Instructions for Preparing and Submitting the Fiscal Year (FY) 2017 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	EHB Access (Mondays)	EHB Deadline (Fridays at 5:00 PM ET)
January 1, 2017	July 11, 2016	September 2, 2016
February 1, 2017	July 26, 2016	September 19, 2016
March 1, 2017	August 22, 2016	October 14, 2016
April 1, 2017	September 26, 2016	November 18, 2016
May 1, 2017	October 24, 2016	December 16, 2016
June 1, 2017	November 14, 2016	January 13, 2017

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 FY 2017 BPR reports on progress made from the beginning of an award recipient's FY 2016 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 2017 budget period.

The BPR is completed by award recipients who **do not** have a project period end date in FY 2017 (October 1, 2016 – September 30, 2017).

Summary of Changes (compared to the FY 2016 BPR)

Changes to the Program Narrative Update include:

- The Supplemental Awards section has been updated to reflect the most current list of supplemental awards.
- The One-Time Funding Awards section has been added to collect information on activities based on recent one-time funding awards.
- The Clinical Performance Measures section includes notes regarding several recently revised measures.

I. TECHNICAL ASSISTANCE

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

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

Carolyn Testerman
Office of Federal Assistance Management
HRSA Division of Grants Management Operations
301-594-4244
ctesterman@hrsa.gov

Programmatic technical assistance is available by contacting:

Karen Fitzgerald
Office of Policy and Program Development
HRSA Bureau of Primary Health Care
301-594-4300
BPHCBPR@hrsa.gov

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 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 progress report 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.

Health Center Program award recipients are required to request prior approval from HRSA for post-award changes including, but not limited to, changes in the Project Director/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 HHS at 45 CFR 75.308). These changes must be requested via the Prior Approval Module or Change in Scope (CIS) Module in EHB, as appropriate. For further detail on actions and changes requiring prior approval, review the HHS Grants Policy Statement.

Table 2 identifies the required components for the BPR submission. In the Form Type column of Table 2, the word "Form" refers to forms that are completed online through EHB. The word "Document" refers to materials that must be uploaded into 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 Program Narrative Update, the Budget Narrative, and the Scope Certification 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 EHB user guide available at the BPR TA webpage.
Budget Information: Budget Details	Form	See Section IV for detailed instructions.
Budget Narrative	Document	See Section IV for detailed instructions.

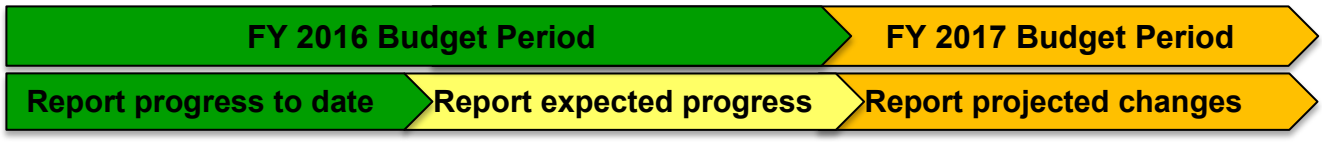
BPR Section	Form Type	Instructions
Form 3: Income Analysis	Form	Provide projected program income for the upcoming budget period.
Forms 5A, 5B, and 5C	Fixed	These forms are pre-populated to reflect the current scope of project. Changes must be requested via the Change in Scope (CIS) module or a self-update in EHB. Contact your Project Officer for guidance.
Scope Certification Form	Form	Certify that the sites and services in scope are accurate or that a CIS request or self-update has been submitted to correct inaccurate information. Contact your Project Officer for guidance.
Program Narrative Update	Form	See Section III for detailed instructions.

III. Instructions for Program Narrative Update

The Program 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 2016 budget period until the date of the BPR submission;
2. Expected progress for the remainder of the FY 2016 budget period; and
3. Projected plans for the FY 2017 budget period.

Reporting Your Budget Period Progress



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

Each of the six key areas requires responses and each response section is limited to 3,000 characters, or approximately 1 page.

1. **Environment:** Discuss changes in the region, state, and/or community over the past year that have directly impacted/affected the project's progress (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 Children's Health Insurance Program (CHIP)).

2. **Organizational Capacity:** Discuss 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, including 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. Explain key factors driving significant changes in patient numbers and any downward trends or limited progress toward the projected patient goals.

4. **Supplemental Awards:** See Table 4: Supplemental Awards. Discuss 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.

   ***Note*:** If you did not receive a Supplemental Award, the system will display "Not Applicable".

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, type "Not applicable" in the Activities column. For reference, a list of recipients for each award is available on the BPR TA webpage.

