

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Bureau of Primary Health Care**



***Look-Alike Initial Designation
Application Instructions***

Release Date: July 7, 2017

Modifications include alignment with minor HRSA Electronic Handbooks (EHB) forms changes and clarification of applicant operational status. All applications in progress or started in the EHB on or after the release date must adhere to these instructions.

Office of Policy and Program Development

Web form: http://bphccommunications.force.com/KnowledgeApp/pkb_oppd

E-mail: lookalike@hrsa.gov

Telephone: 301-594-4300

Initial Designation Technical Assistance Webpage:

<http://bphc.hrsa.gov/programopportunities/lookalike/initialdesignationinstructions.html>



Table of Contents

EXECUTIVE SUMMARY	3
HEATH CENTER PROGRAM LOOK-ALIKE INITIAL DESIGNATION DESCRIPTION	5
ELIGIBILITY	8
APPLICATION SUBMISSION INFORMATION.....	10
APPLICATION REQUIREMENTS	11
Project Abstract	11
Project Narrative.....	11
Attachments.....	23
Program Specific Forms.....	29
Clinical and Financial Performance Measures	42
APPLICATION REVIEW	46
APPLICATION DETERMINATIONS.....	47
DESIGNATION REPORTING & REVIEW	47
APPLICATION TECHNICAL ASSISTANCE	48

EXECUTIVE SUMMARY

Look-Alike Initial Designation

The Health Resources and Services Administration (HRSA), Bureau of Primary Health Care is accepting applications for look-alike (LAL) initial designation (ID). The purpose of the LAL ID application is to establish new look-alike service delivery sites under the Health Center Program to provide comprehensive primary health care services to underserved and vulnerable populations.

Application Availability:	Rolling (no deadline; application is always open)
Application Submission Time Period:	90 calendar days to complete the application in the HRSA Electronic Handbook (EHB) from the date the application is started
Designation Period:	Three years
Eligible Applicants:	<p>Eligible applicants include public and nonprofit entities. The organization must not be owned, controlled, or operated by another entity.</p> <p>At the time of application submission, applicants must:</p> <ol style="list-style-type: none">Be operational and compliant with all Health Center Program requirements.Provide comprehensive primary medical care as its main purpose.Ensure access to services for all individuals in the service area/target population without regard to ability to pay.Serve a designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP). <p>See the Eligibility section of these instructions for complete eligibility information, including exclusions.</p>

Benefits of Look-Alike Designation

Look-alikes are eligible to receive a number of benefits including:

- Purchase of discounted drugs under section 340B Federal Drug Pricing Program;
- FQHC Prospective Payment System (PPS) reimbursement for services provided under Medicare;
- FQHC PPS reimbursement for services provided under Medicaid (or other State-approved Alternative Payment Methodology);
- Automatic Health Professional Shortage Area designation; and
- Access to National Health Service Corps providers.

The benefits of look-alike designation apply only to activities that are included in the approved scope of project¹ which are documented in part in the initial designation application through the following:

- [Form 5A](#): Services Provided;
- [Form 5B](#): Service Sites; and
- [Form 5C](#): Other Activities/Locations.

Summary of Changes

These instructions include the following changes since the last initial designation application instructions were released in September 2016:

- To support an understanding of the current operational status, the Project Abstract and Project Narrative must indicate when patients began receiving primary care services at each service delivery site, consistent with Form 5B: Service Sites.
- To support an understanding of the current operational status, the current number of unduplicated patients being seen at the health center, as indicated on [Form 1A](#): General Information Worksheet, must align with the number of patients indicated on [Attachment 1](#): Patient Origin Study.
- [Form 1C](#): Documents on File is no longer included in the application.
- Clinical performance measures have been updated to align with [Program Assistance Letter 2017-02: Approved Uniform Data System Changes for Calendar Year 2017](#).
- Contact information for Primary Care Offices was updated.

¹ Refer to PIN 2008-01, Defining Scope of Project and Policy for Requesting Changes, located at: <http://bphc.hrsa.gov/programrequirements/pdf/pin2008-01.pdf>.

HEATH CENTER PROGRAM LOOK-ALIKE INITIAL DESIGNATION DESCRIPTION

Background

The Health Resources and Services Administration (HRSA), Bureau of Primary Health Care administers the Health Center Program, authorized by section 330 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254b). Health centers improve the health of the nation’s high need geographic areas and populations by ensuring access to accessible, affordable, quality primary health care services. Individually, each health center plays an important role in the goal of ensuring access to services, and combined, they have a critical impact on the health care status of medically underserved and vulnerable populations throughout the United States and its territories.

An amendment to the Omnibus Budget Reconciliation Acts² created and defined a category of facilities under Medicare and Medicaid known as Federally Qualified Health Centers (FQHCs). One type of FQHC is an entity determined by HRSA to meet the requirements of the Health Center Program that does not receive Health Center Program funding. HRSA refers to these health centers as Health Center Program “look-alikes.”

Health Center Program look-alikes operate and provide services consistent with [Health Center Program requirements](#). While look-alikes do not receive Health Center Program funding, they are eligible to apply to the Centers for Medicare and Medicaid Services (CMS) for reimbursement under FQHC Medicare and Medicaid payment methodologies. Look-alikes are also eligible to purchase discounted drugs through the 340B Federal Drug Pricing Program, receive automatic Health Professional Shortage Area designation, and may access National Health Service Corps providers.

Look-alikes were established to maximize access to care for medically underserved populations and communities by allowing entities that do not receive Health Center Program funding to apply to become part of the Health Center Program. Both Health Center Program award recipients and look-alikes provide comprehensive primary health care services that are responsive to identified health care needs, provide services to all persons regardless of ability to pay, and must meet all Health Center Program requirements. For the purposes of this document, the term “health center” refers to both Health Center Program look-alikes and award recipients.

Health Center Population Types

Applicants may be designated to serve the general medically underserved population and/or a special population authorized under section 330 of the PHS Act. The types of health centers authorized under section 330 of the PHS Act are: Community Health Center (CHC – section 330(e)), Migrant Health Center (MHC – section 330(g)), Health Care for the Homeless (HCH – section 330(h)), and Public Housing Primary Care (PHPC – section 330(i)).

²Omnibus Budget Reconciliation Acts (OBRA) of 1989, 1990, and 1993, amended section 1905 of the Social Security Act (SSA).

Applicants that serve the general population (CHC) *and* a special population (i.e., migratory and seasonal agricultural workers (MHC), people experiencing homelessness (HCH), and/or residents of public housing (PHPC)) must demonstrate compliance with the general Health Center Program requirements and all requirements for each targeted special population. Specific legislative requirements for applicants requesting designation under each health center type are outlined below.

Community Health Center (CHC) Applicants:

- Ensure compliance with PHS Act section 330(e) and program regulations, requirements, and policies.
- Ensure the availability and accessibility of required primary and preventive health care services to underserved populations in the service area.

Migrant Health Center (MHC) Applicants

- Ensure compliance with PHS Act section 330(g); and, as applicable, section 330(e), program regulations, requirements, and policies.³
- Ensure the availability and accessibility of required primary and preventive health care services to migratory and seasonal agricultural workers and their families in the service area.
 - *Migratory agricultural workers* are individuals who are principally employed in agriculture and who establish temporary housing for the purpose of this work, including those individuals who have had such work as their principal employment within 24 months as well as their dependent family members. Agricultural workers who leave a community to work elsewhere are classified as migratory workers in both communities. Aged and disabled former agricultural workers should also be included in this group.
 - *Seasonal agricultural workers* are individuals employed in agriculture on a seasonal basis who do not establish a temporary home for purposes of employment, including their family members.
 - *Agriculture* means farming in all its branches, as defined by the OMB-developed North American Industry Classification System under codes 111, 112, 1151, and 1152.

Health Care for the Homeless (HCH) Applicants

- Ensure compliance with PHS Act section 330(h); and, as applicable, section 330(e), program regulations, requirements, and policies.⁴
- Ensure the availability and accessibility of required primary and preventive health care services to people experiencing homelessness, defined as patients who lack housing, including residents of permanent supportive housing, transitional housing, or other housing programs that are targeted to homeless populations in the service area.⁵ HCH services may continue for up to 12 months for individuals who are no longer homeless as a result of becoming a resident of permanent housing.

³ 42 CFR Part 56 only applies to look-alikes exclusively serving migratory and seasonal agricultural workers.

⁴ 42 CFR Part 51c does not apply to look-alikes exclusively serving homeless individuals or residents of public housing.

⁵ See the [UDS Manual](http://www.bphc.hrsa.gov/datareporting/reporting/index.html) at <http://www.bphc.hrsa.gov/datareporting/reporting/index.html> for examples of shelter arrangements.

- Provide substance abuse services.

Public Housing Primary Care (PHPC) Applicants

- Ensure compliance with PHS Act section 330(i); and, as applicable, section 330(e), program regulations, requirements, and policies.⁶
- Ensure the availability and accessibility of required primary and preventive health care services to residents of public housing and individuals living in areas immediately accessible to public housing.
 - *Public housing* means public housing agency-developed, owned, or assisted low-income housing, including mixed finance projects. It does not mean public housing that is only subsidized through Section 8 housing vouchers.
- Consult with residents of the proposed public housing sites regarding the planning and administration of the program.

Health Center Program Requirements

Look-alikes must demonstrate compliance with the all Health Center Program requirements and related regulations available at <http://www.bphc.hrsa.gov/programrequirements/summary.html>, including the following:

- Evidence that the proposed look-alike site(s) will serve populations in **high need, underserved areas** (as documented in the Need section of the Project Narrative, and throughout the application). If applying to serve the same area served by a current Health Center Program award recipient or look-alike, applicants should conduct a thorough analysis of the level of unmet need before submitting an initial designation application. HRSA will conduct an analysis of all submitted applications to determine the level of unmet need in the area. HRSA's policy and process for determining service area overlap is identified in PIN 2007-09: [Service Area Overlap: Policy and Process](#).
- Evidence that **all persons in the target population will have access to the full range of required primary, preventive, and enabling health care services**, either directly onsite or through established arrangements without regard to ability to pay (as documented in [Form 5A: Services Provided](#), and throughout the application).
- Evidence of **collaborative and coordinated delivery systems** for the provision of health care to the underserved through the demonstration of current or proposed partnerships and collaborative activities (based on the Collaboration section of the Project Narrative and letters of support). See PAL 2011-02: [Health Center Collaboration](#).
- Evidence of appropriate clinical and management staff, as well as **management and financial systems** that facilitate the health center's capacity to provide cost-effective, high-quality primary health care services in the community (as documented in [Form 2: Staffing Profile](#), the Project Narrative, and throughout the application).
- Evidence that the **patient-majority governing board** maintains appropriate authority to oversee the operations of the health center (as documented in the Project Narrative, Bylaws, and throughout the application). See PIN 2014-01: [Health Center Program Governance](#).

⁶ 42 CFR Part 51c does not apply to look-alikes exclusively serving homeless individuals or residents of public housing.

ELIGIBILITY

Applicants must demonstrate eligibility according to the following eligibility requirements both in the initial designation application and during the onsite compliance review (see the [Application Review](#) section).

