Instructions for Preparing and Submitting the Fiscal Year (FY) 2018 Health Center Program (H80) Budget Period Progress Report (BPR) Non-Competing Continuation (NCC)

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Table 1: Submission Schedule

Budget Period Start Date	HRSA EHB Access (Mondays)	HRSA EHB Deadline (Fridays at 5:00 PM ET)
January 1, 2018	June 26, 2017	August 18, 2017
February 1, 2018	July 17, 2017	September 8, 2017
March 1, 2018	August 21, 2017	October 13, 2017
April 1, 2018	September 18, 2017	November 17, 2017
May 1, 2018	October 23, 2017	December 15, 2017
June 1, 2018	November 20, 2017	January 19, 2018

About the Budget Period Progress Report

The Budget Period Progress Report (BPR) Non-Competing Continuation provides an update on the progress of Health Center Program award recipients. The fiscal year (FY) 2018 BPR reports on progress made from the beginning of your FY 2017 budget period until the date of BPR submission; the expected progress for the remainder of the budget period; and any projected changes for the FY 2018 budget period.

The BPR is completed by award recipients who **do not** have a project period end date in FY 2018 (October 1, 2017 – September 30, 2018).

Note: The BPR is made available in the HRSA Electronic Handbook (EHB) according to your budget period start date. See Table 1: Submission Schedule for the date your BPR will be available in the HRSA EHB, as well as the submission deadline.

Summary of Changes (compared to the FY 2017 BPR)

- The Supplemental Awards section was updated to reflect the most current list of supplemental awards.
- The One-Time Funding Awards section was updated to pre-populate funded awards and reflect the most current list of one-time funding awards.
- The Clinical Performance Measures section was updated to reflect the most current list of clinical performance measures. Some Measure Goal fields will not contain data due to the lack of comparable data from past UDS reports.

I. TECHNICAL ASSISTANCE

Technical assistance resources are available on the BPR technical assistance (TA) webpage. The webpage includes copies of forms, the HRSA EHB user guide, frequently asked questions (FAQs), and a slide presentation.

Technical assistance regarding business, administrative, or fiscal issues is available by contacting:

Travis J. Wright
Office of Federal Assistance Management
HRSA Division of Grants Management Operations
301-443-0676
twright@hrsa.gov

Technical assistance regarding this instructions document is available by contacting:

Karen A. Fitzgerald
Office of Policy and Program Development
HRSA Bureau of Primary Health Care
301-594-4300
Contact: https://www.hrsa.gov/about/contact/bphc.aspx

HRSA EHB system technical assistance is available by contacting:

BPHC Helpline
1-877-974-2742
Web Request Form

II. GENERAL INSTRUCTIONS

Progress reports that fail to include all required documents and information will be considered incomplete or non-responsive. Incomplete or non-responsive progress reports will be returned through a "Request Change" notification via HRSA EHB for the provision of missing information or clarification. **Failure to submit the BPR by the established deadline or the submission of an incomplete or non-responsive BPR may result in a delay in Notice of Award issuance or a lapse in funding.** Review your BPR to ensure that it is both complete and responsive prior to submission.

You are required to request prior approval from HRSA for post-award changes including, but not limited to, changes in the project director/chief executive officer (CEO), new or additional sub-awards, significant re-budgeting, and the addition or deletion of sites or services from the approved scope of project (in accordance with Uniform Guidance 2 CFR 200 as codified by Health and Human Services (HHS) at 45 CFR 75.308). These changes must be requested via the Prior Approval, Scope Adjustment, and/or Change in Scope (CIS) Modules in HRSA EHB, as appropriate. For further detail on actions and changes requiring prior approval, review the HHS Grants Policy Statement.

Table 2: Submission Components identifies the required BPR components. In the Form Type column, the word "Form" refers to forms that are completed online in HRSA EHB. The word "Document" refers to materials that must be uploaded into HRSA EHB. The word "Fixed" refers to forms that cannot be altered but may be refreshed from scope.

TABLE 2: SUBMISSION COMPONENTS

- The Budget Narrative is the only document that counts against the page limit.
- Samples of Form 3: Income Analysis, the Project Narrative Update, the Budget Narrative, and the Scope Certification Form are available on the BPR TA webpage.

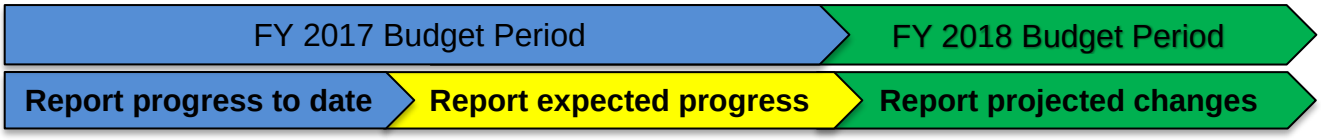
BPR Section	Form Type	Instructions
SF-PPR and SF-PPR-2	Form	Provide basic organizational information. Refer to instructions in the BPR HRSA EHB user guide available at the BPR TA webpage.
Budget Information: Budget Details	Form	Provide the budget for the upcoming budget period broken down by object class categories and federal/nonfederal funding.
Budget Narrative	Document	Provide a line-item budget for the upcoming budget period that corresponds with the Budget Information: Budget Details form.
Form 3: Income Analysis	Form	Provide projected program income for the upcoming budget period.
Forms 5A, 5B, and 5C	Fixed	These forms are pre-populated to reflect the current scope of project. Changes must be requested via the Scope Adjustment or Change in Scope (CIS) modules in HRSA EHB. Contact your Project Officer for guidance.
Scope Certification Form	Form	Certify that the sites and services in scope (listed on Forms 5A and 5B) are accurate or that a Scope Adjustment or CIS request has been submitted to correct inaccurate information. Contact your Project Officer for guidance.
Project Narrative Update	Form	See Section III for detailed instructions.

