

Instructions for Preparing and Submitting the FY 2013 Health Center Program Budget Period Progress Report

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Instructions for Preparing and Submitting the FY 2013 Health Center Program Budget Period Progress Report

I. PURPOSE

The Budget Period Progress Report (BPR) is a streamlined process for grantees applying for non-competitive continuation funding in the Health Resources and Services Administration (HRSA) Electronic Handbooks (EHB). All Health Center Program grantees requesting non-competitive continuation funding must submit a BPR according to these instructions.

The BPR will be used by HRSA to assess progress and significant changes to approved Health Center Program funded activities. The continuation of grant funding will be based on compliance with applicable statutory and regulatory requirements, timely submission of the BPR through EHB, demonstrated organizational capacity to accomplish the project's goals, Congressional appropriations, and a determination that continued funding is in the best interest of the government.

Grantees are reminded that per section 330(k)(3)(H) of the PHS Act as amended (42 U.S.C. 254b), the health center governing board, including the co-applicant board for public centers, must approve the health center's BPR submission, including the proposed budget for the upcoming project period.

II. SUBMISSION SCHEDULE

The Fiscal Year (FY) 2013 BPR will be generated as a reporting requirement in the Grantee Handbook approximately three months prior to the EHB deadline. The following table provides the FY 2013 BPR deadlines.

Table 1: BPR Deadlines

Budget Period Start Date	EHB Deadline (5:00 PM ET)
November 1, 2012	August 15, 2012
December 1, 2012	August 29, 2012
January 1, 2013	September 26, 2012
February 1, 2013	October 24, 2012
March 1, 2013	November 20, 2012
April 1, 2013	December 19, 2012
May 1, 2013	January 16, 2013
June 1, 2013	February 20, 2013

III. TECHNICAL ASSISTANCE

A technical assistance Web site has been established to assist grantees in completing the BPR. The site includes copies of forms, FAQs, and a slide presentation, among other resources. It can be accessed at <http://bphc.hrsa.gov/policiesregulations/continuation>.

Grantees may obtain additional information regarding business, administrative, or fiscal issues by contacting:

Donna Marx
Office of Federal Assistance Management
HRSA Division of Grants Management Operations
5600 Fishers Lane, Room 12A-07
Rockville, MD 20857
Telephone: 301-594-4245
Email: dmarx@hrsa.gov

Grantees may obtain programmatic technical assistance by contacting:

Cheri Daly
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
Email: BPHCBPR@hrsa.gov

Additional technical assistance regarding these instructions may be obtained by contacting the Project Officer noted on the most recent Notice of Award and/or the appropriate Primary Care Association (PCA), Primary Care Office (PCO), or National Cooperative Agreement (NCA). A list of these organizations is available at <http://bphc.hrsa.gov/technicalassistance/partnerlinks>.

Grantees may obtain additional assistance with completing the application in EHB by contacting the BPHC Helpline at 1-877-974-2742 or BPHCHelpline@hrsa.gov.

IV. REPORTING

All Health Center Program grantees must comply with the following reporting and review activities.

a. Audit Requirements

Health centers must maintain accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP), including separating functions appropriate to organizational size to safeguard assets and maintain financial stability. Health centers must ensure an annual independent financial audit is

performed in accordance with Federal audit requirements (Section 330 (k) (3) (D), Section 330 (q) of the PHS Act and 45 CFR Part 74.14 (a) (4), 45 CFR Part 74.21 and 45 CFR Part 74.26). Organizations must submit their audit findings inclusive of the management letter (or provide a signed statement that no letter was issued with the audit) via the process described in Program Assistance Letter 2009-06: New Electronic Process for Submitting Required Annual Financial Audits (which includes Office of Management and Budget (OMB) Circular A-133 directions) located at <http://bphc.hrsa.gov/policiesregulations/policies/pal200906.html>. Failure to submit the audit can result in conditions of award, including draw down restrictions on available funds.

b. Payment Management Requirements

Submit a quarterly electronic Federal Financial Report (FFR) Cash Transaction Report via the Payment Management System (PMS). The report identifies cash expenditures against the authorized grant funds. Failure to submit the report may result in the inability to access grant funds.

c. Status Reports

1. Submit a Federal Financial Report (SF-425) in EHB at the end of each budget period. The report is an accounting of expenditures under the project for that budget period. Grantees will be permitted 90 days to liquidate obligations following the end of the budget period. The report will be due the quarter following the 90 day liquidation period (due date is shown on NoA).
2. Submit a Uniform Data System (UDS) Report. Grantees are required to annually submit a Universal Report and, if applicable, a Special Population Grant Report. The UDS is an integrated reporting system used to collect data on all health centers to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments. Grantees must have systems in place (e.g., self-report intake forms, screening tools) to collect data on patient characteristics as the UDS requires a count of patients from targeted special populations, including migrant and seasonal farm workers, persons who are homeless, and residents of public housing.

V. INSTRUCTIONS

Grantees are required to submit their BPR within the EHB by the applicable FY 2013 BPR deadline. The total size of the BPR must not exceed the equivalent of 60 pages when printed by HRSA, approximately 8 MB. Grantees should submit single-spaced narrative documents with 12 point, easily readable font (e.g., Times New Roman, Arial, Courier) and 1-inch margins. Smaller font (no less than 10 point) may be used for tables and footnotes.

Grantees are reminded that failure to include all required documents as part of the BPR will result in the progress report being considered incomplete or non-responsive. Incomplete or non-responsive progress reports will be returned to the grantee through a

“request change” notification via EHB to provide missing documentation or clarify a portion of the submitted report. **Failure to submit the BPR by the established deadline or submission of an incomplete or non-responsive progress report may result in a delay in Notice of Award issuance or a lapse in funding.** Therefore, it is recommended that grantees carefully review their BPR to ensure it is both complete and responsive prior to submission.

Significant budget revisions or other significant changes to the grant (e.g., change in Project Director/CEO) must be requested via the Prior Approval Module in EHB. Significant budget revisions occur when cumulative transfers among budget categories exceed 25 percent of the total approved budget (inclusive of direct and indirect costs) or \$250,000, whichever is less. For further detail on actions and changes requiring prior approval, review the HHS Grants Policy Statement available at <http://www.hrsa.gov/grants/hhsgrantspolicy.pdf>.

The following tables identify the components for the FY 2013 BPR submission. In the Form Type column of [Tables 2-5](#), the word “E-Form” refers to forms that are completed online through EHB and **DO NOT** require downloading or uploading. The word “Document” refers to materials that must be downloaded, completed in the template provided, and uploaded into EHB. The word “Fixed” refers to forms that cannot be altered. Appendices A, B, and C provide detailed instructions on the required forms and documents.

Table 2: BPR Submission

- It is mandatory to follow the instructions provided in this section to ensure that your BPR can be printed efficiently and consistently.
- Failure to follow the instructions may make your BPR non-responsive. Incomplete or non-responsive BPR submissions will be returned for resubmission, which may result in a delay in Notice of Award issuance and/or a lapse in funding.
- No table of contents is required.

