

**HRSA Electronic Handbooks (EHB)**

# **FY 2019 New Access Points (NAP)**

**HRSA-19-080**

**User Guide for Applicants**

Last updated on January 04, 2019



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This user guide describes the steps you need to follow to submit a Fiscal Year (FY) 2019 New Access Points (NAP) application to the Health Resources and Services Administration (HRSA). This user guide does not replace the Notice of Funding Opportunity, which details the NAP program requirements and the instructions for application development. See the NAP technical assistance webpage at <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP> for additional resources.

## 1. Starting the FY 2019 NAP Application

Complete and submit the FY 2019 NAP application by following a two-step process:

1. Locate the funding opportunity in Grants.gov, download the application package, and submit the required application forms in Grants.gov. To find the application package, search by the announcement number HRSA-19-080 in Grants.gov.
2. You must then validate, complete, and submit this application in the HRSA Electronic Handbooks (EHB). To validate the Grants.gov application, log into EHB and click on the **Grant Applications** link under the Tasks tab (**Figure 1, 1**) and then click on the **Grants.Gov Application Pending Validation: Validate** link (**Figure 1, 2**). You will need your Grants.gov and EHB tracking numbers (emailed after successful Grants.gov submission) (**Figure 2**).

**IMPORTANT NOTE:** If you do not have a username, you must register in EHB. Do not create duplicate accounts. If you experience log in issues or forget your password, contact Health Center Program Support at [https://bphccommunications.secure.force.com/ContactBPHC/BPHC\\_Contact\\_Form](https://bphccommunications.secure.force.com/ContactBPHC/BPHC_Contact_Form) or (877) 464-4772.

Figure 1: Grant Applications Link



**Figure 2: Validating your Grant.gov Application**

**Grants.Gov Application - Validate**

**Note(s):**  
In order to ensure that the correct persons are given permissions to work on this Grants.gov application, you must enter the following validation information from the submitted Grants.gov application

Fields with \* are required

**Announcement Information**

\* Announcement Number  
(From submitted Grants.gov application)  (e.g. HRSA-04-061 or 04-061)

**Grants.gov Application Information**

\* Grants.gov Tracking Number  
(From submitted Grants.gov application)  (e.g. GRANT00059900)

**EHBs Application Information**

\* EHBs Application Tracking Number  
(From email notification)  (e.g. 00025328)

**IMPORTANT NOTE:** Refer to the HRSA SF-424 Two Tier Application Guide (<http://www.hrsa.gov/grants/apply/applicationguide/sf424programspecificappguide.pdf>) for details related to submitting the application in Grants.gov and validating it in EHB.

Once the application is validated in EHB, you can access it in your pending tasks. To access the application in EHB, follow the steps below:

1. After logging into EHB, click the Tasks tab on the EHB **Home** page to navigate to the **Pending Tasks – List** page.
2. Locate the NAP application using the EHB application tracking number and click the **Start** link to begin working on the application in EHB.
  - The system opens the **Application - Status Overview** page of the application (**Figure 3**).

**Figure 3: Application - Status Overview Page**

List of forms that are part of the application package		
Section	Status	Options
Basic Information <span style="border: 1px solid red; padding: 2px;">1</span>		
SF-424	Not Started	
Part 1	Not Started	Update
Part 2	Not Started	Update
Project/Performance Site Location(s)	Not Started	Update
Project Narrative	Not Started	Update
Budget Information <span style="border: 1px solid red; padding: 2px;">2</span>		
Section A-C	Not Started	Update
Section D-F	Not Started	Update
Budget Narrative	Not Started	Update
Other Information <span style="border: 1px solid red; padding: 2px;">3</span>		
Assurances	Not Started	Update
Disclosure of Lobbying Activities	Not Started	Update
Appendices	Not Started	Update
Program Specific Information		
Program Specific Information	Not Complete	Update

The application consists of a standard section and a program specific section. You must complete the forms displayed in both sections to submit your application to HRSA. Click Update to access each section.

## 2. Completing the Standard SF-424 Section of the Application

The standard SF-424 section of the application consists of the following main sections:

- [Basic Information](#) (Figure 3, 1)
- [Budget Information](#) (Figure 3, 2)
- [Other Information](#) (Figure 3, 3)

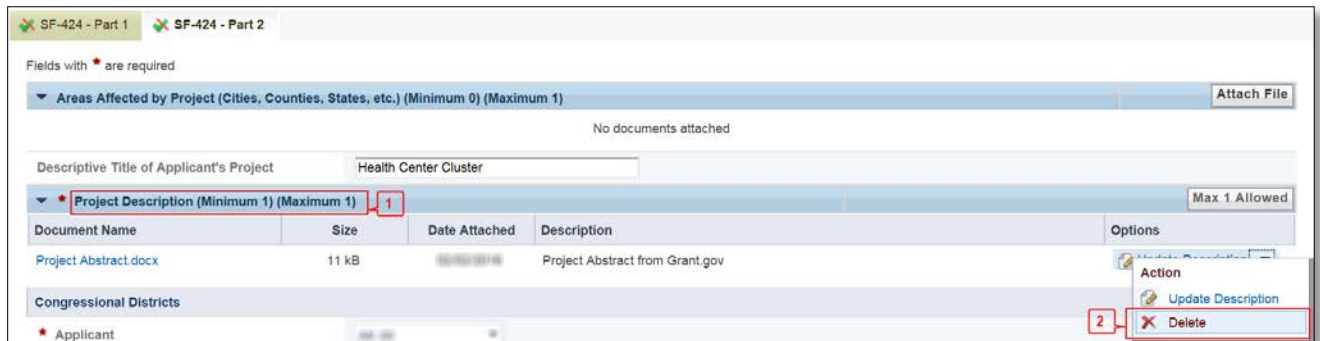
### 2.1 Completing the Basic Information Section

The Basic Information has been imported from Grants.gov and has undergone a data validation check. You may edit this information if necessary. Only the fields marked with a star \* are required for completion. This section consists of the following forms:

- The **SF-424 Part 1** form displays basic information about the application and the applicant organization.
- The **SF-424 Part 2** form displays information about the proposed project, including: the project title, project period, cities, counties, and Congressional districts affected by the project.
  - The Project Abstract has been imported from Grants.gov and placed under the Project Description section (Figure 4, 1). You may update the abstract as necessary, by clicking the

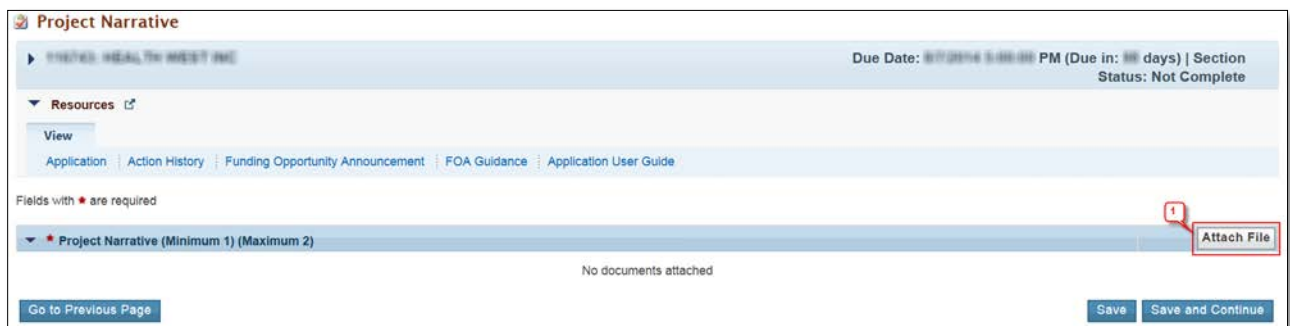
arrow next to the **Update Description** link and selecting Delete to remove the Grants.gov version (**Figure 4, 2**). Then upload an updated abstract by clicking Attach File.

**Figure 4: Project Description on SF-424 Part 2**



- In the Congressional Districts field, select the congressional district where the applicant organization is located. Also select the congressional district where the new access point is located. If you need to include additional congressional districts, you may upload an attachment with the relevant information by clicking the Attach File button on the 'Additional Program/Project Congressional Districts' line.
- For the Proposed Project Period, enter 9/01/2019 to 8/31/2021.
- The Estimated Funding section will update automatically when edits are made to the Budget Information section.
- Refer to the HRSA SF-424 Two Tier Application Guide (<http://www.hrsa.gov/grants/apply/applicationguide/sf424programspecificappguide.pdf>) for details related to the Executive Order 12372 process.
- The **Project/Performance Site Location(s)** form, provided in Grants.gov, displays the site locations where you propose to provide services through the proposed NAP project. You may update the information provided from Grants.gov.
- In the **Project Narrative** form, attach the Project Narrative by clicking the Attach File button (**Figure 5, 1**). See the FY 2019 NAP Notice of Funding Opportunity for detailed requirements for the Project Narrative.

**Figure 5: Project Narrative**



## 2.2 Completing the SF-424A Budget Information

For this section, you must complete the **Budget Information Section A-C** and **D-F** forms and provide a [Budget Justification Narrative](#).

### 2.2.1 Budget Information – Section A-C

The **Budget Information – Section A-C** form consists of the following three sections:

- Section A – Budget Summary
- Section B – Budget Categories
- Section C – Non-Federal Resources

To complete this form, follow the steps below:

1. Click the [Update](#) link for Section A-C on the **Application - Status Overview** page ([Figure 6](#)).

**Figure 6: Budget Information Section A-C Update Link**

List of forms that are part of the application package			
Section	Status	Options	
Basic Information			
SF-424	Not Started		
Part 1	Not Started	Update	
Part 2	Not Started	Update	
Project/Performance Site Location(s)	Not Started	Update	
Project Narrative	Not Started	Update	
Budget Information			
Section A-C	Not Started	Update	
Section D-F	Not Started	Update	
Budget Narrative	Not Started	Update	
Other Information			
Assurances	Not Started	Update	
Disclosure of Lobbying Activities	Not Started	Update	
Appendices	Not Started	Update	
Program Specific Information			
Program Specific Information	Not Complete	Update	

- The system navigates to the **Budget Information – Section A-C** form ([Figure 7](#)).



Figure 7: Budget Information – Section A-C Page

**Budget Information - Section A-C**

Due Date: (Due in: ) | Section Status: Not Complete

Resources

View

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Fields with \* are required

**Section A - Budget Summary** Update

Grant Program Function or Activity	CFDA Number	Estimated Unobligated Funds		New or Revised Budget		Total
		Federal	Non-Federal	Federal	Non-Federal	
Community Health Centers	93.224	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>Update Sub Program</b>	<b>Total</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

**Section B - Budget Categories** Update

Object Class Categories	Grant Program Function or Activity		Total
	Federal	Non-Federal	
Personnel	\$0.00	\$0.00	\$0.00
Fringe Benefits	\$0.00	\$0.00	\$0.00
Travel	\$0.00	\$0.00	\$0.00
Equipment	\$0.00	\$0.00	\$0.00
Supplies	\$0.00	\$0.00	\$0.00
Contractual	\$0.00	\$0.00	\$0.00
Construction	\$0.00	\$0.00	\$0.00
Other	\$0.00	\$0.00	\$0.00
<b>Total Direct Charges</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>
Indirect Charges	\$0.00	\$0.00	\$0.00
<b>Total</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

**Section C - Non Federal Resources** Update

Grant Program Function or Activity	Applicant	State	Local	Other	Program Income	Total
Community Health Centers	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>Total</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

Go to Previous Page Save Save and Continue

- Under **Section A – Budget Summary**, click the Update Sub Program button (**Figure 7, 1**).
  - The **Sub Programs – Update** page opens (**Figure 8**).
  - Select or unselect the sub programs. Only select the programs for which you are requesting funding.
  - Click the Save and Continue button.
  - The **Budget Information – Section A-C** page re-opens showing the selected sub program(s) under the Section A – Budget Summary (**Figure 9, 1**).

**Figure 8: Sub Programs – Update Page**

**Sub Programs - Update**

FUNDING LAPINE COMMUNITY HEALTH CENTER Due Date: 8/30/2014 11:59:00 PM (Due in: 0 days) | Section Status: Not Complete

Resources View

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Sub-Program	CFDA
Community Health Centers	93.224
<input checked="" type="checkbox"/> Health Care for the Homeless	93.224
<input type="checkbox"/> Migrant Health Centers	93.224
Public Housing	93.224

Cancel Save and Continue

**Figure 9: Section A – Budget Summary Showing Addition of Sub Program**

Grant Program Function or Activity	CFDA Number	Estimated Unobligated Funds		New or Revised Budget		
		Federal	Non-Federal	Federal	Non-Federal	Total
Health Care for the Homeless	93.224	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input type="checkbox"/> Migrant Health Centers	93.224	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Update Sub Program	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Update

- To enter or update the budget information for each sub program, click the Update button displayed in the top right corner of the Section A – Budget Summary header (Figure 9, 2).
  - The Section A – Update page opens.

**Figure 10: Section A – Update Page**

**Section A - Update**

FUNDING LAPINE COMMUNITY HEALTH CENTER Due Date: 8/30/2014 11:59:00 PM (Due in: 0 days) | Section Status: Not Complete

Resources View

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Fields with \* are required

Grant Program Function or Activity	CFDA Number	Estimated Unobligated Funds		New or Revised Budget		
		Federal	Non-Federal	Federal	Non-Federal	Total
Health Care for the Homeless	93.224	\$0.00	\$0.00	\$ 0.00	\$ 0.00	\$0.00
Migrant Health Centers	93.224	\$0.00	\$0.00	\$ 0.00	\$ 0.00	\$0.00
Total		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Cancel Save and Continue

- Under the **New or Revised Budget** section, in the Federal column, enter the amount of federal funds requested for the first 12-month period of the NAP project for each requested sub program (CHC, MHC, HCH, and/or PHPC) (Figure 10, 1). In the Non-Federal column, enter the non-federal funds in the budget for the first 12-month period for each requested sub program (Figure 10, 2). Do not enter amounts in the Estimated Unobligated Funds columns.

**IMPORTANT NOTE:** The federal amount refers only to the NAP funding request, not all federal grant funding that an applicant receives. The total federal amount cannot exceed \$650,000.

5. Click the Save and Continue button.
  - The **Budget Information – Section A-C** page re-opens displaying the updated New or Revised Budget under Section A – Budget Summary (**Figure 11**).

**Figure 11: Section A – Budget Summary Page after Update**

Section A - Budget Summary <span style="float: right;">Update</span>						
Grant Program Function or Activity	CFDA Number	Estimated Unobligated Funds		New or Revised Budget		
		Federal	Non-Federal	Federal	Non-Federal	Total
Health Care for the Homeless	93.224	\$0.00	\$0.00	\$30,000.00	\$0.00	\$30,000.00
Migrant Health Centers	93.224	\$0.00	\$0.00	\$20,000.00	\$0.00	\$20,000.00
Update Sub Program	Total	\$0.00	\$0.00	\$50,000.00	\$0.00	\$50,000.00

6. In Section B – Budget Categories, provide the federal and non-federal funding distribution across object class categories for the first 12-month period. Click the Update button provided at the top right corner of the Section B header (**Figure 12**).

**Figure 12: Section B – Budget Categories**

Section B - Budget Categories <span style="float: right;">Update</span>				
Object Class Categories	Grant Program Function or Activity		Total	
	Federal	Non-Federal		
Personnel	\$0.00	\$0.00	\$0.00	
Fringe Benefits	\$0.00	\$0.00	\$0.00	
Travel	\$0.00	\$0.00	\$0.00	
Equipment	\$0.00	\$0.00	\$0.00	
Supplies	\$0.00	\$0.00	\$0.00	
Contractual	\$0.00	\$0.00	\$0.00	
Construction	\$0.00	\$0.00	\$0.00	
Other	\$0.00	\$0.00	\$0.00	
Total Direct Charges	\$0.00	\$0.00	\$0.00	
Indirect Charges	\$0.00	\$0.00	\$0.00	
Total	\$0.00	\$0.00	\$0.00	

- The system navigates to the **Section B – Update** page (**Figure 13**).
7. Enter the federal dollar amount for each applicable object class category under the Federal column (**Figure 13, 1**).  
 In Year 1 only, up to \$150,000 may be requested for equipment (enter on the Equipment row) and/or minor alteration/renovation (enter on the Construction row). The one-time funding information entered in [Form 1B: BPHC Funding Request Summary](#) must be consistent with the request here in Section B of the SF-424A Budget Information form.
  8. Similarly, enter the non-federal dollar amount for each applicable object class category under the Non-Federal column (**Figure 13, 2**). Applicants must present the total budget for the NAP project,

which includes all non-grant funds (i.e., Non-Federal funding), including both program income and all other non-grant funding sources that support the NAP scope of project.

**Figure 13: Section B – Update Page**

**Section B - Update**

**Note(s):**  
 Total federal amount in Section B must be equal to the total new or revised budget, federal amount specified in budget summary (section A) \$50,000.00.  
 Total non-federal amount in Section B must be equal to the total new or revised budget, non-federal amount specified in budget summary (section A) \$0.00.