III. Instructions for the Project Narrative Update

The Project Narrative Update must address the following:

1. Progress and changes that have impacted the community/target population and awardee organization from the beginning of the FY 2017 budget period until the date of the BPR submission;
2. Expected progress for the remainder of the FY 2017 budget period; and
3. Projected plans for the FY 2018 budget period.

Reporting Your Budget Period Progress



Respond to each item below in HRSA EHB and ensure consistency between the Project Narrative Update and other components of the BPR submission. The BPR TA webpage includes frequently asked questions that may assist you in completing the Project Narrative Update.

Each of the six key areas requires a narrative response, and each response section is limited to 3,000 characters, or approximately 2 pages.

1. **Environment:** Discuss the major changes in the region, state, and/or community over the past year that have directly impacted/affected the progress of the funded project (e.g., changing service area demographics/shifting target population needs, changes in major health care providers in the service area, changes in key program partnerships, changes in insurance coverage, including Medicaid, Medicare and the Children's Health Insurance Program (CHIP)).

2. **Organizational Capacity:** Discuss the major changes in the organization's capacity over the past year that have impacted or may impact the progress of the funded project, including changes in:
   - Staffing, staff composition, and/or key staff vacancies;
   - Operations;
   - Systems, including financial, clinical, and/or practice management systems; and
   - Financial status.

3. **Patient Capacity:** See Table 3: Patient Capacity. Discuss the trend in unduplicated patients served and report progress in reaching the projected number of patients to be served in the identified categories. In the Patient Capacity Narrative column, explain key factors driving significant changes in patient numbers and any downward trends or limited progress toward the projected patient goals.

   Note: Patient Capacity data are pre-populated from Table 3a in the Uniform Data System (UDS) Report. The Total Unduplicated Patients value in the Projected Number of Patients column is the Patient Target communicated via email to the

authorizing official and project director on May 8, 2017. If you did not receive this email, contact BPHCPatientTargets@hrsa.gov.

4. **Supplemental Awards:** See Table 4: Supplemental Awards. Discuss the progress made in implementing recent supplemental Health Center Program awards. For each applicable supplement, provide current data on progress in the Numeric Progress Toward Goal column.

   In the Supplemental Award Narrative column, describe the following:
   a. Progress toward goals;
   b. Key contributing and restricting factors impacting/affecting progress toward goals; and
   c. Plans for sustaining progress and/or overcoming barriers to ensure goal achievement.

   ***Notes*:**
   Numeric Goal column: The value in the Numeric Goal column is pre-populated. If you did not receive a Supplemental Award, the system will display "Not Applicable."

   Supplemental Award Narrative for Access Increases in Mental Health and Substance Abuse Services (AIMS): If you recently received AIMS funding and do not have activities to report as of yet, write "No Progress to Date" in the Supplemental Award Narrative column.

5. **One-Time Funding Awards**: See Table 5: One-Time Funding Awards. For each applicable One-Time Funding Award, in the Activities column, discuss the activities for which the funds were used and the impact on the organization.

   ***Note*:** If you did not receive a One-Time Funding Award, the system will display "Not Applicable."

6. **Clinical/Financial Performance Measures:** See Table 6: Performance Measures. Referencing the % Change 2014-2016 Trend, % Change 2015-2016 Trend, and % Progress Toward Goal columns, discuss the trends in Clinical and Financial Performance Measures. Downward trends or limited progress toward the projected goals must be explained.

   In the Clinical/Financial Performance Measures Narrative column, describe the following as they relate to the data:
   a. Progress toward goals;
   b. Key contributing and restricting factors affecting progress toward goals; and
   c. Plans for sustaining progress and/or overcoming barriers to ensure goal achievement.

   ***Notes*:**
   Values in Table 6: Ten of the 16 Clinical Performance Measures were revised in 2016, and for most awardees, the Measure Goal field will not be pre-populated. If a

performance measure does not have a pre-populated Measure Goal, you are required to establish a goal in this submission. See related note in Table 6.

Special Populations: If you receive funds to serve special populations (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing), you must ensure that any additional clinical performance measures that address the health care needs of these populations, as established in your most recent SAC application, are included.

Awardees that were previously look-alikes: Look-Alike UDS data will not be pre-populated.

TABLE 3: PATIENT CAPACITY

	2014 Patient Number	2015 Patient Number	2016 Patient Number	% Change 2014-2016 Trend	% Change 2015-2016	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
Project Period: (Pre-populated from most recent Notice of Award)								
Total Unduplicated Patients	Pre-populated from 2014 UDS	Pre-populated from 2015 UDS	Pre-populated from 2016 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	3,000 character limit

Notes:
- 2014–2016 Patient Number data are pre-populated from Table 3a in the UDS Report.
- The Projected Number of Patients value is pre-populated from the Patient Target communicated via email to the authorizing official and project director on May 8, 2017. If you did not receive this email, contact BPHCPatientTargets@hrsa.gov.

