

**U.S. Department of Health and Human Services
Health Resources and Services Administration (HRSA)
Bureau of Primary Health Care (BPHC) Health Center Program (HCP)**



**LOOK-ALIKE ANNUAL CERTIFICATION
SUBMISSION INSTRUCTIONS**

Release Date: July 21, 2016

All submissions started in the HRSA Electronic Handbooks (EHB) on or after the release date must adhere to the instructions contained herein.

Office of Policy and Program Development

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

E-mail: lookalike@hrsa.gov

Telephone: 301-594-4300

Annual Certification Technical Assistance Webpage:

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

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ABOUT THE ANNUAL CERTIFICATION SUBMISSION

The Annual Certification (AC) submission provides an update on the progress of Health Center Program look-alikes. The AC submission reports on progress made from the beginning of a look-alike's (LAL) current certification period until the date of AC submission; the expected progress for the remainder of the current certification period; and any projected changes for the upcoming certification period.

SUMMARY OF CHANGES (COMPARED TO THE NOVEMBER 8, 2013 AC APPLICATION)

The AC submission has been streamlined to be a succinct progress report, rather than a lengthy application submission. Many of the forms and documents previously required as part of the AC submission are no longer required. Please read through this entire document before beginning your submission. A complete list of the forms and documents required for the AC submission appears in [Table 1: Submission Components](#).

I. TECHNICAL ASSISTANCE

Technical assistance resources are available at the [AC TA Webpage](#). The website includes copies of forms, the EHB [AC User Guide](#), frequently asked questions (FAQs), and a slide presentation.

LALs may obtain AC programmatic technical assistance by contacting:

LAL Response Team

301-594-4300

Web form: http://bphccommunications.force.com/KnowledgeApp/pkb_oppd
lookalike@hrsa.gov

LALs may obtain assistance with system problems encountered when completing the submission in EHB by contacting:

BPHC Helpline

1-877-974-2742

[Submit a request via web form](#)

II. GENERAL INSTRUCTIONS

Annual Certification submissions are due 90 days prior to the end of the certification period. The HRSA EHB system will send email reminders to the organization’s contacts identified in the EHB system 150 days prior to the end of the certification period to inform them that the submission is accessible in EHB. Once notified that the submission is available within the EHB, applicants will have 60 days to complete and submit it in the EHB system.



Annual Certification submissions lacking all required documents and information will be considered incomplete or non-responsive. Incomplete or non-responsive AC submissions will be returned through a “request change” notification via EHB for the provision of missing information or clarification. Health Center Program look-alikes are required to submit an AC submission within the certification period, by the established deadline timeframes. **Failure to submit a timely and complete AC submission may result in termination of the look-alike designation and all corresponding benefits.** LALs should carefully review their AC submission to ensure it is both complete and responsive prior to submission.

[Table 1](#) identifies the required components for the AC submission. In the Form Type column of [Table 1](#), the word “Form” refers to forms that are completed online through the EHB. The word “Document” refers to materials that must be uploaded into the EHB. The word “Fixed” refers to forms that cannot be altered but may be refreshed from scope.

TABLE 1: SUBMISSION COMPONENTS

- Refer to [Appendix A](#) for detailed instructions on completing the forms listed below, unless otherwise noted.
- Samples of [Form 3: Income Analysis](#), the [Program Narrative Update](#), the [budget narrative](#), and the [Scope Certification Form](#) are available on the [AC TA Webpage](#).

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

III. INSTRUCTIONS FOR PROGRAM NARRATIVE UPDATE

The Program Narrative Update must address the following:

1. Progress and changes that have impacted the community/target population and look-alike organization from the beginning of the current certification period until the date of AC submission;
2. Expected progress for the remainder of the certification period; and

3. Projected plans for the upcoming certification period.

Reporting Your Certification Period Progress



Respond to each item below and ensure consistency between the Program Narrative Update and other components of the AC submission. The [AC TA Webpage](#) includes resources that may assist you in completing the Program Narrative Update.

Each of the four key areas requires responses, and each section is limited to 3,000 characters (approximately 2 page).

