Issuance Date: July 6, 2017

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

Rael Ammon
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Bureau of Primary Health Care, Office of Policy and Program Development
Contact: https://www.hrsa.gov/about/contact/bphc.aspx (Select either Applicant or LAL Designee, Lookalike (LAL))
Telephone: (301) 594-4300
Look-Alike Renewal of Designation Technical Assistance Web site:
EXECUTIVE SUMMARY

Look-alikes (LALs) were established to maximize health care access for medically underserved populations and communities by allowing entities that do not receive Health Center Program funding to become Federally Qualified Health Centers (FQHCs). LALs operate and provide services consistent with health centers funded under the Health Center Program.

The Health Resources and Services Administration (HRSA), Bureau of Primary Health Care is accepting applications for look-alike (LAL) Renewal of Designation (RD). Submission and approval of the LAL RD application assures continued access to affordable, quality primary health care services in areas already served by LAL organizations.

<table>
<thead>
<tr>
<th>Application Availability</th>
<th>HRSA Electronic Handbook (EHB) access granted 180 calendar days prior to the end of the current designation period (approximately 2.5 years into a 3-year designation period or approximately 6 months into a 1-year designation period).</th>
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<tr>
<td>Application Due Date</td>
<td>90 calendar days after HRSA EHB access is granted (90 calendar days before the end of the current designation period).</td>
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<tr>
<td>Designation Period</td>
<td>Up to 3 years.</td>
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<td>Eligible Applicants:</td>
<td>Eligible applicants are LAL organizations in the last year of their current designation period.</td>
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<td>At the time of RD submission, an applicant must:</td>
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<td>a. Provide comprehensive primary medical care as its main purpose at one or more permanent service delivery sites.</td>
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<td></td>
<td>b. Ensure access to services in the service area/target population, for all individuals, without regard to ability to pay.</td>
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<tr>
<td></td>
<td>c. Serve a designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP).</td>
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<td></td>
<td>See the Eligibility section for complete eligibility information, including exclusions.</td>
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Technical Assistance
Application resources, including a webinar recording and form samples, are available at the RD Technical Assistance Web site (https://bphc.hrsa.gov/programopportunities/lookalike/RD/index.html).

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. Organizations interested in seeking funding under the Health Center Program or improving their current LAL projects through technical assistance are encouraged to subscribe several staff at https://public.govdelivery.com/accounts/USHHSHRSA/subscriber/new?topic_id=USHHSHRSA_118.

Throughout the application development and preparation process, you are encouraged to work with the appropriate Primary Care Associations (PCAs) and/or National Cooperative Agreements (NCAs) to prepare a quality application. For a listing of HRSA-supported PCAs and NCAs, refer to HRSA’s Strategic Partnerships Website.

Summary of Changes
- The Project Narrative is streamlined to reduce applicant burden, more closely align with Health Center Program requirements as defined by statute and regulation, and streamline the collection of information.
- Form 1C: Documents on File is no longer included in the RD application.
- Two required Clinical Performance Measures are revised and four are renamed. Details are provided in Appendix B and Program Assistance Letter 2017-02: Approved Uniform Data System (UDS) Changes for Calendar Year 2017, available at https://bphc.hrsa.gov/datareporting/pdf/pal201702.pdf.

Other Federal Benefits
Receipt of LAL renewal of designation, while a basis for eligibility, does not, of itself, confer such federal benefits such as Federally Qualified Health Center (FQHC) reimbursement or 340B Drug Pricing Program participation. Such benefits depend upon compliance with applicable requirements in addition to renewal of designation, including the completion of separate applications, as appropriate. This includes Health Center Program LAL designation and the completion of separate applications, as appropriate. The Centers for Medicare & Medicaid Services (CMS) manages FQHC reimbursement (see https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html). More information about the 340B Drug Pricing Program is available in the Other Information section. LAL RD does not confer Federal Tort Claims Act (FTCA) coverage.
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I. Renewal of Designation Description

1. Purpose

These Renewal of Designation instructions will be used by current LAL organizations to apply to renew their LAL designation. LALs were established to maximize health care access for medically underserved populations and communities by allowing entities that do not receive Health Center Program funding to become Federally Qualified Health Centers (FQHCs).

While LALs do not receive Health Center Program funding, they are eligible to apply to the Centers for Medicare and Medicaid Services (CMS) for FQHC reimbursement. LALs are also eligible to apply to participate in the 340B Federal Drug Pricing Program, receive automatic Health Professional Shortage Area designation, and may access National Health Service Corps providers.

These instructions detail the eligibility requirements and designation factors for organizations seeking continued look-alike (LAL) designation. For the purposes of this document, the term “health center” encompasses Health Center Program LALs designated under the following statutory subsections of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254b):

- Community Health Center (CHC – section 330(e))
- Migrant Health Center (MHC – section 330(g))
- Health Care for the Homeless (HCH – section 330(h))
- Public Housing Primary Care (PHPC – section 330(i))

2. Background

The Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC) administers the Health Center Program. Health centers improve the health of the nation’s high need geographic areas and populations by ensuring access to accessible, affordable quality primary health care services. Individually, each health center plays an important role in ensuring access to services. Combined, health centers have a critical impact on improving the health care status of millions of medically underserved and vulnerable individuals throughout the United States and its territories.

An amendment to the Omnibus Budget Reconciliation Acts\(^1\) 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 that meets the requirements of the Health Center Program, as determined by HRSA, but 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 an LAL “entity may not be owned, controlled or operated by another entity.”

Look-alike designation allows entities that do not receive Health Center Program funding to provide services and obtain federal benefits consistent with those health

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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 primary health care needs, provide services to all persons regardless of ability to pay, and meets 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.

**Designation Application Requirements**

Current LAL organizations will use these instructions to renew their LAL designation.

Your application must document an understanding of the ongoing need for primary health care services in your service area and propose a comprehensive plan to meet this need. The plan must ensure the availability and accessibility of primary health care services to all individuals in the service area and target population, regardless of ability to pay. You must further demonstrate that your plan includes collaborative and coordinated delivery systems for the provision of health care to the underserved.

Your application must also demonstrate compliance with applicable Health Center Program requirements and corresponding regulations and policies, in accordance with section 330 of the PHS Act and 2 CFR part 200. Failure to comply with all Health Center Program requirements may jeopardize your LAL designation. HRSA will assess compliance prior to and during the designation period. When non-compliance is identified, HRSA will place a condition on your Notice of Look-Alike Designation (NLD), which will follow the Progressive Action process.

The Progressive Action process provides a time-phased approach to resolve compliance issues. HRSA may terminate your organization’s LAL designation if you fail to resolve conditions via the Progressive Action process. For more information, refer to the Health Center Program Compliance Manual, Chapter 2: Health Center Program Oversight.

In addition to the Health Center Program requirements, specific requirements for applicants requesting designation under each health center type are summarized 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 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 availability and accessibility of required primary and preventive health care services to migratory and seasonal agricultural workers and their families in the service area.
  o 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.
  o 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.
  o Agriculture means farming in all its branches, as defined by the Office of Management and Budget (OMB)-developed North American Industry Classification System under codes 111, 112, 1151, and 1152 (48 CFR § 219.303).

