

**FY 2015 New Access Point (NAP) Funding Opportunity Announcement (FOA)
Frequently Asked Questions (FAQs)**

HRSA-15-016

Below are common questions and corresponding answers for the Fiscal Year (FY) 2015 NAP funding opportunity. New FAQs will be added as necessary, so please check the NAP Technical Assistance page located at <http://www.hrsa.gov/grants/apply/assistance/nap> for updates. The FAQs are organized under the following topics:

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General Information

1. What is the purpose of the New Access Point (NAP) funding opportunity?

The purpose of this grant program is to support new primary health care service delivery sites that address the health needs of the Nation’s underserved communities and vulnerable populations. Funding provides operational support for NAP service delivery sites.

2. What is a new access point?

A new access point is a new service delivery site for the provision of comprehensive primary and preventive medical health care services. New access points will increase access to comprehensive, culturally competent, quality primary health care services and improve the health status of medically underserved and vulnerable populations. See pages 2-5 in the funding opportunity announcement (FOA) for a detailed discussion of program expectations.

3. How much funding is available to support NAP grants in FY 2015?

HRSA anticipates that approximately \$100 million will be available to support an estimated 150 NAP grant awards in FY 2015. Pending the final Health Center Program appropriation funding level, HRSA may adjust the amount of funding and number of awards available under this funding opportunity announcement. In addition, all approvable but unfunded

applications from the FY 2015 award cycle will remain eligible for potential funding for up to 1 year.

4. Can my organization request funding for more than one new access point site?

Yes. You may request Federal support to establish a single new access point site or multiple sites in a single NAP application as long as one proposed new access point site is a full-time, permanent site. An organization cannot request more than \$650,000 in Federal funding regardless of the number of new access point sites proposed.

5. Can my organization request funding for more than one type of health center?

The term “health center” refers to four types of health centers (also called sub-programs) supported under section 330 of the PHS Act, as amended:

- Community Health Center (CHC – section 330(e))
- Migrant Health Center (MHC – section 330(g))
- Health Care for the Homeless (HCH – section 330(h))
- Public Housing Primary Care (PHPC – section 330(i))

You may request funding to support one or multiple types of health centers (i.e., CHC, MHC, HCH, PHPC) within a single application based on the population(s) to be served. For example, if you propose to serve both the general community and migratory and seasonal agricultural workers, you can submit a NAP application requesting both CHC and MHC funding. You are expected to demonstrate compliance with the specific requirements of each health center type for which funding is requested. See pages 3-4 of the FOA.

6. What are special populations?

“Special populations” refers to three population groups and the legislatively-mandated health center types that serve them:

- Migratory and seasonal agricultural workers – Migrant Health Center (MHC)
- Individuals and families experiencing homelessness – Health Care for the Homeless (HCH)
- Individuals living in public housing – Public Housing Primary Care (PHPC)

Eligibility (NEW questions added 9/18/2014)

7. Who can apply for NAP funding?

Organizations eligible to compete for NAP funds include public or nonprofit private entities, including tribal, faith-based, and community-based organizations. (See the detailed list of eligibility requirements in Section III of the FOA on pages 6-7.) Applications may be submitted by organizations that do not receive operational grant support under section 330 (new start applicants) or organizations currently receiving funding under section 330 (satellite applicants).

8. What is a new start applicant?

A new start applicant is an organization that is not currently a direct recipient of operational grant support under the Health Center Program, including look-alikes. It is important that

new start applicants correctly identify their application type as “New” for Item 2 on the Application for Federal Assistance SF-424 in Grants.gov.

9. What is a satellite applicant?

A satellite applicant is an organization that currently receives operational funding under the Health Center Program. It is important that satellite applicants correctly identify their application type for Item 2 on the Application for Federal Assistance SF-424 in Grants.gov. Satellite applicants should select “Revision” on SF-424, and then choose “Other” and type “Supplement” and the H80 grant number. **Organizations that received initial Health Center Program funding in FY 2013 or 2014 are eligible to apply for New Access Point funding only if at least one site has been verified operational by the application submission date.**

10. Are there new eligibility criteria compared to the FY 2013 NAP FOA?

The following eligibility criteria have been clarified. Changes include:

- Clarification that an applicant may not apply on behalf of another organization.
- Clarification of the requirement that the proposed new access point project (across all proposed sites) must:
 - Provide comprehensive primary medical care as its main purpose
 - Provide services without regard to ability to pay either directly onsite or through established arrangements
 - Ensure access to services for all individuals in the targeted service area or population

Clarification that organizations that received Health Center Program funding for the first time in FY 2013 or FY 2014 are eligible to apply for NAP funding only if at least one site has been verified operational by the application submission date.

11. What is a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP)?

A Medically Underserved Area (MUA) is a federally-designated geographic area in which residents have a shortage of personal health services. A Medically Underserved Population (MUP) is a federally-designated group of persons who face economic, cultural, or linguistic barriers to health care. For more information on the designation process, refer to <http://www.hrsa.gov/shortage> and/or contact your State Primary Care Office (listing available at <http://bhpr.hrsa.gov/shortage/hpsas/primarycareoffices.html>).

12. How do MUA and MUP designations affect my eligibility for NAP?

If requesting section 330(e) funding for CHC, you must provide MUA or MUP designation information. If requesting funding only under section 330(g), 330(h), and/or 330(i) for MHC, HCH, and/or PHPC respectively, you are not required to have MUA/MUP designation for the proposed service area and/or target population.

Satellite applicants may list MUAs or MUPs currently served or indicate a different MUA or MUP designation for the proposed service area. New start NAP applicants requesting section 330(e) funding for CHC must propose to serve a defined geographic area that is officially designated, in whole or in part, as an MUA or MUP. Provide the MUA and/or MUP numbers that best describe the proposed service area.

To determine if the area is designated an MUA or an MUP, search on Find Shortage Areas at <http://muafind.hrsa.gov/>. If the area is not currently an MUA or MUP, provide documentation that a request for designation has been submitted. MUA/MUP designation must be received prior to a final HRSA FY 2015 NAP funding decision. For more information on designation process, refer to <http://www.hrsa.gov/shortage/> and/or contact your State Primary Care Office (listing available at <http://bhpr.hrsa.gov/shortage/hpsas/primarycareoffices.html>).

13. **NEW: The HRSA Shortage Designation webpage indicates that online processing of shortage designation applications will resume in December 2014. How do I provide documentation to meet this eligibility requirement that a request for MUAMUP designation has been submitted?**

HRSA is implementing a new Shortage Designation Management System (SDMS), which will begin accepting new designation applications on September 29, 2014. Pending designation applications will be processed after December 14, 2014, prior to FY 2015 NAP funding decisions. In your NAP application, indicate that the MUA or MUP designation request is pending. Contact your State Primary Care Office to assist with this request (listing available at <http://bhpr.hrsa.gov/shortage/hpsas/primarycareoffices.html>).

14. **Does the new access point have to be located in an MUA to be eligible for NAP funding?**

Although the NAP site does not have to be located in an MUA, if requesting section 330(e) funding for CHC funding, you must demonstrate that the new access point will serve individuals that reside in a MUA or are a part of a MUP.

15. **My organization is applying for Migrant Health Center funding. Can we propose a seasonal site?**

Yes. The **only** exception to the requirement that a NAP application must propose to operate at least one permanent site 40 hours or more per week is for proposed NAP projects requesting **only** section 330(g) funding for MHC, which may propose a full-time (40 hours or more per week), seasonal service delivery site. All applicants may request a seasonal site in conjunction with a permanent site.

16. **Does an organization have to be currently providing health services to be eligible to apply for NAP funding?**

No; however, you must present a plan demonstrating that **all** proposed sites in the NAP application will be operational and fully compliant with the Health Center Program requirements within 120 days of Notice of Award.

17. **Are organizations located outside of the United States eligible to apply for NAP funding?**

Eligible organizations must be located in the United States or its territories, or be part of a Compact of Free Association (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau).

18. **Can I apply for NAP funding to operate only a mental health clinic?**

No. To be eligible, you must propose to establish at least one full-time, permanent new access point for the provision of comprehensive primary health care services as its main purpose. You may **not** propose only one new access point to provide only a single service,

such as dental, behavioral health, or prenatal services, or to address only a particular disease such as diabetes or HIV/AIDS.