6. **Clinical/Financial Performance Measures:** See Table 6: Performance Measures. Referencing the % Change 2013-2015 Trend, % Change 2014-2015, and % Progress Toward Goal columns, discuss the trends in Clinical and Financial Performance Measures. Maintenance or improvement in performance is expected; 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 impacting/affecting progress toward goals; and
    c. Plans for sustaining progress and/or overcoming barriers to ensure goal achievement.

    ***Note*:** The Clinical and Financial Performance measure goals cannot be changed in the BPR.

    Awardees that were previously Look-Alikes: Look-Alike UDS data will not be pre-populated in the BPR.

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TABLE 3: PATIENT CAPACITY

	2013 Patient Number	2014 Patient Number	2015 Patient Number	% Change 2013-2015 Trend	% Change 2014-2015	% 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 2013 UDS	Pre-populated from 2014 UDS	Pre-populated from 2015 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	3,000 character limit

Notes:

- 2013 – 2015 Patient Number data are pre-populated from Table 3a in the UDS Report.
- % Change and % Progress Data are pre-populated calculations based on UDS Reporting.
- The Projected Number of Patients value is pre-populated from the Patient Target communicated via email to the Authorizing Official, Business Official, and Project Director on April 21, 2016. If you did not receive this email, contact BPHCPatientTargets@hrsa.gov.

TABLE 3: PATIENT CAPACITY (CONTINUED)

	2013 Patient Number	2014 Patient Number	2015 Patient Number	% Change 2013-2015 Trend	% Change 2014-2015	% 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 2013 UDS	Pre-populated from 2014 UDS	Pre-populated from 2015 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 2013 UDS	Pre-populated from 2014 UDS	Pre-populated from 2015 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 2016 BPR, if available*	Pre-populated from 2014 UDS	Pre-populated from 2015 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	3,000 character limit

Notes:

- The Projected Number of Patients column is pre-populated from the patient projection in the application that initiated your current project period (SAC) plus 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 based on when you last completed a SAC application.
- If pre-populated patient projections are not accurate, provide adjusted projections and explanation in the Patient Capacity Narrative section.
- 2013 – 2015 Patient Number data are pre-populated from Table 4 in the UDS Report.
- % Change and % Progress Data are pre-populated calculations based on UDS Reporting.
- (*) 2014 and 2015 public housing patient data are pre-populated from UDS. Since the 2013 public housing patient data were not included in Table 4 of the UDS Report, these data are pre-populated from the FY 2016 BPR, if available. If data are not pre-populated in this cell, provide the 2013 public housing patient number, as applicable, from your health center data.

TABLE 4: SUPPLEMENTAL AWARDS

Type of Supplemental Award	Programmatic Goal	Numeric Goal	Numeric Progress Toward Goal	Supplemental Award Narrative
FY 2014 NAP Satellite Grant	Achieve operational status and increase number of patients	Pre-populated with end of project period patient projection	As applicable	3,000 character limit
FY 2015 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 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 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 2014 Expanded Services (ES) Supplement	Increase the number of patients and expand availability of services	Pre-populated with the number of new patients to receive expanded services (new Expanded Medical Capacity patients)	As applicable	3,000 character limit
FY 2015 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 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

TABLE 5: ONE-TIME FUNDING AWARDS

For assistance with completing the One-Time Funding Awards section, visit the BPR TA webpage for a list of recipients for each noted one-time award. Use the Activities column to describe how funding will be or was already spent for all one-time awards received and the impact on the organization. "Not applicable" may be listed in the Activities column for any awards that were not received.

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)	Developing and improving health center 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

Type of One-Time Funding Award	Allowable Activities	Activities
FY 2016 Quality Improvement Assistance (September 2016)	Developing and improving health center 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: • purchasing supplies to support care coordination, case management, and medication management • developing and implementing 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 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

TABLE 6: PERFORMANCE MEASURES

	2013 Measure	2014 Measure	2015 Measure	% Change 2013-2015 Trend	% Change 2014-2015	% Progress Toward Goal	Measure Goal	Measure Narrative
Perinatal Health								
Access to prenatal care in 1st trimester	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	3,000 character limit
Low birth weight (< 2500 grams)	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Preventive Health Screenings and Services								
Oral health—sealants*	Data not available	Data not available	Award recipient to provide data	Data not available	Data not available	Pre-populated calculation if 2015 data and a Measure Goal are provided	Pre-populated if a goal was provided in the FY 2016 SAC or BPR	3,000 character limit
Weight assessment and counseling for children and adolescents	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Adult weight screening and follow up	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	