HEALTH CARE FOR THE HOMELESS (HCH) APPLICANTS:
• Ensure compliance with PHS Act section 330(h); and, as applicable, section 330(e), program regulations, requirements, and policies.
• Provide a plan that ensures the availability and accessibility of required primary and preventive health care services to people experiencing homelessness, defined as patients who lack housing, including residents of permanent supportive housing, transitional housing, or other housing programs that are targeted to homeless populations, in the service area. This plan may also allow for the continuation of services for up to 12 months to individuals no longer homeless, because of becoming a resident of permanent housing.
• Provide substance abuse services.

PUBLIC HOUSING PRIMARY CARE 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 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 can only be proposed via a Change in Scope request in HRSA EHB.
II. Designation Information

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, and a decision that continued designation is in the best interest of the Federal Government. Required submissions include, but are not limited to, the Renewal of Designation and Annual Certification (AC) applications, as well as annual Uniform Data System (UDS) submissions.

III. Eligibility Information

Applicants must meet all of the following eligibility requirements. If your application does not demonstrate compliance with all eligibility requirements, it may be considered ineligible or will have conditions placed on the NLD. You must address these conditions to ensure ongoing designation.

1) You must be a currently designated LAL organization. Current LAL organizations include public and nonprofit private entities, including faith-based and community-based organizations, Tribes, and tribal organizations.

2) You must not be owned, controlled, or operated by another entity. Organizational structures such as parent-subsidiary arrangements or network corporations may not be eligible for designation.

3) You are expected to perform a substantive role in the project and meet the program requirements. You cannot apply on behalf of another organization.

4) You must indicate, on Form 1A: General Information Worksheet, comprehensive, primary medical care as your organization’s main purpose.

5) You must continue operating a health center that makes all required primary health care services, including preventive and enabling services, available and accessible in the service area, either directly or through established arrangements, without regard to ability to pay. You may not propose to provide only a single type of service, such as dental, behavioral, or prenatal services.

6) You 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.,

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2 For more information about becoming a LAL refer to the LAL Initial Designation Technical Assistance Web site located at https://bphc.hrsa.gov/programopportunities/lookalike/initialdesignationinstructions.html.

3 Section 1905(l)(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.
homeless children), you must ensure that health center services will be made available and accessible to others who seek services at the LAL site(s).

7) Your organization (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

8) PUBLIC HOUSING PRIMARY CARE APPLICANTS ONLY: If you have a PHPC designation, your application must demonstrate that your organization has consulted with residents of public housing when preparing the application. You must also ensure ongoing consultation with the residents regarding the planning and administration of the health center, as documented in the GOVERNANCE section of the Project Narrative.

9) You must meet the application deadline (90 days prior to the end of your current designation period). See Submitting the Application for detailed information about the application timeline and due date.

IV. Application and Submission Information

In addition to following these instructions, review the HRSA EHB RD User Guide. Applications must be submitted in the English language.

Application Requirements
Submit the following application components in HRSA EHB:
- Project Abstract
- Project Narrative
- Budget Narrative
- Program Specific Forms (samples are available on the RD TA Website)
- Attachments

Application Page Limit
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 narratives, and attachments (including letters of support). Standard OMB-approved forms that are included in the application package do not count in the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) will not be counted in the page limit. Please ensure your application does not exceed the specified page limit.

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

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

5 The list of MUAs and MUPs is available at http://www.hrsa.gov/shortage.
1) You certify, by submission of this application, that neither your organization nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.

2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376 and 31 U.S.C. 3321).

3) Where you are unable to attest to the statements in this certification, an explanation shall be included in Attachment 12: Other Relevant Documents.

**Submitting the Application**

You must submit your application electronically through HRSA EHB. Refer to the RD Application User Guide available on the [RD TA Website](https://rd.ta.hrsa.gov) for HRSA EHB submission instructions.

Your application is due 90 days prior to the end of your organization’s current designation period. The HRSA EHB system will send an email notice regarding the availability of the application to your organization’s contacts, as you’ve identified in HRSA EHB, 180 days prior to the end of the current designation period. This means you will have 90 calendar days to complete and have your Authorizing Official (AO) submit the RD application in HRSA 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.**

**Application Components**

Include the following in your RD application:

**i. Cover Page**
A HRSA EHB form that provides a summary of project-related information.

**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 should be a brief description of your 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 your organization, the community you serve, and your target population.

A brief summary of the major health care needs and barriers to care you will address through the proposed project. This summary should include the needs of any targeted special populations (migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing).

How your proposed project will address the need for comprehensive primary health care services in your community.

Number of current and proposed patients, providers, and service delivery sites and locations.

### iii. Project Narrative

Provide a comprehensive framework and description of all aspects of the proposed project. Your Project Narrative should be succinct, consistent with other application components, and organized by section headers (Need, Response, Collaboration, Evaluative Measures, Resources/Capabilities, and Governance).

Your Project Narrative must:

- Demonstrate compliance with Health Center Program requirements, as detailed in the Health Center Program requirements at [https://bphc.hrsa.gov/programrequirements/index.html](https://bphc.hrsa.gov/programrequirements/index.html).
- Address the specific Project Narrative elements below, with 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 HRSA EHB submission.
- Reflect your currently approved scope of project. You **must** request any changes through a Scope Adjustment or Change in Scope request through HRSA EHB.⁶

### NEED

Information provided in the NEED section must:

- Demonstrate compliance with the Needs Assessment Health Center Program requirement.
- Serve as the basis for, and align with, the activities and goals described throughout your application.
- Be utilized to inform and improve the delivery of health center services.

1) Describe the proposed service area (consistent with [Attachment 1: Service Area Map and Table](#)), including:
   a) The service area boundaries.

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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).
b) How you review annually and determine your service area based on where patients reside, as reported in the 2016 UDS.\(^7\)

2) Citing data sources and the frequency of assessments, describe the service area/target population and the current health care needs, specifically addressing items a-d below. This description must include the unique needs of each special population for which you are requesting designation (MHC, HCH, and PHPC).\(^8\)

a) Factors associated with access to care and health care utilization (e.g., geography, transportation, occupation, unemployment, income level, educational attainment, transient populations).

b) The most significant causes of morbidity and mortality (e.g., diabetes, cardiovascular disease, cancer, low birth weight, mental health and/or substance abuse).

c) Health disparities.

d) Unique health care needs or characteristics that impact health, access to care, or health care utilization (e.g., social factors, environmental factors, occupational factors, cultural/ethnic factors, language needs, housing status).

**RESPONSE**

Information provided in the RESPONSE section must demonstrate compliance with the following Health Center Program requirements:

- Required and Additional Services
- Accessible Hours of Operation/Locations
- After Hours Coverage
- Hospital Admitting Privileges and Continuum of Care
- Sliding Fee Discounts

1) Describe how you will ensure access to all required and additional services (consistent with Form 5A: Services Provided) and other activities, as applicable, (consistent with Form 5C: Other Activities/Locations) to meet the identified needs, including:

a) The method of provision of services (as indicated on Form 5A: Services Provided).

b) How services provided through contractual agreements (Form 5A: Services Provided, Column II), will be documented in the patient’s health center record and how the health center will pay for the services.

c) How services provided through referral arrangements (Form 5A: Services Provided, Column III) will be managed, and the process for tracking and referring patients back to the health center for appropriate follow-up care.

d) Interpretation and translation services for patients with limited English proficiency.