	2014 Patient Number	2015 Patient Number	2016 Patient Number	% Change 2014-2016 Trend	% Change 2015-2016	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
Project Period: (Pre-populated from most recent Notice of Award)								
Total Migratory and Seasonal Agricultural Worker Patients	Pre-populated from 2014 UDS	Pre-populated from 2015 UDS	Pre-populated from 2016 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	3,000 character limit
Total People Experiencing Homelessness Patients	Pre-populated from 2014 UDS	Pre-populated from 2015 UDS	Pre-populated from 2016 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	3,000 character limit
Total Public Housing Resident Patients	Pre-populated from 2014 UDS	Pre-populated from 2015 UDS	Pre-populated from 2016 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	3,000 character limit

Notes:
- 2014-2016 Patient Number data are pre-populated from Table 4 in the UDS Report.
- The Projected Number of Patients column is pre-populated from the patient projection in the submission that initiated your current project period (SAC/NAP) plus the patient projections from selected supplemental funding awarded after the start of the current project period. See the frequently asked questions on the BPR TA webpage for details on the selected supplemental funding patient projections included.
- If pre-populated patient projections are not accurate, provide adjusted projections and an explanation in the Patient Capacity Narrative section.

TABLE 4: SUPPLEMENTAL AWARDS

Type of Supplemental Award	Programmatic Goal	Numeric Goal	Numeric Progress Toward Goal	Supplemental Award Narrative
FY 2014 Behavioral Health Integration (BHI) Supplement	Increase the number of patients with access to integrated behavioral health care	Pre-populated with the number of new patients to receive integrated behavioral health care	As applicable	3,000 character limit
FY 2015 New Access Points (NAP) Satellite Grant	Achieve operational status and increase number of patients	Pre-populated with December 31, 2016 patient projection	As applicable	3,000 character limit
FY 2015 BHI Supplement	Increase the number of patients with access to integrated behavioral health care	Pre-populated with the number of new patients to receive integrated behavioral health care	As applicable	3,000 character limit
FY 2015 Expanded Services (ES) Supplement	Increase the number of patients and expand services	Pre-populated with the number of new patients to receive expanded services (across all services proposed for expansion)	As applicable	3,000 character limit
FY 2016 Substance Abuse Expansion	Increase the number of patients receiving integrated substance abuse services, including Medication-Assisted Treatment (MAT)	Pre-populated with the number of new patients to receive integrated substance abuse services by December 31, 2017	As applicable	3,000 character limit
FY 2016 Oral Health Expansion	Increase the percentage of health center patients receiving integrated dental services at the health center	Pre-populated with the projected percentage of health center patients to receive integrated dental services at the health center	As applicable	3,000 character limit
FY 2017 NAP Satellite	Achieve operational status and increase number of patients	Pre-populated with December 31, 2018 patient projection	As applicable	3,000 character limit
FY 2017 Access Increases in Mental Health and Substance Abuse Services (AIMS)	Increase the number of patients with access to mental health services, and substance abuse services focusing on the treatment, prevention, and awareness of opioid abuse	Pre-populated with the number of existing patients to newly receive mental health and/or substance abuse services by December 31, 2018	As applicable	3,000 character limit

TABLE 5: ONE-TIME FUNDING AWARDS

Type of One-Time Funding Award	Allowable Activities	Activities
FY 2015 Quality Improvement Assistance (December 2014)	Developing and improving health center quality improvement (QI) systems and infrastructure: • Training staff • Developing policies and procedures • Enhancing health information technology, certified electronic health record, and data systems • Data analysis • Implementing targeted QI activities (including hiring consultants) Developing and improving care delivery systems: • Supplies to support care coordination, case management, and medication management • Developing contracts and formal agreements with other providers • Laboratory reporting and tracking • Training and workflow redesign to support team-based care • Clinical integration of behavioral health, oral health, HIV care, and other services • Patient engagement activities	3,000 character limit
FY 2015 Quality Improvement Assistance (August 2015)		3,000 character limit
FY 2016 Quality Improvement Assistance (September 2016)		3,000 character limit
FY 2016 Delivery System Health Information Investment	Implementing strategic investments in health information technology (health IT) enhancements to: • Accelerate health centers' transition to value-based models of care • Improve efforts to share and use information to support better decisions • Increase engagement in delivery system transformation Funding must be used for health IT investments in one or more of the following Activity Categories, with the option to expand telehealth in one or more of the categories as well: • Equipment and supplies purchase (required if the health center does not have an electronic health record (EHR) certified by the Office of the National Coordinator for Health IT (ONC) in use at any site) • Health information system enhancements • Training • Data aggregation, analytics, and data quality improvement activities	3,000 character limit

FY 2017 Access Increases in Mental Health and Substance Abuse Services (AIMS)	Implementing health information technology (health IT) and/or training investments to: • Expand mental health services, and substance abuse services focusing on the treatment, prevention, and awareness of opioid abuse • Integrate expanded services into primary care Funding must be used for health IT and/or training investments in one or more of the following Activity Categories: • Medication Assisted Treatment • Telehealth • Prescription Drug Monitoring Program • Clinical Decision Support • EHR Interoperability • Quality Improvement • Cybersecurity • Other Training • Other IT	3,000 character limit