- 1) The applicant organization must be a public or nonprofit entity. Tribes, tribal organizations,⁷ faith-based organizations, and community-based organizations are eligible to apply. Applicant demonstrates current status by submitting proof of nonprofit or public agency status ([Attachment 9](#)).
- 2) The applicant organization cannot be owned, controlled, or operated by another entity.⁸ Organizational structures such as parent-subsidary arrangements or network corporations may not be eligible for look-alike designation. An applicant must demonstrate independent status through the required attachments: [Attachment 4](#): Corporate Bylaws, [Attachment 8](#): Articles of Incorporation, and [Attachment 15](#): Financial Statements and Independent Financial Audit. For further clarification, see PIN 2014-01: [Health Center Program Governance](#).
- 3) The applicant organization must be compliant with all Health Center Program requirements at the time of application. More information on Health Center Program requirements is available at <http://www.bphc.hrsa.gov/programrequirements/summary.html>. The applicant must demonstrate compliance in the Project Narrative and during an onsite compliance review.
- 4) The applicant organization must be operational under the authority of a compliant governing board at the time of application submission. The applicant must document compliance with operational status by submitting:
 - a. Attachment 4: Corporate Bylaws;
 - b. Attachment 5: Governing Board Meeting Minutes;
 - c. Attachment 10: Medicare and Medicaid Documentation;
 - d. Attachment 15: Financial Statements and Independent Financial Audit; and
 - e. Form 6A: Current Board Member Characteristics.
- 5) The applicant organization must currently provide comprehensive primary medical care as its main purpose as documented on [Form 1A](#): General Information Worksheet (number of current and projected medical patients is greater than current and projected patients for other service types) and [Form 5A](#): Services Provided (General Primary Medical Care is provided directly (Column I) and/or through formal written contractual agreements in which the health center pays for the service (Column II)).
- 6) The applicant organization must provide all required services at the time of application, either directly onsite or through established arrangements as documented on [Form 5A](#): Services Provided.

⁷ Tribal and Urban Indian organizations that receive funds from the Indian Health Service may already be considered eligible for Federally Qualified Health Center (FQHC) benefits and may not derive additional benefits from applying for look-alike initial designation.

⁸ Section 1905(I)(2)(B)(iii) of the Social Security Act, as amended.

Contracts and/or written formal referral arrangements must be in place for any services not provided directly by the applicant.

- 7) The applicant organization must ensure access to services for all individuals in the targeted service area or population (e.g., cannot exclusively serve a single age group, racial/ethnic group, or health issue/disease category) without regard to ability to pay, as documented in the Project Narrative and demonstrated by [Attachment 14](#): Sliding Fee Discount Schedule.
- 8) The applicant organization must request initial designation for at least one permanent service delivery site that provides comprehensive primary medical care as its main purpose and operates for a minimum of 40 hours per week, as documented on [Form 5B](#): Service Sites (with the exception of health centers that request designation for only migratory and seasonal agricultural workers, which may have a seasonal rather than permanent site). A permanent site is a fixed building location that operates year-round. An applicant may also have sites that are mobile, seasonal, or intermittent in addition to the permanent site(s). A mobile van may be listed on Form 5B: Service Sites as a site in scope only if at least one full-time, permanent site is also listed on Form 5B.⁹ A mobile van must be affiliated with a location setting (i.e., the permanent service site), and be fully equipped and staffed by health center clinicians providing direct primary care services.
- 9) The applicant organization must only include sites in the look-alike scope of project that are **not** currently sites in the scope of project of any Health Center Program award recipient. In other words, the applicant's sites listed on Form 5B cannot be the same address as any sites already in any Health Center Program award recipient approved scope of project.
- 10) The applicant organization must serve a defined geographic area that is federally designated, in whole or in part, as a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP) as documented on [Form 1A](#): General Information Worksheet, [Attachment 2](#): Service Area Map, and [Attachment 3](#): Current MUA/MUP Designation.¹⁰ **Note:** Applicants requesting look-alike designation *only* for special populations (MHC, HCH, and/or PHPC) are not required to have MUA/MUP designation. See [Health Center Population Types](#) above for definitions of MHC, HCH, and PHPC populations.
- 11) The applicant organization must define its service area to include those zip codes where at least 75 percent of the current patients reside, based on the Service Area Zip Codes entered on [Form 5B](#): Service Sites and listed on [Attachment 1](#): Patient Origin Study and [Attachment 2](#): Service Area Map and Table.
- 12) **Public Housing Primary Care applicants only:** The applicant organization must demonstrate that it has consulted with the public housing residents in the preparation of the initial designation application and will ensure ongoing consultation with the residents regarding the planning and administration of the health center, as documented in the [RESPONSE](#) section of the Project Narrative.

⁹ Health centers that request designation for only migratory and seasonal agricultural workers may have a seasonal rather than permanent site.

¹⁰ Search for MUAs and MUPs at <http://www.hrsa.gov/shortage/find.html>.

- 13) **School-based health center applicants only:** Applicants with school-based service delivery sites that do not independently provide all required services and/or are not accessible to the general population of the service area must demonstrate how the health center will ensure that the entire underserved population in the service area (including the area served by the school-based health center) has access to all required services, as documented in the Project Narrative and on [Form 5A: Services Provided](#). Because applicants must ensure access to services for all individuals in the targeted service area or population, a service delivery site that is a school-based health center must:
- Be a permanent, full time site (as proposed on [Form 5B](#)) that provides all required primary and preventive health care services to students of the school as well as the general underserved population in the service area without regard for ability to pay; OR
 - Be included in the look-alike scope of project as proposed on [Form 5B](#) in addition to a permanent, full time site that provides comprehensive primary health care.
- 14) **Current Health Center Program award recipients only:** Applicants that are applying for dual status (when an organization receives Health Center Program funding as well as a look-alike designation for different sites) must demonstrate how they currently and will continue to maintain separate and distinct scopes of project for the look-alike designation and Health Center Program award, as documented in the Project Narrative, [Attachment 1: Patient Origin Study](#), [Attachment 15: Financial Statements](#), [Form 5B: Service Sites](#), and during the onsite compliance review.
- 15) Applications must include the Need, Response, Collaboration, Evaluative Measures, Resources/Capabilities, and Governance sections of the Project Narrative to be considered complete.

APPLICATION SUBMISSION INFORMATION

Initial designation applications are accepted on a rolling basis throughout the year. Once you begin your application in the HRSA Electronic Handbook (EHB), you will have 90 days to complete it and have your Authorizing Official (AO) submit it in EHB. HRSA will not accept submission of applications after the 90-day application period. See the EHB Look-Alike Initial Designation User Guide at <http://bphc.hrsa.gov/programopportunities/lookalike/initialdesignationinstructions.html> for more information about creating and submitting the application in EHB.

In order to create and submit your application in EHB, the AO and other application preparers must first register in the system. To register, go to <https://grants.hrsa.gov/webexternal/> and click Create an Account. Registration is required once for each user, who then associates his/her username with the applicant organization.

Applications must be submitted in the English language.

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

- 1) The applicant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.

- 2) Where the applicant is unable to attest to any of the statements in this certification, the applicant must attach an explanation to this application.

APPLICATION REQUIREMENTS

Look-alike applications must include the following required components:

- Project Abstract
- Project Narrative
- Attachments
- Program Specific Forms
- Clinical and Financial Performance Measures

The total size of all uploaded files may not exceed the equivalent of 200 pages when printed by HRSA. The page limit includes the abstract, project and budget narrative, and attachments (including letters of commitment and support). Standard OMB-approved forms that are included in EHB are NOT included in the page limit.

Project Abstract

The project abstract should be a single-spaced, one page summary of the application. The abstract should be concise and without reference to other parts of the application. Place the following at the top of the abstract:

- Project Title: Look-Alike Initial Designation
- Applicant organization name and address
- Web site address (if applicable)
- Project Director name, phone number, and email address

Briefly summarize the following:

1. Brief history of the organization, including the length of time the organization has been in compliance with Health Center Program requirements and when each site began serving primary care patients;
2. Community and population group(s) served;
3. Major health care needs and barriers to care in the service area and how the health center will address those needs and increase access to care; and
4. Current number of providers, current service delivery locations, services currently being provided, and current annualized number of patients and visits.

Project Narrative

The Project Narrative provides a comprehensive description of the applicant organization, including the organizational structure, the community/target population currently served, and how the organization is addressing the identified primary health care needs of the community. Together with the required forms and attachments, the Project Narrative must demonstrate compliance with [Health Center Program requirements](#).

The Project Narrative should be organized by section headers with the requested information appearing in the appropriate section of the Project Narrative or the designated forms and attachments.

Need

Information provided in the Need Section must serve as the basis for, and align with, the current activities and goals described throughout the application. Reference data sources where appropriate, including local target population needs assessments when available. Recommended data sources for select characteristics can be found on the [Look-Alike Initial Designation Web page](#).

- 1) Describe how the following **characteristics of the target population** affect access to primary health care, health care utilization, and health status:
 - a) Percent of the target population that is uninsured.
 - b) Unemployment and educational attainment.
 - c) Income and poverty level.
 - d) Health disparities.
 - e) Unique characteristics not previously addressed (e.g., ethnicity, sexual orientation, gender identity, disability, health literacy, language, cultural attitudes and beliefs).

- 2) Describe how the following **characteristics of the service area** impact access to care for the target population:¹¹
 - a) Geographical/transportation barriers to include the distance (miles) OR travel time to the nearest primary care provider accepting new Medicaid and uninsured patients (consistent with [Attachment 2](#): Service Area Map and Table).
 - b) Other primary health care services available in the service area, including their location and accessibility by the target population.
 - c) The number of individuals in the target population/service area for every one full-time equivalent (FTE) primary care physician as a ratio (i.e., number of patients: 1 FTE primary care physician).

- 3) Describe the **health care environment** and its impact on your organization's current and future operations, including any significant changes that affect the availability of health care services and patient characteristics, including:
 - a) Insurance coverage, including Medicaid, Medicare, and Children's Health Insurance Program (CHIP).
 - b) State, local, and/or private uncompensated care programs.
 - c) Economic and demographic shifts (e.g., influx of immigrant/refugee populations, closing of local hospitals, ambulatory care sites, or major local employers).
 - d) Natural disasters or emergencies (e.g., hurricanes, flooding, terrorism).
 - e) Changes affecting specific populations (e.g., children experiencing homelessness, lesbian, gay, bisexual, and transgender (LGBT) individuals).

¹¹ See <http://bphc.hrsa.gov/programopportunities/lookalike/initialdesignationinstructions.html> for recommended data sources.

- 4) **Applicants requesting special population look-alike designation** to serve migratory and seasonal agricultural workers (MHC), people experiencing homelessness (HCH), and/or residents of public housing (PHPC):
 - a) **MHC:** Describe the specific health care needs and access issues of migratory and seasonal agricultural workers, including:
 - The agricultural environment (e.g., crops and growing seasons, demand for labor, number of temporary workers);
 - Approximate migratory/seasonal residency period(s), including the availability of local providers to provide primary health care services during these times;
 - Occupational factors (e.g., working hours, housing, hazards, including pesticides and other chemical exposures); and
 - Significant increases or decreases in migratory and seasonal agricultural workers.
 - b) **HCH:** Describe the specific health care needs and access issues of people experiencing homelessness, such as the number of providers treating people experiencing homelessness, availability of homeless shelters, and significant increases or decreases in people experiencing homelessness.
 - c) **PHPC:** Describe the specific health care needs and access issues of residents of public housing, such as the availability of public housing and its impact on the residents in the targeted public housing communities served, and significant increases or decreases in residents of public housing.

- 5) Describe any statewide or regional strategic planning that has identified primary care needs in the current service area.