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\(^8\) Special populations refer to Migratory and Seasonal Agricultural Workers and Families (MHC), Public Housing Residents (PHPC), or People Experiencing Homelessness (HCH).
e) Arrangements and resources that enable staff to deliver services in response to current access to care and health care utilization barriers (e.g., geography, transportation, occupation, transience, unemployment, income level, educational attainment) or any other unique health care needs or characteristics that impact health status or access to, or utilization of, primary care (e.g., social factors, the physical environment, cultural/ethnic factors, language needs, housing status). Specifically, describe any enabling services designed to increase access, particularly for any targeted special populations.

f) **If HCH designation is requested:** Document how substance abuse services will be made available (consistent with Form 5A: Services Provided).

2) Describe the proposed service delivery sites (consistent with Form 5B: Service Sites) and how the sites assure availability, prompt accessibility, and continuity of services (consistent with Forms 5A: Services Provided and 5C: Other Activities/Locations) within the proposed service area relative to where the target population lives and works (e.g., areas immediately accessible to public housing for health centers targeting public housing residents). Specifically address:
   a) Access barriers (i.e., barriers resulting from the area’s physical characteristics, residential patterns, or economic and social groupings).
   b) Distance and duration for patients to travel to or between service sites to access the full range of services proposed (consistent with Form 5A: Services Provided).
   c) How the total number and 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 are responsive to patient needs by facilitating the ability to schedule appointments and access services.

3) Describe the clinical capacity, operating procedures, and arrangements for promptly responding to patient medical emergencies during and after regularly scheduled hours, including:
   a) Having at least one staff member certified in basic life support skills at each service delivery site (consistent with Form 5B: Service Sites) during regularly scheduled hours of operation.
   b) After-hours coverage via telephone or face-to-face by an individual with the qualification and training necessary to exercise professional judgment in assessing the need for emergency care.
   c) Referring patients for further consultation (e.g., licensed independent practitioner, emergency room, urgent care) for further assessment or immediate care.
   d) How limited English proficiency is addressed (i.e., language(s), literacy levels, and formats of materials/messages).

4) Describe continuity of care for patients in a hospital setting, including:
   a) Contracts or other appropriate documentation that address health center patient admissions, including hospital admitting privileges for health center providers, or formal arrangements between the health center and non-health center providers or entities (e.g., hospital, hospitalists, obstetrics group practice).
b) Internal operating procedures and related provisions in formal arrangements with non-health center providers or entities, if any, that address the following for patients who are hospitalized or visit a hospital’s emergency department:
   • Health center receipt and recording of medical information from non-health center providers/entities (e.g., hospital discharge follow-up instructions, laboratory, radiology, or other results).
   • Health center staff follow-up, when appropriate.

5) Describe your organization’s sliding fee discount program, including the board-approved policies (consistent with Attachment 9: Sliding Fee Discount Schedule(s)). Specifically address the:
   a) Definitions of, and requirements for, verifying income and family size.
   b) Methods and operating procedures of assessment eligibility of all patients based only on income and family size.
   c) Structuring the Sliding Fee Discount Schedule (SFDS) to ensure that charges are adjusted based on a patient’s ability to pay.
   d) Nominal charges for patients at or below 100 percent of the Federal Poverty Guidelines (FPG), available at https://aspe.hhs.gov/poverty-guidelines, which must: be flat charges, be considered nominal from the perspective of the patient, and not reflect the actual cost of the service provided.
   e) Mechanisms for informing patients of the availability of sliding fee discounts (e.g., materials at appropriate language and literacy-levels, inclusion in the intake process, published on the health center’s Website).
   f) Application of discounts to patients who are eligible for sliding fee discounts and have third-party coverage, ensuring that they are charged no more for out of pocket costs than they would have paid under the applicable discount pay class.
   g) Applicability to all required and additional services within the scope of project (Form 5A: Services Provided).
   h) Evaluation of the sliding fee discount program, including how patient access/service utilization data (by discount pay class and those at or below 100 percent of the FPG who are accessing services) are used to determine and ensure the effectiveness of the program in reducing financial barriers to care.

6) In Attachment 9: Sliding Fee Discount Schedule(s), document the following components of your Sliding Fee Discount Schedule(s) (SFDS):
   a) A full discount is provided for individuals and families with annual incomes at or below 100 percent of the current FPG, unless there is a nominal charge. If there is a nominal charge, it is flat and less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.
   b) Partial discounts are provided for individuals and families with incomes above 100 percent of the FPG, and at or below 200 percent of the FPG, that adjust in accordance with income using a minimum of three discount pay classes.
   c) No discounts will be provided to individuals and families with annual incomes above 200 percent of the FPG.
   d) Incorporation of the most current FPG.
e) If you have more than one SFDS, the schedules are based on services (e.g., distinct schedules for medical and dental services, distinct schedules for preventive dental and additional dental services) or service delivery methods (Columns I, II, and III of Form 5A: Services Provided).

7) Describe how the unduplicated patient commitment (number of patients projected to be served by the end of the designation period as documented on Form 1A: General Information Worksheet) was determined and how it is achievable given recent and anticipated changes in the local health care landscape, organizational structure, and/or workforce capacity.

COLLABORATION

Information in the COLLABORATION section must:

- Demonstrate compliance with the Collaborative Relationships Health Center Program requirement.
- Be consistent with Form 8: Health Center Agreements and Attachment 7: Summary of Contracts and Agreements.
- Be supported by documents provided in Attachment 8: Collaboration Documentation.

1) Describe and document (e.g., dated letters of support, signed memoranda of agreement) efforts to collaborate with other primary care providers serving similar patient populations in the service area (consistent with Attachment 1: Service Area Map and Table). At a minimum, this includes establishing, documenting, and maintaining relationships with the following in the service area:
   - Other Health Center Program award recipients and look-alikes.
   - Health departments.
   - Local hospitals.
   - Rural health clinics.
   - Any additional organizations that support continuity of care and access to services beyond the scope or capacity of the health center.

If documentation of collaboration with one or more of the entities above is not provided, explain why it could not be obtained (e.g., “Health center X did not respond to a request for a letter of support”) and document the request (e.g., the email requesting such support) in Attachment 8.

2) Describe both formal and informal collaboration activities with other providers or programs in the service area (consistent with Attachment 1: Service Area Map and Table), including private provider groups serving low income and/or uninsured patients or otherwise underserved communities or vulnerable populations.


**EVALUATIVE MEASURES**

Information in the EVALUATIVE MEASURES section must demonstrate compliance with the following Health Center Program requirements:

- Quality Improvement/Quality Assurance Plan
- Program Data Reporting Systems

1) Describe how the quality improvement and quality assurance (QI/QA) program specifically addresses:
   a) The quality and utilization of health center services.
   b) Patient satisfaction and grievances processes.
   c) Patient safety, including adverse events.

