

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration**

Bureau of Primary Health Care
Health Center Program



***Look-Alike Renewal of Designation
Application Instructions***

Issuance Date: July 21, 2016

All applications 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

Renewal of Designation Technical Assistance Webpage:

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

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Bureau of Primary Health Care is accepting applications for look-alike (LAL) Renewal of Designation (RD). The purpose of the LAL RD application is to improve the health of the nation's underserved communities and vulnerable populations by assuring continued access to comprehensive, culturally competent, quality primary health care services in areas already served by LAL organizations. LALs 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 become Federally Qualified Health Centers (FQHCs) by operating and providing services consistent with health centers funded under the Health Center Program.

Application Availability:	HRSA Electronic Handbooks (EHB) access granted 180 calendar days prior to the end of the current three-year designation period (approximately 2.5 years into the current designation period)
Application Submission Timeframe:	90 calendar days after EHB access is granted
Application Due Date:	90 calendar days before the end of the current three-year designation period
Designation Period:	Up to 3 years
Eligible Applicants:	<p>Eligible applicants are current LAL organizations in the last year of their current designation period.</p> <p>At the time of RD submission, an applicant must:</p> <ul style="list-style-type: none">a. Provide comprehensive primary medical care as its main purpose at one or more permanent service delivery sites.b. Ensure access to services for all individuals in the service area/target population without regard to ability to pay.c. Serve a designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP). <p>See the Eligibility section for complete eligibility information, including exclusions.</p>

Technical Assistance

Application resources, including a webinar recording, and form samples are available at the [RD Technical Assistance \(TA\) webpage](#).

Throughout the application development and preparation process, you are encouraged to work with the appropriate Primary Care Associations (PCAs), Primary Care Offices (PCOs), and/or National Cooperative Agreements (NCAs) to prepare a quality application. For a complete listing of HRSA-supported PCAs, PCOs, and NCAs, refer to [Support Networks](#).

Summary of Changes

- Applicants' primary medical care projected patients as indicated on Form 1A: General Information Worksheet must be greater than projected patients for all other services provided.
- Form 1C: Documents on File has been added as a required form.
- Form 2: Staffing Profile will no longer collect salary data to reduce duplication with the budget narrative. A column was added to collect information on use of contracted staff. This form will be completed twice: once to collect information on current staffing and a second time to collect information about proposed staffing by the end of the designation period.
- Form 3: Income Analysis was revised to simplify the reporting of projected income.
- Form 4: Community Characteristics was revised to remove four characteristics and add two: "Individuals Best Served in a Language Other Than English" and "Veterans."
- Form 5A: Services Provided was revised to facilitate more accurate, simplified data entry for health centers, including with the addition of interactive descriptors for each data field.
- Form 5B: Service Sites was streamlined and several non-essential fields were deleted.
- Form 6B: Request for Waiver of Board Member Requirements was added.
- Form 8: Health Center Agreements was streamlined to remove the governance checklist. Select items from the governance checklist were added to the Governance section of the Project Narrative.
- Form 9: Need for Assistance Worksheet was removed. Select items from the form were added to the Need section of the Project Narrative.
- Clinical and Financial Performance Measures were updated to align with PAL 2016-02: [Approved Uniform Data System Changes for Calendar Year 2016](#). Details are included in Appendix B.
- All sections of the Project Narrative have been updated to align with information required from Health Center Program award recipients (as applicable).

Other Federal Benefits

You are reminded that receipt of renewal of LAL designation, while a basis for eligibility, does not, of itself, confer such federal benefits as FQHC reimbursement or 340B Drug Pricing Program participation, both of which depend upon compliance with applicable requirements in addition to Health Center Program LAL designation.

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BACKGROUND

The Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC) 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 underserved communities and vulnerable populations by ensuring access to comprehensive, culturally competent, quality primary health care services. Individually, each health center plays an important role in 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 Acts¹ 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" (LALs). The Balanced Budget Act (BBA) of 1997 added the requirement that a LAL "entity may not be owned, controlled or operated by another entity." Further clarification can be found in PIN 2014-01: [Health Center Program Governance](#).

Health Center Program LALs operate and provide services consistent with Health Center Program requirements. While LALs 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. LALs 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.

LALs were established to help maximize access to care for underserved populations and communities by allowing entities that do not receive Health Center Program funding to operate and provide services consistent with those health centers funded under the Health Center Program. Both Health Center Program award recipients and LALs provide a comprehensive system of care that is responsive to identified health care needs, provide services to all persons regardless of ability to pay, and meet all Health Center Program requirements. For the purposes of this document, the term "health center" refers to both Health Center Program LALs and award recipients.

¹ Omnibus Budget Reconciliation Acts (OBRA) of 1989, 1990, and 1993, amended section 1905 of the Social Security Act (SSA).

Designation Application Requirements

These Renewal of Designation (RD) Instructions will be used by current LAL organizations to apply to renew their LAL designation. The RD application instructions detail the eligibility requirements and other requirements for organizations seeking renewal of LAL designation.

In your RD application, you must document an understanding of the ongoing need for primary health care services in the service area and propose a sound plan to meet this need that:

- Ensures the availability and accessibility of primary and preventive health care services to all individuals in the service area and target population.
- Includes collaborative and coordinated delivery systems for the provision of health care to the underserved.

You must also demonstrate compliance with [Health Center Program requirements](#) and applicable corresponding regulations and policies. Failure to comply with all Health Center Program requirements may jeopardize your LAL designation. HRSA will assess LAL organizations for program compliance on an ongoing basis. When non-compliance is identified, HRSA will place a condition on the Notice of Look-Alike Designation (NLD), which follows the Progressive Action process. The Progressive Action process provides a time-phased approach to resolve compliance issues. If an organization fails to successfully resolve conditions via the Progressive Action process, HRSA may terminate LAL designation. For more information, see PAL 2014-08 [Health Center Program Requirements Oversight](#) and PAL 2014-11: [Applicability of PAL 2014-08: Health Center Program Requirements Oversight to LALs](#).

In addition to the Health Center Program requirements, specific 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.
- Provide a plan that ensures the ongoing 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.
- Provide a plan that ensures the ongoing 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 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 1152.²

HEALTH CARE FOR THE HOMELESS (HCH) APPLICANTS:

- Ensure compliance with PHS Act section 330(h); and section 330(e), as applicable, program regulations, requirements, and policies.
- Provide a plan that ensures the ongoing 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. This plan may also allow for the continuation of services for up to 12 months to individuals no longer homeless as a result of becoming a resident of permanent housing.
- 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.
- Provide a plan that ensures the ongoing 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.

