service area.

- (a) **Migrant and Seasonal Farmworkers (section 330(g)):** Highlight the **CURRENT STATUS** and describe any **CHANGES** in the factors (e.g., access barriers, past utilization) related to the health care needs and demand for services of migrant and seasonal farm workers, including:
- Agricultural environment (e.g., crops and growing seasons, need for labor, number of temporary workers);
 - Approximate period(s) of residence of migrant workers and their families; and
 - Migrant occupation-related factors (e.g., working hours, housing, sanitation, hazards including pesticides and other chemical exposures).
- (b) **People Experiencing Homelessness (section 330(h)):** Highlight the **CURRENT STATUS** and describe any **CHANGES** in the specific health care needs and access issues impacting people experiencing homelessness (e.g., number of providers treating homeless individuals, availability of homeless shelters and/or affordable housing).
- (c) **Residents of Public Housing (section 330(i)):** Highlight the **CURRENT STATUS** and describe any **CHANGES** in the health care needs and access issues impacting residents of public housing (e.g., availability of public housing).
3. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the primary health care services (including behavioral and oral health) currently available in the service area, including any gaps in service (e.g., provider shortages) and the role and location of other providers who currently serve the target population.
4. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the health care environment that have affected the community's ability to provide services, the target population's ability to access health care, and/or the FQHC Look-Alike's fiscal stability. Topics to be addressed may include:
- (a) Changes in the availability or level of insurance coverage, including Medicaid, Medicare, and CHIP. Changes in State/local/private uncompensated care programs; and
 - (b) Changes in the economic or demographic environment of the service area (e.g., influx of refugee population; closing of/changes to local hospitals, community health care providers, or major local employers; major emergencies such as hurricanes, flooding, terrorism).

RESPONSE

1. Highlight the **CURRENT STATUS** and describe any **CHANGES** made since the last application (Initial, Renewal of Designation, or Annual Certification) in response to the issues identified in the **NEED** section.
2. Describe the outcome of any change(s) in scope and/or funding approved/awarded since the last application (Initial, Renewal of Designation, or Annual Certification) including the

date when the change in scope was approved or award was issued. Specifically address reasons for/results of any **CHANGES** in the

- (a) Locations where services are provided, and/or
- (b) Hours of operation.

Discuss how these changes continue to assure that services are available and accessible at locations and times that meets the needs of the target population.

3. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the accessibility and/or availability of primary health care services for all life cycles without regard to ability to pay. Changes made to the mode of service delivery in the past year via the EHB scope module (direct vs. referral; shifts between any columns on Form 5A) must be described. Specifically address reasons for and results of any **CHANGES** in the clinical operations and patient care services made as a result of organizational or community changes, including:
 - (a) Provision of required and additional clinical and non-clinical services, including whether these are provided directly or by referral;
 - (b) How services are culturally and linguistically appropriate (e.g., availability of interpreter/translator services, bilingual/multicultural staff, training opportunities);
 - (c) Arrangements for admitting privileges for health center physicians at one or more hospitals to ensure continuity of care, discharge planning, and patient tracking among providers;
 - (d) Professional coverage during hours when the health center is closed; and
 - (e) Referral relationships for additional health services and specialty care with other health care providers with an emphasis on working collaboratively to meet local needs.
4. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the clinical team staffing plan, including the number and mix of primary care physicians, nurse practitioners, physician assistants, certified nurse midwives, oral health providers, behavioral health professionals, social workers, and other providers, as well as clinical support staff necessary for:
 - (a) Providing services for the projected number of patients,
 - (b) Assuring appropriate linguistic and cultural competence, and/or
 - (c) Carrying out required preventive, enabling, and additional health services as appropriate and necessary, either directly or through established arrangements and referrals.
5. Highlight the **CURRENT STATUS** and describe any **CHANGES** in, contracts for a substantial portion of the operation of the health center, and/or other agreements between the FQHC Look-Alike and an outside organization, including any change in oversight and authority to assure compliance with Health Center Program requirements. For any required services provided via referral for which the FQHC Look-Alike does not pay (third column of Form 5A), the FQHC Look-Alike must document that a formal written arrangement/agreement is in place for each such service per Policy Information Notice 2008-01, Defining Scope of Project and Policy for Requesting Changes (<http://www.bphc.hrsa.gov/policiesregulations/policies/pin200801.html>). For **new or**

revised arrangements, contracts, and/or agreements, include a summary of the agreements in Attachment 3: Affiliation, Contract, and/or Referral Agreements.

NOTE: All contracts and Memorandums of Agreement or Understanding (MOAs/MOUs) must be kept on file at the FQHC Look-Alike organization and must be made available to HRSA **upon request** within 3-5 business days. Do **NOT** include these items with the Annual Certification submission.