THIBOD LAFFINE COMMUNITY HEALTH CENTER Due Date: 8/30/2014 11:58:00 PM (Due in: 0 days) | Section Status: Not Complete

**Resources**  
 View  
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Fields with \* are required

**\* Section B - Budget Categories**

Object Class Categories	Grant Program Function or Activity		Total
	Federal	Non-Federal	
Personnel	\$ 0.00	\$ 0.00	\$0.00
Fringe Benefits	\$ 0.00	\$ 0.00	\$0.00
Travel	\$ 0.00	\$ 0.00	\$0.00
Equipment	\$ 0.00	\$ 0.00	\$0.00
Supplies	\$ 0.00	\$ 0.00	\$0.00
Contractual	\$ 0.00	\$ 0.00	\$0.00
Construction	\$ 0.00	\$ 0.00	\$0.00
Other	\$ 0.00	\$ 0.00	\$0.00
Indirect Charges	\$ 0.00	\$ 0.00	\$0.00
<b>Total</b>	\$0.00	\$0.00	\$0.00
<b>Total Budget specified in Budget Summary (Section A)</b>	\$50,000.00	\$0.00	\$50,000.00

Cancel Save and Continue

**IMPORTANT NOTES:**

- The total federal amount in Section B – Budget Categories must be equal to the total new or revised federal budget amount specified in Section A – Budget Summary (no greater than \$650,000).
- The total non-federal amount in Section B – Budget Categories must be equal to the total new or revised non-federal budget amount specified in Section A – Budget Summary.
- Adding/updating values in the Equipment and/or Construction categories will lead to specific selection options for the One Time Funding Request on Form 1B.

9. Click the Save and Continue button (Figure 13, 3) to navigate to the **Budget Information – Section A-C** page (Figure 7).
10. In Section C – Non-Federal Resources, click the Update button in the top right corner of Section C header to distribute the non-federal budget amount specified in Section A – Budget Summary across the applicable non-federal resources (Figure 14, 1). Include other non-NAP federal funds in the “other” category, if applicable. Program Income should be consistent with the Total Program Income (patient service revenue) presented in Form 3: Income Analysis.

Figure 14: Section C - Non-Federal Resources

Section C - Non Federal Resources							1 Update
Grant Program Function or Activity	Applicant	State	Local	Other	Program Income	Total	
Health Care for the Homeless	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
Migrant Health Centers	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
<b>Total</b>	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	

Go to Previous Page 2 Save Save and Continue

**IMPORTANT NOTE:** The total non-federal amount in Section C – Non-Federal Resources must be equal to the total new or revised non-federal budget amount specified in Section A – Budget Summary.

11. Click the Save and Continue button to proceed to the next form (Figure 14, 2).

### 2.2.2 Budget Information – Section D-F

The **Budget Information – Section D-F** page consists of the following three sections:

- Section D – Forecasted Cash Needs
- Section E – Federal Funds Needed for Balance of the Project
- Section F – Other Budget Information

Figure 15: Budget Information – Section D-F

**Budget Information - Section D-F**

Due Date: 11/28/2019 11:58:00 PM (Due in: 38 days) | Section Status: Not Complete

Resources

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Section D - Forecasted Cash Needs						1 Update
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total	
Federal	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
Non-Federal	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
<b>Total</b>	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	

Section E - Federal Funds Needed for Balance of the Project					2 Update
Grant Program	Future Funding Periods (Years)				
	5 First	Second	Third	Fourth	
Health Care for the Homeless	\$0.00	\$0.00	\$0.00	\$0.00	
Migrant Health Centers	\$0.00	\$0.00	\$0.00	\$0.00	
<b>Total</b>	\$0.00	\$0.00	\$0.00	\$0.00	

Section F - Other Budget Information		3 Update
Direct Charges	No information added.	
Indirect Charges	No information added.	
Remarks	No information added.	

Go to Previous Page 4 Save Save and Continue

To complete this form, follow the steps below:

1. Section D – Forecasted Cash Needs is optional and may be left blank. However, you may enter the amount of cash needed by quarter during the first year for both the federal and non-federal request by clicking the Update button in the top right corner of Section D (Figure 15, 1).

2. In Section E – Federal Funds Needed for Balance of the Project, click the Update button in the top right corner of Section E to request NAP funding for Budget Year 2 (Figure 15, 2). Enter the NAP funding requested for Year 2 in the “First” column under Future Funding Periods (Years), broken down for each proposed type of Health Center Program funding (CHC, MHC, HCH, and/or PHPC). (Figure 15, 5). The maximum amount that may be requested for Year 2 cannot exceed \$650,000. The Second, Third, and Fourth year columns must remain \$0.
3. In Section F – Other Budget Information, click the Update button provided in the top right corner of Section F to provide general information regarding direct and indirect charges (Figure 15, 3). This section is optional.
4. Finally, click the Save and Continue button on the **Budget Information – Section D-F** to proceed to the next form (Figure 15, 4).

### 2.2.3 Budget Narrative

Attach a budget narrative by clicking the Attach File button (Figure 16, 1). Once completed, click the Save and Continue button to proceed to the next form.

**IMPORTANT NOTE:** If using Excel or other spreadsheet documents, do not use multiple pages (sheets). Make sure that the information that needs to be viewed is set in the “Print Area” of the document if the Budget Narrative is presented as a spreadsheet.

Figure 16: Budget Narrative

## 2.3 Completing the Other Information section

The Other Information section consists of the Assurances, Disclosure of Lobbying Activities, and Appendices forms.

### 2.3.1 Completing the Assurances Form

The **Assurances** form verifies that you are aware of and agree to comply with all federal requirements should NAP funds be awarded. To complete this form, you must select ‘Agree’ on the certification question at the bottom of the form (Figure 17, 1). The name of the Authorizing Official will prepopulate when the application is submitted. Click on the Save and Continue button to proceed to the **Disclosure of Lobbying Activities** form.

Figure 17: Assurances

**Assurances**

Due Date: 07/10/2019 10:40:02 AM (Due in: 07 days) | Section Status: Not Complete

▼ Resources View

Application | Action History | Funding Opportunity Announcement | FOA Guidance | Application User Guide

**SF-424B: Assurances, Non-Construction**

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award, and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4726-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§409a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. 45 CFR 75, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

**Certification**

Name of the authorized certifying official: \_\_\_\_\_

Title: \_\_\_\_\_

Applicant organization: \_\_\_\_\_

I certify that I have read and agree to comply with the requirements of form SF 424B upon award of funds.

Agree  Do not agree

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

### 2.3.2 Completing the Disclosure of Lobbying Activities Form

Answer the question regarding lobbying activities. If yes, complete all sections of the **Disclosure of Lobbying Activities** form. If no, the remainder of the form is optional. Click the Save and Continue button to proceed to the **Appendices** form.

**IMPORTANT NOTE:** If you certify that you do NOT currently receive more than \$100,000 in federal funds and engage in lobbying activities, you are not required to complete the Disclosure of Lobbying Activities form.

### 2.3.3 Completing the Appendices Form

To complete the **Appendices** form, upload the following attachments by clicking the associated Attach File buttons:

- Attachment 1: Service Area Map and Table – required
- Attachment 2: Bylaws – required

- Attachment 3: Project Organizational Chart – required
- Attachment 4: Position Descriptions for Key Management Staff – required
- Attachment 5: Biographical Sketches for Key Management Staff – required
- Attachment 6: Co-Applicant Agreement – required for public center applicants that have a co-applicant board
- Attachment 7: Summary of Contracts and Agreements – as applicable
- Attachment 8: Sliding Fee Discount Schedule(s) – required
- Attachment 9: Collaboration Documentation – required
- Attachment 10: Articles of Incorporation – required for new applicants
- Attachment 11: Evidence of Nonprofit or Public Center Status – required for new applicants
- Attachment 12: Operational Plan – required
- Attachment 13: Floor Plans – required
- Attachment 14: Other Relevant Documents – as applicable

**IMPORTANT NOTE:** See Section 5.2 of HRSA’s SF-424 Two-Tier Application Guide at <http://www.hrsa.gov/grants/apply/applicationguide/sf424programspecificappguide.pdf> for attachment formatting Guidelines.

After completing the **Appendices** form, click the Save and Continue button to proceed to the **Program Specific Information – Status Overview** page.

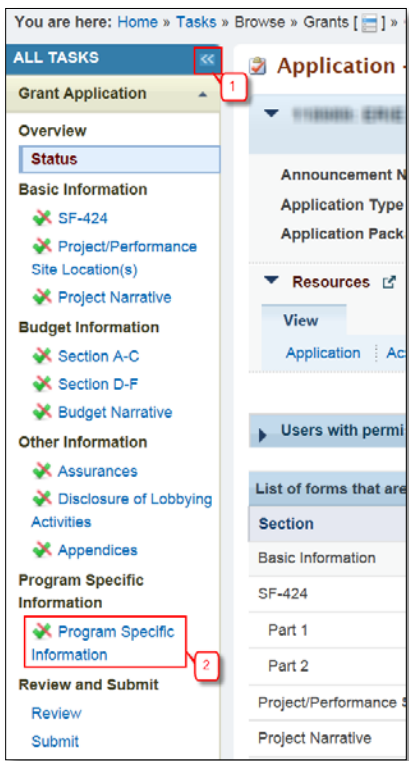
### 3. Completing the Program Specific Forms

1. Expand the left navigation menu if not already expanded by clicking the double arrows displayed near the form name at the top of the page (**Figure 18, 1**). Click the **Program Specific Information** link (**Figure 18, 2**) under the Program Specific Information section in the left menu to open the **Status Overview** page for the Program Specific Information forms (**Figure 19**). Click the **Update** link to edit a form (**Figure 19, 1**).

**IMPORTANT NOTE:** Your session remains active for 30 minutes after your last activity. Save your work every five minutes to avoid losing data.



Figure 18: Left Navigation Menu



**Figure 19: Status Overview Page for Program Specific Forms**

**Status Overview**

Announcement Number: HRSA-19-000 | Announcement Name: New Access Point | Due Date: (Due In: Days) | Program Specific Status: Not Complete

Grant Number: | Target Population: | Application Type: New

**Program Specific Information Status**

Section	Status	Options
<b>General Information</b>		
Form 1A - General Information Worksheet	Not Started	Update
Form 1C - Documents On File	Not Started	Update
Form 4 - Community Characteristics	Not Started	Update
<b>Budget Information</b>		
Form 1B - Funding Request Summary	Not Started	Update
Form 2 - Staffing Profile	Not Started	Update
Year 1	Not Started	Update
Form 3 - Income Analysis	Not Started	Update
<b>Sites and Services</b>		
Form 5A - Services Provided	Not Started	Update
Required Services	Not Started	Update
Additional Services	Not Started	Update
Form 5B - Service Sites	Not Started	Update
Form 5C - Other Activities/Locations	Not Started	Update
Alteration/Renovation (ARI) Information	Not Started	Update
<b>Other Forms</b>		
Form 6A - Current Board Member Characteristics	Not Started	Update
Form 6B - Request for Waiver of Governance Requirements	Not Started	Update
Form 8 - Health Center Agreements	Not Started	Update
Form 10 - Annual Emergency Preparedness Report	Not Started	Update
Form 12 - Organization Contacts	Not Started	Update
<b>Performance Measures</b>		
Clinical Performance Measures	Not Started	Update
Financial Performance Measures	Not Started	Update
<b>Other Information</b>		
Equipment List	Not Started	Update
Summary Page	Not Started	Update

[Return to Complete Status](#)

### 3.1 Form 1A: General Information Worksheet

**Form 1A - General Information Worksheet** provides a summary of information related to the applicant, proposed service area, and patient and visit projections. This form is comprised of the following sections:

- [Applicant Information](#) (Figure 20, 1)
- [Proposed Service Area](#) (Figure 20, 2)

Figure 20: Form 1A: General Information Worksheet

**Form 1A - General Information Worksheet**

Due Date: (Due In: Days) | Section Status:

Resources: View  
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Fields with \* are required

**1. Applicant Information**

Applicant Name:

\* Fiscal Year End Date: Select Option

Application Type: New

Grant Number: N/A

\* Business Entity: Select Option

- All
- Faith based
- Hospital
- State government
- City/County/Local Government or Municipality
- University
- Community based organization
- Other

\* Organization Type (Select all that apply)

If 'Other' please specify:   
 (maximum 100 characters)

**2. Proposed Service Area**

**Note(s):**  
 Applicants applying for Community Health Center (CHC) funding in Section A of the SF-424A Budget Information form must serve at least one MUA or MUP. Provide the IDs for all MUAs and/or MUPs within the service area proposed in this application.

**2a. Service Area Designation**

\* Select MUA/MUP  
 (Each ID must be an integer that is at least 5 but not greater than 12 digits. Use commas to separate multiple IDs, without spaces)

Find an MUA/MUP

- Medically Underserved Area (MUA) ID #
- Medically Underserved Population (MUP) ID #
- Medically Underserved Area Application Pending ID #
- Medically Underserved Population Application Pending ID #

**2b. Service Area Type**

**Note(s):**  
 You must select Urban or Rural. If you select Rural, Sparsely Populated may also be selected, if applicable.

\* Choose Service Area Type

- Urban
- Rural
  - Sparsely Populated - Specify population density by providing the number of people per square mile:  (Provide a value ranging from 0.01 to 7)

**2c. Patients and Visits**

**Unduplicated Patients and Visits by Population Type**

\* How many unduplicated patients are projected to be served by December 31, 2020?

Population Type	Projected by December 31, 2020 (January 1 - December 31, 2020)	
	Patients	Visits
* Total	<input type="text"/>	<input type="text"/>
* General Underserved Community (Include all patients/visits not reported in the rows below)	<input type="text"/>	<input type="text"/>
* Migratory and Seasonal Agricultural Workers and Families	<input type="text"/>	<input type="text"/>
* Public Housing Residents	<input type="text"/>	<input type="text"/>
* People Experiencing Homelessness	<input type="text"/>	<input type="text"/>

**Patients and Visits by Service Type**

Service Type	Projected by December 31, 2020 (January 1 - December 31, 2020)	
	Patients	Visits
* Total Medical Services	<input type="text"/>	<input type="text"/>
* Total Dental Services	<input type="text"/>	<input type="text"/>
Behavioral Health Services		
* Total Mental Health Services	<input type="text"/>	<input type="text"/>
* Total Substance Use Disorder Services	<input type="text"/>	<input type="text"/>
* Total Enabling Services	<input type="text"/>	<input type="text"/>

Go to Previous Page Save Save and Continue

### 3.1.1 Completing the Applicant Information Section

The **Applicant Information** section is pre-populated with application and grant-related information, as applicable. Complete this section by providing information in the following required fields (**Figure 21**):

1. In the 'Fiscal Year End Date' field, select month and day of the applicant organization's fiscal year end date (e.g., June 30) to inform HRSA of the expected audit submission timeline in the Federal Audit Clearinghouse (<https://harvester.census.gov/facweb/default.aspx>).
2. Select one category in the 'Business Entity' field. An applicant that is a Tribal or Urban Indian entity and meets the definition for a public or private entity should select the Tribal or Urban Indian category.
3. Select one or more categories for the 'Organization Type.' If you choose to select 'Other' as one of the Organization Type values (**Figure 21, 1**), you must specify the organization type.

**Figure 21: Applicant Information Section**

The screenshot shows a web form titled "1. Applicant Information". It contains several fields: "Applicant Name" (text input), "Fiscal Year End Date" (dropdown menu with "Select Option" selected), "Application Type" (New), "Grant Number" (N/A), "Business Entity" (dropdown menu with "Select Option" selected), and "Organization Type (Select all that apply)" (checkboxes). The "Other" checkbox is selected and circled in red, with a red "1" next to it. Below the "Other" checkbox is a text input field for specifying the organization type. A note at the bottom right indicates a maximum of 100 characters.

### 3.1.2 Completing the Proposed Service Area Section

The Proposed Service Area section is further divided into the following sub-sections:

- [2a. Service Area Designation](#)
- [2b. Service Area Type](#)
- [2c. Patients and Visits](#)
  - Unduplicated Patients and Visits by Population Type
  - Patients and Visits by Service Type

#### 3.1.2.1 Service Area Designation

In the **Select MUA/MUP** field (**Figure 22, 1**), select the options that best describe the designated service area you propose to serve. Enter ID number(s) for the MUA and/or MUP in the proposed service area. To find out if a designated MUA or MUP is located in your proposed service area, see <https://data.hrsa.gov/tools/shortage-area/mua-find>.

**IMPORTANT NOTE:** If you are applying for Community Health Centers funding, you must provide an ID number for at least one of the line items listed in this field. Otherwise, providing an MUA or MUP ID number is optional.

**Figure 22: Service Area Designation**

The screenshot shows a web form section titled "2a. Service Area Designation". At the top, there is a "Note(s)" box with a blue information icon and the text: "Applicants applying for Community Health Center funding must serve at least one MUA or MUP. Provide the IDs for all MUAs and/or MUPs within your service area." Below the note, the section title "2a. Service Area Designation" is displayed. Underneath, there is a red asterisk followed by the text "Select MUA/MUP" and a sub-note: "(Each ID must be a 5 digit integer. Use commas to separate multiple IDs, without spaces)". To the left of the input fields is a blue link that says "Find an MUA/MUP" with an external link icon. On the right side, there are four input fields, each preceded by an unchecked checkbox. The fields are: "Medically Underserved Area (MUA) ID #", "Medically Underserved Population (MUP) ID #", "Medically Underserved Area Application Pending ID #", and "Medically Underserved Population Application Pending ID #". A red square with the number "1" is positioned over the first input field.