Note: The RD application must request designation for the same health center type(s) included in the current designation (i.e., CHC, MHC, HCH, and/or PHPC). Changes to the designation types must be proposed via a Change in Scope request in EHB.

DESIGNATION PERIOD

² For more information about the North American Industry Classification System, see <https://www.census.gov/eos/www/naics/index.html>.

Designation will be granted for a period of up to three years. Continued designation is contingent upon satisfactory LAL performance, including the timely submission of all required LAL submissions (RD and Annual Certification (AC) applications and annual Uniform Data System (UDS) submissions), and a decision that continued designation is in the best interest of the Federal Government. See the Designation Length Criteria section for more information.

ELIGIBILITY

Applicants must meet all of the following eligibility requirements. RD applications that do not demonstrate compliance with all of the eligibility requirements outlined in this section at the time of application submission will be considered ineligible or will have conditions placed on the NLD that must be addressed to ensure ongoing designation. Applicants must demonstrate eligibility according to the following requirements.

- 1) The applicant must be a currently designated LAL organization. Current LAL organizations are public and nonprofit private entities, including faith-based and community-based organizations, Tribes, and tribal organizations.
- 2) The applicant organization must not be owned, controlled, or operated by another entity.³ Organizational structures such as parent-subsidary arrangements or network corporations may not be eligible for designation. Additionally, the applicant organization is expected to perform a substantive role in the project and meet the program requirements (it cannot apply on behalf of another organization).
- 3) The applicant must continue to provide comprehensive primary medical care as its main purpose, as documented on [Form 1A: General Information Worksheet](#) (number of projected medical patients is greater than the projected patients for other service types).
- 4) The applicant must continue operating a health center that makes all required primary health care services, including preventive and enabling health care services, available and accessible in the service area, either directly or through established arrangements, without regard to ability to pay.⁴ The applicant may **not** propose to provide only a single type of service, such as dental, behavioral, or prenatal services.
- 5) The applicant must continue to provide access to services for all individuals in the service area and target population. In instances where a sub-population is targeted (e.g., homeless children; lesbian, gay, bisexual, and transgender (LGBT) individuals), health center services must be made available and accessible to others who seek services at the LAL site(s).

³ Section 1905(I)(2)(B)(iii) of the Social Security Act, as amended.

⁴ Refer to the [Service Descriptors for Form 5A: Services Provided](#) for details regarding required comprehensive primary, preventive, and enabling health care services.

- 6) The applicant (with the exception of applicants with designation for only serving special populations (i.e., MHC, HCH, and/or PHPC)) must continue to serve a defined geographic area that is currently federally designated, in whole or in part, as a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP).⁵
- 7) *PUBLIC HOUSING PRIMARY CARE APPLICANTS ONLY*: If the applicant has a PHPC designation, it must demonstrate that it has consulted with residents of public housing in the preparation of the RD application. The applicant must also 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.
- 8) The applicant must meet the application deadline or its RD application may not be considered for continued designation.

APPLICATION AND SUBMISSION INFORMATION

In addition to following these instructions, you should review the [RD User Guide](#) for step-by-step EHB submission instructions. See [Submitting the Application](#) for detailed information about the application timeline and due date.

Application Requirements

The following application components must be submitted in the HRSA EHB:

- Project Abstract
- Project Narrative
- Budget Narrative
- Program Specific Forms (samples are available on the [RD TA webpage](#))
- Attachments

The total size of all uploaded files may not exceed the equivalent of 160 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.

Applications must be complete, within the specified page limit, and submitted by the HRSA EHB deadline or the application may not be considered for designation.

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

⁵ The list of MUAs and MUPs is available at <http://www.hrsa.gov/shortage>.

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.

Submitting the Application

You must submit your application electronically through EHB. Refer to the [RD User Guide](#) available on the [RD TA webpage](#) for step-by-step EHB submission instructions.

RD applications are due 90 days prior to the end of the current designation period. The EHB system will send an email notice to the organization's contacts identified in EHB 180 days prior to the end of the current designation period to inform them the application is accessible. This means you will have 90 calendar days to complete and have your Authorizing Official (AO) submit the RD application in EHB.

You are urged to submit in advance of the 90-day deadline. **Failure to submit your RD application by the due date** (90 days prior to the end of your current designation period) **may result in termination of the LAL designation and all corresponding benefits** (e.g., Medicare and Medicaid FQHC reimbursement, 340B Drug Pricing Program benefits).

APPLICATION COMPONENTS

Include the following in your RD application:

i. Cover Page

An EHB form that provides a summary of information related to the project at the time of application submission.

ii. Project Abstract

An attachment that provides a brief summary of the project. Include the following at the top of the Project Abstract:

- Project Title: Look-Alike Renewal of Designation
- Congressional District(s) for your Organization and Service Area
- Type(s) of Health Center Program Designation (i.e., CHC, MHC, HCH, and/or PHPC)

The abstract must include a brief description of the proposed project, including your organization, target population, needs to be addressed, and proposed services. Include the following in the body of the abstract:

- A brief history of the organization, the community to be served, and the target population.

- A summary of the major health care needs and barriers to care to be addressed by the proposed project, including the needs of special populations (migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing).
- How the proposed project will address the need for comprehensive primary health care services in the community and target population.
- Number of current and proposed patients, visits, providers, service delivery sites and locations, and services to be provided.

iii. Project Narrative

Provide a comprehensive framework and description of all aspects of the proposed project. It should be succinct, consistent with other application components, and organized by section headers (Need, Response, Collaboration, Evaluative Measures, Resources/Capabilities, and Governance). An application that fails to address the required elements within each of these sections may be returned for the submission of additional information, which could result in a lapse in designation.

The Project Narrative must:

- Demonstrate compliance with [Health Center Program Requirements](#).
- Address the specific Project Narrative elements below, with the requested information appearing under the appropriate Project Narrative section header or the designated forms and attachments.
- Reference attachments and forms as needed. Referenced items must be part of the EHB submission.
- Reflect your currently approved scope of project. Any changes **must** be requested through a Change in Scope and **must** be submitted separately through HRSA EHB.⁶
- Be organized by the six specified 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 proposed activities and goals described throughout the application. Reference/cite data sources where appropriate. Describe how referenced/cited data and trends are reflective of the target population in the proposed service area.