6. **Migrant Health Center (section 330(g)), Health Care for the Homeless (section 330(h)) and/or Public Housing Primary Care (section 330(i)):** Highlight the **CURRENT STATUS** and describe any **CHANGES** in formal arrangements with other organizations that provide services or support to the special population(s) served (e.g., Migrant Head Start, Public Housing Authority, homeless shelters).
7. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the system used to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay, including any changes or updates to the established schedule of charges and its corresponding schedule of discounts which ensure that no patient will be denied services due to an inability to pay. Provide the current sliding fee discount schedule(s) in Attachment 7.
8. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the organization's ongoing quality improvement/quality assurance (QI/QA) and risk management plan(s). Specifically, address any changes or progress in the following areas:
 - (a) The clinical director's responsibility in supporting the quality improvement/assurance program and the provision of high-quality patient care;
 - (b) Periodic assessment of the appropriateness of service utilization, quality of services delivered, and the health outcomes of health center patients; and
 - (c) How the findings of QI/QA assessments have been used to improve organizational performance and what formal institutional mechanisms/processes are in place to ensure this occurs.
9. Highlight the **CURRENT STATUS** and describe any **CHANGES** in board-approved policies and procedures related to:
 - (a) Clinical standards of care,
 - (b) Provider credentials and privileges,
 - (c) Risk management procedures,
 - (d) Patient grievance procedures,
 - (e) Incident management, and
 - (f) Confidentiality of patient records.
10. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the health center's short- and long-term strategic plans and how community needs as well as data from the FQHC Look-Alike's performance improvement systems (e.g., Clinical and Financial Performance

Measures, patient satisfaction findings, QI/QA assessments) have been used to inform the strategic planning process.

11. Describe any **PROPOSED CHANGES** being considered for the **UPCOMING** certification period in services, service sites, provider types, and/or hours of operation based on ongoing strategic planning.

NOTE: No change in scope or self-update is allowed in the Annual Certification submission; all changes must be completed in accordance with Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes (<http://www.bphc.hrsa.gov/policiesregulations/policies/pin200801.html>).

12. Discuss the organizational response (i.e., actions steps taken) to address any actions taken to improve performance as a result of a BPHC-supported site visit or BPHC-supported technical assistance/training session that are not described in the Clinical and Financial Performance Measures.
13. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the organization's ability to:
 - (a) Maximize FQHC-related benefits (e.g., FQHC Medicare/Medicaid/CHIP reimbursement, 340B Drug Pricing Program, Vaccines for Children Program, National Health Service Corps Providers); and
 - (b) Address BPHC/HRSA-targeted initiatives (e.g., Health Center Accreditation, Health Center Controlled Networks, Patient-Centered Medical/Health Home, National HIV/AIDS Strategy, Accountable Care Organizations).
14. Highlight the **CURRENT STATUS** and describe any **SIGNIFICANT CHANGES**, referencing the budget as needed, that have impacted:
 - (a) How the total budget is aligned and consistent with the proposed service delivery plan; and
 - (b) The maximization of reimbursement from third party payors (e.g., Medicare, Medicaid, CHIP, private insurance) and how this relates to any **SIGNIFICANT CHANGES** in the patient and payor mix and/or number of projected patients and visits.

COLLABORATION

1. Highlight the **CURRENT STATUS** and describe any **CHANGES** in both formal and informal collaboration and coordination of services with other health care providers. Specifically discuss collaboration with existing section 330 grantees, FQHC Look-Alikes, rural health clinics, hospitals, other federally-supported grantees (e.g., Ryan White programs), State and local health departments, private providers, and programs serving the same target populations (e.g., social services; job training; Women, Infants, and Children (WIC); coalitions; community groups).

FQHC Look-Alikes should review Program Assistance Letter 2011-02, Health Center Collaboration available at <http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html> for additional information on maximizing opportunities to collaborate with other health care safety net providers.

2. Provide evidence of **NEW** or **REVISED** collaborations by providing letters of support, commitment, or investment that reference the specific collaboration and/or coordinated activities.

EVALUATIVE MEASURES

1. Describe **PROGRESS** made on each of the Clinical Performance Measures identified in the most recent application (Initial, Renewal, or Annual Certification) in the Progress toward Goal and Comments fields of the Clinical Performance Measures forms. Do **NOT** repeat information previously provided; instead, discuss overall progress with regard to each performance measure goal. Specifically, FQHC Look-Alikes must:
 - (a) Discuss progress toward the goal identified for each Clinical Performance Measure, and
 - (b) Describe contributing and/or restricting factors that impacted progress toward the goal identified for each Clinical Performance Measure.

Include any information that exceeds the 1,000 character limit of the Comments field in this section of the Program Narrative.

2. Describe **PROGRESS** made on each of the Financial Performance Measures identified in the most recent application (Initial, Renewal or Annual Certification) in the Progress toward Goal and Comments fields of the Financial Performance Measures forms. Do **NOT** repeat information previously provided; instead, report and discuss overall progress with regard to each performance measure goal. Specifically, FQHC Look-Alikes must:
 - (a) Discuss progress toward the goal identified for each Financial Performance Measure, and
 - (b) Describe contributing and/or restricting factors that impacted progress toward the goal identified for each Financial Performance Measure.

Include any information that exceeds the Comments field's 1,000 character limit in this section of the Program Narrative.

