



**Fiscal Year 2023 Health Center Program
Budget Period Progress Report
Non-Competing Continuation
Instructions**

Table of Contents

I. TECHNICAL ASSISTANCE	3
II. GENERAL INFORMATION AND INSTRUCTIONS.....	4
III. INSTRUCTIONS FOR THE PROJECT NARRATIVE UPDATE.....	6
IV. BUDGET PRESENTATION INSTRUCTIONS.....	9
APPENDIX A: PROGRAM SPECIFIC FORMS INSTRUCTIONS	15

Issuance Date: June 20, 2022

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

Karen A. Fitzgerald, MPH
Public Health Analyst, Bureau of Primary Health Care
Office of Policy and Program Development
Contact: <https://hrsa.force.com/support/s/>
Telephone: 301-594-4300
Budget Period Progress Report (BPR) Noncompeting Continuation (NCC) Technical Assistance
Webpage: <https://bphc.hrsa.gov/funding/funding-opportunities/budget-period-progress-report-bpr-noncompeting-continuation-ncc>

508 COMPLIANCE DISCLAIMER

Note: Persons using assistive technology may not be able to fully access information in this file. For assistance, email or call one of the HRSA staff listed in [Section I. Technical Assistance](#).

TABLE 1: SUBMISSION SCHEDULE

Budget Period Start Date	EHBs Access	EHBs Deadline (5:00 PM ET)
January 1, 2023	June 27, 2022	August 19, 2022
February 1, 2023	July 18, 2022	September 9, 2022
March 1, 2023	August 15, 2022	October 7, 2022
April 1, 2023	September 12, 2022	November 4, 2022
May 1, 2023	October 17, 2022	December 9, 2022
June 1, 2023	November 7, 2022	December 30, 2022
September 1, 2023	December 5, 2022	January 27, 2023

Note: Failure to submit the Budget Period Progress Report (BPR) by the established deadline or the submission of an incomplete or non-responsive BPR may result in a delay in Notice of Award (NoA) issuance or a lapse in funding.

About the Budget Period Progress Report

The Budget Period Progress Report Non-Competing Continuation (hereafter, BPR) provides an update on the progress of your Health Center Program (H80) award. The fiscal year (FY) 2023 BPR reports on progress made since submission of the last application (SAC or BPR) until the date of the current BPR submission; expected progress for the remainder of the budget period; and projected changes for the FY 2023 budget period.

Continuation funding is subject to the availability of appropriated funds for the Health Center Program in subsequent fiscal years, satisfactory progress, and a decision that continued funding is in the best interest of the Federal Government.

Important Notice:

Due to the ongoing COVID-19 public health emergency, for health centers in a three-year period of performance scheduled to end in FY 2023, Health Resources and Services Administration (HRSA) has extended periods of performance by one year. These health centers must submit a BPR in FY 2023 and subsequently will submit an FY 2024 Service Area Competition (SAC) application.

Additionally, health centers whose period of performance end date is not in FY 2023 (October 1, 2022 - September 30, 2023) – those already scheduled to complete an FY 2023 BPR – should submit an FY 2023 BPR.¹

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

Summary of Changes (compared to the FY 2022 BPR)

- Patient Capacity narrative has been updated and requires the discussion of factors that adversely affect patient trends.
- The Executive Level II salary limitation is updated to \$203,700 (see [Salary Limitation](#)).

I. TECHNICAL ASSISTANCE

Technical assistance resources are available on the [BPR technical assistance \(TA\) webpage](#). The webpage includes the EHBs user guide, frequently asked questions (FAQs), and a slide presentation.

Technical assistance regarding business, administrative, or fiscal issues is available by contacting:

Travis J. Wright
Grants Management Specialist
Office of Federal Assistance Management
HRSA Division of Grants Management
Operations 301-443-0676
twright@hrsa.gov

Technical assistance regarding this instructions document is available by contacting:

Karen A. Fitzgerald
Public Health Analyst
Office of Policy and Program
Development HRSA Bureau of Primary
Health Care
301-594-4300
<https://hrsa.force.com/support/s/>

EHBs technical assistance is available by contacting:

Health Center Program Support
1-877-464-4772
BPHC Contact Form: <https://hrsa.force.com/support/s/>

¹ Refer to your most recent H80 Notice of Award (NoA) for the period of performance end date (Project Period End Date in item 26).