2) Describe the responsibilities of the individual designated to oversee the QI/QA program related to:
   a) Implementation and frequency of updating of QI/QA operating procedures and related assessments.
   b) Monitoring of associated QI/QA outcomes.

3) Describe how the health center operating procedures address:
   a) Adherence to current evidence-based clinical guidelines and standards of care in the provision of services.
   b) Processes for:
      - Identifying, analyzing, and addressing patient safety and adverse events, including implementing follow-up actions, as necessary.
      - Assessing patient satisfaction, including hearing and resolving patient grievances.
   c) Completion of quarterly (or more frequent) QI/QA assessments to inform modifications to the provision of services.
   d) Production and sharing of QI/QA reports to support oversight of and decision-making regarding the provision of services by key management staff and the governing board.

4) Describe how the health center’s physicians or other licensed health care professionals conduct QI/QA assessments using data systematically collected from patient records to ensure:
   a) Provider adherence to current evidence-based clinical guidelines, standards of care, and standards of practice.
   b) The identification of patient safety and adverse events, and the implementation of related follow-up actions.

5) Describe how the organization’s record system (e.g., electronic health record (EHR) system) will be used to:
   a) Optimize health information technology.
b) Protect the confidentiality of patient information and safeguard it against loss, destruction, or unauthorized use, consistent with federal and state requirements.
c) Collect and organize data required to meet HHS reporting requirements, including data elements for annual UDS reporting.
d) Monitor program performance beyond required reporting.

6) On the Clinical Performance Measures form only (see detailed instructions in Appendix B), establish realistic goals that are responsive to clinical performance and associated needs. Goals should be informed by measure-specific contributing and restricting factors affecting achievement.

7) On the Financial Performance Measures form only (see detailed instructions in Appendix B), establish realistic goals that are responsive to the organization’s financial performance and associated needs. Goals should be informed by measure-specific contributing and restricting factors affecting achievement.

RESOURCES/CAPABILITIES

Information in the RESOURCES/CAPABILITIES section must demonstrate compliance with the following Health Center Program requirements:

- Staffing Requirement
- Key Management Staff
- Contracts/Affiliation Agreements
- Conflict of Interest Policy
- Financial Management and Control Policies
- Billing and Collections

1) Describe how your organizational structure (including any contractors) is appropriate to implement the proposed project (consistent with Attachments 2: Bylaws and 3: Project Organizational Chart, and, as applicable, Attachments 6: Co-Applicant Agreement and 7: Summary of Contracts and Agreements).

2) Describe the following related to the staffing plan (consistent with Form 2: Staffing Profile):
   a) How it ensures that clinical and related support staff are in place to provide all required and additional services (consistent with Form 5A: Services Provided).
   b) How the size, demographics, and health care needs of the service area and patient population were considered in determining the number and mix of clinical support staff.
   c) How the operating procedures for the initial and recurring review and documentation of credentials and privileges for all clinical staff members (i.e., health center employees, contractors, or volunteers) ensure verification of:
      - Current licensure, registration, or certification.
      - Education and training for initial credentialing, using primary sources for licensed independent practitioners.
• Completion of a query through the National Practitioner Data Bank (NPDB), available at https://www.npdb.hrsa.gov/.
• Clinical staff identification verification for initial credentialing using a government issued picture identification.
• Drug Enforcement Administration (DEA) registration, if applicable.
• Current documentation of Basic Life Support skills.
• Health fitness, including physical and mental health status, immunization and communicable disease status, and any impairments that may interfere with the safe and effective provision of care permitted under the requested clinical privileges.
• Current clinical competence via reference reviews, training and education for initial privileging, and peer review or other comparable methods for renewal of privileges.
• Criteria and processes for modifying or removing privileges based on the outcomes of clinical competence assessments.

d) How provisions in contracts and/or formal written referral agreements with provider organizations ensure your providers are:
• Licensed, certified, or registered as verified through a credentialing process, in accordance with applicable federal, state, and local laws.
• Assessed as competent to perform the contracted or referred services through a privileging process.

Note: Your 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 the majority of your organization’s core primary health care services will be secured via contract, include the contract/agreement as an attachment to Form 8: Health Center Agreements.

3) Describe your management team (e.g., project director (PD), clinical director (CD), chief executive officer (CEO), chief financial officer (CFO), chief information officer (CIO), chief operating officer (COO)), including:
   a) Lines of authority for the operation and oversight, scope, and complexity of the proposed project.
   b) Training, experience, skills, and qualifications necessary to execute each defined role (demonstrated in Attachment 4: Position Descriptions for Key Management Staff), as well as the amount of time that each will dedicate to Health Center Program activities (consistent with Form 2: Staffing Profile).
   c) Identification of individuals who will serve in the defined roles (demonstrated in Attachment 5: Biographical Sketches for Key Management Staff). If applicable, identify individuals that will fill more than one key management position, including the positions they will fill (e.g., CFO and COO combined role), and describe any changes in key management staff in the last year or significant changes in their roles.
   d) CEO responsibilities for the oversight of other key management staff. This should include reports to the governing board for accomplishing the day-to-day activities of the proposed project.
e) The plan to recruit qualified individuals to fill open key management positions, or those that are likely to become open and, the plan to retain current and future key management staff.

4) Describe your procurement procedures and conformance with applicable state, local, and tribal laws and regulations.

5) Describe how your organization will maintain appropriate oversight and authority over all contracted services and sites (consistent with Forms 5A: Services Provided, 5B: Service Sites, and 8: Health Center Agreements, and Attachment 7: Summary of Contracts and Agreements), including:
   a) The structure of the agreement.
   b) Ensuring the contractor is compliant, and performs in accordance with all applicable terms, conditions, and requirements, including those found in section 330 of the PHS Act, implementing program regulations, and grants regulations in 45 CFR Part 75.
   c) Mechanisms to monitor contractor performance.
   d) Requirements for the contractor to provide data necessary for you to meet applicable federal financial and programmatic reporting requirements, as well as provisions addressing record retention and access, audit, and property management.

   Note: Upon designation, your organization will be the legal entity held accountable for carrying out the approved Health Center Program scope of project, including any activities in the approved scope of project that may be carried out by contractors.

6) Document in your health center’s bylaws (Attachment 2) and/or other board-approved policy documents (Attachment 12: Other Relevant Documents) that provisions are in place to prohibit real or apparent conflict of interest by board members, employees, consultants, and others in the procurement of supplies, property (expendable), equipment, and services.

7) Describe how your financial accounting and internal control systems, as well as related systems:
   a) Reflect Generally Accepted Accounting Principles (GAAP), if you are a private non-profit health center, or Government Accounting Standards Board (GASB) principles, if you are a public agency.
   b) Will maintain effective control over, and accountability for, all funds, property, and other assets associated with the proposed project.
   c) Will safeguard all assets to assure they are used solely for authorized purposes in accordance with the terms and conditions of the Health Center Program designation and requirements.