	2013 Measure	2014 Measure	2015 Measure	% Change 2013-2015 Trend	% Change 2014-2015	% Progress Toward Goal	Measure Goal	Measure Narrative
Tobacco use screening and cessation	Data not available	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Data not available	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Colorectal cancer screening	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Cervical cancer screening	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Childhood immunizations by 3rd birthday	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Chronic Disease Management								
Asthma treatment—pharmacologic therapy	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	3,000 character limit

	2013 Measure	2014 Measure	2015 Measure	% Change 2013-2015 Trend	% Change 2014-2015	% Progress Toward Goal	Measure Goal	Measure Narrative
Coronary artery disease (CAD) and lipid-lowering therapy	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Ischemic Vascular Disease (IVD) and aspirin or other anti-thrombotic therapy	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Blood pressure control	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Diabetes control**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
HIV linkage to care	Data not available	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Data not available	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Depression screening and follow up	Data not available	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Data not available	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	

	2013 Measure	2014 Measure	2015 Measure	% Change 2013-2015 Trend	% Change 2014-2015	% Progress Toward Goal	Measure Goal	Measure Narrative
Financial Measures								
Total cost per patient	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	3,000 character limit
Medical cost per medical visit	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Health Center Program grant cost per patient* **	Data not available	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Data not available	Pre-populated calculation	Pre-populated calculation after goal is established	Pre-populated from the application that initiated the current budget 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 budget period	3,000 character limit

Notes:

- Measure goals are pre-populated from the Measure Goal from your FY2016 SAC/BPR.
- If pre-populated performance measure goals are not accurate, provide adjusted goals and explain (e.g., goal for the blood pressure control measure has increased based on improved patient tracking via a new EHR) in the appropriate Measure Narrative section.
- (*)The Oral health—sealants Measure %Progress Toward Goal field will be prepopulated if a goal was provided in the FY 2016 SAC or BPR. An Oral health—sealants goal must be established in the FY17 BPR if one was not established last year. For providing 2015 Oral health—sealants data, your 2015 UDS Report should serve as a useful resource.
- (**)Due to the fact that award recipients set their diabetes goals and reported UDS data based on different diabetes measure definitions, N/A will be shown for all fields, and narrative progress toward the goal is not required in this submission. However, work should continue in this priority area and progress should be shown in the 2016 UDS Report.
- (***)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

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-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-grant funds, provided that the projected budget complies with all applicable HHS policies and other Federal requirements. See PIN 2013-01 for additional information on health center budgeting.

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: 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 (e.g., CHC, MHC). 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.

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 (e.g., CHC, MHC). 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 (e.g., CHC, MHC). 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

Provisions enacted in the Consolidated Appropriations Act, 2016 Division H, § 202, (P.L. 114-113) will continue in 2017. The 2016 Consolidated Appropriations Act limits the salary amount that may be awarded and charged to HRSA grants. Award funds may not be used to pay the salary of an individual at a rate in excess of Federal Executive Level II of the Federal Executive Pay scale (currently $185,100). This amount reflects an individual's base salary exclusive of fringe benefits and income that an individual may be permitted to earn outside of the duties to the health center organization (i.e. the rate limitation only limits the amount that may be awarded and charged to HRSA grants). This salary limitation also applies to sub-awards/subcontracts under a HRSA grant.

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 $185,100, 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 $115,688 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 Application Budget due to the Legislative Salary Limitation: Individual's base full time salary adjusted to Executive Level II: $185,100 (50% of time will be devoted to the project)	
Direct Salary	$92,550
Fringe (25% of salary)	$23,138
Total Salary claimed	$115,688

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 which 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 and 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 EHB. Include the following:

Personnel Costs: Personnel costs must be explained by listing in line-item format the exact amount requested for the upcoming budget period. ***Reminder:*** Health Center Program grant funds may not be used to pay the salary of an individual at a rate in excess of Federal Executive Level II or $185,100.[1] An individual's base salary, per se, is **not** constrained by the legislative provision; the rate limitation restricts the amount of the salary that may be charged to the Health Center Program grant. Provide all base salaries at the full amount even if they exceed the salary limit.

See **Table 8** below for the information that **must** be included in the BPR submission for each staff position supported in whole or in part with federal Health Center Program grant funds. Staff supported entirely with non-federal funds do not require this level of information.

[1] While the BPR focuses on 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 $185,100.

TABLE 8: BUDGET SAMPLE FOR SALARY LIMITATION

Name	Position Title	% of FTE	Base Salary	Adjusted Annual Salary	Federal Amount Requested
J. Smith	Physician	50%	$ 255,000	$185,100	$92,550
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 of the fringe benefit rate (e.g., health insurance, taxes, unemployment insurance, life insurance, retirement plan, and tuition reimbursement). Fringe benefits must be directly proportional to the portion of personnel costs.