19. Can I use NAP funding to provide access to services that address specific local health issues, such as respiratory ailments of coal miners as part of a Black Lung program?

An application may **not** propose only one new access point to provide a single service or to address only a particular disease. However, such services can be included in your comprehensive NAP project since many of the services typically delivered as part of a Black Lung program are required services, per Form 5A (e.g., outreach, primary care (including screening, diagnosis, and treatment), and patient education and counseling).

20. Can New Access Point funding be used to operate a school-based health center?

You may propose to establish a school-based health center for the delivery of primary care services as long as it (a) is a permanent, full time site, or is proposed in addition to a permanent, full time site presented in the application, **AND** (b) provides (directly or by referral) all required primary and preventive health care services to students of the school as well as the general underserved population in the service area without regard for ability to pay. School-based health centers must demonstrate how members of the general community and students will have access to all required primary health care services, not only during school hours, but also when the school-based site is not accessible. This can be accomplished through services at the school, at other sites operated by the organization, or through other providers. All services must be available on a sliding fee scale.

21. Can New Access Point funding be used to operate a mobile van?

You may propose a mobile medical van as a new access point only if a permanent, full-time site is also proposed in the NAP application. A mobile van must be affiliated with a permanent or seasonal service site (at a fixed building location) and fully equipped and staffed by health center clinicians providing direct primary care services. Proposals to expand the operation of an existing mobile van within the current scope of project (e.g., add new providers or services, expand hours of operation at current locations) are **NOT** eligible for consideration.

22. As an existing Health Center Program grantee, may I propose to use NAP funding to consolidate two of my existing sites into a larger, centrally located new site?

No. NAP funding may not support the relocation of current Health Center Program grantee sites.

23. I recently submitted a Change in Scope request in EHB to operate a service site at 123 Main Street. May I propose to expand this site with NAP funding?

No. You cannot propose to support a site that is included in an active Change in Scope request at the time of application. Further, you cannot propose support for a site already in any Health Center Program grantee's approved scope of project.

24. **NEW:** We would like to include additional hours and services at one of our existing grantee sites to serve our proposed NAP population. Is that expense acceptable for this NAP application?

No, the NAP application cannot propose the expansion of capacity (e.g., additional providers, additional patients, new services, new populations) at any site already in any Health Center Program grantee's approved scope of project. Although new patients from the NAP site may be referred to existing sites for particular services, NAP grant funds cannot be used to support staff at other sites if they are not the proposed NAP sites.

25. **If a health center received a BPHC Capital Development grant, can we apply for NAP funding for this site?**

No. Sites that were funded for construction and/or alteration/renovation projects under previous capital funding opportunities are included in the health center's scope of project and, therefore, are **not** eligible for NAP funding.

26. **How do we determine if our NAP site is located in another health center's scope of project?**

Health center scope of project relates to sites currently supported by an existing Health Center Program grant. Under the FY 2015 NAP, you cannot propose a site that is already a Health Center Program funded health center (a physical site address already being operated by a current grantee or one of its sub-recipients/contractors). Tools are available to assist you in determining the location of current Health Center Program grantee sites, including the UDS Mapper (<http://www.udsmapper.org>) and Find a Health Center (<http://findahealthcenter.hrsa.gov>).

27. **Can I propose to serve zip codes in an existing grantee's service area?**

Yes, as long as you can demonstrate unmet need in the proposed zip codes.

28. **What is a co-applicant? Can a non-profit organization apply with a co-applicant?**

Only public entities can apply with a co-applicant. When a public agency's board cannot independently meet all applicable health center governance requirements, the public agency may establish a separate co-applicant governing board that meets the Health Center Program governance requirements. Refer to the Health Center Program Governance policy available at <http://www.bphc.hrsa.gov/policiesregulations/policies/pin201401.html>.

Program Requirements and Expectations

29. **What are the program requirements for New Access Points under the Health Center Program?**

Health Center Program requirements are established by section 330 of the PHS Act, as amended, and applicable regulations. See Appendix F in the FOA for a summary of the Health Center Program requirements and visit <http://bphc.hrsa.gov/about/requirements/>.

30. Does the applicant organization have to be compliant with the program requirements at the time of application?

NAP applicants are expected to demonstrate compliance with the requirements of section 330 of the PHS Act and applicable regulations at the time of application, or provide a detailed plan demonstrating the steps that will be taken to become fully compliant within 120 days of grant award.

31. What is the difference between readiness and full operational capacity?

Applicants must demonstrate readiness to initiate services, meaning that within 120 days of grant award, all sites proposed in the NAP application must be operational and providing services for the proposed population. It is expected that full operational capacity as outlined in the NAP application will be achieved by December 31, 2016. Full operational capacity is assessed by progress toward the projected provider and patient numbers when providing all of the services in the manner proposed in the application. Applicants will be held accountable for meeting the unduplicated patient projection by December 31, 2016.

32. Can we use our mobile van in lieu of an operational site to satisfy the requirement to provide services within 120 days of award?

No. All proposed NAP sites must be operational within 120 days of the Notice of Award. You should carefully consider your ability to ensure that all proposed sites will meet this requirement when developing your proposal.

33. What is the Implementation Plan?

The Implementation Plan outlines the your plans for having all proposed sites open, operational, and compliant with all 19 Health Center Program requirements within 120 days of the Notice of Award (NoA). You can choose from the list of focus areas in Appendix C of the FOA and/or include other focus areas and goals as appropriate. For example, if you have a governing board of seven people at the time of application, you would detail the steps it will take to add additional board members to meet the minimum requirement of 9 members within the required 120 days. An Implementation Plan template is available at <http://www.hrsa.gov/grants/apply/assistance/nap>.

34. Our health center is currently operational and compliant with all the program requirements. What do we include in the Implementation Plan?

Demonstrate your compliance with the program requirements, both in the project narrative and in the Implementation Plan. Specifically describe compliance at all proposed sites and highlight changes in access to care that will occur, planned service expansion and outreach, new collaborations/partnerships, and any other changes that would come as a result of the award. You have the option of setting your own goals in the Implementation Plan.

35. Does a tribal organization have to meet all of the program requirements?

No. Applicants that are Indian tribes or tribal or Indian organizations under the Indian Self-Determination Act or urban Indian organizations under the Indian Health Care Improvement Act (25 U.S.C. 1651) are not required to meet the governance requirements of the Health Center Program. However, tribal entities must meet all of the other statutory and regulatory requirements.

36. What organizations are eligible for a waiver of the board composition governance requirement?

Applicants requesting funding for special populations only (i.e., MHC, HCH, and/or PHPC) that do not currently receive or are not requesting CHC funding under section 330(e) are eligible for a waiver of the governance requirement that board composition has a 51 percent consumer/patient majority. If funded, grantees may request this waiver post-award. An approved waiver does not relieve the organization's governing board from fulfilling all other statutory and regulatory board responsibilities and requirements. For detailed information regarding Health Center Program governance requirements, see Policy Information Notice 2014-01 at <http://bphc.hrsa.gov/policiesregulations/policies/pin201401.html>.

Application Development

37. Where can I access the New Access Point funding opportunity announcement (FOA) and application package?

The New Access Point FOA and application package are available at <http://www.grants.gov>. Follow the instructions below:

- Go to <http://www.grants.gov>.
- Under Search Grants, enter HRSA-15-016 in the Keyword or Funding Opportunity Number field and click SEARCH or GO.
- Click the Funding Opportunity Number link (HRSA-15-016).
- Click the Application Package tab (to the right of the Synopsis and Full Announcement tabs).
- Under Instructions and Application, click the Download link.
- Click the Download Application Instructions link for the FOA.
- Click the Download Application Package link for the Grants.gov application.

38. What technical assistance is available as I develop my application?

HRSA will hold a pre-application conference call and webcast shortly following the release of the FOA. The call will provide an overview of the FOA and offer an opportunity to ask questions. Visit the NAP TA website at <http://www.hrsa.gov/grants/apply/assistance/nap> for call details. The webcast will be posted on the NAP TA website approximately one week after the call is completed. Additional webcasts, technical assistance resources, and contact information will also be posted on the NAP TA website.