TABLE 6: PERFORMANCE MEASURES

	2014 Measure	2015 Measure	2016 Measure	% Change 2014-2016 Trend	% Change 2015-2016	% Progress Toward Goal	Measure Goal	Measure Narrative
Perinatal Health								
Access to Prenatal Care	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated from 2016 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	3,000 character limit
Low Birth Weight	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated from 2016 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	
Preventive Health Screenings and Services								
Dental Sealants	Data not available	Data not available	Pre-populated from 2016 UDS (if available)	Data not available	Data not available	Pre-populated calculation	Pre-populated from the application that initiated the current project period*	3,000 character limit
Weight Assessment and Counseling for Children and Adolescents	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated from 2016 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	
Adult Weight Screening and Follow-Up	Data not available	Data not available	Pre-populated from 2016 UDS (if available)	Data not available	Data not available	Pre-populated calculation	Pre-populated from the application that initiated the current project period*	

	2014 Measure	2015 Measure	2016 Measure	% Change 2014-2016 Trend	% Change 2015-2016	% Progress Toward Goal	Measure Goal	Measure Narrative
Tobacco Use Screening and Cessation Intervention	Data not available	Data not available	Pre-populated from 2016 UDS (if available)	Data not available	Data not available	Pre-populated calculation	Pre-populated from the application that initiated the current project period*	
Colorectal Cancer Screening	Data not available	Data not available	Pre-populated from 2016 UDS (if available)	Data not available	Data not available	Pre-populated calculation	Pre-populated from the application that initiated the current project period*	
Cervical Cancer Screening	Data not available	Data not available	Pre-populated from 2016 UDS (if available)	Data not available	Data not available	Pre-populated calculation	Pre-populated from the application that initiated the current project period*	
Childhood Immunization Status	Data not available	Data not available	Pre-populated from 2016 UDS (if available)	Data not available	Data not available	Pre-populated calculation	Pre-populated from the application that initiated the current project period*	
Chronic Disease Management								
Asthma: Use of Appropriate Medications	Data not available	Data not available	Pre-populated from 2016 UDS (if available)	Data not available	Data not available	Pre-populated calculation	Pre-populated from the application that initiated the current project period*	3,000 character limit

	2014 Measure	2015 Measure	2016 Measure	% Change 2014-2016 Trend	% Change 2015-2016	% Progress Toward Goal	Measure Goal	Measure Narrative
Coronary Artery Disease (CAD): Lipid Therapy	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated from 2016 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated from 2016 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	
Hypertension: Controlling High Blood Pressure	Data not available	Data not available	Pre-populated from 2016 UDS (if available)	Data not available	Data not available	Pre-populated calculation	Pre-populated from the application that initiated the current project period*	
Diabetes: Hemoglobin A1c Poor Control	Data not available	Data not available	Pre-populated from 2016 UDS (If available)	Data not available	Data not available	Pre-population calculation	Pre-populated from the application that initiated the current project period*	
HIV linkage To Care	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated from 2016 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	
Depression Screening and Follow-Up	Data not available	Data not available	Pre-populated from 2016 UDS (if available)	Data not available	Data not available	Pre-populated calculation	Pre-populated from the application that initiated the current project period*	

	2014 Measure	2015 Measure	2016 Measure	% Change 2014-2016 Trend	% Change 2015-2016	% Progress Toward Goal	Measure Goal	Measure Narrative
Financial Measures								
Total Cost Per Patient (Costs)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated from 2016 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	3,000 character limit
Medical Cost Per Medical Visit (Costs)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated from 2016 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	
Health Center Program Grant Cost Per Patient (Grant Costs)**	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated from 2016 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	
Additional Measures								
Additional Measures (if applicable)	Provide data if available	Provide data if available	Provide data if available	Pre-populated calculation (if data are provided)	Pre-populated calculation (if data are provided)	Pre-populated calculation (if data are provided)	Pre-populated from the application that initiated the current project period	3,000 character limit

Notes:

- See PAL 2016-02 for details about the ten performance measures that were updated in 2016.
- (*) For the updated performance measures, if the application that initiated your current project period was an FY 2017 SAC, the Measure Goal field will be pre-populated and cannot be edited. However, if the application that initiated your current project period was an FY 2016 SAC or an FY 2017 NAP, provide a goal in the Measure Goal field that corresponds to the updated performance measure. The goal must be provided before the % Progress Toward Goal value can be calculated.
- If pre-populated performance measure goals are not accurate, provide adjusted goals and explain (e.g., goal for the low birth weight measure has increased based on improved patient tracking via a new EHR) in the appropriate Measure Narrative section.
- (**)The Health Center Program Grant Cost Per Patient UDS data is pre-populated from the total BPHC Health Center Program grant drawn-down reported for each calendar year divided by the total unduplicated patients reported for each calendar year.

Refer to the UDS Manual and the UDS TA Site for assistance with analyzing performance measure progress.

IV. BUDGET PRESENTATION INSTRUCTIONS

BPR funding is based on program compliance, organizational capacity to accomplish the project's goals, congressional appropriation, and a determination that continued funding would be in the best interest of the federal government.

A complete budget presentation includes the submission of the Budget Information: Budget Details form, Budget Narrative, and Form 3: Income Analysis.