Progress Report Section	Form Type	Instructions	Counted in Page Limit?
SF-PPR and SF-PPR-2 (Required)	E-Form	Complete the form online. Specific instructions are included in the BPR EHB user guide available within EHB and at http://bphc.hrsa.gov/policiesregulations/continuation .	No
Budget Information: Budget Details (Required)	E-Form	Complete the form online. Specific instructions are included in the BPR EHB user guide available within EHB and at http://bphc.hrsa.gov/policiesregulations/continuation .	No
Budget Narrative (Required)	Document	Upload the Budget Narrative. Refer to Section VI for detailed instructions.	Yes
Program Specific Forms (Required)	Varies	See Table 3 . Refer to Appendix A for detailed instructions.	No
Program Specific Information (Required)	E-Forms	See Table 4 . Refer to Appendix B for detailed instructions.	No
Attachments (Varies)	Documents	See Table 5 . Refer to Appendix C for detailed instructions. Please note, the Program Narrative Update will be submitted as Attachment 1.	Yes

Table 3: BPR Program Specific Forms

- Refer to [Appendix A](#) for detailed instructions on completing the forms/documents listed below.
- The Program Specific Forms **DO NOT** count against the page limit.

Program Specific Forms	Form Type	Instructions
Form 1A : General Information Worksheet (Required)	E-Form	Complete the form online.
Form 1C : Documents on File (Required)	E-Form	Complete the form online.
Form 2 : Staffing Profile (Required)	E-Form	Complete the form online.
Form 3 : Income Analysis (Required)	Document	Complete the document using the template provided in EHB and upload as an attachment within the Income Analysis Section of the Program Specific forms.
Form 5A : Services Provided (Read Only)	Fixed	This form is pre-populated to reflect the current scope of project and CANNOT be modified. NOTE: A change in scope request is required to modify services provided listed on this form. Contact your project officer for guidance.
Form 5B : Service Sites (Read Only)	Fixed	This form is pre-populated to reflect the current scope of project and CANNOT be modified. NOTE: A change in scope request is required to modify service sites listed on this form. Contact your project officer for guidance.
Form 5C : Other Activities/Locations (Read Only)	Fixed	This form is pre-populated to reflect the current scope of project and CANNOT be modified. NOTE: A change in scope request is required to modify other activities/locations listed on this form. Contact your project officer for guidance.

Program Specific Forms	Form Type	Instructions
Form 6A : Current Board Member Characteristics (As Applicable)	E-Form	Complete the form online.
Form 10 : Annual Emergency Preparedness Report (Required)	E-Form	Complete the form online.
Form 12 : Organization Contacts (Required)	E-Form	Complete the form online.

Table 4: BPR Program Specific Information

- Refer to [Appendix B](#) for detailed instructions on completing the forms listed below.
- The Program Specific Information forms **DO NOT** count against the page limit.

Program Specific Information	Form Type	Instructions
Clinical Performance Measures (Required)	E-Form	Complete the form online. A sample form can be found at http://bphc.hrsa.gov/policiesregulations/continuation .
Financial Performance Measures (Required)	E-Form	Complete the form online. A sample form can be found at http://bphc.hrsa.gov/policiesregulations/continuation .

Table 5: BPR Attachments

- Refer to [Appendix C](#) for detailed instructions on completing the attachments listed below.
- The Attachments **WILL** count against the page limit.
- Attachments 1 and 2 are required; attachments 3 – 8 (as applicable) can be omitted.

Attachments	Form Type	Instructions
Attachment 1 : Program Narrative Update (Required)	Document	Upload the Program Narrative Update, reporting the current status and describing significant changes for all aspects of the overall program.
Attachment 2 : Sliding Fee Discount Schedule(s) (Required)	Document	Upload the most current sliding fee discount schedule(s), indicating the most recent review/revision date.
Attachment 3 : Service Area Map (As Applicable)	Document	If new service areas/sites have been added, upload a map of the service area for the project, noting the organization’s new service sites (listed in Form 5B).
Attachment 4 : Organizational Chart (As Applicable)	Document	If changes have occurred, upload a one-page document that depicts the governing board, key personnel, staffing, and any sub-recipients and/or affiliated organizations.
Attachment 5 : Position Descriptions for Key Management Staff (As Applicable)	Document	If the descriptions have changed, upload position descriptions for any CURRENT VACANT key management staff positions.
Attachment 6 : Biographical Sketches for Key Management Staff (As Applicable)	Document	Upload biographical sketches for NEW key management staff hired since the submission of the most recent SAC, NAP, or BPR.
Attachment 7 : Summary of Contracts and Agreements (As Applicable)	Document	Upload a BRIEF SUMMARY describing any NEW or REVISED contracts and/or agreements.
Attachment 8 : Other Relevant Documents (As Applicable)	Document	Upload other documents to support the program updates.

VI. BUDGET PRESENTATION INSTRUCTIONS

A complete budget presentation includes the submission of the Budget Information: Budget Details form, budget narrative, and two Program Specific Forms ([Form 2](#) – Staffing Profile and [Form 3](#) – Income Analysis).

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

The BPR may not be used to request additional Health Center Program funds, including minor capital improvements, or to request changes in the total, type, or allocation of Health Center Program funds.

A. Budget Information: Budget Details Form (Required)

In Section A: Budget Summary, verify the pre-populated list of Health Center Program funding types (i.e., Community Health Center – CHC, Migrant Health Center – MHC, Health Care for the Homeless – HCH, and/or Public Housing Primary Care – PHPC). If the funding types are incorrect, make necessary adjustments using the **Update Sub-Program** button.

In Section A: Budget Summary, in the Federal column, provide the Health Center Program grant request for each Health Center Program funding type (e.g., CHC, MHC). The total Federal funding requested across all Health Center Program funding types must equal the Recommended Federal Budget figure that appears at the top of the Budget Information: Budget Details form. This figure corresponds with the recommended future support figure (Item 13 or 19) on the most recent Notice of Award.

In the Non-Federal column, provide the total of the non-Federal funding sources (e.g. state, local) for each type of Health Center Program (e.g., CHC, MHC). The total for the non-Federal column should equal the total non-Federal share value on [Form 3](#): Income Analysis. The amount(s) in the total column will be calculated automatically as the sum of the Federal and non-Federal columns.

In Section B: Budget Categories, provide a breakdown of the budgeted funds (both Federal and non-Federal) by object class category (e.g., Personnel, Fringe Benefits) for each type of Health Center Program funding (e.g., CHC, MHC). Grantees may want to use the Budget Categories form submitted with the most recent BPR or the SF-424A submitted with the most recent SAC or NAP as a reference point, noting that the total value for each Object Class Category may be different from year to year based on programmatic changes. The total for each Health Center Program funding type (e.g., CHC, MHC) in Section B should match the total for each Health Center Program funding type (e.g., CHC, MHC) in Section A.

The amounts in the Total Direct Charges row and the Total column will be calculated automatically. Indirect costs may only be claimed with an approved indirect cost rate (see details in the Budget Narrative section below).

In Section C: Non-Federal Resources, provide a breakdown of non-Federal funds by funding source for each type of Health Center Program funding (e.g., CHC, MHC). Please note that if the grantee is a State agency, the State column should be left blank in favor of including State funding in the Applicant column. The total for the Program Income column should equal the Total Program Income value on [Form 3](#): Income Analysis.