Response

- 1) Describe the service delivery sites and how they are appropriate for the needs of the service area and target population. **Note:** *To be eligible for designation, at least one full-time, permanent, fixed building site must be identified on [Form 5B: Service Sites](#) (with the exception of health centers serving only migratory and seasonal agricultural workers, which may have a seasonal rather than permanent site).* Specifically address:
 - a) Site(s)/location(s) where services are being provided and when patients began receiving primary care services at each site (consistent with [Attachment 2: Service Area Map and Table](#), [Forms 5B: Service Sites](#) and [5C: Other Activities/Locations](#)). Upload Floor Plans as [Attachment 17](#) for all sites. If the site is leased, lease documentation must be included in [Attachment 20: Other Relevant Documents](#).
 - b) How the type (e.g., fixed site, mobile van, school-based clinic), hours of operation, and location of each service delivery site (consistent with [Form 5B: Service Sites](#)) assures that services are accessible and available at times that meet the needs of the target population (consistent with [Forms 5B: Service Sites](#) and [5C: Other Activities/Locations](#)).
 - c) Capacity at the service site(s) to achieve the projected number of patients and visits (consistent with [Form 1A: General Information Worksheet](#)).
 - d) Professional coverage for medical emergencies during hours when service sites are closed and provisions for follow-up by the health center for patients accessing after hours coverage. Specifically, discuss how these arrangements are appropriate for the services provided and the number of patients served.

- 2) Describe how the primary health care services (consistent with [Form 2: Staffing Profile](#) and [Form 5A: Services Provided](#)) and other activities (consistent with [Form 5C: Other Activities/Locations](#)) are appropriate for the needs of the target population, including:
 - a) Provision of each required service and any additional services, including whether these are provided directly or through formal written contracts/agreements or referral arrangements.¹²
 - b) How enabling services (e.g., case management, outreach and enrollment activities, transportation) are integrated into primary care. Describe any enabling services designed to increase access for targeted special populations or populations with identified unique health care needs such as translation services for populations with limited English proficiency and accommodations to facilitate veterans' access to care.
 - c) How services are culturally and linguistically appropriate.
 - d) How the following special populations criteria were met, if applicable:
 - If you are requesting HCH designation, you must document how substance abuse services are being made available either directly, via formal written contracts/agreements, and/or through a formal written referral arrangement.
 - If you are requesting MHC designation, you must document how you are currently addressing any occupational or environmental health hazards or conditions.
 - If you are requesting PHPC designation, you must document that the service delivery plan was developed in consultation with residents of the targeted public housing and describe ongoing plans for consultation with residents regarding the administration of the health center.
- 3) Describe how you ensure continuity of care for health center patients, including:
 - a) Arrangements for admitting privileges for health center physicians to ensure continuity of care for health center patients at one or more hospitals (consistent with [Form 5C: Other Activities/Location](#)). In cases where hospital privileges are not possible, describe other established arrangements to ensure continuity of care (i.e., timely follow-up) for patient hospitalizations.
 - b) How these arrangements ensure a continuum of care for health center patients, including discharge planning, post-hospitalization tracking, and patient tracking (e.g., interoperability of electronic health records (EHRs)).
- 4) Describe the current and future clinical staffing plan (consistent with [Form 2: Staffing Profile](#) and the Budget Narrative), including how the mix of provider types and support staff is appropriate for:
 - a) Providing services for the current number of patients and the projected growth in patients (consistent with [Form 1A: General Information Worksheet](#)) at the sites in scope (consistent with [Form 5B: Service Sites](#)).
 - b) Assuring appropriate linguistic and cultural competence (e.g., bilingual/multicultural staff, training opportunities).

¹² Refer to the [Service Descriptors for Form 5A: Services Provided](#) and to [Form 5A Column Descriptors](#) for details regarding required and additional services and service delivery methods.

- c) Carrying out required and additional health care services (as appropriate and necessary), either directly or through established formal written arrangements and referrals (consistent with [Form 5A: Services Provided](#)).

Note: Contracted Providers should be indicated on [Form 2: Staffing Profile](#) and the summary of current contracts/agreements in [Attachment 7: Summary of Contracts and Agreements](#). If a majority of core primary care services and/or any health center key management positions (e.g. Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO)) are contracted, include the contract/agreement as an attachment to [Form 8: Health Center Agreements](#).

- 5) Describe the sliding fee discount schedule(s) (consistent with PIN 2014-02: [Sliding Fee Discount and Related Billing and Collections Program Requirements](#) and [Attachment 14: Sliding Fee Discount Schedule and Schedule of Charges](#)), including:
- a) Policies and procedures used to implement the sliding fee discount schedule(s), including how they specifically address:
- Definitions of income and family size.
 - Assessment of all patients for eligibility for sliding fee discounts based on income and family size only. **Note:** No other factors (e.g., insurance status) can be considered.
 - Documentation and verification requirements used to determine patient eligibility for sliding fee discounts and frequency of re-evaluation of patient eligibility.
 - Language and literacy level-appropriate methods used for making patients aware of the availability of sliding fee discounts (e.g., signs posted in accessible and visible locations, registration materials, brochures, verbal messages delivered by staff).
 - How sliding fee discounts are applied to both required and additional services within the scope of project (consistent with the services and service delivery methods indicated on [Form 5A: Services Provided](#), Columns I, II, or III).
 - Method and frequency of evaluating the sliding fee discount program from the perspective of reducing patient financial barriers to care.
- b) How the sliding fee discount schedule(s):
- Are updated annually to reflect the most recent Federal Poverty Guidelines (FPG) available at <http://aspe.hhs.gov/poverty>.
 - Are applied only for individuals and families with an annual income at or below 200 percent of the poverty rate according to the most current FPG. Describe adjustment of fees for individuals and families with incomes above 100 percent of FPG, and at or below 200 percent of the FPG, using at least three (3) discount pay classes.
 - Provide a full discount (no charge) or only a nominal charge for individuals and families with an annual income at or below 100 percent of the poverty rate.
- c) How any nominal charges are determined. If a nominal charge is applied for individuals and families with annual incomes at or below 100 percent of the FPG, how the charge is:
- Determined to be nominal from the perspective of the patient (e.g., input from patient focus groups, patient surveys).
 - A fixed fee (not a percentage of the actual charge/cost) that does not reflect the true cost of the service(s) being provided.
 - Not more than the fee paid by a patient in the first SFDS pay class above 100 percent of the FPG.

- 6) Describe your quality improvement/quality assurance (QI/QA) program, including:
 - a) Accountability and communication throughout the organization for systematically improving the provision of quality health care, including a clinical director whose responsibilities clearly include oversight of the QI/QA program.
 - b) The process and parties responsible for developing and updating board-approved QI/QA policies and procedures.
 - c) The process and parties responsible to ensure that all providers (e.g., employed, contracted, volunteers, locum tenens) have appropriate credentials and are privileged to perform proposed services (consistent with [Form 5A](#)) at proposed sites/locations, including methodologies for verifying current clinical competence (e.g., peer review).
 - d) Processes for hearing and resolving patient grievances and incident reporting and management.
 - e) Monitoring the impact of services on the health outcomes of the target population.
 - f) Maintenance of confidentiality of patient records throughout the continuum of care.
 - g) Periodic assessment of the appropriateness of service utilization, quality of services delivered, and patient outcomes, conducted by physicians or other licensed health professionals under the supervision of physician, including methodologies for the systematic evaluation of patient records to identify areas for improvement in documentation of services provided either directly or through referral.
 - h) Use of appropriate information systems (e.g., electronic health records, payment management systems) for analyzing key performance data, including data necessary for 1) improving health outcomes and 2) tracking of diagnostic tests and other services provided to health center patients to ensure appropriate follow up and documentation in patient record.
 - i) Use of QI results to improve performance.

Note: *Clinical directors may be full or part-time staff and must have appropriate credentials to support the QI/QA program as determined by the needs and size of the health center.*

- 7) Describe current efforts and future plans for assisting individuals in determining their eligibility for and enrollment in affordable health insurance options available through the Marketplace, Medicaid, and CHIP, including:
 - a) How potentially eligible individuals (both current patients and other individuals in the service area) are identified and informed of the available options.
 - b) The type of assistance that is provided for determining eligibility and completing the relevant enrollment process.
- 8) **Current Health Center Program award recipients ONLY:** Describe how the scope of project for the proposed look-alike site(s) is separate and distinct from the Health Center Program award scope of project as documented in [Attachment 1](#): Patient Origin Study and [Form 5B](#): Service Sites.

Collaboration

- 1) Describe both formal and informal collaboration and coordination of services¹³ with the following community providers in the service area (consistent with in [Attachment 2](#): Service Area Map and Table) or explain if such community services are not available:
 - a) Existing health centers (Health Center Program award recipients and look-alikes).
 - b) State and local health departments.
 - c) Rural health clinics.
 - d) Critical access hospitals.
 - e) Free clinics.
 - f) Federally-supported award recipients (e.g., Ryan White programs, Title V Maternal and Child Health programs).
 - g) Private provider groups serving low income/uninsured patients.
 - h) Evidence-based home visiting programs serving the same target population.¹⁴
 - i) Additional programs serving the same target population (e.g., social services; job training; Women, Infants, and Children (WIC); coalitions; community groups; school districts).
 - j) If applicable, organizations that provide services or support to the special population(s) for which designation is sought (e.g., Migrant Head Start, Public Housing Authority, homeless shelters).
 - k) If applicable, veterans service organizations, U.S. Department of Veterans Affairs (VA), Veteran's Health Administration community based outpatient clinics, VA medical centers, and other local veteran-serving organizations.
 - l) If applicable, neighborhood revitalization initiatives such as the Department of Housing and Urban Development's Choice Neighborhoods, the Department of Education's Promise Neighborhoods, and/or the Department of Justice's Byrne Criminal Justice Innovation Program. If a neighborhood within your service area has been designated as a [Promise Zone](#) or named a [Strong Cities, Strong Communities](#) location, discuss how you will collaborate with these efforts (see http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/economicdevelopment/programs/pz and <https://www.huduser.gov/portal/sc2/home.html>).

Note: Formal collaborations (e.g., contracts, memoranda of understanding or agreement) should also be summarized in [Attachment 7](#): Summary of Contracts and Agreements.

- 2) Document support for the look-alike designation through current dated letters of support¹⁵ that reference specific coordination or collaboration from all of the following in the service area (as defined in [Attachment 2](#): Service Area Map and Table), or indicate if such organizations do not exist in the service area:
 - a) Existing health centers (Health Center Program award recipients and look-alikes).
 - b) State and local health departments.
 - c) Rural health clinics.

¹³ Refer to PAL 2011-02: [Health Center Collaboration](#) for information on maximizing collaborative opportunities.

¹⁴ Examples of evidence-based home visiting programs are available at the [Maternal, Infant, and Early Childhood Home Visiting Program web site](#).

¹⁵ Letters of support should be addressed to the organization's board, CEO, or other appropriate key management staff member (e.g., Medical Director) and submitted with the application.

- d) Critical access hospitals.
- e) Other community organizations with whom you collaborate (e.g., social service organization, school, homeless shelter).
- f) **If you are requesting designation to serve special populations**, organizations that also serve the targeted special population(s).

If such letters cannot be obtained from organizations in the service area, include documentation of efforts made to obtain the letters along with an explanation for why such letters could not be obtained.

- 3) Document support for the look-alike designation through current dated letters of support from relevant State public agencies:
 - a) State health department/state primary care office
 - b) State Medicaid agency.