II. GENERAL INFORMATION AND INSTRUCTIONS

GENERAL INFORMATION

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

Prior Approval for Post-Award Changes

You are required to request prior approval from HRSA for post-award changes including, but not limited to, changes in the project director/chief executive officer (CEO), new or additional sub-awards, significant re-budgeting (i.e., greater than 25%), and the addition or deletion of sites or services from the approved scope of project (in accordance with [45 CFR 75.308](#)). These changes must be requested via the Prior Approval, Scope Adjustment, and/or Change in Scope (CIS) Modules in the EHBs, as appropriate. For further detail on actions and changes requiring prior approval, review the [HHS Grants Policy Statement](#).

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).

Requirements of Subawards

The terms and conditions in the Notice of Award (NoA) apply directly to the recipient of HRSA funds. The recipient is accountable for the performance of the project, program, or activity; the appropriate expenditure of funds under the award by all parties; and all other obligations of the recipient, as cited in the NoA. In general, the requirements that apply to the recipient, including public policy requirements, also apply to subrecipients under awards, and it is the recipient's responsibility to monitor the compliance of all funded subrecipients. See [45 CFR § 75.101 Applicability](#) for more details.

Health Center Program award recipients that make subawards are required to document that, at the time a subaward is made (e.g., through a CIS or funding opportunity application), the subrecipient meets all of the Health Center Program requirements applicable to the award recipient's Health Center Program federal award. This includes, but is not limited to, those requirements found in Section 330 of the PHS Act ([42 U.S.C. § 254b](#)), implementing program regulations found in [42 CFR Part 51c](#) and [42 CFR Part 56](#) (for CHC and MHC, respectively), and grants regulations found in [45 CFR Part 75](#). Consistent with 45 CFR § 75.351(a), entities that receive a subaward for the purpose of carrying out a portion of a federal award are responsible for adherence to applicable federal program requirements specified in the federal award.

Submission Instructions

Progress reports should be submitted via EHBs according to your budget period start date. The progress report submission must include all forms and attachments identified in

[Table 2: Submission Components](#). Complete forms directly in EHBs, and upload attachments into EHBs. Progress reports that fail to include all required documents and information will be considered incomplete or non-responsive. Incomplete or non-responsive progress reports will be returned through a “Request Change” notification via the EHBs for you to provide missing information or clarification. Failure to submit the BPR by the established deadline or the submission of an incomplete or non-responsive BPR may result in a delay in NoA issuance or a lapse in funding. Review your BPR to ensure that it is both complete and responsive prior to submission.

[Table 2: Submission Components](#) outlines required forms and attachments. In the Document Type column, the word “Form” refers to forms that you complete online in EHBs. The word “Attachment” refers to materials that you must upload into EHBs. “Fixed” forms are pre-populated to reflect the current approved scope of project and are provided for reference only.

TABLE 2: SUBMISSION COMPONENTS

- The [Budget Narrative](#) and the Indirect Cost Rate Agreement are the only documents that you should upload within the EHBs.
- Samples of Form 3: Income Analysis, the Project Narrative Update, and the Budget Narrative are available on the [BPR TA webpage](#).

BPR Section	Document Type	Instructions
SF-PPR and SF-PPR-2	Form	Provide basic organizational information. Refer to instructions in the EHBs user guide available at the BPR TA webpage .
Budget Information: Budget Details	Form	Provide the budget for the upcoming budget period broken down by object class categories and federal/nonfederal funding. Refer to Section IV for detailed instructions
Budget Narrative	Attachment	Provide a line-item budget for the upcoming budget period that corresponds with the Budget Information: Budget Details form.
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 budget period.
Forms 5A, 5B, and 5C	Fixed	Provide a request for change via the Scope Adjustment or CIS Modules in EHBs, if any information is incorrect in these forms. Refer to the Scope of Project TA Webpage and/or contact your Health Center Engagement (HCE) Program Analyst via the BPHC Contact Form for additional guidance.