IMPACT

1. Describe **PROGRESS** made toward the projected number of patients to be served by the end of the designation period compared to the baseline number of patients presented in the most recent application (Initial Designation, Renewal of Designation or Annual Certification). The projected number of patients to be served by the end of the designation period must be consistent with the number presented on Form 1A: General Information Worksheet. Specifically, FQHC Look-Alikes must discuss:

- (a) Any contributing or restricting factors affecting the achievement of the goal. Reference the growth in patients noted in Form 1A in the Number at End of Designation Period column of the Patients and Visits by Population Type table. Decreasing trends in patient levels must be fully explained;
- (b) FQHC Look-Alikes that currently designated to serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330(h)), and/or residents of public housing (section 330(i)) **MUST** discuss reasons for any decrease in the special populations served (e.g., large group of migrant workers no longer working in the service area); and
- (c) FQHC Look-Alikes that have added any service sites during the current designation period must identify progress made toward any proposed increase in patients, visits, providers, and/or services. If there have been major problems or start-up delays related to new service site, address these issues.

RESOURCES/CAPABILITIES

1. Highlight the **CURRENT STATUS** and describe any **CHANGES** to the organizational structure of the health center (i.e., changes that affect the budget or scope of project³⁹), including any NEW or REVISED affiliation agreements/arrangements. Reference Attachment 4: Organizational Chart and Attachment 3: Affiliation, Contract, and/or Referral Arrangements as applicable.
2. Discuss any **KEY MANAGEMENT STAFF CHANGES** or vacancies in the last year, and describe plans for filling these vacancies. Key management positions include chief executive officer (CEO), chief clinical officer (CCO), chief financial officer (CFO), chief information officer (CIO), and chief operating officer (COO). Specify how long each key management position has been vacant and if a temporary/interim person has been assigned. Reference Attachment 5: Position Descriptions for Key Management Staff and Attachment 6: Resumes for Key Management Staff as needed.
3. Highlight the **CURRENT STATUS** and describe any **CHANGES** to staffing plans, as well as any contributing or restricting factors encountered during the designation period for recruiting and retaining key management staff and/or health care providers.
4. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the acquisition/development and implementation of certified EHR technology systems used for tracking patient and clinical data to achieve meaningful use.
5. Highlight the **CURRENT STATUS** and describe any **CHANGES** to the organization's financial management capabilities, accounting and control systems, policies, and procedures that

³⁹ Changes in scope requiring prior approval **MUST** be submitted through HRSA's Electronic Handbook (EHB). Refer to Policy Information Notice 2008-01, Defining Scope of Project and Policy for Requesting Changes available at <http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html>.

have impacted the organization's financial status, as well as actions taken to address adverse trends, including:

- (a) Actions taken to address adverse financial trends in areas such as expenses, revenue, operating deficit, debt burden, or cash flow.
- (b) Changes to financial information systems available for collecting, organizing, and tracking key performance data utilized for supporting management decision making and reporting the organization's financial status (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).

6. Highlight the **CURRENT STATUS** and describe any **CHANGES** related to corrective actions taken to address any findings, questioned costs, reportable conditions, material weaknesses, and significant deficiencies cited in the most recent audit.
7. Highlight the **CURRENT STATUS** and describe any **CHANGES** to systems in place to maximize collection of payments and reimbursement for services, including policies and procedures for eligibility determination, billing, credit, and collection.
8. Highlight the **CURRENT STATUS** and describe any **CHANGES** related to the development and implementation of an emergency preparedness and management plan, including participation in drills or exercises and participation or attempts to participate with State and local emergency planners.

GOVERNANCE

NOTE: Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups, should respond to ONLY Item 5 below.⁴⁰

1. Provide a copy of the health center's signed and dated bylaws in Attachment 2 **ONLY if these have been revised** during the designation period. Discuss the type and purpose of all revisions.
2. Highlight the **CURRENT STATUS** and describe any **CHANGES** to the composition of the governing board, providing reasons for changes in terms of size, expertise, non-patient board member income from the health care industry, and representativeness of the service area/target population and special populations⁴¹ served.

⁴⁰ 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.

⁴¹ A FQHC Look-Alike who is currently designated to serve general community (CHC) **AND** special populations (HCH, MHC, and/or PHPC) must have appropriate representation on the board from these populations. At minimum, there must be at least one representative from each of the special population groups for which the organization is designated. Special population representatives should be individuals that can clearly communicate the needs/concerns of the target population and represent this population on the board.

3. Highlight the **CURRENT STATUS** and describe any **CHANGES** made to resolve issues in the following areas:
 - (a) Meeting monthly, as applicable;
 - (b) Maintaining a 51 percent consumer/patient majority, as applicable;
 - (c) Exercising required oversight responsibilities and authorities (e.g., selecting, evaluating, and dismissing the CEO/Executive Director; establishing hours of operation; approving annual budget; conducting board self-assessment);
 - (d) Training new and existing governing board members;
 - (e) Evaluating board performance (i.e., processes developed for addressing board needs/challenges, including training needs, communication issues, and meeting documentation); and
 - (f) Using health center performance trend data that is consistent with the Clinical and Financial Performance Measures to inform strategic planning, support ongoing review of the health center's mission and bylaws, evaluate patient satisfaction, review monthly financial and clinical performance, and update sliding fee discount schedule(s).
4. FQHC Look-Alikes that **ARE NOT** designated under Community Health Center (section 330(e)) and have an approved waiver for either the 51 percent consumer/patient majority and/or monthly meeting requirement(s) must **PROVIDE AN UPDATE** on the status of their alternative mechanism and discuss how the mechanism continues to meet the intent of the statute by ensuring consumer/patient representation and/or regularly scheduled meetings (as applicable to the type of waiver).