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

10 For further guidance on these requirements, please see the HHS Grants Policy Statement, at https://www.hrsa.gov/grants/hhsgrantspolicy.pdf.
d) Demonstrate the capacity to track the financial performance of the health center, including identification of trends or conditions that may warrant action to maintain financial stability.

e) Enable the collection and reporting of the organization’s financial status, as well as tracking of key financial performance data (e.g., visits, revenue generation, aged accounts receivable by income source or payer type, aged accounts payable, lines of credit).

f) Identify accounts of all Federal awards.

g) Provide accurate, current, and complete disclosure of the financial results of each Federal award or program in accordance with reporting requirements.

h) Assure that costs under awards are allowable in accordance with the terms and conditions of the Federal Award and Federal Cost Principles.

8) Describe your billing and collections systems, including:

a) Requesting applicable payments from patients, while ensuring that no patient is denied service based on inability to pay.

b) Educating patients on insurance and, if applicable, related third-party coverage options available to them.

c) Establishing arrangements for billing Medicare, Medicaid, Children’s Health Insurance Program (CHIP), and other public and private assistance programs or insurance in a timely manner, as applicable.

d) Incorporating additional elements such as payment plans, grace periods, and prompt payment incentives, if applicable.

e) Maintaining policies and operating procedures that address the waiving or reducing of amounts owed by patients due to a patient’s specific circumstances related to inability to pay.

f) Collecting reimbursements for costs in providing health care services, consistent with the terms of such contracts and arrangements.

g) Maintaining policies and procedures regarding informing patients of out of pocket costs prior to the time of service if you provide supplies or equipment that are related to, but not included in, a service as part of prevailing standards of care (e.g., eyeglasses, prescription drugs, dentures) and you charge patients for these items.

h) Maintaining policies and procedures that distinguish between refusal to pay and inability to pay if a health center elects to limit or deny services based on a patient’s refusal to pay.

9) 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).

10) Describe your current status or future plans for participating in related federal benefits (e.g., FQHC Medicare/FQHC Medicaid/CHIP reimbursement, 340B Drug Pricing Program, National Health Service Corps) and your plans for maintaining or obtaining private malpractice insurance coverage. Refer to Section VIII for details.
GOVERNANCE

Information in the GOVERNANCE section must demonstrate compliance with the Health Center Program Compliance Manual, Chapter 19: Board Authority and Chapter 20: Board Composition.

Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups are required ONLY to respond to Item 3 below.

1) Document your governing board composition requirements, member selection and removal process, and authorities and responsibilities in Attachment 2: Bylaws. This attachment must specify the following:11
   a) Board size must be at least 9 and no more than 25 members, with either a specific number or range of board members prescribed (compliance demonstrated on Form 6A: Board Member Characteristics).
   b) At least 51 percent of board members must be patients served by the health center (compliance demonstrated on Form 6A: Board Member Characteristics).12,13
   c) Patient members of the board, as a group, must reasonably represent the patient population in terms of demographic factors (e.g., race, ethnicity, gender) (compliance demonstrated on Form 6A: Board Member Characteristics, consistent with Form 4: Community Characteristics).
   d) Non-patient members must be representative of the community in which the health center is located, by either living or working in the community or by having a demonstrable connection to the community.
   e) Non-patient members must be selected to provide relevant expertise and skills (e.g., community affairs, local government, finance and banking, legal affairs, trade unions and other commercial and industrial concerns, social services) (compliance demonstrated on Form 6A: Board Member Characteristics).
   f) No more than one-half of non-patient board members may earn more than ten percent of their annual income from the health care industry (compliance demonstrated on Form 6A: Board Member Characteristics).
   g) Health center employees, contractors, and immediate family members of employees may not be health center board members.14
   h) Meetings must occur monthly.
   i) Approving the selection and dismissal or termination of the project director/CEO.
   j) Evaluating the project director/CEO.

11 The health center must maintain documentation of adherence to requirements outlined in the bylaws.
12 For the purposes of the Health Center Program, the term “board member” refers only to voting members of the board.
13 For the purposes of board composition, a patient is an individual who has received at least one service in the past 24 months that generated a health center visit, where both the service and the site where the service was received are within the HRSA-approved scope of project.
14 In the case of public agencies with co-applicant boards, this includes employees or immediate family members of either the co-applicant organization or of the public agency component in which the health center project is located (for example, employees within the same department, division, or agency).
k) Approving applications related to the health center project, including approving the annual budget, which outlines the proposed uses of both federal and non-federal resources and revenue.

l) Approving proposed sites, hours of operation, and services, including contracting for a substantial portion of the proposed services.

m) Evaluating the performance of the health center.

n) Establishing or adopting policy related to the operations of the health center.

o) Assuring the health center operates in compliance with applicable federal, State, and local laws and regulations.

p) If you are requesting designation to target any special populations, you must have one representative on the board from/for each of the special populations who can clearly communicate the special population’s needs/concerns (e.g., migratory and seasonal agricultural workers advocate, former or current homeless individual, current resident of public housing).

2) Describe the efficient operation of your governing board within your organization’s structure (consistent with Attachment 3: Project Organizational Chart) to ensure that the board maintains authority and oversight of the project, as outlined in Attachments 2: Bylaws and 6: Co-Applicant Agreement, and recorded in board minutes and other relevant documents. Specifically:

a) Describe how your governing board ensures that no individual, entity, or committee (including, but not limited to, an executive committee authorized by the board) may reserve or have approval/veto power over the board with regard to the required authorities and functions.

b) Describe how collaboration or agreements with the other entities do not restrict or infringe upon your governing board’s required authorities and functions.

c) Describe the process (vs. the content of the policies themselves) for adopting, evaluating (at least once every three years), and updating (if necessary) the following policies:
  - Sliding Fee Discount Program.
  - Quality Improvement/Assurance Program.
  - Billing and Collections.
  - Financial Management.
  - Personnel.

d) Applicants requesting PHPC designation: Document how 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) INDIAN TRIBES OR TRIBAL, INDIAN, OR URBAN INDIAN GROUPS ONLY:
Describe your organization’s governance structure, operation, and process for assuring adequate:

a) Input from the community/target population on health center priorities.

b) Fiscal and programmatic oversight of the proposed project.

iv. Budget Narrative
LAL designation is based on program compliance, organizational capacity to accomplish the project’s goals, and the determination that continued designation would be in the best interest of the federal government.

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 designation 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:** Explain personnel costs by listing each staff member who will be directly employed by the LAL, name (if possible), position title, percent full-time equivalency, and annual salary.

**Fringe Benefits:** List the components that comprise the fringe benefit rate (e.g., health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement). The fringe benefits should be directly proportional to the portion of personnel costs reported under Personnel.

**Travel:** List travel costs according to local and long distance travel. For local travel, outline the mileage rate, number of miles, reason for travel, and staff members/patients/board members completing the travel. The budget should also reflect travel expenses (e.g., airfare, lodging, parking, per diem) for each person and trip associated with participating in meetings and other proposed trainings or workshops.