BPR Section	Document Type	Instructions
Project Narrative Update	Form	Provide updates to Organizational and Patient Capacity. 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 budget period in the organization’s capacity that have impacted or may impact the progress of the funded 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 2022 budget period; and
- Projected changes for the FY 2023 budget period.

- 2. Patient Capacity:** See [Table 3: Patient Capacity](#). Discuss negative trends in patient capacity, including factors that adversely affect patient trends, 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 you to provide a comment if you have not experienced a negative trend.

TABLE 3: PATIENT CAPACITY

	2019 Patient Number	2020 Patient Number	2021 Patient Number	% Change 2019-2021 Trend	% Change 2020-2021 Trend	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
Period of Performance: (Pre-populated from most recent Notice of Award)								
Total Unduplicated Patients	Pre-populated from 2019 UDS	Pre-populated from 2020 UDS	Pre-populated from 2021 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"> •If you have experienced a negative trend in Patient Capacity, the system WILL require you to provide a comment in the Patient Capacity Narrative column. •2019–2021 Patient Number data are pre-populated from Table 3a in the UDS Report. •The Projected Number of Patients values are pre-populated from the Patient Target Management Module (PTM) in EHBs. If you have questions related to your Patient Target, contact the Patient Target Response Team. To formally request a change in your Patient Target, you must submit a request via the PTM in EHBs. 								

	2019 Patient Number	2020 Patient Number	2021 Patient Number	% Change 2019-2021 Trend	% Change 2020-2021 Trend	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
Period of Performance: (Pre-populated from most recent Notice of Award)								
Total Migratory and Seasonal Agricultural Worker Patients	Pre-populated from 2019 UDS	Pre-populated from 2020 UDS	Pre-populated from 2021 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 2019 UDS	Pre-populated from 2020 UDS	Pre-populated from 2021 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 2019 UDS	Pre-populated from 2020 UDS	Pre-populated from 2021 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"> •If you have experienced a negative trend in Patient Capacity, the system WILL require you to provide a comment in the Patient Capacity Narrative column. •2019-2021 Patient Number data are pre-populated from Table 4 in the UDS Report. •The Projected Number of Patients values is pre-populated from the PTM using patient projections in the Service Area Competition (SAC) that initiated your current period of performance plus the patient projections from selected supplemental funding awarded after the start of the current period of performance. See the frequently asked questions on the BPR TA webpage for details on the selected supplemental funding patient projections included. •The Projected Number of Patients values cannot be edited during the BPR submission. If these values are not accurate, provide an explanation in the Patient Capacity Narrative section. 								

	2019 Patient Number	2020 Patient Number	2021 Patient Number	% Change 2019-2021 Trend	% Change 2020-2021 Trend	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
Period of Performance: (Pre-populated from most recent Notice of Award)								
Total Medical Services Patients	Pre-populated from 2019 UDS	Pre-populated from 2020 UDS	Pre-populated from 2021 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 2019 UDS	Pre-populated from 2020 UDS	Pre-populated from 2021 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 2019 UDS	Pre-populated from 2020 UDS	Pre-populated from 2021 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 2019 UDS	Pre-populated from 2020 UDS	Pre-populated from 2021 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	1,000 character limit
Total Vision Services Patients	Pre-populated from 2019 UDS	Pre-populated from 2020 UDS	Pre-populated from 2021 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 2019 UDS	Pre-populated from 2020 UDS	Pre-populated from 2021 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	1,000 character limit
Notes:								
<p>If you have experienced a negative trend in Patient Capacity, the system WILL require you to provide a comment in the Patient Capacity Narrative column.</p> <ul style="list-style-type: none"> •2019-2021 Patient Number data are pre-populated from Table 5 in the UDS Report. •The Projected Number of Patients column is pre-populated from the PTM using patient projections in the SAC that initiated your current period of performance plus the patient projections from selected supplemental funding awarded after the start of the current period of performance. See the frequently asked questions on the BPR TA webpage for details on the selected supplemental funding patient projections included. •The Projected Number of Patients values cannot be edited during the BPR submission. If these values are not accurate, provide an explanation in the Patient Capacity Narrative section. 								

