# Health Center Program Site Visit Protocol:

# Consolidated Documents Checklist

*Last updated: May 26, 2022*

**NOTE**: This resource complements the Site Visit Protocol (SVP), which is the primary tool for assessing compliance with Health Center Program requirements during Operational Site Visits (OSVs). Refer to the Health Center Program Compliance Manual as the principal resource to assist health centers in understanding and demonstrating compliance with Health Center Program requirements and the SVP for complete guidance on OSVs.

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# NEEDS ASSESSMENT

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Service area reports or analysis documentation.
- Most recent needs assessment and documentation (for example, studies, resources, reports) used to develop the needs assessment.

# REQUIRED AND ADDITIONAL HEALTH SERVICES

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- For services delivered via Column I of the health center's current Form 5A: Services Provided, provide a list of service sites to be toured. Sites selected are those where the majority of services are provided directly by the health center. If the health center has more than one service site, the list must include at least two health center service sites.
- For health centers with Column II services, health center internal procedures that address documentation of information in the patient's health center record for any contracted service(s) that occur at a location(s) other than a health center Form 5B in-scope site (for example, lab results, x-ray results).
- For health centers with Column III services, operating procedures for tracking and managing referred services.
- If a Column I service(s) cannot be verified through the site tours, provide documentation of service(s) provision in a current patient record.[1]
- For services delivered via Column II of the health center's current Form 5A (whether or not the service is also delivered via Column I and/or Column III):

  *Contracts/Agreements:*
  - **At least one but no more than three** written contracts/agreements for EACH Required and EACH Additional Service.
  - To assist in the review, the health center should flag all relevant provisions within contracts/agreements related to:
    - How the service will be documented in the patient's health center record; and
    - How the health center will pay for the service.

  **Note:** *The same sample of contracts/agreements is to be used for the review of Required and Additional Health Services, Clinical Staffing, and Sliding Fee Discount Program. The sampling methodologies for Required and Additional Health Services are different from Contracts and Subawards and Conflict of Interest, although they may result in some overlap in the contracts/agreements.*

  *Patient Records:*
  - Three to five health center patient records for patients who have received required and additional health services (**as specified in the methodology under demonstrating compliance element "a"**) in the past 24 months from a contracted provider(s)/organization(s).
- For services delivered via Column III of the health center's current Form 5A (whether or not the service is also delivered via Column I and/or Column II):

  *Referral Arrangements:*

[1] Health centers may choose to provide samples of patient records before or during the site visit. If patient records will be provided during the site visit, this should be communicated before the site visit to avoid any disruption or delay in the site visit process.

  - **At least one but no more than three** written referral arrangements for EACH Required and EACH Additional Service.
  - To assist in the review, the health center should flag all relevant provisions within referral arrangements related to:
    - The manner by which referrals will be made and managed; and
    - The process for tracking and referring patients back to the health center for appropriate follow-up care (for example, exchange of patient record information, receipt of lab results).

    If these provisions are not present within the referral arrangements, provide additional documentation (for example, health center standard operating procedures) that contain those provisions.

  **Note:** *The same sample of referral arrangements is to be used for the review of Required and Additional Health Services, Clinical Staffing, and Sliding Fee Discount Program.*

  *Patient Records:*

  - Three to five health center patient records for patients who have received a required and additional service(s) (**as specified in the methodology under demonstrating compliance element "a"**) in the past 24 months from a referral provider(s)/organization(s). Ensure each record clearly documents the patient's entire referral process, from initial referral to receipt of care and follow-up by the health center.
- Sample of key health center documents (for example, materials/application used to assess eligibility for the health center's sliding fee discount program, intake forms for clinical services, instructions for accessing after-hours services) translated for patients with limited English proficiency.

**Note:** *Refer to the Sampling Review Resource Guide to assist in assembling the samples for Required and Additional Health Services.*

# CLINICAL STAFFING

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Credentialing and privileging procedures (including Human Resource procedures, if applicable).
- Website URL (if applicable).
- Current clinical staffing profile: name, position, FTE, credential (for example, RN, MD), provider type (licensed independent practitioners (LIP), other licensed or certified practitioners (OLCP), or other clinical staff), hire date. Indicate staff with interpretation/translation capabilities (i.e., bilingual, multilingual).
- Needs Assessment(s) or related studies or resources.
- If clinical services are provided via Column II or III, written contracts/agreements and written referral arrangements:
  - **No more than three** contracts with provider organizations. Prioritize contracts for any clinical services that are offered only via Column II.
  - **No more than three** written referral arrangements. Prioritize referral arrangements for any clinical services that are offered only via Column III.