Present the total budget for the project, including Health Center Program Federal grant funds and all non-Health Center Program grant funds that support the health center scope of project. The total budget represents projected operational costs for the health center scope of project where all proposed expenditures directly relate to and support in-scope activities. The total budget must reflect projections from all anticipated revenue sources from program income (e.g., fees, premiums, third party reimbursements, and payments) generated from the delivery of services, and from other non-Health Center Program grant sources such as state, local, or other Federal grants or contracts, private contributions, and income generated from fundraising. Health centers have discretion regarding how they propose to allocate the total budget between Health Center Program grant funds and non-Health Center Program grant funds, provided that the projected budget complies with all applicable HHS policies and other Federal requirements. See Chapter 17: Budget of the Compliance Manual for additional information.

The BPR may not be used to request changes in the total, type (i.e., Community Health Center – CHC, Migrant Health Center – MHC, Health Care for the Homeless – HCH, and/or Public Housing Primary Care – PHPC), or allocation of Health Center Program funds between funding types.

Note: Pursuant to existing law and consistent with Executive Order 13535 (75 FR 15599), health centers are prohibited from using federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered). This includes all funds awarded under this announcement and is consistent with past practice and long-standing requirements applicable to awards to health centers. You are required to have the necessary policies, procedures, and financial controls in place to ensure that your organization complies with all federal funding requirements and prohibitions such as lobbying, gun control, abortion, etc. The effectiveness of these policies, procedures and controls is subject to audit.

A. Budget Information: Budget Details Form

In **Section A**: Budget Summary, verify the pre-populated list of Health Center Program funding types (i.e., CHC, MHC, HCH, and/or PHPC). If the funding types are incorrect, make necessary adjustments using the **Update Sub-Program** button. In the Federal column, provide the grant request for each Health Center Program funding type (i.e., CHC, MHC, HCH, and/or PHPC). The total federal funding requested across all Health Center Program funding types must equal the Recommended Federal Budget figure

that is pre-populated at the top of the Budget Information: Budget Details form. This figure should correspond with the recommended future support figure (Item 13 or Box 13) on the most recent Notice of Award.

Note: If your organization received FY 2017 AIMS funding, which included 12-months of funding from September 1, 2017 through August 31, 2018, the Recommended Federal Budget figure will include FY 2018 prorated ongoing AIMS funding to provide support through the end of the FY 2018 budget period. HRSA anticipates that annualized ongoing AIMS funding (equivalent to the amount of ongoing AIMS funding included in your FY 2017 award) will be included in your FY 2019 base award amount.

Funding must be requested and will be awarded proportionately for all population types as currently funded under the Health Center Program. No new population types may be added.

In the Non-Federal column, provide the total of the non-federal funding sources for each type of Health Center Program (i.e., CHC, MHC, HCH, and/or PHPC). The total for the Non-Federal column should equal the Total Non-Federal value on Form 3: Income Analysis. The amount(s) in the total column will be calculated automatically as the sum of the federal and non-federal columns.

In **Section B: Budget Categories**, by object class category, provide the Health Center Program federal funding request for the upcoming budget period in the first column and the non-federal funding in the second column. Each line represents a distinct object class category that must be addressed in the Budget Narrative.

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

In **Section C: Non-Federal Resources**, provide a breakdown of non-federal funds by funding source (e.g., state, local) for each type of Health Center Program funding (i.e., CHC, MHC, HCH, and/or PHPC). If the awardee is a State agency, leave the State column blank and include State funding in the Applicant column. Note that Program Income must be consistent with the Total Program Income presented in Form 3: Income Analysis.

Salary Limitation

The Consolidated Appropriations Act, 2017 Division H, § 202, (P.L. 115-31), states, "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II." The Executive Level II salary of the Federal Executive Pay scale is currently $187,000. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to your organization. This salary limitation also applies to subawards/subcontracts under a HRSA grant. Note that these or other salary limitations will apply in FY 2018, as required by law.

Example of Application of this Limitation:
If an individual's base salary is $255,000 per year plus fringe benefits of 25 percent, and that individual is devoting **50 percent of his/her time to this award**, the base salary must be adjusted to $187,000, plus fringe benefits of 25 percent, when calculating the amount that may be charged to the Health Center Program grant. This results in a total of $116,875 that may be included in the project budget and charged to the award in salary/fringe benefits for this individual. See the breakdown below.

TABLE 7: SALARY LIMITATION – ACTUAL VS. CLAIMED

Current Actual Salary: Individual's actual base full time salary: $255,000 (50% of time will be devoted to project)	
Direct Salary	$127,500
Fringe (25% of salary)	$31,875
Total Salary	$159,375
Amount of Actual Salary Eligible to be Claimed on the Submission Budget due to the Legislative Salary Limitation: Individual's base full time salary adjusted to Executive Level II: $187,000 (50% of time will be devoted to the project)	
Direct Salary	$93,500
Fringe (25% of salary)	$23,375
Total Salary claimed	$116,875

B. Budget Narrative

The Budget Narrative must detail the costs of each line item within each object class category from the Budget Information: Budget Details form. The Budget Narrative must contain sufficient detail to enable HRSA to determine if costs are allowable.

Include a line item Budget Narrative that explains the amounts requested for each row of Section B: Budget Categories of the Budget Information: Budget Details form. The Budget Narrative is for **one year based on your upcoming 12-month budget period (this period will follow immediately after the current budget period listed on your most recent Notice of Award)**.

