# Fiscal Year 2019 Health Center Program
# Budget Period Progress Report
# Non-Competing Continuation Instructions

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### TABLE 1: SUBMISSION SCHEDULE

| Budget Period Start Date | HRSA EHBs Access (Mondays) | HRSA EHBs Deadline (Fridays at 5:00 PM ET) |
|---|---|---|
| January 1, 2019 | June 25, 2018 | August 17, 2018 |
| February 1, 2019 | July 16, 2018 | September 7, 2018 |
| March 1, 2019 | August 20, 2018 | October 12, 2018 |
| April 1, 2019 | September 17, 2018 | November 9, 2018 |
| May 1, 2019 | October 22, 2018 | December 14, 2018 |
| June 1, 2019 | November 19, 2018 | January 11, 2019 |

## 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) 2019 BPR reports on progress made from the beginning of your FY 2018 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 2019 budget period.

Complete the BPR if you **do not** have a project period end date in FY 2019 (October 1, 2018 – September 30, 2019).

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

## Summary of Changes (compared to the FY 2018 BPR)

- Health Center Program requirements are detailed in the Health Center Program Compliance Manual (Compliance Manual).
- The Telehealth section was added to the Project Narrative Update.
- The Patient Capacity section was updated to include Patients and Visits by Service Type.
- The Supplemental Awards section was updated to streamline reporting and to reflect the most current list of supplemental awards. Reporting on progress for supplemental awards released in late FY 2018 or early FY 2019 will be included in the FY 2020 BPR.
- The One-Time Funding Awards section was updated to reflect the most current list of one-time funding awards.
- The Clinical Performance Measures section was updated to reflect the most current list of Uniform Data System (UDS) clinical performance measures and highlights measures aligned with HRSA and BPHC clinical and financial priorities.
- The term "*substance use disorder services*" has replaced "*substance abuse services*," both in this document and on 5A: Services Provided.
- All narrative fields have been reduced from 3,000 to 2,000 characters to streamline reporting.

## I. TECHNICAL ASSISTANCE

Technical assistance resources are available on the BPR technical assistance (TA) webpage. The webpage includes copies of forms, the HRSA EHBs 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
https://www.hrsa.gov/about/contact/bphc.aspx (select either Applicant or BPHC Grantee, Application/Progress Report: Instructions, BPR)

HRSA EHBs system technical assistance is available by contacting:
BPHC Helpline
1-877-974-2742
https://www.hrsa.gov/about/contact/bphc.aspx (select either Applicant or BPHC Grantee, Electronic Handbooks (EHBs))

## 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 the HRSA EHBs 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 (NoA) 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 the HRSA EHBs, 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 the HRSA EHBs. The word "Document" refers to materials that must be uploaded into the HRSA

EHBs. 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.

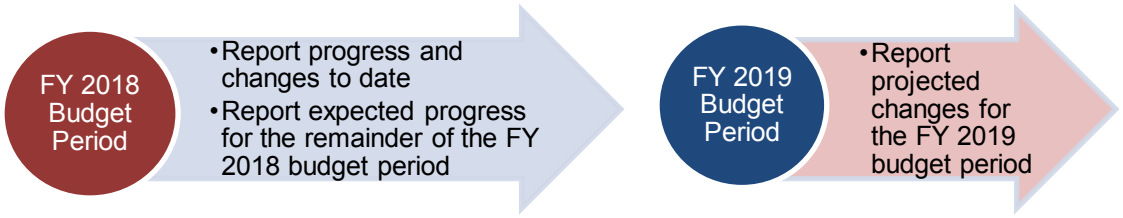
| BPR Section | Form Type | Instructions |
|---|---|---|
| SF-PPR and SF-PPR-2 | Form | Provide basic organizational information. Refer to instructions in the HRSA EHBs user guide available at the BPR TA webpage. |
| Budget Information: Budget Details | Form | Provide the budget for the upcoming budget 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 the HRSA EHBs. 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 includes seven Key Areas (Environment, Organizational Capacity, Telehealth, Patient Capacity, Supplemental Awards, One-Time Funding Awards, and Clinical/Financial Performance Measures) that require narrative reporting (see below). The narrative for each section should address the following:

1. Progress towards goals and/or and changes that have impacted the community/target population and your organization from the beginning of the FY 2018 budget period until the date of the BPR submission;
2. Expected progress for the remainder of the FY 2018 budget period; and
3. Projected changes for the FY 2019 budget period.