  **Notes:**
  - In selecting contracts and referral arrangements, select those that support clinical services (for example, general primary medical care, preventive dental). HRSA recognizes that contracts or referral arrangements for enabling services (for example, transportation, translation, outreach) may not contain provisions for credentialing and privileging.
  - The same sample of contracts/agreements is to be used for the review of Required and Additional Health Services, Clinical Staffing, and Sliding Fee Discount Program. The sampling methodologies for Clinical Staffing are different from Contracts and Subawards and Conflict of Interest, although they may result in some overlap in the contracts/agreements.
  - The same sample of referral arrangements is to be used for the review of Required and Additional Health Services, Clinical Staffing, and Sliding Fee Discount Program.
- Sample of files for current clinical staff that contain credentialing and privileging information: four to five LIP files; four to five OLCP files; and, only if applicable, two to three files for other clinical staff. For the selected files, include:
  - Representation from different disciplines and sites.
  - Providers directly employed and contracted, in addition to volunteers (if applicable).
  - Providers who do procedures beyond core privileges for their discipline(s).
  - Providers who have been initially credentialed.
  - Providers who have been re-credentialed/re-privileged.
- Contract or agreement with Credentialing Verification Organization (CVO) or other entity used to perform credentialing functions (such as primary source verification) on behalf of the health center (if applicable).

# ACCESSIBLE LOCATIONS AND HOURS OF OPERATION

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- List of health center sites, including site addresses, hours of operation by site, and information on what general services (for example, medical, oral health, behavioral health) are offered at each service site.
  **Note:** *These may be presented in separate documents or as references to health center websites.*
- Uniform Data System (UDS) Mapper Service Area Map (if updated since last application submission to HRSA).
- Patient satisfaction surveys or other forms of patient input.
- Needs assessment(s) or related studies or resources.

# COVERAGE FOR MEDICAL EMERGENCIES DURING AND AFTER HOURS

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Operating procedures for addressing medical emergencies during health center's hours of operation.
- Operating procedures for responding to patient medical emergencies after hours.
- Staffing schedules for up to five service delivery sites that identify the individual(s) with current certification in basic life support at each site.
- Provider on-call schedules and answering service contract (if applicable; for health centers whose own providers cover after-hours calls).
- Written arrangements with non-health center providers/entities (for example, formal agreements with other community providers, "nurse call" lines) for after-hours coverage (if applicable; for health centers that use non-health center providers).
- List of service delivery sites with names of at least one individual (clinical or non-clinical staff member) at each site trained and certified in basic life support, including a copy of that individual's current certification (for example, credentialing file for licensed independent practitioner or other licensed or certified practitioner, certification of training if non-clinical staff).
- Instructions or information provided to patients for accessing after-hours coverage.
- Three samples of after-hours clinical advice documentation in the patient record[2] (for example, screenshots selected by the health center), including associated documentation of follow-up.
  **Note:** *The samples will be based on after-hours calls that necessitated follow-up by the health center. If the health center has fewer than three after-hours calls that required follow-up, the health center will make up the difference with after-hours call documentation that did not require follow-up.*
- Documentation demonstrating systems/methods of tracking, recording, and storing of after-hours coverage interactions (for example, log of patient calls) and, if applicable, related follow-up.

[2] Health centers may choose to provide samples of patient records before or during the site visit. If patient records will be provided during the site visit, this should be communicated before the site visit to avoid any disruption or delay in the site visit process.

# CONTINUITY OF CARE AND HOSPITAL ADMITTING

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Health center's internal operating procedures and/or documentation from arrangements with non-health center provider(s) for tracking of patient hospitalization and continuity of care.
- Documentation of EITHER:
    - Provider hospital admitting privileges (for example, hospital staff membership, provider employee contracts) that address delivery of care in a hospital setting to health center patients by health center providers; OR
    - Formal arrangements with provider(s) or entity(ies) that address health center patient hospital admissions (for example, transfer agreement(s), supporting procedures, or other documentation of inpatient care coordination with the health center).
- Sample of 5–10 health center patient records[3] (for example, using live navigation of the Electronic Health Records (EHR), screenshots from the EHR, or actual records if the records are not electronic/EHR records) for patients who were hospitalized or who had Emergency Department (ED) visits within the past 12 months. Ensure each record clearly documents the health center's entire hospitalization tracking process, from admission and follow-up through closure.

