



Look-Alike Renewal of Designation (RD) Application Instructions Briefing

[RD Technical Assistance \(TA\) Webpage](#)



HRSA
Health Resources & Services Administration

Participant Question #1

Is this your first time completing an RD application?

1. Yes, my organization became a designated look-alike (LAL) within the past few years and I have never completed an RD.
2. Yes. Although my organization has been a LAL for some time, I have never completed an RD.
3. No, I have completed the RD in previous years.
4. Not applicable (e.g., BPHC staff, PCA staff)

Agenda

- **Overview**
- **Summary of Changes**
- **Eligibility**
- **Timeline**
- **Submission Components**
 - Cover Page
 - Project Abstract
 - Project Narrative
 - Budget Narrative
 - Program Specific Forms
 - Clinical and Financial Performance Measures
 - Attachments
- **Technical Assistance Resources**
- **Questions & Answers**

Overview

- **Currently we have approximately 60 LALs**
- **LAL instructions last updated in 2013**
- **New RD instructions are closely aligned to the Service Area Competition (SAC) application submitted by the award recipients**

Summary of Changes

- **The forms required for submission have changed slightly to mirror SAC submission requirements**
- **Clinical and Financial Performance Measures in the application align with performance measures required by the award recipients**
- **Form 1C: Documents on File has been included**
- **Scope Certification Form has been included**
- **Attachments align with SAC (as applicable)**
- **160 page limit for the RD application** (includes the abstract, project and budget narratives, and attachments, including letters of support)

Eligibility

New Business Rule to Ensure Focus on Medical Services

Form 1A: General Information Worksheet requires you to propose to serve more medical patients than patients in any other service category (i.e., dental, mental health, substance abuse, or enabling services)

Eligibility (cont'd)

2c. Patients and Visits

Unduplicated Patients and Visits by Population Type

* How many unduplicated patients are projected to be served by end of the Designation Period?

Population Type	Current Number		Projected by End of Designation Period	
	Patients	Visits	Patients	Visits
* Total	<input type="text" value="108467"/>	<input type="text" value="328905"/>	<input type="text" value="110000"/>	<input type="text" value="110000"/>
* General Underserved Community (Include all patients/visits not reported in the rows below)	<input type="text" value="22"/>	<input type="text" value="22"/>	<input type="text" value="110000"/>	<input type="text" value="110000"/>
* Migratory and Seasonal Agricultural Workers and Families	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
* Public Housing Residents	<input type="text" value="107063"/>	<input type="text" value="328883"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
* People Experiencing Homelessness	<input type="text" value="1382"/>	<input type="text" value="1382"/>	<input type="text" value="0"/>	<input type="text" value="0"/>

Patients and Visits by Service Type

Service Type	Current Number		Projected by End of Designation Period	
	Patients	Visits	Patients	Visits
* Total Medical Services	<input type="text" value="103093"/>	<input type="text" value="301704"/>	<input type="text" value="1"/>	<input type="text" value="1"/>
* Total Dental Services	<input type="text" value="12444"/>	<input type="text" value="24663"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Behavioral Health Services				
* Total Mental Health Services	<input type="text" value="944"/>	<input type="text" value="2207"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
* Total Substance Abuse	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>

Timeline

- Email will be sent to AO when RD is available in EHB (approximately 6 months before designation period ends)
- LALs will have 90 days to complete and submit the RD in the EHB
- Failure to submit a timely and complete RD submission may result in termination of the LAL designation and all corresponding benefits

Submission Components

Cover Page
Project Abstract
Project Narrative
Budget Narrative
Program Specific Forms
Clinical & Financial Performance Measures
Attachments (1-12)

Cover Page

Cover Page

001-..... Due Date: 11/05/2016 (Due In: 113 Days) | Section Status: Complete

Look-Alike Number: LAL00000000 Original Deadline: 10/05/2016 Created On: 07/07/2016
 Project Officer: Cosby, Kelle Project Officer Email: testester1@hotmail.com Project Officer Contact #: (301) 443-8997
 Last Updated By: Tester, Jane 7/14/2016 8:02:51 PM Application Type: Renewal Of Designation Program Name: Look-Alike Health Center Program

Resources 02

View

Application | LAL RD Instructions | LAL Application User Guide

Fields with * are required

Applicant Information

Legal Name: C.....