B. Budget Narrative (Required)

Include a line-item budget narrative which explains the amounts requested for each row in Section B: Budget Categories of the Budget Information: Budget Details form. The budget narrative (often referred to as the budget justification) is for **1 year based on your upcoming 12-month budget period (this period will follow immediately after the current budget period listed on your Notice of Award)**. Upload the budget narrative in the Budget Narrative Form section in EHB. Refer to the HHS Grants Policy Statement available at <http://www.hrsa.gov/grants/hhsgrantspolicy.pdf> for information on allowable costs.

The 1-year budget narrative must itemize **revenues AND expenses** of your total operating budget for each type of Health Center Program funding. Use the budget narrative to clearly explain each line-item within each cost element. The budget narrative must be concise and should not be used to expand the Program Narrative Update ([Appendix C: Attachment 1](#)).

NOTE: It is important to ensure that the budget narrative contains detailed calculations explaining how each line-item expense is derived (e.g., number of visits, cost per unit).

Include the following in the budget narrative:

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

Salary Limitation: Per the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, HRSA funds may not be used to pay the salary of an individual at a rate in excess of \$179,700 (the Executive Level II salary of the Federal Executive Pay Scale). Reasonableness and allowability regulations continue to remain in effect.

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

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

Equipment: Identify the cost per item and justify the need for each piece of equipment to carry out the proposed project. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture that meet the definition of equipment (a unit cost of \$5,000 or more and a useful life of one or more years).

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

Contractual: Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. List both patient care (e.g., laboratory) and non-patient care (e.g., janitorial) contracts. Each grantee is responsible for ensuring that it has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring contracts.

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

Indirect Costs: Costs incurred for common or joint objectives that cannot be readily identified but are necessary to organizational operation (e.g., facility operation and maintenance, depreciation, administrative salaries). Indirect costs may only be claimed if the grantee provides documentation of an approved indirect cost rate. If an organization does not have an approved indirect cost rate, one may be obtained through the HHS Division of Cost Allocation (DCA). Visit <http://rates.psc.gov/> to learn more about rate agreements, including the process for applying for them. **Note: If your organization claims indirect costs in your budget, you must upload a copy of your most recent indirect cost rate agreement.**

APPENDIX A: PROGRAM SPECIFIC FORMS INSTRUCTIONS

Program Specific Forms must be completed electronically in EHB. Portions of the Forms that are “blocked/grayed” out are not relevant to the BPR and DO NOT need to be completed. To preview the forms to be completed online, visit <http://www.bphc.hrsa.gov/policiesregulations/continuation>.

FORM 1A: General Information Worksheet (Required)

Form 1A provides a summary of information related to the project. 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. Use the Fiscal Year End Date field to select the month and day in which the grantee organization’s fiscal year ends (e.g., June 30).

2. PROPOSED SERVICE AREA

2a. Target Population and Service Area Designation

Population Type

Population types for which funding is requested will be pre-populated based on information provided in the Budget Information: Budget Details form. If the population types are not pre-populated or if changes are required, make them using the **Update Sub-Program** button found on the Budget Information: Budget Details form.

Service Area Designation

Grantees applying for CHC (section 330(e)) funding 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 <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).

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 since the target population is generally a subset of the service area population. Use 2011 UDS data for all “current” information. If more up to date information is available, discuss in [Item 1 of the Impact section](#) of the Program Narrative Update.

Provider FTEs by Type

1. Provide a count of current provider full-time equivalents (FTEs), paid and voluntary, by staff type. This number should be consistent with the reporting of FTEs in UDS (see the 2011 UDS Manual available at <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting>). **Include only provider FTEs** (e.g., physician, nurse practitioner, certified nurse midwife, dentist, dental hygienist, psychiatrist, psychologist, social worker, case manager, patient educator, outreach worker).
2. Project the number of provider FTEs anticipated at the end of the project period based on maintaining the current level of funding.
3. Do **NOT** report provider FTEs functioning outside the scope of project or those providing vision or pharmacy services.

Patients and Visits by Service Type

1. List the current number of unduplicated patients and visits consistent with the 2011 UDS Report within each service type category: medical, dental, behavioral health, substance abuse, and enabling. Within each category, an individual can only be counted once as a patient. An individual who receives multiple types of services should be counted once for each service type (e.g., once for medical and once for dental).
2. The projected number of patients/visits (at the end of the project period) must be consistent with the projections included in the most recent SAC or NAP. Be sure to include any increase in projections based on new awards received since the start of the project period (e.g., NAP). **Note: HRSA does NOT expect the number of patients to decline.** Any projected decrease in the number of patients/visits must be discussed in [Item 1 of the Impact section](#) of the Program Narrative Update.
3. Do **NOT** report patients and visits for services provided outside the scope of project. Do not report vision services patient or visit data.

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

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

- A patient is an individual who had at least one visit in the previous year.
- Since a patient must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.

Patients and Visits by Population Type

1. Consistent with the 2011 UDS Report, provide the current number of patients and visits within each population type category: general community, homeless persons, migrant/seasonal farm workers, and public housing residents. Within each category, an individual can only be counted once as a patient.

Note: The population types in this section of the form do NOT apply only to grantees that request target funding for special populations (i.e., CHC, MHC, HCH, and/or PHPC). For example, a grantee with only CHC funding (general underserved community) that also serves the homeless should report patients/visits in both the general community and homeless persons population type categories.

2. Project the number of unduplicated patients and visits for calendar year 2012 in the Number at End of Year 1.

Note: Grantees submitting their BPRs in 2013 may be able to provide accurate patient/visit counts rather than projected data for 2012.

3. Projecting the number of unduplicated patients and visits by the end of the entire project period using the Number at End of Project Period column. The projected numbers for the end of the project period should be consistent with the projections included in the most recent SAC or NAP. Be sure to include any increase in projections based on new awards received since the start of the project period (e.g., NAP) and describe such projected increases in [Item 1 of the Impact section](#) of the Program Narrative Update.

FORM 1C: Documents on File (Required)

Provide the date that each document listed was last reviewed and, if appropriate, revised. This form provides a summary of documents that support the implementation of Health Center Program Requirements and key areas of health center operations. The requirement numbers listed on the form correspond to the list of Health Center Program requirements found at <http://bphc.hrsa.gov/about/requirements>; reference this list for more detailed information about each requirement. Please note that Form 1C is not intended to provide an exhaustive list of all types of health center documents (e.g., policies and procedures, protocols, legal documents).

All documents noted on [Form 1C](#) should be maintained and updated by key management staff and, as appropriate, approved and monitored by the health center's governing board. Keep these documents on file, making them available to HRSA **upon request** within 3-5 business days. **DO NOT** submit these documents with the progress report.

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

FORM 2: Staffing Profile (Required)

Report personnel salaries supported by the total budget for the **upcoming 12-month budget period (this period will follow immediately after the current budget period listed on your Notice of Award)**, 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 must be addressed in the Program Narrative Update ([Item 4 of the Response section](#) or [Item 3 of the Resources/Capabilities section](#)).

- 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 scope of project.
- Do not include contracted staff on this form.

NOTE: The amount for total salaries (this figure will auto-calculate in EHB) may not match the amount allocated for the Personnel cost category in the Section B: Budget Categories of the Budget Information: Budget Details form due to the inclusion of salaries charged to indirect costs on Form 2 - Staffing Profile.

FORM 3: Income Analysis (Required)

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

Note: Do not include funds from pending supplemental grants or unapproved changes in scope (e.g., sites, services).