[3] Health centers may choose to provide samples of patient records before or during the site visit. If patient records will be provided during the site visit, this should be communicated before the site visit to avoid any disruption or delay in the site visit process.

# SLIDING FEE DISCOUNT PROGRAM

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Sliding fee discount program (SFDP) policy(ies).
- SFDP procedure(s).
- Sliding fee discount schedule (SFDS), including SFDSs that differ by service or service delivery method (if applicable).
- Any related policies, procedures, forms and materials that support the SFDP (for example, registration and scheduling, financial eligibility, screening, enrollment, patient notifications, billing and collections).
- Sample of 5–10 records, files or other forms of documentation of patient income and family size. Ensure the sample includes records for:
  - Uninsured and insured patients; and
  - Initial assessments for income and family size as well as re-assessments.
- For any service delivered via Column II (whether or not the service is also delivered via Column I and/or Column III), at least one but no more than three written contracts/agreements for EACH Required and EACH Additional Service. Provide any other supporting documentation demonstrating how the health center ensures sliding fee discounts for those selected services.
  **Note:** *The same sample of contracts/agreements is to be used for the review of Required and Additional Health Services, Clinical Staffing, and Sliding Fee Discount Program. The sampling methodologies for Sliding Fee Discount Program are different from Contracts and Subawards and Conflict of Interest, although they may result in some overlap in the contracts/agreements.*
- For any service delivered via Column III (whether or not the service is also delivered via Column I and/or Column II), at least one but no more than three written referral arrangements for EACH Required and EACH Additional Service. Provide any other supporting documentation demonstrating how the health center ensures sliding fee discounts for those selected services.
  **Note:** *The same sample of referral arrangements is to be used for the review of Required and Additional Health Services, Clinical Staffing, and Sliding Fee Discount Program.*
- If the board-approved SFDP policy does not state a specific amount for nominal charge(s), other documentation (for example, board minutes, reports) of board involvement in setting the amount of nominal charge(s).
- Data, reports, or any other relevant materials used to evaluate the SFDP.
- If the health center is subject to legal or contractual restrictions regarding sliding fee discounts for patients with third-party coverage, the health center will produce documentation of such restrictions.

# QUALITY IMPROVEMENT/ASSURANCE

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Policy(ies) that establishes the Quality Improvement/Quality Assurance (QI/QA) program.
- QI/QA-related operating procedures or processes that address:
  - Clinical guidelines, standards of care, and standards of practice;
  - Patient safety and adverse events, including implementation of follow-up actions;
  - Patient satisfaction;
  - Patient grievances;
  - Periodic QI/QA assessments; and
  - QI/QA report generation and oversight.
- Systems or procedures for maintaining and monitoring the confidentiality, privacy, and security of patient records.
- Sample of patient satisfaction results.
- Sample of two QI/QA assessments from the past 12 months and/or the related reports resulting from these assessments.
- Job or position description(s) of individual(s) who oversee the QI/QA program.
- Sample of 5–10 health center patient records[4] (for example, using live navigation of the Electronic Health Records (EHR), screenshots from the EHR, or actual records if the records are not electronic/EHR records) that include clinic visit note(s) and/or summary of care.
  **Note:** *The same sample of patient records used for reviewing other program requirement areas also may be used for this sample.*
- Documentation for related systems that support QI/QA (if applicable) (for example, event reporting system, tracking resolutions and grievances, dashboards).
- QI/QA assessment schedule or calendar.

[4] Health centers may choose to provide samples of patient records before or during the site visit. If patient records will be provided during the site visit, this should be communicated before the site visit to avoid any disruption or delay in the site visit process.

# KEY MANAGEMENT STAFF

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Health center organization chart(s) with names and titles of key management staff (if updated since last submission to HRSA).
- Position descriptions of key management staff (if updated since last submission to HRSA).
- Bios or resumes for key management staff (if updated since last application submission to HRSA).
- Co-applicant agreement (if applicable) (if updated since last application submission to HRSA).
- Human Resources procedures relevant to recruiting and hiring of key management staff (if applicable, for health centers with key management staff vacancies).
- Project Director/CEO employment agreement.
- Project Director/CEO's W-2 or, if a W-2 has not yet been issued, documentation of receipt of salary directly from the health center (for example, pay stub).
- Notice of Award (NOA)/Notice of Look-Alike Designation (NLD) approving any Project Director/CEO position change(s) since start of the current project period or designation period OR documentation that a prior approval request(s) for such change(s) is still under review by HRSA.
- Contracts for key management staff (if applicable).
- Documentation associated with filling key management staff vacancies (if applicable) (for example, job advertisements, revised position descriptions).