**Reporting Your Budget Period Progress**




The BPR TA webpage includes frequently asked questions that may assist you in completing the Project Narrative Update.

## Seven Key Areas of the Project Narrative Update

Each of the seven Key Areas requires a narrative response, and each response section is limited to 2,000 characters, or approximately 1.5 pages.

1. **Environment:** Discuss the major changes at the community level, as well as state and/or regional level changes, over the past year that have directly impacted the progress of the funded project, including changes in:
    - Service area demographic and shifting target population needs;
    - Major health care providers in the service area;
    - Key program partnerships; and
    - 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, including key vacancies;
    - Operations;

- Systems, including financial, clinical, and/or practice management systems; and
- Financial status, including the most current audit findings, as applicable.

3. **Telehealth:** Describe your use of telehealth to provide comprehensive primary health care services and engage in professional education, as applicable. Telehealth is defined as the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

4. **Patient Capacity:** See Table 3: Patient Capacity. Discuss the trends 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 changes in patient numbers and any negative trends or limited progress toward the projected patient goals.

5. **Supplemental Awards:** See Table 4: Supplemental Awards. In the Supplemental Award Narrative column, describe the following:
   - Implementation status and progress toward goals;
   - Key contributing and restricting factors impacting progress toward goals; and
   - Plans for sustaining progress and/or overcoming barriers to ensure goal achievement.

6. **One-Time Funding Awards:** See Table 5: One-Time Funding Awards. In the Activities column, discuss the activities for which the funds were used and the impact on your organization.

7. **Clinical/Financial Performance Measures:** See Table 6: Performance Measures. Referencing the % Change 2015-2017 Trend, % Change 2016-2017 Trend, and % Progress Toward Goal columns, discuss the trends for:
   - Each of the measures aligned with HRSA and BPHC clinical and financial priorities:
     - Diabetes: Hemoglobin A1c Poor Control
     - Screening for Clinical Depression and Follow-Up Plan
     - Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
     - Body Mass Index (BMI) Screening and Follow-Up
     - Health Center Program Grant Cost Per Patient (Grant Costs)
   - The measures within each of the remaining sections for which you have experienced a negative trend. If you have no negative trends within one or more of these sections (e.g., Preventive Health Screenings and Services), state this in the Measure Narrative field for the relevant section(s).

In the Clinical/Financial Performance Measures Narrative column, describe the following as it relates to the data:

a. An explanation of negative trends;
b. Key contributing and restricting factors affecting progress toward goals; and
c. Plans for improving progress and/or overcoming barriers to ensure goal achievement.

## TABLE 3: PATIENT CAPACITY

| | 2015 Patient Number | 2016 Patient Number | 2017 Patient Number | % Change 2015-2017 Trend | % Change 2016-2017 Trend | % 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 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Pre-populated calculation | Pre-populated calculation | Pre-populated calculation | Pre-populated (see note for explanation) | 2,000 character limit |

**Notes:**
- 2015–2017 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 noted in the Patient Target Management Module in the HRSA EHBs. If you have questions related to your Patient Target, contact the Patient Target Response Team at BPHCPatientTargets@hrsa.gov. To formally request a change in your Patient Target, you **must** submit a request via the Patient Target Management Module in the HRSA EHBs.