Note: Merge all letters of support from Items 2 and 3 into a single document and upload as [Attachment 16: Letters of Support](#).

Evaluative Measures

- 1) Within the Clinical Performance Measures form (see detailed instructions under [Program Specific Forms](#)), outline realistic goals that are responsive to clinical performance and identified needs.
- 2) Within the Financial Performance Measures form (see detailed instructions under [Program Specific Forms](#)), outline realistic goals that are responsive to the organization's financial performance.
- 3) Describe your process for periodic assessment of the health care needs of the target population to inform and improve the delivery of health care services, including:
 - a) The frequency of assessments and when the last assessment occurred.
 - b) Community engagement.
 - c) Assessment tools and methods, including cultural and linguistic appropriateness.
 - d) Analysis and dissemination of results to board members, health center staff, community stakeholders, project partners, and patients.
- 4) Describe how your certified electronic health record (EHR) system¹⁶ is used for tracking patient and clinical data to achieve meaningful use¹⁷ and improve quality outcomes. If you do not have an EHR system, or have an EHR system that is not yet functional or integrated into all service sites, outline your plans for full EHR implementation at all sites (consistent with [Form 5B: Service Sites](#)).

¹⁶ Information about certified EHR systems is available at [HealthIT.gov: ONC – Authorized Testing and Certification Body](http://www.healthit.gov/ONC-Authorized-Testing-and-Certification-Body).

¹⁷ Information about meaningful use is available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html.

Resources/Capabilities

- 1) Describe how the organizational structure is appropriate for the operational needs of the health center (consistent with [Attachments 4](#): Corporate Bylaws and [11](#): Project Organizational Chart, and, as applicable, [Attachments 6](#): Co-Applicant Agreement and [7](#): Summary of Contracts and Agreements), including:
 - a) How lines of authority are maintained from the governing board to the CEO.
 - b) Whether your organization is part of a parent, affiliate, or subsidiary organization (consistent with [Form 8](#): Health Center Agreements).
- 2) Describe how your organization maintains appropriate oversight and authority (in accordance with Health Center Program requirements) over all service sites, including contracted sites, and services including (as applicable):
 - a) Contracts and agreements summarized in [Attachment 7](#): Summary of Contracts and Agreements.
 - b) Contracts or parent/affiliate/subsidiary agreements uploaded in [Form 8](#): Health Center Agreements.
- 3) Describe how your organization's management team (CEO, CMO, CFO, Chief Operating Officer (COO), and Chief Information Officer (CIO), as applicable) is appropriate for the operational and oversight needs, scope, and complexity of the health center, including:
 - a) Defined roles (consistent with [Attachment 12](#): Position Descriptions for Key Management Staff), in particular the CEO's responsibilities for day-to-day program management of health center activities;
 - b) Skills and experience for the defined roles (consistent with [Attachment 13](#): Biographical Sketches for Key Management Staff); and
 - c) If applicable, shared key management positions (e.g., shared CFO/COO role) and time dedicated to health center activities (e.g., 0.5 FTE).
- 4) Describe your organizational experience in the following areas:
 - a) Serving the target population.
 - b) Developing and implementing systems and services appropriate for addressing the target population's identified health care needs.
- 5) Describe your ongoing strategic planning process, including:
 - a) The roles of the governing board and key management staff.
 - b) The frequency of strategic planning meetings.
 - c) Strategic planning products (e.g., strategic plan, operational plan).
 - d) Incorporation of needs assessment and program evaluation findings.
- 6) Describe any national quality recognition your organization has received or is in the process of achieving (e.g., Patient-Centered Medical Home, Accreditation Association for Ambulatory Health Care, Joint Commission, state-based or private payer initiatives).
- 7) Describe your plans for participating in FQHC-related benefits (e.g., FQHC Medicare/Medicaid/CHIP reimbursement, 340B Drug Pricing Program, National Health Service Corps providers).

- 8) Describe your billing and collections policies and procedures, including:
 - a) How the established schedule of charges for health center services (consistent with [Form 5A: Services Provided](#)) is consistent with locally prevailing rates and is designed to cover the reasonable cost of service operation.
 - b) Efforts to collect appropriate reimbursement from Medicaid, Medicare, and other public and private insurance sources (e.g., CHIP, Marketplace qualified health plans) (consistent with [Form 3: Income Analysis](#)).¹⁸
 - c) Efforts to secure payments owed by patients that do not create barriers to care.
 - d) Criteria for waiving charges and staff authorized to approve such waivers.

- 9) Describe how your financial accounting and control systems, as well as related policies and procedures:
 - a) Are appropriate for the size and complexity of the organization.
 - b) Reflect Generally Accepted Accounting Principles (GAAP).
 - c) Separate functions/duties, as appropriate for the organization's size, to safeguard assets and maintain financial stability.
 - d) Enable the collection and reporting of the organization's financial status, as well as tracking of key financial performance data (e.g., visits, revenue generation, aged accounts receivable by income source or payer type, aged accounts payable, lines of credit).
 - e) Support management decision-making.
 - f) Ensure that the scope of project for the look-alike designation is maintained as separate and distinct from the Health Center Program award scope of project (if applicable) and any other lines of business, consistent with [Attachment 15: Financial Statements and Independent Financial Audit](#).

- 10) Describe your organization's current financial status, including profitability (change in net income/total expenses), cash-on-hand (total unrestricted cash/daily expenses), and solvency (total liabilities/total net assets). Reference source documents (e.g., current income statement and balance sheet) uploaded to [Attachment 15: Financial Statements and Independent Financial Audit](#).

- 11) Describe your annual independent auditing process performed in accordance with federal audit requirements (if applicable) and submit the most recent financial audit and management letter (or a signed statement that no letter was issued with the audit) as [Attachment 15](#). Explain any adverse audit findings (e.g., questioned costs, reportable conditions, cited material weaknesses) and corrective actions that have been implemented to address such findings. If you do not have an audit, explain why and when the audit will be available.

- 12) Describe your emergency preparedness planning, including efforts to participate in state and local emergency planning. If applicable, explain negative responses on [Form 10: Emergency Preparedness Report](#) and plans for resolution.

¹⁸ Refer to PIN: 2013-01: [Health Center Budgeting and Accounting Requirements](#) for information on Health Center Program budgeting and accounting requirements.

Governance¹⁹

Note: Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups are required ONLY to respond to Item 6 below.

- 1) Describe your organization's independent governing board and how it retains (i.e., does not delegate) the following unrestricted authorities, functions, and responsibilities (reference [Attachment 4](#): Corporate Bylaws, and if applicable, [Attachment 6](#): Co-Applicant Agreement):²⁰
 - a) Meets at least once a month.
 - b) Ensures that minutes documenting the board's functioning are maintained.
 - c) Determines executive committee function and composition.
 - d) Selects the services to be provided.
 - e) Determines the hours during which services are provided.
 - f) Measures and evaluates the organization's progress and develops a plan for the long-range viability of the organization through: strategic planning and periodic review of the organization's mission and bylaws; evaluating patient satisfaction; monitoring organizational performance; setting organizational priorities; and allocating assets and resources.
 - g) Approves the health center's annual budget, federal applications for funding and look-alike designation, and selection/dismissal/performance appraisal of the organization's CEO.
 - h) Establishes policies to prohibit conflict of interest by board members, employees, consultants, and those who furnish goods or services to the health center.
 - i) Establishes general policies for the organization.

- 2) Describe the composition of the board (consistent with [Form 6A](#): Current Board Member Characteristics). Document that the structure of the board (co-applicant board for a public center, if applicable) is appropriate in terms of size, composition, and expertise by describing how the following criteria are met:
 - a) At least 51 percent of board members are individuals who are patients of the health center.
 - b) As a group, the patient board members reasonably represent the individuals served by the organization in terms of race, ethnicity, and gender (consistent with [Form 4](#): Community Characteristics and [Form 6A](#): Current Board Member Characteristics).
 - c) Non-patient board members are representative of the service area and selected for their expertise in any of the following areas: community affairs; local government; finance and banking; legal affairs; trade unions and related organizations; and/or social services.
 - d) Board has a minimum of nine but no more than 25 members, as appropriate for the complexity of the organization.

¹⁹ For detailed information regarding Health Center Program governance requirements, see PIN 2014-01: [Health Center Program Governance](#).

²⁰ Public centers that are not able to independently meet all Health Center Program governance requirements may comply with these requirements through a co-applicant arrangement. The public center and the co-applicant are collectively referred to as the "health center." In the case of public centers with co-applicant governing boards, the public center is permitted to retain authority for establishing general fiscal and personnel policies for the health center. Refer to PIN 2014-01: [Health Center Program Governance](#) for information on public centers and co-applicant arrangements.

- e) No more than half of the non-patient board members derive more than 10 percent of their annual income from the health care industry.
- f) No board member is an employee of the health center or an immediate family member of an employee.

Note: *If you are requesting designation to serve the general community (CHC) AND one or more special population (MHC, HCH, and/or PHPC), you must have appropriate board representation. At minimum, there must be at least one representative from/for each special population group for which designation is requested who can clearly communicate the target population's needs/concerns (e.g., advocate for migratory and seasonal agricultural workers, formerly homeless individual, current resident of public housing). If your organization is targeting only special populations, you may request a waiver of the 51 percent patient majority board composition requirement on [Form 6B: Request for Waiver of Governance Requirement](#) (as applicable). HRSA will not consider a waiver of the 51 percent patient majority governance requirement for organizations that serve the general population or the general population in conjunction with a special population.*

- 3) Document the effectiveness of the governing board by describing how the board:
 - a) Operates, including the organization and responsibilities of board committees (e.g., Executive, Finance, QI/QA, Risk Management, Personnel, Planning).
 - b) Monitors and evaluates its own (the board's) performance (e.g., identifies and develops processes for assessing and addressing board weaknesses, challenges, training needs).
 - c) Provides training, development, and orientation for new board members to ensure that they have sufficient knowledge to make informed decisions regarding the strategic direction, general policies, and financial position of the organization.
- 4) **Applicants with a co-applicant governing board** (consistent with [Attachment 6: Co-Applicant Agreement](#)) **or parent/affiliate/subsidiary:** Describe how this organizational structure/relationship does not impact or restrict the health center's governing board composition and/or required authorities (reference [Attachment 4: Corporate Bylaws](#) and other attachments as needed), including:
 - a) Selection of the board chairperson, a majority of board members (both patient and non-patient), and Executive Committee members.
 - b) Selection or dismissal of the CEO/Executive Director, including arrangements that combine this position with other key management positions.
 - c) Ensuring that no outside entity has the authority to override board approval (e.g., dual or super-majority voting, prior approval process, veto power, final approval).

Note: *Only public center applicants are permitted to establish a separate co-applicant health center governing board that meets all Health Center Program requirements.*

- 5) Describe how the composition of the governing board will be modified if changes occur in the demographics or needs of the target population and/or service area.
- 6) **Indian Tribes or Tribal, Indian, or Urban Indian Applicants ONLY:** Describe your governance structure and how it will assure adequate:
 - a) Input from the community/target population on health center priorities.
 - b) Fiscal and programmatic oversight of the look-alike.

Attachments

Provide the following attachments in the order specified below. Label each attachment according to the number provided (e.g., Attachment 4: Corporate Bylaws). Merge similar documents (e.g., letters of support) into a single file. Provide a table of contents for attachments with multiple components.