# CONTRACTS AND SUBAWARDS

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Procedures for purchasing and procurement, including, if applicable or separate, procedures for contracting and contract management.
- Policies/procedures for subrecipient monitoring.
- Most recent annual audit and management letters.
- If the health center has contracts that support the HRSA-approved scope of project (i.e., to provide health center services or to acquire other goods and services), provide a complete list of these contracts. Include all active contracts and all contracts that had a period of performance which ended less than 3 years ago. In the list, include all of the following information for each contract:
    - Whether the health center uses federal award funds to pay in whole or in part for the contract (not applicable to look-alikes);
    - Contractor/contract organization;
    - Value of the contract (if there is a federal share, state the federal share amount);
    - Brief description of the good(s) or service(s) provided; and
    - Period of performance/timeframe (for example, ongoing contractual relationship, specific duration).
- All subrecipient agreements (if updated since last application submission to HRSA) (not applicable to look-alikes and as applicable for awardees) that support the awardee's Health Center Program scope of project.
  **Note:** *Per 45 CFR 75.351(c): "In determining whether an agreement between a pass-through entity [Health Center Program awardee] and another non-federal entity casts the latter as a subrecipient or a contractor, the substance of the relationship is more important than the form of the agreement. All of the characteristics [listed above; see 45 CFR 75.351(a) and (b)] may not be present in all cases, and the pass-through entity [Health Center Program awardee] must use judgment in classifying each agreement as a subaward or a procurement contract."*
- Based on the list of contracts provided before the site visit that support the HRSA-approved scope of project:
    - Five contracts AND related supporting procurement documentation for actions that **use federal award funds.** Choose the contracts that use the largest amounts of federal award funds.
      **Note:** *The same sample of contracts/agreements is to be used for the review of both Contracts and Subawards and Conflict of Interest. The sampling methodologies for Contracts and Subawards are different from Required and Additional Health Services, Clinical Staffing, and Sliding Fee Discount Program, although they may result in some overlap in the contracts/agreements.*
    - Sample of five contracts AND related supporting procurement documentation for actions that **do NOT use federal award funds**.
- Two to three reports or records (for example, monthly invoices or billing reports, data run of patients served, visits provided) drawn from the sample of contractors selected from the list provided before the site visit.

- Documentation of subrecipient monitoring methods (not applicable to look-alikes and as applicable for awardees).
- Sample of financial and performance reports from within the current project period from the subrecipient, including the subrecipient's annual audit (not applicable to look-alikes and as applicable for awardees).
- Documentation of prior approval for contracts for the performance of substantive work (i.e., contracting with a single entity for the majority of health care providers) under the federal award (if applicable).
- Documentation of prior approval of subrecipient arrangement(s) (not applicable to look-alikes and as applicable for awardees).
- Documentation of subrecipient monitoring by the health center (that occurred during the current project period).
- Findings from the health center's subrecipient monitoring process on subrecipient deficiencies (if applicable) and documentation that the health center has ensured the subrecipient has taken corrective action.
- The following documentation used by the health center to confirm subrecipient compliance:
  - Subrecipient articles of incorporation, bylaws, or other corporate documents;
  - Subrecipient sliding fee discount program (SFDP) policy;
  - Current subrecipient board roster or Form 6A (the latter, if subrecipient is a Health Center Program awardee or look-alike) indicating current board member characteristics as follows:
    - For all board members: patient status, area of expertise, and percentage income from the healthcare industry; and
    - For patient board members: gender, race, and ethnicity;
  - Subrecipient billing records from within the past 24 months to confirm the patient status of subrecipient board members;
  - Subrecipient's portion of Uniform Data System (UDS) data for an overview of subrecipient patient population demographic factors (race, ethnicity, and gender); and
  - If the subrecipient board-approved SFDP policy does not state a specific amount for nominal charge(s), other documentation (for example, subrecipient board minutes, subrecipient reports) of subrecipient board involvement in setting the amount of nominal charge(s).