- 1) Describe how the following **characteristics of the target population** affect access to primary health care, health care utilization, and health status, referencing/citing data sources.⁷

⁶ Refer to the [Scope of Project](#) documents and resources for details pertaining to changes to the current services, providers, sites, service area zip codes, and target population(s).

⁷ Refer to the Available Data Sources document on the [LAL TA webpage](#) for recommended data sources.

- 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, veterans' health care).
- 2) Describe how the following **characteristics of the service area** impact access to care for the target population, referencing/citing data sources:
- a) Geographical/transportation barriers to include the distance (miles) OR travel time to the nearest primary provider accepting new Medicaid and uninsured patients (consistent with [Attachment 1: 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: one FTE primary care physician).
- 3) Describe the **health care environment** and its impact on your organization's current and future operations, including any recent or anticipated significant changes that affect the availability of health care services and patient characteristics in the service area, such as shifts in the number of patients served, including:
- a) Insurance coverage, including Medicaid, Medicare, and Children's Health Insurance Program (CHIP).
 - b) State/local/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, LGBT individuals).
- 4) **Applicants with special population 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.

RESPONSE

- 1) Describe the service delivery sites and how they are appropriate for the needs of the service area and target population. Specifically address:
 - a) Site(s)/location(s) where services will be provided (consistent with [Attachment 1: Service Area Map and Table](#), and [Forms 5B: Service Sites](#) and [5C: Other Activities/Locations](#)).
 - b) How the type (e.g., fixed site, mobile van, school-based clinic), hours of operation, and location (e.g., proximity to public housing) of each proposed 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 [Form 5B: Service Sites](#) and [5C: Other Activities/Locations](#)).
 - c) Capacity at the service site(s) (consistent with [Form 5B: Service Sites](#)) to collectively 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 proposed and the projected number of patients (consistent with [Form 1A: General Information Worksheet](#)).

- 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) The provision of required and additional services, including whether these are provided directly or through formal written contracts/agreements or referral arrangements.⁸
 - 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.

⁸ 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.

Note:

- Applicants with HCH designation must document how substance abuse services will be made available either directly, through formal written contracts/agreements, and/or via a formal written referral arrangement.
- Applicants with MHC designation must document how they will address any specific needs of this population (e.g., provide additional services such as environmental health).
- Applicants with PHPC designation must document that the service delivery plan was developed in consultation with residents of the targeted public housing and describe how residents of public housing will be involved in administration of the proposed project.

- 3) Describe plans to 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/Locations](#)). 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 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 projected number of patients (consistent with [Form 1A: General Information Worksheet](#)) at the proposed sites (consistent with [Form 5B: Service Sites](#)).
 - b) Assuring appropriate linguistic and cultural competence (e.g., bilingual/multicultural staff, training opportunities).
 - 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 or proposed contracts/agreements in [Attachment 7: Summary of Contracts and Agreements](#). If a majority of core primary care services will be contracted out, include the contract/agreement as an attachment to [Form 8: Health Center Agreements](#).

- 5) Describe policies and procedures used to implement the sliding fee discount program (consistent with [Attachment 9: Sliding Fee Discount Schedule](#)), including how these specifically address the following:⁹
 - a) Definitions of income and family size.
 - b) 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.
 - c) Process for determining patient eligibility for sliding fee discounts, including frequency of re-evaluation of patient eligibility.
 - d) 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).
 - e) How sliding fee discounts are applied to all services within the approved scope of project (i.e., required and additional services, consistent with the services and service delivery methods indicated on [Form 5A: Services Provided](#), Columns I, II, or III).
 - f) Method and frequency of evaluating the sliding fee discount program from the perspective of reducing patient barriers to care.

- 6) Describe the following aspects of the Sliding Fee Discount Schedule(s) (SFDS) (consistent with [Attachment 9: Sliding Fee Discount Schedule](#)):
 - a) Annual updates to reflect the most recent [Federal Poverty Guidelines](#) (FPG).
 - b) 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.
 - c) Provision of a full discount (or nominal charge) for individuals and families with annual incomes at or below 100 percent of the FPG.¹⁰
 - d) 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.

- 7) Describe the organization's quality improvement/quality assurance (QI/QA) and risk management plan(s) for systematically assuring and improving health care quality, including policies, procedures, and parties responsible for:

⁹ 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 and related billing and collections requirements.

¹⁰ Sliding fee discounts may not be applied for individuals and families with annual incomes above 200 percent of the FPG.

- a) Addressing patient grievances.
 - b) Incident reporting and management.
 - c) Patient records, including maintaining confidentiality of such records.
 - d) Periodic assessment by physicians (or other licensed health care professionals under the supervision of a physician) of service utilization, quality of services delivered, and patient outcomes.
 - e) Ensuring providers (e.g., employed, contracted, volunteers, locum tenens) are appropriately licensed, credentialed, and privileged to perform proposed health center services.
 - f) Utilization of appropriate information systems (e.g., EHRs, practice management systems) for tracking, analyzing, and reporting key performance data, including 1) reporting required clinical and financial performance measures and 2) tracking diagnostic tests and other services provided to ensure appropriate patient record documentation and follow-up.
 - g) Developing, updating, and implementing such policies and procedures.
 - h) Communication to all project stakeholders and utilization of QI/QA results to improve performance.
 - i) Accountability throughout the organization, specifically the role and responsibilities of the Clinical Director in providing oversight of the QI/QA program.
- 8) Describe 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) will be identified and informed of the available options.
 - b) The type of assistance that will be provided for determining eligibility and completing the relevant enrollment process.

COLLABORATION

- 1) Describe both formal and informal collaboration and coordination of services with the following community providers in the service area (consistent with [Attachment 1: Service Area Map and Table](#) for items a through e below), or explain if such community services are not available:¹¹
 - a) Existing health centers (Health Center Program award recipients and LALs).
 - b) State and local health departments.
 - c) Rural health clinics.
 - d) Critical access hospitals.
 - e) Free clinics.
 - f) Other 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.

¹¹ Refer to PAL 2011-02: [Health Center Collaboration](#) for information on maximizing collaborative opportunities.

- h) Evidence-based home visiting programs serving the same target population.¹²
- 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 continued 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) must also be summarized in [Attachment 7: Summary of Contracts and Agreements](#).