Note: EHB will not accept file attachments with names that exceed 100 characters.

Attachment 1—Patient Origin Study (Required)

The Patient Origin Study identifies the number of patients currently served by your organization and the zip codes where patients reside. Upload a table listing all the zip codes in which current patients reside, starting with the zip code with the greatest number of patients served. Identify the number of patients residing in each zip code (see table below). Your service area is comprised of the zip codes where at least 75 percent of the current patients reside. This list of zip codes should be consistent with the zip codes entered on [Form 5B: Service Sites](#) and shown on Attachment 2: Service Area Map and Table. The total number of patients should be consistent with the current number of unduplicated patients indicated on [Form 1A: General Information Worksheet](#).

	Zip Code	Number of Patients	Percent of Total
Service Area Zip Codes (at least 75%)	00005	806	40%
	00004	499	25%
	00001	293	15%
	00008	202	10%
Zip Codes for Other Patients Served	00002	65	3%
	00007	20	1%
	Other	67	3%
	Unknown	58	3%
TOTAL		2,010	100%

Attachment 2—Service Area Map and Table (Required)

Upload a map of the current service area, indicating the health center site(s) listed in [Form 5B: Service Sites](#). The map must clearly indicate the service area zip codes, the medically underserved area (MUA) and/or medically underserved population (MUP) served, and Health Center Program award recipients, look-alikes, and other health care providers serving the same service area. Maps should be created using [UDS Mapper](#).

Include a corresponding table that lists each zip code tabulation area (ZCTA) in the service area, the number of health centers serving each ZCTA, the dominant award recipient serving each ZCTA, total population, total low-income population, total Health Center Program patients, and penetration levels for both the low-income and total population for each ZCTA and for the overall proposed service area. This table will be automatically created in UDS Mapper. For a tutorial, see [Specific Use Cases: Create a Service Area Map and Data Table](#).

Attachment 3— Current MUA/MUP Designation (Required)

Upload a dated copy of the current MUA/MUP designation for all or part of your service area. Acceptable documentation of the MUA/MUP includes the confirmation page from HRSA’s “Find Shortage Areas” website indicating an address within the service area, based on the zip codes listed on [Form 5B: Service Sites](#). For information regarding MUAs or MUPs, see the Shortage Designation Web site at <http://www.hrsa.gov/shortage>, call 1-888-275-4772 (press option 1, then option 2), or contact the Shortage Designation Branch at sdb@hrsa.gov. **Note:** *If you are requesting look-alike designation only for special populations (MHC, HCH, and/or PHPC), you are not required to have MUA/MUP designation.*

Attachment 4—Corporate Bylaws (Required)

Upload (in its entirety) your most recent bylaws. Bylaws must demonstrate compliance with the Health Center Program governance requirements. Additionally, they must be signed and dated by the appropriate individual indicating review and approval by the governing board. Public centers that have a co-applicant must submit the co-applicant governing board bylaws. See the [GOVERNANCE](#) section of the Project Narrative for more details.

Attachment 5—Governing Board Meeting Minutes (Required)

Upload the most current six months of consecutive governing board meeting minutes that demonstrate how the board exercises its authority over organizational operations in compliance with Health Center Program requirements, including evidence of board oversight and decision making. The board meeting minutes must be signed and dated, and indicate the board’s involvement in the development and approval of the look-alike application.

Attachment 6—Co-Applicant Agreement for Public Centers (Required for public center applicants that have a co-applicant board)

Public center applicants that have a co-applicant board must submit the entire formal co-applicant agreement signed by both the co-applicant governing board and the public center. **Note:** *Public centers must comply with all applicable governance requirements and regulations.* In cases where the public center’s board cannot directly meet all applicable health center governance requirements, a separate co-applicant health center governing board must be established that meets all Health Center Program governance requirements. When a public center has a co-applicant board, the public center and co-applicant board must have a formal co-applicant agreement that stipulates roles, responsibilities, and the delegation of authorities of each party in the oversight and management of the public health center, detailing any shared roles and the responsibilities of each party in carrying out governance functions. See PIN 2014-01: [Health Center Program Governance](#) for information on the required components of the co-applicant agreement.

Attachment 7—Summary of Contracts and Agreements (As applicable)

Upload a comprehensive list and summary of each contract, referral arrangement, and/or affiliation agreement, including those which are also discussed and attached in full as part of [Form 8: Health Center Agreements](#). Indicate with an asterisk (*) agreements summarized in Attachment 7 that are also attached as part of Form 8. As a reminder, contracts must be compliant with section 330 of the PHS Act

and 42 CFR Part 51c. If you do not have formal agreements with another entity, you should clearly indicate such in the narrative. Refer to the [Scope of Project](#) policy documents, including the [Column Descriptors for Form 5A: Services Provided](#), for the requirements for providing services via formal written contract/agreement and formal written referral arrangement. Organize the document by the following categories:

Formal Written Contracts/Agreements for Services Provided

Summaries of formal written contracts/agreements for services (indicated in [Form 5A: Services Provided](#), Column II) must include:

1. Name and contact information for each provider or provider group.
2. Brief description of the purpose and scope of each contract, including the type of services to be provided, how and where services will be provided, and the timeframe for the agreement/contract.
3. How the service will be documented in the patient record.
4. How you will pay and/or bill for the service.
5. How your organization's sliding fee scale and other policies and procedures will apply.

Formal Written Referral Arrangements for Services Provided

Summaries of formal written referral arrangements for services (indicated in [Form 5A: Services Provided](#), Column III) must include:

1. Name and contact information for each referral organization or provider.
2. Brief description of the purpose and scope of each arrangement/agreement, including type of services to be provided, how and where services will be provided, and the timeframe for the agreement/arrangement.
3. How services will be provided on a sliding fee scale compliant with Health Center Program requirements.
4. The manner by which the referral will be made and managed and how the referred visit will be documented in the patient record.
5. How continuity of care for the referred patients will be assured and the process for referring patients back to your organization for appropriate follow-up care.

Other Contracts and Affiliation Agreements

Summaries of other contracts (i.e., affiliation agreements or contracts for management and other services not included on Form 5A: Services Provided) must include:

1. Name and contact information for each affiliated agency or contractor. Do not include contracts for the acquisition of supplies, material, equipment, or general support services (e.g., janitorial services).
2. Brief description of the purpose and scope of each contract/affiliation, including the type of services to be provided, how and where services will be provided, and the timeframe for the contract/affiliation.
3. How the health center will reimburse costs.
4. How you will ensure oversight and authority over contracted services.

Note: All contract, referral, and affiliation agreements must be available for review during the onsite compliance review (see the [Application Review](#) section).

Attachment 8—Articles of Incorporation (Required)

Upload the official signatory page (including state seal) of your organization’s Articles of Incorporation. A public center with a co-applicant should upload the co-applicant’s Articles of Incorporation signatory page, if incorporated.

Attachment 9—Evidence of Non-Profit or Public Agency Status (Required)

Upload your organization’s evidence of nonprofit or public center status.

Private Nonprofit: A private, nonprofit organization must submit any one of the following as evidence of its nonprofit status:

- A copy of a currently valid Internal Revenue Service (IRS) tax exemption certificate.
- A statement from a state taxing body, state Attorney General, or other appropriate state official certifying that your organization has a nonprofit status.
- A certified copy of the organization’s certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- Any of the above proof for a state or national parent organization, and a statement signed by the parent organization that your organization is a local nonprofit affiliate.

Public Center: Public center applicants must provide documentation demonstrating that the organization qualifies as a public agency (e.g., health department) for the purposes of section 330 of the PHS Act, as amended. A public center must submit any one of the following as evidence:

- Affirm Instrumentality Letter (4076C) from the IRS or a letter of authority from the federal, state, or local government granting your agency one or more sovereign powers.
- A determination letter issued by the IRS providing evidence of a past positive IRS ruling or other documentation demonstrating that your organization is an instrumentality of government, such as documentation of the law that created the organization or documentation showing that the state or a political subdivision of the state controls your organization.
- Formal documentation from a sovereign state’s taxing authority equivalent to the IRS granting the entity one or more governmental powers.

Attachment 10—Medicare and Medicaid Documentation (Required)

Upload a copy of official CMS and State Medicaid agency notifications that document that your organization is an approved primary care Medicare and Medicaid provider, including the corresponding provider numbers.

Attachment 11—Organizational Chart (Required)

Provide an organizational chart showing your organizational and management structure. The chart should demonstrate that the governing board retains ultimate authority and leadership of the health

center. Public entities with co-applicant arrangements should document the relationship between the co-applicant and the public entity and the lines of authority for the health center. Include:

- Lines of authority, including the governing board.
- Key employee position titles, names, and full-time equivalents (FTEs) of each individual.

Attachment 12—Position Descriptions for Key Personnel (Required)

Submit a copy of position descriptions for all key management positions: CEO, CMO, CFO, COO, and Project Director. Indicate if key management positions are combined and/or part-time (e.g., CFO and COO roles are shared). Limit each position description to one page and include:

- Position title
- Description of duties and responsibilities
- Position qualifications
- Supervisory relationships
- Skills, knowledge, and experience requirements
- Travel requirements
- Salary range
- Work hours

Attachment 13—Biographical Sketches for Key Personnel (Required)

Upload current biographical sketches for key management staff: CEO, CMO, CFO, COO, and Project Director. Biographical sketches should not exceed **two pages** each. When applicable, biographical sketches must include training, language fluency, and experience working with the cultural and linguistically diverse populations to be served.

Attachment 14—Sliding Fee Discount Schedule and Schedule of Charges (Required)

Provide the current schedule of charges and the corresponding sliding fee discount schedule for which charges are adjusted on the basis of the patient's ability to pay. Discounts must apply only to persons with incomes between 100-200 percent of the federal poverty level (see the Federal Poverty Guidelines (FPG) at <http://aspe.hhs.gov/poverty>). Patients with incomes below 100 percent of the FPG may not be charged for services (a nominal fee is acceptable if it is not a barrier to obtaining services). No discounts may be given to patients with incomes over 200 percent of the Federal Poverty Guidelines. Refer to PIN 2014-02: [Sliding Fee Discount and Related Billing and Collections Program Requirements](#) for details on the Health Center Program sliding fee discount program requirements.

Attachment 15—Financial Statements and Independent Financial Audit (Required)

Upload the most recent six consecutive months of financial statements. In addition, submit your most recent annual independent financial audit. The audit must include the auditor's opinion statement (i.e., management letter), the balance sheet, profit and loss statement, audit findings, and any noted exceptions. If you do not have an audit, explain why and provide the date when the audit will be available.

Attachment 16—Letters of Support (Required)

Submit current, dated letters that document support for look-alike designation. See the [COLLABORATION](#) section of the Project Narrative for details on required letters of support. If one or more letters from other providers serving the same population are not provided, include documentation that the letters were requested and explain why they were not obtained in the Project Narrative.

Attachment 17—Floor Plans (Required)

For all service sites listed on [Form 5B](#), upload floor plans that show exam rooms and waiting area(s). Indicate the area of the building to be used (e.g., suites, floors) and the address.