Throughout the application development and preparation process, you are encouraged to discuss your NAP project with appropriate Primary Care Association (PCA), Primary Care Office (PCO), and/or National Cooperative Agreements (NCAs). For a listing of PCAs, PCOs, and NCAs, refer to <http://www.bphc.hrsa.gov/technicalassistance/partnerlinks/index.html>.

39. Can more than one application be submitted by an organization?

No. An organization can submit only one application.

40. Is there a page limit for the NAP application?

Yes. There is a 200-page limit on the length of the total application when printed by HRSA. Refer to Tables 2-5 of the FOA for more information on what is counted in the page limit. It is critical that the page limit is strictly followed. Applications exceeding the page limit are automatically rejected and will not be reviewed.

41. Does HRSA have guidelines (e.g., font type, font size) for the Project Narrative of the application?

Yes. Narrative documents should be single-spaced in 12-point, easily readable font (e.g., Times New Roman, Ariel, Courier) with 1-inch margins. Smaller font (no less than 10-point) may be used for tables, charts, and footnotes. For more information, reference the *HRSA Electronic Submission User Guide* available at <http://www.hrsa.gov/grants/apply/userguide.pdf>.

42. How does the Project Narrative differ from the Review Criteria?

The Project Narrative details the information you must include to provide a complete picture of the new access point proposed for this funding opportunity. The Review Criteria is the tool grant reviewers on the Objective Review Committee (ORC) will use to evaluate the information presented. You should review both the Project Narrative and Review Criteria when developing your application.

43. Why do the Project Narrative and Review Criteria repeatedly refer me to other sections of the application (e.g., appendices, attachments, forms)?

The Project Narrative and Review Criteria were written to guide applicants and reviewers to the relevant sections of the application where information should be presented. Both applicants and reviewers are expected to check the cross-referenced documents to ensure the application is providing complete and consistent information.

44. Where do I submit the Public Health System Impact Statement (PHSIS) mentioned on page 38 of the FOA?

The PHSIS is submitted to the state or local health agencies in the areas to be impacted by the proposed project. For applicants in states that have a Single Point of Contact (SPOC), contact the SPOC to alert them that you will be submitting an application and ask where to submit the PHSIS, if you do not already know. For applicants in states that do not have a SPOC, you may contact your Primary Care Office (PCO) for guidance. See http://www.whitehouse.gov/omb/grants_spoc for the list of SPOCs and <http://bhpr.hrsa.gov/shortage/hpsas/primarycareoffices.html> for the list of PCOs.

Budget Preparation

45. How much Federal funding can I request?

HRSA has established an annual cap of \$650,000 for section 330 support of new access points regardless of the number and/or type of new access point sites proposed. As part of the \$650,000, you may request up to \$150,000 in Year 1 only for one-time minor capital costs for equipment and/or alterations/renovations.

46. Are there activities that are ineligible for NAP funding?

Yes. NAP funding may not be used for construction of facilities, fundraising, grant writing, or lobbying efforts. See section IV.5. in the NAP FOA for further information.

47. Do I submit one budget for all requested NAP funds?

No. An individual budget should be prepared for each 12-month period of the 2-year project period – one each for Year 1 and Year 2.

48. Is a budget justification the same thing as a budget narrative?

Yes, for the purpose of NAP FOA, they are the same.

49. What should be included in the budget justification?

A detailed budget justification in line-item format must be completed for each 12-month period of the 2-year project period. The budget justification must break down the federal section 330 request and non-federal (non-section 330) funding and detail the costs of each line item within each object class category. The budget justification must clearly describe each cost element and explain how each cost contributes to meeting the project's goals. It should explain how each line-item expense is derived (e.g., number of visits, cost per unit). A sample budget justification is available at <http://www.hrsa.gov/grants/apply/assistance/nap>.

50. What is the Non-Federal share in the NAP application budget?

While cost sharing or matching is not a requirement for NAP funding, the NAP application requires the submission of a total project budget that shows all funding required for project implementation. The non-federal share refers to non-section 330 funding and includes Program Income (fees, premiums, third party reimbursements, and payments for services) and Other Income (State, Local, or other Federal grants or contracts; local or private support that is not generated from charges for services delivered).

51. What should I do if the budget figures change between the Grants.gov submission and the EHB submission?

Budget information submitted in Grants.gov may be updated in EHB.

52. How do I show my Year 2 funding request on the SF-424A?

Section E of the SF-424A (Federal Funds Needed for Balance of the Project) is used to request funding for Year 2 of the NAP project period. In Section E, enter the Federal funds requested for Year 2 only in the "First" column under Future Funding Periods (Years) for each proposed sub-program. Even though the column is labeled "First", it indicates Year 2 of the NAP project. The Second, Third, and Fourth columns must be \$0, since these correspond to future funding years beyond the scope of the NAP project. See section 2 of the **FY 2015 NAP User Guide for Grant Applicants** posted at <http://www.hrsa.gov/grants/apply/assistance/nap/>.

53. If the sub-program is incorrect on the SF-424A: Budget Information form, how can I change it?

In the Budget Information form, click on Change Sub-Program, then select the applicable sub-program(s). Once the selection is made, the correct sub-program(s) (i.e., Community

Health Center, Migrant Health Center, Health Care for the Homeless, and/or Public Housing Primary Care) will appear in the Budget forms and Form 1A.

54. Does NAP include funding for alteration/renovation or construction?

You may request one-time funding of up to \$150,000 in Year 1 only to support minor alteration and renovation. Section 330 funds may not be used for construction of a facility or for major alteration and renovation.

55. Are equipment purchases allowable?

You may request one-time funding of up to \$150,000 in Year 1 only for the purchase of equipment and/or alteration/renovation.

56. Can I purchase/enhance an EHR with NAP funding?

Electronic health record (EHR) systems are an allowable cost, as are site licenses and associated hardware. EHR costs fall under the one-time funding request of up to \$150,000 in Year 1 only for the purchase of equipment, except for EHR licenses, which may be budgeted in the Other object class category.

57. Does the salary limitation enacted in 2014 apply to FY 2015 NAP awards?

The Consolidated Appropriations Act, 2014 (P.L. 113-76) enacted on January 17, 2014, limits use of HHS funds awarded relative to salary amounts as follows: "SEC. 203. None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II." The Executive Level II salary is currently \$181,500. Because the FY 2015 NAP awards are supported by the Affordable Care Act, this salary limitation does not apply. However, future year's funding may be subject to the salary limitation or other restrictions based on appropriations' provisions.

58. Does HRSA require applicant organizations to have an indirect cost rate?

No. If you do not have an indirect cost rate agreement, costs that would fall into such a rate (e.g., the cost of operating and maintaining facilities, administrative salaries) may be charged as direct line item costs. If you wish to apply for an indirect cost rate agreement, more information is available at <https://rates.psc.gov/>.

59. If we have an indirect cost rate, what needs to be included in the application?

The current Federal indirect cost rate agreement must be provided in Attachment 15: Other Relevant Documents.

Forms (NEW question added 9/18/2014)

60. How should I complete the Type of Application field on the SF-424?

- **New Start:** An organization that does not currently receive Health Center Program section 330 operational grant funding. Select "New" on Application Form SF-424.
- **Satellite:** An organization that currently receives Health Center Program section 330 operational grant funding. Select "Revision" on Application Form SF-424, then choose "Other" and type "Supplement" and the H80 grant number.

61. What dates should be listed in Item 17 of the SF-424 for the Proposed Project Start Date and Proposed Project End Date?

Enter May 1, 2015 for the Proposed Project Start Date. Enter April 30, 2017 for the Project End Date.

62. How do I change the SF-424 information submitted in Grants.gov?

The SF-424 components are transferred into EHB under the Basic Information, Budget Information, and Other Information sections. You can update this information in EHB as desired. See sections 1 and 2 of the **FY 2015 NAP User Guide for Grant Applicants** posted at <http://www.hrsa.gov/grants/apply/assistance/nap/>.

63. Can I change the abstract after the Grants.gov submission?

To make changes to the abstract in EHB, go to the SF-424 Part 2 under the Basic Information section. The project abstract is attached in this form, under Project Description. You can view the original abstract submitted via Grants.gov, delete it, and replace it by uploading a revised abstract.