- 2) Document support for the proposed project through current dated letters of support that reference specific coordination or collaboration from all of the following in the service area (as defined in [Attachment 1: Service Area Map and Table](#)), or state if such organizations do not exist in the service area:
 - a) Existing health centers (Health Center Program award recipients and LALs).
 - b) State and local health departments.
 - c) Rural health clinics.
 - d) Critical access hospitals.

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) **If you are designated to serve one or more special populations**, you must provide current dated letters of support that reference specific coordination or collaboration with community organizations that also serve the targeted special population(s) (e.g., Migrant Head Start, Public Housing Authority, homeless shelters).

¹² Examples of evidence-based home visiting programs are available at the [Maternal, Infant, and Early Childhood Home Visiting Program Web site](#).

Note: Merge all letters of support from Items 2 and 3 into a single document and submit it as [Attachment 8: Letters of Support](#).

EVALUATIVE MEASURES

- 1) Within the Clinical Performance Measures form (see detailed instructions in [Appendix B](#)), outline realistic goals that are responsive to clinical performance and identified needs. Goals should be informed by contributing and restricting factors affecting achievement.
- 2) Within the Financial Performance Measures form (see detailed instructions in [Appendix B](#)), outline realistic goals that are responsive to the organization's financial performance. Goals should be informed by contributing and restricting factors affecting achievement.
- 3) Describe the organization's evaluation process for additional assessment of the health care needs of the target population, including:
 - a) The frequency and when the last assessment occurred.
 - b) Community engagement.
 - c) Assessment tools/methods (e.g., written or verbal patient satisfaction surveys), and analysis, including cultural appropriateness.
 - d) Dissemination of results to board members, health center staff, community stakeholders, project partners, and patients.
- 4) Describe how your certified electronic health record (EHR) system will be used to optimize health information technology to achieve meaningful use and improve quality outcomes.^{13,14} If you do not have an EHR system, or have an EHR system that is not yet functional or integrated into proposed sites, outline plans for full EHR implementation at all proposed sites (consistent with [Form 5B: Service Sites](#)).
- 5) If any additional evaluation activities are planned for the designation period, provide a brief description of the additional activities, including data collection tools.

RESOURCES/CAPABILITIES

- 1) Describe how the organizational structure (including any contractors) is appropriate for the operational needs of the project (consistent with Attachments [2: Corporate Bylaws](#) and [3: Project Organizational Chart](#), and, as applicable, Attachments [6: Co-Applicant Agreement for Public Centers](#) and [7: Summary of Contracts and Agreements](#)), including:
 - a) How lines of authority are maintained from the governing board to the CEO.

¹³ Information about certified EHR systems is available at [HealthIT.gov: ONC – Authorized Testing and Certification Body](#).

¹⁴ Information about meaningful use is available at [Centers for Medicare and Medicaid Services EHR Incentive Programs](#).

- 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 over all proposed service sites, including contracted sites, and services including (as applicable):
- a) Current or proposed 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](#).

Note: Exclude contracts for the acquisition of supplies, material, equipment, or general support services (e.g., janitorial services, contracts with individual providers).

- 3) Describe how your organization's management team (Chief Executive Officer (CEO), Clinical Director (CD), Chief Financial Officer (CFO), Chief Information Officer (CIO), and Chief Operating Officer (COO), as applicable) is appropriate for the operational and oversight needs, scope, and complexity of the proposed project, including:
- a) Defined roles (consistent with [Attachment 4: Position Descriptions for Key Personnel](#)), 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 5: Biographical Sketches for Key Personnel](#)).
 - 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).
 - d) If applicable, changes in key management staff in the last year or significant changes in roles and responsibilities.
- 4) Describe your plan for recruiting and retaining key management staff and health care providers necessary for achieving the proposed staffing plan (consistent with [Form 2: Staffing Profile](#)).
- 5) 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.
- 6) Describe your organization's 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.

- 7) 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).
- 8) Describe your current status or plans for participating in related federal benefits (e.g., FQHC Medicare/Medicaid/CHIP reimbursement, 340 Drug Pricing Program, National Health Service Corps providers). Also, describe your plans for malpractice insurance coverage.
- 9) 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](#)).¹⁵
 - 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.
- 10) Describe how your financial accounting and internal 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 payor type, aged accounts payable, lines of credit).
 - e) Support management decision-making.
 - f) *DUAL STATUS LALS ONLY*: Describe how you currently and will continue to maintain separate and distinct scopes of project for the LAL designation and Health Center Program award.¹⁶
- 11) 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). You may upload source documents (e.g., current income statement and balance sheet) to [Attachment 12: Other Relevant Documents](#), as desired.

¹⁵ Refer to PIN 2013-01: [Health Center Budgeting and Accounting Requirements](#) for information on Health Center Program budgeting and accounting requirements.

¹⁶ "Dual status" occurs when an organization receives a grant under section 330 as well as maintains FQHC Look-Alike designation. For more information about dual status health centers refer to PAL 2006-01: [Dual Status—Health Centers that are both FQHC Look-Alikes and Section 330 Grantees](#).

- 12) Describe your annual independent auditing process performed in accordance with federal audit requirements.¹⁷ 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.
- 13) Describe your status of emergency preparedness planning and development efforts, including plans to participate in state and local emergency planning. If applicable, explain negative responses on [Form 10: Emergency Preparedness Report](#) and plans for resolution.

GOVERNANCE¹⁸

Note: Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups are required ONLY to respond to Item 7 below.

- 1) Describe how Attachments [2: Corporate Bylaws](#) and [6: Co-Applicant Agreement for Public Centers](#) demonstrate that your organization has an independent governing board that retains (i.e., does not delegate) the following unrestricted authorities, functions, and responsibilities:¹⁹
 - 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 will be 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 general policies for the organization.
- 2) Document that the structure of your 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:

¹⁷ Information about administrative and audit requirements are available at [Uniform Guidance 2 CFR part 200 as codified by HHS at 45 CFR part 75](#).

¹⁸ Refer to PIN 2014-01: [Health Center Program Governance](#) for more information on Governance requirements.

¹⁹ 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.

- 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.
- 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 special populations (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 you are designated. Board members representing a special population should be individuals 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). Applicants targeting only special populations may request a waiver of the 51 percent patient majority board composition requirement on [Form 6B: Request of Waiver of Board Member Requirements](#) (as applicable). HRSA will not consider a waiver of the 51 percent patient majority governance requirement for organizations with CHC designation (alone or in conjunction with special population(s) designations).