| | 2015 Patient Number | 2016 Patient Number | 2017 Patient Number | % Change 2015-2017 Trend | % Change 2016-2017 Trend | % 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 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Pre-populated calculation | Pre-populated calculation | Pre-populated calculation | Pre-populated (see note for explanation) | 2,000 character limit |
| **Total People Experiencing Homelessness Patients** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Pre-populated calculation | Pre-populated calculation | Pre-populated calculation | Pre-populated (see note for explanation) | 2,000 character limit |
| **Total Public Housing Resident Patients** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Pre-populated calculation | Pre-populated calculation | Pre-populated calculation | Pre-populated (see note for explanation) | 2,000 character limit |

**Notes:**
- 2015-2017 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 projections in the submission that initiated your current project period (Service Area Competition (SAC)) 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.
- Patient projections cannot be edited during the BPR submission. If pre-populated patient projections are not accurate, provide adjusted projections and an explanation in the Patient Capacity Narrative section.

| | 2015 Patient Number | 2016 Patient Number | 2017 Patient Number | % Change 2015-2017 Trend | % Change 2016-2017 Trend | % Progress Toward Goal | Projected Number of Patients | Patient Capacity Narrative |
|---|---|---|---|---|---|---|---|---|
| **Project Period: (Pre-populated from most recent Notice of Award)** | | | | | | | | |
| **Total Medical Services Patients** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Pre-populated calculation | Pre-populated calculation | Pre-populated calculation | Pre-populated (see note for explanation) | 2,000 character limit |
| **Total Dental Services Patients** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Pre-populated calculation | Pre-populated calculation | Pre-populated calculation | Pre-populated (see note for explanation) | 2,000 character limit |
| **Total Mental Health Services Patients** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Pre-populated calculation | Pre-populated calculation | Pre-populated calculation | Pre-populated (see note for explanation) | 2,000 character limit |
| **Total Substance Use Disorder Services Patients** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Pre-populated calculation | Pre-populated calculation | Pre-populated calculation | Pre-populated (see note for explanation) | 2,000 character limit |
| **Total Enabling Services Patients** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Pre-populated calculation | Pre-populated calculation | Pre-populated calculation | Pre-populated (see note for explanation) | 2,000 character limit |

**Notes:**

- 2015-2017 Patient Number data are pre-populated from Table 5 in the UDS Report.
- The Projected Number of Patients column is pre-populated from the patient projections in the submission that initiated your current project period (SAC) 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.
- Patient projections cannot be edited during the BPR submission. 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 | Supplemental Award Narrative |
|---|---|---|
| **FY 2016 Substance Abuse Expansion** | Increase the number of patients receiving integrated substance use disorder services, including Medication-Assisted Treatment (MAT) by December 31, 2017 | 2,000 character limit |
| **FY 2016 Oral Health Expansion** | Increase the percentage of health center patients receiving integrated dental services at the health center by December 31, 2017 | 2,000 character limit |
| **FY 2017 NAP Satellite** | Achieve operational status and increase the number of patients by December 31, 2018 | 2,000 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 use disorder services focusing on the treatment, prevention, and awareness of opioid abuse by December 31, 2018 | 2,000 character limit |

**Notes:**
- If you did not receive a Supplemental Award, the system will not require narrative in the Supplemental Award Narrative column.
- Supplemental awards released late in FY 2018 or early in FY 2019 will be included in the FY 2020 BPR.

