



**Fiscal Year 2022 Look-Alike
Annual Certification
Submission Instructions**

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Release Date: August 2, 2021

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

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

TABLE 1: SUBMISSION SCHEDULE

Certification Period Start Date	EHBs Access*	EHBs Deadline
January 1, 2022	8/3/2021	10/2/2021
February 1, 2022	9/3/2021	11/2/2021
March 1, 2022	10/1/2021	11/30/2021
April 1, 2022	11/1/2021	12/31/2021
May 1, 2022	12/1/2021	1/30/2022
June 1, 2022	1/1/2022	3/2/2022

*EHBs access and deadline dates are auto-generated by EHBs. Please work within these dates and, if needed, request technical assistance prior to the deadline if the deadline falls on a weekend or holiday.

ABOUT THE ANNUAL CERTIFICATION SUBMISSION

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

Important Notice:

Due to the ongoing COVID-19 public health emergency, for LALs in a 3-year designation period scheduled to end in FY 2022, HRSA has extended designation periods by one year. These LALs must submit an AC in FY 2022 and subsequently will submit an FY 2023 Renewal of Designation (RD). HRSA plans a similar extension process for LALs whose 3-year designation periods are scheduled to end in FY 2023.

Additionally, LALs whose designation period end date is not in FY 2022 (October 1, 2021 — September 30, 2022) – those already scheduled to complete an FY 2022 AC – should submit an FY 2022 AC.¹

The AC is available in the HRSA Electronic Handbooks (EHBs) according to your certification period start date. See [Table 1: Submission Schedule](#) for the date your AC will be available in EHBs, as well as the submission deadline.

¹ Refer to item 6 of your most recent LAL Notice of Look-alike Designation (NLD) for the designation period end date.

SUMMARY OF CHANGES (COMPARED TO THE AUGUST 3, 2021 AC INSTRUCTIONS)

- Each Narrative text box in the Project Narrative Update is limited to 1,000 characters (including spaces), or approximately 1/2 page.
- The Organizational Capacity question includes multiple narrative text boxes to facilitate complete responses.
- Patient Capacity narrative is required only for negative trends.
- Nonprofit/public center documentation was added to [Form 1C: Documents on File](#).

I. TECHNICAL ASSISTANCE

Technical assistance resources are available on the [AC Technical Assistance \(TA\) webpage](#). The AC TA webpage includes copies of forms, the Electronic Handbooks (EHBs) [AC User Guide](#), and a slide presentation.

Technical assistance regarding this instructions document is available by contacting:

Karen A. Fitzgerald, MPH
Office of Policy and Program Development
HRSA Bureau of Primary Health Care
301-594-4300
<https://www.hrsa.gov/about/contact/bphc.aspx>

EHBs system technical assistance is available by contacting:

Health Center Program Support
1-877-464-4772
<https://www.hrsa.gov/about/contact/bphc.aspx>

II. GENERAL INFORMATION AND INSTRUCTIONS

GENERAL INFORMATION

Health Center Program requirements are detailed in the Health Center Program Compliance Manual ([Compliance Manual](#)).

Prior Approval for Post-Designation Changes

You are required to request prior approval from HRSA for LAL changes including, but not limited to, changes in the project director/chief executive officer (CEO) and the addition or deletion of sites or services from the approved scope of project. These changes must be requested via the Scope Adjustment and/or Change in Scope (CIS) Modules in the EHBs, as appropriate.

Accessibility Provisions and Non-Discrimination Requirements

You must comply with applicable federal civil rights laws. HRSA supports its recipients in preventing discrimination, reducing barriers to care, and promoting health equity. For more information on your civil rights obligations, visit the HRSA [Office of Civil Rights, Diversity, and Inclusion webpage](#). The HHS Office of Civil Rights (OCR) provides guidance on complying with civil rights laws that prohibit discrimination on these bases. HHS also provides specific guidance for recipients on meeting legal obligation under Title VI of the Civil Rights Act of

1964, which prohibits discrimination on the basis of race, color or national origin in programs and activities that receive federal financial assistance (42 U.S.C. § 2000d, and implementing regulations at 45 CFR part 80).

INSTRUCTIONS

The EHBs system will send an email to your LAL’s contacts identified in the system 150 days prior to the end of the certification period to inform them that the submission is accessible in the EHBs. Once notified that the AC is available within the EHBs, you will have 60 days to complete and submit it in the EHBs system. AC submissions are due 90 days prior to the end of the certification period.