- 1. Environment:** Discuss changes in the region, state, and/or community over the past year that have directly impacted/affected the project's progress (e.g., changing service area demographics/shifting target population needs, changes in major health care providers in the service area, changes in key program partnerships, changes in insurance coverage, including Medicaid, Medicare and Children's Health Insurance Program (CHIP)).
- 2. Organizational Capacity:** Discuss changes in the organization's capacity over the past year that have impacted or may impact the progress of the designated project, including changes in:
 - Staffing, including staff composition and/or key staff vacancies;
 - Operations;
 - Systems, including financial, clinical, and/or practice management systems; and
 - Financial status.
- 3. Patient Capacity:** See [Table 2: Patient Capacity](#). Discuss the trend in the number of unduplicated patients served and report progress in reaching the projected number of patients to be served in the identified categories. Explain key factors driving significant changes in patient numbers and any downward trends or limited progress towards the projected patient goals.
- 4. Clinical/Financial Performance Measures:** See [Table 3: Performance Measures](#). Referencing the % Change 2013-2015 Trend, % Change 2014-2015 Trend, and % Progress Toward Goal columns, discuss the trends in Clinical and Financial Performance Measures. Maintenance or improvement in performance is expected; downward trends or limited progress towards the projected goals must be explained. In the Clinical/Financial Performance Measures Narrative column, describe the following as they relate to the data:
 - a. Progress toward goals;
 - b. Key contributing and restricting factors impacting/affecting progress toward goals; and

- c. Plans for sustaining progress and/or overcoming barriers to ensure goal achievement.

Note: The Clinical and Financial Performance Measure goals cannot be changed in the AC submission.

TABLE 2: PATIENT CAPACITY

	2013 Patient Number	2014 Patient Number	2015 Patient Number	% Change 2013-2015 Trend	% Change 2014-2015	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
Designation Period: (Pre-populated from most recent Notice of Look-Alike Designation)								
Total Unduplicated Patients	Pre-populated from 2013 UDS	Pre-populated from 2014 UDS	Pre-populated from 2015 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current certification period	3,000 character limit
Total Migratory and Seasonal Agricultural Worker Patients	Pre-populated from 2013 UDS	Pre-populated from 2014 UDS	Pre-populated from 2015 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current certification period	3,000 character limit
Total People Experiencing Homelessness Patients	Pre-populated from 2013 UDS	Pre-populated from 2014 UDS	Pre-populated from 2015 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current certification period	3,000 character limit
Total Public Housing Resident Patients	LAL to provide data*	Pre-populated from 2014 UDS	Pre-populated from 2015 UDS	Pre-populated calculation if 2013 data is provided	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current certification period	3,000 character limit
Notes: <ul style="list-style-type: none"> • 2013 – 2015 Patient Number data are pre-populated from Tables 3a and 4 in the UDS Report. • % Change and % Progress Data are pre-populated calculations based on UDS Reporting. • If pre-populated patient projections are not accurate, provide adjusted projections and explanations in the Patient Capacity Narrative section. • (*) Since the 2013 public housing patient data were not included in Table 4 of the UDS Report, provide the 2013 public housing patient number, as applicable, from your health center data. 								

TABLE 3: PERFORMANCE MEASURES

	2013 Measure	2014 Measure	2015 Measure	% Change 2013-2015 Trend	% Change 2014-2015	% Progress toward Goal	Measure Goal*	Measure Narrative
Perinatal Health								
Access to prenatal care in 1st trimester	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	LAL to provide goal	3,000 character limit
Low birth weight (< 2500 grams)	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	LAL to provide goal	
Preventive Health Screenings and Services								
Oral health—sealants**	No data available	No data available	LAL to provide data	No data available	No data available	Pre-populated calculation if 2015 data is provided and a goal is established	LAL to establish goal	
Weight assessment and counseling for children and adolescents	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	LAL to provide goal	3,000 character limit

	2013 Measure	2014 Measure	2015 Measure	% Change 2013-2015 Trend	% Change 2014-2015	% Progress toward Goal	Measure Goal*	Measure Narrative
Adult weight screening and follow up	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	LAL to provide goal	
Tobacco use screening and cessation	No data available	Pre-populated from 2014 UDS, if available	Pre-populated from 2015 UDS (if available)	No data available	Pre-populated calculation	Pre-populated calculation	LAL to provide goal	
Colorectal cancer screening	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	LAL to provide goal	
Cervical cancer screening	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	LAL to provide goal	
Childhood immunizations by 3rd birthday	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	LAL to provide goal	