## TABLE 5: ONE-TIME FUNDING AWARDS

| Type of One-Time Funding Award | Allowable Activities | Activities |
|---|---|---|
| **FY 2016 Delivery System Health Information Investment** | Implementing strategic investments in health information technology (health IT) enhancements to:<br>• Accelerate health centers' transition to value-based models of care<br>• Improve efforts to share and use information to support better decisions<br>• Increase engagement in delivery system transformation<br><br>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:<br>• 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)<br>• Health information system enhancements<br>• Training<br>• Data aggregation, analytics, and data quality improvement activities | 2,000 character limit |
| **FY 2016 Quality Improvement Assistance (September 2016)**<br><br>**FY 2017 Quality Improvement Assistance (August 2017)** | Developing and improving health center quality improvement (QI) systems and infrastructure:<br>• Training staff<br>• Purchasing medically accessible clinical equipment<br>• Enhancing health information technology, certified electronic health record, and data systems<br>• Data analysis<br>• Implementing targeted QI activities (including hiring consultants)<br><br>Developing and improving care delivery systems:<br>• Purchasing supplies to support care coordination, case management, and medication management<br>• Laboratory reporting and tracking<br>• Training and workflow redesign to support team-based care<br>• Clinical integration of behavioral health, oral health, HIV care, and other services | 2,000 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:<br>• Expand mental health services, and substance use disorder services focusing on the treatment, prevention, and awareness of opioid abuse<br>• Integrate expanded services into primary care<br><br>Funding must be used for health IT and/or training investments in one or more of the following Activity Categories:<br>• Medication Assisted Treatment<br>• Telehealth<br>• Prescription Drug Monitoring Program<br>• Clinical Decision Support<br>• EHR Interoperability<br>• Quality Improvement<br>• Cybersecurity<br>• Other Training<br>• Other IT | 2,000 character limit |
| **Notes:**<br>• If you did not receive a One-Time Funding Award, the system will not require narrative in the Activities column.<br>• One-time awards released late in FY 2018 or early in FY 2019 will be included in the FY 2020 BPR. | | |

## TABLE 6: PERFORMANCE MEASURES

| | 2015 Measure | 2016 Measure | 2017 Measure | % Change 2015-2017 Trend | % Change 2016-2017 Trend | % Progress Toward Goal | Measure Goal | Measure Narrative |
|---|---|---|---|---|---|---|---|---|
| **Measures Aligned with HRSA and BPHC Clinical and Financial Priorities** | | | | | | | | |
| **Clinical Measures** | | | | | | | | |
| **Diabetes: Hemoglobin A1c Poor Control** | Data not available | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Data not available | Pre-populated calculation | Pre-population calculation | Pre-populated from the application that initiated the current project period | 2,000 character limit |
| **Screening for Clinical Depression and Follow-Up Plan** | Data not available | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Data not available | Pre-populated calculation | Pre-populated calculation | Pre-populated from the application that initiated the current project period | 2,000 character limit |
| **Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Pre-populated calculation | Pre-populated calculation | Pre-populated calculation | Pre-populated from the application that initiated the current project period | 2,000 character limit |
| **Body Mass Index (BMI) Screening and Follow-Up** | Data not available | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Data not available | Pre-populated calculation | Pre-populated calculation | Pre-populated from the application that initiated the current project period | 2,000 character limit |

| | 2015 Measure | 2016 Measure | 2017 Measure | % Change 2015-2017 Trend | % Change 2016-2017 Trend | % Progress Toward Goal | Measure Goal | Measure Narrative |
|---|---|---|---|---|---|---|---|---|
| **Financial Measure** | | | | | | | | |
| **Health Center Program Grant Cost Per Patient (Grant Costs)** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Pre-populated calculation | Pre-populated calculation | Pre-populated calculation | Pre-populated from the application that initiated the current project period | 2,000 character limit |
| **Perinatal Health**** | | | | | | | | |
| **Early Entry into Prenatal Care** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Pre-populated calculation | Pre-populated calculation | Pre-populated calculation | Pre-populated from the application that initiated the current project period | 2,000 character limit |
| **Low Birth Weight** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | 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 for Children between 6 – 9 Years** | Data not available | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Data not available | Pre-populated calculation | Pre-populated calculation | Pre-populated from the application that initiated the current project period | 2,000 character limit |
| **Tobacco Use: Screening and Cessation Intervention** | Data not available | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Data not available | Pre-populated calculation | Pre-populated calculation | Pre-populated from the application that initiated the current project period | |