The two major classifications of revenues are as follows:

- **Program Income (Part 1)** includes fees, premiums, third party reimbursements, and payments generated from the projected delivery of services. Program income is divided into Fee for Service and Capitated Managed Care. **All service-related income must be reported in this section of the form.**
- **Other Income (Part 2)** includes state, local, other Federal grants or contracts (e.g., Ryan White, HUD, Head Start), and local or private support that is not generated from charges for services delivered.

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

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

PART 1: PROGRAM INCOME

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

Projected Fee For Service Income

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

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

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

Column (b): Enter the average charge per visit by payor category. An analysis of charges will generally reveal different average charges (e.g., average Medicare charges may be higher than average Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) charges). If this level of detail is not available, calculate averages on a more general level (i.e., at the payor, service type, or agency level).

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

Column (d): Enter the adjustment rate (percentage) to the average charge per visit listed in column (b). In actual operation, adjustments may be taken either before or

after the bill is submitted to a first or third party. Adjustments reported here do NOT include adjustments for bad debts which are shown in columns (f) and (g).

Adjustments in column (d) include those related to:

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

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

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

Column (f): Enter the estimated collection rate by payor category. The collection rate is the amount projected to be collected divided by the net charges. As a rule, collection rates will not exceed 100%, and may be less than 100% due to factors such as bad debts (especially for self pay), billing errors, or denied claims not re-billable to another source. Explain any rate greater than 100% using the Comments/Explanatory Notes box.

Note: Do not show sliding discount percentages here; they are included in column (d). Show the collection rate for actual direct patient billings.

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

Column (h): Enter the actual accrued income by payor category for the most recent 12-month period for which data are available (e.g., previous fiscal year, previous audit year) and state the time period in the text box below Line 6. Any significant variance between projected income in column (g) and actual accrued income in column (h) must be explained in [Item 3 of the SUPPORT REQUESTED section of the Program Narrative](#). New applicants and current grantees applying to serve a new service area that are not yet operational in the service area should report zero in this column.

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.

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

Number of Member Months (Column a): The number of member months for which payment is received. One person enrolled for one month is one member month; a family of five enrolled for six months is 30 member months. A member month may cover just medical services, or medical and dental, or a unique mix of services. Unusual service mixes that provide for unusually high or low per member per month (PMPM) payments must be described in the Comments/Explanatory Notes box.

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

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

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

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

PART 2: OTHER INCOME

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

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

Note: In-kind donations **MUST NOT** be included on the Income Analysis form. However, applicants may discuss in-kind contributions in the Program Narrative.

Additionally, such donations may be included on the Budget Information: Budget Details form (Section A: Budget Summary—Non-Federal column under New or Revised Budget; Section C: Non-Federal Resources).

FORMS 5A (Services Provided), 5B (Service Sites), and 5C (Other Activities/Locations)—READ ONLY

Data will be pre-populated from the grantee's official scope of project and **CANNOT** be modified. Only services, sites, and other activities/locations included on Forms 5A, 5B, and 5C respectively are considered to be in a grantee's approved scope of project, regardless of what is described or detailed in other portions of the submission. Any changes to information included on the forms require prior approval via a change in scope request. Refer to the Scope of Project documents at <http://bphc.hrsa.gov/policiesregulations/policies> for additional information.

NOTE: If current services provided/service sites/other activities/locations do not match what is pre-populated, contact your Project Officer regarding initiating a change in scope request. Some changes (e.g., service area census tracts, service area zip codes (service site only), Medicare/Medicaid billing numbers) can be made to your scope of project via self update in EHB.

Form 5A: All referral arrangements/agreements for required services must be formal written arrangements/agreements.

Form 5B: Ensure that each permanent/seasonal site listed on [Form 5B](#) has a unique Medicare billing number in order to maintain reimbursement by Medicare under the Federally Qualified Health Center (FQHC) benefit. Refer to Program Assistance Letter HRSA 2011-04: Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit at <http://bphc.hrsa.gov/policiesregulations/policies/pal201104.html> for more information on this topic.

FORM 6A: Current Board Member Characteristics (As Applicable)

List all current board members and provide the requested details.

- Indian tribes or tribal, Indian, or urban Indian groups are **not** required to complete this form.
- Public centers (previously referred to as public entities) 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. Provide justification for all negative responses in [Item 1 of the Resources/Capabilities section](#) of the Program Narrative Update.

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 BPR submission.

APPENDIX B: PROGRAM SPECIFIC INFORMATION INSTRUCTIONS

A. Clinical and Financial Performance Measures

The Clinical and Financial Performance Measures are performance improvement tools that provide a summary of **PROGRESS** towards the goals identified in the most recently approved SAC, NAP, or BPR. Grantees are required to complete the Clinical and Financial Performance Measures forms in EHB.

The Clinical Performance Measures forms **MUST** include one Behavioral Health (e.g., mental health, substance abuse) and one Oral Health (e.g., screenings and exams, referrals, dental caries) performance measure. For more information regarding the Clinical and Financial Performance Measures, visit

<http://bphc.hrsa.gov/policiesregulations/performanceasures>. To review specific performance measure details, consult the most recent UDS Reporting Manual and training materials available at <http://www.hrsa.gov/data-statistics/health-center-data/reporting>.

Important Details about the Performance Measures

- You must provide qualitative information regarding contributing and/or restricting factors that have impacted progress during the budget period.
- Project period end goals and the Quantitative field cannot be edited for measures whose Quantitative data is being pre-populated from UDS. If major accelerated progress or barriers were experienced which will impact the project period end goals, note this in the Comments field.

B. New 2012 UDS Performance Measures

For the 2012 UDS Report (to be submitted early in 2013), grantees will be required to report on new Clinical Performance Measures. In preparing the BPR progress report, grantees are encouraged (but not required) to include the new Clinical Performance Measures listed below to establish baseline data. Grantees who select *Not Applicable* for these measures will be required to report on these measures in the 2012 UDS Report. More information on the new Clinical Performance Measures is available at <http://www.hrsa.gov/data-statistics/health-center-data/reporting>.

Coronary Artery Disease (CAD): Lipid Therapy: Percentage of patients age 18 years and older with a diagnosis of CAD prescribed a lipid lowering therapy (based on current ACC/AHA guidelines) during the measurement year

Numerator Description: Number of patients age 18 years and older with a diagnosis of CAD prescribed a lipid lowering therapy (based on current ACC/AHA guidelines) during the measurement year, among those patients included in the denominator

Denominator Description: Number of patients age 18 years and older as of December 31 of the measurement year with a diagnosis of CAD who have been seen in the clinic at least once during the measurement year

Ischemic Vascular Disease (IVD): Aspirin Therapy: Percentage of patients age 18 years and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA), or who had a diagnosis of Ischemic Vascular Disease (IVD), and who had documentation of use of aspirin or another antithrombotic during the measurement year

Numerator Description: Number of patients age 18 years and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA), or who had a diagnosis of Ischemic Vascular Disease (IVD), and who had documentation of use of aspirin or another antithrombotic during the measurement year, among those patients included in the denominator

Denominator Description: Number of patients age 18 years and older as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA), or who had a diagnosis of Ischemic Vascular Disease (IVD), who have been seen in the clinic at least once during the measurement year

Colorectal Cancer Screening: Percentage of patients age 50 to 75 years who had appropriate screening for colorectal cancer (includes colonoscopy \leq 10 years, flexible sigmoidoscopy \leq 5 years, or annual fecal occult blood test)

Numerator Description: Number of patients age 50 to 75 years who had appropriate screening for colorectal cancer (includes colonoscopy \leq 10 years, flexible sigmoidoscopy \leq 5 years, or annual fecal occult blood test), among those patients included in the denominator

Denominator Description: Number of patients age 50 to 75 years as of December 31 of the measurement year, who have been seen in the clinic at least once during the measurement year

Special Instructions for Existing Performance Measures

Report the **Diabetes Clinical Performance Measure** revised in 2011 as follows:

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

The **Child Health Performance Measure** has been revised to include the following: 4 DTP/DTPaP, 3 IPV, 1 MMR, 2 Hib*, 3 HepB, 1VZV (Varicella), 4 Pneumococcal conjugate, 2 HepA, 2 or 3 RV, and 2 influenza vaccines. ***Note:** While 2 Hib shots are required, HRSA recommends that 3 Hib shots be given per the CDC recommendation.