Employer Identification Number (e.g. 53-2079819):

Organizational DUNS:

Mailing Address:, CA 90006-3102

* Select Target Population(s)

Select	Target Population Type
<input checked="" type="checkbox"/>	Community Health Centers
<input type="checkbox"/>	Health Care for the Homeless
<input type="checkbox"/>	Migrant Health Centers
<input type="checkbox"/>	Public Housing

Fields with * are required

* Point of Contact (POC) Information

Title of Position	Name	Phone	Email	Options
Point of Contact	Tester Jane	(123) 456-7890	testemail@tester.com	Change ▾

Fields with * are required

* Authorizing Official (AO) Information

Title of Position	Name	Phone	Email	Options
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Project Abstract

- Provides a brief summary of the project, including your organization, target population, needs to be addressed, and services.
- The following information must be included 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 (CHC, MHC, HCH, and/or PHPC)

Participant Question #2

How long do you have to complete and submit the RD application?

- A. 30 days
- B. 60 days
- C. 90 days
- D. 120 days

Answer to Question #2

The correct answer is C:

- A. 30 days
- B. 60 days
- C. 90 days**
- D. 120 days

Project Narrative

- **Need**
- **Response**
- **Collaboration**
- **Evaluative Measures**
- **Resources/Capabilities**
- **Governance**

Budget Narrative

- Line item format for each 12-month period of the three-year designation period
- Itemization of revenues and expenses is only necessary for the first year
- Subsequent years should highlight the changes from Year 1 or clearly indicate that there are no substantive changes
- Should align with the amounts listed in Forms 3 and 3A
- A sample is available on the [RD TA Webpage](#)

Budget Narrative (cont'd)

REVENUE	Year 1	Year 2	Year 3
REVENUE – Consistent with information presented in Form 3: Income Analysis.			
APPLICANT ORGANIZATION			
STATE FUNDS			
LOCAL FUNDS			
FEDERAL FUNDING (break out by source — e.g., HUD, CDC)			
OTHER SUPPORT			
PROGRAM INCOME (fees, third party reimbursements, and payments generated from the projected delivery of services)			
TOTAL REVENUE			
EXPENSES: Object class totals should be consistent with those presented in Form 3A: Look-Alike Budget Information.			
PERSONNEL			
ADMINISTRATION			
MEDICAL STAFF			
DENTAL STAFF			
BEHAVIORAL HEALTH STAFF			
MENTAL HEALTH SERVICES			
SUBSTANCE ABUSE SERVICES			
ENABLING STAFF			
OTHER STAFF			
TOTAL PERSONNEL			

Note: The budget narrative is uploaded as Attachment 11 in the RD application.

Program Specific Forms

Form 1A: General Information Worksheet

Form 1C: Documents on File NEW

Form 2: Staffing Profile

Form 3: Income Analysis

Form 3A: Look-Alike Budget Information

Form 4: Community Characteristics

Form 5A: Services Provided (pre-populated & locked)

Form 5B: Service Sites (pre-populated & locked)

Form 5C: Other Activities/Locations (pre-populated & locked)

Form 6A: Current Board Member Characteristics

Form 6B: Request for Waiver of Board Member Requirements NEW

Form 8: Health Center Agreements

Form 10: Emergency Preparedness Report

Form 12: Organization Contacts

Scope Certification Form

Form 1A: General Information Worksheet

2c. Patients and Visits

Unduplicated Patients and Visits by Population Type

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* Total Substance Abuse	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>

Form 1C: Documents on File

Note: Example date formats for use on this form are 01/15/2016, First Monday of every April, and bi-monthly (last rev 01/16).