**Equipment:** List equipment costs and provide justification for the need of the equipment to carry out the program’s goals. 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. Any items that do not meet the threshold for equipment are considered supplies (see definition below).

**Supplies:** Personal property, excluding equipment and tangible property, with an acquisition cost less than $5,000. List the items that will be used to implement the proposed project. Separate items into three categories: office supplies (e.g., paper, pencils), medical supplies (e.g., syringes, blood tubes, gloves), and educational supplies (e.g., brochures, videos). Items must be listed separately.
**Contractual:** Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. For proposed contracts, provide the basis for your cost estimate. You are responsible for ensuring that your organization has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring contracts. For consultant services, list the total costs for all consultant services. Identify each consultant, the services each consultant will perform, total number of work days, travel costs, and total estimated costs. Refer to Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75 for regulations regarding contractor agreements.

Per the suspension and debarment rules in the Uniform Administrative Requirements, as implemented by HRSA under 45 CFR § 75.212, non-federal entities and contractors are subject to the non-procurement debarment and suspension regulations implementing Executive Orders 12549 and 12689, 2 CFR parts 180 and 376. These regulations restrict awards, subawards, and contracts with certain parties that are debarred, suspended, or otherwise excluded from or ineligible for participation in federal assistance programs or activities.

**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., EHR provider licenses, audit, legal counsel). In some cases, rent, utilities, and insurance fall under this category if they are not included in an approved indirect cost rate.

You may include the cost of access accommodations as a part of your project’s budget, including sign language interpreters, plain language materials in alternate formats (e.g., Braille, large print), and linguistic competence modifications (e.g., translation or interpretation services).

**Indirect Charges:** Indirect costs are costs incurred for common or joint objectives. While indirect costs are not identified within a particular project or program, they are necessary to the operations of the organization (e.g., the cost of operating and maintenance, depreciation, administrative salaries). For some institutions the term “facilities and administration” (F&A) is used to denote indirect costs. Visit [https://rates.psc.gov/](https://rates.psc.gov/) to learn more about rate agreements, including the process for applying to them.

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

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 HRSA EHB. Refer to Appendix A for Program-Specific Forms instructions and Appendix B for Performance Measure Forms instructions. Sample forms are available at the RD Technical Assistance Web site.

- Cover Page
- Form 1A: General Information Worksheet
- Form 2: Staffing Profile
- Form 3: Income Analysis
- Form 3A: Look-Alike Budget Information
- Form 4: Community Characteristics
- Form 5A: Services Provided
- Form 5B: Service Sites
- Form 5C: Other Activities/Locations (if applicable)
- 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

Provide the following items in the order specified below to complete the content of the application. Unless otherwise noted, attachments count toward the application page limit. Indirect cost rate agreements will not count toward the page limit. Each attachment must be clearly labeled.

Label each attachment according to the number provided (e.g., Attachment 2: Bylaws). Merge similar documents (e.g., collaboration documentation) into a single file. Provide a table of contents for attachments with multiple components. Attachment-specific table of contents pages are not counted toward the page limit. Number the electronic pages sequentially, restarting at page 1 for each attachment. NOTE: The HRSA EHB will not accept file attachments with 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), and Health Center Program award recipients, look-alikes, and other health care providers serving the zip codes. You should create the maps using UDS Mapper, available at https://www.udsmapper.org/index.cfm. When utilizing UDS Mapper, you may need to place markers for the locations of other major private provider groups serving low income/uninsured patients.

Include the corresponding table created automatically by the UDS Mapper. This table lists:

- Each zip code tabulation area (ZCTA) in the service area.
- The number of Health Center Program award recipients and look-alikes serving each ZCTA.
- The dominant award recipient serving each ZCTA.
- Total population for each ZCTA.
- Low-income population for each ZCTA.
- Total Health Center Program award recipient patients, low-income population, and total population penetration levels for each ZCTA and for the overall proposed service area.

See the RD Technical Assistance Web site 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, available at http://www.udsmapper.org/tutorials.cfm.

Attachment 2: Bylaws
Upload a complete copy of 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: Project 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 Management Staff
Upload current position descriptions for key management staff: CEO, CD, CFO, CIO, COO, and 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 role, responsibilities, and qualifications.

Attachment 5: Biographical Sketches for Key Management Staff
Upload current biographical sketches for key management staff: CEO, CD, CFO, CIO, COO, and PD. Biographical sketches should not exceed two pages each. Biographical sketches must include training, language fluency, and experience working with the cultural and linguistically diverse populations to be served, as applicable.

Attachment 6: Co-Applicant Agreement (as applicable)
Public center applicants that have a co-applicant board must submit a complete copy of the formal co-applicant agreement signed by both the co-applicant governing board and the public center. See the RESOURCES/CAPABILITIES and GOVERNANCE sections of the Project Narrative for more 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 and 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 to an affiliate or subsidiary organization), denote this with an asterisk (*).

Attachment 8: Collaboration Documentation
Upload current dated documentation of collaboration activities to provide evidence of commitment to the project. See the COLLABORATION section of the Project Narrative for details on required documentation. Letters of support should be addressed to the organization’s board, CEO, or other appropriate key management staff member (e.g., Clinical Director), and must be submitted with the application for consideration.

Attachment 9: Sliding Fee Discount Schedule(s)
Upload the current sliding fee discount schedule(s). See the RESPONSE section of the Project Narrative for details.

Attachment 10: Most Recent Independent Financial Audit
Upload the 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)
Include other relevant documents to support the proposed project (e.g., indirect cost rate agreements, charts, organizational brochures, lease agreements). Maximum of two uploads.
V. REVIEW AND DESIGNATION PROCESS

If you do not include all required attachments and information, your application will be considered incomplete or non-responsive. **Failure to submit the RD application by the established deadline or the submission of an incomplete or non-responsive RD application may result in conditions applied to the NLD that must be addressed to maintain designation, 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. These factors include, but are not limited to, past performance, including unsuccessful Progressive Action condition resolution, management systems, continued eligibility, and current compliance with Health Center Program requirements. HRSA may conduct onsite visits and/or use the current compliance status to inform designation decisions. Designation decisions, including designation period length, are discretionary and are not subject to appeal to any HRSA or HHS official or board.

**Designation Period Length Criteria**

The length of a designation period is determined by a comprehensive evaluation of compliance with program requirements by HRSA. 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-related conditions.
- Three or more unresolved conditions related to Health Center Program requirements in the 60-day phase of Progressive Action 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 carried over into the new designation period.

HRSA will not designate your organization if your organization has had two consecutive one-year designation periods and meets the criteria for a third consecutive one-year designation period.

VI. DESIGNATION AND REPORTING INFORMATION

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15 See the Health Center Program Compliance Manual, Chapter 2: Health Center Program Oversight for information regarding the Progressive Action process.
Notice of Designation

If you RD application is timely, complete, and eligible, HRSA will issue a new NLD prior to your current designation period end date.

Reporting

If you are re-designated, you must comply with the following reporting activities:

1) **Uniform Data System (UDS) Report** – The UDS is an integrated reporting system used to collect accurate 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. Lack of timely submission of the 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 and collects performance measure data to track progress and impact. You will receive an email notification via HRSA 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.