NOTE: *An approved waiver does not relieve the health center's governing board from fulfilling all other board authorities and responsibilities required by statute.*

5. HEALTH CENTERS OPERATED BY INDIAN TRIBES OR TRIBAL, INDIAN, OR URBAN INDIAN GROUPS: Describe the 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 project.

B. Annual Certification Form Instructions

FQHC Look-Alike Program-Specific forms MUST be completed electronically in the HRSA EHB. "Forms" refer to those documents that are completed online in the system and do not require any downloading or uploading. "Documents" are those requirements that must be downloaded in the template provided, completed, and then uploaded into the system. Please complete each required form. Please note that only these forms which are available via the online application, approved by the U.S. Office of Management and Budget, should be submitted with the application.

Please note the following:

- Any portions of the Program Specific Forms that are “blocked/grayed-out” are not required for the FQHC Look-Alike Annual Certification application and DO NOT need to be completed.
- The Electronic Health Records (EHR) Form and the Clinical and Financial Performance Measures Forms are required for all applicants.

➤ **FORM 1A – GENERAL INFORMATION WORKSHEET (Required)**

Form 1A provides a summary of information related to the project at the time of application submission. The following instructions are intended to clarify the information to be reported in each section of the form.

1. APPLICANT INFORMATION

Complete all relevant information that is not pre-populated.

2. PROPOSED SERVICE AREA

2a. Target Population and Service Area Designation

Population Type:

FQHC Look-Alikes must specify the population type(s) for which they are currently designated

Service Area Designation:

FQHC Look-Alikes with designation for CHC (section 330(e)) 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 and provide all relevant identification numbers. 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/>.

2b. Service Area Type: Select the type (urban, rural, or sparsely populated) that best describes the majority of the target population. If sparsely populated is selected, provide the number of people per square mile (must be 7 or less). A sparsely populated area is defined as a geographical area with seven people or fewer per square mile for the entire service area.

2c. Target Population and Provider Information: For all portions of this section, report aggregate data for all sites included in the scope of project.

Service Area and Target Population:

Provide the estimated number of individuals currently composing the service area and target population. **NOTE:** The target population numbers must be smaller than or equal to the service area numbers.

Provider FTEs by Type:

- a. Report the number of provider full-time equivalents (FTEs), paid and voluntary, by staff type. **Provide the count of billable provider FTEs ONLY** (e.g., physician, nurse practitioner, physician assistant, certified nurse midwife, psychiatrist, psychologist, dental hygienist, dentist, social worker).
- b. Project the number of billable provider FTEs at the end of the certification period.
- c. Do **NOT** report provider FTEs functioning outside the scope of project.

Patients and Visits by Service Type:

- a. List the current number of unduplicated patients and visits.
- b. The projected number of patients/visits must be consistent with the projections included in the most recent application (initial, Renewal or Annual Certification). Be sure to include any increase in projections based on new sites added in the last certification period. **NOTE: HRSA does NOT expect the number of patients to decline. Any projected decrease must be discussed in the Program Narrative.**
- c. Do **NOT** report patients and visits for services provided outside the scope of project.

When providing an unduplicated count of patients and visits, note the following:

- a. Visit is defined as a documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services rendered must be documented in the patient's record.
- b. Patient is defined as an individual who had at least one visit in the previous year.
- c. 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.

Patients and Visits by Population Type:

- a. List the current number of unduplicated patients and visits by population type.
- b. Follow instructions #2-3 under ***Patients and Visits by Service Type*** for projecting the number of unduplicated patients and visits by the end of the **UPCOMING** certification period using the Number at End of Year 1 columns.
- c. Follow instructions #2-3 under ***Patients and Visits by Service Type*** for projecting the number of unduplicated patients and visits and by the end of the entire designation period using the Number at End of Designation Period columns.

➤ **FORM 2 – STAFFING PROFILE (Required)**

The Staffing Profile reports personnel salaries supported by the total budget for the upcoming certification period (a one year period) of the proposed FQHC Look-Alike project. Include staff for the entire scope of project (i.e., all sites, include volunteer providers). Anticipated staff changes must be addressed in the Program 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.
- Do **NOT** report portions of salaries that support activities outside the proposed scope of project.

➤ **FORM 3 – INCOME ANALYSIS (Required)**

Each organization must complete the Income Analysis Form. The form projects program income, by source, for the upcoming certification period (a one year period).