IV. BUDGET PRESENTATION INSTRUCTIONS

A complete budget presentation includes the submission of the [Budget Information: Budget Details form](#), the [Budget Narrative](#), and [Form 3: Income Analysis](#).

You must present the total FY23 budget for the H80 project, including Health Center Program federal grant funds and all non-Health Center Program grant funds that support the health center scope of project. Funding awarded under H8C, H8D, H8E, and H8F should not be included as part of this budget proposal. The Total Project or Program Costs are the total allowable costs (inclusive of direct and indirect costs) you incur to carry out a HRSA-supported project or activity. Total project or program costs include costs charged to the award and costs borne by you.

The total budget represents all proposed expenditures that directly relate to and support in-scope activities. Therefore, the total budget must reflect projections from all anticipated revenue sources that will support the Health Center Program project. See [Form 3: Income Analysis](#) for details.

The amount of funds awarded in any fiscal year may not exceed the costs of health center operations for the budget period less the total of state, local, and other operational funding provided to the center and the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in the fiscal year. Health Center Program award funds must be used in compliance with applicable federal statutes, regulations, and the terms and conditions of the federal award. Nongrant funds may be used as permitted under section 330 of the PHS Act and may be used for such other purposes as are: (1) not specifically prohibited under section 330, and (2) if such use furthers the objectives of the project.²

Note: The federal cost principles apply to use of grant funds but do not apply to use of nongrant funds.

[45 CFR Part 75](#) includes information about allowable expenses. Note that funds under this notice may not be used for fundraising or the construction of facilities.

Pursuant to existing law and consistent with Executive Order 13535 (75 FR 15599), health centers are prohibited from using federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered). This includes all funds awarded under this announcement and is consistent with past practice and long-standing requirements applicable to awards to health centers.

You are required to have the necessary policies, procedures, and financial controls in place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding, including, but not limited to, statutory restrictions on use of funds for lobbying, executive salaries, gun control, and abortion. Like those for all other applicable grants requirements, the effectiveness of these policies, procedures, and controls is subject to audit.

² Section 330(e)(5)(D) of the PHS Act.

Be aware of the requirements for HRSA recipients and subrecipients at 2 CFR § 200.216 regarding prohibition on certain telecommunications and video surveillance services or equipment. For details, see the [HRSA Grants Policy Bulletin Number: 2021-01E](#).

All program income generated as a result of awarded funds must be used for approved project-related activities. You can find post-award requirements for program income at [45 CFR § 75.307](#). In accordance with Sections 330(e)(5)(D) and 330(k)(3)(D) the health center must use any non-grant funds as permitted under section 330, and may use such funds for such other purposes as are not specifically prohibited under section 330, if such use furthers the objectives of the health center project.

A. Budget Information: Budget Details Form

In **Section A: Budget Summary**, verify the pre-populated list of Health Center Program funding types (CHC, MHC, HCH, PHPC).³ If the funding types are incorrect, make necessary adjustments using the **Update Sub-Program** button. In the Federal column, provide the grant request for each Health Center Program funding type (CHC, MHC, HCH, PHPC). The total federal funding requested across all Health Center Program funding types must equal the Recommended Federal Budget figure that is pre-populated at the top of the Budget Information: Budget Details form. This figure should correspond with the recommended future support figure (Item 33) on the most recent H80 NoA.

Note: The BPR may **not** be used to request changes in the total award, funding type(s), or allocation of Health Center Program funds between funding types. **Funding must be requested and will be awarded proportionately for all funding types as currently funded under the Health Center Program.**

In the Non-Federal column, provide the total of the non-federal funding sources for each type of Health Center Program (CHC, MHC, HCH, PHPC). The total for the Non-Federal column should equal the Total Non-Federal value on [Form 3: Income Analysis](#). The amount(s) in the total column will be calculated automatically as the sum of the federal and non-federal columns.

In **Section B: Budget Categories**, by object class category, provide the Health Center Program federal funding request for the upcoming budget period in the first column and the non-federal funding in the second column. Each line represents a distinct object class category that must be addressed in the [Budget Narrative](#).

Indirect costs may only be claimed with an approved indirect cost rate (see details in the [Budget Narrative](#) section below).