Overview of the Performance Measures Form Fields

In Table 6, YES in the **Is this a Pre-Populated Field?** column notes an item that is pre-populated. A single asterisk (*) in this column denotes a field that will be pre-populated

from the latest SAC, NAP, or BPR submission. A double asterisk (**) denotes a field that will be pre-populated from the 2011 UDS submission.

Table 6: Overview of Clinical and Financial Performance Measures Form Fields

Field	Is this a Pre-Populated Field?	Is this Field Editable?	About this Field
Focus Area	YES	NO	This field contains the content area description for each required performance measure. Grantees may specify an additional focus area for Oral Health and Behavioral Health measures and when adding a non-required performance measure.
Performance Measure	YES*	NO	This field defines each measure. This field is editable for Oral Health, Behavioral Health, and Other performance measures. Grantees are required to provide a justification for each edit in the Comments field.
Performance Measure Applicability	YES	YES	<p>The new Clinical Performance Measures (Coronary Artery Disease (CAD): Lipid Therapy, Ischemic Vascular Disease (IVD): Aspirin Therapy, Colorectal Cancer Screening) may be marked <i>Not Applicable</i> for the 2013 BPR only. If marked <i>Not Applicable</i>, a justification must be provided in the Comments field and all other fields must be left blank. If data are available, grantees are encouraged to mark these measures <i>Applicable</i> and report available baseline data.</p> <p>Prenatal Health and Perinatal Health Clinical Performance Measures can be marked <i>Not Applicable</i> by grantees that do not provide or pay for such services (only the third column will be checked on Form 5A for these services). Such designation requires justification in the Comments field regarding referral and tracking practices.</p> <p>Audit-related Financial Performance Measures (Change in Net Assets to Expense Ratio, Working Capital to Monthly Expense Ratio, and Long Term Debt to Equity Ratio) may be marked <i>Not Applicable</i> ONLY by tribal and public center grantees.</p>
Target Goal Description	YES*	YES	This field provides a description of the target goal. Edits must be justified in the Comments field.

Field	Is this a Pre-Populated Field?	Is this Field Editable?	About this Field
Numerator Description	YES*	NO	<p>In the case of the Clinical Performance Measures, the numerator is the number of patients that meet the criteria identified by the measure (e.g., patients in a specified age range that received a specified service). In the Financial Performance Measures, the numerator field must be specific to the organizational measure.</p> <p>This field can be edited for only Oral Health, Behavioral Health, and Other Performance Measures. All edits require justification in the Comments field.</p>
Denominator Description	YES*	NO	<p>In the case of the Clinical Performance Measures, the denominator is all patients to whom the measure applies (e.g., patients in a specified age range, regardless of whether they received a specified service). In the Financial Performance Measures, the denominator field must be specific to the organizational measure.</p> <p>This field can be edited for only Oral Health, Behavioral Health, and Other Performance Measures. All edits require justification in the Comments field.</p>
Baseline Data Baseline Year Measure Type Numerator Denominator	YES* YES* YES* YES*	NO NO NO NO	<p>This field contains subfields that provide information regarding the initial threshold used to measure progress over the course of the project period. This information will pre-populate from the last SAC/NAP/BPR application with no opportunity to edit.</p> <p>This field can be edited for Oral Health, Behavioral Health, and Other Performance Measures. It can also be edited for audit related financial measures. All edits require justification in the Comments field.</p> <p>The Baseline Year subfield identifies the initial data reference point. The Measure Type subfield provides the unit of measure (e.g., percentage, ratio). The Numerator and Denominator subfields specify patient or organizational characteristics (see rows above).</p> <p>If pre-populated baseline data is not reflective of the current project (e.g., new EHR system, site changes, supplemental funding), note this in the Comments field (explanation and desired new baseline data).</p>
Projected Data	YES*	NO	<p>This field provides the goal for the end of the project period from the most recent SAC/NAP. If pre-populated projected data is not reflective of the current project (e.g., new EHR system, site changes, supplemental funding), note this in the Comments field (explanation and desired new projected data).</p>

Field	Is this a Pre-Populated Field?	Is this Field Editable?	About this Field
Data Source and Methodology	YES*	YES	<p>This field provides information about the data sources used to establish quantitative progress. Grantees are required to cite data sources and discuss the methodology used to collect and analyze data (e.g., UDS data based on electronic health records (EHR), disease registries, sample, or all patient records). Data must be valid, reliable, and derived from established management information systems.</p> <p>For Clinical Performance Measures, grantees must select if data are from EHR, Chart Audit, or Other (please specify) before describing the methodology.</p>
Contributing and Restricting Factors	YES*	NO	<p>This field provides the contributing and restricting factors noted in the last SAC/NAP application. Use this field to guide Qualitative Progress Toward Goal updates (see row below).</p>
Progress Toward Goal Quantitative Qualitative	YES** NO	NO YES	<p>Quantitative data is pre-populated from the most recent UDS report.</p> <p>This is not editable for measures for which quantitative data is populated from UDS. But this field can be edited for Oral Health, Behavioral Health, and Other Performance Measures. It can also be edited for audit related financial measures.</p> <p>Qualitative information regarding contributing and/or restricting factors that have impacted the grantee's progress during the budget period MUST be provided. The Qualitative subfield should also be used to identify other issues that have impacted progress toward the performance measures (e.g., site closure/opening). In providing qualitative information, consider performance measure trends, such as percent increases or decreases. Responses are limited to 1,500 characters.</p>
Comments	NO	YES	<p>This open text field, limited to 1,500 characters, enables the provision of additional information. Justifications required from changes made to other fields must be included here. Grantees may use the Evaluative Measures section of the Program Narrative Update to include any information that exceeds the limit.</p>

C. Other Performance Measures

In addition to the required Clinical and Financial Performance Measures, grantees may identify other measures relevant to their health center and/or target population.

Additional measures must be defined by a numerator and a denominator, and progress

must be tracked over time. If a grantee no longer tracks a self-defined Other performance measure, this must be noted by marking the measure *Not Applicable* and including a justification in the Comments field as to why reporting is no longer possible and/or relevant.

D. Resources for Performance Measures

Grantees are encouraged to use their UDS Health Center Trend Report and/or Site Summary Report available in EHB when considering how improvements to their past performance can be undertaken. Instructions for accessing these reports can be found at <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting> under the UDS Website and Reports heading.