Current Certification Period



AC submissions that fail to include all required documents and information will be considered incomplete or non-responsive. Incomplete or non-responsive AC submissions will be returned through a “Request Change” notification via the EHBs for the provision of missing information or clarification. You are required to submit an AC by the established deadline within the certification period.

Note: Failure to submit a timely and complete AC may result in termination of the LAL designation and all corresponding benefits. Review your AC to ensure it is both complete and responsive prior to submission.

[Table 2: Submission Components](#) identifies the required AC components. In the Form Type column of Table 2, the word “Form” refers to forms that are completed online in the EHBs. The word “Document” refers to materials that must be uploaded into the EHBs.

TABLE 2: SUBMISSION COMPONENTS

- The [Budget Narrative](#) is the only document that you should upload within the EHBs.
- Samples of Form 1C: Documents on File, Form 3: Income Analysis, Form 3A: Look-Alike Budget Information, the Project Narrative Update, and the Budget Narrative are available on the [AC TA webpage](#).
- Refer to [Appendix A: Program Specific Forms Instructions](#) for detailed instructions on completing the forms listed in the table, unless otherwise noted.

AC Section	Form Type	Instructions
Cover Page	Form	Provide a summary of information related to the project.
Budget Narrative	Document	Provide a line-item budget for the upcoming certification period.
Form 1C: Documents on File	Form	Provide the dates when the listed documents were last updated, if applicable.
Form 3: Income Analysis	Form	Provide projected program income for the upcoming certification period.
Form 3A: Look-Alike Budget Information	Form	Provide the budget for the upcoming certification period.
Forms 5A, 5B, and 5C	Fixed	These forms are pre-populated to reflect the current approved scope of project and are only provided for reference only. If any information is incorrect in these forms, submit your request for change via the Scope Adjustment or CIS Modules in EHBs. Refer to the Scope of Project TA Webpage and/or contact your project officer for additional guidance.
Project Narrative Update	Form	Refer to Section III for detailed instructions.

III. INSTRUCTIONS FOR THE PROJECT NARRATIVE UPDATE

Note: Narrative response in each section is limited to 1,000 characters (including spaces), or approximately 1/2 page.

- 1. Organizational Capacity:** Discuss major changes, since the last certification period, in the organization's capacity that have impacted or may impact the progress of the designated project, including changes in:
 - Staffing, including key vacancies;
 - Operations, including changes in policies and procedures as they relate to COVID-19; and
 - Financial status, including the most current audit findings, as applicable.

Include a discussion of the following for each area outlined above:

- Progress and changes to date;
- Impact of COVID-19;
- Expected progress for the remainder of the FY 2021 certification period; and
- Projected changes for the FY 2022 certification period.

2. **Patient Capacity:** See [Table 3: Patient Capacity](#). Discuss negative trends in patients and plans for reaching the projected number of patients.

Note: You are only required to respond to the Patient Capacity section if you are experiencing a **negative** trend for any of the fields in Table 3: Patient Capacity. The system will not require narrative if you have not experienced a negative trend.

TABLE 3: PATIENT CAPACITY

	2018 Patient Number	2019 Patient Number	2020 Patient Number	% Change 2018-2020 Trend	% Change 2019-2020 Trend	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
Designation Period: (Pre-populated from most recent Notice of Look-Alike Designation)								
Total Unduplicated Patients	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated from 2020 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	1,000 character limit
Total Migratory and Seasonal Agricultural Worker Patients	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated from 2020 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	1,000 character limit
Total People Experiencing Homelessness Patients	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated from 2020 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	1,000 character limit
Total Public Housing Resident Patients	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated from 2020 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	1,000 character limit

Notes:

- 2018 – 2020 Patient Number data are pre-populated from Tables 3a and 4 in the UDS Report.
- If you did **not** experience a negative trend in Patient Capacity, the system will not require narrative in the Patient Capacity Narrative column.
- The Projected Number of Patients value is pre-populated from the patient projections in the LAL submission that initiated your current designation period.
- The Projected Number of Patients values cannot be edited during the AC submission. If these values are not accurate, provide adjusted projections and an explanation in the Patient Capacity Narrative section.