The Income Analysis Form provides a format for presenting the estimated non-Federal revenues and other sources of income for the organization. Any specific entries that require additional explanation should be discussed in the “Comments/Explanatory Notes” box at the bottom of page 2 of the form and if necessary, detailed in the management and finance program narrative. The worksheet must be based on the proposed project. It may not include any grant funds from any pending grants or other unapproved changes in sites, services or capacity. There are two major classifications of revenues, Program Income and Other Income.

- **Part 1: Program Income** includes fees, premiums and third party reimbursements and payments generated from the projected delivery of services. Program income is divided into two types of income: Fee for Service and Capitated Managed Care.
- **Part 2: Other Income** includes State, Local or other Federal grants (e.g., Ryan White, HUD, Head Start, etc.) or contracts 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 or Other Income, such as “pharmacy” organizations may add lines for any additional income source if necessary. Clarifications for these additions may be noted in the “Comments/Explanatory Notes” box at the bottom of page 2 of the form.

Part 1: Program Income

NOTE: This form reports only on those visits which are billable to first or third parties including individuals who, after the schedule of discounts/sliding fee scale, may pay little or none of the actual charge.

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 organization has a Blue Cross fee-for-service managed Medicaid contract, the information would be included on lines 1a.-1e., not on lines 3a.-3c. If the Child Health Insurance Program (CHIP) is paid through Medicaid, it should be included in the appropriate category on lines 1a-1e. In addition, if the organization receives Medicaid reimbursement via a Primary Care Case Management (PCCM) model, this income should be included on line 1e. “Medicaid: Other Fee for Service.”

Line 5 (Other Public): Include here any CHIP reimbursement not paid through the Medicaid Program as well as any other State or local programs that pay for visits including Title X family planning visits, CDC’s Breast and Cervical Cancer Early Detection Program, Title I and II Ryan White visits, etc.

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.

Column (b): Enter the average charge per visit by payor category. A sophisticated analysis of charges will generally reveal different average charges; for example, Medicare charges may be higher than average Medicaid EPSDT charges. If this level of detail is not available, averages may be calculated on a more general level (i.e., at the payor or service type or agency level).

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

Column (d): Enter the average adjustment to the average charge per visit in column (b). A negative number reduces and a positive number increases the Net Charges calculated in column (e). (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. These are shown in columns f and g. Adjustments in column (d) include those related to:

- Projected contractual allowances or discounts to the average charge per visit.
- Sliding discounts given to low-income patients (with incomes 0 to 200% of the Federal poverty guidelines as applicable).
- Adjustments to bring the average charge up/down to the negotiated FQHC or PPS established reimbursement rate or the cost based reimbursement expected after completion of a cost reimbursement report.
- Any other applicable adjustments. These should be discussed in the “Comments/Explanatory Notes” box at the bottom of page 2 of the form.

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

Column (f): Based on previous experience, enter the estimated collection rate (%) by payor category. The collection rate is the amount projected to be collected divided by the amount actually billed. 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” section of the form. **NOTE:** Do not show

sliding discount percentages here – they are included above in column (d); do show the collection rate for actual direct patient billings.

Column (g): Enter Projected income for each payor category calculated as: column (e) * column (f).

Column (h): Enter the actual accrued income by payor category for the most recent 12-month period for which data are available. Any significant variance between projected income (column g) and actual accrued income (column h) should be explained in the management and finance program narrative portion of the application. If 12-months of data are not available, enter the amount available and indicate the time frame.

Projected Capitated Managed Care Income

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. Note also, that unlike the fee-for-service section of this form, organizations will group together all types of services on a single line for the type of payor. Thus, capitated Medicaid dental visits and capitated Medicaid medical visits are added together and reported on line 7a.

Number of Member Months (Column a): “Member months” are the number of member months for which the organization receives payment. 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 an even more unique mix of services. Unusual service mixes which provide for unusually high or low per-member per-month (PMPM) payments should be described in the notes section.

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 actually be based on multiple age/gender specific rates or on service specific plans, but all these should be averaged together for a “blended rate” for the provider type.

Risk Pool Adjustment (Column c): This is an estimate of the total amount that will be earned from risk or performance pools. It includes any payment made by the HMO to the organization for effectively and efficiently managing the health care of the enrolled members. It is almost always for a prior period, but must be accounted for in the period it is received. Describe risk pools in the narrative. Risk pools may be estimated by using the average risk pool receipt PMPM over an appropriate prior period selected by the organization.

FQHC and Other Adjustments (Column d): This is the total amount of payments made to the organization to cover the difference between the PMPM amount paid for Medicaid or Medicare managed care visits and the organization’s PPS/FQHC rate.

Projected Gross Income (Column e): Column e is calculated for each line as:
 $[\text{column (a)} * \text{column (b)}] + [\text{column c} + \text{column d}] = \text{e}.$

Actual Gross Income (Column f): Identify the actual gross income the organization accrued for the most recent 12-month period. Any significant variance between projected income (columns e) and actual accrued income (column f) should be explained in the management and finance program narrative portion of the application. If 12-months of data are not available, enter the amount available and indicate the time frame.

Part 2: Other Income

This category includes all other income not entered elsewhere on this table. 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, foundations, etc.

Line 9. “Applicant” refers to any income generated by the organization through the expenditure of its own assets such as income from reserves or realized sale of property.