The one-year Budget Narrative must itemize **revenues AND expenses** of your federal request and non-federal contribution. Additionally, the one-year Budget Narrative must clearly explain each line item within each cost element. Ensure that the Budget Narrative contains detailed calculations explaining how each line-item expense is derived (e.g., number of visits, cost per unit). Refer to the Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75 for information on allowable costs.

Upload the completed document in the Budget Narrative Form section in HRSA EHB. Include the following:

Personnel Costs: Explain personnel costs by listing each staff member who will be supported from Health Center Program funds, name (if possible), position title, percentage of full-time equivalency and annual salary. ***Reminder:*** Award funds may not be used to pay the salary of an individual at a rate in excess of Federal Executive

Level II or $187,000.[1] An individual's base salary, per se, is **not** constrained by the legislative provision for a limitation of salary. The rate limitation simply limits the amount that may be awarded and charged to HRSA grants and cooperative agreements. Provide an individual's actual base salary if it exceeds the cap. See Table 8.

TABLE 8: PERSONNEL JUSTIFICATION TABLE

Name	Position Title	% of FTE	Base Salary	Adjusted Annual Salary	Federal Amount Requested
J. Smith	Physician	50%	$255,000	$187,000	$93,500
R. Doe	Nurse Practitioner	100%	$75,950	no adjustment needed	$75,950
D. Jones	Data/AP Specialist	25%	$33,000	no adjustment needed	$8,250

Fringe Benefits: List the components that comprise the fringe benefit rate (e.g., health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement). The fringe benefits should be directly proportional to the portion of personnel costs that are allocated for the project. If an individual's base salary exceeds the legislative salary cap (i.e., $187,000), adjust fringe proportionally.

Travel: List travel costs according to local and long distance travel. For local travel, outline the mileage rate, number of miles, reason for travel, and staff members/consumers completing the travel. The budget should also reflect travel expenses (e.g., airfare, lodging, parking, per diem) for each person and trip associated with participating in meetings and other proposed trainings, or workshops. Name the traveler(s) if possible, describe the purpose of the travel, provide number of trips involved, the destinations and the number of individuals for whom funds are requested.

Equipment: List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of items that meet the definition of equipment (a unit cost of $5,000 or more and a useful life of one or more years). For example, large items of medical equipment. Any items that do not meet the threshold for equipment are considered supplies (see definition below).

Supplies: Personal property, excluding equipment and tangible property, with an acquisition cost less than $5,000. List the items that will be used to implement the proposed project. Separate items into three categories: office supplies (e.g., paper, pencils), medical supplies (e.g., syringes, blood tubes, gloves), and educational supplies (e.g., brochures, videos). Items must be listed separately.

[1] While the BPR focuses on the application of the salary limitation to the federal Health Center Program grant funds, the salary limitation applies across all HRSA funding. In other words, if a full-time staff member is paid from several HRSA grants, the total federal contribution to that staff person's salary cannot exceed $187,000.

Per 45 CFR § 75.321, property will be classified as supplies if the acquisition cost is under $5,000. Note that items such as laptops, tablets and desktop computers are classified as a supply if the value is under the $5,000 equipment threshold.

Contractual: Provide a clear explanation as to the purpose of each contract/subaward, how the costs were estimated, and the specific contract/subaward deliverables. For proposed contracts, provide the basis for your cost estimate. You are responsible for ensuring that your organization has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts/subawards. Recipients must notify potential subrecipients that entities receiving subawards must be registered in SAM and provide the recipient with their DUNS number. For consultant services, list the total costs for all consultant services. Identify each consultant, the services he/she will perform, total number of days, travel costs, and total estimated costs. Any contractual operational service position must follow the salary limitation guidelines.

For subawards to entities that will help carry out the work of the grant, describe how you will monitor their work to ensure the funds are being properly used.

Per the Suspension and Debarment rules in the Uniform Administrative Requirements, as implemented by HRSA under 45 CFR § 75.212, non-federal entities and contractors are subject to the non-procurement debarment and suspension regulations implementing Executive Orders 12549 and 12689, 2 CFR parts 180 and 376. These regulations restrict awards, subawards, and contracts with certain parties that are debarred, suspended, or otherwise excluded from or ineligible for participation in federal assistance programs or activities.

Other: Include all costs that do not fit into any other category and provide an explanation of each cost (e.g., EHR provider licenses, audit, legal counsel). In some cases, rent, utilities, and insurance fall under this category if they are not included in an approved indirect cost rate.

You may include the cost of access accommodations as a part of your project's budget, including sign language interpreters, plain language materials in alternate formats (e.g., Braille, large print); and linguistic competence modifications (e.g., translation or interpretation services).

Indirect Charges: Indirect costs are costs incurred for common or joint objectives which cannot be readily and specifically identified with a particular project or program, but are necessary to the operations of the organization (e.g., the cost of operating and maintenance, depreciation, administrative salaries). For some institutions, the term "facilities and administration" (F&A) is used to denote indirect costs. If your organization does not have an indirect cost rate, you may wish to obtain one through HHS's Division of Cost Allocation (DCA). Visit DCA's website at Program Support Center (PSC) to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.