**3.1.2.2 Service Area Type**

In the **Service Area Type** section (**Figure 23**), indicate whether the service area is Urban or Rural. If Rural is selected, then Sparsely Populated may also be selected. When Sparsely Populated is selected, also specify the population density by providing the number of people per square mile (values ranging from 0.01 to 7).

**IMPORTANT NOTE:** For information about rural populations, visit the Office of Rural Health Policy’s website ([http://www.hrsa.gov/ruralhealth/policy/definition\\_of\\_rural.html](http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html)).

**Figure 23: Service Area Type Section**

The screenshot shows a web form section titled "2b. Service Area Type". At the top, there is a "Note(s)" box with a blue information icon and the text: "You must select Urban or Rural. If you select Rural, Sparsely Populated may also be selected, if applicable." Below the note, the section title "2b. Service Area Type" is displayed. Underneath, there is a red asterisk followed by the text "Choose Service Area Type". To the right of this text are three radio button options: "Urban" (which is selected), "Rural", and "Sparsely Populated - Specify population density by providing the number of people per square mile: \_\_\_\_\_ (Provide a value ranging from 0.01 to 7)".

**3.1.2.3 Patients and Visits**

To complete this section, follow the steps below:

1. In the **Unduplicated Patients and Visits by Population Type** section, provide the total number of patients and visits projected to be served from January 1, 2020 to December 31, 2020 (**Figure 24, 1**). The system will auto-populate the number in the Total row of the Patients column under the 'Projected by December 31, 2020 (January 1 - December 31, 2020)' heading (**Figure 24, 3**) when you click the Save or Save and Continue button.
2. Provide the number of patients and visits that you project to serve annually under the 'Projected by December 31, 2020 (January 1 - December 31, 2020)' heading for each listed population type (**Figure 24, 2**). Patients and visits must not be duplicated across the population types (i.e., an individual can only be counted once as a patient).

**Figure 24: Unduplicated Patients and Visits by Population Type**

**IMPORTANT NOTES:**

- Projected values should include ONLY the number of new patients who are projected to receive services as a direct result of NAP funding from January 1, 2020 – December 31, 2020. Patient projections from this section will be added to the applicant’s overall Patient Target, if funded.
- For the population types corresponding to the sub programs selected in [Section A – Budget Summary](#) form of this application, the number of patients in the Projected by December 31, 2020 column (**Figure 24, 3**) must be greater than zero. For the remaining population types, zeroes are acceptable if there are no projected numbers.
- The number of projected visits (**Figure 24, 4**) must be greater than or equal to the number of projected patients (**Figure 24, 3**).
- The ‘General Underserved Community’ row should include all patients and visits not captured in the special populations rows.

3. In the **Patients and Visits by Service Type** section, provide the annual number of patients and visits that you project to serve from January 1, 2020 to December 31, 2020 for each applicable service type (**Figure 25, 1**). 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).

**Figure 25: Patients and Visits by Service Type**

#### **IMPORTANT NOTES:**

- For 'Total Medical Services' (**Figure 25, 2**), the number of patients must be greater than the number of patients you provide for each of the 'Total Dental', 'Total Mental Health', 'Total Substance Abuse Services', and 'Total Enabling Services' service types.
- The number of projected visits (**Figure 25, 4**) must be greater than or equal to the number of projected patients (**Figure 25, 3**).
- The Patients and Visits by Service Type section does not have a row for total numbers, since an individual patient may be included in multiple service type categories.

4. After completing all sections of **Form 1A**, click the Save and Continue button to save your work and proceed to the next form.

### **3.2 Form 1C: Documents on File**

**Form 1C - Documents on File** displays a list of documents to be maintained by your organization.

1. To complete **Form 1C**, enter the review/revision dates for each document listed on this form (Figure 26). The headings on Form 1C such as Clinical Staffing, etc., are also hyperlinks to the corresponding chapters of the Health Center Program Compliance Manual.

Figure 26: Form 1C: Documents on File

**Form 1C - Documents on File**

**Note(s):**

- Headers in the table below link to chapters in the [Compliance Manual](#), and the listed elements align with the Demonstrating Compliance elements in the manual.
- Policies noted with an asterisk (\*) indicate those that must be evaluated by the health center board at least once every 3 years in order to demonstrate compliance with Health Center Program requirements. For more information, review element d within [Chapter 19, Board Authority](#) of the Compliance Manual.
- Example date formats for use on this form are 01/15/2018, First Monday of every April, and bi-monthly (last rev 01/18).

Due Date:  (Due In:  Days) | Section Status:

Announcement Number: HRSA-19-080      Announcement Name: New Access Point      Application Type: New  
 Grant Number:       Target Population:       Total Funding Requested:

**Resources**

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Fields with \* are required

Section	Date of Latest Review/Revision (Maximum 100 characters)
<b>Clinical Staffing</b>	
* Procedures for Review of Credentials (element c)	<input type="text"/>
* Procedures for Review of Privileges (element d)	<input type="text"/>
<b>Coverage for Medical Emergencies During and After Hours</b>	
* Procedures for Responding to Emergencies During Hours of Operation (element b)	<input type="text"/>
* Procedures or Arrangements for After-Hours Coverage (element c)	<input type="text"/>
<b>Continuity of Care and Hospital Admitting</b>	
* Procedures for Hospitalized Patients (element b)	<input type="text"/>
<b>Sliding Fee Discount Program</b>	
* Sliding Fee Discount Policies (element b)	<input type="text"/>
* Procedures for Assessing Income and Family Size (element f)	<input type="text"/>
<b>Quality Improvement/Assurance</b>	
* QI/QA Program Policies (element a)	<input type="text"/>
* QI/QA Procedures or Processes (element c)	<input type="text"/>
* Systems for Protecting Confidentiality of Patient Information (element f)	<input type="text"/>
<b>Contracts and Subawards</b>	
* Procurement Procedures (element a)	<input type="text"/>
<b>Conflict of Interest</b>	
* Standards of Conduct (element a)	<input type="text"/>
<b>Financial Management and Accounting Systems</b>	
* Financial Management and Internal Control Systems (element a)	<input type="text"/>
* Procedures for Drawdown, Disbursement, and Expenditure (element c)	<input type="text"/>
<b>Billing and Collections</b>	
* Billing and Collections Systems and Procedures (element d)	<input type="text"/>
* Policies for Waiving or Reducing Fees (element h)	<input type="text"/>

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**IMPORTANT NOTE:** Examples of formats to provide dates on this form are 01/15/2019, First Monday of every April, bi-monthly (last rev 01/19).

2. After completing all sections of **Form 1C**, click the Save and Continue button to save your work and proceed to the next form.



### 3.3 Form 4: Community Characteristics

**Form 4: Community Characteristics** reports current service area and target population data for the NAP scope of the project (i.e. all NAP sites). “Service Area Population” refers to the entire population in the proposed service area.

To complete **Form 4**, follow the steps below:

1. Enter the Service Area Population (**Figure 27, 6**) and corresponding Target Population Number (**Figure 27, 7**) for each of the following categories. Target Population data is a subset of Service Area Population data, and in most cases, is greater than the number of patients projected on Form 1A. Patient data should not be used to report target population data since patients are typically a subset of all individuals targeted for service.
  - a. **Race and Ethnicity (Figure 27, 1)**
  - b. **Hispanic or Latino Ethnicity (Figure 27, 2)**
  - c. **Income as a Percent of Poverty Level (Figure 27, 3)**
  - d. **Principal Third Party Payment Source (Figure 27, 4)**

#### **IMPORTANT NOTES:**

- Information provided regarding race and/or ethnicity will be used only to ensure compliance with statutory and regulatory Governing Board requirements. Data on race and/or ethnicity collected on this form will not be used as an awarding factor.
- When entering data, the total Service Area Population Numbers for Race, Hispanic or Latino Ethnicity, Income as a Percent of Poverty Level, and Primary Third-Party Payment Source sections must be equal. Similarly, the total Target Population Numbers for Race, Hispanic or Latino Ethnicity, Income as a Percent of Poverty Level, and Primary Third-Party Payment Source sections must be equal.

2. To automatically calculate the Total Service Area Population Numbers and Total Target Population Numbers for all four sections, click on the Save and Calculate Total button (**Figure 27, 8**) under any of the sections. The system will also auto-calculate the population percentages.
3. Under the **Special Populations and Select Population Characteristics** section (**Figure 27, 5**), enter the Service Area Population and the corresponding Target Population Number for each population group listed. Individuals may be counted in multiple population groups, so the numbers in this section do not have to match those in the other sections of this form.

Figure 27: Form 4: Community Characteristics

**Form 4 - Community Characteristics**

**Note(s):**  
All information provided regarding race and/or ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements. Data on race and/or ethnicity collected on this form will not be used as an awarding factor.

Due Date: [ ] (Due In: [ ] Days) | Section Status: [ ]

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Fields with \* are required **1**

Race and Ethnicity <b>6</b>	Service Area Population	Service Area Percent	Target Population Number <b>7</b>	Target Population Percent
* Asian	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* Native Hawaiian	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* Other Pacific Islanders	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* Black/African American	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* American Indian/Alaska Native	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* White	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* More than One Race	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* Unreported/Declined to Report (if applicable)	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
Total	0		0	

Click the 'Save and Calculate Total' button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form. **8** Save and Calculate Total

Hispanic or Latino Ethnicity <b>2</b>	Service Area Population	Service Area Percent	Target Population Number	Target Population Percent
* Hispanic or Latino	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* Non-Hispanic or Latino	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* Unreported/Declined to Report (if applicable)	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
Total	0		0	

Click the 'Save and Calculate Total' button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form. Save and Calculate Total

Income as a Percent of Poverty Level <b>3</b>	Service Area Population	Service Area Percent	Target Population Number	Target Population Percent
* Below 100%	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* 100-199%	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* 200% and Above	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
Total	0		0	

Click the 'Save and Calculate Total' button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form. Save and Calculate Total

Principal Third Party Payment Source <b>4</b>	Service Area Population	Service Area Percent	Target Population Number	Target Population Percent
* Medicaid	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* Medicare	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* Other Public Insurance	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* Private Insurance	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* None/Uninsured	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
Total	0		0	

Click the 'Save and Calculate Total' button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form. Save and Calculate Total

Special Populations and Select Population Characteristics <b>5</b>	Service Area Population	Service Area Percent	Target Population Number	Target Population Percent
* Migratory/Seasonal Agricultural Workers and Families	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* People Experiencing Homelessness	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* Residents of Public Housing	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* School Age Children	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* Veterans	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* Lesbian, Gay, Bisexual and Transgender	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* HIV/AIDS-Infected Persons	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* Individuals Best Served in a Language Other Than English	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
* Other	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %
Please specify:	<input type="text"/>			
Approximately 1/8 page (Max 200 Characters without spaces): 200 Characters left. <b>9</b>	<input type="text"/>	0.00 %	<input type="text"/>	0.00 %

Go to Previous Page Save Save and Continue

#### **IMPORTANT NOTES:**

- If you select the sub programs related to special populations (i.e. MHC, HCH and/or PHPC) in the [Budget Information – Section A–C](#) form of this application, you must provide a value greater than zero (0) for the Service Area Population and Target Population Number for the corresponding ‘Migratory/Seasonal Agricultural Workers and Families,’ ‘Homeless,’ and/or ‘Residents of Public Housing’ line item(s), as appropriate for your funding selection.
- In the ‘Other’ row ([Figure 27, 9](#)), you may specify a population group that is not listed (if desired), and then enter the Service Area Population and the corresponding Target Population Number for the specified population group.

4. After completing all the sections on **Form 4**, click the Save and Continue button to save your work and proceed to the next form.

### **3.4 Form 1B: Funding Request Summary**

**Form 1B: Funding Request Summary** collects the funding request for the NAP application.

1. For each sub program you requested funding in [Section A – Budget Summary](#), enter **Operational Funds** ([Figure 28, 1](#)) for Year 1.
2. Enter an amount for **One-Time Funding** for Year 1 ([Figure 28, 2](#)), if appropriate.
3. The combined total of the Operational Funds for each sub program and the One-Time Funding for Year 1 must equal to the Total Federal funds requested in the [Section A – Budget Summary](#) form.

#### **IMPORTANT NOTES:**

- Before completing this form, the [SF-424A: Budget Information](#) forms must be completed. You must request Operational Funds that are greater than \$0 for every sub program you selected in the [Section A – Budget Summary](#) form in the standard section of this NAP application.
- You may request One-Time Funding for Year 1 of up to \$150,000. If requested, the One-Time Funding amount must match the sum of the ‘Equipment’ and ‘Construction’ rows in the [Section B – Budget Categories](#) form in the standard section of this NAP application.
- The combined total of the Operational Funds and the One-Time Funding for Year 1 must not exceed the NAP maximum funding amount of \$650,000.

**Figure 28: Form 1B: Funding Request Summary**

**Form 1B - Funding Request Summary**

**Note(s):**

- Before completing Form 1B, the SF-424A: Budget Information form must be completed.
- The Total Federal Funding Request for Year 1 on Form 1B must match the Total Federal Funds requested for Year 1 on the SF-424A. Go to Section A – Budget Summary in Budget Information form to edit the Total Federal Funds requested for Year 1.
- The one-time funding request on Form 1B must total the Equipment and Construction (minor A/R) line items on the SF-424A. Go to Section B – Budget Categories in Budget Information form to edit the Federal funds requested for Equipment and Construction (minor A/R).
- Go to Section E – Budget Estimates Of Federal Funds Needed For Balance Of The Project in Budget Information form to edit the Total Federal Funds requested for Year 2.

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Fields with \* are required

**Federal Funds Requested: Based on a 12-month Budget for each Budget Period**

Type of Health Center	Program	Year 1		Year 2		Funding Population Percentage
		Operational		Operational		
Community Health Centers	CHC-330(e)	\$0.00		\$0.00		0%
* Health Care for the Homeless	HCH-330(h)			\$0.00		0%
Migrant Health Centers	MHC-330(g)	\$0.00		\$0.00		0%
Public Housing Primary Care	PHPC-330(i)	\$0.00		\$0.00		0%
Total Operational Costs	<input type="button" value="Calculate"/>	\$0.00		\$0.00		
* One-Time Funding	<input type="button" value="Calculate"/>		\$0.00		\$0.00	
Total Federal Funding Requested	<input type="button" value="Calculate"/>	\$0.00		\$0.00		

**Note(s):**

- If you select 'N/A' below, the following forms will not be available in your application: Equipment List, A/R Project Cover Page, and Other Requirements for Sites.
- If you select 'Equipment only' below, you must include the equipment amount in the equipment line item in Section B – Budget Categories on the Budget Information form and complete the Equipment List form.
- If you select 'Minor alteration/renovation with equipment' below, you must include the minor A/R amount in the construction line item and the equipment amount in the equipment line item in Section B – Budget Categories on the Budget Information form and complete the Equipment List form, A/R Project Cover Page, and Other Requirements for Sites form.
- If you select 'Minor alteration/renovation without equipment' below, you must include the minor A/R amount in the construction line item in Section B – Budget Categories on the Budget Information form and complete the A/R Project Cover Page and Other Requirements for Sites form.

\* **One-Time Funding Request**

Indicate below if you are requesting one-time funding in year 1 for equipment and/or minor alteration/renovation (A/R).

**One-time funds will be used for:**

N/A  
 Minor alteration/renovation without equipment  
 Minor alteration/renovation with equipment  
 Equipment only

**Note(s):** If you indicate that you are requesting one-time funds, the system will require you to complete the applicable equipment and/or minor A/R forms. After providing required information in the relevant one-time funding forms, if you change the selected option above, the system will **delete** information from all one-time funding forms that are no longer applicable.

4. Click the **One-time funds will be used for:** radio button (Figure 28, 3) that describes how you will use one-time funds if requested (Equipment only, Minor alteration/renovation with equipment, or Minor alteration/renovation without equipment). Select the “N/A” radio button if you are not requesting **One-Time Funding**.

#### **IMPORTANT NOTES:**

- If the **Equipment** line item and **Construction** line item in Section B - Budget Categories have a dollar value, then the only option that may be selected would be “**Minor A/R with equipment**” ([Figure 28, 3](#)).
- If the **Equipment** line item has a dollar value and **Construction** line item does not have a dollar value in Section B - Budget Categories, then the only option that may be selected would be “**Equipment Only**” ([Figure 28, 3](#)).
- If the **Equipment** line item does not have a dollar value and **Construction** line item has a dollar value in Section B - Budget Categories, then the only option that may be selected would be “**Minor A/R without equipment**” ([Figure 28, 3](#)).
- If both the **Equipment** line item and **Construction** line item do not have any dollar value in Section B - Budget Categories, then the only option that may be selected would be “**N/A**” ([Figure 28, 3](#)).

5. Year 2 **Operational Funds** in **Form 1B** will be pre-populated with the federal funds requested for the first future funding year in [Section E - Budget Estimates of Federal Funds Needed for Balance of the Project](#) ([Figure 28, 4](#)).