Please note that in-kind donations should not be included in the Income Analysis; however organizations may discuss in-kind contributions as applicable, in the management and finance program narrative.

➤ **FORM 3A — FQHC LOOK-ALIKE BUDGET INFORMATION**

Each organization must complete the FQHC Look-Alike Budget Information Form. The form reports program budget, by program, function, and activity for the upcoming one-year certification period.

The FQHC Look-Alike Budget Information Form provides a format for reporting the estimated expenses and revenue for the organization. The worksheet must be based on the proposed project. There are two parts to this form, Expenses and Revenue.

- **Part 1: Expenses:** includes personnel, fringe benefits, travel, equipment, supplies, contractual, construction, and other. Indirect charges may also be included.
- **Part 2: Revenue:** includes funds supplied by the applicant and/or Federal, State, local, other sources.

Part 1: Expenses

For each of the expense categories enter the projected upcoming year’s expenses for each of the Program(s), Function(s), or Activity(s) where applicable. If the categories in the form do not describe all possible expenses, organizations may enter expenses in the “Other” category. The total fields are calculated automatically as you move through the form.

Part 2: Revenue

For each of the revenue categories, enter the projected upcoming year’s revenue from each of the Program(s), Functions(s), or Activity(s) where applicable. If revenue is collected from sources other than the listed sources, indicate those in the “Other” category. The total fields are calculated automatically as you move through the form.

➤ **FORM 5A – SERVICES PROVIDED (Read Only)**

Data will be pre-populated from the FQHC Look-Alike’s official scope of project and **CANNOT** be modified. Any change in scope or self-update will **NOT** be allowed at the time of the Annual Certification submission.

Only services included on Form 5A are considered to be in a FQHC Look-Alike’s approved scope of project. Services that are identified elsewhere in the application (e.g., Program Narrative) and are not identified on Form 5A will not be considered to be in the approved scope of project.

NOTE: If your organization has a pending Change in Scope application to add a service, it cannot be included in Form 5A until the Change in Scope has been approved.

➤ **FORM 5B – SERVICE SITES**

Data will be pre-populated from the FQHC Look-Alike’s official scope of project. Essential attributes are read-only and **CANNOT** be modified. Other attributes in this form are modifiable. Any change in scope or self-update will **NOT** be allowed at the time of the Annual Certification submission.

Only service sites included on Form 5B are considered to be in a FQHC Look-Alike’s approved scope of project. Sites that are identified elsewhere in the application (e.g., Program Narrative) and are not identified on Form 5A will not be considered to be in the approved scope of project.

NOTE: If your organization has a pending Change In Scope application to add a site, it cannot be included in Form 5B until the Change In Scope has been approved.

➤ **FORM 5C – OTHER ACTIVITIES/LOCATIONS (Read Only)**

Data will be pre-populated from the FQHC Look-Alike’s official scope of project and **CANNOT** be modified. Any change in scope or self-update will **NOT** be allowed at the time of the Annual Certification submission. Only Other Activities/Locations included on Form 5C (e.g., home visits, health fairs) are considered to be in a FQHC Look-Alike’s approved scope of project.

➤ **FORM 6A – CURRENT BOARD MEMBER CHARACTERISTICS (Required)**

List all current board members, including *ex officio* members, and provide the details requested.

- Tribal organizations are *not* required to complete this form.

- Public centers with co-applicant health center governing boards must list the co-applicant board members.
- Grantees with a current waiver of the consumer majority requirement must list the health center's board members, not the members of any advisory council(s).

➤ **FORM 10 – ANNUAL EMERGENCY PREPAREDNESS REPORT (Required)**

Select the appropriate responses regarding emergency preparedness. 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 Annual Certification submission.

C. Instructions and Format for Annual Certification Clinical and Financial Performance Measures

The clinical and financial performance measures are ongoing performance improvement tools that provide a summary of an FQHC Look-Alike's PROGRESS towards the goals that were identified in their most recently approved Initial Designation or Renewal of Designation application. The Clinical and Financial Performance Measures Forms should outline time-framed and realistic goals and related performance measures (as referenced below) with baselines that are responsive to the identified primary health care needs of the community served and the strategic needs of the overall organization, including multiple sites and/or various activities at multiple sites.

Important Details about the Clinical and Financial Performance Measures

- In the Clinical and Financial Performance Measures Forms for Calendar Year 2011/2012 Annual Recertification applications, FQHC Look-Alike organizations will need to manually type in the goals they listed in their most recently approved Initial Designation or Renewal of Designation applications. FQHC Look-Alikes should then provide PROGRESS TOWARD THE GOALS for each performance measure identified in their most recently approved FQHC Look-Alike application (Initial Designation or Renewal of Designation).
- Designation Period end goal can be revised if MAJOR accelerated progress or barriers have been experienced in the previous annual certification period. The rationale and comments for any revisions must be provided in the comments sections and/or the Program Narrative, as applicable.
- The comments section for each performance measure is an open text field where FQHC Look-Alikes are expected to provide information regarding their progress toward the performance measure goal. The comments section has a 1,000 character limit. FQHC

Look-Alikes are encouraged to use the Evaluative measures section of the Program Narrative to include any additional comments from the clinical and financial performance measures comment fields that exceed the character limit.

