

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b> <b>Health Resources and Services Administration</b>  <b>Project Narrative</b>	<b>FOR HRSA USE ONLY</b>		
	<b>Grant Number</b>		<b>Application Tracking Number</b>
	<b>Maximum Eligible Amount:</b>		<b>Total Federal Requested Amount:</b>
	<b>Service Types Selected:</b>		

**Need**

Describe the need to expand or begin providing the proposed service(s), and how this proposal will respond to the health care needs of the target population (with reference to relevant special populations, demographic characteristics, and/or access to care/health status indicators).

*(2,000 characters maximum – about one page)*

[Applicant enters required response here]

**Response**

Describe the following:

1. An appropriate timeline for project implementation that demonstrates operational readiness within 120 days of award for the provision of new and expanded existing services.

*(1,000 characters maximum – about half of a page)*

[Applicant enters required response here]

2. How the health center will ensure that all proposed services are or will be integrated into the existing service delivery model.

*(1,000 characters maximum – about half of a page)*

[Applicant enters required response here]

3. How the health center will ensure that all proposed services are accessible without regard to ability to pay through a sliding fee discount program.

*(1,000 characters maximum – about half of a page)*

[Applicant enters required response here]

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<p>4. How the health center plans to ensure that all patients will have reasonable access to any proposed new services, as appropriate. Include details about any services or staff proposed under the Other Enabling Services category on Form 5A and/or the Staffing Impact Form.</p> <p><i>(1,000 characters maximum – about half of a page)</i></p> <p>[Applicant enters required response here]</p>			
<p>5. If any services will be provided by a Formal Written Agreement (via Column II on Form 5A), describe how the health center maintains oversight over all services provided via contracts/agreements or sub-recipient arrangements in accordance with Health Center Program requirements. If services are not provided via Formal Written Agreement, indicate that this question is not applicable.</p> <p><i>(1,000 characters maximum – about half of a page)</i></p> <p>[Applicant enters required response here]</p>			
<p><b><u>Impact</u></b></p> <p>Describe the following:  The impact of the proposed project, including the number of 1) proposed new patients, 2) existing patients with increased access to services (as applicable), and 3) new providers.</p> <p>Include a detailed explanation for how the projections were calculated (including data sources).</p> <p><i>(2,000 characters maximum – about one page)</i></p> <p>[Applicant enters required response here]</p>			

OMB No.: 0915-0285. Expiration Date: 9/30/2016

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0285. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857.