HRSA Electronic Handbooks (EHBs)

Look-Alike Renewal of Designation Application User Guide

User Guide for Look-Alike Designees

Health Resources & Services Administration

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This user guide describes the steps you need to follow to submit a Look-Alike Renewal of Designation (RD) application to the Health Resources and Services Administration (HRSA).

For steps that have a corresponding image, the format (e.g., **Figure 5**, **1**) will include a hyperlink to the blue figure text and a reference to the red numbered box on the image pointing to the location on the screen the user should perform the action.

1. Starting the Look-Alike Renewal of Designation Application

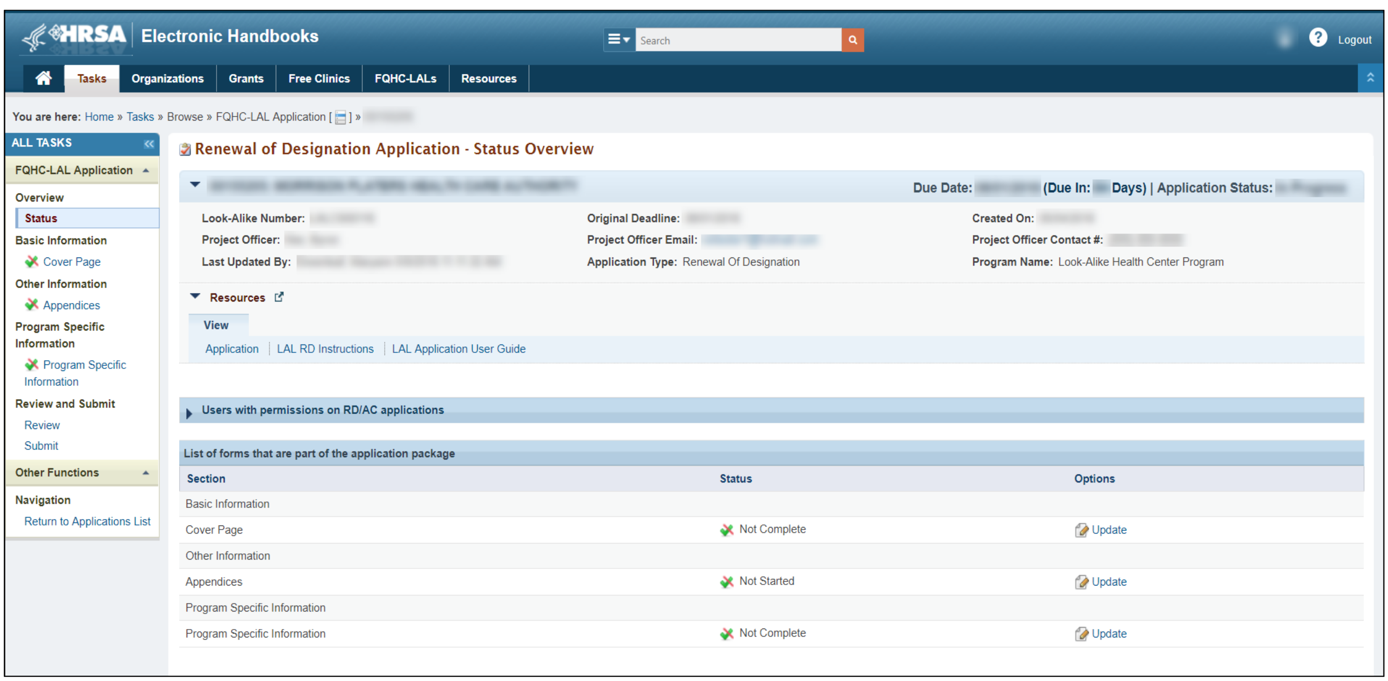
Complete and submit the application by following the below process:

1. You must have an Electronic Handbooks (EHBs) user account to create a Look-Alike application (also known as a Renewal of Designation or RD).
2. After logging into EHBs, click the **Tasks** tab on the EHBs Home page to navigate to the **Pending Tasks – List** page.
3. Locate the Look-Alike RD application using the EHBs Application tracking number received in an email and click the **Start** link to begin working on the application in EHBs