64. How do I change the population types on Form 1A – General Information Worksheet?

The system automatically populates the Population Types from the budget information. If you need to change the “Population Type” information, refer to sections **4.1 and 2.1** in the **FY 2015 NAP User Guide for Grant Applicants** posted at <http://www.hrsa.gov/grants/apply/assistance/nap/>.

65. On Form 1A, what is meant by “general community”?

On Form 1A, “general community” refers to anyone you anticipate serving who does not fall into one of the special population categories listed (homeless individuals, migratory and seasonal agricultural workers, and/or public housing residents).

66. Should all staff be included on the Form 2 – Staffing Profile?

Only list the proposed new access point staff on Form 2, including staff whose salaries are paid through an indirect cost rate. Contracted providers should not be included on Form 2. Such providers (current/proposed) should be included in Attachment 7: Summary of Contracts and Agreements. See Appendix A in the FOA for Form 2 instructions.

67. In Form 3 – Income Analysis, what kind of visits, charges, and projected income do we include?

Form 3 should include all billable visits, including medical, dental, mental health, substance abuse, and vision service visits. Do not include visits for laboratory, imaging, or pharmacy services. See detailed instructions in Appendix A of the FOA.

68. Where do I find data to complete Form 4 – Community Characteristics?

You can find population, economic, and geographic information at <http://www.census.gov/>. Click the Data tab for state and county Quick Facts or the American FactFinder that provides a searchable database of U.S. Census information.

- 69. Do the data for percent uninsured and percent population below 200% FPL need to match in Forms 4 and 9?**

Due to variances in data sources, it is acceptable if the data on Form 9 and Form 4 do not match. Explain as appropriate in the Need section of the project narrative.

- 70. NEW: As a current grantee, how do I complete form 5A: Services Provided if we are referring NAP patients to one of our existing sites for a particular service?**

Form 5A should be completed to reflect the method by which the service will be delivered. If the service will be provided directly by the grantee, even if the service is located at a different site in the health center's scope of project, then it should be indicated in column I on Form 5A. The program narrative should explain if the service is not delivered at the proposed NAP site(s).

- 71. The Grants.gov Project Performance Site Location(s) Form and Form 5B seem to be asking for the same information. Does the same information have to be provided in both places?**

Proposed NAP sites must be listed on both Form 5B and the Project Performance Site Location(s) Form. However, only information on Form 5B will be used to determine the scope of project for the NAP.

- 72. What should be entered on Form 5B for the Medicaid Billing Number and the Medicare Billing Number?**

Each service site should have its own Medicaid and Medicare numbers. If the site is not operational yet and you do not have a Medicaid or Medicare billing number, you may enter 00000.

- 73. If we are providing Service Area Zip codes, should we also provide Service Area Census Tracts?**

The service area for the scope of project will be based on the zip codes listed on Form 5B. At a minimum, zip codes for each proposed site must be entered. However, we encourage you to provide complete details on your service area, including census tracts.

- 74. How many board members should be listed on Form 6A – Current Board Member Characteristics?**

Include no less than 9 and no more than 25 board members on this form. These numbers are determined by Health Center Program regulations. If the organization currently has less than 9 board members, input TBD and include steps for ensuring that the minimum number of board members is achieved within 120 days of grant award in the Implementation Plan.

- 75. On Form 6A, how do we complete the gender, ethnicity, and race sections?**

Enter the gender, ethnicity, and race numbers only for each board member that is a patient of the health center. See the instructions for Form 6A in Appendix A of the FOA for the definition of a patient board member.

76. On Form 8 – Health Center Agreements, what qualifies as a substantial portion of the proposed project?

You must attach in Form 8 any contracts or memoranda of agreement/understanding for a substantial portion of the proposed project as well as any agreements that impact the governing board. This includes, but is not limited to, contracts for Chief Medical Officer, Chief Executive Officer, or Chief Financial Officer. It also would include any contract with an organization to provide a wide range of services on behalf of the health center to its patients (including any subrecipient/subaward arrangement).

Agreements that do not rise to the threshold of “substantial portion” should be summarized in Attachment 7, kept onsite, and should a NAP grant be awarded, provided to HRSA for review upon request.

77. Why do I have to certify the Summary Page Form?

Use this form to verify key application data utilized by HRSA when reviewing the NAP applications. In addition to ensuring accurate information, the summary page requires you to verify your commitments to achieving the goals proposed in the application. Specifically, applicants that are funded will be held accountable for reaching the total unduplicated patient service projection made on Form 1A by December 31, 2016. For current grantees, these projections will be added to your current Health Center Program patient goals. You also must verify that all NAP sites proposed on Form 5B will be operational within 120 days of award.

Form 9: Need for Assistance Worksheet (NEW questions added 9/18/2014)

78. Why does HRSA require applicants to complete the Need for Assistance worksheet?

The Need for Assistance (NFA) worksheet provides a quantitative description of the need for services for the target population in a service area using objective and evidence-based indicators. Due to the high competition for funding, the NFA worksheet helps HRSA determine which applications demonstrate the greatest need. A portion of the application’s final score (a maximum of 20 points) is based on the indicator and barrier data provided.

79. We plan to apply for NAP funding for more than one site. Do we need to submit a separate NFA Worksheet for each site?

No. If you propose multiple sites, the NFA Worksheet responses should represent the total combined population for all sites. **Only one response may be submitted for each health indicator.** Data values for different sites and/or populations should be combined into one aggregate response.

80. Is there any technical assistance for completing Form 9: NFA Worksheet?

The Data Resource Guide posted at the NAP TA webpage (<http://www.hrsa.gov/grants/apply/assistance/nap/>) provides data sources, data parameters, extrapolation instructions, and other resources for completing the NFA. You should use the Data Resource Guide for step-by-step instructions for accessing and extrapolating data for each health indicator on the NFA worksheet. Also posted on the

NAP TA webpage are sample extrapolation spreadsheets to use as a tool for data extrapolation.

81. Have changes been made to the Data Resource Guide since 2013?

Yes, instructions for the Core Barriers and several health indicators were updated based on changes to the online data sources available.

82. Can we use data sources that are not listed in the Data Resource Guide to complete the NFA Worksheet? If we use other sources, how does it affect our application?

Alternate data sources are permitted if they meet the conditions listed on pages 4-5 of the Data Resource Guide. In the NFA worksheet, you must explain the data source and methodology used. On the summary page form, you are required to certify that the information provided in the application is complete and accurate, including the NFA data sources and calculations. All the information in the application is considered in the review process.

83. How many Core Barriers and Health Indicators must a health center complete?

A complete NFA Worksheet includes:

- Section 1: data for three of the four Core Barriers
- Section 2: data for one Core Health Indicator in each category: Diabetes, Cardiovascular Health, Cancer, Prenatal and Perinatal Health, Child Health, and Behavioral Health
- Section 3: data for two of the 13 Other Health and Access Indicators

84. When completing the NFA Worksheet, should we provide responses based on data for our target population or the proposed service area?

All responses – with the exception of those for Core Barriers B, C, and D – should be based on data for the target population within the proposed service area to the extent appropriate and possible. You should report data for the NFA Worksheet indicators based on the population groups specified in the Data Reporting Guidelines Table found in the Form 9 instructions in Appendix A on page 65 of the FOA.

85. What if data are not available for my target population and/or service area?

In cases where data are not available for the specific service area or target population, you may use extrapolation techniques to make valid estimates using data available for related areas and population groups. The Data Resource Guide at <http://www.hrsa.gov/grants/apply/assistance/nap/> provides additional information on the use of extrapolation. Where data are not directly available and extrapolation is not feasible, use the best available data for the service area or target population and explain the data provided.

86. What is extrapolation?

For the purposes of the NFA, extrapolation is the process of using data that describes one population to estimate data for a comparable population, based on one or more common differentiating demographic characteristics. For information on using and documenting acceptable extrapolation techniques, refer to the Data Resource Guide and the Sample Extrapolation Spreadsheets posted at <http://www.hrsa.gov/grants/apply/assistance/nap/>.

87. How is the NFA Worksheet calculated and how is this score incorporated into the overall score for the application?

The NFA Worksheet will be scored out of a total possible 100 points. See pages 67-72 in the FOA for point distributions. The NFA Worksheet score will be converted to a 20-point scale using the Conversion Table on page 72 of the FOA. The NFA will account for 20 of the 30 total points for the Need section of the Project Narrative.

