U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

POLICY INFORMATION NOTICE

DOCUMENT NUMBER: 2009-07

DATE: November 23, 2009

DOCUMENT NAME: Amendment to PIN 2009-06, Federally Qualified Health Center (FQHC) Look-Alike Guidelines and Application

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

This Policy Information Notice (PIN) amends PIN 2009-06, Federally Qualified Health Center (FQHC) Look-Alike Guidelines and Application. Effective immediately, all organizations must provide an assurances cover page when submitting FQHC Look-Alike applications for New Designation, Recertification, Renewal of Designation, or Change in Scope of Project.

The cover page must include the organization's legal name and address, as well as, the name, title, address, and contact information of an authorized representative. The authorized representative must sign and date the cover page assuring that the data provided in the application is correct and true to the best of his/her knowledge and that the application submission is executed by the individual as the authorized representative of the organization. The cover page must include the signature, date, and seal of a notary public.

In addition, an applicant organization may authorize the Health Resources and Services Administration to discuss its application with persons other than the authorized representative, by acknowledging this on the cover page and including any additional representatives' names, titles, and contact information.

If you have any questions regarding the FQHC Look-Alike program, then please contact the Office of Policy and Program Development at 301-594-4300.

/S/

James Macrae
Associate Administrator
Attachment

ATTACHMENT

Sample Cover Page for
Federally Qualified Health Center (FQHC) Look-Alike
Application Submissions

Organization's Legal Name: _____

Address: _____
_____
_____

ASSURANCES STATEMENT
This is to certify that to the best of my knowledge and belief all data provided in the FQHC Look-Alike application are true and correct. This submission is executed by me as the Authorized Representative of the organization.

Authorized Representative

Name: _____
Title: _____
Full Address: _____
_____
_____
Telephone: _____ Fax: _____ E-mail: _____

SIGNATURE_____ DATE _____
Authorized Representative

I further certify that the Health Resources and Services Administration has my permission to discuss the enclosed FQHC Look-Alike application with the following:

Additional Authorized Representative(s)

Name: _____
Title: _____
Organization: _____
Full Address: _____
_____
_____
Telephone: _____ Fax: _____ E-mail: _____

Additional authorized representatives may be added.

SIGNATURE_____ DATE _____
Authorized Representative

Notary:
SIGNATURE_____ DATE _____

NOTARY SEAL