   IMPORTANT NOTE:

   - If you have previously accessed the application, the Start link will be replaced with Edit.
4. The system opens the **Renewal of Designation Application - Status Overview** page of the application (**Figure 1**)
5. The application consists of three sections you must complete in order to submit your application to HRSA.
   a. Cover Page
   b. Appendices
   c. Program Specific Information

Figure 1: Renewal of Designation Application - Status Overview Page



2. Completing the Standard Side of the Application

There are two sections of the standard side of the application that must be completed:

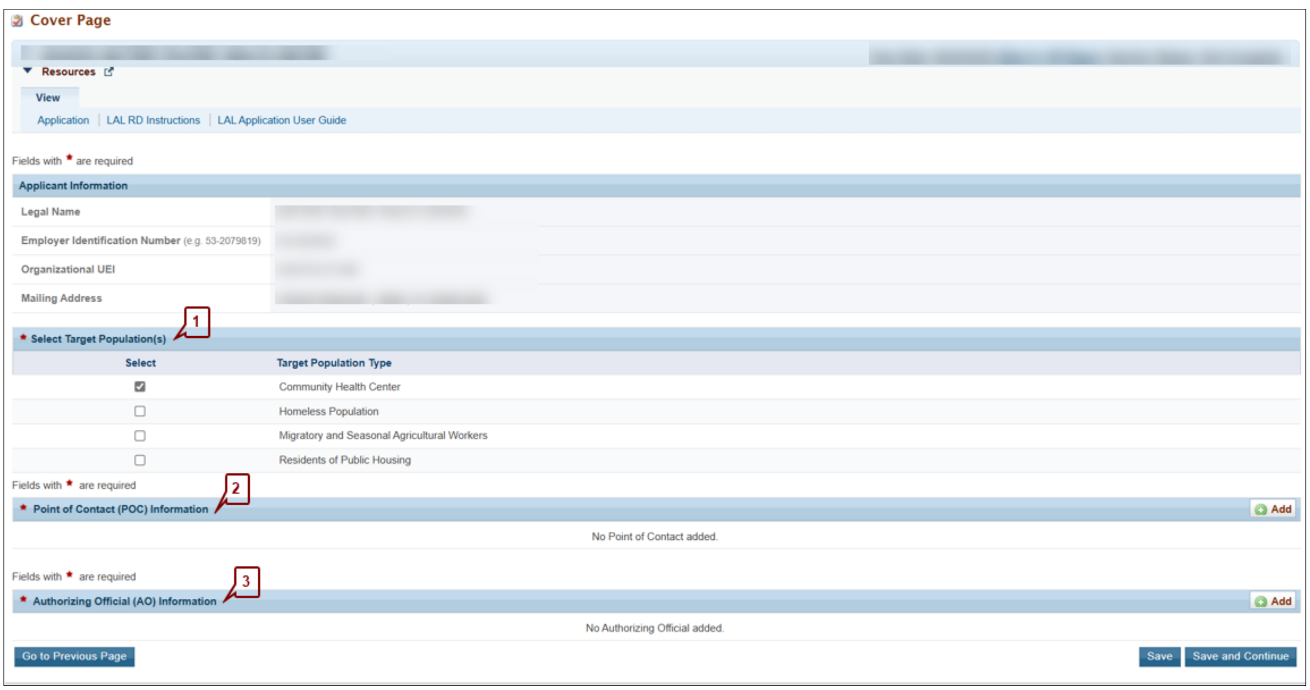
1. Cover Page
2. Appendices

2.1 Complete the Look-Alike Cover Page Section of the Application

The Cover Page (**Figure 2**) requires the following information, as indicated by the red asterisks to the left of these fields:

1. **Select Target Population(s)** (**Figure 2**, **1**) – select the target population type(s) served by the applicant health center: Community Health Centers (CHC), Homeless Population (HP), Migratory and Seasonal Agricultural Workers (MSAW), and/or Residents of Public Housing (RPH).
2. **Point of Contact (POC) Information** (**Figure 2**, **2**) – enter the information of the person to be contacted on matters involving this Look-Alike Renewal of Designation application.
3. **Authorized Official (AO) Information** (**Figure 2**, **3**) – enter the person who is authorized by the board of directors to submit the Look-Alike Renewal of Designation application.
4. Once completed, click the **Save and Continue** button to proceed to the **Appendices** form.