#### **IMPORTANT NOTES:**

- In **Form 1B**, you will not be able to edit the information pre-populated from the standard section of the NAP application. If you need to edit this information, navigate to the [SF-424A: Budget Information](#) section of this application.
- Operational Funds requested for Year 2 for every sub program you selected in the [Section A – Budget Summary](#) form must be greater than \$0.
- Total Operational Funds requested for Year 2 should not exceed the yearly NAP maximum funding amount of \$650,000. You cannot request One-Time Funding for Year 2.

6. Click the Save and Continue button at the bottom of the screen to save your work and proceed to the next form.

## **3.5 Form 2: Staffing Profile**

**Form 2: Staffing Profile** reports the personnel supported by the total budget (federal and non-federal funds) for the first budget year (12 months) of the proposed project for all sites included on Form 5B: Service Sites. This form has the following sections:

- [Staffing Positions by Major Service Category](#)
  - Key Management Staff/Administration ([Figure 29, 1](#))
  - Facility and Non-Clinical Support ([Figure 29, 2](#))
  - Physicians ([Figure 29, 3](#))
  - Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives ([Figure 29, 4](#))
  - Medical ([Figure 29, 5](#))

- Dental ([Figure 29, 6](#))
- Behavioral Health (Mental Health and Substance Use Disorder) ([Figure 30, 7](#))
- Professional Services ([Figure 30, 8](#))
- Vision Services ([Figure 30, 9](#))
- Pharmacy Personnel ([Figure 30, 10](#))
- Enabling Services ([Figure 30, 11](#))
- Other Programs and Services ([Figure 30, 12](#))
- [Total FTEs](#) ([Figure 30, 13](#))

Figure 29: Form 2- Staffing Profile

**Form 2 - Staffing Profile**

**Note(s):**  
 The health center must directly employ its Project Director/CEO. Allocate staff time by function among the positions listed. An individual's full-time equivalent (FTE) should not be duplicated across positions. For example, a provider serving as a part-time family physician and a part-time Clinical Director should be listed in each respective category, with the FTE portion allocated to each position (e.g., Clinical Director 0.3 (30%) FTE and family physician 0.7 (70%) FTE). Do not exceed 1.0 FTE for any individual. Refer to the [most recent UDS manual](#) for position descriptions.

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**Key Management Staff/Administration**

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Project Director/Chief Executive Officer (CEO)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Finance Director/Chief Financial Officer (CFO)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Chief Operating Officer (COO)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Chief Information Officer (CIO)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Clinical Director/Chief Medical Officer (CMO)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Administrative Support Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

**Facility and Non-Clinical Support**

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Fiscal and Billing Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* IT Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Facility Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Patient Support Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

**Physicians**

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Family Physicians	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* General Practitioners	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Internists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Obstetricians/Gynecologists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Pediatricians	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Specialty Physicians Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

**Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives**

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Nurse Practitioners	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Physician Assistants	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Certified Nurse Midwives	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

**Medical**

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Nurses	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Medical Personnel (e.g. Medical Assistants, Nurse Aides)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Laboratory Personnel	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* X-Ray Personnel	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

**Dental**

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Dentists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Dental Hygienists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Dental Therapists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Dental Personnel Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

Figure 30: Form 2- Staffing Profile continued...

Behavioral Health (Mental Health and Substance Use Disorder)		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Psychiatrists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Licensed Clinical Psychologists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Licensed Clinical Social Workers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Licensed Mental Health Providers Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Mental Health Staff Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Substance Use Disorder Providers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Professional Services		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Other Professional Health Services Staff Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Vision Services		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Ophthalmologists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Optometrists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Vision Care Staff Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Pharmacy Personnel		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Pharmacy Personnel	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Enabling Services		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Case Managers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Patient/Community Education Specialists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Outreach Workers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Transportation Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Eligibility Assistance Workers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Interpretation Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Community Health Workers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Enabling Services Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Programs and Services		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Quality Improvement Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Programs and Services Staff Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Total FTEs		
Totals	Direct Hire FTEs	Contract/Agreement FTEs
Totals <input type="button" value="Calculate"/>	0	N/A

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### 3.5.1 Completing Form 2: Staffing Profile

1. In the Direct Hire FTEs column, provide the number of Full Time Employees (FTEs) directly hired by the health center and volunteers for each staffing position. Enter zero (0) if not applicable (**Figure 31, 1**).
2. In the Contract/Agreement FTEs column, indicate whether contracts are used for specific staff categories. (**Figure 31, 2**). Positions marked Yes should align with Attachment 7: Summary of Contracts and Agreements and Form 5A: Services Provided, Column II.
3. If both direct hire staff and contracts are used, provide the number of Direct Hire FTEs only and check Yes in the Contract/Agreement FTEs column.

#### IMPORTANT NOTES:

- Allocate staff time in the Direct Hire FTE column by function among the staff positions listed. An individual's FTE should not be duplicated across positions. For example, a provider serving as a part-time family physician and a part-time Clinical Director should be listed in each respective category with the FTE percentage allocated to each position (e.g., CMO 0.3 FTE and family physician 0.7 FTE). Do not exceed 1.0 FTE for any individual.
- For position descriptions, refer to the UDS Reporting Manual (<https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/reporting/2018-uds-reporting-manual.pdf>)
- The health center must directly employ its Project Director/CEO.

**Figure 31: Direct Hire and Contract/Agreement FTEs columns**

Key Management Staff/Administration	Direct Hire FTEs <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">1</span>	Contract/Agreement FTEs <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">2</span>
Staffing Positions by Major Service Category		
• Project Director/Chief Executive Officer (CEO)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
• Finance Director/Chief Financial Officer (CFO)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
• Chief Operating Officer (COO)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
• Chief Information Officer (CIO)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
• Clinical Director/Chief Medical Officer (CMO)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
• Administrative Support Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

4. To calculate the total Direct Hire FTEs, click on the Calculate button (**Figure 32**).

**Figure 32: Total FTEs**

Total FTEs		
Totals	Direct Hire FTEs	Contract/Agreement FTEs
Totals ⓘ <span style="border: 1px solid red; padding: 2px;">Calculate</span>	0	N/A
<a href="#">Go to Previous Page</a>	<a href="#">Save</a>	<a href="#">Save and Continue</a>

5. Click the Save and Continue button to save your work and proceed to the next form.

### 3.6 Form 3: Income Analysis

**Form 3: Income Analysis** collects the projected patient services and other income from all sources (other than the Health Center Program grant funds) for the **first year** of the proposed project. This form has the following sections:

- [Payer Category \(Figure 33, 1\)](#)
- [Comments/Explanatory Notes \(Figure 33, 2\)](#)

**Figure 33: Form 3: Income Analysis**

**Form 3 - Income Analysis**

**Note(s):**  
The value in the Projected Income (d) column should equal the value in the Billable Visits (b) column multiplied by the value in the Income per Visit (c) column. If not, explain in the Comments/Explanatory Notes box. In the Prior FY Income (e) column, enter the income data from the health center's most recent fiscal year audit or interim financial statement.

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Payer Category	Patients By Primary Medical Insurance (a)	Billable Visits (b)	Income Per Visit (c)	Projected Income (d)	Prior FY Income (e)
<b>Part 1: Patient Service Revenue - Program Income</b>					
* 1. Medicaid					
* 2. Medicare					
* 3. Other Public					
* 4. Private					
* 5. Self Pay					
6. Total (Lines 1 to 5)	0	0	N/A	\$0	\$0
<b>Part 2: Other Income - Other Federal, State, Local and Other Income</b>					
* 7. Other Federal	N/A	N/A	N/A		
* 8. State Government	N/A	N/A	N/A		
* 9. Local Government	N/A	N/A	N/A		
* 10. Private Grants/Contracts	N/A	N/A	N/A		
* 11. Contributions	N/A	N/A	N/A		
* 12. Other	N/A	N/A	N/A		
* 13. Applicant (Retained Earnings)	N/A	N/A	N/A		
14. Total Other (Lines 7 to 13)	N/A	N/A	N/A	\$0	\$0
<b>Total Non-Federal (Non-Health Center Program) Income (Program Income Plus Other)</b>					
15. Total Non-Federal Income (Lines 6+14)	N/A	N/A	N/A	\$0	\$0

Comments/Explanatory Notes (if applicable)  
Approximately 2 pages (Max 2500 Characters without spaces) 2500 Characters left

Go to Previous Page Save Save and Continue

#### 3.6.1 Completing the Payer Category section

The Payer Category section has the following sub-sections:

- Part 1: Patient Service Revenue - Program Income
- Part 2: Other Income - Other Federal, State, Local and Other Income
- Total Non-Federal (Non-Health Center Program) Income (Program Income Plus Other)

To complete the **Payer Category** section, follow the steps below:

1. In column (a), project the number of Patients by Primary Medical Insurance for each Payer Category in Part 1. Enter 0 if not applicable (**Figure 33, 3**).
2. In column (b), project the number of Billable Visits for each Payer Category in Part 1. Billable Visits should be greater than or equal to the number of Patients by Primary Medical Insurance in column (a). Enter zero (0) if not applicable (**Figure 33, 4**).
3. In column (c), provide the amount of Income per Visit for each Payer Category in Part 1. Enter zero (0) if not applicable. (**Figure 33, 5**).
4. In column (d), calculate the amount of Projected Income for each Payer Category in Parts 1 and 2. Enter zero (0) if not applicable (**Figure 33, 6**).
5. In column (e), provide the amount of Prior FY Income for each Payer Category in Parts 1 and 2. Enter zero (0) if not applicable (**Figure 33, 7**).
6. Click the Calculate Total and Save button to calculate and save the values for each Payer Category in Parts 1 and 2. (**Figure 33, 8**).

#### **IMPORTANT NOTES:**

- In the Patient Service Revenue - Program Income section, the value in the Projected Income (d) column should equal the value in the Billable Visits (b) column multiplied by the value in the Income per Visit (c) column. If not, provide an explanation in the [Comments/Explanatory Notes](#) box.
- The Patients by Primary Medical Insurance (a), Billable Visits (b) and Income Per Visit (c) columns in Part 2 are disabled and set to 'N/A'.

7. Click the Calculate Total and Save button in the **Total Non-Federal (Non-Health Center Program) Income (Program Income Plus Other)** section to calculate and save Total Non-Federal Income (**Figure 33, 9**).

### **3.6.2 Completing the Comments/Explanatory Notes section**

In this section, enter any comments/explanations related to this form.

1. As applicable, provide an explanation for each Payer Category for which Projected Income (d) is not equal to the value obtained by multiplying Billable Visits (b) with Income per Visit (c).
2. Note significant exclusions and/or additions to the Billable Visits data in the comments box.
3. Click Save and Continue to save your work and proceed to **Form 5A: Services Provided**.

## **3.7 Form 5A: Services Provided**

**Form 5A – Services Provided** identifies the services to be provided and how they will be provided by the applicant organization. You may provide required and additional services directly, by contracting with another provider, or by referral to another provider. These modes of service provision differ according to the service provider and the payment source (**Table 1**). See the Form 5A Column Descriptors at <https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/scope/form5acolumndescriptors.pdf> for descriptions and requirements for each of the three service delivery modes. All referral arrangements/agreements for services noted on Form 5A as provided via Column II and/or III must be formal written arrangements/agreements.

**Table 1: Modes of Service Provision**

Mode of Service Provision	Your Organization Provides the Service	Your Organization Pays for the Service
1. Column I – Service provided directly by health center ( <a href="#">Figure 34, 3</a> )	Yes	Yes
2. Column II – Service provided by formal written contract/agreement ( <a href="#">Figure 34, 4</a> )	No	Yes
3. Column III – Service provided by formal written referral arrangement ( <a href="#">Figure 34, 5</a> )	No	No

Only one form is required regardless of the number of proposed sites. **Form 5A – Services Provided** has the following two sections:

- [Required Services](#) ([Figure 34, 1](#))
- [Additional Services](#) ([Figure 34, 2](#))

**Figure 34: Form 5A – Services Provided (Required Services)**

**Form 5A - Services Provided (Required Services)**

**Note(s):**  
Select service delivery methods for services as applicable to the proposed NAP project. For more information, refer to the [Service Descriptors for Form 5A: Services Provided](#) and the [Column Descriptors for Form 5A: Services Provided](#).

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Required Services | Additional Services

Service Type	Column I - Direct (Health Center Pays)	Column II - Formal Written Contract/Agreement (Health Center Pays)	Column III - Formal Written Referral Arrangement (Health Center DOES NOT Pay)
General Primary Medical Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic Laboratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic Radiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Screenings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coverage for Emergencies During and After Hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Voluntary Family Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Well Child Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gynecological Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obstetrical Care			
Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intrapartum Care (Labor & Delivery)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Postpartum Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preventive Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharmaceutical Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HCH Required Substance Use Disorder Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eligibility Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outreach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Translation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Go to Previous Page | Save | Save and Continue

### 3.7.1 Completing the Required Services Section

To complete this section of **Form 5A**, follow the instructions below:

1. Check one or more boxes to indicate the service delivery mode(s) for each of the required services as applicable to the proposed NAP project (**Figure 34, 3-5**). See the Form 5A Service Descriptors at <https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/scope/form5aservicedescriptors.pdf> for descriptions of the general elements for all services.
2. Click the Save and Continue button to navigate to the **Additional Services** section OR click the Save button on the **Required Services** section and select the **Additional Services** tab (**Figure 34, 2**).

**IMPORTANT NOTES:**

- You must select Column I and /or Column II for the 'General Primary Medical Care' (**Figure 34, 6**) service row for your application to be eligible for funding.
- If you are applying to receive "Health Care for the Homeless" (HCH) sub program funding, as noted in the Budget Information: [Section A - Budget Summary](#) form, then you must select at least one service delivery method for the 'HCH Required Substance Use Disorder Services' service row (**Figure 34, 7**) in the Required Services section. If you are not requesting HCH sub program funding, this row will be disabled in your application.

### **3.7.2 Completing the Additional Services Section**

The Additional Services section of **Form 5A** is optional. You are not required to identify modes of provision for any additional services listed in this section. However, if you will provide additional services in scope through the proposed NAP project, follow the instructions below to complete this section of **Form 5A**:

1. Check one or more boxes to indicate the service delivery mode(s) for additional services as applicable to the proposed NAP project (**Figure 34**).

**IMPORTANT NOTE:** If you are not applying to receive HCH sub program funding, as noted in the Budget Information: [Section A - Budget Summary](#) form, you will not be able to select 'HCH Required Substance Use Disorder Services' in the Required Services section. However, you may select 'Substance Use Disorder Services' in the Additional Services section (**Figure 35, 1**).

**Figure 35: Form 5A – Services Provided (Additional Services)**

**Form 5A - Services Provided (Additional Services)**

**Note(s):**

- Select service delivery methods for additional services as applicable to you. If you do not wish to propose service delivery methods for any of the additional services listed below, click on 'Save' or 'Save and Continue' button at the bottom of this section.
- For more information on Form 5A, refer to [Form 5A Column Descriptors](#).

00161257: Wayne Enterprises Due Date: 01/25/2019 (Due In: 45 Days) | Section Status: Not Started

**Resources**

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Fields with \* are required

Required Services **Additional Services**

Service Type	Column I - Direct (Health Center Pays)	Column II - Formal Written Contract/Agreement (Health Center Pays)	Column III - Formal Written Referral Arrangement (Health Center DOES NOT Pay)
Additional Dental Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use Disorder Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recuperative Care Program Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environmental Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech-Language Pathology/Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complementary and Alternative Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Enabling/Supportive Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Go to Previous Page Save Save and Continue

- After completing **Form 5A**, click the Save and Continue button to save your work and proceed to the next form.

### 3.8 Form 5B: Service Sites

**Form 5B: Service Sites** identifies the sites where you will provide services and/or perform administrative tasks for the NAP project.

You will be able to propose the following types of sites in this form:

- Service Delivery Site
- Administrative/Service Delivery Site
- Admin-only Site

**IMPORTANT NOTE:** You are required to propose at least one 'Service Delivery' or 'Administrative/Service Delivery' site in the NAP application.

To propose a new site, follow the steps below:

- Click the Add New Site button ([Figure 36](#)) provided above the **Proposed Sites** section.

**Figure 36: Add New Site Button**

**Form 5B - Service Sites**

**Note(s):**

- If you are requesting funding to target the general underserved community (CHC), residents of public housing (PHPC), or people experiencing homelessness (HCH), you must propose at least one new Service Delivery site or Administrative/Service Delivery site with the Location Type as 'Permanent' and operating for at least 40 hours.
- If you are proposing to serve ONLY migrant and seasonal agricultural workers (MHC), you must propose at least one new Service Delivery site or Administrative/Service Delivery site with the Location Type as 'Permanent' or 'Seasonal' and operating for at least 40 hours.

Due Date: (Due In: Days) | Section Status:

**Resources**

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**Add New Site** 1

**Proposed Sites**

No sites added

Go to Previous Page | Save | Save and Continue

- The system navigates to the **Service Site Checklist** page.
2. Answer the questions displayed on the **Service Site Checklist** page.

**IMPORTANT NOTES:**

- The answer to question 1 must be 'No' (**Figure 37, 1**) if you will provide required or additional services at the site being added through your NAP application.
- To qualify as a service site, you must select 'Yes' for questions 'a' through 'd'.
- Indicate if the site being added is a domestic violence site by answering 'Yes' or 'No' to question 2 (**Figure 37, 2**). Domestic Violence site is a confidential site serving victims of domestic violence and the site address cannot be published due to the necessity to protect the location of the domestic violence shelter.
- If the answer to question 1 is 'Yes' (**Figure 37, 1**), i.e. if the site being added is an 'Admin-only' site, the remaining questions are not applicable.