Grantees may find it useful to do the following:

- Note that all the UDS clinical performance measures are aligned with the meaningful use measures specified at http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp.
- Examine the performance measures of other health centers that serve similar target populations.
- Consider state and national performance UDS benchmarks and comparison reports (available <http://www.hrsa.gov/data-statistics/health-center-data/reporting>).
- Use the Healthy People 2020 goals/objectives when developing performance measures. Information on Healthy People 2020 is available at <http://www.healthypeople.gov> and Healthy People 2020 objectives are available at <http://www.healthypeople.gov/2020/topicsobjectives2020>. Six of these objectives can be compared directly to UDS clinical performance measures (high blood pressure under control, diabetes HbA1c readings less than or equal to nine, low and very low birth weight infants, access to prenatal care in the first trimester, tobacco use assessment, and tobacco cessation counseling).

APPENDIX C: INSTRUCTIONS FOR ATTACHMENTS

Attachments 1 and 2 are required. Attachments 3-8 may be omitted if no changes have occurred.

Attachment 1: Program Narrative Update

The Program Narrative Update must address **broad issues and changes** that have impacted the community/target population during the last 12-month budget period and discuss progress on the plan outlined in the most recent SAC or NAP (including any changes made based on the last BPR submission). Broad issues and changes include, but are not limited to, changes that impact operations, number of patients/visits, and/or financial viability of the health center. This information is critical as it is utilized by HRSA to monitor grantee progress.

Note: Information MUST be provided for each element below. Grantees MAY NOT indicate “no change” for any element.

Grantees **must** use the Program Narrative Update to discuss the extent to which program specific requirements continue to be met and provide plans to address any noted deficiencies. See <http://bphc.hrsa.gov/about/requirements> 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 other relevant Program Specific Forms and Attachments. Grantees should use the prescribed section headings (i.e., **NEED, RESPONSE, COLLABORATION, EVALUATIVE MEASURES, IMPACT, RESOURCES/CAPABILITIES, GOVERNANCE, SUPPORT REQUESTED**) but should NOT repeat or cut and paste the instructions specific to each item in their BPR submissions. Throughout the Program Narrative Update, reference may be made to required attachments and forms, as needed, to reflect information about multiple sites or geographic and demographic data. The Program Narrative Update must address **broad issues and changes/progress** in the following areas.

A. NEED

1. Report the **CURRENT STATUS** and describe **CHANGES** in the target population and service area that affect access to primary health care, health care utilization, and health status.
2. For grantees receiving targeted funding to serve designated special populations, report the **CURRENT STATUS** and describe **CHANGES** in the following areas, including increases or decreases in the special populations in the service area.
 - a) **Migrant and Seasonal Farm Workers (section 330(g))**: Report the **CURRENT STATUS** and describe **CHANGES** in the health care needs and access issues impacting 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.
- Migrant occupation-related factors (e.g., working hours, housing, sanitation, hazards including pesticides and other chemical exposures).

- b) **People Experiencing Homelessness (section 330(h)):** Report the **CURRENT STATUS** and describe **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)):** Report the **CURRENT STATUS** and describe **CHANGES** in the health care needs and access issues impacting residents of public housing (e.g., availability of public housing).

A grantee that does not receive targeted special population funding (see categories above), but currently serves or may serve these populations in the future, is encouraged to report the **CURRENT STATUS** and describe **CHANGES** in the unique health care needs of these populations.

3. Report the **CURRENT STATUS** and describe **CHANGES** in the primary health care services 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. Report the **CURRENT STATUS** and describe **CHANGES** in the health care environment that have affected the grantee's ability to provide services, the target population's ability to access health care, and/or the grantee's fiscal stability. Topics to be addressed include:
 - a) Changes in the availability or level of insurance coverage, including Medicaid, Medicare, and CHIP. Changes in State/local/private uncompensated care programs.
 - 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, and terrorism).

B. RESPONSE

1. Report the **CURRENT STATUS** and describe **CHANGES** in response to the issues identified in the **NEED** section.
2. Describe the outcome of any change(s) in scope to services, sites, and/or activities/locations and funding awarded, including the date when the change in scope was approved or award was issued. Specifically address the impact of these **CHANGES** in the:

- a) Locations where services are provided
- b) Hours of operation

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

3. Report the **CURRENT STATUS** and describe **CHANGES** (including changes resulting from approved change in scope requests and/or funding awarded) in the accessibility and 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. formal referral; shifts between any columns on [Form 5A](#)) must be described. In addition, specifically address reasons for and the impact of any service-related **CHANGES** made as a result of internal (e.g., grantee organization) or external (e.g., community) factors, including:
 - a) Provision of required and additional clinical and non-clinical services, including whether these are provided directly or by referral. REMINDER: All services provided via formal written referral arrangements currently recorded in scope (third column of [Form 5A](#)) must meet the requirements outlined in Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes (<http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html>). For any required service(s) provided ONLY via referral (only the third column of [Form 5A](#)), include a narrative statement that a formal written referral arrangement is in place for each such service.
 - b) Availability of culturally and linguistically appropriate services (e.g., interpreter/translator services, bilingual/multicultural staff).
 - c) Arrangements for admitting privileges for health center physicians at one or more hospitals or other established arrangements to ensure continuity of care, discharge planning, and patient tracking between hospitals and the health center.
 - d) Professional coverage for emergencies during hours when the health center is closed.
 - e) Formal referral relationships for additional and specialty health care services as appropriate for the needs of the grantee's target population, with an emphasis on working collaboratively to meet local needs.

4. Report the **CURRENT STATUS** and describe **CHANGES** in the clinical team staffing plan, including the number and mix of clinical staff (e.g., physician, nurse practitioner, certified nurse midwife, dentist, dental hygienist, psychiatrist, psychologist, social worker, case manager, patient educator, outreach worker) as well as clinical support staff necessary for:
 - a) Providing services for the projected number of patients.
 - b) Carrying out required preventive, enabling, and additional health services as appropriate and necessary, either directly or through established arrangements and referrals.

5. Report the **CURRENT STATUS** and describe **CHANGES** in sub-recipient arrangements¹, contracts for a substantial portion of the operation of the health center, and/or other formal agreements between the grantee and an outside organization, including any agreements that have or will impact the health center's oversight and authority to assure compliance with Health Center Program requirements. For **new or significantly revised** arrangements, contracts, and/or agreements, include a summary in [Attachment 7: Summary of Contracts and Agreements](#).

Note: All contracts, referral arrangements, and Memoranda of Agreement/Understanding (MOAs/MOUs) must be kept on file at the grantee organization and must be made available to HRSA **upon request** within 3-5 business days. Do **NOT** include these items with the BPR submission.