Figure 2: Cover Page of FQHC-LAL Application

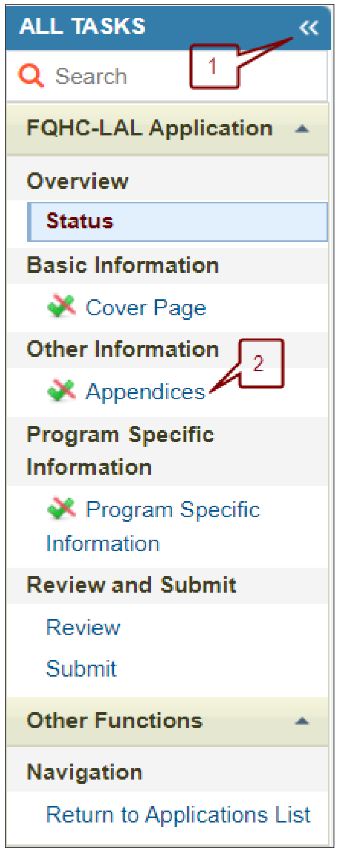


2.2 Completing the Appendices

The Appendices section of the application denotes required fields with asterisks and includes the minimum and maximum values for each attachment listed.

1. The Appendices can be accessed from **Save and Continue** button on the **Cover Page** or by expanding the left navigation menu (if not already expanded). To expand the Left Menu, select the double arrows from the top of the page (**Figure 3**, **1**), and select the Appendices link (**Figure 3**, **2**).

Figure 3: Left Navigation Menu



2. Upload the following attachments by clicking the associated Attach File buttons:
   a. **Project Abstract**
      i. (Minimum 1 and Maximum 1) (Required)
   b. **Project Narrative**
      i. (Minimum 1 and Maximum 1) (Required)
   c. **Attachment 1 - Service Area Map and Table**
      i. (Minimum 1 and Maximum 1) (Required)
   d. **Attachment 2 - Bylaws**
      i. (Minimum 1 and Maximum 1) (Required)
   e. **Attachment 3 - Project Organizational Chart**
      i. (Minimum 1 and Maximum 1) (Required)
   f. **Attachment 4 - Position Descriptions for Key Management Staff**
      i. (Minimum 1 and Maximum 1) (Required)
   g. **Attachment 5 - Biographical Sketches for Key Management Staff**

i. (Minimum 1 and Maximum 1) (Required)

h. Attachment 6 - Co-Applicant Agreement

i. (Maximum 1) (as applicable)

i. Attachment 7 - Summary of Contracts and Agreements

i. (Maximum 1) (as applicable)

j. Attachment 8 - Collaboration Documentation

i. (Minimum 1 and Maximum 1) (Required)

k. Attachment 9 - Sliding Fee Discount Schedule(s)

i. (Minimum 1 and Maximum 1) (Required)

l. Attachment 10 - Budget Justification Narrative

i. (Minimum 1 and Maximum 1) (Required)