Need	Date of Latest Review/Revision (maximum 100 characters)
Needs Assessment (Program Requirement 1)	
Management and Finance	Date of Latest Review/Revision (maximum 100 characters)
Personnel Policies and/or Procedures, including related Conflict of Interest Provisions (Program Requirements 3, 9, 17, and 19)	
Data Collection and Confidentiality (Clinical and Financial) Policies and/or Procedures (Program Requirements 8 and 15)	
Billing and Collection Policies and/or Procedures and Schedule of Fees for Services (Program Requirement 13 and Policy Information Notice 2014-02 – http://bphc.hrsa.gov/programrequirements/policies/pin201402.html)	
Procurement Policies and/or Procedures, including related Conflict of Interest Provisions (Program Requirements 10, 12, and 19 and Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75 (http://www.ecfr.gov/cgi-bin/text-	

Form 2: Staffing Profile

Key Management Staff/Administration		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Project Director/Chief Executive Officer (CEO)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Finance Director/Chief Financial Officer (CFO)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Chief Operating Officer (COO)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Chief Information Officer (CIO)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Clinical Director/Chief Medical Officer (CMO)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Administrative Support Staff		<input type="checkbox"/> Yes <input type="checkbox"/> No
Facility and Non-Clinical Support Staff		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/ Agreement FTEs
Fiscal and Billing Staff		<input type="checkbox"/> Yes <input type="checkbox"/> No
IT Staff		<input type="checkbox"/> Yes <input type="checkbox"/> No
Facility Staff		<input type="checkbox"/> Yes <input type="checkbox"/> No

Form 3: Income Analysis

- Provides a breakdown of projected income for the first year of the proposed new designation period.
- Detailed instructions are included in Appendix A of the RD instructions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration				FOR HRSA USE ONLY	
FORM 3: INCOME ANALYSIS				Number	Application Tracking Number
Note: The value in the Projected Income (d) column should equal the value in the Billable Visits (b) column multiplied by the value in the Income per Visit (c) column. If not, explain in the Comments/Explanatory Notes box.					
Part 1: Patient Service Revenue – Program Income					
Payer Category	Patients by Primary Medical Insurance (a)	Billable Visits (b)	Income per Visit (c)	Projected Income (d)	Prior FY Income
1. Medicaid					
2. Medicare					
3. Other Public					
4. Private					
5. Self Pay					
6. Total (Lines 1-5)	will auto-calculate in EHB	will auto-calculate in EHB	N/A	will auto-calculate in EHB	will auto-calculate in EHB
Part 2: Other Income – Other Federal, State, Local, and Other Income					
7. Other Federal	N/A	N/A	N/A		

Program Specific Forms:

Form 3A: Look-Alike Budget Information

- Provides a breakdown of projected expenses and revenue for the first year of the proposed designation period.
- Should be consistent with amounts described in the budget narrative.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration		FOR HRSA USE ONLY			
		LAL Number	Application Tracking Number		
FORM 3A: LOOK-ALIKE BUDGET INFORMATION					
Note: The program income total on this form must match the program income total on Form 3.					
Budget Category	Community Health Centers (CHC - 330(e))	Migrant Health Centers (MHC - 330(g))	Health Care for the Homeless (HCH - 330(h))	Public Housing Primary Care (PHPC - 330(i))	Total <i>will auto-calculate in EHB</i>
1. Expenses					
a. Personnel					
b. Fringe Benefits					
c. Travel					
d. Equipment					
e. Supplies					
f. Contractual					
g. Construction					
h. Other					

Form 4: Community Characteristics

Race and Ethnicity	Service Area Population	Service Area Population Percent	Target Population	Target Population Percent
Asian		will auto-calculate in EHB		will auto-calculate in EHB
Native Hawaiian		will auto-calculate in EHB		will auto-calculate in EHB
Other Pacific Islanders		will auto-calculate in EHB		will auto-calculate in EHB
Black/African American		will auto-calculate in EHB		will auto-calculate in EHB
American Indian/Alaska Native		will auto-calculate in EHB		will auto-calculate in EHB
White		will auto-calculate in EHB		will auto-calculate in EHB
More than One Race		will auto-calculate in EHB		will auto-calculate in EHB
Unreported/Decided to Report (if applicable)		will auto-calculate in EHB		will auto-calculate in EHB
Total:	will auto-calculate in EHB	100%	will auto-calculate in EHB	100%
Hispanic or Latino Ethnicity	Service Area Population	Service Area Population Percent	Target Population	Target Population Percent
Hispanic or Latino		will auto-calculate in EHB		will auto-calculate in EHB
Non-Hispanic or Latino		will auto-calculate in EHB		will auto-calculate in EHB