6. Report the **CURRENT STATUS** and describe **CHANGES** in the system used to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. Attach the current sliding fee discount schedule(s) as [Attachment 2](#). Specifically, discuss any changes to the following:
- a) The established schedule of charges upon which the current sliding fee discount schedule(s) are based.
 - b) The policies and procedures used to implement the sliding fee discount schedule(s), including provisions that assure that no patient will be denied services based on an inability to pay.
 - c) Nominal fees (e.g. increases or decreases). Nominal fees maybe collected from patients at or below 100 percent of the Federal Poverty Guidelines if the imposition of the nominal fee is consistent with project goals and **does not** pose a barrier to receiving care.
 - d) The date the sliding fee discount schedule(s) were last updated to reflect the most recent Federal Poverty Guidelines (see <http://aspe.hhs.gov/poverty/index.shtml#latest>).
 - e) How patients are made aware of available discounts (e.g., signs posted in accessible and visible locations, registration materials, brochures, verbal messages delivered by staff).
7. Report the **CURRENT STATUS** and describe **CHANGES** in the grantee's ongoing quality improvement/quality assurance (QI/QA) and risk management plan(s). Specifically, address progress, implementation, and results 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.

¹ A sub-recipient is an organization that receives a sub-award from a health center grantee to carry out a portion of the grant-funded scope of project. Sub-recipients must be compliant with all Health Center Program statutory and regulatory requirements, as well as applicable grant requirements specified in 45 CFR Part 74. All sub-recipient arrangements must be documented through a formal written contract/agreement (Section 330(a)(1) of the PHS Act), and a copy must be provided to HRSA in the grantee's competitive application. The grantee must demonstrate to HRSA that it has systems in place to provide reasonable assurances that the sub-recipient organization complies with—and will continue to comply with—all statutory and regulatory section 330 requirements throughout the period of the award.

- b) Periodic assessment of the appropriateness of service utilization, quality of services delivered, and the health outcomes of health center patients.
8. Report how the findings of QI/QA assessments have been systematically collected and utilized to improve organizational performance and what formal institutional mechanisms/processes are in place to ensure that this occurs. Specifically, document the implementation of the QI/QA and risk management plan(s) related to two specific BPHC-required performance measures (i.e., one clinical and one financial performance measure). The discussion for each measure should be limited to ½ page and should briefly address the following elements:
- a) Data collection and analysis processes (including the baseline and target goal)
 - b) Action taken to improve results
 - c) Timeline used to track and report progress within the organization and to the board
 - d) Specific staff and managers involved in the processes (i.e., organizational titles of involved staff and managers)

Note: QI/QA committee minutes and plan updates must be made available to HRSA upon request within 3-5 business days.

9. Report the **CURRENT STATUS** and describe **CHANGES** in board-approved policies and procedures that support the QI/QA and risk management plan(s) related to:
- a) Clinical standards of care.
 - b) Peer reviews.
 - c) Chart audits.
 - d) Provider licensure, credentials, and privileges [ensuring that all providers (e.g., employed, contracted, volunteers, locum tenens) are appropriately licensed, credentialed, and privileged to perform the proposed services (consistent with [Form 5A](#)) at the proposed sites/locations (consistent with Forms [5B](#) and [5C](#))], including the utilization of formal privileging lists for all such providers.
 - e) Risk management procedures.
 - f) Patient grievance procedures.
 - g) Patient satisfaction assessments.
 - h) Incident management.
 - i) Confidentiality of patient records.
10. Report the **CURRENT STATUS** and describe **CHANGES** in the health center's short- and long-term strategic plans, including any changes made in response to issues identified in the **Need** section as well as data or findings from the grantee's quality improvement plans (e.g., Clinical and Financial Performance Measures, patient satisfaction findings).
11. Report the **CURRENT STATUS** and describe **CHANGES** in the organization's ability to maximize or participate in FQHC-related benefits (e.g., Federal Tort Claim Act (FTCA) coverage, FQHC Medicare/Medicaid/CHIP reimbursement, 340B Drug

Pricing Program, Vaccines for Children Program, National Health Service Corps Providers).

12. Discuss the organizational response to the following items, as applicable:
 - a) Responses taken and action planned for the future budget period to address outstanding grant conditions or terms, including draw down restrictions or progressive action conditions that will not be resolved by the end of the current budget period.
 - b) Corrective actions taken based on reports from Office of Inspector General (OIG) or Division of Financial Integrity (DFI).
 - c) Performance Improvement Areas identified by the grantee's Project Officer or onsite technical assistance visits (e.g., Operational Site Visit, Targeted Technical Assistance Site Visit).

13. Describe any **PROPOSED CHANGES** being considered for the **UPCOMING** budget period (**this period will follow immediately after the current budget period listed on your Notice of Award**) in services, service sites, provider types, and/or hours of operation. If applicable, contact your Project Officer to initiate any changes in the scope of project.

C. COLLABORATION

1. Report the **CURRENT STATUS** and describe **CHANGES** in collaboration and coordination of services with other health care providers. Specifically, discuss collaboration with existing section 330 grantees, FQHC Look-Alikes, relevant Primary Care Associations, rural health clinics, critical access hospitals, other federally-supported grantees (e.g., Ryan White programs), state and local health departments, private providers, and programs serving the same target population (e.g., social services; job training; Women, Infants, and Children (WIC); coalitions; community groups).

Grantees may wish to 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. Describe significant **NEW** or **REVISED** collaborations/coordinated activities that have an impact on the approved scope of project or health center program activities.

3. **Migrant Health Center (section 330(g)), Health Care for the Homeless (section 330(h)), and/or Public Housing Primary Care (section 330(i)) grantees:** Report 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).

D. EVALUATIVE MEASURES

NOTE: Include any information that exceeds the 1,500 character limit of the Comments field of the Clinical and Financial Performance Measures forms in this section of the Program Narrative Update.

1. On the Clinical Performance Measures form, describe **CURRENT STATUS/PROGRESS** made on each of the Clinical Performance Measures identified in the most recent SAC, NAP, or BPR in the Progress Toward Goal and Comments fields.
2. On the Financial Performance Measures form, describe **CURRENT STATUS/PROGRESS** made on each of the Financial Performance Measures identified in the most recent SAC, NAP, or BPR in the Progress Toward Goal and Comments fields.
3. Provide a brief description of **CURRENT STATUS/PROGRESS** on additional evaluation activities used to enhance the assessment of progress and project improvement.

E. IMPACT

1. Describe **PROGRESS** made toward the projected number of unduplicated patients and visits compared to the baseline number of patients (current number on most recent SAC or NAP application). The projected number of patients to be served by the end of the project period must be consistent with the number presented on [Form 1A](#): General Information Worksheet in the most recent SAC or NAP. Specifically, grantees must discuss:
 - a) How the current trend compares to the number of patients projected by the end of the project period in the most recent SAC or NAP, and any facilitators or barriers affecting the achievement of the goal. Reference the growth in patients toward the goal noted in [Form 1A](#) (Number at End of Project Period column of the Patients and Visits by Population Type table). Decreasing trends in patient levels must be fully explained.
 - b) Grantees that currently receive targeted funding to serve migrant and seasonal farm workers (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).
 - c) Grantees that have received additional funding (e.g., NAP grant awards) during the current project period must identify progress made toward any proposed increase in patients and visits. If there have been major problems or start-up delays related to new funding, explain these issues.

F. RESOURCES/CAPABILITIES

1. Report the **CURRENT STATUS** and describe **CHANGES** to the organizational structure of the health center (i.e., changes that affect the budget or scope of

project). Reference [Attachment 4](#): Organizational Chart and [Attachment 7](#): Summary of Contracts and Agreements as applicable.