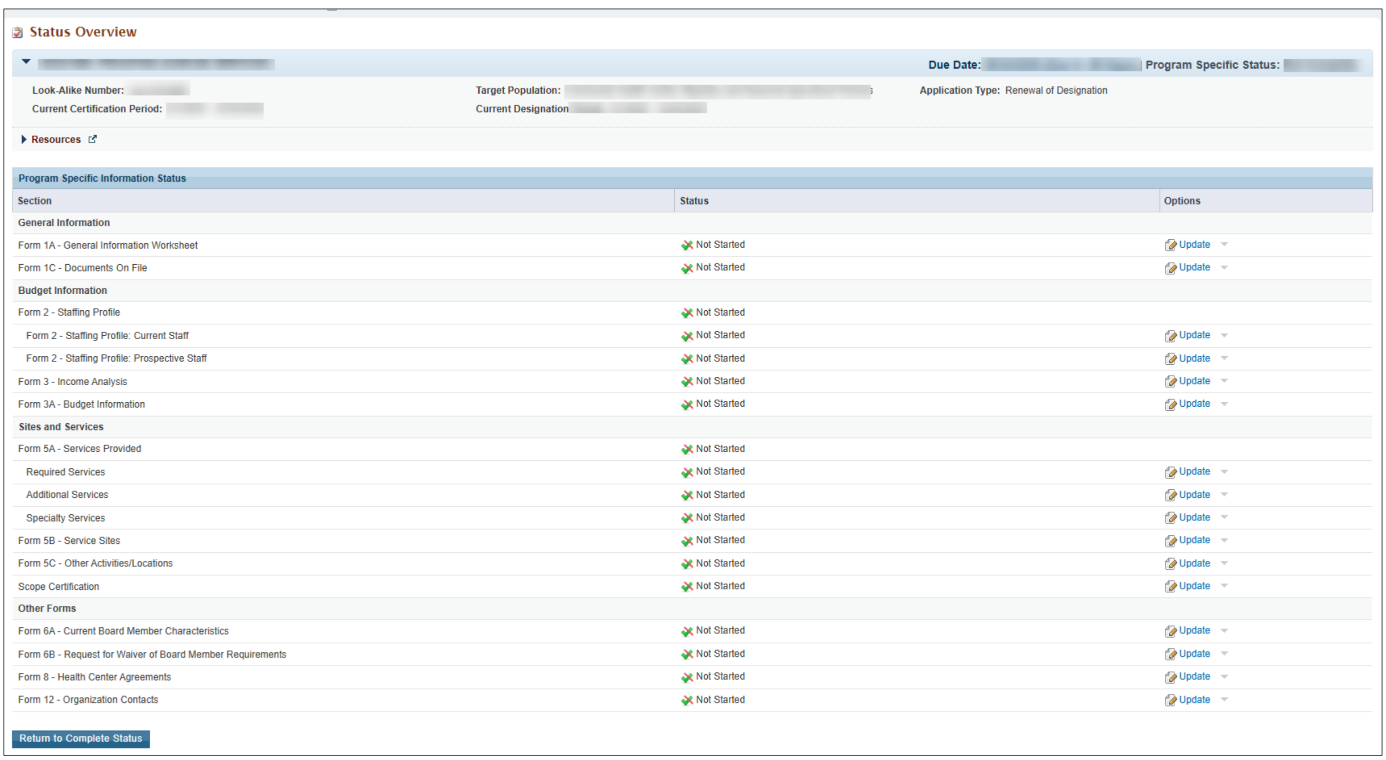
m. Attachment 11 - Other Relevant Documents

i. (Maximum 5) (as applicable)

3. Completing the Program Specific Forms

Click the Update link for any form to start updating it or access the forms from the left side menu. Once completed, click the Save and Continue button to proceed to the next listed form (**Figure 4**).

Figure 4: Status Overview Page for Program Specific Forms


Status Overview

Due Date: Program Specific Status:

Look-Alike Number: | Target Population: | Application Type: Renewal of Designation
Current Certification Period: | Current Designation

Resources

Program Specific Information Status

Section	Status	Options
General Information		
Form 1A - General Information Worksheet	Not Started	Update
Form 1C - Documents On File	Not Started	Update
Budget Information		
Form 2 - Staffing Profile	Not Started	
Form 2 - Staffing Profile: Current Staff	Not Started	Update
Form 2 - Staffing Profile: Prospective Staff	Not Started	Update
Form 3 - Income Analysis	Not Started	Update
Form 3A - Budget Information	Not Started	Update
Sites and Services		
Form 5A - Services Provided	Not Started	
Required Services	Not Started	Update
Additional Services	Not Started	Update
Specialty Services	Not Started	Update
Form 5B - Service Sites	Not Started	Update
Form 5C - Other Activities/Locations	Not Started	Update
Scope Certification	Not Started	Update
Other Forms		
Form 6A - Current Board Member Characteristics	Not Started	Update
Form 6B - Request for Waiver of Board Member Requirements	Not Started	Update
Form 8 - Health Center Agreements	Not Started	Update
Form 12 - Organization Contacts	Not Started	Update