# CONFLICT OF INTEREST

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Procedures for purchasing and procurement, including, if applicable or separate, procedures for contracting and contract management.
- Two most recent annual audits and management letters.
- Documentation containing the health center's standards of conduct (for example, articles of incorporation, bylaws, board manual, employee manual, policies and procedures, disclosure forms). For contracts that support the HRSA-approved scope of project, five contracts AND related supporting procurement documentation for actions that **use federal award funds.** Choose the contracts that use the largest amounts of federal award funds.
  **Note:** *The same sample of contracts/agreements is to be utilized for the review of both Contracts and Subawards and Conflict of Interest. The sampling methodologies for Conflict of Interest are different from Required and Additional Health Services, Clinical Staffing, and Sliding Fee Discount Program, although they may result in some overlap in the contracts/agreements.*
- For look-alikes that have a parent, affiliate, or subsidiary that is not a state, local government, or Indian tribe: five contracts AND related supporting procurement documentation for procurements involving the related parent, affiliate or subsidiary organization(s). Contracts in the sample are either active or have a period of performance which ended less than 3 years ago.
- In cases where a real or apparent conflict of interest was identified in the procurement action, related written disclosures (for example, board minutes documenting disclosure(s), standard form(s) to report disclosure(s)) completed by employees, officers, board members, and agents of the health centers.
- Agreements with parent corporation, affiliate, subsidiary, or subrecipient organization (if applicable).

# COLLABORATIVE RELATIONSHIPS

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Documentation of established collaboration with other providers and organizations in the health center's service area, including local hospitals, specialty providers, and social service organizations, to provide access to services not available through the health center.
- Documentation of coordination efforts with other federally-funded, as well as state and local, health services delivery projects and programs serving similar patient populations in the service area. At a minimum, this includes documentation of efforts to establish coordination with one or more health centers in the service area (for example, email or other correspondence of requests and responses for coordination).
- Uniform Data System (UDS) Mapper documentation showing other health centers with sites in the service area.

**Note:** *Examples of collaboration or coordination documentation may include but are not limited to memoranda of agreement (MOAs) or memoranda of understanding (MOUs); letters; monthly collaboration meeting agendas with health center leaders; cross-referral of patients between health centers; or evidence of membership in a city-wide community health planning council or emergency room diversion program.*

# FINANCIAL MANAGEMENT AND ACCOUNTING SYSTEMS

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Financial management and internal control procedures (may also be in the form of financial/accounting policies, manuals, or other related documents).
- Procedures for drawdown, disbursement, and expenditure of federal award funds (may be included in the financial management and internal control procedures or may be separate).
- Policies or procedures that govern and track the use of non-grant funds.
- Two most recent annual audits and management letters.
- Sample of two financial reports provided to the board and key management staff (selected from the past 6 months) including the most recent interim financial statements.
- Manuals or documentation of the financial management system(s) used by the health center (for example, financial accounting software, practice management system). **Note:** *Some or all of the financial management system(s) may be contracted out or carried out via a Health Center Controlled Network.*
- Sample of source documentation to support expenditures made under the federal Health Center Program award for the last quarter:
  - Drawdowns under the Health Center Program award with supporting documentation (for example, financial records, receipts, invoices);
  - Last non-payroll drawdown under the Health Center Program award with supporting documentation;
  - If there was a capital-related Health Center Program award drawdown within the last 3 years, the last capital drawdown with supporting documentation; and
  - Copy of the journal entry that records these drawdowns in the general ledger under the Health Center Program award.
- Aged Accounts Receivable (as of most recent interim financial statements).
- Aged Accounts Payable (as of most recent interim financial statements).