88. For Core Barrier A: Population to One FTE Primary Care Physician, the FOA states that applicants can use the target population to report the ratio; however, the Data Resource Guide says this data cannot be extrapolated. How do I report the ratio for my target population?

The data reported should reflect the providers available to the target population to the degree possible. Extrapolation from service area access data to target population access data does not work because there are often unique target population characteristics that result in reduced access in comparison to the service area population (extrapolation would result in numbers that make it appear that the target population has more access than it actually has). If your target population is a subset of the service area population, you must directly assess the physician access of the target population for Core Barrier A: Population to One FTE Primary Care Physician. If the target population is a subset of the service area population, AND population-specific HPSA data are not available for the target population, AND following the HPSA process is not possible, you should use service area level data as the basis for the ratio as indicated in Table 1 and the instructions on pages 6-9 of the Data Resource Guide.

89. There are zero physicians in our proposed service area. How do I report this on Form 9?

If there are zero physicians in the entire proposed service area, enter 99999 as the data response for Core Barrier A: Population to One FTE Primary Care Physician.

90. How do we measure distance to the nearest provider for Core Barrier D: Distance (miles) or Travel Time (minutes) to the Nearest Primary Care Provider Accepting New Medicaid Patients and Uninsured Patients?

Distance should be measured from the address of the proposed service site to the nearest provider accepting new Medicaid patients and uninsured patients. If multiple sites are proposed, distance should be the average of the distance of the proposed sites to the nearest provider(s). See the Data Resource Guide at <http://www.hrsa.gov/grants/apply/assistance/nap/> for detailed instructions on completing this core barrier. For a provider to be counted as accepting uninsured patients, the provider must be willing to provide services to uninsured patients on a sliding fee scale or at no cost.

91. NEW: I received an email notice about modifications to the New Access Point funding opportunity announcement. What changed?

On page 66, the word Physician was changed to Provider (twice). Core Barrier D is the Distance or Travel Time to Nearest Primary Care *Provider* Accepting New Medicaid and Uninsured Patients.

92. **How many “Other” responses within Section II can be used? What is the maximum number of points for an “Other” indicator?**

You are not restricted in the number of “Other” options allowable within Section II. However, if you use an “Other” indicator, the maximum score for that indicator is 4 points.

93. **NEW: In the Data Resource Guide, one of the recommended data sources for Diabetes Prevalence – the Behavioral Risk Factor Surveillance System (BRFSS) – does not appear to be age-adjusted. Can I use this data source?**

Although the BRFSS data source for Diabetes Prevalence is no longer age-adjusted, because it is one of the recommended data sources in the Data Resource Guide, it is acceptable to continue to use the BRFSS data to address the Diabetes Prevalence core health indicator. Similarly, other data sources that meet the requirements for alternate data sources listed on pages 4-5 in the Data Resource Guide are acceptable, regardless of whether the data are age-adjusted.

94. **What is the definition for “Data Response” which appears on the Need for Assistance Worksheet?**

The Data Response is the actual data result for each specified indicator. For instance, in Section I, the ratio you provide for the Population to One FTE Primary Care Physician Ratio for your service area and the percentage you provide for the Percent of Population Below 200% FPL would be the Data Responses. Data Responses are either ratios or percentages.

95. **Our target population is homeless individuals. Can we complete the NFA using data for the low-income population in the service area?**

Yes. You may also contact the National Health Care for the Homeless Council at <http://www.nhchc.org/> for assistance in finding appropriate homeless data for your service area.

96. **Is patient data an acceptable source of information for Form 9?**

No. Form 9 is intended to work hand-in-hand with the Need section of the Project Narrative to quantitatively describe need in the target population. Patient data would be a subset of the target population and would not be appropriate to represent the entire target population.

97. **Where can comparison data (e.g., state, national) be included on Form 9 so reviewers will better understand the severity of needs in a given service area?**

Additional information beyond the benchmarks provided in the form can be included in Item 1 of the Need section of the Project Narrative.

Performance Measures (NEW questions added 9/18/2014)

98. **NEW: Where can I find more information on the Performance Measures?**

Refer to Appendix B of the FOA for instructions on how to complete the Performance Measures Forms. Copies of the Performance Measures Forms that are completed in EHB are posted at <http://www.hrsa.gov/grants/apply/assistance/nap/> as well as a webinar on the performance measures. The Uniform Data System (UDS) Reporting Manual

(<http://bphc.hrsa.gov/healthcenterdatastatistics/reporting/2013udsreport.pdf>) provides additional measurement details such as exclusionary criteria. Useful information and training materials are available at <http://www.hrsa.gov/data-statistics/health-center-data/reporting/index.html>.

99. NEW: What dates should be listed for the Project Start Date and End Date for the performance measures?

Enter May 1, 2015 for the Project Start Date. Enter April 30, 2017 for the Project End Date.

100. Which performance measures must be included in the application?

You are required to include the 16 Clinical Performance Measures listed in Appendix B of the FOA. While most measures are standardized, you must define an individualized Oral Health measure.

You are required to include five Financial Performance Measures which are also listed in Appendix B of the FOA. Tribal and public center applicants are not required to include the three audit-related measures: Change in Net Assets to Expense Ratio, Working Capital to Monthly Expense Ratio, and Long Term Debt to Equity Ratio. Tribal or public center applicants may provide substitute measures specific to the scope of the new access point project, such as net income or loss as a percent of expense.

You may define as many additional Other measures as desired (both clinical and financial). Please note that all measures defined in the application will be reported on yearly for the duration of the project period if the application is funded.

101. Can I include measures other than the required performance measures?

Yes. In addition, applicants who request funding under section 330(g), 330(h), and/or 330(i) for MHC, HCH, and/or PHPC respectively must include at least one measure that relates to each special population. All applicants may identify other performance measures unique to their local community or that highlight special characteristics of their proposed health center program.

102. Have changes been made to the performance measures since 2013?

Yes. The Tobacco Use Assessment measure and Tobacco Cessation Counseling measure have been combined into one performance measure: Tobacco Use Screening and Cessation. Two new Clinical Performance Measures have been added: Depression Screening and Follow Up and New HIV Cases With Timely Follow Up.

103. Are the clinical and financial measures based on the entire organization or the NAP site(s) only?

The clinical and financial performance measures should address only the service area and target population of the proposed new access point(s). However, because an audit includes information for all sites operated by the applicant, the audit-related measures (Change in Net Assets to Expense Ratio, Working Capital to Monthly Expense Ratio, and Long Term Debt to Equity Ratio) will reflect organizational level data.

104. In general, how should I develop baselines for the performance measures?

Baselines for performance measures should be developed from current data that are valid, reliable, and derived from established management information systems wherever possible. Data sources could include electronic health records, disease registries, and/or chart sampling.

Refer to the most recent version of the UDS manual, found at <http://www.hrsa.gov/data-statistics/health-center-data/reporting/index.html>, for exclusion criteria, baseline formulas (numerator and denominator), and sampling methodology for each measure.

Use of electronic health records is the preferred method for development and tracking of performance measures. For chart sampling, the random sample should consist of 70 charts or all charts for patients who meet the criteria noted in the denominator for each measure if that number is less than 70. Consult the UDS Reporting Manual for specific measurement details and guidelines for chart sampling. Please note that chart sampling is not acceptable for the Prenatal Health or Perinatal Health performance measures.

If the proposed NAP is not currently in operation, but you have comparable operations elsewhere, you are encouraged to use that experience as a basis for estimating baselines for the NAP. Applicants with no operations should put zeros in the Numerator and Denominator subfields of the Baseline Data field and provide an explanation in the Comments field describing why baseline data are not yet available and stating when data will be available.

105. How do you calculate baseline data for a clinical or financial measure if you are a satellite applicant or current Health Center Program look alike?

Use data available from your existing site(s) as a starting point for estimating baselines for the NAP. For the three audit-related Financial Performance Measures, use the data from the last corporate audit. For the remaining two Financial Performance Measures (Total Cost per Patient and Medical Cost per Medical Visit), use UDS data as a starting point.