| | 2015 Measure | 2016 Measure | 2017 Measure | % Change 2015-2017 Trend | % Change 2016-2017 Trend | % Progress Toward Goal | Measure Goal | Measure Narrative |
|---|---|---|---|---|---|---|---|---|
| **Colorectal Cancer Screening** | Data not available | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Data not available | Pre-populated calculation | 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 2017 UDS | Data not available | Data not available | Pre-populated calculation | Pre-populated from the application that initiated the current project period | |
| **Childhood Immunization Status (CIS)** | Data not available | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Data not available | Pre-populated calculation | Pre-populated calculation | Pre-populated from the application that initiated the current project period | |
| **Chronic Disease Management**** | | | | | | | | |
| **Use of Appropriate Medications for Asthma** | Data not available | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Data not available | Pre-populated calculation | Pre-populated calculation | Pre-populated from the application that initiated the current project period | 2,000 character limit |

| | 2015 Measure | 2016 Measure | 2017 Measure | % Change 2015-2017 Trend | % Change 2016-2017 Trend | % Progress Toward Goal | Measure Goal | Measure Narrative |
|---|---|---|---|---|---|---|---|---|
| **Coronary Artery Disease (CAD): Lipid Therapy** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | 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 Antiplatelet*** | Data not available | Data not available | Pre-populated from 2017 UDS | Data not available | Data not available | Pre-populated calculation | Pre-populated from the application that initiated the current project period | |
| **Controlling High Blood Pressure** | Data not available | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Data not available | Pre-populated calculation | Pre-populated calculation | Pre-populated from the application that initiated the current project period | |
| **HIV Linkage to Care** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Pre-populated calculation | Pre-populated calculation | Pre-populated calculation | Pre-populated from the application that initiated the current project period | |

| | 2015 Measure | 2016 Measure | 2017 Measure | % Change 2015-2017 Trend | % Change 2016-2017 Trend | % Progress Toward Goal | Measure Goal | Measure Narrative |
|---|---|---|---|---|---|---|---|---|
| **Financial Measures**** | | | | | | | | |
| **Total Cost Per Patient (Costs)** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | Pre-populated calculation | Pre-populated calculation | Pre-populated calculation | Pre-populated from the application that initiated the current project period | 2,000 character limit |
| **Medical Cost Per Medical Visit (Costs)** | Pre-populated from 2015 UDS | Pre-populated from 2016 UDS | Pre-populated from 2017 UDS | 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 | 2,000 character limit |

**Notes:**

- See PAL 2017-02 for details about the two performance measures that were updated in 2017.
- 2015 – 2017 Measure fields will prepopulate from UDS, if available.
- (*) Due to the fact that Cervical Cancer and IVD goals were set and reported in UDS based on different measure definitions, data will not display for some fields.
- Performance measure goals cannot be edited during the BPR submission. If pre-populated performance measure goals are not accurate, provide an adjusted goal and explanation in the appropriate Measure Narrative section (e.g., goal for the low birth weight measure has increased based on improved patient tracking via a new EHR).
- (**) If you have no negative trends within one or more of these sections (e.g., Preventive Health Screenings and Services), state this in the Measure Narrative field for the relevant section(s).
- (***) 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 are included, as established in your most recent SAC application.
- If you were previously a look-alike, your look-alike UDS data will not pre-populate.

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 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.

You must 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. Therefore the total budget must reflect projections from **all** anticipated revenue sources from program income (e.g., fees, premiums, third party reimbursements, payments) that is generated from the delivery of services, and from "other non-Health Center Program grant sources" such as state, local, other federal, and non-federal sources. Health centers have discretion regarding how they propose to allocate the total budget between Health Center Program grant funds and other funding that supports the project, 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, funding type(s)[1], or allocation of Health Center Program funds between funding types.

***Notes:***
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.

As per the requirements in 45 CFR §75.205, HRSA performs risk assessments of organizations to be funded which includes a financial review. HRSA may apply special conditions to the award that correspond to the degree of risk assessed.