In **Section C: Non-Federal Resources**, provide a breakdown of non-federal funds by funding source (e.g., state, local) for each type of Health Center Program funding (CHC, MHC, HCH, PHPC). If you are a state agency, leave the State column blank and include State funding in the Applicant column. Note that Program Income must be consistent with the Total Program Income presented in [Form 3: Income Analysis](#).

³ Community Health Center – CHC, Migrant Health Center – MHC, Health Care for the Homeless – HCH, and/or Public Housing Primary Care – PHPC

Salary Limitation

The Consolidated Appropriations Act, 2021 (P.L. 116-260), Division H, § 2022 (P.L. 117-70), states “None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of [Executive Level II](#),” which is currently \$203,700. This amount reflects an individual’s base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to your organization. This salary limitation also applies to subrecipients under a HRSA grant or cooperative agreement. See Section 5.1.iv Budget – Salary Limitation of HRSA’s [SF-424 Application Guide](#) for additional information. Note that these or other salary limitations will apply in the following fiscal years, as required by law.

Example of Application of this Limitation:

If an individual’s base full time salary is \$255,000 per year plus fringe benefits of 25 percent, and that individual is devoting **50 percent of his/her time to this award (0.5 FTE)**, the base salary must be adjusted to \$203,700, plus fringe benefits of 25 percent, when calculating the amount that may be charged to the Health Center Program grant. This results in a total of \$127,313 that may be included in the project budget and charged to the award in salary/fringe benefits for this individual. See the breakdown below.

TABLE 4: SALARY LIMITATION – ACTUAL VS. CLAIMED

Current Actual Salary: \$255,000	
Individual base full-time salary	\$255,000
Direct Salary (0.5 FTE)	\$127,500
Fringe (25% of salary)	\$31,875
Total Amount	\$159,375
Adjusted Salary for Budget Submission: \$203,700	
Individual base full-time salary adjusted to Executive Level II	\$203,700
Direct Salary (0.5 FTE)	\$101,850
Fringe (25% of salary)	\$ 25,463
Total Amount	\$127,313

B. Budget Narrative

Provide a budget narrative that explains the amounts requested for each line item of the budget in the object class categories from Section B of the Budget Information: Budget Details form. The budget narrative should specifically describe how each item will support the achievement of proposed objectives. Be careful about showing how each item in the “other” category is justified.

The budget narrative is for **one year based on your upcoming FY2023 12-month budget period**.

The Budget Narrative must itemize both your federal request and non-federal resources. Ensure that the Budget Narrative contains detailed calculations explaining how each line-item expense within each cost category is derived (e.g., number of visits, cost per unit). Refer to [45 CFR 75](#) for information on allowable costs.

Upload the completed attachment in the Budget Narrative section within the EHBs. Include the following in the Budget Narrative:

Personnel Costs: Explain personnel costs by listing each staff member who will be supported from Health Center Program funds, name (if possible), position title, percentage of full-time equivalency, and annual salary. **Reminder:** Award funds may not be used to pay the salary of an individual at a rate in excess of Federal Executive Level II or \$203,700.⁴ An individual's base salary, per se, is **NOT** constrained by the legislative provision for a limitation of salary. The rate limitation simply limits the amount that may be awarded and charged to the HRSA grant. Provide an individual's actual base salary if it exceeds the cap. Refer to the Sample Budget Narrative on the [BPR TA webpage](#).

In order to be considered as allowable costs on your HRSA award, you need to ensure that personnel costs are supported by official records that accurately reflect the work performed and that internal controls provide reasonable assurance that the personnel costs are accurate, allowable, and allocable to the HRSA award.

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 that portion of personnel costs that are allocated for the project. If an individual's base salary exceeds the legislative salary cap (i.e., \$203,700), adjust fringe proportionally.

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 the travel expenses (e.g., airfare, lodging, parking, per diem, etc.) for each person and trip associated with participating in meetings and other proposed trainings or workshops. Name the traveler(s) if possible, describe the purpose of the travel, provide the number of trips involved, the destinations, and the number of individuals for whom funds are requested.