Figure 37: Service Site Checklist page

**Service Site Checklist**

Due Date: 03/15/2018 (Due In: 00 Days)

Resources

Fields with \* are required

**Site Qualification Criteria**

\* 1. Is the site an "admin-only" site? 1  Yes  No  
If Yes, the site is an 'Admin-only' site, select 'Not Applicable' for questions 'a' to 'd' below. If No, the site is a Service Delivery site, answer questions 'a' to 'd' Yes or No.

a. Are/will health center visits be generated by documenting in the patients records face-to-face contacts between patients and providers?  Yes  No  Not Applicable

b. Do/will providers exercise independent judgment in the provision of services to the patient?  Yes  No  Not Applicable

c. Are/will services be provided directly by or on behalf of the grantee, whose governing board retains control and authority over the provision of the services at the location?  Yes  No  Not Applicable

d. Are/will services be provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every month)?  Yes  No  Not Applicable

\* 2. Is the site a Domestic Violence (Confidential) shelter? 2  Yes  No  Not Applicable

[Go to Previous Page](#) 3 [Verify Qualification](#)

3. Click the Verify Qualification button (Figure 37, 3).
  - The system navigates to the **List of Pre-Registered Performance Sites at HRSA Level** page displaying all the sites that are registered by your organization within EHB.
4. To use a new location for the site you are proposing in **Form 5B**, click the Register Performance Site button (Figure 38, 1) and register your site using the Enterprise Site Repository (ESR) system by following the steps below:
  - On the Basic Information – Enter page, provide a site name and select a site type from the following options: Fixed or Mobile. Click the Next Step button.
  - On the Address – Enter page, enter the physical address of the site. The NAP funding opportunity requires you to provide a verifiable physical street address when registering a new site for your application. Click the Next Step button.
  - On the Register – Confirm page, the system displays physical address you entered on the Address – Enter page along with the standardized format of the address. Select the option you want and click the Confirm button.
  - On the Register – Result page, click the Finish button to register the site to your organization.

**Figure 38: List of Pre-Registered Performance Sites at HRSA Level page**

**List of Pre-registered Performance Sites at HRSA Level**

**Note(s):**

- Click on 'Register Performance Site' to register a new Performance Site at HRSA level. Select a site and click on 'Update the Registered Performance Site' button to update the site information. Select a site and click on 'Select This Location' button to complete adding the site.
- Ensure that the Site Address of the selected site is accurate before adding it to your NAP application. To be eligible, sites must have a street address.

Due Date: 10/15/2019 (Due In: 90 Days)

Resources

Register Performance Site **1**

List of Pre-registered Performance Sites

Site Name	Performance Site Type <sup>(1)</sup>	Performance Site Address	Performance Site Address Category	Options
NEDH-Richmond	Fixed	4021 Kennedy Rd, Wood-Richmond, VA 23092-7300	Accurate <b>3</b>	Select Site Location <b>2</b>
NEDH-Lexington	Fixed	802 Stage Boulevard STE 201/202, Richmond, VA 23062	Accurate	Select Site Location
Tri-Cities Community Health-Pasco Medical	Fixed	818 W Court St, Pasco, WA 99021-0707	Accurate	Select Site Location <b>4</b>
Richmond	Fixed	1111 Main, Richmond, VA 23021	Accurate	Select Site Location
NEDH - Pasco (2019)	Fixed	818 W Court St, Pasco, WA 99021-0707	Accurate	Select Site Location
NEDH-Asheville Community (2019)	Fixed	800 W. Vineyard Dr., Harrisville, VA 26036-8001	Approximate	Select Site Location
ONE LA CLAYTON HENDERSON	Fixed	1018 W. Clearwater Ave STE 6, Harrisville, VA 26036-1018	Accurate	Select Site Location
Benton-Pasco Counties Detox Center	Fixed	1000 E 7th Ave, Pasco, WA 99021-0706	Accurate	Select Site Location

Cancel

- Select a site for the NAP from the list of pre-registered performance sites and click its **Select Site Location** link (Figure 38, 2). Standardized addresses will be listed as “Accurate” (Figure 38, 3). If the address is “Approximate,” ensure that the site address entered is a verifiable physical street address.

**IMPORTANT NOTE:** The system disables the **Select Site Location** link (Figure 38, 4) for the sites under any of the categories mentioned below. You will not be able to select such a site location:

- If the site is already included in the current application.
- If the site is already in your Health Center Program scope or in another award recipient’s Health Center Program scope with active or pending verification status.
- If the site is a Mobile site and applicant is trying to propose an “Admin-only” site.
- If the site is a confidential site and the applicant is trying to propose a non-confidential/non-domestic violence site.
- If the site is a non-confidential site and the applicant is trying to propose a confidential/domestic violence site.

In any of these cases, the system provides you the reasons for which the site is disabled when you hover over the **Select Site Location** link (Figure 38, 4).

- If you wish to update the name of any site on the list of pre-registered performance sites, click the **Update the Registered Performance Site** link (Figure 39) and update the site name.

**Figure 39: Update the Registered Performance Site link**

List of Pre-registered Performance Sites				
Site Name	Performance Site Type	Performance Site Address	Performance Site Address Category	Options
Test 1	Fixed	300 MAIN STREET, HAMPTON, VA 23107-2077	Accurate	Select Site Location
Test 2	Fixed	507 LIBERTY STREET, PHOENIX, AZ 85014-2713	Accurate	Select Site Location
Test 3	Fixed	4000 Orange Park Blvd, Orlando, FL 32816	Approximate	Select Site Location
Test 4	Fixed	1000 HOPKINS STREET, PHOENIX, AZ 85014-2713	Accurate	Select Site Location
Test 5	Fixed	4000 Orange Park Blvd, Orlando, FL 32816	Accurate	Select Site Location

Action

- Select Site Location
- Update the Registered Performance Site

- When you click the **Select Site Location** link of a site, the system navigates to the **Form 5B: Edit** page where you must provide all the required information for the site (Figure 40). Fields marked with an asterisk (\*) are required.

**Figure 40: Form 5B: Edit page**

**Form-5B : Edit**

**Note(s):**  
It is recommended that you save your work often (e.g., every 5 minutes) to avoid a loss of data due to unforeseeable technical issues.

Fields with \* are required for all site types.

**Site Information** Status: Not Started

<p>* Name of Service Site <input type="text" value="Change Site Name"/></p> <p>* Service Site Type <input type="text" value="Administrative Site"/></p> <p>* Web URL <input type="text"/></p>	<p>* Site Physical Address <input type="text"/></p> <p>* Site Phone Number ( ) - - Ext</p>
---	--

The following fields are required for "Service Delivery" and "Administrative/Service Delivery" site types, other than where exceptions are noted:

<p>* Location Type <input type="text" value="Permanent"/></p> <p>Date Site was Added to Scope <input type="text" value="N/A"/></p> <p>FQHC Site Medicare Billing Number Status <input type="text" value="Select Medicare Billing Number Status"/></p> <p>FQHC Site National Provider Identification (NPI) Number <input type="text"/></p> <p>Months of Operation <input type="text"/></p> <p>Saved Months of Operation <input type="text"/></p> <p>Number of Contract Service Delivery Locations (Voucher Screening Only) <input type="text"/></p> <p>* Site Operated by <input type="text" value="Select Site Operated By"/></p>	<p>* Location Setting (Required for Service Site) <input type="text" value="Select Site Setting"/></p> <p>* Site Operational By <input type="text"/></p> <p>* Medicare Billing Number <input type="text"/></p> <p>* Total Hours of Operation (When patients will be served per week) <input type="text"/></p> <p>Number of Intermittent Sites (Intermittent Only) <input type="text"/></p>
---	--

Add Subrecipient/Contractor

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By'... (+ View More))

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN	Options
---	--	-----------------------------	---------

No Subrecipient or Contractor information to be displayed

Service Area Zip Code (Include only those from which the majority of the patient population will come)

\* Service Area Zip Codes

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Saved Service Area Zip Code(s)

Go to Previous Page
Save Save and Continue

**IMPORTANT NOTES:**

- If you are proposing to serve Community Health Center, Public Housing Primary Care, and/or Health Care for the Homeless (with or without Migrant Health Center), you must propose at least one Service Delivery site or Administrative/Service Delivery site that has a Location Type as 'Permanent', and that operates for at least 40 hours a week.
- If you are requesting only Migrant Health Center funding (based on the sub program you selected in the [Section A – Budget Summary](#) form), you must propose at least one Service Delivery site or Administrative/Service Delivery site that has a Location Type as "Permanent" or "Seasonal," and that operates for at least 40 hours a week.

8. For Service Delivery sites, complete the form by following the steps below:

- The name, address, and service site type populate from the list of pre-registered performance sites.
- Select a Location Setting (i.e., all other clinic types, hospital, or school) and Location Type (i.e., permanent, seasonal, or mobile).
- Enter the date that the site will be or became operational. The date must be no more than 120 days after the project start date.
- Select the Medicare billing status and enter Medicare billing number, if applicable. Enter 'N/A' if you do not have a billing number.
- Enter the total hours of operation per week for the site.
- Select whether the site is operated by the health center/applicant, contractor, or subrecipient.
- If the site is operated by a contractor or subrecipient, you must enter information about the operating organization.
- Enter the zip codes for the NAP service area. After each five zip codes entered, click Save Zip Codes, to save and add more, if applicable.

**IMPORTANT NOTES:**

- The zip codes entered in **Form 5B** will be used to calculate the Unmet Need Score for your application. See the NAP technical assistance webpage at <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP> for additional information.
- You must add the zip code included in the physical address of the site in the Service Area Zip Codes field of **Form 5B: Edit** page.

9. After providing the complete information on **Form 5B – Edit** page, click the **Save and Continue** button.

- **Form 5B – Service Sites** list page opens with the newly added site displayed in the **Proposed Site** section ([Figure 41](#)).

**Figure 41: Newly added site displayed under Proposed Sites section**

**Form 5B - Service Sites**

**Note(s):**

- If you are proposing to serve Community Health Centers, Public Housing Health Centers or Homeless Health Centers with or without Migrant Health Centers, you must propose at least one new Service Delivery site or Administrative/Service Delivery site with Location Type as 'Permanent' and operating for at least 40 hours.
- If you are proposing to serve only Migrant Health Centers, you must propose at least one new Service Delivery site or Administrative/Service Delivery site with Location Type as 'Permanent' or 'Seasonal' and operating for at least 40 hours.

**Success:**  
Site added Successfully

Due Date: 10/15/2018 (Due In: 11 Days) | Section Status: Complete

**Resources**

[Add New Site](#)

**Proposed Sites**

Site Name	Physical Address	Service Site Type	Location Type	Site Status	Performance Site Address Category	Options
		All	All	All		
12345 Main St	4567 Main St, Unit 1234 Portland, OR 97201-1234	Administrative/Service Delivery Site	Permanent	Complete	Accurate	<a href="#">Update</a>

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

10. To add additional sites, follow the steps 1-9 above. Once you have completed **Form 5B** for each NAP site, click the Save and Continue button to save your work and proceed to the next form.

### 3.9 Form 5C: Other Activities/Locations

**IMPORTANT NOTE:** This is an optional form. If you do not want to propose any other activities or locations in your application, you can click on the Save and Continue button provided at the bottom of the form to complete it.

**Form 5C – Other Activities/Locations** identifies other activities or locations associated with your NAP project. To add new activities or locations, follow the steps below:

- Click the Add New Activity/Location button provided at the top of the form (**Figure 42**).

**Figure 42: Add New Activity/Location button**

**Form 5C - Other Activities/Locations**

Due Date:

**Resources**

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[Add New Activity/Location](#)

**Activity/Location Information**

Type of Activity	Frequency of Activity	Description of Activity	Type of Location(s) where Activity is Conducted	Status	Options
No other activities/locations added.					

[Go to Previous Page](#) [Save and Continue](#)

- The system navigates to the **Activity/Location - Add** page (**Figure 43**).

**Figure 43: Activity/Location – Add page**

Fields with \* are required

**Activity/Location Information**

\* Type of Activity   
If Other, Please Specify

\* Frequency of Activity

\* Description of Activity

\* Type of Location(s) where Activity is Conducted

2. Provide information in all the fields on this page and click the Save and Continue button.
  - The system navigates to the **Form 5C** list page displaying the newly added activity on the form (**Figure 44**). Once the activity is added, it can be updated or deleted as needed.

**Figure 44: Activity/Location added**

Activity Type	Description	Frequency	Type of Location	Status	Options
<input type="text" value="Hospital Admitting"/>	<input type="text" value="Admitting patients to hospitals"/>	<input type="text" value="Daily"/>	<input type="text" value="Permanent"/>	<input type="text" value="All"/>	<input type="button" value="Update"/>

3. After completing **Form 5C**, click the Save and Continue button to save your work and proceed to the next form.

### 3.10 Alteration/Renovation (A/R) Information

#### IMPORTANT NOTES:

- If you requested One-Time Funding for Year 1 in [Form 1B: Funding Request Summary](#) and indicated that you will be using these funds for minor alteration/renovation (with or without equipment), you will be required to complete the Alteration/Renovation (A/R) Information page, consisting of the [Alteration/Renovation \(A/R\) Project Cover Page](#) and [Other Requirements for Sites](#) forms for at least one service site proposed in [Form 5B: Service Sites](#) of this NAP application.
- If you did not request One-Time Funding for minor alteration/renovation in [Form 1B: Funding Request Summary](#), this form will not apply to you ([Figure 45](#)). If the form is not applicable to you, click the Continue button to proceed to the next form.

Figure 45: A/R Information Page – “Not Applicable” Message

The screenshot shows the 'Alteration/Renovation (A/R) Information' page. At the top, it displays the organization name 'SEPTICIDE ALBANY AREA PRIMARY HEALTH CARE, INC.' and the due date 'Due Date: 02/26/2016 (Due In: 36 Days) | Section Status: Complete'. Below this, there is a yellow alert box with a warning icon. The alert text reads: 'Alert: This form is not applicable to you as in Form 1B of this application, one of the following is true:'. The list of reasons includes: 'You have not requested one-time funding, or', 'You have requested one-time funding but not indicated how you plan to use these funds, or', and 'You have requested one-time funding for equipment only use'. At the bottom of the page, there are two buttons: 'Go to Previous Page' on the left and 'Continue' on the right.

When the **Alteration/Renovation (A/R) Information** page is applicable to you, the system populates all the ‘Service Delivery’ and ‘Administrative/Service Delivery’ sites you proposed in the [Form 5B – Service Sites](#) form of this NAP application ([Figure 46, 1](#)). Any ‘Administrative-only’ sites proposed in [Form 5B: Service Sites](#) will *not* be listed on the A/R Information page because you cannot use one-time funds for alteration or renovation of an ‘Administrative-only’ site. Follow the steps below to complete this form:

Figure 46: A/R Information Page when Applicable

The screenshot shows the 'Select site' page with a table of sites. The table has five columns: 'Site Name', 'Physical Address', 'Are you requesting federal one-time funding for minor alteration/renovation at this site?', 'Status', and 'Options'. There are two rows of data. The first row has a site name 'Test Test', physical address 'Tested, 00 20171', a 'Yes' radio button selected, status 'Not Started', and an 'Update' button. The second row has a site name 'Test Test', physical address '00, 00 20000', a 'Yes' radio button selected, status 'Not Started', and an 'Update' button. Red boxes and numbers 1, 2, and 3 are overlaid on the image to highlight the site name, the 'Yes' radio button, and the 'Update' button respectively. At the bottom of the page, there are three buttons: 'Go to Previous Page', 'Save', and 'Save and Continue'.

1. Answer whether you are requesting federal one-time funding for minor alteration/renovation at each site by clicking “Yes” or “No” ([Figure 46, 2](#)).
2. For each site for which you clicked “Yes”, click the Update button ([Figure 46, 3](#)) to complete the [Alteration/Renovation \(A/R\) Project Cover Page](#) and [Other Requirements for Sites](#) forms ([Figure 47](#)).

**IMPORTANT NOTES:**

- If you requested One-Time Funding for Year 1 in [Form 1B: Funding Request Summary](#) and indicated that you will be using these funds for minor alteration and renovation, you must answer 'Yes' for the one-time funding question for at least one site listed on this form.
- You will be required to complete the [Alteration/Renovation \(A/R\) Proposal Cover Page](#) and [Other Requirements for Sites](#) forms for each site for which you answer 'Yes' for the one-time funding question.
- You will not be able to provide A/R information for sites for which you answer 'No' for the one-time funding question.

**3.10.1 Alteration/Renovation (A/R) Project Cover Page**

1. On the **A/R Project Cover Page**, answer all the questions and attach the documents as requested. Fields and attachments marked with an asterisk (\*) are required.
2. After you have completed the **A/R Project Cover Page (Figure 47)**, click the Save and Continue button at the bottom of the screen to save your work and proceed to the **Other Requirements for Sites** section.

**IMPORTANT NOTE:** For the Environmental Information Documentation (EID) checklist, download the template to your computer, complete the form, and attach it to your application in the form.