- 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 performance, inclusive of identifying training needs.
 - c) Provides training, development, and orientation for **new 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 for Public Centers](#)) **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 2: 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).
- 5) Document that your bylaws (consistent with [Attachment 2: Corporate Bylaws](#)) and/or other board-approved policy document(s) and procedures include specific provisions that prohibit real or apparent conflict of interest by board members, employees, consultants, and others in the procurement of supplies, property (real or expendable), equipment, and other services procured with federal funds.
- 6) 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.
- 7) **INDIAN TRIBES OR TRIBAL, INDIAN, OR URBAN INDIAN GROUPS 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 proposed project.

iv. Budget Narrative

You must provide a detailed budget narrative in line-item format for each 12-month period of the requested three-year designation period. **An itemization of revenues and expenses is necessary only for the first year of the budget narrative.** For subsequent years, the narrative should highlight the changes from Year 1 or clearly indicate that there are no substantive changes. Upload the budget narrative as Attachment 11. 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. 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.

Construction: Include costs related to construction and/or renovation related to the LAL site(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). 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).

v. Program Specific Forms

All of the following forms, with the exception of [Form 5C: Other Activities/Locations](#), are required. You must complete these OMB-approved forms directly in EHB. Refer to [Appendix A](#) for Program Specific Forms instructions and [Appendix B](#) for Performance Measure Forms instructions. Samples are available at the [RD TA webpage](#).

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[Form 1A](#): General Information Worksheet

[Form 1C](#): Documents on File

[Form 2](#): Staffing Profile
[Form 3](#): Income Analysis
[Form 3A](#): Look-Alike Budget Information
[Form 4](#): Community Characteristics
[Form 5A](#): Services Provided (read only format)
[Form 5B](#): Service Sites (read only format)
[Form 5C](#): Other Activities/Locations (if applicable and read only format)
[Form 6A](#): Current Board Member Characteristics
[Form 6B](#): Request for Waiver of Board Member Requirements
[Form 8](#): Health Center Agreements
[Form 10](#): Emergency Preparedness Report
[Form 12](#): Organization Contacts
[Clinical Performance Measures](#)
[Financial Performance Measures](#)
[Scope Certification Form](#)

vi. Attachments

Label each attachment according to the number provided (e.g., Attachment 2: 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 attachments with file names that exceed 100 characters.

Attachment 1: Service Area Map and Table

Upload a map of the service area for the LAL project, indicating the health center site(s) listed in [Form 5B: Service Sites](#). The map must clearly indicate the service area zip codes, any medically underserved areas (MUAs) and/or medically underserved populations (MUPs), Health Center Program award recipients and LALs, and any other health care providers serving the service area zip codes. Create the map using [UDS Mapper](#). You may need to manually place markers for the locations of other major private provider groups serving low income/uninsured patients.

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

Attachment 2: Corporate Bylaws

Upload (in its entirety) your organization's most recent bylaws. Bylaws must be signed and dated 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 details.

Attachment 3: Organizational Chart

Upload a one-page document that depicts your current organizational structure, including the governing board, key personnel, staffing, and any affiliated organizations.

Attachment 4: Position Descriptions for Key Personnel

Upload current position descriptions for key management staff: Chief Executive Officer (CEO), Clinical Director (CD), Chief Financial Officer (CFO), Chief Information Officer (CIO), Chief Operating Officer (COO), and Project Director (PD). Indicate on the position descriptions 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, at a minimum, the position title; description of duties and responsibilities; position qualifications; supervisory relationships; skills, knowledge, and experience requirements; travel requirements; salary range; and work hours.

Attachment 5: Biographical Sketches for Key Personnel

Upload current biographical sketches for key management staff: CEO, CD, CFO, CIO, COO, and PD. 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 6: Co-Applicant Agreement for Public Centers (as applicable)

Public center applicants that have a co-applicant board must submit, in its entirety, the formal co-applicant agreement signed by both the co-applicant governing board and the public center.²⁰ See the [RESOURCES/CAPABILITIES](#) and [GOVERNANCE](#) sections of the Project Narrative for details.

Attachment 7: Summary of Contracts and Agreements (as applicable)

Upload a brief summary describing all current or proposed patient service-related contracts and agreements, consistent with [Form 5A: Services Provided, columns II and III](#), respectively. The summary must address the following items for each contract or agreement:

- Name of contract/referral organization.
- Type of contract or agreement (e.g., contract, referral agreement, Memorandum of Understanding or Agreement).
- Brief description of the type of services provided and how/where services are provided.
- Timeframe for each contract or agreement (e.g., ongoing contractual relationship, specific duration).

If a contract or agreement will be attached to [Form 8: Health Center Agreements](#) (e.g., contract with a parent, affiliate, or subsidiary organization), denote this with an asterisk (*).

²⁰ Public centers were referred to as “public entities” in the past.

Attachment 8: Letters of Support

Upload current dated letters of support to document commitment to the project. See the [COLLABORATION](#) section of the Project Narrative for details on required letters of support. Letters of support should be addressed to the organization's board, CEO, or other appropriate key management staff member (e.g., Clinical Director). If one or more letters cannot be obtained, include proof that the letter was requested along with an explanation of why it is not available.

Attachment 9: Sliding Fee Discount Schedule(s)

Upload the current or proposed sliding fee discount schedule(s). See the [RESPONSE](#) section of the Project Narrative for details.

Attachment 10: Most Recent Independent Financial Audit

Upload your most recent 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.

Attachment 11: Budget Narrative

Upload your budget narrative. See the [Budget Narrative](#) section for details.

Attachment 12: Other Relevant Documents (as applicable)

If desired, include other relevant documents to support the proposed project (e.g., indirect cost rate agreements, charts, organizational brochures, lease agreements). Maximum of five uploads.

REVIEW AND DESIGNATION PROCESS

RD applications that do not include all required attachments and information will be considered incomplete or non-responsive. Incomplete or non-responsive RD submissions will be returned through a "request change" notification via EHB for the provision of missing information or required clarification. Failure to submit or re-submit the RD application by the established deadline or the submission of an incomplete or non-responsive RD application may result in a delay in NLD issuance or a lapse in designation and loss of corresponding benefits. Review the RD to ensure that it is both complete and responsive prior to submission.

When determining designation period length (see [Designation Period Length Criteria](#) section), HRSA will consider additional factors.²¹ These factors include, but are not limited to, past performance, including unsuccessful Progressive Action condition resolution and current compliance with Health Center Program requirements. HRSA reserves the right to conduct onsite visits and/or use the current compliance status to inform designation decisions.