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

Equipment: Identify the cost per item and justify the need for each piece of equipment to carry out the proposed project. Equipment includes moveable items that are non-expendable, 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 (a) the capitalization level established by the awardee for its financial statement purposes, or (b) $5,000.

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

Contractual: Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. List both patient care (e.g., laboratory) and non-patient care (e.g., janitorial) contracts. Each awardee is responsible for ensuring that its organization/institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring contracts. Refer to Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75 for regulations regarding sub-recipient and contractor agreements.

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

cultural/linguistic competence modifications (e.g., use of cultural brokers, translation, or interpretation services at meetings, clinical visits, and conferences).

Indirect Charges: Costs incurred for common or joint objectives that cannot be readily identified but are necessary to organizational operation (e.g., facility operation and maintenance, depreciation, administrative salaries). Visit https://rates.psc.gov/ to learn more about rate agreements, including the process for applying for them.

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. This includes all income from medical, dental, mental health, substance abuse, other professional, vision, and other clinical services, as well as income from ancillary services such as laboratory, pharmacy, and imaging services.

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 FQHC rate and the interim amounts received. It includes risk pool and other incentive income as well as primary care case management fees.

Patient service revenue associated with sites or services not in the approved scope of project, including those pending approval, must be excluded.

Patients by Primary Medical Insurance - Column (a): These are the projected number of unduplicated patients classified by payer based upon the patient's primary medical insurance. The primary insurance is the payer that is billed first. The patients are classified in the same way as found in the UDS Manual, Table 4, lines 7 – 12. This column should 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): This includes all billable/reimbursable visits.[2] The value is typically based on assumptions about consolidated individual clinician time, productivity, and visits by payer. There may be other exclusions or 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, there are some forms of patient service income which do not generate reportable visits in the UDS or on Form 3 or which is not earned from providing visits, such as income from laboratory or pharmacy services; capitated managed care; performance incentives; wrap payments; and cost report settlements. Applicants may choose to include some or all of this income in the income per visit assumption, basing it on historical experience. Applicants may also choose to separately budget for some or all of these sources of patient service income.

Income per Visit - Column (c): This value may be calculated by dividing projected income in Column (d) by billable visits in Column (b).

Projected Income - Column (d): This is the projected accrued net revenue, including an allowance for bad debt from all patient services for each pay grouping in the first year of the upcoming budget period. Pharmacy income may be estimated by 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 in Column (d).

Prior FY Income – Column (e): This is the income data from the health center's most recent fiscal year, which will be either interim statement data or audit data. The fiscal year was specified because the interim data can eventually be compared to actual audit data.

Alternative Instructions for Capitated Managed Care:
Health center's may use their own methods for budgeting patient service income 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.

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

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, that income is to be shown on the self-pay line. If the co-payment is to be paid by another payer, that income should be shown on the other payer's line. It is acceptable if the applicant 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. In the event the applicant does not normally classify the projected ancillary or other service revenue by payer category, the projected income is to be allocated by payer group using a reasonable allocation 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): This includes 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): This includes 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 care management fee income from the Affordable Care Act (ACA) Medicare Demonstration Program.

Other Public (Line 3): This includes income from federal, state, or local government programs earned for providing services that is not reported elsewhere. 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. Examples of these include the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and the Title X Family Planning Program.

Private (Line 4): This includes income from private insurance plans, managed care plans, insurance plans from the ACA marketplaces/exchanges, 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): This includes 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): This is the 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 (patients of an entity with which the health center is contracting) 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. See Lines 9 and 10 for examples of services provided to non-health center patients (patients of an entity with which the health center is contracting).

Other Federal (Line 7): This is income from federal funds where the applicant 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 others. It includes Department of Health and Human Service (DHHS) funding under the Ryan White HIV/AIDS Program Part C, DHHS Capital Development funding, and others. 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): This is 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): This is 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): This is income from private sources, such 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): This is income from private entities and individual donors that may be the result of fund raising.

Other (Line 12): This is incidental income not reported elsewhere and includes 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): This is the amount of funds needed from the applicant'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): This is the sum of lines 7 – 13.

Total Non-Federal (Line 15): This is the sum of Lines 6 and 14 and is the total non-federal (non-Health Center Program) income.

Note*:* In-kind donations are not included as income on Form 3. Such donations may be included on the SF-424A (Section A: Budget Summary—Non-Federal Resources under New or Revised Budget).

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. Review the Scope of Project resources, 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: Services 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 CIS request to correct the presented information.**