	2018 Patient Number	2019 Patient Number	2020 Patient Number	% Change 2018-2020 Trend	% Change 2019-2020 Trend	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
Designation Period: (Pre-populated from most recent Notice of Look-Alike Designation)								
Total Medical Services Patients	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated from 2020 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	1,000 character limit
Total Dental Services Patients	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated from 2020 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	1,000 character limit
Total Mental Health Services Patients	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated from 2020 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	1,000 character limit
Total Substance Use Disorder Services Patients	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated from 2020 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	1,000 character limit
Total Vision Services	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated from 2020 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	1,000 character limit
Total Enabling Services Patients	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated from 2020 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	1,000 character limit
Notes: <ul style="list-style-type: none"> • 2018-2020 Patient Number data are pre-populated from Table 5 in the UDS Report. • If you did not experience a negative trend in Patient Capacity, the system will not require narrative in the Patient Capacity Narrative column. • The Projected Number of Patients value is pre-populated from the patient projections in the LAL submission that initiated your current designation period. • The Projected Number of Patients values cannot be edited during the AC submission. If these values are not accurate, provide adjusted projections and an explanation in the Patient Capacity Narrative section. 								

IV. BUDGET PRESENTATION INSTRUCTIONS

LAL designation is based on progress toward accomplishing the project's goals and a determination that continued designation would be in the best interest of the federal government.

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

Note: The AC may not be used to request changes in the designation type(s).²

Budget Narrative

Provide a detailed budget narrative in line-item format for the upcoming certification period. An itemization of revenues and expenses is necessary. Upload the budget narrative in the Appendices section in the EHBs. Definitions for the expense categories are as follows:

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

Fringe Benefits: List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plans, and tuition reimbursement. The fringe benefits should be directly proportional to the portion of personnel costs that are allocated for the project.

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 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), with a per-unit cost of \$5,000 or more and a useful life of one or more years (e.g., large items of medical equipment). Any items that do not meet the threshold for equipment are considered supplies (see definition below).

Supplies: 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.

² Community Health Center – CHC, Migrant Health Center – MHC, Health Care for the Homeless – HCH, and/or Public Housing Primary Care – PHPC

Per [45 CFR § 75.321](#), property will be classified as supplies if the acquisition cost is under \$5,000 per item. Note that items such as laptops, tablets and desktop computers are classified as supplies if the value is under the \$5,000 per item equipment threshold.

Contractual/Consultant: Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. You should not provide line item details on the proposed contracts, rather you should provide the basis for your cost estimate for the contract. 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 all contracts. For consultant services, list the total costs for all consultant services. In the budget narrative, identify each consultant, the services he/she will perform, total number of days, travel costs, and total estimated costs.

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 contracts with certain parties that are debarred, suspended, or otherwise excluded from or ineligible for participation in federal assistance programs or activities.

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 and health literacy print materials in alternate formats (including, Braille, large print, etc.); and linguistic competence modifications (e.g., translation or interpretation services).

Indirect Charges: Indirect costs are costs incurred for common or joint objectives which cannot be readily and specifically identified with a particular project or program, but 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 HHS's Cost Allocation Services (CAS) website at [Program Support Center](#) (PSC) to learn more about rate agreements, the process for applying for them, and the regional office which negotiates them.

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

APPENDIX A: PROGRAM SPECIFIC FORMS INSTRUCTIONS

Form 1C: Documents on File

Form 1C collects information about documents that support the implementation of Health Center Program requirements, as outlined in the [Health Center Program Compliance Manual](#). However, it does not provide an exhaustive list of all types of health center documents (e.g., policies and procedures, protocols, legal documents).

You must provide the date that each document was last reviewed/revised or, as appropriate, select Not Applicable (N/A).

DO NOT submit these documents as AC attachments. HRSA will review these documents as part of an Operational Site Visit and/or may request these for review post-designation.

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

Form 3: Income Analysis (Required)

Form 3 collects the projected income from all sources for the upcoming certification period (one year). Form 3 income is divided into two parts: (1) Patient Service Revenue - Program Income and (2) Other Income - 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. This includes services reimbursed by health insurance plans, managed care organizations, categorical grant programs (e.g., breast and cervical cancer screening), employers, and health provider organizations. 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 Federally Qualified Health Center (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 your approved LAL scope of project.