²¹ See PAL 2014-11: [Applicability of PAL 2014-08: Health Center Program Requirements Oversight to Look-Alikes](#) for information regarding the Progressive Action process.

Designation Period Length Criteria

The designation period length is determined by a comprehensive evaluation of compliance with program requirements. If you have one or more of the following characteristics, you will receive a one-year designation period:

- Ten or more Health Center Program requirement conditions.
- Three or more unresolved conditions related to Health Center Program requirements in the 60-day phase of Progressive Action to be carried over into the new designation period.
- One or more unresolved conditions related to Health Center Program requirements in the 30-day phase of Progressive Action to be carried over into the new designation period.

If a LAL has had two consecutive one-year designation periods and meets the criteria for a third consecutive one-year designation period, the application will not be designated.

DESIGNATION AND REPORTING INFORMATION

Pending timely and complete RD application submission, the NLD for the new designation period will be sent prior to the current designation period end date.

If you are re-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 LALs 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 the LAL designation and all corresponding benefits.
- 2) **Progress Report** – The LAL 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 new RD 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 LAL designation and all corresponding benefits.

CONTACTS

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

You may obtain RD programmatic technical assistance by contacting:

LAL Response Team

301-594-4300

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

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

BPHC Helpline (Monday-Friday, 8:30 a.m. to 5:30 p.m. ET)

1-877-974-2742

[Submit a request via web form](#)

OTHER INFORMATION

BPHC Primary Health Care Digest

The [BPHC Primary Health Care Digest](#) is a weekly email newsletter containing information and updates pertaining to the Health Center Program, including release of all competitive funding opportunities and technical assistance resources. Organizations interested in improving their health centers or seeking funding under the Health Center Program are encouraged to subscribe several staff.

340B Drug Pricing Program

The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, codified as [Section 340B of the Public Health Service Act](#), as amended. The program limits the cost of covered outpatient drugs for certain federal award recipients, LALs, and qualified disproportionate share hospitals. Covered entities may realize a cost savings of 20-50 percent on outpatient drug purchases and additional savings on other value-added services through participation in the 340B Prime Vendor Program (PVP). Pharmacy related technical assistance is available at 866-PharmTA (866-742-7682). There is no cost to participate in the 340B program or the 340B Prime Vendor Program, and eligible entities are not required to have an established in-house pharmacy to participate. For additional information, contact the Office of Pharmacy Affairs (OPA) at 800-628-6297 or visit the [Office of Pharmacy Affairs Web site](#).

APPENDIX A: PROGRAM SPECIFIC FORMS INSTRUCTIONS

Program Specific Forms must be completed electronically in EHB. All forms are required. Forms 5A-C are in read only format and are locked for editing. Sample forms are available at the [RD TA webpage](#).

Cover Page

This form collects required LAL applicant organization information. Verify or provide requested information as needed.

Form 1A: General Information Worksheet

1. Applicant Information

- Complete all relevant information that is not pre-populated.
- Use the Fiscal Year End Date field to note the month and day in which your organization's fiscal year ends (e.g., December 31).
- You may check only one category in the Business Entity section. If you are a Tribal or Urban Indian entity and meet the definition for a public or private entity, you 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 you have CHC designation, you MUST serve at least one Medically Underserved Area (MUA) or Medically Underserved Population (MUP) and must provide the relevant identification number(s).
- For inquiries regarding MUAs or MUPs, visit the [Shortage Designation Web site](#) or email sdb@hrsa.gov.

2b. Service Area Type

- Select the type (urban, rural, or sparsely populated) that describes the majority of the service area. If sparsely populated is selected, provide the number of people per square mile (values must range from .01 to 7). For information about rural populations, visit the [Office of Rural Health Policy's Web site](#).

2c. Patients and Visits

General Guidance for Patient and Visit Numbers:

When providing the count of patients and visits within each service type category, note the following (see the [UDS Manual](#) 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 rendered must be paid for by your organization and documented in the patient's record.
- A patient is an individual who had (current data) or is projected to have (projected data) at least one visit in the calendar year (January 1 through December 31).
- 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 LAL sites.
- Baseline patient data will pre-populate from the most recent UDS report. If UDS data does not accurately reflect current numbers (e.g., due to change in scope or shifting service area characteristics such as influx of new populations), indicate the accurate current data and describe the discrepancy between UDS and current data in [Item 3 of the NEED section](#) of the Project Narrative.
- Do not report patients and visits for services outside the LAL 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:

1. Project the number of unduplicated patients to be served by the end of the three-year designation period.
2. Current patients across the population type categories will pre-populate from the most recent UDS data. To maintain consistency with the patients and visits reported in UDS, do not include patients and visits for pharmacy services or services outside the proposed scope of project in your patients by population type projections.
3. The total number of unduplicated patients projected by the end of the three-year designation period will pre-populate from Item 1 above. Project the **total** number of visits by the end of the three-year designation period, then categorize the projected total by the population type categories. **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 designation categories (i.e., CHC, MHC, HCH, and/or PHPC). An applicant designated for only CHC 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:

1. Current patients and visits for each service type category will pre-populate from the most recent UDS data.
2. Project the number of patients and visits anticipated within each service type category by the end of the three-year designation period. In general, HRSA does not expect the number of patients and visits to decline over time.
3. To maintain consistency with the number of patients and visits reported in UDS, do not report patients and visits for vision or pharmacy services or services outside the proposed scope of project. Refer to the [Scope of Project](#) policy documents.
4. Because a LAL's main purpose must be the provision of comprehensive primary medical care, the number of projected medical patients must be greater than the number of projected patients within each of the other service types.

NOTE: In the Patients and Visits by Service Type section, an individual patient should be included in multiple service types, as appropriate (i.e., a single patient should be counted as a patient for each service type received).

Form 1C: Documents on File

This form provides a summary of documents that support the implementation of [Health Center Program requirements](#) and key areas of health center operations. It does not provide an exhaustive list of all types of health center documents (e.g., policies and procedures, protocols, legal documents). Provide the date that each document was last reviewed and, if appropriate, revised. Reference the Health Center Program requirements for detailed information about each requirement.

Keep these documents on file. **DO NOT** submit these documents with the application.

Note: Beyond [Health Center Program requirements](#), other federal and state requirements may apply. You are encouraged to seek legal advice from your own counsel to ensure that organizational documents accurately reflect all applicable requirements. For example, 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.