If indirect costs are included in the budget, include a copy of the indirect cost rate agreement in the Budget Narrative attachment. If you have never received a negotiated indirect cost rate and you are not a governmental department or agency unit that receives more than $35 million in direct federal funding, you may elect to charge a de minimis rate of 10 percent of modified total direct costs (MTDC), which may be used indefinitely. However, if chosen, this methodology must be used consistently for all federal awards until you negotiate for an indirect cost rate.

APPENDIX A: PROGRAM SPECIFIC FORMS INSTRUCTIONS

Form 3: Income Analysis

Form 3 collects the projected patient services and other income from all sources (other than the Health Center Program funds) for the upcoming budget period. Form 3 income is divided into two parts: (1) Patient Service Revenue - Program Income and (2) Other Income - Other Federal, State, Local, and Other Income.

Part 1: Patient Service Revenue — Program Income

Patient service revenue is income directly tied to the provision of services to the health center's patients. Services to patients that are reimbursed by health insurance plans, managed care organizations, categorical grant programs (e.g., breast and cervical cancer screening), employers, and health provider organizations are classified as patient service revenue. Reimbursements may be based upon visits, procedures, member months, enrollees, the achievement of performance goals, or other service related measures.

The program income section groups billable visits and income into the same five payer groupings used in the UDS Manual. All patient service revenue is reported in this section of the form.

Patient service revenue includes income earned from Medicaid and Medicare rate settlements and wrap reconciliations that are designed to make up the difference between the approved Federally Qualified Health Center (FQHC) rate and the interim amounts received. It includes risk pool and other incentive income as well as primary care case management fees.

Only include patient service revenue associated with sites or services in the approved scope of project. Do not include patient service revenue for sites or services not in the approved scope of project or pending HRSA approval.

Patients by Primary Medical Insurance — Column (a): The projected number of unduplicated patients classified by payer based upon the patient's primary medical insurance (payer billed first). The patients are classified in the same way as in the UDS Manual, Table 4, lines 7 – 12. Do not include patients who are only seen for non-billable or enabling service visits. Examples for determining where to count patients include:

- A crossover patient with Medicare and Medicaid coverage is to be classified as a Medicare patient on line 2.
- A Medicaid patient with no dental coverage who is only seen for dental services is to be classified as a Medicaid patient on line 1 with a self-pay visit on line 5.

Billable Visits — Column (b): Includes all billable/reimbursable visits.[2] The value is typically based on assumptions about the amount of available clinician time, average visit time (based on complexity of patient conditions and use of team provider arrangements) and types of billable visits by payer. There may be other exclusions or

[2] These visits will correspond closely with the visits reported on the UDS Manual Table 5, excluding enabling service visits.

additions, which, if significant, should be noted in the Comment/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column (see Ancillary Instructions below).

Note: The patient service income budget is primarily based upon income per visit estimates. However, some forms of patient service income do not generate reportable visits, such as income from laboratory or pharmacy services, capitated managed care, performance incentives, wrap payments, and cost report settlements. You may choose to include some or all of this income in the income per visit assumption, basing it on historical experience. You may also choose to separately budget for some or all of these sources of patient service income.

Income per Visit — Column (c): Calculated by dividing projected income in Column (d) by billable visits in Column (b).

Projected Income — Column (d): Projected accrued net revenue, including an allowance for bad debt, from all patient services for each pay grouping. Pharmacy income may be estimated using historical data to determine the number of prescriptions per medical visit and the average income per prescription. All separate projections of income are consolidated and reported here.

Prior FY Income — Column (e): The income data from the health center's most recent fiscal year, which will be either interim statement data or audit data.

Alternative Instructions for Capitated Managed Care:
Health centers may use their own methods for budgeting patient service income other than those noted above, but must report the consolidated result in Projected Income Column (d), along with the related data requested in Columns (a) through (e). Income for each service may be estimated by multiplying the projected visits by assumed income per visit. For example, capitated managed care income may be based upon member-month enrollment projections and estimated capitation rates for each plan, grouped by payer and added to the projected income. The estimated visits associated with these managed care plans are entered in Column (b).

Payer Categories (Lines 1 – 5): There are five payer categories including Medicaid, Medicare, Other Public, Private, and Self-Pay, reflecting the five payer groupings in UDS. The UDS Manual must be used to define each payer category.

Visits are reported on the line of the primary payer (payer billed first). Income is classified by the payer groupings where the income is earned. When a single visit involves more than one payer, attribute that portion of the visit income to the payer group from which it is earned. In cases where there are deductibles and co-payments to be paid by the patient, report that income on the self-pay line. If the co-payment is to be paid by another payer, report that income on the other payer's line. It is acceptable if you cannot accurately associate the income to secondary and subsequent sources.

Ancillary Instructions: All service income is to be classified by payer, including pharmacy and other ancillary service revenue. If you do not normally classify the projected ancillary or other service revenue by payer category, allocate the by projected income by payer group using a reasonable method, such as the proportion of medical visits or charges. The method used should be noted in the Comments/Explanatory Notes section at the bottom of the form.

Medicaid (Line 1): Income from FQHC cost reimbursement; capitated managed care; fee-for-service managed care; Early Periodic Screening, Diagnosis, and Treatment (EPSDT); Children's Health Insurance Program (CHIP); and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from FQHC cost reimbursement reconciliations, wrap payments, incentives, and primary care case management income.