106. Is there a field on the clinical and financial performance measures form to enter the percentage for the measure baseline?

The baseline data entered for each clinical performance measure includes baseline year, measure type, numerator, and denominator. The percentage is automatically calculated.

107. How do I calculate “Projected Data” for the performance measures?

Projected data are goals for the end of the 2-year project period based on data trends to date, including an assessment of contributing/restricting factors and past performance. Goals (projected data) should be realistic for achievement by the end of the 2-year project period. They should be based on data trends and expectations, factoring in predicted contributing and restricting factors as well as past performance.

108. Can you clarify the age range for the Cancer performance measure?

The measure is for women receiving a Pap test in the measurement year or two years prior, creating a “look-back period” (i.e., a woman who is currently 24 years old may have been 21 years old when she received a Pap test two years prior to the current measurement year). The data reflects women age 21-64, though the 24-64 age range is used to obtain the data.

109. What is the best way to integrate data from Healthy People 2020 in my health performance measures?

Healthy People 2020 (HP 2020) objectives, available at <http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf>, may be used as a guide to assist you in setting goals for clinical performance measures. It is important to keep in mind that HP 2020 data and targets are for the United States as a *whole*, while health centers are serving a specific underserved population. Several of the HP 2020 objectives can be compared directly to UDS clinical performance measures. A table outlining the HP 2020 objectives related to these performance measures can be found at <http://www.hrsa.gov/grants/apply/assistance/nap>.

Attachments (NEW questions added 9/18/2014)

110. How should attachments be formatted?

HRSA will accept PDF, Microsoft Word, and/or Excel files. Do not use spaces or special characters when naming files. If using Excel or other spreadsheet documents, be aware that reviewers will only see information that is set in the "Print Area" of the document. Be sure to upload the attachments in the appropriate fields in EHB.

111. What is the purpose of Attachment 1: Service Area Map and Table?

The primary purpose of the Service Area Map and Table is to depict your service area and the local health care environment. The map is a visual representation of the service area demonstrating opportunities for collaboration described in the narrative. The table is a companion to the map, providing additional information on need.

112. NEW: The data table that corresponds with the service area map created on UDS Mapper does not include all the requirements listed in the FOA. Do I need to adjust the table?

Use the data table that is generated from UDS Mapper. The dominant health center's share of patients does not need to be included in the data table.

113. Our service area is the county, but the zip codes that make up the county have significant area located outside the county. Should Attachment 1: Service Area Map and Table reflect only the county? Should the data collected for other forms match the map and accompanying information table?

The Service Area Map should reflect the service area. You can draw the boundary lines on the map to reflect partial zip codes by outlining the county only. The data reported in Forms 4 and 9 should reflect the service area and target population, as appropriate. Since the data in UDS Mapper is reported by Zip Code Tabulation Area (ZCTA), if you define your service area differently (e.g., by partial zip codes), data reported in the Attachment 1 table and Forms 4 and 9 may be different. You can explain differences in the data in the narrative by clearly explaining how the service area and target population are defined.

114. For Attachment 3: Applicant Organizational Chart, who is considered key personnel?

Key personnel may include key management staff such as the Chief Executive Officer (CEO), Chief Clinical Officer (CCO), Chief Financial Officer (CFO), Chief Information

Officer (CIO), and Chief Operating Officer (COO), along with other individuals directly involved in oversight of the proposed new access point project (e.g., Project Director).

115. What is the difference between a Position Description (Attachment 4) and a Biographical Sketch (Attachment 5)?

A position description outlines the key aspects of a position (e.g., position title; description of duties and responsibilities; position qualifications; supervisory relationships; skills, knowledge, and experience requirements; travel requirements; salary range; work hours). A biographical sketch describes the key aspects of an individual that make him/her qualified for a position (e.g., past work experience, education/training, language fluency, experience working with the cultural and linguistically diverse populations to be served).

116. What should a public entity submit for Attachment 8 (Audit), Attachment 9 (Articles of Incorporation), and Attachment 12 (Proof of Public Center Status)?

A public entity (the applicant for a public center) is required to submit an annual audit (Attachment 8). If the public entity has a co-applicant, submit the co-applicant's Articles of Incorporation (Attachment 9), if applicable. See Table 2 on page 18 of the FOA for acceptable proof of public status.

117. What should a Tribal entity submit for Attachment 8 (Audit), Attachment 9 (Articles of Incorporation) and Attachment 14 (Corporate Bylaws)?

A Tribal applicant is required to submit an annual audit (Attachment 8). If a Tribal applicant does not have Articles of Incorporation, the Tribal Constitution or Health Center Board Charter is an acceptable submission for Attachment 9. For Attachment 14: Corporate Bylaws, a Tribal applicant may provide a work plan/document that explains:

- how it is going to establish a governing body over the health center (if one does not already exist);
- how it will incorporate community/target population/patient input into health center operations, including input from the total population to be served by the health center; and
- how it will maintain fiscal and programmatic oversight over the Health Center Program grant project.

118. To whom should letters of support be addressed and how should they be provided?

Letters of support should be addressed to the appropriate applicant organization contact person (e.g., board, CEO). They should **not** be addressed to HRSA or mailed separately from the application. Letters of support must be included with the application as Attachment 10 or they will not be considered by objective reviewers.

119. NEW: What should be included in letters of support from state Medicaid agencies and health departments?

These entities can provide information to HRSA related to the need in the area where the new access point(s) is being proposed and any details the agency may have regarding the ability of the applicant organization to carry out the project in compliance with Health Center Program requirements. See the list of key Health Center Program requirements at <http://bphc.hrsa.gov/about/requirements/index.html>.

120. NEW: Can I provide a letter of support from the local health department instead of the state health department or state Medicaid agency?

Applicants must provide letters of support for the proposed NAP project that demonstrate collaboration and coordination with both state and local entities as outlined in the FOA.

121. NEW: The State Medicaid agency, State Health Department, and State Primary Care Office are the same entity in my state. Do I need separate letters of support from each one?

If the State Medicaid Office, State Health Department, and/or State Primary Care Office are part of the same entity in your state, you can obtain one letter of support from an entity on behalf of the two or three offices/agencies/departments included as a part of that entity. The letter of support should make it clear which part(s) of the entity it represents.

122. NEW: What if I am not able to get a letter of support from one or more of the entities required in the FOA?

When efforts to obtain one or more letters of support are unsuccessful, documentation of the organization's efforts to obtain the letter(s) and any additional efforts toward collaboration and coordination are requested for this aspect of the collaboration review criteria.

123. Can I upload additional attachments?

Yes. You may upload additional relevant material in Attachment 15. Documents provided in this attachment will be included in the page limit.

One-Time Funding for Alteration/Renovation

124. What is the maximum amount I can request for one-time funding activities?

You may not request more than \$150,000 regardless of the scope of activities proposed for the one-time funding.

125. What types of projects are appropriate for the NAP one-time funding?

You may propose minor alternation and renovation (A/R) (such as converting existing unused space into exam rooms or replacing the existing HVAC system) and/or equipment purchases relevant to the proposed project (such as an x-ray machine or dental chair).

126. What is the difference between Alteration/Renovation (A/R) and Construction?

Alteration/Renovation (eligible): Work required to modernize, improve, and/or reconfigure the interior arrangements or other physical characteristics of a facility; work to improve and/or replace exterior envelope; and work to improve accessibility (such as sidewalks and ramps) and/or life safety requirements in an existing facility. This type of project does not increase the total square footage of an existing building, and does not require ground disturbance or footings. Exceptions that would be considered minor A/R include:

- Minor parking lot renovation, such as resurfacing or restriping;
- Adding a covered walkway, which may require footing and ground disturbance; and/or
- Adding a sidewalk or an accessible ramp, which may require minimal footing and ground disturbance.

Construction (not eligible): A project that will increase physical square footage—either by building on to an existing facility or constructing a new facility from the ground up. This may include:

- Adding a wing to an existing facility;
- Adding a floor to an existing facility;
- Constructing a brand new structure;
- Demolishing a structure and building a new one in the same location;
- Permanently affixing a modular or prefabricated unit to an existing facility or land; and/or
- Expanding parking beyond an existing surfaced parking area.