Figure 47: A/R Project Cover Page

**Alteration/Renovation (A/R) Project Cover Page**

**Note(s):**

- Please provide project cover page details for the site below.
- To save the information entered in this page, click on the "Save" button or use the "Save and Continue" button to go to the next section. To return to the previous section, click on the "Go to Previous Page" button. The form will not be marked as COMPLETE if any information required below is missing or is incorrect.

**Due Date:** \_\_\_\_\_

**Resources**

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Fields with \* are required

**Alteration/Renovation (A/R) Project Cover Page** [Other Requirements for Sites](#)

**1. Site Information**

Name of Service Site \_\_\_\_\_

Site Address \_\_\_\_\_

Improved Project Square Footage \_\_\_\_\_

**2. Project Description**

- Provide a detailed description of the scope of work of the minor A/R project. Identify the major clinical and non-clinical spaces that will result from or be improved by the project.
- List key improvements, such as permanently affixed equipment to be installed; modifications and repairs to the building exterior (including windows); HVAC modifications (including the installation of climate control and duct work); electrical upgrades; and plumbing work.
- Describe how potential adverse impacts on the environment will be minimized. Indicate whether, and if so, how the project will implement green/sustainable design practices/principles (e.g., using project materials, design/renovation strategies).

Approximately 2 pages (Max 4000 Characters without spaces): 4000 Characters left

*[Rich Text Editor]*

**3. Project Management/Resources/Capabilities**

- Explain the oversight for the minor A/R project, including the Project Manager and the Project Team, if applicable, responsible for managing the project.
- Describe how the Project Team has the expertise and experience necessary to successfully manage and complete the project within the time frame and achieve the goals and objectives established for this project.

Approximately 2 pages (Max 4000 Characters without spaces): 4000 Characters left

*[Rich Text Editor]*

**4. Is the proposed minor alteration/renovation project part of a larger scale renovation, construction, or expansion project?**

Provide a response below.

Yes  No

**Attachments**

Provide following documents related to this site:

**A/R Project Budget Justification (Minimum 1) (Maximum 1)** [Attach File](#)

No documents attached

**Environmental Information Documentation (EID) Checklist**

[Download Template](#)

Name	Description	Options
EID Checklist	Template for EID Checklist	<a href="#">Download</a>

**BID Checklist (Minimum 1) (Maximum 1)** [Attach File](#)

No documents attached

**Floor Plans/Schematic Drawings (Minimum 1) (Maximum 2)** [Attach File](#)

No documents attached

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

### 3.10.2 Other Requirements for Sites

Applicants requesting one-time funding for minor alteration/renovation must complete the **Other Requirements for Sites** form for each site where minor alteration/renovation activities will occur. This form addresses site control, federal interest, and cultural resources and historic preservation considerations related to the minor A/R project. To complete this form:

1. Answer all the questions on the form.
2. If the site is a leased property, you must attach a Landlord Letter of Consent in the Attachments section.
3. Click the Save and Continue button at the bottom of the form.
  - You will be returned to the **A/R Information Page** with the list of proposed sites.

**Figure 48: Other Requirements for Sites**

**Other Requirements for Sites**

**Note(s):**

- Please provide project cover page details for the site below.
- To save the information entered in this page, click on the "Save" button or use the "Save and Continue" button to go to the next section. To return to the previous section, click on the "Go to Previous Page" button. The form will not be marked as COMPLETE if any information required below is missing or is incorrect.

**Success:**  
Information entered on Other Requirements for Sites was saved successfully. This form is now Complete.

**Due Date:**

**Resources**

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Fields with \* are required

Alteration/Renovation (A/R) Project Cover Page **Other Requirements for Sites**

**Site Information**

Name of Service Site  
Site Address

**1. Site Control and Federal Interest**

\* 1a. Identify current status of property site (If 'Leased', please answer Question 1b)

Owned  Leased

\* 1b. If Leased, please check the following:

The applicant certifies the following:

- The existing lease will provide you reasonable control of the project site for at least a period of 5 years after the renovation is completed.
- The existing lease is consistent with the proposed scope of project.
- You understand and accept the terms and conditions regarding Federal Interest in the property.

**2. Cultural Resource Assessment and Historic Preservation Considerations**

\* 2a. Was the project facility constructed prior to 1975?

Yes  No

\* 2b. Is the project facility 50 years or older?

Yes  No

\* 2c. Does any element of the overall work at the project site include:

- Any renovation/modifications to the exterior of the facility (for example: roof, HVAC, windows, siding, signage, exterior painting, generators, etc.) or
- Ground disturbance activity (for example: expansion of building footprint, parking lot, sidewalks, utilities, etc.)?

Yes  No

\* 2d. Does the project involve renovation to a facility that is, or near a facility that is, architecturally, historically, or culturally significant?

Yes  No

\* 2e. Is the site located on or near Native American, Alaskan Native, Native Hawaiian, or equivalent culturally significant lands?

Yes  No

**Attachments**

If property status is 'Leased', applicant must provide Landlord Letter of Consent.

Landlord Letter of Consent (Maximum 1) Attach File

No documents attached

4. After you have completed the A/R Information, click the Save and Continue button at the bottom of the form to save your work and proceed to the next form.

**IMPORTANT NOTES:**

- If you add a new 'Service Delivery' or an 'Administrative/Service Delivery' site in [Form 5B: Service Sites](#) after completing the A/R Information form, you will be required to revisit the A/R Information page to answer the one-time funding question for that site and provide the A/R information for the site, as applicable.
- If you remove a site from [Form 5B: Service Sites](#), then the site will be removed from the A/R Information page.

### 3.11 Form 6A: Current Board Member Characteristics

**Form 6A: Current Board Member Characteristics** provides information about your organization's current board members.

**IMPORTANT NOTES:**

- This form is optional if you selected "Tribal" or "Urban Indian" as the Business Entity in [Form 1A: General Information Worksheet](#). You can click the Save or the Save and Continue button at the bottom of the page to proceed to the next form.
- If you chose a Business Entity other than "Tribal" or "Urban Indian," you must enter all required information on **Form 6A**.
- If **Form 6A** is optional for you, but you choose to enter information, then you must enter all required information.

Applicants are required to list all the current board members and provide the requested details. For existing award recipients submitting a satellite NAP application, the system will pre-populate the board member information from the last awarded Health Center Program application. Applicants will have the option to update or delete the pre-populated information and add board members, as applicable.

To complete **Form 6A**, follow the steps below:

1. To add information for a board member, click the Add New Board Member button ([Figure 49, 1](#)). You must provide a minimum of 9 and maximum of 25 board members.

**Figure 49: Form 6A Current Board Member Characteristics**

**Form 6A - Current Board Member Characteristics**

**Note(s):**  
For satellite applicants, the system will pre-populate the list of board members. Update pre-populated information as applicable.

**Success:**  
Board Member Information added successfully

**Due Date:**

**Resources**

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Fields with \* are required

**Add New Board Member** 1

**List of All Board Member(s)**

Name	Current Board Office Position Held	Area of Expertise	>10% of Income from health industry	Health Center Patient	Live or Work in Service Area	Special Population Representative	Options
							Update <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">2</span>
							Update
							Update
							Update
							Update
							Update
							Update
							Update

**Patient Board Member(s) Classification**

Gender	Number of Patient Board Members
* Male	
* Female	
* Unreported/Declined to Report	
<b>Ethnicity</b>	<b>Number of Patient Board Members</b>
* Hispanic or Latino	
* Non-Hispanic or Latino	
* Unreported/Declined to Report	
<b>Race</b>	<b>Number of Patient Board Members</b>
* Native Hawaiian	
* Other Pacific Islanders	
* Asian	
* Black/African American	
* American Indian/Alaska Native	
* White	
* More Than One Race	
* Unreported/Declined to Report	

**Note(s):**  
An answer to the question below is required if you selected Public (non-Tribal or Urban Indian) as the Business Entity on Form 1A of this application. In all other cases, select N/A.

**If you are a public organization/center, do the board members listed above represent a co-applicant board?**

Yes  No  N/A

If yes, ensure that the co-applicant agreement is included as Attachment 6 in the Appendices form of this application.

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

➤ The system navigates to the **Current Board Member - Add** page (Figure 50).

2. Provide the required board member information on this page. Click the Save and Continue button to save the information and navigate back to the **Form 6A** list page (Figure 50, 1), or the Save and Add New button to save the information and add a new board member (Figure 50, 2).

Figure 50: Current Board Member – Add Page

3. To update or to delete information for any board member, click on **Update** or **Delete** link under the options column in the **List of All Board Members** section (Figure 49, 2).
4. Enter the gender, ethnicity, and race of board members who are patients of the health center in the **Patient Board Member Classification** sections (Figure 49, 3).

**IMPORTANT NOTES:**

- The totals of each Patient Board Member Classification section must be equal.
  - The total number of patient board members under each classification section should be less than or equal to the total number of board members added in the List of All Board Members section.
5. If you selected Public (non-Tribal or Urban Indian) as the business entity in [Form 1A: General Information Worksheet](#) of this application, select ‘Yes’ or ‘No’ for the public organization/center related question. If you selected a different business entity in [Form 1A](#), select ‘N/A’ for this question. If you answer ‘Yes’ to this question, ensure that the Co-applicant Agreement is included as **Attachment 6** in the **Appendices** form of this application.
  6. After providing all the necessary information on **Form 6A**, click the Save and Continue button to save the information and proceed to the next form.

### 3.12 Form 6B: Request for Waiver of Governance Requirements

If you are proposing to serve only Migrant Health Center, Health Care for the Homeless, and/or Public Housing Primary Care, **Form 6B** is used to request a waiver of the 51% patient majority governance requirement. Note that HRSA will not grant a waiver request if your organization currently receives or is applying for Community Health Center (CHC) funding.

### 3.12.1 Completing Form 6B when it is not applicable

Form 6B will not be applicable in the following cases:

- You selected “Tribal” or “Urban Indian” as the Business Entity in [Form 1A: General Information Worksheet](#).
- You are currently receiving Community Health Centers (CHC) funding, or you selected CHC as one of the sub programs in the Budget Information: [Section A - Budget Summary](#) form of this application.

If the form is not applicable to you, click the Continue button to proceed to the next form ([Figure 51, 1](#)).

**Figure 51: Form 6B: Request for Waiver of Governance Requirements – Not Applicable**

**Form 6B - Request for Waiver of Governance Requirements**

Due Date: 10/15/2018 (Due In: 00 Days) | Section Status: Complete

Resources

**Alert:**  
This form is not applicable to you as you are currently receiving or applying to receive Community Health Centers (CHC) funding and/or you have selected 'Tribal' or 'Urban Indian' as the Business Entity in Form 1A.

Go to Previous Page

Continue

### 3.12.2 Completing Form 6B when it is applicable

To complete **Form 6B** when it is applicable and necessary for your organization, follow the steps provided below:

1. Indicate whether you are requesting a new waiver of the 51% patient majority governance requirement under the **New Waiver Request** section ([Figure 52, 1](#)) or if you currently have a waiver in the **For Applicants With Previous Waiver** section ([Figure 52, 2](#)).

**Figure 52: Form 6B: Request for Waiver of Governance Requirements – Applicable**

2. If you answered ‘Yes’ to question 2a, you must answer ‘Yes’ or ‘No’ for question 2b. Select ‘N/A’ for question 2b if you answered ‘No’ to question 2a.
3. If you answered ‘Yes’ to question 1 or question 2b, you must answer the remaining questions on the form.
4. After completing **Form 6B**, click the Save and Continue button to save your work and proceed to the next form.

### 3.13 Form 8: Health Center Agreements

**Form 8** indicates whether 1) you have a parent, affiliate, or subsidiary organization; and/or 2) you have or propose to utilize:

- Contract(s) with another organization to perform substantive programmatic work within the proposed scope of project; or
- Subaward(s) to carry out a portion of the proposed scope of project. The purpose of a subaward is to carry out a portion of the federal award and creates a federal assistance relationship with the subrecipient.

This form has the following sections:

- [Part I: Health Center Agreements \(Figure 53, 1\)](#)
- [Part II: Adding Organization Agreement details \(Figure 53, 2\)](#)

Figure 53: Form 8 – Health Center Agreements

**Form 8 - Health Center Agreements**

**Note(s):**  
If a Health Center Program award recipient wishes to enter into an additional agreement/arrangement post-award that will either (1) result in another organization carrying out a substantial portion of the approved scope of project or (2) impact the governing board's composition, authorities, functions, or responsibilities, a Prior Approval request must be submitted in EHB and approved by HRSA before the agreement/arrangement can be formalized and implemented.

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Fields with \* are required

**PART I: Health Center Agreements**

\* 1. Does your organization have a parent, affiliate, or subsidiary organization?  Yes  No

\* 2. Do you currently have, or propose to utilize: a) Contract(s) with another organization to perform substantive programmatic work within the proposed scope of project? *For the purposes of the Health Center Program, contracting for substantive programmatic work applies to contracting with a single entity for the majority of health care providers.*  
Or  
b) Subawards to carry out a portion of the proposed scope of project. *The purpose of a subaward is to carry out a portion of the Federal award and creates a Federal assistance relationship with the subrecipient.*

**Note(s):**

- Subawards or contracts made to related organizations such as a parent, affiliate, or subsidiary must also be addressed in this form.
- The acquisition of supplies, material, equipment, or general support services (e.g., janitorial services, contracts with individual providers) is not considered programmatic work.

If **Yes**, indicate the number of each agreement by type in 2a and/or 2b below and complete Part II. If **No, Part II is Not Applicable**.

2a. Number of contracts with another organization to perform substantive programmatic work within the proposed scope of project.  (positive integer up to 4 digits)

2b. Number of subawards made to subrecipients to carry out a portion of the proposed scope of project.  (positive integer up to 4 digits)

2c. **Total** number of contracts and/or subawards for a substantial portion of the proposed scope of project.

**Save and Calculate**

**Add Organization Agreement**

**Part II: Attachments**  
All contracts or subawards, including those which involve a parent, affiliate, or subsidiary organization referenced in Part I must be uploaded in full. Uploaded documents will NOT count against the page limit.

No organization agreement details added

**Go to Previous Page** **Save** **Save and Continue**

### 3.13.1 Completing Part I: Health Center Agreements

To complete Part I of **Form 8**, follow the steps below:

1. Answer question 1 ([Figure 54, 1](#)) and question 2 ([Figure 54, 2](#)). Select 'Yes' for question 2 if any current or proposed agreements exist with another organization to perform substantive programmatic work within the scope of project. For the purposes of the Health Center Program, contracting for substantive programmatic work applies to contracting with a single entity for most of health care providers.

**IMPORTANT NOTE:** If any of the new sites proposed in [Form 5B: Service Sites](#) are being operated by a "Subrecipient" or a "Contractor", the system will set the answer for question 2 to 'Yes'.



Figure 54: Form 8, Part I

**Form 8 - Health Center Agreements**

**Note(s):**  
If a Health Center Program award recipient wishes to enter into an additional agreement/arrangement post-award that will either (1) result in another organization carrying out a substantial portion of the approved scope of project or (2) impact the governing board's composition, authorities, functions, or responsibilities, a Prior Approval request must be submitted in EHB and approved by HRSA before the agreement/arrangement can be formalized and implemented.

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Fields with \* are required

**PART I: Health Center Agreements**

\* 1. Does your organization have a parent, affiliate, or subsidiary organization?  Yes  No

\* 2. Do you currently have, or propose to utilize: a) Contract(s) with another organization to perform substantive programmatic work within the proposed scope of project? For the purposes of the Health Center Program, contracting for substantive programmatic work applies to contracting with a single entity for the majority of health care providers.  
Or  
b) Subawards to carry out a portion of the proposed scope of project. The purpose of a subaward is to carry out a portion of the Federal award and creates a Federal assistance relationship with the subrecipient.

**Note(s):**

- Subawards or contracts made to related organizations such as a parent, affiliate, or subsidiary must also be addressed in this form.
- The acquisition of supplies, material, equipment, or general support services (e.g., janitorial services, contracts with individual providers) is not considered programmatic work.

If Yes, indicate the number of each agreement by type in 2a and/or 2b below and complete Part II. If No, Part II is Not Applicable.

2a. Number of contracts with another organization to perform substantive programmatic work within the proposed scope of project.  (positive integer up to 4 digits)

2b. Number of subawards made to subrecipients to carry out a portion of the proposed scope of project.  (positive integer up to 4 digits)

2c. Total number of contracts and/or subawards for a substantial portion of the proposed scope of project.  **Save and Calculate**

**Add Organization Agreement**

**Part II: Attachments**  
All contracts or subawards, including those which involve a parent, affiliate, or subsidiary organization referenced in Part I must be uploaded in full. Uploaded documents will NOT count against the page limit.  
No organization agreement details added

**Go to Previous Page** **Save** **Save and Continue**

- If 'Yes' was selected for question 2, complete questions 2a and 2b (Figure 54, 3-4). Click Save and Calculate to show the total number of contracts or subawards in 2c (Figure 54, 5).

### 3.13.2 Completing Part II: Adding Organization Agreement details

If you answered 'Yes' to questions 1 or 2, provide each agreement with external organizations as noted in Part I. The agreements will be organized by organization. To add agreements, follow the steps below:

- Click the Add Organization Agreement button located above Part II (Figure 55, 1).