Return to Complete Status

3.1 Completing the General Information Section

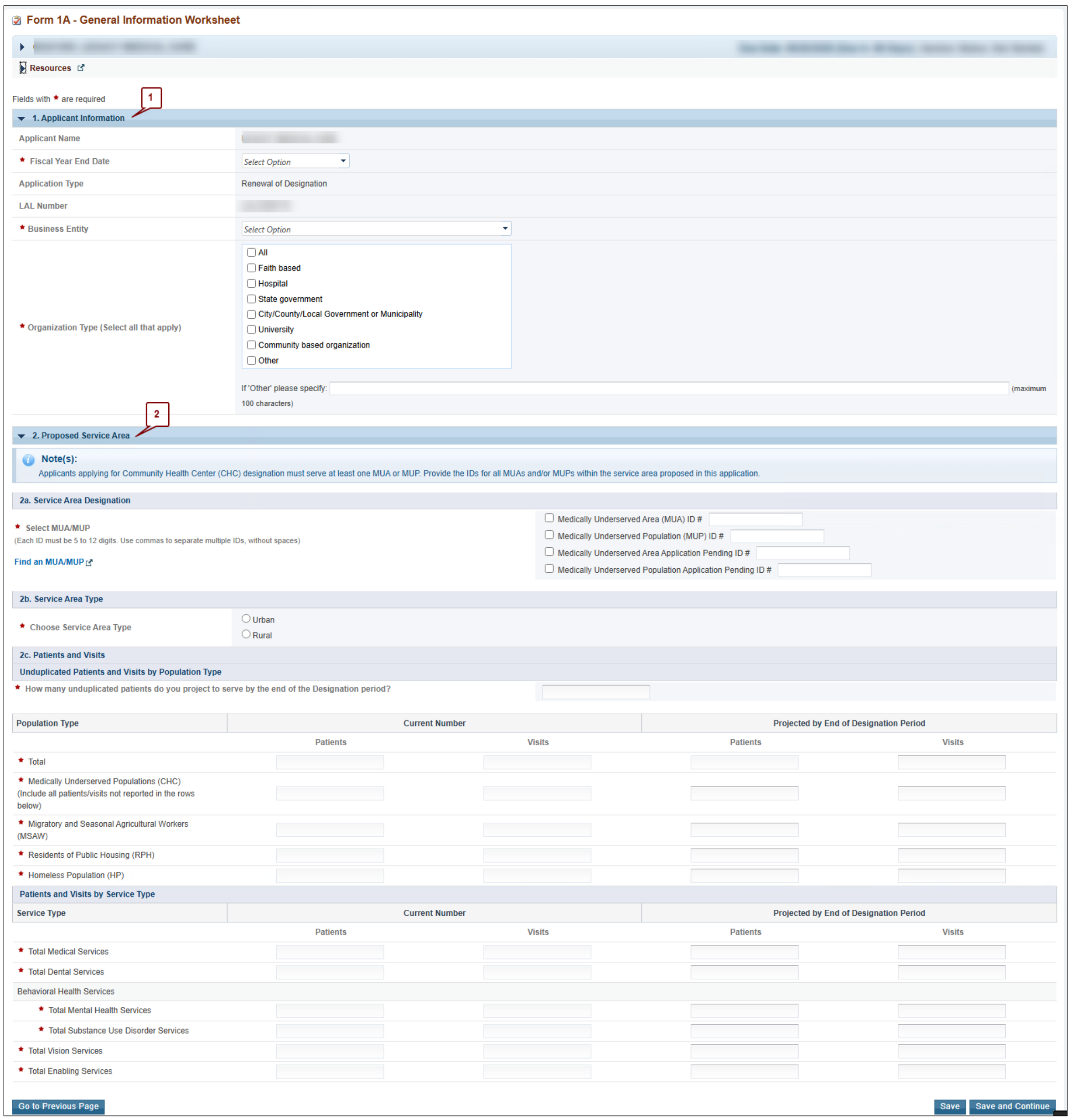
To complete this section, you must complete the following forms:

3.1.1 Completing Form 1A – General Information Worksheet

Form 1A - General Information Worksheet provides a summary of information related to the applicant, proposed service area, population, and patient and visit projections. This form comprises the following sections:

1. Applicant Information (**Figure 5**, **1**)
2. Proposed Service Area (**Figure 5**, **2**)

Figure 5: Form 1A – General Information Worksheet



Form 1A - General Information Worksheet

Resources

Fields with * are required

1

1. Applicant Information

Applicant Name

* Fiscal Year End Date — Select Option

Application Type — Renewal of Designation

LAL Number

* Business Entity — Select Option

* Organization Type (Select all that apply)
- All
- Faith based
- Hospital
- State government
- City/County/Local Government or Municipality
- University
- Community based organization
- Other

If 'Other' please specify: (maximum 100 characters)

2

2. Proposed Service Area

Note(s):
Applicants applying for Community Health Center (CHC) designation must serve at least one MUA or MUP. Provide the IDs for all MUAs and/or MUPs within the service area proposed in this application.

2a. Service Area Designation

* Select MUA/MUP
(Each ID must be 5 to 12 digits. Use commas to separate multiple IDs, without spaces)
Find an MUA/MUP

- Medically Underserved Area (MUA) ID #
- Medically Underserved Population (MUP) ID #
- Medically Underserved Area Application Pending ID #
- Medically Underserved Population Application Pending ID #

2b. Service Area Type

* Choose Service Area Type
- Urban
- Rural

2c. Patients and Visits

Unduplicated Patients and Visits by Population Type

* How many unduplicated patients do you project to serve by the end of the Designation period?

Population Type	Current Number		Projected by End of Designation Period	
	Patients	Visits	Patients	Visits
* Total				
* Medically Underserved Populations (CHC) (Include all patients/visits not reported in the rows below)				
* Migratory and Seasonal Agricultural Workers (MSAW)				
* Residents of Public Housing (RPH)				
* Homeless Population (HP)				

Patients and Visits by Service Type

Service Type	Current Number		Projected by End of Designation Period	
	Patients	Visits	Patients	Visits
* Total Medical Services				
* Total Dental Services				
Behavioral Health Services				
* Total Mental Health Services				
* Total Substance Use Disorder Services				
* Total Vision Services				
* Total Enabling Services				

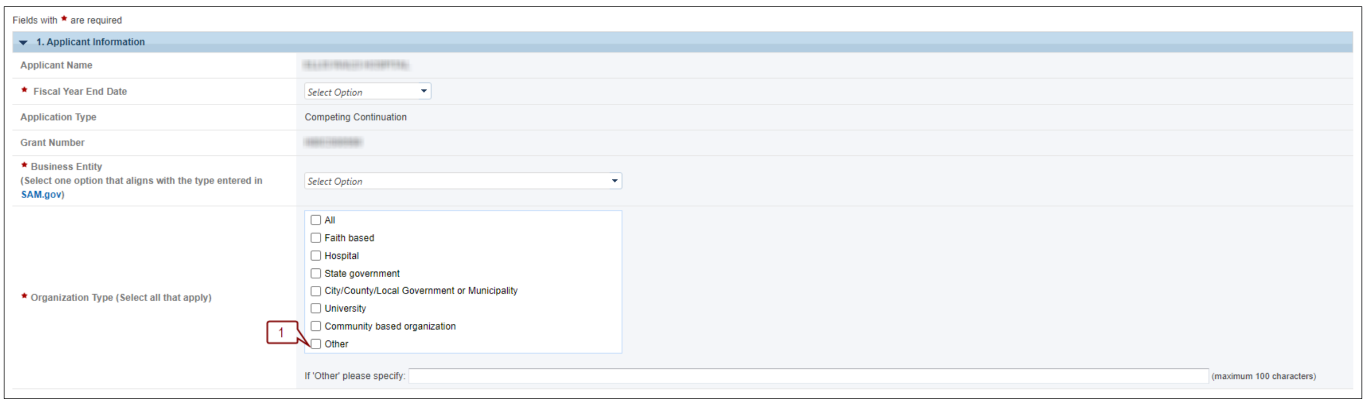
Go to Previous Page | Save | Save and Continue