127. Is it allowable to use the services of an architect that is a direct employee of the organization?

You must justify the use of your organization's work force (force account) by demonstrating that it will be cost effective and that qualified personnel are available to accomplish the work. Further information is available at <http://bphc.hrsa.gov/policiesregulations/forcefaq.pdf>.

128. Who should complete and sign the Environmental Information Documentation (EID) checklist?

The Authorizing Official of the applicant organization may complete and the sign the EID checklist. Because this is a certification of conditions and the potential impacts on and around a proposed project site, you are strongly encouraged to seek consultation from a qualified professional with experience with the National Environmental Policy Act (NEPA) to fully understand the information requested and ensure accurate responses.

129. If we propose to renovate a facility using one-time funds, what are the environmental and historic preservation requirements?

For information on environmental and historic preservation compliance requirements, see <http://www.bphc.hrsa.gov/policiesregulations/capital/environmentandhistoric/capitaldevelopment.html>. Although applicants proposing renovation projects typically do not require preparation of a full Environmental Assessment under the National Environmental Policy Act (NEPA), you may need to comply with other requirements, as applicable:

- If the proposed project involves exterior work, ground disturbance, or work on a building that is over 50 years old, the project may require State Historic Preservation Office (SHPO) consultation under Section 106 of the NEPA.
- Buildings constructed prior to 1985 may require submission of a hazmat study and abatement plan.
- If the site is located in a coastal state, the project may require compliance with the Coastal Zone Management Act.
- If the proposed project is in a 100 or 500 year floodplain, it may require compliance with E.O. 11988, Floodplain Management.

130. Can I propose A/R for a site that is leased?

Yes, leasehold improvements are allowed. Please note that NAP funds for a proposed site in a leased property cannot be used to address facility needs that are part of the terms of the lease (are the obligation of the lessor). If proposing A/R for a leased facility, you must

provide a signed Landlord Letter of Consent from the facility owner (see sample at <http://bphc.hrsa.gov/policiesregulations/capital/postaward/landlordconsent.pdf>) that addresses the following components:

- Approval of the scope of the project;
- Agreement to provide the health center reasonable control of the project site for the appropriate amount of time; and
- Acknowledgement that there will be Federal interest in the property and agreement to file a Notice of Federal Interest (NFI) in the land records of the local jurisdiction before the project begins if an NFI applies. For information regarding the NFI, see <http://bphc.hrsa.gov/policiesregulations/capital/nfifilingguide.pdf>.

131. What is the time-frame for recipients to use the one-time funding?

Grantees must complete one-time funding activities within the first year of the project period. Regardless of the proposed A/R one-time funding activities, all new access points must be operational and begin providing services within 120 days of award.

132. Can one-time funding be used to pay for a portion of a large equipment purchase, like a mobile medical unit?

Yes. Mobile medical vans are considered equipment and are subject to the \$150,000 cap on the use of one-time funding. You can use other sources of funding to cover the remaining costs of purchasing the equipment beyond the \$150,000. Please note that you may propose a mobile medical van as a new access point only if a permanent, full-time site is also proposed in the NAP application.

133. Can you provide more instruction on how to prepare the A/R project budget justification?

A budget justification is required for each site-specific project that will utilize one-time funding for A/R. The budget justification must provide a detailed break-out and description of each cost element in the budget, and provide sufficient narrative detail to explain each cost. If there are additional sources of funding, you should identify which costs will be covered by the one-time funding. A sample A/R budget justification is available at <http://www.hrsa.gov/grants/apply/assistance/nap/>.

Application Submission

134. How do I submit my application and when is it due?

There is a two-step application submission process for the FY 2015 NAP applications via Grants.gov and the HRSA Electronic Handbooks (EHB).

- **Step 1 – Grants.gov:** Application must be completed and successfully submitted via Grants.gov by 11:59 PM ET on **August 20, 2014**.
- **Step 2 – HRSA EHB:** Application must be completed and successfully submitted by 8:00 PM ET on **October 7, 2014**.

HRSA recommends that applications be submitted in Grants.gov as soon as possible to ensure that maximum time is available for providing the extensive required information in EHB.

135. When can I begin the HRSA EHB submission process?

You can begin Step 2 in HRSA EHB only after Step 1 in Grants.gov has been successfully completed by the Grants.gov due date and HRSA has assigned the application a tracking number. The applicant's Authorizing Official (AO) will be notified by email when the application is ready within EHB for the completion of Step 2. This email notification will be sent within 7 business days of the Grants.gov submission.

136. How will I be notified if my application was not successfully submitted in Grants.gov and/or EHB?

Grants.gov will send a series of e-mails to the AO, BO, PD, and SPOC listed on the Grants.gov application to notify you once the Grants.gov application has been validated or if there are errors. **If there are errors, you must correct the errors and re-submit the application in Grants.gov prior to the due date/time. You are strongly encouraged to closely monitor your e-mail accounts, including spam folders, for e-mail notifications and/or error messages from Grants.gov.** Once the Grants.gov application is validated, you will receive an email stating that the application is available in HRSA EHB. You will complete and submit the application in EHB. All validation errors must be resolved in EHB before the application can be submitted to HRSA by the AO. The status of the application in EHB will appear as "Application Submitted to HRSA" once it has been submitted successfully.

Please note that only the AO can submit the final EHB application to HRSA. You should allow proper time for this to occur before the due date/time.

Award Information

137. When will NAP funds be awarded?

NAP awards will be issued on or around May 1, 2015.

138. How many NAP grants does HRSA intend to award?

Subject to the availability of appropriated funds, HRSA anticipates awarding approximately \$100 million in FY 2015 for an estimated 150 NAP awards. Pending the final Health Center Program appropriation funding level, HRSA may adjust the amount of funding and number of awards available under this funding opportunity announcement.

139. What is the cap for Federal funds that can be requested?

NAP funding requested cannot exceed \$650,000 in each year of the project period.

140. If awarded, what is the formal notification of a NAP award?

HRSA will electronically transmit a formal notification to the applicant organization in the form of a Notice of Award (NoA).

141. If awarded, will Federal funding for the NAP grant continue beyond the 2-year project period?

Continuation grants beyond the initial 2-year project period may be awarded in subsequent years on a competitive basis subject to availability of funds, satisfactory grantee

performance, and a determination that continued funding would be in the best interest of the Federal government.

142. If an organization receives a NAP grant, does it automatically become a Federally Qualified Health Center (FQHC)?

No. Once a NAP grant is awarded and a health center is operational (within 120 days of Notice of Award), a grantee must then apply to the Medicare Program and to their State Medicaid Program to be enrolled and reimbursed as an FQHC. For more information on the Medicare application process and timelines, see Program Assistance Letter 2011-04, available at <http://bphc.hrsa.gov/policiesregulations/policies/pal201104.html>.

Funding Priorities (NEW question added 9/22/2014)

143. What are funding priorities and how do I get these points?

A funding priority is defined as the favorable adjustment of review scores when applications meet specified criteria. **You will not be required to request consideration for the funding priorities.** Prior to final funding decisions, HRSA will assess all NAP applications within the fundable range for eligibility to receive priority point adjustments. The FY 2015 NAP funding opportunity has three funding priorities:

- Unserved, High Poverty Population (3-15 points);
- Sparsely Populated Area (5 points); and
- Health Center Program Look-Alikes (5 points).

144. I realize that we do not need to request funding priorities but may I still include a section in my application to specifically address the funding priorities?

You may address funding priorities within their application where appropriate. However, HRSA will determine whether funding priority points are awarded based on the criteria and conditions listed under Section IV.2. Review and Selection on pages 46-47 in the FOA.

145. I serve only migratory agricultural patients and receive section 330(g) funding; why am I not eligible for the sparsely populated area funding priority?

This funding priority is based in statute – section 330(p) of the PHS Act – which directs HRSA to give special consideration to the unique needs of sparsely populated rural areas, including giving priority in the awarding of grants for new health centers under sections 330(c) – planning grants and 330(e) – Community Health Centers (CHC). Therefore, this funding priority can only apply to applicants who are requesting section 330(e) funding (CHC), in whole or in part.

146. What is the intent of the “Unserved, High Poverty Population” funding priority and can you provide an example of how is it calculated?