[1] Community Health Center – CHC, Migrant Health Center – MHC, Health Care for the Homeless – HCH, and/or Public Housing Primary Care – PHPC

## A. Budget Information: Budget Details Form

In **Section A: Budget Summary**, verify the pre-populated list of Health Center Program funding types (CHC, MHC, HCH, 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 (CHC, MHC, HCH, 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.

**Funding must be requested and will be awarded proportionately for all funding types as currently funded under the Health Center Program. No new funding 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 (CHC, MHC, HCH, 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 (CHC, MHC, HCH, PHPC). If the award recipient 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, 2018 (P.L. 115-31), Division H, 202 provides a salary rate limitation. The law 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 of Executive Level II, which is currently $189,600. See Section 5.1.iv Budget – Salary Limitation of HRSA's SF-424 Two-Tier Application Guide for additional information. 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 subrecipients under a HRSA grant. *Note* that these or other salary limitations will apply in FY 2019, 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 $189,600, 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 $118,500 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: $189,600 (50% of time will be devoted to the project) | |
| Direct Salary | $94,800 |
| Fringe (25% of salary) | $23,700 |
| Total Salary claimed | $118,500 |

## 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 the HRSA EHBs. 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 $189,600.[2] 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 the HRSA grant. 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 | $189,600 | $94,800 |
| 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 |
| D. Green | Outreach Coordinator | 50% | $65,000 | no adjustment needed | $32,500 |
| N. Merchant | Dentist | 100% | $200,000 | $189,600 | $189,600 |
| **Total** | **N/A** | **N/A** | **$628,950** | **N/A** | **$401,100** |

*Used when the base salary is over the limitation of $189,600

Ensure that personnel costs are supported by official records that accurately reflect the work performed and that internal controls provide reasonable assurance that the personnel costs are accurate, allowable, and allocable to the HRSA award.

**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., $189,600), 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 completing the travel. The budget should also reflect the 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, and provide the number of trips involved, the destinations, and the number of individuals for whom funds are requested.

[2] 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 $189,600.

**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.

**Supplies:** 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.

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/Subawards/Consultant:** 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 (see 2 CFR part 25). 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.

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 interpreters, plain language and health literacy print 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. Any non-federal entity that has never received a negotiated indirect cost rate, (except a governmental department or agency unit that receives more than $35 million in direct federal funding) 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.

## 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.[3] The value is typically based on assumptions about the amount of available clinician time, clinical productivity (visits per unit of time), and mix of billable by payer. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in

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

this column (see Ancillary Instructions below). Note other significant exclusions or additions in the Comment/Explanatory Notes box at the bottom of the form.

***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. Based on historical experience, you may choose to include some or all of this income in the income per visit assumption. 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 Fiscal Year (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, when available.

**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 the 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. Enter the estimated visits associated with these managed care plans in Column (b).

**Payer Categories (Lines 1 – 5):** The five payer categories (Medicaid, Medicare, Other Public, Private, and Self-Pay) reflect the five payer groupings in UDS. The UDS Manual includes definitions for each payer category.

Visits are reported on the line of the primary payer, which is the 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 each 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 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, wraparound payments, incentives, pharmaceutical reimbursements, 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, pharmaceutical reimbursements, and case management fee income.

**Other Public (Line 3):** Income not reported elsewhere from federal, state, or local government programs earned for providing services or pharmaceuticals. 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 services or pharmaceuticals. 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 Veterans 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 visits, procedures, or other specific services. Income is to be classified based on the source of revenue. 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 an NoA 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 Centers for Disease Control (CDC), Housing and Urban Development (HUD), Centers for Medicare and Medicaid Services (CMS), and Department of Health and Human Service funding under the Ryan White HIV/AIDS Program Part C, Facility Investment Program grants, and others. The CMS 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; Special Supplemental Nutrition Program for 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 received directly from the municipality would 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 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 fundraising.

**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 typically 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. Review the Scope of Project resources. For more information, review Chapter 4: Required and Additional Health Services and Chapter 6: Accessible Locations and Hours of Operation of the Compliance Manual. You may 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.**