Attachment 18—Budget Narrative (Required)

Provide a detailed budget narrative for the first year of the look-alike designation period. The budget narrative should be consistent with [Form 3A](#): Look-Alike Budget Information, [Form 3](#): Income Analysis, and [Form 2](#): Staffing Profile. Reference the forms as needed. Include revenues and expenses for the entire look-alike scope of project. Present the budget in line-item format with accompanying narrative justification that explains how each line item expense is derived (e.g., number of visits, cost per unit). If using Excel or other spreadsheet documents, do not use multiple sheets (tabs), as they may not print out in their entirety. Include the following expense categories, as needed:

- 1. Personnel Costs:** Personnel costs must be explained by listing each staff member directly employed by the health center, name (if possible), position title, percent full time equivalency, and annual salary.
- 2. 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 should be directly proportional to the portion of personnel costs.
- 3. 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 should be outlined. The budget must also reflect travel expenses associated with participating in proposed meetings, trainings, or workshops.
- 4. Equipment:** Identify the cost per item and justify the need for each piece of equipment to carry out the 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 organization for its financial statement purposes, or (b) \$5,000.
- 5. Supplies:** List the items necessary for implementing the project, separating items into three categories: office supplies, medical supplies, and educational supplies (e.g., brochures).
- 6. 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. 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 contracts. Refer to [Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75](#) for regulations regarding contractor agreements.
- 7. Construction:** Include costs related to construction and/or renovation related to the proposed look-alike site(s), including architectural and engineering fees, site work, and build-out of space, as applicable.
- 8. Other:** Include all costs that do not fit into any other category and provide an explanation of each cost. Rent, utilities, organizational membership fees, and insurance may fall under this category.

- 9. 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).

Note: *If your organization receives any federal funding, you are required to have the necessary policies, procedures, and financial controls in place to ensure that you comply with all federal funding requirements and prohibitions such as lobbying, gun control, abortion, etc. The effectiveness of these policies, procedures, and controls may be subject to audit.*

Attachment 19—Health Center Program Requirements Compliance (Required)

Provide a table that indicates where within the application your organization’s compliance with the following [Health Center Program requirements](#) has been addressed.

1. Needs Assessment
2. Required and Additional Services
3. Staffing Requirement
4. Accessible Hours of Operation/Locations
5. After Hours Coverage
6. Hospital Admitting Privileges and Continuum of Care
7. Sliding Fee Discounts
8. Quality Improvement/Assurance Plan
9. Key Management Staff
10. Contractual/Affiliation Agreements
11. Collaborative Relationships
12. Financial Management and Control Policies
13. Billing and Collections
14. Budget
15. Program Data Reporting Systems
16. Board Authority
17. Board Composition
18. Conflict of Interest Policy

Attachment 20—Other Relevant Documents (As applicable)

If desired, include other relevant documents to support the project plan. If the site is leased, lease documentation must be included in this attachment.

Program Specific Forms

Program Specific forms must be completed electronically in EHB. To preview the forms, visit <http://bphc.hrsa.gov/programopportunities/lookalike/initialdesignationinstructions.html>. All forms are required, with the exceptions of Form 5C: Other Activities/Locations and 6B: Request for Waiver of Board Member Requirements. Data provided in the forms must be consistent with information provided in the Project Narrative and other parts of the application. See the EHB Look-Alike Initial Designation User Guide at <http://bphc.hrsa.gov/programopportunities/lookalike/initialdesignationinstructions.html> for assistance completing the forms in EHB.

FORM 1A: General Information Worksheet (Required)

This form provides information related to your organization's current operations, service area, and patient and visit projections.

1. APPLICANT INFORMATION

- Applicant name and type is pre-populated from the Cover Page that you complete when creating the application.
- Select your organization's fiscal year end date.
- Select one option in the Business Entity section. An applicant that is a Tribal or Urban Indian entity and also meets the definition for a public or private entity should select the Tribal or Urban Indian category.
- You may select one or more categories for the Organization Type section.

2. PROPOSED SERVICE AREA

2a. Service Area Designation

- If requesting designation for Community Health Centers (CHC), you MUST serve patients that reside in a Medically Underserved Area (MUA) and/or are part of a Medically Underserved Population (MUP).
- Select the MUA and/or MUP designation(s) for the service area and enter the identification number(s).
- For inquiries regarding MUAs or MUPs, visit the Shortage Designation Web site at <http://www.hrsa.gov/shortage>, call 1-888-275-4772 (select option 1 then option 2), or contact the Shortage Designation Branch at SDB@hrsa.gov.

2b. Service Area Type

- Select the type (urban, rural, or sparsely populated) that describes the service area. If sparsely populated is selected, provide the number of people per square mile (must be 7 or less). For information about rural populations, visit the [Office of Rural Health Policy's Web site](#).

2c. Patients and Visits

When providing the count of patients and visits, note the following guidelines (see the UDS Manual available at <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting> for detailed information):

- A visit is a documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services must be paid for by your organization and documented in the patient's record.
- A patient is an individual who had at least one visit in the reporting year.
- Since a patient must have at least one documented visit, the number of patients cannot exceed the number of visits.
- If you have more than one service site, you must report aggregate data for all sites listed on [Form 5B](#).
- Report current baseline values based on services your organization is currently providing in the service area (report annualized data).

- Do not report patients and visits for services outside the look-alike’s scope of project. Specifically, the scope of project defines the service sites, services, providers, service area, and target population for which look-alike designation may be applicable. For more information, see PIN 2008-01: [Defining Scope of Project and Policy for Requesting Changes](#) and other [Scope of Project](#) documents.

Unduplicated Patients and Visits by Population Type:

- Answer the question, “How many unduplicated patients are projected to be served by the end of designation period?” by projecting the number of unduplicated patients to be served annually in the last year of the three-year designation period. If designated, progress toward this projection will be tracked via annual UDS reports.
- Provide the number of current unduplicated patients and visits for each population type category in the Current Number columns. Across all population type categories, an individual can only be counted once as a patient. The total number of current unduplicated patients being seen at the health center must be consistent with [Attachment 1: Patient Origin Study](#).
- To maintain consistency with the patients and visits reported in UDS, do not include patients and visits for pharmacy services.
- The total number of unduplicated patients projected by the end of designation period will pre-populate from the question above. Project the corresponding annual number of visits. Then categorize these projected numbers for each population type category. Across all population type categories, an individual can only be counted once as a patient.

Note: *The population types in this table do not refer only to the requested designation categories (i.e., CHC, MHC, HCH, and/or PHPC). If requesting designation for only CHC, you may still have patients/visits listed in the other population type categories. All patients/visits that do not fall within the Migratory and Seasonal Agricultural Workers, Public Housing Residents, or People Experiencing Homelessness categories must be included in the General Underserved Community category.*

Patients and Visits by Service Type:

- Provide the number of current patients and visits within each service type category in the Current Number columns. A patient who receives multiple types of services should be counted once for each service type (e.g., an individual who receives both medical and dental services should be counted once for medical and once for dental).
- Project the annual number of patients and visits anticipated within each service type category across all sites by the end of the three-year designation period.
- Do not include patients and visits for vision or pharmacy services.
- Because a look-alike’s main purpose must be the provision of comprehensive primary medical care, the number of current and projected medical patients must be greater than the number of current and projected patients within each of the other service types.

FORM 2: Staffing Profile (Required)

This form is completed twice. On the “Current” tab, indicate all staff **currently** employed or under contract.²¹ On the “Prospective” tab, indicate all staff projected to be employed or under contract by the end of the three-year designation period. Include only staff for sites included on [Form 5B](#): Service Sites.

- Allocate staff time in the Direct Hire FTE column by function among the staff positions listed. An individual’s full-time equivalent (FTE) should not be duplicated across positions. For example, a provider serving as a part-time family physician and a part-time Clinical Director should be listed in each respective category with the FTE portion allocated to each position (e.g., CMO 0.3 (30%) FTE and family physician 0.7 (70%) FTE). Do not exceed 1.0 (100%) FTE for any individual. For position descriptions, refer to the [UDS Manual](#).
- Volunteers must be recorded in the Direct Hire FTEs column.
- For health centers that provide services through formal written contracts/agreements ([Form 5A](#), Column II), Select Yes in the Contract/Agreement FTEs column. Contracted staff should be summarized in [Attachment 7](#): Summary of Contracts and Agreements and/or included in contracts uploaded to [Form 8](#): Health Center Agreements, as needed.
- Contracted staff are indicated by answering Yes or No only. **Do not quantify contracted staff in the Direct Hire column of this form.**

FORM 3: Income Analysis (Required)

Form 3 collects the projected patient services and other income from all sources for the **first year** of the designation period. Form 3 income is divided into two parts: (1) Patient Service Revenue - Program Income and (2) Other Income - 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.

²¹ HRSA utilizes Internal Revenue Service (IRS) definitions to differentiate employees and contractors. To be considered as an employee by the IRS, the individual must receive a salary from the entity on a regular basis, with applicable taxes and benefits deducted along with coverage for unemployment compensation in most cases. The entity should issue a W-2 form to an individual who is an employee, and a Form 1099 to an individual who is a contractor.

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.

Only include patient service revenue associated with sites and services to be included in the look-alike scope of project.

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): These include all billable/reimbursable visits.²² The value is typically based on assumptions about the amount of available clinician time, average visit time (based on complexity of patient conditions and use of team provider arrangements), and types of billable visits by payer. There may be other exclusions or additions, which, if significant, should be noted in the Comment/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column. (See [Ancillary Instructions](#) below.)

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

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

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 designation period. 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.

²² These visits will correspond closely with the visits reported on the [UDS Manual](#) Table 5, excluding enabling service visits.

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.

Alternative Instructions for Capitated Managed Care:

Health centers 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 used in UDS. The [UDS Manual](#) must be used to define each payer category.

Visits are reported on the line of the primary payer (payer billed first). Income is classified by the payer groupings where the income is earned. When a single visit involves more than one payer, attribute that portion of the visit income to the payer group from which it is earned. In cases where there are deductibles and co-payments to be paid by the patient, 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 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. In the event you do 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.

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. An example of this is

the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program.

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

Self-Pay (Line 5): 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 – Federal, State, Local, and Other Income

This section includes all income other than the patient service revenue shown in Part 1. It includes 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.

Federal (Line 7): This is income from direct federal funds where your organization is the recipient of a Notice of Award from a federal agency. It does not include federal funds awarded through intermediaries (see Line 9 below). It includes funds from federal sources such as the CDC, CMS, Housing and Urban Development (HUD), 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 grants, contracts, and programs, including uncompensated care funding; state indigent care income; emergency preparedness grants; mortgage assistance; capital improvement grants; school health grants; Women, Infants, and Children (WIC); immunization grants; 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 grants, 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 as foundations, non-profit entities, hospitals, nursing homes, drug companies, employers, other health centers, and similar entities. For example, a health center operating a 340B pharmacy in part for its own patients and in part as a contractor to another health center is to report the pharmacy income for its own patients in Part 1 and the income from the contracted health center on this line.

Contributions (Line 11): 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 your 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.

Total Other (Line 14): This is the sum of lines 7 – 13.

Total Income (Line 15): This is the sum of Lines 6 and 14 and is the total income for the scope of project.

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

FORM 3A: Look-Alike Budget Information (Required)

Part 1: Expenses

For each of the expense categories (personnel, fringe benefits, travel, equipment, supplies, contractual, construction, other, and indirect charges), enter the projected first year of expenses for each Health Center Program type for which designation is requested (i.e., CHC, MHC, HCH, PHPC). See the [Budget Narrative](#) section for a definition of each expense category. The total fields are calculated automatically when you save the form.

Part 2: Revenue

For each of the revenue categories, enter the projected first year of revenue by funding source. Include funds provided by the applicant organization, federal, state, and local include support for the health center from those sources. Other revenue includes contributions from other sources not noted above. If the applicant is a state agency, state funding should be included in the applicant field. The total fields are calculated automatically when you save the form.