This funding priority aims to ensure that NAP funding goes to support high need, unserved communities and populations, as illustrated by data showing (1) limited access to health center services and (2) a large unserved low-income population.

Here is an example that helps to demonstrate how this funding priority is calculated: ABC Health Center proposed a new access point to serve the entire county. Based on data contained in UDS Mapper, ABC County has a total low-income population (less than 200%

of the FPL) of 8,000 residents, 7,000 of whom are unserved. The only other health center in the surrounding area, GHI Health Center, serves the remaining 1,000 low-income individuals at its health center. Therefore, the **Percent Penetration of the Low Income Population** for the service area (ABC County) is only 12.5% (1,000 out of 8,000 residents).

ABC County projects that it can serve 3,000 of those 7,000 unserved residents by the end of its two-year project period; this means the **Percent of High Poverty Unserved Residents Compared to Proposed Patients** is 230% (7,000 residents compared to 3,000 proposed patients, which meets the threshold that unserved, low-income residents must be at least 150% of the proposed patients to be served).

Upon completing these calculations and assuming that ABC Health Center scored in the fundable range, HRSA would award ABC Health Center 9 priority points (per the scale on page 46 of the FOA).

147. How does HRSA determine the Health Center Program penetration rate for the low-income population?

HRSA uses the most recent UDS data submitted by Health Center Program grantees and look-alikes to determine the percentage of the low-income population served by the Health Center Program. The 2013 UDS data will be included in the UDS Mapper when it is updated in the summer of 2014. For more information on UDS Mapper data sources, refer to <http://www.udsmapper.org/>.

148. NEW: My organization is dual status grantee and look-alike. For the 2013 UDS report, we reported look-alike data for four look-alike sites, and have since moved two of those sites into our grantee scope of project. Are we eligible for look-alike priority points?

In cases where look-alike sites have been moved into a grantee's scope of project and what is reported in the look-alike 2013 UDS no longer aligns with the current look-alike scope of project, HRSA will adjust assessment of priority points for the following two criteria:

- The criterion that the NAP Form 5B service area zip codes must include those in which at least 75% of current look-alike patients reside.
- The criterion that the total unduplicated patient projection by December 31, 2016 on the NAP Form 1A is greater than the total unduplicated patients included in the look-alike 2013 UDS report.

For both criteria, HRSA will base the assessment on two categories of patients: (1) those that reside in zip codes linked to the look-alike sites being proposed in the NAP application and (2) those that reside in zip codes that were not linked to any sites that were included in the look-alike 2013 UDS. For the latter category, patients will be proportionately attributed to each site that was included in the 2013 look-alike UDS report. Current dual status grantees hoping to receive the look-alike priority points should contact the NAP technical assistance team at bphcnap@hrsa.gov for assistance in determining if their proposed NAP project will qualify for these priority points.

Application Review and Selection Process

149. Who will review NAP applications?

NAP applications will be subject to an internal and external review. The internal HRSA review assesses completeness, eligibility, service area overlap, funding priorities, environmental impact, and current grantee performance status. Applications deemed complete and eligible will also be externally reviewed by an Objective Review Committee (ORC). The ORC reviewers are selected based on training and experience in fields or disciplines related to the Health Center Program. Each reviewer provides an objective, unbiased evaluation based on the review criteria in the FOA and the guidelines in the HRSA scoring rubric located at <http://www.hrsa.gov/grants/apply/assistance/nap/>.

150. What criteria does the ORC use in assessing NAP applications?

Refer to the Project Narrative requirements and the Review Criteria, described in Sections IV and V of the FOA. The Project Narrative requirements and the Review Criteria are aligned, so ORC reviewers will be looking at the Program Narrative, as well as supporting additional documentation throughout the application, when assigning points to each review criterion. You should carefully review the Project Narrative requirements and the Review Criteria to ensure that your application meets or exceeds the established criteria.

151. Does HRSA make award decisions based solely on the final application score?

No. As described on page 45 of the FOA, the Objective Review Committee will evaluate the technical merits of each proposal using the review criteria presented in the FOA, up to a maximum of 80 points. The NFA Worksheet (Form 9) will be scored automatically within EHB using the NFA Worksheet scoring criteria and will account for up to 20 points. HRSA will then assess all applications within the fundable range for an adjustment to the overall application score based on the funding priorities in the FOA, giving HRSA a final overall application score.

In conjunction with the overall ORC score, HRSA will consider other factors such as geographic distribution, past performance, and compliance with section 330 program requirements and applicable regulations. As discussed in Section V.2. of the FOA under Special Funding Considerations, this may include awarding grants to applications out of rank order in order to meet statutory requirements such as:

- Maintaining an urban/rural distribution that ensures no more than 60 percent and no fewer than 40 percent of centers serve people from either rural or urban areas.
- Ensuring continued proportionate distribution of funds across the Health Center Program.
- Considering geographic distribution and the extent to which an area may currently be served by another section 330-funded health center.

Finally, HRSA will review fundable applicants for compliance with HRSA program requirements through reviews that may include site visits, audit data, Uniform Data System (UDS) or similar reports, Medicare/Medicaid cost reports, external accreditation, and other performance reports, as applicable. The results of this review may impact final funding decisions. For example, based on review of applicants by the Division of Financial Integrity, applicants with serious financial sustainability concerns will not receive a NAP award.

152. Why is HRSA putting limitations on satellite applicants (existing grantees) who have program requirement conditions?

HRSA has the responsibility of ensuring that grantees are implementing projects in accordance with program requirements. If a current grantee is experiencing difficulties in meeting these requirements, HRSA expects the grantee to focus on addressing those concerns prior to expanding services via a NAP (see Section V.2.Review and Selection Process of the FOA).

153. Therefore, approximately 45 days prior to award date, HRSA will assess the status of all current Health Center Program grantees applying to establish satellite sites. Applicants within the fundable range will not receive a NAP award if they:

- Have three or more active 60 day health center program requirement conditions on current grant award;
- Have one or more 30 day health center program requirement condition(s) on current grant award; or
- Received initial Health Center Program funding in FY 2013 or FY 2014 and one or more of the proposed sites have not been verified operational.

154. I am a current grantee who has three progressive action conditions related to program requirements on my award. Can I apply?

You may apply. However, if your organization has three or more 60 day program requirement conditions or one or more 30 day program requirement conditions on its award approximately 45 days prior to the award date, HRSA will not award your organization a NAP grant.

Technical Assistance and Contact Information

155. If I encounter technical difficulties when trying to submit my application in Grants.gov, who should I contact?

Refer to <http://www.grants.gov/web/grants/applicants/applicant-faqs.html> for applicant FAQs or contact the Grants.gov Contact Center 24 hours a day, 7 days a week (excluding Federal holidays) at 1-800-518-4726 or support@grants.gov. Register as early as possible since registration may take up to one month.

156. If I encounter technical difficulties when trying to submit my application in HRSA EHB, who should I contact?

Contact the BPHC Helpline Monday through Friday, 8:30 AM to 5:30 PM ET (excluding Federal holidays) at 1-877-974-2742 or BPHCHelpline@hrsa.gov. Other useful resources are the *HRSA Electronic Submission User Guide* available at <http://www.hrsa.gov/grants/apply/userguide.pdf> and the **FY 2015 NAP User Guide for Grant Applicants** posted at <http://www.hrsa.gov/grants/apply/assistance/nap/>.

157. Who should I contact with programmatic questions concerning the new access point application requirements and process?

Refer to the NAP TA page at <http://www.hrsa.gov/grants/apply/assistance/nap> for TA slides, NAP presentation webcasts, FAQs, samples, templates, and other resources. You

may also contact Joanne Galindo in the Bureau of Primary Health Care's Office of Policy and Program Development at BPHCNAP@hrsa.gov.

158. Who should I contact with questions about preparing my NAP application budget?

Contact Angela Wade in the Division of Grants Management Operations at awade@hrsa.gov or 301-594-5296.

159. Are there other sources for TA that I could contact?

You are encouraged to contact the appropriate Primary Care Association (PCA), Primary Care Office (PCO), and/or National Cooperative Agreements (NCAs) to develop a NAP application. Refer to <http://bphc.hrsa.gov/technicalassistance/partnerlinks> for a complete listing of PCAs, PCOs, and NCAs.