# BILLING AND COLLECTIONS

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Registration, eligibility, outreach, and enrollment procedures.
- Current fee schedule(s) for each service area (for example, medical, dental, behavioral health).
- Billing and Collections policies or procedures and systems including:
  - Provision(s) to waive or reduce fees owed by patients;
  - Third-party payor billing procedures and/or contracts;
  - Refusal to pay policy (if applicable); and
  - Procedures for notifying patients of additional costs for supplies and equipment related to but not included in the service (if applicable).
- List of provider and program/site billing numbers for Medicaid, CHIP, Medicare, or any other documentation of participation (for example, individual provider NPIs).
- Current data on the following revenue cycle management metrics, if available: collection ratios, bad debt write off as a percentage of total billing, collections per visit, charges per visit, percentage of accounts receivable (A/R) less than 120 days, days in A/R (for context on billing and collections efforts).
- Sample of claims submissions and resubmissions. For the sample, randomly choose 7 claims submissions and resubmissions for patient visits reflective of the health center's major third-party payors from across at least 3 unique services (for example, routine primary care, preventive dental, behavioral health, obstetrics) for a total of at least 21 claims submissions and resubmissions reviewed. Within this sample of 21 claims submissions and resubmissions, include at least 7 rejected claims.
- Report showing the last 6 months of claims data, specifically including the claims numbers, dates of service, and dates claims were filed/billed.
- Sample of billing and payment records for charges requested from patients. For the sample, randomly choose 5 records for patient visits from across at least 3 unique services (for example, routine primary care, preventive dental, behavioral health, obstetrics) for a total of at least 15 records reviewed:
  - Ensure the sample includes patients that are eligible for the health center's sliding fee discount program (SFDP) (i.e., incomes at or below 200 percent of the Federal Poverty Guidelines (FPG)).
  - If applicable, include records for patients that are not eligible for the SFDP (i.e., incomes above 200 percent of the FPG).
- Sample of two to three billing records where patient fees were waived or reduced.
- Documentation of methods for notifying patients of additional costs for supplies and equipment related to but not included in the service (if applicable).
- Documentation of cases where the health center has applied its refusal to pay policy within the past 24 months (if applicable).
- Documentation used to determine fee schedule(s) based on health center costs and locally prevailing rates (for example, operating costs for service delivery, relative value units (RVUs) or other relevant data sources, Medicare/Medicaid cost reports).

- Documentation of participation in other public or private program or health insurance plans (if applicable) (for example, list or copy of third-party payor contracts including any managed care contracts).
- Contracts with outside organizations that conduct billing or collections on behalf of the health center (if applicable).

# BUDGET

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Updated annual budget for the health center project (if updated since last application submission to HRSA).
- Financial management procedures (for context and background on budget development process).
- Most recent annual audit and management letters or audited financial statements (as reference for any other lines of business).
- Budget to actual comparison reports for the current fiscal year and the prior fiscal year.
- Separate organizational budget(s) (if applicable) (in situations where the health center has an organizational budget that is separate from the budget for the health center project).

# PROGRAM MONITORING AND DATA REPORTING SYSTEMS

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Sample of one to two data-based reports generated by the health center for the governing board or key management staff from the past 12 months (for example, dashboards, board packets, reports provided to the Finance or Quality Improvement Committee, routine reports generated by the health center for key management staff) that include information on:
  - Patient service utilization;
  - Trends and patterns in the patient population; and
  - Overall health center clinical, financial, or operational performance.

# BOARD AUTHORITY

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Health center organization chart(s) with names of key management staff.
- Corporate organization chart(s) (only applicable for public agencies or for organizations with a parent or subsidiary).
- Articles of Incorporation.
- Bylaws (if updated since last application submission to HRSA).
- Co-applicant agreement (if applicable) (if updated since last application submission to HRSA).
- Position description for the Project Director/CEO.
- Board calendar or other related scheduling documents for most recent 12 months.
- Board agendas and minutes for:
    - Most recent 12 months.
    - Any other relevant meetings from the past 3 years that demonstrate board authorities were explicitly exercised, including approving key policies on:
        - Sliding Fee Discount Program;
        - Quality Improvement/Assurance Program;
        - Billing and Collections (policy for waiving or reducing patient fees and if applicable, refusal to pay);
        - Financial Management and Accounting Systems; and
        - Personnel.
- Sample board packets from two board meetings from within the past 12 months.
- Board committee minutes OR committee documents from the past 12 months.
- Strategic plan or long term planning documents within the past 3 years.
- Most recent evaluation of Project Director/CEO.
- Project Director/CEO employment agreement (for the purposes of provisions regarding Project Director/CEO selection, evaluation, and dismissal or termination).
- Agreements with parent corporation, affiliate, subsidiary, or subrecipient organization (if applicable).
- Collaborative or contractual agreements with outside entities that may impact the health center board's authorities or functions.