Form 3A should be consistent with [Attachment 18](#): Budget Narrative.

Form 4: Community Characteristics (Required)

Report current service area and target population data for the entire scope of project (all proposed sites on [Form 5B: Service Sites](#)). Information provided regarding race and ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements. If you compile data from multiple data sources, you may find that the total numbers vary across sources. If this is the case, you should make adjustments as needed to ensure that the total numbers for the first four sections of this form match.

The service area must be specific to the proposed project and correspond to the zip codes listed on Form 5B: Service Sites. Service area data must include the total number of individuals in the service area for each characteristic (percentages will automatically calculate in EHB). If information for the service area is not available, extrapolate data from the U.S. Census Bureau, local planning agencies, health departments, and other local, state, and national data sources. Estimates are acceptable.

Target population data are most often a subset of service area data. Report the number of individuals for each characteristic (percentages will automatically calculate in EHB). Estimates are acceptable.

Patient data should not be used to report target population data since patients are typically a subset of all individuals targeted for service.

If the target population includes a large number of transient individuals (e.g., the county has an influx of migratory and seasonal agricultural workers during the summer months) that are not included in the dataset used for service area data (e.g., Census data), adjust the service area numbers accordingly to ensure that the target population numbers are always less than or equal to the service area numbers. Adjustments must be explained in Item 1 of the [NEED](#) section of the Project Narrative.

Note: The total numbers for the first four sections of this form (i.e., Race, Hispanic or Latino Ethnicity, Income as a Percent of Poverty Level, and Primary Third Party Payment Source) must match.

Guidelines for Reporting Race

- All individuals must be classified in one of the racial categories, including individuals who also consider themselves Hispanic or Latino. If the data source does not separately classify Hispanic or Latino individuals by race, report them as Unreported/Declined to Report.
- Utilize the following race definitions:
 - Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
 - Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, Tonga, Palau, Truk, Yap, or other Pacific Islands in Micronesia, Melanesia, or Polynesia.
 - Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Indonesia, Thailand, and Vietnam.
 - American Indian/Alaska Native – Persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
 - More Than One Race – Persons who choose 2 or more races.

Guidelines for Reporting Hispanic or Latino Ethnicity

- If ethnicity is unknown, report individuals as Unreported/Declined to Report.

- Utilize the following ethnicity definition: Hispanic or Latino – Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Guidelines for Reporting Special Populations

The Special Populations section of Form 4 does not have a row for total numbers. Individuals that represent multiple special population categories should be counted in all applicable categories.

Forms 5A, 5B, and 5C

General Guidelines for Scope of Project

- You must complete Forms 5A: Services Provided and 5B: Service Sites. Form 5C: Other Activities/Locations may be completed, as applicable. Complete these forms based only on the scope of project for the service area.
- If you are designated as a look-alike, only the services, sites, and other activities/locations listed on these forms will be considered to be in the approved scope of project, regardless of what is described or detailed elsewhere in the application.
- Refer to the Scope of Project policy documents and resources at this link: <http://bphc.hrsa.gov/programrequirements/scope.html> for information about defining your scope of project (i.e., services, sites, service area zip codes, target population).

Form 5A: Services Provided (Required)

Identify the services that are currently available at all sites and how the services are provided (i.e., Column I – direct by health center, Column II – formal written agreement (health center pays for service), Column III – formal written referral arrangement). All required services must be provided either directly onsite or through established agreements/arrangements without regard to ability to pay and on a sliding fee discount schedule. Refer to the [Service Descriptors for Form 5A: Services Provided](#) for descriptions of the general elements for all required and additional services. Established agreements must be summarized in [Attachment 7](#) and, if they constitute a substantial portion of your scope of project, agreements/contracts must be attached to Form 8. See the [Column Descriptors for Form 5A: Services Provided](#) for descriptions of the three service delivery methods used by health centers and the specific requirements for using them.

Because comprehensive primary medical care is the main purpose of the Health Center Program, General Primary Medical Care must be offered either directly by the health center (Column I) or through formal written contractual agreements in which the health center pays for the service (Column II). General Primary Medical Care cannot be provided solely by referral.

Additional services are not required. However, when offered, they must be made available to all patients, and provided without regard to ability to pay and on a sliding fee discount schedule.

Specialty services may not be added to your scope of project at the time of initial designation submission. However, specialty services may be requested for addition to the scope of project through the Change in Scope process after look-alike designation.²³

Note: All services must be accessible to all patients in the service area, though the mode of service delivery may be different across sites.

Form 5B: Service Sites (Required)

On Form B, identify the look-alike site(s) and provide the required data for each site, including:

- Site address;
- Location type (permanent, seasonal, or mobile van);
- Site operational date (must be prior to time of application submission);
- Total hours of operation per week;
- Medicare status;
- Service area zip codes; and
- Contractor information, if applicable.

At least one service site must be a full-time (operational 40 hours or more per week), permanent service delivery site (with the exception of health centers that request designation for only migratory and seasonal agricultural workers, which may have a seasonal rather than permanent site) that provides comprehensive primary medical care as its main purpose. A permanent site is a fixed building location. Subsequent service sites may be part-time, seasonal, etc.

Provide the required data for each site that meets the definition of a service site. Refer to PIN 2008-01: [Defining Scope of Project and Policy for Requesting Changes](#) for more information on defining service sites and for special instructions for recording mobile, intermittent, or other site types.

On each Form 5B, you should include the zip codes for the area served by the site. The Service Area Zip Codes field (across all proposed sites) must include those zip codes where at least 75 percent of the current patients reside. Your entire service area (as described on [Attachment 1: Patient Origin Study and Form 4: Community Characteristics](#)) should be represented by the zip codes across all service sites (indicated on each Form 5B).

Note: In the Site Qualification Criteria, indicate if the site is a Domestic Violence site (e.g., emergency shelter). Select “yes” for this question only if the proposed site is a site serving victims of domestic violence and the street address cannot be published to protect the confidentiality of the precise location.

Form 5C: Other Activities/Locations (As Applicable)

Provide requested data for other activities/locations (e.g., home visits, health fairs). List only activities/locations that:

²³ See PIN 2009-02: [Specialty Services and Health Centers’ Scope of Project](#).

- 1) Do not meet the definition of a service site;
- 2) Are conducted on an irregular timeframe/schedule; and/or
- 3) Offer a limited activity from within the full complement of health center activities included within the scope of project.

Refer to PIN 2008-01: [Defining Scope of Project and Policy for Requesting Changes](#) for more information on defining other activities and locations that should be included on Form 5C.

Form 6A: Current Board Member Characteristics (Required)

List all current board members (minimum of nine; maximum of 25) and provide the requested details. To be eligible, the board must be compliant with Health Center Program governance requirements. For more information regarding board requirements, refer to the Health Center Program Governance policy available at <http://bphc.hrsa.gov/programrequirements/policies/pin201401.html>.

- Public centers with co-applicant health center governing boards must list the co-applicant board members.
- Special population applicants requesting a waiver of the patient majority requirement must list the health center's board members, not the members of an advisory council.
- List all current board members; current board office held for each board member, if applicable (e.g., Chair, Treasurer); and each board member's area of expertise (e.g., finance, education, nursing). Do not list the CEO or other health center employees.²⁴
- Indicate if each board member derives more than 10 percent of income from the health care industry.
- Indicate if each board member is a health center patient. A patient board member must be a currently registered patient of the health center and must have accessed the health center in the past 24 months to receive at least one in-scope service that generated a health center visit.
- Indicate if each board member lives and/or works in the service area. **Note:** *This is not a requirement to serve on a health center board, but assists with assessing how representative the board is of the community being served.*
- Indicate if each board member is a representative of/for a special population (i.e., persons experiencing homelessness, migratory and seasonal agricultural workers and families, residents of public housing).
- Indicate gender, ethnicity, and race of board members who are patients of the health center and make up the patient majority.

Note: *Indian tribes or tribal, Indian, or urban Indian organizations are not required to complete this form, but may include information, as desired.*

Form 6B: Request for Waiver of Board Member Requirements (As Applicable)

This form is only applicable if you are requesting designation to serve **only** special populations (i.e., HCH, MHC, and/or PHPC). If you are requesting designation to serve the general underserved population

²⁴ The CEO may serve only as a non-voting, ex-officio board member and is generally only a member by virtue of being CEO of the health center.

(section 330(e) – CHC), you are not eligible for a waiver. Indian tribes or tribal, Indian, or urban Indian groups are not required to complete this form and cannot enter information.

When requesting a waiver, briefly demonstrate good cause as to why the patient majority board composition requirement cannot be met, and describe your current efforts in ensuring patient input and participation in the organization, direction, and ongoing governance of the health center. These efforts must provide all of the following:

- Clear description of the alternative mechanism(s) for gathering patient input. If advisory councils or patient representatives are proposed, include a list of the members in [Attachment 20: Other Relevant Documents](#) that identifies these individuals and their reasons/qualifications for participation on the advisory council or as governing board representatives.
- Specific types of patient input to be collected.
- Methods for collecting and documenting such input.
- Process for formally communicating the input directly to the health center governing board (e.g., monthly presentations of the advisory group to the full board, monthly summary reports from patient surveys).
- Specifics on how the patient input will be used by the governing board for: 1) selecting health center services; 2) setting health center operating hours; 3) defining strategic priorities; 4) evaluating the organization’s progress in meeting goals, including patient satisfaction; and 5) other relevant areas of governance that require and benefit from patient input.

Note: An approved waiver does not absolve the organization’s governing board from fulfilling all other statutory board responsibilities and requirements.

Form 8 – Health Center Agreements (Required)

On Form 8, indicate whether your organization:

- Has a parent, affiliate, or subsidiary organization.
- Has or intends to contract with another organization to carry out a substantial portion of the proposed scope of project.

Select **Yes** in Part I if your organization has any agreements that constitute a substantial portion of your scope of project, including:

- Your organization contracts with a related organization such as a parent, affiliate, or subsidiary.
- Any sites that are currently operated by a contractor, as identified in [Form 5B: Service Sites](#).
- Your organization contracts for the majority of core primary care services and/or contracts for the CEO, and/or the entire key management team inclusive of the CEO.

Refer to [Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75](#) for the definition of “substantial” and characteristics of a contractor agreement. If there are agreements that constitute a substantial portion of the project, indicate the number of contracts/agreements and attach the complete agreement and/or contract in Part II.

Form 10: Emergency Preparedness Report (Required)

Select the appropriate responses regarding emergency preparedness. If any answer is no, explain the response in the [RESOURCES/CAPABILITIES](#) section of the Project Narrative.

Form 12: Organization Contacts (Required)

Provide the requested contact information. For the Contact Person field, provide an individual who can represent the organization in communication regarding the application.