Form 2: Staffing Profile

This form is completed twice. On the “Current” tab, indicate all staff currently employed or under contract. 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 percentage allocated to each position (e.g., Clinical Director 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 Contracts/Agreements 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

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

Part 1: Patient Service Revenue - Program Income

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

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

Patient service revenue includes income earned from Medicaid and Medicare rate settlements and wrap reconciliations that are designed to make up the difference between the approved

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

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

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

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

Billable Visits - Column (b): This includes all billable/reimbursable visits.²² 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 UDS or on Form 3, 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 in Column (d) by billable visits in Column (b).

Projected Income - Column (d): This is the projected accrued net revenue, including an allowance for bad debt from all patient services for each pay grouping in the first year of the proposed designation 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).

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. 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.

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 case 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 your organization is the recipient of an NoA 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 Centers for Disease Control and Prevention (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 your organization's retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why applicant funds (retained earnings) are needed to achieve a breakeven budget. Amounts from non-federal sources should be adequate to support normal operations.

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

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

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

Form 3A: Look-Alike Budget Information

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 first year of the proposed new designation period for each Health Center Program type for which you are designated (i.e., CHC, MHC, HCH, PHPC). 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.) Form 3A should be consistent with amounts in the budget narrative.

Part 2: Revenue: For each of the revenue categories (applicant, federal, state, local, other, and program income), enter the projected revenue for the first year of the proposed new designation period from each applicable program. 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 4: Community Characteristics

Report current service area and target population data. Information provided regarding race and ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements and will not be used as a designating factor. 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. Adjustments must be explained in [Item 1 of the NEED](#) section of the Project Narrative.

Service area data must be specific to the proposed project and include the total number of individuals 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 and families 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.

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:
 - 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.
 - 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.
 - 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 – Person who chooses two 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

The application should reflect only the current scope of project. Therefore, these forms will be pre-populated and cannot be modified. Changes in services, sites, and other activities/locations require prior approval through a Change in Scope request submitted in EHB. If the pre-populated data do not reflect recently approved scope changes, click the **Refresh from Scope** button in the EHB to display the latest scope of project.

Form 5A: Services Provided

Data will pre-populate from your official scope of project. Services identified elsewhere in the application (e.g., Project Narrative) that are not identified on Form 5A will not be considered to be in the approved scope of project.

NOTE: *If your organization has a pending Change in Scope application to add a service, it will not be included in Form 5A until the Change in Scope has been approved.*

Form 5B: Service Sites

Data will pre-populate from your official scope of project. Sites identified elsewhere in the application (e.g., Project Narrative) and not identified on Form 5B will not be considered to be in the approved scope of project.

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

Data will pre-populate from your official scope of project. This form includes activities/locations that: 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 details.

Form 6A: Current Board Member Characteristics

The list of board members will be pre-populated from your last LAL submission. **You must update pre-populated information as appropriate.**²³ Public centers with co-applicant health center governing boards must list the co-applicant board members.

²³ Refer to PIN 2014-01: [Health Center Program Governance](#) for information on Governance requirements.

- 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 the board member derives more than 10 percent of income from the health care industry.
- Indicate if the 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 documented health center visit.
- Indicate if the board member lives and/or works in the service area.
- Indicate if the 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 the total gender, ethnicity, and race of board members who are patients of the health center.

Note:

- Indian tribes or tribal, Indian, or urban Indian organizations are not required to complete this form, but may include information, as desired.
- If you are requesting a waiver of the 51% patient majority board composition requirement (see below), you must list your board members, NOT the members of any advisory council.

Form 6B: Request for Waiver of Board Member Requirements

- If you have CHC designation, you are not eligible for a waiver and cannot enter information.
- Indian tribes or tribal, Indian, or urban Indian groups are not required to complete this form and cannot enter information.
- If you wish to continue an existing waiver, you must complete this form.
- When requesting a waiver, demonstrate good cause as to why the patient majority board composition requirement cannot be met, and present a plan for ensuring patient input and participation in the organization, direction, and ongoing governance of the health center. The plan 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 12: Other Relevant Documents](#) that identifies these individuals and their reasons/qualifications for participation on the advisory council or as governing board representatives.
 - Specifics on the type of patient input to be collected.
 - Methods for collecting and documenting such input.

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.

- 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 budget 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.

Form 8 – Health Center Agreements

Complete Part I, by selecting **Yes** if you have 1) a parent, affiliate, or subsidiary organization; and/or 2) any current or proposed agreements that will constitute a substantial portion of the proposed scope of project, including a proposed site to be operated by a contractor, as identified in [Form 5B: Service Sites](#).

Refer to [Uniform Guidance 2 CFR part 200 as codified by HHS at 45 CFR part 75](#) for the definition of “substantial” and characteristics of a contractor agreement. You must use judgment in classifying each agreement, based on the substance of the relationship. If there are current/proposed agreements that will constitute a substantial portion of the project, indicate the number of each type in the appropriate field and attach the complete agreements in Part II.

If either of questions 1 or 2 were answered, “Yes” in Part I, you must upload associated agreements in Part II. Part II will accept a maximum of 10 Affiliate/Contract Organizations with five document uploads for each. Additional documentation that exceeds this limit should be included in [Attachment 12: Other Relevant Documents](#).

Note: Items attached to Form 8 will **not** count against the page limit; however, documents included in Attachment 12 **will** count against the page limit.

Form 10: Emergency Preparedness Report

Select the appropriate responses regarding emergency preparedness. If any answer is no, explain the response in [Item 13 of the RESOURCES/CAPABILITIES](#) section of the Project Narrative.

Form 12: Organization Contacts

As necessary, revise the pre-populated data.

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 RD application. Second, certify that the scope of project for sites is accurate, as presented on Form 5B: Service Sites in the RD application. **If you cannot certify the accuracy of Form 5A and/or Form 5B, you must certify that you have submitted a Change in Scope (CIS) request to HRSA to correct the presented information.**

APPENDIX B: PERFORMANCE MEASURES INSTRUCTIONS

The Clinical and Financial Performance Measures forms record the proposed clinical and financial goals. The goals must be responsive to identified community health and organizational needs and correspond to proposed service delivery activities and organizational capacity discussed in the [Project Narrative](#). Further detail is available at the [Clinical and Financial Performance Measures webpage](#) (refer to the [UDS Manual](#) for specific measurement details such as exclusionary criteria). Sample forms can be found at the [LAL TA webpage](#).