	2013 Measure	2014 Measure	2015 Measure	% Change 2013-2015 Trend	% Change 2014-2015	% Progress toward Goal	Measure Goal*	Measure Narrative
Chronic Disease Management								
Asthma treatment— pharmacologic therapy	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	LAL to provide goal	3,000 character limit
Coronary artery disease (CAD) and lipid-lowering therapy	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	LAL to provide goal	
Ischemic Vascular Disease (IVD) and aspirin or other anti-thrombotic therapy	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	LAL to provide goal	
Blood pressure control	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	LAL to provide goal	
Diabetes control***	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
HIV linkage to care**	No data available	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	No data available	No data available	Pre-populated calculation	LAL to establish goal	

	2013 Measure	2014 Measure	2015 Measure	% Change 2013-2015 Trend	% Change 2014-2015	% Progress toward Goal	Measure Goal*	Measure Narrative
Depression screening and follow up**	No data available	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	No data available	No data available	Pre-populated calculation	LAL to establish goal	
Financial Measures								
Total cost per patient	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	LAL to provide goal	3,000 character limit
Medical cost per medical visit	Pre-populated from 2013 UDS (if available)	Pre-populated from 2014 UDS (if available)	Pre-populated from 2015 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	LAL to provide goal	
Additional Measures								
Additional Measures (if applicable)	Provide data if available	Provide data if available	Provide data if available	Pre-populated calculation (if data are provided)	Pre-populated calculation (if data are provided)	Pre-populated calculation (if data are provided)	LAL to provide goal	3,000 character limit
Notes: <ul style="list-style-type: none"> (*) LALs are required to provide goals for all clinical and financial performance measures in this submission. Reference the goals from your last LAL submission and, as needed, the metric definitions provided on the AC TA Webpage when providing the goals. If any goals differ from these included in your last LAL submission, use the Measure Narrative column to provide an explanation. (**) Since the Oral health—sealants, HIV linkage to care, and Depression screening and follow-up measures were not included in previous ID, RD, or AC applications, LALs must establish a goal to be reached by the end of the designation period for these measures. See the metric definitions provided on the AC TA Webpage for details. (***) Due to the fact that LALs set their diabetes goals and reported UDS data based on different diabetes measure definitions, N/A will be shown for all fields, and narrative progress toward the goal is not required in this submission. However, work should continue in this priority area and progress should be shown in the 2016 UDS report. Self-defined Oral Health and Behavioral Health measures that were included in previous LAL submissions will appear in the Additional Measures section. 								

Refer to the [UDS Manual](#) and the [UDS TA Site](#) for assistance with analyzing performance measure progress.

IV. BUDGET PRESENTATION INSTRUCTIONS

A complete budget presentation includes [Form 3](#): Income Analysis, [Form 3A](#): Look-Alike Budget Information (see instructions form Forms 3 and 3A in [Appendix A](#)), and the submission of the budget narrative.

Please note: the Annual Certification may not be used to request changes in the designation type (i.e., Community Health Center – CHC, Migrant Health Center – MHC, Health Care for the Homeless – HCH, and/or Public Housing Primary Care – PHPC).

Budget Narrative

Provide a detailed budget narrative in line-item format for the upcoming certification period. An itemization of revenues and expenses is necessary. Upload the budget narrative in the Appendices section in the EHB. Please be aware that Excel or other spreadsheet documents with multiple pages (sheets) may not print out in their entirety. **Definitions for the expense categories are as follows:**

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.

Fringe Benefits: List the components of the fringe benefit rate (e.g., health insurance, taxes, unemployment insurance, life insurance, retirement plan, and tuition reimbursement). Fringe benefits must be directly proportional to the portion of personnel costs.

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

Equipment: Identify the cost per item and justify the need for each piece of equipment to carry out the proposed project. Equipment includes moveable items that are non-expendable, tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of (a) the capitalization level established by the LAL for its financial statement purposes, or (b) \$5,000.

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

Contractual: Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. List both patient care (e.g., laboratory) and

non-patient care (e.g., janitorial) contracts. Each LAL is responsible for ensuring that its organization/institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring contracts. Refer to [Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75](#) for regulations regarding sub-recipient and contractor agreements.

Construction: Include costs related to construction and/or renovation related to the look-alike sites(s), including architectural and engineering fees, site work, and build-out space, as applicable.

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

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

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.

APPENDIX A: PROGRAM SPECIFIC FORMS INSTRUCTIONS

Form 3: Income Analysis (Required)

Form 3 will show the projected patient services and other income from all sources for the upcoming certification period (one year). Form 3 income is divided into two parts: (1) Patient Service Revenue - Program Income and (2) Other Income - Other Federal, State, Local, and Other Income.