Clinical and Financial Performance Measures

The Clinical and Financial Performance Measures forms record the clinical and financial goals for the three-year designation period. The goals must be responsive to identified community health and organizational needs and correspond to service delivery activities and organizational capacity discussed in the Project Narrative. Further detail is available at the [Clinical and Financial Performance Measures Web site](#) (refer to the [UDS Manual](#) for specific measurement details such as exclusionary criteria).²⁵

Required Clinical Performance Measures

1. Diabetes: Hemoglobin A1c Poor Control
2. Controlling High Blood Pressure
3. Cervical Cancer Screening
4. Early Entry into Prenatal Care
5. Low Birth Weight
6. Childhood Immunization Status
7. Dental Sealants for Children Between 6-9 Years
8. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
9. Body Mass Index (BMI) Screening and Follow-Up
10. Tobacco Use: Screening and Cessation Intervention
11. Use of Appropriate Medications for Asthma
12. Coronary Artery Disease: Lipid Therapy
13. Ischemic Vascular Disease: Use of Aspirin or Another Antiplatelet
14. Colorectal Cancer Screening
15. HIV Linkage to Care
16. Screening for Clinical Depression and Follow-Up Plan

Required Financial Performance Measures

1. Total Cost per Patient
2. Medical Cost per Medical Visit

²⁵ Refer to [Program Assistance Letter 2017-02: Approved Uniform Data System Changes for Calendar Year 2017](#) for details about updated performance measures.

Important Details about the Performance Measures Forms

- The Dental Sealants for Children between 6-9 Years clinical performance measure is currently only applicable to health centers that provide preventive dental services directly or by a formal agreement in which the health center pays for the service ([Form 5A](#), Columns I and II). A health center that only provides preventive dental services via a formal referral (Form 5A, Column III) may set the goal for this performance measure as zero. If the goal for this performance measure is set to zero, at least one self-defined Oral Health performance measure must be tracked under the Additional Clinical Performance Measures section.
- Baselines for performance measures should be developed from data that are valid, reliable, and whenever possible, derived from currently established information management systems. If baselines are not available, enter zero for the numerator and denominator and provide a date by which baseline data will be available in the comments field. Regardless of whether baseline data is available, a goal for each measure must be established.
- If you are applying for designation to serve special populations (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing), you must include at least one additional clinical performance measure that addresses the health care needs of each targeted special population. In providing additional performance measures specific to a special population, you must reference the target group in the performance measure. For example, if you serve migratory and seasonal agricultural workers, then the measure should identify *“the percentage of migratory and seasonal agricultural workers who...”*.
- If you have identified unique issues (e.g., populations, age groups, health issues, risk management efforts) in the [NEED](#) section of the Project Narrative, you are encouraged to include additional related performance measures.

Overview of Performance Measures Form Fields

Field Name	Description
Focus Area	This field contains the content area description for each required performance measure. You will specify focus areas when adding self-defined measures in the Additional Performance Measures section.
Performance Measure	This field defines each performance measure and is editable for measures in the Additional Performance Measures section.
Target Goal Description	In this field, provide a description of the target goal to be met by the end of the designation period.
Numerator Description	<p>In the Clinical Performance Measures, the numerator is the number of patients that meet the criteria identified by the measure (e.g., patients in a specified age range that received a specified service).</p> <p>In the Financial Performance Measures, the numerator field must be specific to the organizational measure.</p> <p>You must specify a numerator for Additional Performance Measures.</p>
Denominator Description	<p>In the Clinical Performance Measures, the denominator is all patients to whom the measure applies (e.g., patients in a specified age range, regardless of whether they received a specified service).</p> <p>In the Financial Performance Measures, the denominator field must be specific to the organizational measure.</p> <p>You must specify a denominator for Additional Performance Measures.</p>
Baseline Data	This field contains subfields (i.e., Baseline Year, Measure Type, Numerator, and Denominator) that provide information regarding the initial threshold used to measure progress over the course of the designation period.
Baseline Year	Enter the initial data reference point (year) for this Baseline Data subfield.
Measure Type	This Baseline Data subfield provides the unit of measure (e.g., percentage, ratio).
Numerator and Denominator	Provide the value for the Numerator and Denominator in these Baseline Data subfields based on the numerator and denominator descriptions (see rows above).

Field Name	Description
Projected Data	In this field, provide the goal to be met by the end of the three-year designation period.
Data Source and Methodology	This field provides information about the data sources used to develop each performance measure. Identify a data source and discuss the methodology used to collect and analyze data. For Clinical Performance Measures, select the data source from EHR, Chart Audit, or Other. Data must be valid, reliable, and derived from established information management systems.
Key Factors and Major Planned Actions	This field contains subfields (i.e., Key Factor Type, Key Factor Description, and Major Planned Action Description) that provide information regarding the factors that must be minimized or maximized to ensure goal achievement.
Key Factor Type	In this subfield of the Key Factors and Major Planned Actions field, select either Contributing or Restricting. You must specify at least one key factor of each type, with a maximum of three in total.
Key Factor Description	In this subfield of the Key Factors and Major Planned Actions field, provide a description of the factors predicted to contribute to or restrict progress toward stated goals (based on the Key Factor Type selection described above).
Major Planned Action Description	In this subfield of the Key Factors and Major Planned Actions field, describe the major actions/strategies planned for addressing the identified key factors.
Comments	Include additional information if desired. If baselines are not yet available, use this field to provide a date by which baseline data will be available.

Resources for the Development of Performance Measures

You may find it useful to do the following:

- Examine the performance measures of other health centers that serve similar target populations.
- Consider state and national performance UDS benchmarks and comparison data (available at [Health Center Data](#)).
- Use the [Healthy People 2020](#) goals as a guide when developing performance measures. Several of these objectives can be compared directly to UDS Clinical Performance Measures. A table outlining the Healthy People 2020 objectives related to applicable performance measures is available at [Healthy People 2020/Health Center Program Measures](#).

APPLICATION REVIEW

Within the application submission, you must provide all information and documentation necessary to demonstrate eligibility and compliance with all Health Center Program requirements. You may also be requested to provide additional documentation as necessary.

The time frame ranges below are influenced by application volume, availability of both the applicant organization and the site visit team, and the number of findings from onsite reviews.

Look-Alike Initial Designation Application Review Process	Approximate Time Frame
<p>HRSA Preliminary Review</p> <p>HRSA will conduct a preliminary review to assess eligibility and completeness of the application. Incomplete or ineligible applications will be disapproved and the applicant will be notified of the reason for disapproval through EHB. Applications determined to be eligible and complete will proceed in the application review process to the site visit and compliance review.</p>	30 days
<p>Site Visit Scheduling and Preparation</p> <p>If the application is determined to be complete and eligible, HRSA will contact the applicant to schedule a three-day onsite review (also referred to as a site visit) to assess operational status and compliance with Health Center Program requirements. HRSA staff will coordinate availability of the applicant and HRSA consultants who will conduct the site visit. The time frame between completion of the preliminary review and the date of the onsite review is dependent on both HRSA reviewers and applicant availability. The site visit team will receive a copy of the organization’s look-alike application and may request additional documentation from the applicant before the onsite review.</p>	60-90 days
<p>HRSA Compliance Review</p> <p>Onsite reviews will typically be conducted by clinical, financial, and governance experts under contract with HRSA. The Health Center Program Site Visit Guide is the standardized review instrument used to conduct the onsite review: http://bphc.hrsa.gov/programrequirements/centerguide.html. All site visit participants are encouraged to review the Site Visit Guide to anticipate the information that will be covered and the documents/resources that will be reviewed during the site visit.</p> <p>HRSA will make compliance determinations based on the onsite review findings and the application submission and will communicate any findings of noncompliance through a technical assistance (TA) tool sent via EHB to the applicant organization’s Authorizing Official. The TA tool will detail the necessary information and documentation required to be submitted by the applicant to demonstrate compliance.</p>	60-75 days

<p>Applicant Response</p> <p>HRSA will allow applicants a time-limited opportunity, typically no more than 30 days, to respond to the TA tool and provide documentation demonstrating that all areas of identified noncompliance have been addressed.</p> <p>HRSA may conduct a follow-up site visit to verify that all areas of noncompliance have been sufficiently addressed. If so, the timeframe for review will be extended.</p> <p>If the applicant organization does not submit a response within the designated timeframe, the initial designation application will be disapproved. However, applicants will be given full and fair consideration if they choose to submit a new look-alike initial designation application in the future.</p>	<p>30 days</p>
<p>HRSA Look-Alike Determination</p> <p>HRSA will approve or disapprove the application based on the application submitted, site visit review findings, and the applicant response to the TA tool. Only eligible organizations that demonstrate compliance with all Health Center Program requirements will be approved.</p>	<p>30-45 days</p>

The total time for the look-alike initial designation review process, including the HRSA preliminary review, site visit scheduling and preparation, compliance review, applicant response period, and final determination is approximately six to nine months.

APPLICATION DETERMINATIONS

Disapproval. Organizations whose applications are disapproved will receive technical assistance that identifies the areas of noncompliance and the required actions to bring the organization into compliance with Health Center Program requirements.

Look-alike application disapproval is not appealable. However, organizations can re-apply for look-alike initial designation at any time, and all applications will receive full and fair consideration. HRSA strongly encourages you to discuss review findings with your Primary Care Association and/or HRSA staff before developing a new application.

Approval. Organizations whose applications are approved will receive a Notice of Look-Alike Designation through EHB for a three-year designation period.

DESIGNATION REPORTING & REVIEW

If designated, you must comply with the following reporting and review activities:

- 1) **Uniform Data System (UDS) Report** – The UDS is an integrated reporting system used to collect data on all health centers to ensure compliance with legislative and regulatory requirements,

improve health center performance and operations, and report overall program accomplishments. All look-alikes are required to submit a UDS Universal Report and, if applicable, a UDS Grant Report annually, by the specified deadline. The Universal Report provides data on patients, services, staffing, and financing across all health centers. The Grant Report provides data on patients and services for special populations served (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing). Lack of timely submission of all required UDS report(s) may result in termination of look-alike designation and all corresponding benefits.

- 2) **Progress Report** – The Annual Certification (AC) submission documents progress on program-specific performance measurement goals to track the impact of the project. You will receive an email notification via EHB that the AC is available for completion approximately 150 days from the end of each year within the designation period (with the exception of the final year of the designation period, when a Renewal of Designation application must be submitted). You will have 60 days to complete and submit the AC. Lack of timely AC submission may result in termination of the look-alike designation and all corresponding benefits.
- 3) **Site Visit** – At least once during the three-year designation period, HRSA will conduct an operational site visit to assess compliance with the Health Center Program requirements and identify needed technical assistance and training.

APPLICATION TECHNICAL ASSISTANCE

The look-alike initial designation technical assistance (TA) Web site at <http://bphc.hrsa.gov/programopportunities/lookalike/initialdesignationinstructions.html> provides essential resources for application preparation, including an instructional webinar, frequently asked questions, and sample documents.

Throughout the application development and preparation process, you are encouraged to work with appropriate Primary Care Association (PCA), Primary Care Office (PCO), and/or National Cooperative Agreement partners (NCAs) to prepare a responsive application. For a complete listing of HRSA-supported PCAs and NCAs, refer to [Support Networks](#). For a list of PCO contacts, refer to <https://bhw.hrsa.gov/shortage-designation/hpsa/primary-care-offices>.

For additional information related to **program issues and/or technical assistance (not related to EHB)**:

Look-Alike Initial Designation Response Team
Office of Policy and Program Development
Bureau of Primary Health Care

Web form: http://bphccommunications.force.com/KnowledgeApp/pkb_oppd

Telephone: 301-594-4300

<http://bphc.hrsa.gov/programopportunities/lookalike/initialdesignationinstructions.html>

For assistance with **navigating and completing your application in EHB**, contact:

Bureau of Primary Health Care (BPHC) Helpline

Telephone: 877-974-2742 ext. 3

Web form: <http://www.hrsa.gov/about/contact/bphc.aspx> (Select Application as the Issue Type)