Equipment: List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of items that meet the definition of equipment (a per-unit cost of \$5,000 or more and a useful life of 1 or more years). For example, large items of medical equipment.

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.

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

⁴ While the BPR focuses on the application of the salary limitation to the federal Health Center Program (H80) grant funds, the salary limitation applies across all HRSA funding. In other words, if a full-time staff member is paid from several HRSA grants, the total federal contribution to that staff person's salary cannot exceed \$203,700.

Contractual/Subawards/Consultant: Provide a clear explanation as to the purpose of each contract/subaward, how the costs were estimated, and the specific contract/subaward deliverables. You should not provide line item details on proposed contracts, rather you should provide the basis for your cost estimate for the contract. You are responsible for ensuring that your organization or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts/subawards. Recipients must notify potential subrecipients that entities receiving subawards must be registered in SAM and provide the recipient with their DUNS number (see [2 CFR part 25](#)). 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.

For subawards to entities that will help carry out the work of the grant, you must describe how you monitor their work to ensure the funds are being properly used.

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.

Other: Include all costs that do not fit into any other category and provide an explanation of each cost in this category (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 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 Costs: 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 maintaining facilities, depreciation, administrative salaries). For some institutions, the term "facilities and administration" (F&A) is used to denote indirect costs.

If your organization does not have an indirect cost rate, you may wish to obtain one through HHS's Cost Allocation Services (CAS). Visit [CAS's website](#) to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them. If indirect costs are included in the budget, attach a copy of the indirect cost rate agreement with the Budget Narrative attachment.

Any non-federal entity that has never received a negotiated indirect cost rate (except a governmental department or agency unit that receives more than \$35 million in direct federal funding) may elect to charge a de minimis rate of 10 percent of modified total

direct costs (MTDC), which may be used indefinitely. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as a non-Federal entity chooses to negotiate for a rate, which the non-Federal entity choose to negotiate for a rate, which the non-Federal entity may apply to do at any time.

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 BPR attachments. HRSA will review these documents as part of an Operational Site Visit and/or may request these for review post-award.

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

Form 3 collects the projected income from all sources other than the Health Center Program grant for the upcoming budget period. Form 3 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 health center 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. If you do not have an FQHC cost reimbursement rate from Medicaid and Medicare, contact your PCA for help with the application process.⁵

Only include patient service revenue associated with sites and services in your H80 scope of project.

⁵ For a map of HRSA-supported PCAs, refer to HRSA's [Strategic Partnerships webpage](#).

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.⁶ 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](#) under Payer Categories 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 on 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 separately budget for some or all 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 Fiscal Year (FY) Income — Column (e): The income data from the health center’s 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 other than those noted above but must report the consolidated result in the 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 in Column (b).

⁶ 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 to include that income on the primary payer line, if you cannot accurately associate the income to secondary and subsequent sources.

Ancillary Revenue 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 reconciliations, risk pool distributions, performance incentives, pharmaceutical reimbursements, and case management fee income.

Other Public (Line 3): Income not reported elsewhere from federal, state, or local government programs earned for providing services or pharmaceuticals that is unearned or based upon meeting the plan's eligibility criteria. A CHIP operated independently from the Medicaid program is an example of other public insurance, as is the COVID-19 Uninsured Program. Other Public income also includes income from categorical grant programs when the grant income is earned by providing services (e.g., Centers for Disease Control and Prevention's (CDC) 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 – Other Federal, State, Local, and Other Income

This section includes all income other than the patient service revenue shown in Part 1 (exclusive of this Health Center Program funding request). It includes other federal, state, local, and other income. It is revenue that is earned but not directly tied to 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.

Other 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 Health Center Program COVID-19 supplemental funding (grant award number begins with H8C, H8D, and H8E, H8F), Expanding Capacity for Coronavirus Testing (ECT), American Rescue Provider Relief Funding for Health Centers, 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](#). Exclude this Health Center Program funding request.

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, include: (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, nonprofits, 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. Amounts from non-federal sources, combined with the Health Center Program funds, should typically be adequate to support operations.

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 aside from the Health Center Program funds).

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

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

Forms 5A-C are 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 HCE Program Analyst via the [BPHC Contact Form](#) for additional guidance.