Organizations are expected to integrate the Health Center performance measures within each Need/Focus Area identified below, as appropriate. The Health Center performance measures are accessible on HRSA's Web site at <http://bphc.hrsa.gov/policiesregulations/performance Measures/>. Additional information on the clinical performance measures can be found in the annual Uniform Data System Reporting Manual available at <http://bphc.hrsa.gov/uds/>. Additional technical assistance related to the clinical and financial performance measures is available through HRSA and the State PCA.

1. Only applicants that provide or assume primary responsibility for some or all of a patient's prenatal care services, whether or not the applicant does the delivery, are required to include prenatal performance measures, including the required measures: Percentage of pregnant women beginning prenatal care in the first trimester and Percentage of births less than 2,500 grams to health center patients.
2. If the applicant is applying for FQHC Look-Alike designation to target special populations (e.g., migrant/seasonal farmworkers, residents of public housing, homeless persons), they are encouraged to include additional goals and related performance measures that address the unique health care needs of these populations in the Plan(s), as appropriate.
3. If the applicant has identified other unique populations, life-cycles, health issues, risk management efforts, etc. in the narrative Need section, they are encouraged to include additional goals and related performance measures in the Form(s) as appropriate.
4. Any additional narrative regarding the clinical and financial performance measures should be included in the Evaluative Measures section of the Program Narrative, as appropriate.

Applicants are expected to address the performance measures provided by HRSA in their Clinical and Financial Performance Measures Forms, as applicable. All applicants are expected also include one Behavioral Health (e.g., Mental Health or Substance Abuse) and one Oral Health performance measure of their choice in the Clinical Performance Measures Form. (Please visit <http://bphc.hrsa.gov/policiesregulations/performance Measures/> to view the HRSA performance measures.)

Applicants may also wish to consider utilizing Healthy People 2020 goals and performance measures when developing their clinical and financial performance measures. Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The program consists of 41 focus areas and more than 1,400 objectives. Further information on Healthy People 2020 goals may be downloaded at <http://www.healthypeople.gov/document/>.

NOTE: FQHC Look-Alike organizations that have not submitted a Renewal of Designation application with five-year Clinical and Financial Performance Measures Forms must do so in this Annual Certification application. Please follow the instructions for preparing Initial/Renewal of Designation Clinical and Financial Performance Measures Forms located on page 52 and page 92 of this document. Organizations should contact the Office of Policy and Program Development at 301-594-4300 or FQHCLAL@hrsa.gov for additional guidance.

Need Addressed/Focus Area

This is a concise categorization of the major need or focus area to be addressed by the applicant for their service area, target population and/or organization to be addressed (Diabetes; Cardiovascular Disease; Costs, Productivity, etc.). Applicants are expected to address each required performance measurement area (as described in the table below), as well as any other key needs of their target population or organization as identified in the application narrative.

Designation Period Goal(s) with Baseline

Goals are relatively broad statements relating to the Need Addressed/Focus Area. Applicants should provide goals which, where possible, can be accomplished by the end of the multi-year designation period. The goal should be reasonable, measurable, and reflect an anticipated impact upon the specified need or focus area. The applicant must also provide baseline data (where possible) to indicate their status at or prior to the beginning of the designation period. Note that for some FQHC Look-Alikes this may mean several years ago. But for FQHC Look-Alikes in the first year of a new designation period, it will mean the value of the most recent reporting year. Baseline data provides a basis for quantifying the amount of growth/change to be accomplished in the designation period. If applicants choose to establish a baseline for any of the new clinical performance measures, they are encouraged to utilize the sampling/chart review instructions provided in the 2009 Uniform Data System Reporting Manual, available at <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting/2009udsreportingmanual.pdf>. Applicants are expected to track performance against these goals throughout the entire approved designation period and to report progress achieved on the goal in this and subsequent Annual Certification applications. However, designation period end goals can be revised if major accelerated progress or barriers have been experienced in the previous certification period. The rationale and comments for any revisions must be provided in the Progress towards Goal section of the Clinical and Financial Performance Measures Forms and/or Program Narrative, as applicable.

Applicants that included additional goals and performance measures in their most recent Initial/Renewal of Designation application must also report progress on these goals. In cases where data on the new clinical performance measures was not previously collected by the organization, these should be listed as “Data Not Available.”

Progress Towards Goal (Report 3-Year Trend—Quantitative)

Report quantitative progress on the related performance measures, including all required measures, stated in the applicant’s most recent Initial/Renewal of Designation application. Applicants should report progress in terms of trends (e.g., % increase or decrease) based on the most recent three-years of complete data if such data are available. Additional measures chosen by the applicant should also define the numerator and denominator⁴² that will be used to determine the level of progress/improvement achieved on each goal (e.g., Numerator: One or more screenings for colorectal cancer. Denominator: All patients age 51-80 years during the measurement year).