Figure 55: Form 8, Part II

**Add Organization Agreement**

**Part II: Attachments**  
All contracts or subawards, including those which involve a parent, affiliate, or subsidiary organization referenced in Part I must be uploaded in full. Uploaded documents will NOT count against the page limit.  
No organization agreement details added

**Go to Previous Page** **Save** **Save and Continue**

- The system navigates to the **Organization Agreement - Add** page (Figure 56).

**Figure 56: Organization Agreement – Add page**

2. Provide the required information for the agreement in the **Organization Agreement Detail** section on this page (Figure 56, 1).
3. Under the **Attachments** section at the bottom of this page, click on the Attach File button (Figure 56, 2) to upload at least one document related to the organization (i.e., the complete affiliation agreement, contract, and/or subaward).

**IMPORTANT NOTE:** Before uploading a document for Form 8, rename the file to include the affiliated organization’s name (e.g., “CincinnatiHospital\_MOA.doc”).

4. Click Save and Continue to return to **Form 8: Health Center Agreements** list page. Following the steps described above, add as many organizations and corresponding agreements as referenced in [Part I](#). This form will accept a maximum of five document uploads for 10 organizations
5. After completing **Form 8**, click the Save and Continue button to save your work and proceed to the next form.

### 3.14 Form 10: Emergency Preparedness Report

**Form 10: Emergency Preparedness Report** assesses your organization’s overall emergency readiness. To complete this form, follow the steps below:

1. Complete all sections of this form by selecting a ‘Yes’ or ‘No’ response for each question (Figure 56).
2. After completing **Form 10**, click the Save and Continue to save and proceed to the next form.

Figure 56: Form 10 –Emergency Preparedness Report

**Form 10 - Annual Emergency Preparedness Report**

Due Date: \_\_\_\_\_

**Resources**

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Fields with \* are required

**Section I : Emergency Preparedness and Management (EPM) Plan**

\* 1. Has your organization conducted a thorough Hazards Vulnerability Assessment?  
If Yes, date completed: \_\_\_\_\_ (mm/dd/yyyy)  Yes  No

\* 2. Does your organization have an approved EPM plan?  
If Yes, date that the most recent EPM plan was approved by your Board: \_\_\_\_\_ (mm/dd/yyyy)  Yes  No  
If No, skip to Readiness section below.

3. Does the EPM plan specifically address the four disaster phases?  
This question is mandatory if you answered Yes to Question 2.

3a. Mitigation  Yes  No

3b. Preparedness  Yes  No

3c. Response  Yes  No

3d. Recovery  Yes  No

4. Is your EPM plan integrated into your local/regional emergency plan?  
This question is mandatory if you answered Yes to Question 2.  Yes  No

5. If No, has your organization attempted to participate with local/regional emergency planners?  
This question is mandatory if you answered Yes to Question 2 and No to Question 4.  Yes  No

6. Does the EPM plan address your capacity to render mass immunization/prophylaxis?  
This question is mandatory if you answered Yes to Question 2.  Yes  No

**Section II : READINESS**

\* 1. Does your organization include alternatives for providing primary care to the current patient population if you are unable to do so during emergency?  Yes  No

\* 2. Does your organization conduct annual planned drills?  Yes  No

\* 3. Does your organization's staff receive periodic training on disaster preparedness?  Yes  No

\* 4. Will your organization be required to deploy staff to Non-Health Center sites/locations according to the emergency preparedness plan for the local community?  Yes  No

\* 5. Does your organization have arrangements with Federal, State and/or local agencies for the reporting of data?  Yes  No

\* 6. Does your organization have a back-up communication system?

6a. Internal  Yes  No

6b. External  Yes  No

\* 7. Does your organization coordinate with other systems of care to provide an integrated emergency response?  Yes  No

\* 8. Has your organization been designated to serve as a point of distribution for providing antibiotics, vaccines and medical supplies?  Yes  No

\* 9. Has your organization implemented measures to prevent financial/revenue and facilities loss due to an emergency?  
(e.g. Insurance coverage for short-term closure)  Yes  No

\* 10. Does your organization have an off-site back up of your information technology system?  Yes  No

\* 11. Does your organization have a designated EPM coordinator?  Yes  No

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

### 3.15 Form 12: Organization Contacts

Use **Form 12: Organization Contacts** to provide contact information for the proposed project.

New applicants will provide the requested contact information. For existing award recipients submitting a satellite application, the system will pre-populate the contact information from the latest awarded Health Center Program application.

To complete this form, follow the steps below:

1. Enter contact information for the Chief Executive Officer, Contact Person, Chief Medical Officer, Dental Director (optional), and Behavioral Health Director (optional) by clicking on the Add button (Figure 57, 1, 2, 3, 4,5).

Figure 57: Form 12 – Organization Contacts

Form 12 - Organization Contacts

Note(s):  
For satellite applicants, the system will pre-populate this form. Update as applicable.

Due Date:

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Fields with \* are required

Contact Information	Name	Highest Degree	Email	Phone Number	Option
* Chief Executive Officer					1 Add Chief Executive Officer
* Contact Person					2 Add Contact Person
* Chief Medical Officer					3 Add Chief Medical Officer
Dental Director					4 Add Dental Director
Behavioral Health Director					5 Add Behavioral Health Director

Go to Previous Page Save Save and Continue

2. Click on the **Add/Update** link to add or update the information for each type of contact.
  - The system directs you to the data entry page for the corresponding contact.
3. To delete the contact information already provided, click on the **Delete** link under the options column.

**IMPORTANT NOTE:** The **Update** and the **Delete** links will be only displayed once you have added the contact information.

4. Enter the required information on this page.

Figure 58: Chief Executive Officer – Add page

The screenshot shows a web form titled "Chief Executive Officer - Add". At the top right, it displays "Due Date: 1/17/2018 (Due In: 18 Days)". Below the title is a "Resources" section. A note states "Fields with \* are required". The form is titled "Add New Contact Information" and contains the following fields: Position Title (pre-filled with "Chief Executive Officer"), Prefix (dropdown menu "Select Option"), First Name (required), Last Name (required), Middle Initial, Suffix (dropdown menu "Select Option" with a text input for "If 'Other', please specify:" and a "(maximum 100 characters)" label), Highest Degree (dropdown menu "Select Option" with a text input for "If 'Other', please specify:" and a "(maximum 100 characters)" label), Email Address (required), and Phone Number (with separate boxes for area code, number, and extension, and an "Ext." label). At the bottom, there are three buttons: "Cancel", "Save", and "Save and Continue".

5. Click Save to save the information and remain on the same page or click Save and Continue to save the information and proceed to the **Form 12: Organizations Contact** page to add information for the next contact.
6. After providing complete information on **Form 12**, click the Save and Continue button to save the information and proceed to the next form.

### 3.16 Clinical Performance Measures

The **Clinical Performance Measures** form collects the goals and performance measures for the NAP project.

**IMPORTANT NOTE:** See the NAP technical assistance webpage at <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP> for more information on completing the **Clinical Performance Measures** form.

The **Clinical Performance Measures** form displays **Required Measures** and **Additional Measures**. The **Required Measures** are HRSA-defined measures; applicants are required to provide requested information for all required measures. **Additional Measures** are self-defined and optional.

#### 3.16.1 Completing the Required Clinical Performance Measures

To complete this form:

1. Click on the **Update** link to start working on a performance measure (**Figure 59, 1**).

Figure 59: Clinical Performance Measures page

**Clinical Performance Measures**

Due Date:

Resources

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Add Additional Performance Measure

Collapse Group | Detailed View

Focus Area	Performance Measure	Baseline Data	Baseline Year	Projected Data	Status	Options
			All		All	
<b>Required Measures</b>						
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.				Not Complete	Update
Screening for Depression and Follow-up Plan	Percentage of patients 12 years of age and older screened for depression on the date of the visit using an age appropriate standardized depression screening tool AND, if screening is positive, a follow-up plan is documented on the date of the positive screen				Not Complete	Update
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3 -17 years of age who had a medical visit and evidence of height, weight, and BMI percentile documentation, and who had documentation of (1) counseling for nutrition, and (2) counseling for physical activity during the measurement period				Not Complete	Update
Body Mass Index (BMI) Screening and Follow-up Plan	Percentage of patients age 18 years and older with a BMI documented during the most recent medical visit during the measurement period, or within the twelve months prior to that visit, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the medical visit or during the previous twelve months of the most recent medical visit with the BMI outside of normal parameters				Not Complete	Update
Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90 mm Hg) during the measurement period				Not Complete	Update
Low Birth Weight	Percentage of babies of health center prenatal care patients born whose birth weight was below normal (less than 2,500 grams)				Not Complete	Update
Early Entry into Prenatal Care	Percentage of prenatal care patients who entered prenatal care during their first trimester				Not Complete	Update
Childhood Immunization Status	Percentage of children 2 years of age who were fully immunized by their second birthday				Not Complete	Update
Cervical Cancer Screening	Percentage of women 21-64 years of age, who were screened for cervical cancer using either of the following criteria: 1) Women age 21-64 who had cervical cytology performed every three years, or 2) Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years				Not Complete	Update
Tobacco Use: Screening and Cessation Intervention	Percentage of patients 18 years of age and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention, if identified as a tobacco user				Not Complete	Update
Use of Appropriate Medications for Asthma	Percentage of patients 5-64 years of age with a diagnosis of persistent asthma and who were appropriately ordered medication during the measurement period				Not Complete	Update
Coronary Artery Disease (CAD): Lipid Therapy	Percentage of patients 18 years of age and older with a diagnosis of coronary artery disease (CAD) who were prescribed a lipid-lowering therapy				Not Complete	Update
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and had documentation of use of aspirin or another antiplatelet during the measurement period.				Not Complete	Update
Colorectal Cancer Screening	Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer				Not Complete	Update
HIV Linkage to Care	Percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 90 days of diagnosis				Not Complete	Update
Dental Sealants for Children Between 6-9 Years	Percentage of children, 6 through 9 years of age, at moderate to high risk for cavities, who received a sealant on a permanent first molar during the measurement period				Not Complete	Update

Go to Previous Page

Save Save and Continue

**IMPORTANT NOTE:** The Clinical Performance Measures form will be 'Complete' when the status of all required measures and additional measures are 'Complete'.

- The system navigates to the Clinical Performance Measure – Update page (Figure 60).

Figure 60: Clinical Performance Measure - Update page

2. Provide a **Target Goal Description**, for each performance measure (Figure 60, 1). For all required measures, the **Numerator** and **Denominator** descriptions are pre-populated (Figure 60, 2).
3. For Baseline Data, enter the year of the data provided and the numerator and denominator values based on the descriptions given. Use the Calculate Baseline button to calculate the baseline percentage (Figure 60, 4).
4. Enter the goal under **Projected Data (by December 31, 2020)** as a percentage (Figure 60, 3).
5. Select 'EHR', "Chart Audit", or 'Other' as the **Data Source**. If 'Other' is selected, specify the data source. Describe the **Methodology** used to collect and analyze data.
6. Click on the Add New Key Factor and Major Planned Action button to add Key factors (Figure 60, 5).

- The system navigates to the **Key Factor and Major Planned Action – Add** page (Figure 61).

7. Provide information for at least one restricting and one contributing Key Factor type.

**Figure 61: Key Factors and Major Planned Action - Add page**

8. Click the Save and Continue button (Figure 61, 1) to save the information on this page and proceed to the **Clinical Performance Measures – Update** page, or click the Save and Add New button (Figure 61, 2) to save the information on this page and proceed to add a new key factor.
9. Provide comments in the Comment field if needed (Figure 60, 6).
10. Click on the Save button to save the information on this page (Figure 60, 7). To go to the **Clinical Performance Measure – List** page, click on the Save and Continue to List button (Figure 60, 8) or click on the Save and Update Next button to update the next performance measure in the list (Figure 60, 9).

### 3.16.2 Adding Additional Performance Measures

To add an additional performance measure to your application, follow the steps below:

1. Click the Add Additional Performance Measure button at the top of the **Clinical Performance Measure – List** page.
  - The **Add Clinical Performance Measure** page opens.



Figure 62: Add Clinical Performance Measure

2. Select a focus area from the drop-down menu (Figure 62, 1).
3. Click on the Load Performance Measure Category button to load the performance measure categories (Figure 62, 2).
4. Select one or more performance measure categories, as applicable.
5. Provide all the required information.
6. Click on the **Add New Key Factor** and **Major Planned Action** button to add **Key Factors**. Provide information for at least one restricting and one contributing **Key Factor** type.
7. Click on the Save button to save the information on this page. To go to the **Clinical Performance Measure – List** page, click on the Save and Continue button. The newly added measure will be listed under **Additional Measures** at the bottom of the page.
8. **Additional Measures** can be updated or deleted by using the **Update** and **Delete** links provided as options.
9. After completing all the Clinical Measures, click the Save and Continue button to save the information and proceed to the next form.

**IMPORTANT NOTE:** If applying for funds to target one or more special populations (i.e., MHC, HCH, PHPC) in addition to the general community, applicants must include at least one additional Clinical Performance Measure that addresses the unique health care needs of the special population(s).

## 3.17 Financial Performance Measures

The **Financial Performance Measures** form collects the goals and performance measures for the NAP project. It displays **Required Measures** and **Additional Measures**. The **Required Measures** are HRSA-defined measures; applicants are required to provide requested information for all required measures. **Additional Performance Measures** are self-defined and optional.

### 3.17.1 Completing the Required Measures

To complete this form:

1. Click on the **Update** link to start working on a performance measure (**Figure 63, 1**).

**Figure 63: Financial Performance Measures – List page**

**Financial Performance Measures**

Due Date: \_\_\_\_\_

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[Add Additional Performance Measure](#) [Collapse Group](#) | [Detailed View](#)

Focus Area	Performance Measure	Baseline Data	Baseline Year	Projected Data	Status	Options
			All		All	
<b>Required Measures</b>						
BPHC Health Center Program ▶ Grant Cost Per Total Patient (Grant Costs)	Ratio of total BPHC section 330 grant funds per patient served in the measurement calendar year.				Not Complete	<a href="#">Update</a>
▶ Total Cost Per Total Patient (Costs)	Ratio of total cost per patient served in the measurement calendar year.				Not Complete	<a href="#">Update</a>
▶ Medical Cost Per Medical Visit (Costs)	Ratio of total medical cost per medical visit in the measurement calendar year.				Not Complete	<a href="#">Update</a>

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

**IMPORTANT NOTE:** The **Financial Performance Measures** form will be 'Complete' when the status of all required measures and additional measures are 'Complete'.

- The system navigates to the **Financial Performance Measure – Update** page (**Figure 64**).

Figure 64: Financial Performance Measure - Update Page

**Financial Performance Measures - Update**

Due Date:

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Fields with \* are required

**Update Financial Performance Measure Information**

Focus Area: BPHC Health Center Program Grant Cost Per Total Patient (Grant Costs)

Performance Measure: Ratio of total BPHC section 330 grant funds per patient served in the measurement calendar year.

Approximately 1/4 page (Max 500 Characters without spaces): 500 Characters left.

\* Target Goal Description (Sample Goal):

Numerator Description: BPHC section 330 grants drawn-down for the period from January 1 to December 31 of the measurement calendar year.

Denominator Description: Total number of patients.

\* Baseline Data

Baseline Year: (yyyy)

Measure Type: Ratio

Numerator:

Denominator:

Calculate Baseline

\* Projected Data (by December 31, 2020) (Sample Calculator):

Projected Goal:

Measure Type: Ratio

Approximately 1/4 page (Max 500 Characters without spaces): 500 Characters left.

\* Data Sources & Methodology

Add New Key Factor and Major Planned Action

List of Key Factors and Major Planned Actions (Minimum 2) (Maximum 3)

Key Factor Type	Description	Major Planned Action	Options
No key factors and major planned actions added			

Comments (Required if performance measure is not applicable)

Approximately 3/4 page (Max 1500 Characters without spaces): 1500 Characters left

Cancel Save Save and Continue to List Save and Update Next

2. Provide a **Target Goal Description**, for each performance measure (Figure 64, 1). For all required measures, the **Numerator** and **Denominator** descriptions are pre-populated.
3. For Baseline Data, enter the year of the data provided and the numerator and denominator values based on the descriptions given. Use the Calculate Baseline button to calculate the baseline data. (Figure 64, 2)
4. Enter the goal under **Projected Data (by December 31, 2020)**.
5. Describe the **Data Sources & Methodology** used to collect and analyze data.
6. Click on the **Add New Key Factor and Major Planned Action** button to add **Key Factors**. Provide information for at least one restricting and one contributing Key Factor type.
7. Click the **Save and Return to Performance Measure** button to save the information on the **Key Factor and Major Planned Action - Add** page and proceed to the **Financial Performance Measures –**

**Update** page or click the Save and Add Another Key Factor button to save the key factor information you provided and proceed to add a new key factor.

8. Provide comments in the Comment field if needed.
9. Click on the Save button to save the information on this page. To go to the **Financial Performance Measures** page, click on the Save and Continue to List button or click on the Save and Update Next button to update the next performance measure in the list.