Medicare (Line 2): Income from the FQHC cost reimbursement, capitated managed care, fee-for-service managed care, Medicare Advantage plans, and other reimbursement arrangements administered either directly by Medicare or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from the FQHC cost reimbursement, risk pool distributions, performance incentives, and case management fee income.

Other Public (Line 3): Income not reported elsewhere from federal, state, or local government programs earned for providing services. A CHIP operated independently from the Medicaid program is an example of other public insurance. Other Public income also includes income from categorical grant programs when the grant income is earned by providing services. An example of this includes the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program.

Private (Line 4): Income from private insurance plans, managed care plans, and other private contracts for service. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, service contracts with employers, and Veteran's Administration Community Based Outpatient Clinic (CBOC) contracts. Income from health benefit plans which are earned by government employees, veterans, retirees, and dependents, such as TRICARE, the federal employee health benefits program, state employee health insurance benefit programs, teacher health insurance, and similar plans are to be classified as private insurance. Private insurance is earned or paid for by the beneficiary and other public insurance is unearned or based upon meeting the plan's eligibility criteria.

Self-Pay (Line 5): Income from patients, including full-pay, self-pay, and sliding fee patients, as well as the portion of the visit income for which an insured patient is personally responsible.

Total (Line 6): Sum of lines 1-5.

Part 2: Other Income – Other Federal, State, Local, and Other Income
This section includes all income other than the patient service revenue shown in Part 1 (exclusive of this Health Center Program funding request). It includes other federal, state, local, and other income. It is income that is earned but not directly tied to providing visits, procedures, or other specific services. Income is to be classified on the lines below based upon the source from whom the revenue is received. Income from services provided to non-health center patients either in-house or under contract with another entity such as a hospital, nursing home or other health center is to be reported in Part 2: Other Income (see examples below). This would include income from in-house retail pharmacy sales to individuals who are not patients of the health center.

Other Federal (Line 7): Income from direct federal funds (where your organization is the recipient of a Notice of Award from a federal agency). It does not include the Health Center Program funding request or federal funds awarded through intermediaries (see Line 9 below). It includes funds from federal sources such as the CDC, Housing and Urban Development (HUD), Centers for Medicare and Medicaid Services (CMS), and Department of Health and Human Service (DHHS) funding under the Ryan White HIV/AIDS Program Part C. The CMS Medicare and Medicaid EHR incentive program income is reported here in order to be consistent with the UDS Manual.

State Government (Line 8): Income from state government funding, contracts, and programs, including uncompensated care funding; state indigent care income; emergency preparedness funding; mortgage assistance; capital improvement funding; school health funding; Women, Infants, and Children (WIC); immunization funding; and similar awards.

Local Government (Line 9): Income from local government grants, contracts, and programs, including local indigent care income, community development block grants, capital improvement project funding, and similar awards. For example: (1) a health center that contracts with the local Department of Health to provide services to the Department's patients is to report all the income earned under this contract on this line, and (2) Ryan White Part A funds are federal funds awarded to municipalities who in turn make awards to provider organizations, so Ryan White Part A funding would be classified as income earned from a local government and be shown on this line.

Private Grants/Contracts (Line 10): Income from private sources, such as foundations, non-profit entities, hospitals, nursing homes, drug companies, employers, other health centers, and similar entities. For example, a health center operating a 340B pharmacy in part for its own patients and in part, as a contractor to another health center is to report the pharmacy income for its own patients in Part 1 and the income from the contracted health center on this line.

Contributions (Line 11): Income from private entities and individual donors that may be the result of fund raising.

Other (Line 12): Incidental income not reported elsewhere, including items such as interest income, patient record fees, vending machine income, dues, and rental income. Applicants typically have at least some Other income to report on Line 12.

Applicant (Retained Earnings) (Line 13): The amount of funds needed from your organization's retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why applicant funds (retained earnings) are needed to achieve a breakeven budget. Amounts from non-federal sources, combined with the Health Center Program funds, should be adequate to support normal operations.

Total Other (Line 14): The sum of lines 7 – 13.

Total Non-Federal (Line 15): The sum of Lines 6 and 14 (the total income aside from this Health Center Program grant).

Note: In-kind donations are not included as income on Form 3.

Forms 5A: Services Provided, 5B: Service Sites, and 5C: Other Activities/Locations – Scope of Project

Only services, sites, and other activities/locations included on Forms 5A, 5B, and 5C respectively are included in your approved scope of project. Data will pre-populate from the official scope of project and cannot be modified. If the pre-populated data do not reflect recent scope changes, click the 'Refresh from Scope' button to update scope data in the BPR.

Note: If the information presented in the BPR on Forms 5A and 5B is not accurate after it has been refreshed, you must take action to correct this information **before** BPR submission. For more information, review Chapter 6: Accessible Locations and Hours of Operation of the Compliance Manual, and contact your Project Officer for additional assistance.

Scope Certification Form

The Scope Certification Form requires certifications for Form 5A: Services Provided and Form 5B: Service Sites. First, certify that the scope of project for services (including service delivery methods) is accurate, as presented on Form 5A: Services Provided in the BPR. Second, certify that the scope of project for sites is accurate, as presented on Form 5B: Service Sites in the BPR. **If you cannot certify the accuracy of Form 5A and/or Form 5B, you must certify that you have submitted a Scope Adjustment or CIS request to HRSA to correct the presented information.**