Note: Ten required Clinical Performance Measures have been revised and are noted below. Rather than the UDS Manual, refer to PAL 2016-02: [Approved Uniform Data System Changes for Calendar Year 2016](#) for details about the updated performance measures.

Required Clinical Performance Measures

1. Diabetes (updated)
2. Hypertension: Controlling High Blood Pressure (updated)
3. Cervical Cancer Screening (updated)
4. Prenatal Care
5. Low Birth Weight
6. Childhood Immunization Status (updated)
7. Oral Health: Sealants (updated)
8. Adolescent Weight Screening and Follow-Up
9. Adult Weight Screening and Follow-Up (updated)
10. Tobacco Use Screening and Cessation (updated)
11. Asthma: Use of Appropriate Medications (updated)
12. Coronary Artery Disease: Lipid Therapy
13. Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic
14. Colorectal Cancer Screening (updated)
15. HIV Linkage to Care
16. Screening for Clinical Depression and Follow-Up Plan (updated)

Required Financial Performance Measures

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

Important Details about the Performance Measures Forms

- The Oral Health: Sealants measure is currently only applicable to health centers that provide preventive dental services directly or by a formal arrangement 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 measure as zero. If the goal is set as 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 yet available, enter zero and provide a date by which baseline data will be available.
- If you are designated to serve special populations (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing), you **must include** additional clinical performance measures that address the health care needs of these populations. Additional performance measures specific to special populations may not replace the required measures listed above. In providing additional performance measures specific to a special population, reference the target group in the performance measure. For example, if you are seeking continued designation to serve migratory and seasonal agricultural workers and their families, you can propose to measure “*the percentage of migratory and seasonal agricultural workers and their families 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.

Additional Performance Measures

In addition to the required measures, you may identify other measures relevant to your target population and/or health center in the Additional Measures section. Each additional measure must be defined by a numerator and denominator, and progress must be tracked over time. If you are no longer tracking a previously self-defined measure listed in the Additional Measures section, note this by marking the measure *Not Applicable* and including a justification in the Comments field as to why reporting is no longer possible and/or relevant.

Overview of the Performance Measures Form Fields

Pre-populated baseline data will be sourced from the most recent UDS report for measures that have not significantly changed.²⁵

²⁵ Refer to the 2016 Clinical Performance Measure Form Field Guide and Sample at the [LAL TA webpage](#).

Table 1: Overview of Measures Form Fields

Field Name	Pre-Populated	Editable	Notes
Focus Area	YES	NO	This field contains the content area description for each required performance measure. You will specify focus areas when adding performance measures in the Additional Measures section.
Performance Measure	YES	NO	This field defines each performance measure and is editable for performance measures in the Additional Measures section. Edits must be explained in the Comments field.
Is this Performance Measure applicable to your organization?	NO	YES	This field is editable for previously self-defined performance measures appearing in the Additional Measures section. If “No” is selected, provide justification in the Comments field.
Target Goal Description	NO	YES	This field provides a description of the target goal (annualized goal for the end of the three-year designation period).
Numerator Description	YES	NO	<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 is specific to the organizational measure.</p> <p>This field can be edited for any previously self-defined Additional Measure. All edits require justification in the Comments field.</p>
Denominator Description	YES	NO	<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>This field can be edited for any previously self-defined Additional Measure. All edits require justification in the Comments field.</p>

Baseline Data			<p>The Baseline Data comprises the subfields below (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 requested new designation period.</p> <p>These fields will be blank and editable for the updated Clinical Performance Measures, since no UDS data are available. Otherwise, data pre-populate from the most recent UDS report and are not editable. For pre-populated data, to report more current data, include information in the Comments field.</p> <p>For previously self-defined Additional Measures, pre-populated information can be edited. Justification is required in the Comments field.</p>
Baseline Year	Varies	Varies	The Baseline Year subfield identifies the initial data reference point. If it is blank and editable, provide the baseline reference year.
Measure Type	YES	NO	The Measure Type subfield provides the unit of measure (e.g., percentage, ratio).
Numerator	Varies	Varies	The Numerator subfield specifies a quantitative value in reference to the Numerator Description above.
Denominator	Varies	Varies	The Denominator subfield specifies a quantitative value in reference to the Denominator Description above.
Progress Field	NO	YES	<p>You MUST use this field to provide information regarding progress for required measures since your last LAL submission (i.e., AC submission).</p> <p>State if progress cannot be reported due to the measure being updated. Limit to 1,500 characters.</p>
Projected Data	NO	YES	This field provides the annualized goal to be met by the end of the designation period.

Data Source and Methodology	NO	YES	<p>This field provides information about the data source used to develop each performance measure.</p> <p>First, identify a data source. For Clinical Performance Measures, select from EHR, Chart Audit, or Other (please specify).</p> <p>Then discuss the methodology used to collect and analyze data. Data must be valid, reliable, and derived from established information management systems. Limit to 500 characters.</p>
Key Factors and Major Planned Actions			<p>This field contains subfields that provide information regarding the factors that must be minimized or maximized to ensure goal achievement.</p>
Key Factor Type	NO	YES	<p>The Key Factor Type subfield requires you to select Contributing or Restricting factor categories. You must specify at least one key factor of each type (maximum of three total).</p>
Key Factor Description	NO	YES	<p>The Key Factor Description subfield provides a description of the factors predicted to contribute to and/or restrict progress toward stated goals.</p>
Major Planned Action Description	NO	YES	<p>The Major Planned Action Description subfield provides a description of the major actions planned for addressing key factors. Use this subfield to provide planned overarching action steps and strategies for achieving each performance measure. Limit to 1,500 characters.</p>
Comments	NO	YES	<p>Provide justifications required from changes made to other form fields as well as any additional information desired. Information exceeding the character limit should be placed in the EVALUATIVE MEASURES section of the Project Narrative. Limit to 1,500 characters.</p>

Resources for the Development of Performance Measures

You are encouraged to use your UDS Health Center Trend Report, if available, and/or Summary Report available in EHB when considering how improvements to past performance can be achieved for performance measures that have not been updated. For help with accessing reports in EHB, contact the BPHC Helpline by submitting a request through the [Web portal](#) or call 877-974-2742. You may also find it useful to do the following:

- Recognize that many UDS Clinical Performance Measures are aligned with the [meaningful use measures](#).
- 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. A table outlining the Healthy People 2020 objectives related to applicable performance measures is available at [Healthy People 2020/Health Center Program Measures](#).