VII. AGENCY CONTACTS

Technical assistance regarding this instruction document is available by contacting:

Rael Ammon  
Office of Policy and Program Development  
Bureau of Primary Health Care (BPHC)  
Health Resources and Services Administration  
Telephone: (301) 594-4300  
Contact: [https://www.hrsa.gov/about/contact/bphc.aspx](https://www.hrsa.gov/about/contact/bphc.aspx) (Select either Applicant or LAL Designee, Lookalike (LAL))  
[RD Technical Assistance Web site](https://www.hrsa.gov/about/contact/bphc.aspx)

HRSA EHB system technical assistance is available by contacting:
VIII. Other Information

Technical Assistance
A technical assistance Web site has been established to provide you with copies of forms and other resources that will help you prepare your application. To review available resources, visit the RD Technical Assistance Web site.

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 designation announcements. 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, available at http://www.hrsa.gov/opa/programrequirements/phsactsection340b.pdf. The program limits the cost of covered outpatient drugs for certain federal award recipients and Health Center Program look-alikes. If you are interested in 340B Program coverage, you must register and be enrolled and comply with all 340B Program requirements. Covered entities may realize a cost savings of 20-50 percent on outpatient drug purchases through participation in the 340B Prime Vendor Program (PVP). 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, visit the Office of Pharmacy Affairs Website at http://www.hrsa.gov/opa.
Appendix A: Program-Specific Forms Instructions

Program-Specific Forms must be completed electronically in HRSA EHB. All forms are required. Sample forms are available at the RD Technical Assistance Web site.

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.
   - Enter 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, 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
      - You 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). The exception to this requirement is an application with designation for the sole service of special populations (e.g., MHC, HCH, and/or PHPC).
      - Select the MUA and/or MUP designations for the proposed service area and enter the identification number(s).
      - For inquiries regarding MUAs or MUPs, visit the Shortage Designation Website at http://www.hrsa.gov/shortage 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 Website at http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html.

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 face-to-face interaction between a patient and a licensed or credentialed 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 (Form 5A: Services Provided, Columns I and/or II) and documented in the patient’s health center chart.

A patient is an individual who had at least one visit in 2016 (current data), or is projected to have at least one visit in 2019 (projected data) in the calendar year.

Since a patient must have at least one documented visit, the number of patients cannot exceed the number of visits.

If you have more than one service site, report aggregate data for all LAL sites in the designated project.

Baseline patient data will pre-populate from the most recent UDS. 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 the Evaluative Measures section of the Project Narrative.

Do not report patients and visits for services outside of the LAL scope of project. Specifically, the scope of project defines the service sites, 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: The population types in this section do NOT refer only to the requested designation categories (i.e., CHC, MHC, HCH, and/or PHPC). If you are a look-alike designated for only CHC (General Underserved Community), you may still have patients/visits reported in the other population type categories. All patients/visits that do not fall within the Migratory and Seasonal Agricultural Workers and Families, Public Housing Residents, or the People Experiencing Homelessness categories must be included in the General Underserved Community category.

1. Project the number of unduplicated patients to be served by the end of the three-year designation period. This value will pre-populate in the corresponding cell within the table below.

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.
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.

3. To maintain consistency with the patients and visits reported in UDS, do not report patients and visits for vision or pharmacy services or other services outside the proposed scope of project.

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: The Patients and Visits by Service Type section does not have a row for total numbers since an individual patient may be included in multiple service type categories (i.e., a single patient should be counted as a patient for each service type received).

Form 2: Staffing Profile

Report personnel for the first certification year of the proposed project. Include only staff for sites included on Form 5B: Service Sites.

- Allocate staff time in the Direct Hire FTEs 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 for contracted staff.
- Contracted staff are indicated by answering “Yes” or “No” only. Do not quantify contracted staff in the Direct Hire column.

Form 3: Income Analysis

Form 3 collects the projected patient services and other income from all sources for the first year of the proposed 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, achievement of performance goals, or other service related measures.

The program income section groups billable visits and income into the same five payer groupings used in the UDS Manual. All patient service revenue is reported in this section of the form.

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

Only include patient service revenue associated with sites or services in the approved scope of project. Do not include patient service revenue for sites or services not in the approved scope of project or pending HRSA approval.

Patients by Primary Medical Insurance - Column (a): The projected number of unduplicated patients classified by payer based upon the patient’s primary medical insurance (payer billed first). The patients are classified in the same way as in the UDS Manual, Table 4, lines 7 – 12. Do not include patients who are only seen for non-billable or enabling service visits. Examples for determining where to count patients include:
  - A crossover patient with Medicare and Medicaid coverage is to be classified as a Medicare patient on line 2.
  - A Medicaid patient with no dental coverage who is only seen for dental services is to be classified as a Medicaid patient on line 1 with a self-pay visit on line 5.

Billable Visits – Column (b): Includes all billable/reimbursable visits.16 The value is typically based on assumptions about the amount of available clinician time, average visit time (based on complexity of patient conditions and use of team provider arrangements) and types of billable visits by payer. There may be other exclusions or additions, which, if significant, should be noted in the Comment/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column. (See ancillary instructions below.)

Note: The patient service income budget is primarily based upon income per visit estimates. However, some forms of patient service income that do not generate reportable visits, such as income from laboratory or pharmacy services, capitated-

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16 These visits will correspond closely with the visits reported on the UDS Manual Table 5, excluding enabling service visits.
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):** Calculated by dividing projected income in Column (d) by billable visits in Column (b).

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

**Prior FY Income – Column (e):** The income data from the health center’s most recent fiscal year, which will be either interim statement data or audit data.

**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](#) includes definitions for 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 each portion of the visit income to the payer group from which it is earned. In cases where there are deductibles and co-payments to be paid by the patient, report that income on the self-pay line. If the co-payment is to be paid by another payer, report that income on the other payer’s line. It is acceptable if you cannot accurately associate the income to secondary and subsequent sources.

**Ancillary Instructions:** All service income is to be classified by payer, including pharmacy and other ancillary service revenue. If you do not normally classify the projected ancillary or other service revenue by payer category, allocate the projected income by payer group using a reasonable method, such as the proportion of medical visits or charges. The method used should be noted in the Comments/Explanatory Notes section at the bottom of the form.
Medicaid (Line 1): Income from FQHC cost reimbursement; capitated managed care; fee-for-service managed care; Early Periodic Screening, Diagnosis, and Treatment (EPSDT); Children’s Health Insurance Program (CHIP); and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from FQHC cost reimbursement reconciliations, wrap payments, incentives, and primary care case management income.

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

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

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

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

Total (Line 6): Sum of lines 1-5.

Part 2: Other Income – Other Federal, State, Local, and Other Income
This section includes all income other than the patient service revenue shown in Part 1. This includes other federal, state, local, and other income. This section includes 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 either in-house or under contract with another entity such as a hospital, nursing home, or other health center is to be reported in Part 2: Other Income (see examples below). This would include income from in-house retail pharmacy sales to individuals who are not patients of the health center.