Form 5A: Services Provided

Form 5B: Service Sites

Form 5C: Other Activities/Location

- **Pre-populated from LAL's approved scope of project**
- **Forms are locked and cannot be changed in the RD submission**
- **Will serve as a reference during completion of the Project Narrative and Scope Certification Form**

NOTE: If information presented in Forms 5A-5C is not accurate after it has been refreshed, you must take action to correct this information prior to RD submission. Please contact the BPHC Helpline for assistance.

Form 6B: Request for Waiver of Board Member Requirements

FORM 6B: REQUEST FOR WAIVER OF BOARD MEMBER REQUIREMENTS	LAL Number	Application Tracking Number
Note: This form is applicable if you are proposing to serve only special populations (i.e., HCH, MHC, and/or PHPC)		
Request for Waiver		
Name of Organization	Will pre-populate in EHB	
1. New Waiver Request		
Are you requesting a new waiver of the 51% patient majority governance requirement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. For Applicants with Previous Waiver		
2a. Do you currently have a waiver of the 51% patient majority governance requirement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2b. Are you requesting the patient majority waiver to be continued? (This question is required if you answered yes to question 2a.)	<input type="checkbox"/> Yes <input type="checkbox"/> No (Governing board is in full compliance)	
3. Demonstration of Good Cause for Waiver (Demonstrate good cause for the waiver request by addressing the following areas)		
3a. Provide a description of the population to be served and the characteristics of the population/service area that would necessitate a waiver. This question is required if you answered 'Yes' to question 1 and/or question 2b.) (maximum 1,000 characters)		

Form 8: Health Center Agreements

PART I Health Center Agreements	
1. Does your organization have a parent, affiliate, or subsidiary organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2. Do you have, or propose to make as part of this application any subawards to subrecipients and/or will you contract with another organization to carry out a substantial portion of the proposed scope of project? Contracts for a substantial portion of the award include contracting for the majority of core primary care services, and/or contracting for the Chief Executive Officer (CEO), and/or the entire key management team inclusive of the CEO.</p> <p>NOTE:</p> <ul style="list-style-type: none"> • Subawards or contracts made to related organizations such as a parent, affiliate, or subsidiary must be addressed in this form. • This form excludes contracts for the acquisition of supplies, material, equipment, or general support services (e.g., janitorial services, contracts with individual providers). <p>If Yes, indicate the number of each agreement by type in 2a and/or 2b below and complete Part II. If No, Part II is Not Applicable.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2a. Number of contracts for a substantial portion of the proposed scope of project for any of the following: the majority of core primary care services and/or contracting for the CEO and/or the entire key management team inclusive of the CEO.	___ (number)
2b. Number of subrecipients that will carry out a substantial portion of the proposed scope of project via a subaward.	___ (number)
2c. Total number of contracts and/or subawards for a substantial portion of the proposed scope of project.	___ (number)
Part II: Attachments	

Form 10: Emergency Preparedness Report

Form 10: EMERGENCY PREPAREDNESS REPORT		Tracking Number
SECTION I - EMERGENCY PREPAREDNESS AND MANAGEMENT (EPM) PLAN		
1. Has your organization conducted a thorough Hazards Vulnerability Assessment? If Yes, date completed: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Does your organization have an approved EPM plan? If Yes, date that the most recent EPM plan was approved by your Board: _____ If No, skip to the Readiness section below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Does the EPM plan specifically address the four disaster phases? (This question is mandatory if you answered Yes to Question 2.)		
3a. Mitigation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3b. Preparedness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3c. Response	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3d. Recovery	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Form 12: Organization Contacts