2. Discuss **KEY MANAGEMENT STAFF CHANGES** or vacancies in the last year, and describe plans for filling these vacancies. Key management positions may include Chief Executive Officer (CEO), Project Director², Chief Medical Officer (CMO), 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](#): Biographical Sketches for Key Management Staff as needed.
3. Report the **CURRENT STATUS** and describe **CHANGES** to overall staffing plans, as well as any and any facilitators or barriers encountered during the budget period for recruiting and retaining key management staff and/or health care providers.
4. Report the **CURRENT STATUS** and describe **CHANGES** in:
 - a) National quality recognition the organization has received or is in the process of achieving (e.g., Patient-Centered Medical Home, Accreditation Association for Ambulatory Health Care, Joint Commission, state-based or private payer initiatives). Specify progress made toward Patient-Centered Medical Home recognition.
 - b) The acquisition/development and implementation of certified EHR technology systems used for tracking patient and clinical data to achieve meaningful use, including progress made toward implementation of EHR at all sites to be used by all providers. Describe the role of Health Center Controlled Networks (HCCNs) or Regional Extension Centers (RECs) assisting with this process. Detailed information about Meaningful Use related to EHR is available at: http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp.
 - c) Address or participate in other BPHC/HRSA/HHS-targeted initiatives (e.g., Health Center Controlled Networks, National HIV/AIDS Strategy, Accountable Care Organizations).
5. Report the **CURRENT STATUS** and describe **CHANGES** to the organization's financial management capabilities, accounting and control systems, policies, and procedures that 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

² Prior approval from HRSA is required for a change in the Project Director/CEO through HRSA's Electronic Handbook (EHB) Prior Approval Module.

accounts payable, lines of credit, debt to equity ratio, net assets to expenses, working capital to expenses).

- c) Report the **CURRENT STATUS** and describe corrective actions taken to address any findings, questioned costs, reportable conditions, material weaknesses, going concern issues, and significant deficiencies cited in the most recent audit. Provide a description of resolution for findings on a current or immediate past audit, and, if needed, include evidence in [Attachment 8](#) to demonstrate such resolution.
6. Report the **CURRENT STATUS** and describe **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.
 7. Report the **CURRENT STATUS** and describe **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.

G. SUPPORT REQUESTED

1. Report the **CURRENT STATUS** and describe **CHANGES**, referencing the budget presentation as needed, that have impacted:
 - a) How the total budget is aligned and consistent with the proposed service delivery plan.
 - b) The proportion of requested Federal grant funds given other sources of income.
 - c) 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 (consistent with Form 3) and/or number of projected patients and visits (consistent with Form 1A).

H. GOVERNANCE

Note: Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups, should respond to ONLY Item 5 below.³

1. Provide a copy of the health center's signed and dated bylaws in [Attachment 8](#) *ONLY if these have been revised* during the budget period. Discuss the type and purpose of all revisions.
2. Provide the **CURRENT STATUS** and describe **CHANGES** to the composition of the governing board, providing reasons for and the impact of changes to overall board size, board member expertise, the consumer/patient majority (unless waived for eligible grantees in the most recent SAC or NAP), the proportion of non-patient board members that derive their income from the health care industry, and patient

³ 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.

board member representatives of the individuals served by the center, including any special populations⁴ served. Reference [Form 6A](#) as applicable.

3. Report the **CURRENT STATUS** and describe **CHANGES** to the following areas of board authority and board performance:
 - a) Meeting monthly (unless waived for eligible grantees in the most recent SAC or NAP).
 - b) Maintaining a 51 percent consumer/patient majority (unless waived for eligible grantees in the most recent SAC or NAP).
 - c) Exercising required oversight responsibilities and authorities (e.g., selecting, evaluating, and dismissing the CEO/Executive Director; establishing hours of operation; approving annual budget; approving grant applications; 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).
 - f) Using health center performance trend data to inform strategic planning; support ongoing review of the health center's mission, bylaws, policies and procedures; evaluate patient satisfaction; and review monthly financial and clinical performance, including progress on the required Clinical and Financial Performance Measures.

4. Grantees that **DO NOT** receive Community Health Center (section 330(e)) funds 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.

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: Report the **CURRENT STATUS** and describe **CHANGES** made to the governance structure and how it assures adequate (1) input from the community/target population on health center priorities and (2) fiscal and programmatic oversight of the project.

Attachment 2: Sliding Fee Discount Schedule(s) (Required)

⁴ A grantee who currently receives funding 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 receives section 330 funding. Special population representatives should be individuals that can clearly communicate the needs/ concerns of the target population and represent this population on the board (e.g., current resident of public housing, an advocate for the homeless, the director of a Migrant Head Start program, a formerly homeless individual).

Upload the current sliding fee discount schedule(s), indicating the date of the most recent review/revision. The sliding fee discount schedule(s) must apply to persons with incomes at or below 200 percent of the Federal poverty guidelines (see the Federal poverty guidelines at <http://aspe.hhs.gov/poverty>).

Attachment 3: Service Area Map (As Applicable)

If there have been changes to the grantee's service area (i.e., new service areas added via CIS or NAP) since the submission of the most recent SAC, NAP, or BPR, upload a current map of the service area, noting the organization's service sites as listed on [Form 5B](#). The map must indicate any medically underserved areas (MUAs) and/or medically underserved populations (MUPs). It must also include other Health Center Program grantees, Federally Qualified Health Centers (FQHC) Look-Alikes, and health care providers serving the same population(s).

Note: Grantees may wish to access UDS Mapper (<http://www.udsmapper.org>) or the HRSA Mapping Services and Data Web site (<http://www.hrsa.gov/data-statistics/mapping-services-data/index.html>) as resources for updating their service area maps.

Attachment 4: Organizational Chart (As Applicable)

If there have been changes to the grantee's organizational structure since the submission of the most recent SAC, NAP, or BPR, upload a one-page document that depicts the governing board, key personnel, staffing, and any sub-recipients or affiliated organizations.

Attachment 5: Position Descriptions for Key Management Staff (As Applicable)

If position descriptions have changed since the last SAC, NAP, or BPR, upload them for **VACANT** key management staff positions. Key management positions include CEO, PD, CMO, CFO, CIO, and COO, as applicable. Indicate in the descriptions if key management positions are combined and/or part time (e.g., CFO and COO roles are shared). Position descriptions must include the roles, responsibilities, and qualifications for the position and be limited to **one page** or less each.

Attachment 6: Biographical Sketches for Key Management Staff (As Applicable)

If new key management staff have been hired since the submission of the most recent SAC, NAP, or BPR, upload biographical sketches if these items have not yet been submitted. Biographical sketches must not exceed **two pages** in length each. In the event that a biographical sketch is included for an individual who is not yet hired, include a letter of commitment from that person with the biographical sketch.

Attachment 7: Summary of Contracts and Agreements (As Applicable)

Upload a summary describing any **new or revised** contracts and/or agreements. Do not discuss contracts and/or agreements for areas such as janitorial services. The summary must address the following items for each contract and/or agreement:

- Name and contact information for each affiliated agency.

- Type of contract and/or agreement (e.g., contract, sub-recipient arrangement, 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.

Attachment 8: Other Relevant Documents (As Applicable)

Upload other documents to support the project plan **if there have been major changes** since the submission of the most recent SAC, NAP, or BPR. Other documents may include facility floor plans and organizational brochures. Merge all additional items into a single document before uploading.