# BOARD COMPOSITION

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Health center organization chart(s) with names of key management staff.
- Corporate organization chart(s) (only applicable for public agencies or for organizations with a parent or subsidiary).
- Updated Form 6A or Board Roster (if board composition has changed since last application submission to HRSA).
- Articles of Incorporation.
- Bylaws (if updated since last application submission to HRSA).
- Co-applicant agreement (if applicable) (if updated since last application submission to HRSA).
- Documentation regarding board member representation (for example, applications, bios, disclosure forms).
- Billing records from within the past 24 months to verify board member patient status.
- For health centers with approved waivers, examples of the use of special populations input (for example, board minutes, board meeting handouts, board packets).

# FEDERAL TORT CLAIMS ACT (FTCA) DEEMING REQUIREMENTS

**Note:** *HRSA provides the documents included in your last application (Service Area Competition (SAC) or New Access Point (NAP)). Health centers do not need to submit these documents again unless the documents changed.*

- Risk management policy(ies) and related operating procedures or protocols (including but not limited to procedures for tracking referrals, diagnostics, and hospital admissions ordered by health center providers, incident reporting for clinically-related complaints, and “near misses”).
  **Note:** *Health centers may have distinct “risk management” operating procedures OR these may be included or integrated within other health center operating procedures or protocols (for example, Human Resources, Quality Improvement/Quality Assurance, Admin, Clinical, Infection Control).*
- Claims management process policy(ies)/procedures.
- Most recent HRSA-approved FTCA deeming application.
- Risk management training plan and documentation of completed training.
- Example(s) of methods used to inform patients of the health center’s deemed status (for example, website, promotional materials, statements posted within an area(s) of the health center visible to patients).
- Documentation (for example, board/committee minutes, supporting data, reports) of the last two quarterly risk management assessments of health center activities designed to reduce the risk of adverse outcomes (for example, environment of care, incident tracking, infection control, patient safety) that could result in medical malpractice or other health or health-related litigation.
- Board meeting minutes and/or most recent report(s) (within past 12 months) to the board that include the status of risk management activities.
- For health centers with **closed** claims from within the past 5 years under the FTCA: For each **closed** claim, documentation of steps implemented to mitigate the risk of such claims in the future (for example, targeted staff training, improved records management, implementation of new clinical protocols).

# ELIGIBILITY REQUIREMENTS FOR LOOK-ALIKE INITIAL DESIGNATION APPLICANTS

**Note:** *HRSA provides the documents included in your Initial Designation application. Health centers do not need to submit these documents again unless the documents changed.*

- Most recent annual audit and management letters or audited financial statements (if audits are not available).
- Health center organization chart(s) with names of key management staff.
- Corporate organization chart(s) (only applicable for public agencies or for organizations with a parent or subsidiary).
- Agreements with parent corporation, affiliate, subsidiary or other controlling organization (if applicable).
- Documentation (for example, employment contracts) that demonstrates the organization is not owned, operated, or controlled by another entity.
- Most recent co-applicant agreement (if applicable).
- If the applicant has contracts that support the proposed Health Center Program scope of project (i.e., to provide health center services or to acquire other goods and services), provide a complete list of these contracts. Include all active contracts and all contracts that had a period of performance which ended less than 3 years ago. In the list, include all of the following information for each contract:
  - Contractor/contract organization;
  - Brief description of the good(s) or service(s) provided;
  - Period of performance/timeframe (for example, ongoing contractual relationship, specific duration); and
  - Whether the contract indicates that a third party plays a substantive role in the Health Center Program project (for example, a contract with a single entity for the majority of health care providers and services, a contract with a single entity for the majority of key management staff, a contract with a single entity for the majority of administrative functions).
- All contracts/memoranda of understanding (MOUs) that indicate that a third party plays a substantive role in the Health Center Program project (for example, a contract for the majority of health care providers and services, a contract for the majority of key management staff, an administrative services agreement for the majority of administrative functions).
- Position description for the Project Director/CEO.
- Patient Services Utilization Report (for example, from the Electronic Health Records (EHR)) from within the past 6 months. Data should include patient demographics, type of services, and how the service was provided (Column I, II, or III).
- Health center selection of three to five health center patient records[5] (for example, using live navigation of the EHR, screenshots from the EHR, or actual records if the records

[5] Health centers may choose to provide samples of patient records before or during the site visit. If patient records will be provided during the site visit, this should be communicated before the site visit to avoid any disruption or delay in the site visit process.

are not electronic/EHR records) that document the provision of various required and additional health services.

- Sample of up to three Medicare or Medicaid claims or other billing documents that demonstrate under what organizational entity or unit billing is conducted.
- Project Director/CEO employment agreement.