**Other Federal (Line 7):** Income from direct federal funds (where your organization is the recipient of a 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 CDC, Housing and Urban Development (HUD), Centers for Medicare and Medicaid Services (CMS), and Department of Health and Human Service funding under the Ryan White HIV/AIDS Program Part C. 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):** 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):** 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. Consequently, 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):** Income from private sources, such as foundations, non-profits, 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):** Income from private entities and individual donors that may be the result of fund raising.

**Other (Line 12):** Incidental income not reported elsewhere, including items such as interest income, patient record fees, vending machine income, dues, and rental income. Applicants typically have at least some other income to report on Line 12.

**Applicant (Retained Earnings) (Line 13):** The amount of funds needed from your organization’s retained earnings or reserves, in order to achieve a breakeven budget.
Explain in the Comments/Explanatory notes section why applicant funds (retained earnings) are needed to achieve a breakeven budget. Amounts from non-federal sources, combined with the Health Center Program funds, should be adequate to support normal operations.

**Total Other (Line 14):** The sum of lines 7 to 13.

**Total Non-Federal (Line 15):** The sum of Lines 6 and 14.

**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 the Budget Narrative section for a definition of each expense category), 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.

**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 category. If you are a State agency, leave the State row blank and include State funding in the Applicant row. If revenue is collected from sources other than those listed, indicate the additional sources in the Other category. The total fields are calculated automatically as you move through the form.
Form 3A should be consistent with amounts described in the budget narrative.

**Form 4: Community Characteristics**
Report current service area and target population data. If you compile data from multiple data sources, the total numbers may vary across sources. If this is the case, make adjustments as needed to ensure that the total numbers for the first four sections of this form match. Adjustments must be explained in the NEED section of the Project Narrative.

Service area data must be specific to the LAL project and include the total number of individuals for each characteristic (percentages will automatically calculate in HRSA 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 HRSA 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 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 must match.

**Guidelines for Reporting Race**
- Classify all individuals 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. 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 designation factor.
- 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, Saipan, Kosrae, Ebeye, Pohnpei, 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 and Select Population Characteristics**
The Special Populations section of Form 4 does not have a row for total numbers. Count individuals representing multiple special population categories in all applicable categories.
Forms 5A: Services Provided, 5B: Service Sites, and 5C: Other Activities/Locations

- These forms will be pre-populated and cannot be modified, to ensure that they reflect the current scope of project.
- If the pre-populated data do not reflect recently approved scope changes, click the **Refresh from Scope** button in HRSA EHB to display the latest scope of project. Note: If you have a pending Scope Adjustment or Change in Scope application, changes will not be included until the Scope Adjustment or Change in Scope has been approved.
- If your organization is re-designated, only the services, sites, and other activities/locations listed on these forms will be considered to be in the approved scope of project, regardless of what is described elsewhere in the application.
- Changes in services, sites, and other activities/locations require prior approval through a Scope Adjustment or Change in Scope request submitted in HRSA EHB.
- Refer to the **Scope of Project** documents and resources for details pertaining to defining and changing scope (i.e., services, sites, service area zip codes, target population).

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.**

17 Public centers with co-applicant health center governing boards must list the co-applicant board members.

- 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 non-voting members (e.g., PD, advisory board members).
- 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. For the purposes of board composition only, a patient is an individual who has received at least one service in the past 24 months that generated a health center visit, where both the service and the site where the service was received are within the HRSA-approved scope of project.
- 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., individuals experiencing homelessness, migratory and seasonal agricultural workers and families, residents of public housing).

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17 Refer to the [Health Center Program Compliance Manual](#), Chapter 19: Board Authority and Chapter 20: Board Composition for information on Governance requirements.
• Indicate the total gender, ethnicity, and race of board members who are patients of the health center. Information provided regarding race and ethnicity will be used to ensure compliance with statutory and regulatory governing board requirements.

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 percent 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, present a “good cause” justification describing the need for a waiver of the patient majority board composition requirement, including:
  o The unique characteristics of the special population (migratory and seasonal agricultural workers advocate, former homeless individual, current resident of public housing) or service area that create an undue hardship in recruiting a patient majority.
  o Attempts to recruit a majority of special population board members within the last three years and why these attempts have not been successful.
  o Strategies that will ensure patient participation and input in the direction and ongoing governance of the organization by addressing the following:
    ▪ Collection and documentation of input from the special population(s).
    ▪ Communication of special population(s) input directly to the health center governing board.
    ▪ Incorporation of special population(s) input into key areas, including but not limited to: selecting health center services; setting hours of operation of health center sites; defining budget priorities; evaluating the organization’s progress in meeting goals, including patient satisfaction; and assessing the effectiveness of the sliding fee discount program.

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. 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/Subaward 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.

**Form 12: Organization Contacts**

As necessary, revise the pre-populated data.

**Scope Certification Form**

This form requires certifications for Form 5A: Services Provided and Form 5B: Service Sites. First, certify that the scope of project for services (including service delivery methods) is accurate, as presented on Form 5A: Services Provided in the 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 Scope Adjustment or Change in Scope (CIS) request to HRSA to correct the presented information.**
Appendix B: Performance Measures Instructions

CLINICAL AND FINANCIAL PERFORMANCE MEASURES
The Clinical and Financial Performance Measures forms record the project’s 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 and sample forms are available at the RD Technical Assistance Web site. Refer to the UDS Manual for specific measurement details such as exclusionary criteria.

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

Required Financial Performance Measures
1. Total Cost per Patient
2. Medical Cost per Medical Visit

New and Updated Performance Measures
- Two required Clinical Performance Measures have been revised and four have been renamed, as noted above.\(^1\)

Important Details about the Performance Measures Forms
- The Dental Sealants for Children between 6-9 Years Clinical Performance Measure is currently only applicable to health centers that provide preventive dental services directly or by a formal arrangement in which the health center

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\(^1\) Refer to Program Assistance Letter 2017-02: Approved Uniform Data System Changes for Calendar Year 2017 for details about new and updated performance measures.
pays for the service (Form 5A, Columns I and/or II). A health center that only provides preventive dental services via a formal referral (Form 5A, Column III) may set the goal for this performance measure as zero. If the goal for the Dental Sealants for Children between 6-9 Years performance measure will be set to 0, 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 0 and provide a date by which baseline data will be available.

- If you are applying for designation to serve special populations (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing), you must include 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, you must reference the target group in the performance measure. For example, if you are seeking designation to serve people experiencing homelessness, then you must propose to measure “the percentage of people experiencing homelessness who…” rather than simply “the percentage of patients 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.

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

### Additional Performance Measures

In addition to the required Clinical and Financial Performance Measures, you may identify other measures relevant to your target population and/or health center. 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 in the Additional Performance 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.

### Resources for the Development of Performance Measures

You may find it useful to:

- 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 your UDS Health Center Trend Report and/or Summary Report available in HRSA EHB when considering how improvements to past performance can be achieved. For help with accessing reports in HRSA EHB, contact the BPHC Helpline by submitting a request through the Web portal (https://www.hrsa.gov/about/contact/bphc.aspx) or calling 877-974-2742.