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). Patients are classified in the same way as in the [UDS Manual](#), Table 4, lines 7 – 12. Examples for determining where to count patients include:

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

Billable Visits – Column (b): Includes all billable/reimbursable visits.³ The value is typically based on assumptions about the amount of available clinician time, clinician productivity (visits per unit of time), and mix of billable visits by payer. Do not include billable services related to laboratory, pharmacy, imaging, and other ancillary services in this column (see [Ancillary Instructions](#) below). Note other significant exclusions or additions in the Comment/Explanatory Notes box at the bottom of the form.

Note: The patient service revenue budget is primarily based upon income per visit estimates. However, some forms of patient service income do not generate reportable visits, such as income from laboratory or pharmacy services, capitated-managed care, performance incentives, wrap payments, and cost report settlements. Based on historical experience, you may choose to include some or all of this income in the income per visit assumption. You may also choose to include some or all of this income in the income per visit assumption. 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. Consolidate all separate projections of income and report them here.

Prior FY Income – Column (e): The income data from the health center's most recently completed fiscal year, which will be either interim statement data or audit data, when available.

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. Enter the estimated visits associated with these managed care plans are entered in Column (b).

³ These visits will correspond closely with the visits reported on the [UDS Manual](#) Table 5, excluding enabling service visits.

Payer Categories (Lines 1 – 5): The five payer categories (Medicaid, Medicare, Other Public, Private, and Self-Pay) reflect 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, which is the payer billed first. 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 revenue 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 Medicaid agency or by a fiscal intermediary. It includes all projected revenue from managed care capitation, settlements from FQHC cost reimbursement reconciliations, wrap-around payments, performance incentives, pharmaceutical reimbursements, 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 (e.g., CDC's National Breast and Cervical Cancer Early Detection Program).

Private (Line 4): Income earned from private insurance plans, managed care plans, and other private contracts for services or pharmaceuticals. This includes plans such as commercial insurance (Blue Cross and Blue Shield), managed care plans, self-insured employer plans, group contracts with unions and employers, service contracts with employers, and Veterans Health Administration Community Based Outpatient Clinic (CBOC) contracts. Revenue 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.

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 –Federal, State, Local, and Other Income

This section includes all income other than the patient service revenue shown in Part 1. It includes other federal, state, local, and other income. It is revenue that is earned but not directly tied to providing visits, procedures, or other specific services. It includes income from services provided to non-health center patients (see examples below). This would include income from in-house retail pharmacy sales to individuals who are not patients of the health center. Income is to be classified based on the source from which it was received and not the source from which it originated.

Federal (Line 7): Income from direct federal funds, where your organization is the recipient of a notice of award (NoA) directly from a federal agency. It includes funds from federal sources such as Expanding Capacity for Coronavirus Testing (ECT), American Rescue Plan: Funding for Look-Alikes, other COVID-19 funding, the CDC, Housing and Urban Development (HUD), Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services funding under the Ryan White HIV/AIDS Program Part C, and others. The CMS EHR incentive program income is reported here 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; Special Supplemental Nutrition Program for 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, federal funding awarded through intermediaries, and similar awards. For example: (1) income earned under a contract with the local Department of Health to provide services to the Department's patients, and (2) Ryan White Part A funds that are awarded through municipalities.

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, if you operate a pharmacy in part for your own patients and, in part as a contractor to another health center, report the pharmacy income for your own patients in Part 1 under the appropriate payer categories 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 fundraising.

Other (Line 12): Incidental and other income not reported elsewhere, including items such as Payroll Protection Program revenue, 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 retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why your funds (retained earnings) are needed for this purpose.

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

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

Note: In-kind donations are not included as income on Form 3. You may discuss in-kind donations in the [Budget Narrative](#).

Form 3A: Look-Alike Budget Information (Required)

Part 1: Expenses

For each of the expense categories (personnel, fringe benefits, travel, equipment, supplies, contractual, other, and indirect charges – see the [Budget Narrative](#) section for a definition of each expense category), enter the projected expenses for the upcoming certification period for each of the applicable categories. 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 upcoming certification 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](#).

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

Forms 5A-C are being provided for reference only. If any information is incorrect, submit your request for change via the Scope Adjustment or Change in Scope (CIS) Modules in EHBs. Contact your project officer for guidance.