### 3.17.2 Adding Additional Performance Measures

To add an additional financial performance measure to your application, follow the steps below:

1. Click the Add Additional Performance Measure button on the Financial Performance Measures list page.
  - The **Financial Performance Measures – Add** page opens.
2. Select a focus area from the drop-down menu.
3. Provide all the required information.
4. To add the key factors, click on the Add New Key Factor and Major Planned Action button. Provide information for at least one restricting and one contributing Key Factor type.
5. Click on the Save button to save the information on this page. To go to the performance measure list page, click on the Save and Continue button. The newly added measure will be listed under the **Additional Measures** at the bottom of the **Financial Performance Measures** page.
6. **Additional Measures** can be updated or deleted by using the **Update** and **Delete** links provided as options.
7. After completing all the **Financial Measures**, click the **Save and Continue** button to save the information and proceed to the next form.

## 3.18 Equipment List

The **Equipment List** form provides a line-item list of proposed equipment to be purchased with grant funds.

**IMPORTANT NOTE:** If you requested One-Time Funding for Year 1 in [Form 1B: Funding Request Summary](#) and indicated that you will be using these funds for 'Equipment only' or for 'Minor Alteration/Renovation with Equipment', you will be required to complete the **Equipment List** form. Otherwise, this form is not applicable ([Figure 65](#)). If the form is not applicable to you, click the Continue button to proceed to the next form.

Figure 65: Equipment List Page – Not Applicable

The screenshot shows the 'Equipment List' page for 'SOUTHERN ALBANY AREA PRIMARY HEALTH CARE, INC'. The page header includes the organization name, a 'Due Date: 11/20/2018 (Due In: 16 Days)', and 'Section Status: Complete'. A yellow alert box contains the following text: 'Alert: This form is not applicable to you as in Form 1B of this application, one of the following is true: - You have not requested one-time funding, or - You have requested one-time funding but not indicated how you plan to use these funds, or - You have requested one-time funding for minor alteration/renovation without equipment use'. At the bottom, there are 'Go to Previous Page' and 'Continue' buttons.

To complete this form when it is applicable, follow the steps below:

1. Click the Add button to add equipment (Figure 66).

Figure 66: Equipment List Page

The screenshot shows the 'Equipment List' page with a 'Note(s):' section stating: 'Provide the equipment information requested for the sites in the Equipment List page below. Click on the "Save and Continue" button to go to the next section. To return to the previous section, click on the "Go to Previous Page" button. The form will not be marked as COMPLETE if any information required below is missing.' Below the note is a 'Resources' section with a 'View' button and links for 'FY2019 NAP User Guide' and 'Funding Opportunity Announcement'. A second 'Note(s):' section provides detailed instructions: 'Equipment costs entered here should be consistent with those provided in the Budget Narrative attachment. Equipment means tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level established by the non-federal entity for financial statement purposes, or \$5,000. Equipment that does not meet the \$5,000 threshold should be considered Supplies and would not be entered on this form. Click on the "Save and Continue" button to go to the next section. To return to the previous section, click on the "Go to Previous Page" button. The form will not be marked as COMPLETE if any information required below is missing.' The 'Add' button is highlighted with a red box. Below is a table titled 'List of Equipment' with columns: Type, Description, Unit Price, Quantity, Total Price, and Options. The table currently contains the text 'No equipment added.' At the bottom, there are 'Go to Previous Page', 'Save', and 'Save and Continue' buttons.

2. The system navigates to the **Equipment Information - Add Page (Figure 67)**.

Figure 67: Equipment Information - Add Page

3. Select an equipment Type and enter the Description, Unit Price (\$), and Quantity.
4. Click the Save and Continue button at the bottom of the screen. You will be returned to the **Equipment List** page (Figure 68).

Figure 68: Equipment List Page with Equipment Added

Type	Description	Unit Price	Quantity	Total Price	Options
Clinical	Testing Equipment	\$20,000.00	1	\$20,000.00	Update <sup>1</sup>
Non-Clinical	Metal Detector	\$1,000.00	2	\$2,000.00	Action Update Delete <sup>2</sup>
<b>Total</b>			3	\$40,000.00	

5. To edit an equipment list item, click on the **Update** link under the Options menu (Figure 68, 1). To delete an equipment item, click on the **Delete** link under the Options menu (Figure 68, 2).

**IMPORTANT NOTE:** Include equipment that equals or exceeds \$5,000 per unit. Otherwise, equipment items that cost less than \$5,000 each should not be included here and instead, listed under supplies in the budget.

6. When you have finished entering the equipment, click the Save and Continue button at the bottom of the screen to save your work and proceed to the next form.

### 3.19 Summary Page

This form displays read-only information provided in the following program specific forms of the NAP application: [Form 1A](#), [Form 1B](#), [Form 2](#) and [Form 5B](#). You are required to acknowledge and certify application information.

1. Review the data displayed on the **Summary page** ([Figure 69](#)). If changes are required, edit the forms by clicking on the form name in the left navigation panel. Be advised that the information in the forms should be consistently identified throughout the entire application.
2. The site table under #2 lists site information for the proposed NAP sites, including the service area zip codes. ([Figure 69,1](#)).
3. The “Unmet Need Score” (UNS) will be calculated based on the service area zip codes listed in the table, from Form 5B: Service Sites. These zip codes correspond to Zip Code Tabulation Areas (ZCTAs) to determine the UNS. The **Summary Page** will display the UNS Score (out of 100) and the UNS Converted Score ([Figure 69,2](#)). The UNS Converted Score (out of 20 points) will be included as part of your NAP application overall score. Use the UNS Workbook on the NAP TA website to determine the ZCTAs for your proposed service area (enter your Form 5B service area zip codes), view the unmet need data associated with each ZCTA, and see how that data composes the service area UNS.
4. The funding table under #5 displays budget information for Year 1 and 2, and calculates the percentage of funding for each sub program, as well as the funding amount per patient ([Figure 69,3](#)).
5. When the form is complete, click the Save and Continue button ([Figure 69,4](#)).

**IMPORTANT NOTE:** If you update the information in any of the related forms after completing the **Summary Page**, you will be required to revisit the **Summary Page** to review and acknowledge the updated information.

Figure 69: Summary Page

### Summary Page

**Note(s):**  
The information below is pre-populated based on data that you provided in the forms of this NAP application. If any information is incorrect, please edit the forms by clicking on the form name in the Menu on the left of the screen. Be advised that the information in the forms should be consistently identified throughout the entire application.

**Warning:**  
One or more details displayed below may have been updated in one of the forms (Form 1A, Form 1B, Form 2 or Form 5B) of this NAP Application. Please review the information on this form and click 'Save' button displayed at the bottom of this page.

Due Date: (Due In: Days) | Section Status:

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**Summary Information**

1. Select your applicant type:

I am a satellite applicant (I am a current Health Center Program award recipient with an H80 grant).  
 I am a new applicant (not an H80 award recipient), and I am not a look-alike.  
 I am a new applicant (not an H80 award recipient), and I am a designated look-alike.

2. I am proposing the following sites, which will be open within 120 days of award.

These are the NAP proposed sites and service area. If changes are required, revisit Form 5B.

Site Name	Physical Street Address for Site	Service Site Type	Location Type	Hours per Week	Service Area Zip Codes
No Site Added					

By checking this box, I certify that all sites described in my application are included on Form 5B (as summarized above) and that all sites included on Form 5B (as summarized above) will be open and operational within 120 days of receipt of the Notice of Award.

3. The Unmet Need Score (UNS) is the aggregate objective assessment of unmet need based on the service area zip codes entered on Form 5B (out of 100 points). The UNS converted score represents up to 20 points of the 30 available points in the Need section.

Unmet Need Score: 0  
UNS Converted Score: 0

By checking this box, I understand that the UNS converted score (out of 20 points) will be included as part of my NAP application overall score and I acknowledge that the service area ZIP codes used to calculate the Unmet Need Score are accurate (as listed above and on Form 5B). In addition, I understand that these zip codes correspond to ZCTAs to determine the UNS.

**Note(s):**  
Use the UNS Workbook on the NAP TA website to determine the ZCTAs for your proposed service area (enter your Form 5B service area zip codes); view the unmet need data associated with each ZCTA, and see how that data composes the service area UNS.

---

4. Total number of unduplicated patients projected to be served in calendar year 2020 (by December 31, 2020) entered on Form 1A:  
If changes are required, revisit Form 1A.

0

By checking this box, I acknowledge that the health center will be held accountable for meeting this NAP unduplicated patient projection in calendar year 2020. For new applicants, this becomes your Patient Target. For satellite applicants, the figure will be added to your Patient Target.

5. I am requesting the following types of Health Center Program funding.  
This is the NAP Federal funding request. If changes are required, revisit Form 1A, Form 1B.

Type of Health Center	Operational funds for Year 1 (a)	Operational funds for Year 2 (b)	Funding population percentage for Year 2 (c)	CY 2020 Patient Projection (d)	Federal Dollars Per Patient (e+b/d)
Community Health Centers	\$0.00	\$0.00	0%	-	\$0.00
Health Care for the Homeless	-	\$0.00	0%	-	\$0.00
Migrant Health Centers	-	\$0.00	0%	-	\$0.00
Public Housing Primary Care	-	\$0.00	0%	-	\$0.00
One-time funding	\$0.00				
<b>Total</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>0%</b>	<b>0</b>	<b>\$0.00</b>

6. I am requesting one-time funding in Year 1 for the following type of project:  
If changes are required, revisit Form 1B.

N/A  
 Minor alteration/renovation without equipment  
 Minor alteration/renovation with equipment  
 Equipment only

7. Total number of full time equivalent (FTE) staff at full capacity:  
This is the proposed FTE staff for the NAP project. If changes are required, revisit Form 2.

0

8. Certifications  
 By checking this box, I certify that:

- The main purpose of this NAP project is to provide comprehensive primary medical care for all underserved individuals in the targeted service area or population.
- I have consulted with appropriate State and local government agencies, and health care providers regarding the need for the health services to be provided at the proposed NAP site(s).

9. Compliance  
 By checking this box, I acknowledge that, in accordance with Section 330(e)(1)(B):

- My health center must maintain compliance with all Health Center Program requirements.
- I must address areas of noncompliance within the timeframe specified in applicable conditions.
- If I am a new start applicant or a look-alike with unresolved conditions on my Notice of Look-alike Designation related to Health Center Program requirements, I must submit a Compliance Achievement Plan within 120 days of Notice of Award which outlines steps the health center will take to meet the Health Center Program requirements.

[Go to Previous Page](#)
[Save](#)
[Save and Continue](#)



## 4. Reviewing and Submitting the FY 2019 NAP Application to HRSA

To review your application, follow the steps below:

1. Navigate to the standard section of the application using the [Grant Application](#) link in the navigation links displayed at the top of the **Program Specific** forms.
  - On the **Application - Status Overview** page, click the [Review](#) link in the Review and Submit section of the left menu ([Figure 70, 1](#)). The system navigates to the **Review** page.

Figure 70: Review Link

**Application - Status Overview**

STATUS: COMMUNITY HEALTH CONNECTIONS, INC. Due Date: 8/13/2018 11:58:58 PM (Due in: 80 days) | Application Status: Complete

Announcement Number: HRSA-18-010 Announcement Name: Affordable Care Act New Access Point Grants Created by: John Daniels on 08/08/2018 3:51:58 PM  
Application Type: Competing Coordination Grant Number: HRSA-180007 Last Updated By: John Daniels on 08/08/2018 3:51:58 PM  
Application Package: SF424 Application FY: 2018 Program Type: Non-Construction

**Resources**

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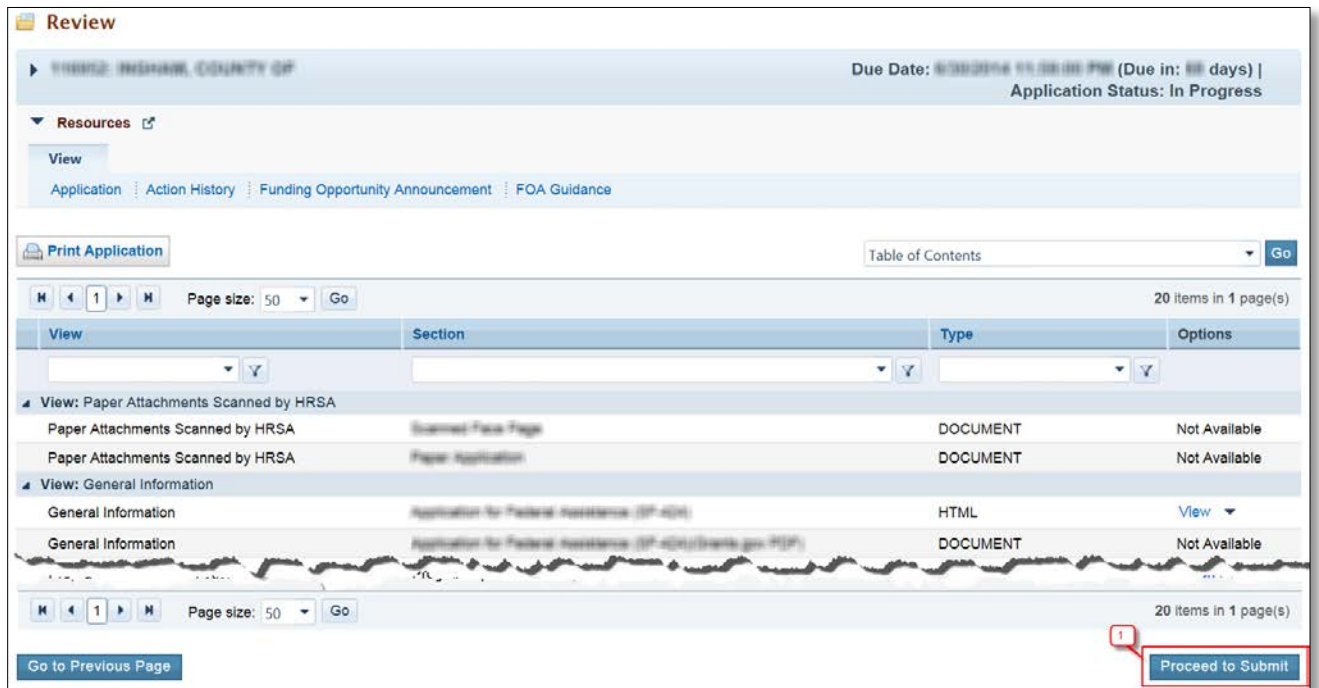
**Users with permissions on this application (1)**

**List of forms that are part of the application package**

Section	Status	Options
Basic Information		
SF-424	Complete	
Part 1	Complete	Update
Part 2	Complete	Update
Project/Performance Site Location(s)	Complete	Update
Project Narrative	Complete	Update
Budget Information		
Section A-C	Complete	Update
Section D-F	Complete	Update
Budget Narrative	Complete	Update
Other Information		
Assurances	Complete	Update
Disclosure of Lobbying Activities	Complete	Update
Appendices	Complete	Update
Program Specific Information		
Program Specific Information	Complete	Update

2. Verify the information displayed on the **Review** page.
3. Once all sections indicate 'Complete', when you are ready to submit the application to HRSA, click the Proceed to Submit button at the bottom of the **Review** page ([Figure 71, 1](#)).

**Figure 71: Review Page – Proceed to Submit**



- The system navigates to the **Submit** page.
4. Click the Submit to HRSA button at the bottom of the **Submit** page.
    - The system navigates to a confirmation page.

**IMPORTANT NOTES:**

- To apply, you must have the ‘Submit’ privilege. This privilege must be given by the Project Director (PD) to the Authorizing Official (AO).
- If you are not the AO, a Submit to AO button will be displayed at the bottom of the Submit page. Click the button to notify the AO that their action is required to submit the application to HRSA ([Figure 72](#)).
- Applicants are strongly encouraged to notify the AO directly and ensure that they leave adequate time for the AO to complete the submission process prior to the deadline.

Figure 72: Submit to AO

**Application - Submit**

**AFFORDABLE COMMUNITY HEALTH CONNECTIONS, INC.** Due Date: 8/30/2016 11:59:59 PM (Due in: 87 days) | Application Status: Complete

Announcement Number: HRSA-15-215      Announcement Name: Affordable Care Act New Access Point Grants      Created by: John DeMatteis on 08/29/2016 at 3:21:58 PM  
 Application Type: Continuing Continuation      Grant Number: HRSA-15-215-017      Last Updated By: John DeMatteis on 08/29/2016 at 3:21:58 PM  
 Application Package: SF424      Application FY: 2016      Program Type: Health Connections

**Resources**

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance | Application User Guide

**Users with permissions on this application (1)**

List of forms that are part of the application package

Section	Status	Options
Basic Information		
SF-424	Complete	
Part 1	Complete	Update
Part 2	Complete	Update
Project/Performance Site Location(s)	Complete	Update
Project Narrative	Complete	Update
Budget Information		
Section A-C	Complete	Update
Section D-F	Complete	Update
Budget Narrative	Complete	Update
Other Information		
Assurances	Complete	Update
Disclosure of Lobbying Activities	Complete	Update
Appendices	Complete	Update
Program Specific Information		
Program Specific Information	Complete	Update

Go to Previous Page      **Submit to AO**

5. Answer the questions displayed under the Certifications and Acceptance section of the confirmation page and click the Submit Application button to submit the application to HRSA.
6. If you experience any technical issues (e.g. problems with submitting the application in EHB), contact the **Health Center Program Support** at 1-877-464-4772 (Monday – Friday, 8:30 AM - 5:30 PM ET) or send an email through the **Web Request Form** (<http://www.hrsa.gov/about/contact/bphc.aspx>).