Progress Towards Goal (Qualitative)

Describe qualitative progress, such as major processes, strategies or objectives achieved to date that contribute to the achievement of the goal. Also, include any significant changes in the contributing and/or restricting factors impacting the FQHC Look-Alike’s performance on the measure as well as any significant changes in the key actions or major planned responses to these factors.

NOTE: Detailed narrative regarding contributing or restricting factors affecting progress on the clinical or financial performance measures should be included in the Evaluative Measures section of the Program Narrative, as appropriate.

SAMPLE MEASURES

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE CLINICAL PERFORMANCE MEASURE	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	XYZ Health Center	00000
	Designation Period Date	01/01/2011 - 12/31/2016
Focus Area: Diabetes		
Performance Measure: Percentage of diabetic patients whose HbA1c levels are less than or equal to 9 percent		
Is this Performance Measure Applicable to your Organization?	Yes	
Target Goal Description	By the end of the Designation Period, increase the % of adult patients with type 1 or 2 diabetes whose most recent hemoglobin A1c (HbA1c) is ≤ 9% (under control) up to 65%	
Numerator Description	Number of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator.	

⁴² When used here, “denominator” means the universe of patients who fit the criteria. It is assumed that most FQHC Look-Alikes will measure these ratios by using a scientifically drawn sample.

FQHC Look-Alike Application Instructions CY 2011-2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE CLINICAL PERFORMANCE MEASURE	FOR HRSA USE ONLY		
	Organization Name	Application Tracking Number	
	XYZ Health Center	00000	
	Designation Period Date	01/01/2011 - 12/31/2016	
Denominator Description	Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria		
Baseline Data	Baseline Year: 2009 Measure Type: Percentage Numerator: 2200 Denominator: 4000	Projected Data (by End of Designation Period)	65%
Data Source & Methodology	Representative sample of patient records. (Data run on 1/10/2010).		
Progress Toward Goal	Quantitative: 53.6% Qualitative: We had an 11% improvement in performance on this measure compared to our baseline and are well on our way to addressing our goal of 65% by the end of the designation period. The main contributor to our success this year was the implementation of physician champions across all of our sites who allotted administrative time to work with fellow staff to test and implement changes to our diabetes management protocols. The agency-wide and site-specific teams formed a collaborative infrastructure that provided diabetic patients with the necessary tools and support to successfully manage their disease. We plan to continue our work with the physician champions and further improve performance by developing an incentive plan that rewards providers to improve their patients' health outcomes.		
Comments			

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE CLINICAL PERFORMANCE MEASURE	FOR HRSA USE ONLY		
	Organization Name	Application Tracking Number	
	XYZ Health Center	00000	
	Designation Period Date	01/01/2011 - 12/31/2016	
Focus Area: Costs			
Performance Measure: Medical Cost per Medical Visit			
Is this Performance Measure Applicable to your Organization?	Yes		
Progress Toward Goal	By the end of the Designation Period, maintain rate of increase not exceeding 5% per year, such that medical cost per medical visit is less than or equal to 164.83.		
Numerator Description	Total accrued medical staff and medical other cost after allocation of overhead (excludes lab and x-ray costs)		

FQHC Look-Alike Application Instructions CY 2011-2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE CLINICAL PERFORMANCE MEASURE	FOR HRSA USE ONLY		
	Organization Name	Application Tracking Number	
	XYZ Health Center	00000	
	Designation Period Date	01/01/2011 - 12/31/2016	
Denominator Description	Non-nursing medical visits (excludes nursing (RN) and psychiatrist visits)		
Baseline Data	Baseline Year: 2009 Measure Type: Ratio Numerator: 492000 Denominator: 4000	Projected Data (by End of Designation Period)	164.83
Data Source & Methodology	UDS		
Progress Toward Goal	Quantitative: 127.01 Qualitative: We experienced a 3.3% increase in our medical cost per medical visit. During the middle of the year we were able to hire a nurse practitioner who works in two of our sites. The addition of the nurse practitioner has increased the overall number of medical visits to the health center. We plan to continue to review our staffing mix to ensure we are staffed in a manner that maximizes our productivity and supports our goal of cost increases minimal.		
Comments			

D. Agency Contacts

Additional information related to the overall program issues and/or technical assistance regarding the Annual Certification application may be obtained by contacting:

FQHC Look-Alike Program
 Office of Policy and Program Development
 HRSA, Bureau of Primary Health Care
 5600 Fishers Lane, Room 17C-26
 Rockville, MD 20857
 Telephone: 301-594-4300
 Fax: 301-594-4997
 Email: FQHCLAL@hrsa.gov
 Technical Assistance Resources: <http://bphc.hrsa.gov/about/lookalike/index.html>

For Assistance with Application Submission and the HRSA electronic Handbooks (EHB):

Applicants who need assistance preparing and submitting their application electronically through HRSA’s EHB can contact the HRSA Call Center, Monday – Friday, 9:00 AM to 5:30 PM ET:

HRSA Call Center
 Phone: 877-Go4-HRSA or 877-464-4772 [TTY: 877-897-9910]
 Fax: 301-998-7377
 Email: CallCenter@hrsa.gov