Part 1: Patient Service Revenue - Program Income

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

The program income section groups billable visits and income into the same five payer groupings used in the [UDS Manual](#). All patient service revenue is reported in this section of the form. This includes all income from medical, dental, mental health, substance abuse, other professional, vision, and other clinical services, as well as income from ancillary services such as laboratory, pharmacy, and imaging services.

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

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

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

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

Billable Visits - Column (b): This includes all billable/reimbursable visits.¹ The value is typically based on assumptions about consolidated individual clinician time, productivity, and visits by payer. There may be other exclusions or additions, which, if significant, should be noted in the Comment/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column (See [Ancillary Instructions](#) below.)

Note: The patient service income budget is primarily based upon income per visit estimates. However, there are some forms of patient service income which do not generate reportable visits in the UDS or on Form 3 or which is not earned from providing visits, such as income from laboratory or pharmacy services; capitated managed care; performance incentives; wrap payments; and cost report settlements. Applicants may choose to include some or all of this income in the income per visit assumption, basing it on historical experience. Applicants may also choose to separately budget for some or all of these sources of patient service income.

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

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

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

Alternative Instructions for Capitated Managed Care:

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

¹ These visits will correspond closely with the visits reported on the [UDS Manual](#) Table 5, excluding enabling service visits.

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

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

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

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

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

Private (Line 4): This includes income from private insurance plans, managed care plans, insurance plans from the ACA marketplaces/exchanges, and other private contracts for service. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, service contracts with employers, and Veteran's Administration Community Based Outpatient Clinic

(CBOC) contracts. Income from health benefit plans which are earned by government employees, veterans, retirees, and dependents, such as TRICARE, the federal employee health benefits program, state employee health insurance benefit programs, teacher health insurance, and similar plans are to be classified as private insurance. Private insurance is earned or paid for by the beneficiary and other public insurance is unearned or based upon meeting the plan's eligibility criteria.

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

Total (Line 6): This is the sum of lines 1-5.

Part 2: Other Income – Other Federal, State, Local, and Other Income

This section includes all income other than the patient service revenue shown in Part 1. It includes other federal, state, local, and other income. It is income that is earned but not directly tied to providing visits, procedures, or other specific services. Income is to be classified on the lines below based upon the source from whom the revenue is received. Income from services provided to non-health center patients (patients of an entity with which the health center is contracting) either in-house or under contract with another entity such as a hospital, nursing home or other health center is to be reported in Part 2: Other Income (see examples below). This would include income from in-house retail pharmacy sales to individuals who are not patients of the health center. See Lines 9 and 10 for examples of services provided to non-health center patients (patients of an entity with which the health center is contracting).

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

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

Local Government (Line 9): This is income from local government grants, contracts, and programs, including local indigent care income, community development block grants, capital improvement project funding, and similar awards. For example: (1) a health center that contracts with the local Department of Health to provide services to the Department's patients is to report all the income earned under this contract on this line, and (2) Ryan White Part A

funds are federal funds awarded to municipalities who in turn make awards to provider organizations, so Ryan White Part A funding would be classified as income earned from a local government and be shown on this line.

Private Grants/Contracts (Line 10): This is income from private sources, such 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 the applicant's retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why applicant funds (retained earnings) are needed to achieve a breakeven budget.

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

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

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

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 – see details below), enter the projected expenses for the upcoming certification period for each of the applicable programs. If the categories in the form do not describe all possible expenses, enter expenses in the Other category. The total fields are calculated automatically as you move through the form. (See the [Budget Narrative](#) section for a definition of each expense category.)

Part 2: Revenue

For each of the revenue categories (applicant, federal, state, local, other, and program income), enter the projected revenue for the upcoming certification period from each of the applicable programs. If the LAL is a State agency, leave the State row blank and include State funding in the Applicant row. If revenue is collected from sources other than the listed sources, indicate those in the Other category. The total fields are calculated automatically as you move through the form.

Form 3A should be consistent with amounts described in the budget narrative.

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

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

Note: If the information presented in the AC submission on Forms 5A and 5B is not accurate after it has been refreshed, you must take action to correct this information **before** AC submission. Review the [Scope of Project](#) resources, and contact your Project Officer for additional assistance.

Scope Certification Form

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