Form 12: ORGANIZATION CONTACTS		Tracking Number
<i>Note: This form will pre-populate for look-alikes</i>		
Chief Executive Officer		
Position Title		
Prefix		
Name		
Suffix		
Highest Degree		
Email		
Phone Number		
Contact Person		
Position Title		
Prefix		
Name		
Suffix		
Highest Degree		
Email		

Scope Certification Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	LAL Number	Application Tracking Number
1. Scope of Project Certification – Services – <i>select only one below</i>		
<input type="checkbox"/> By checking this option, I certify that I have reviewed my Form 5A: Services Provided and it accurately reflects all services and service delivery methods included in my current approved scope of project.		
<input type="checkbox"/> By checking this option, I certify that I have reviewed my Form 5A: Services Provided and it requires changes that I have submitted through the change in scope process.		
2. Scope of Project Certification – Sites – <i>select only one below</i>		
<input type="checkbox"/> By checking this option, I certify that I have reviewed my Form 5B: Service Sites and it accurately reflects all sites included in my current approved scope of project.		
<input type="checkbox"/> By checking this option, I certify that I have reviewed my Form 5B: Service Sites and it requires changes that I have submitted through the change in scope process.		

Participant Question #3

Which one of these Forms is pre-populated and not editable in the RD application?

- A. Form 2: Staffing Profile
- B. Form 8: Health Center Agreements
- C. Form 4: Community Characteristics
- D. Form 5A: Services Provided

Answer to Question #3

The correct answer is D:

- A. Form 2: Staffing Profile
- B. Form 8: Health Center Agreements
- C. Form 4: Community Characteristics
- D. Form 5A: Services Provided**

Clinical and Financial Performance Measures

- 16 Clinical Performance Measures
- 10 of the Clinical Performance Measures have been updated (baseline data will not pre-populate for updated Clinical Performance Measures)
 - [Clinical Performance Measure Crosswalk](#)
 - [2015 UDS Manual](#)
 - [Program Assistance Letter 2016-02](#)
- 2 Financial Performance Measures
- For pre-populated baseline data, more current data may be provided in the Comments field, if desired
- Appendix B provides complete performance measure instructions
- Look-Alikes with special populations designation (MHC, HCH, and/or PHPC) must have at least one performance measure specific to each targeted special population

Attachments

Attachment 1:	Service Area Map and Table
Attachment 2:	Corporate Bylaws
Attachment 3:	Organizational Chart
Attachment 4:	Position Descriptions by Key Personnel
Attachment 5:	Biographical Sketches for Key Personnel
Attachment 6:	Co-Applicant Agreement for Public Centers
Attachment 7:	Summary of Contracts and Agreements
Attachment 8:	Letters of Support
Attachment 9:	Sliding Fee Discount Schedule
Attachment 10:	Most Recent Independent Financial Audit
Attachment 11:	Budget Narrative
Attachment 12:	Other Relevant Documents

NOTE REGARDING THE RD SUBMISSION

- You are required to submit an RD application before the end of the designation period, by the established deadline timeframes (90 days before the end of your designation period).
- RD submissions lacking all required documents and information will be considered incomplete or non-responsive.
- Incomplete or non-responsive RD applications will be returned through a “request change” notification via EHB.
- **Failure to submit a timely and complete RD application may result in termination of the LAL designation and all corresponding benefits.**
- Carefully review your RD application to ensure it is both complete and responsive prior to submission.

Technical Assistance (TA) Contacts

- **Renewal of Designation TA Webpage:**
<http://bphc.hrsa.gov/programopportunities/lookalike/RD/index.html>
- **Program related questions: Look-Alike Response Team**
 - Web Form: http://bphccommunications.force.com/KnowledgeApp/pkb_oppd
 - Email and Phone: lookalike@hrsa.gov or 301-594-4300

(Note: The lookalike@hrsa.gov email address is being phased out and will not be operational in the coming months. Please submit questions via the Web form.)
- **EHB related questions: BPHC Helpline**
 - Web Form: <http://www.hrsa.gov/about/contact/bphc.aspx>
 - Phone: 877-974-2742

Questions & Answers



Participant Questions #4 & #5

Did this presentation help you feel more prepared to provide a complete RD application?

What other information about the RD application would you find helpful?