3.1.1.1 Completing the Applicant Information Section

The Applicant Information section is pre-populated with the applicant's name and application type. Complete this section by providing information in the required fields (**Figure 6**).

1. Select the applicant organization's **Fiscal Year End Date** (e.g., June 30) from the drop-down menu.
2. Select one option in the **Business Entity** section. An applicant that is a 'Tribal or Urban Indian' entity and meets the definition for a public or private entity should select the 'Tribal or Urban Indian' category.
3. If you select 'Other' (**Figure 6**, **1**) for the Organization Type, you must specify the organization type.

Figure 6: Applicant Information Section



3.1.1.2 Completing the Proposed Service Area Section

The Proposed Service Area section has the following sub-sections:

1. 2a. Service Area Designation
2. 2b. Service Area Type
    a. Urban
    b. Rural
3. 2c. Patients and Visits
    a. Unduplicated Patients and Visits by Population Type
    b. Patients and Visits by Service Type

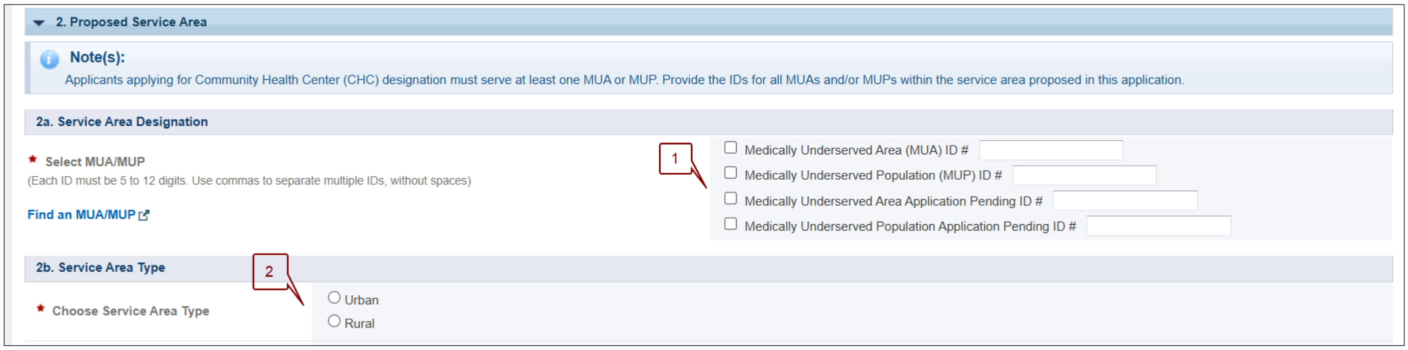
3.1.1.3 Completing 2a. Service Area Designation

In the Select MUA/MUP field (**Figure 7**, **1**), select the MUA and/or MUP designations (multiple selections are allowed) for the proposed service area and enter the identification number(s). Select the options that best describe the service area you propose to serve.

IMPORTANT NOTES:

- For inquiries regarding MUAs or MUPs, visit the [What Is Shortage Designation? | Bureau of Health Workforce (hrsa.gov)] or call 1-888-275-4772 (option 1 then option 2) or contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816.

Figure 7: Proposed Service Area Section



3.1.1.4 Completing 2b. Service Area Type

In the Service Area Type field (**Figure 7**, **2**), indicate whether the service area is urban or rural.

IMPORTANT NOTES:

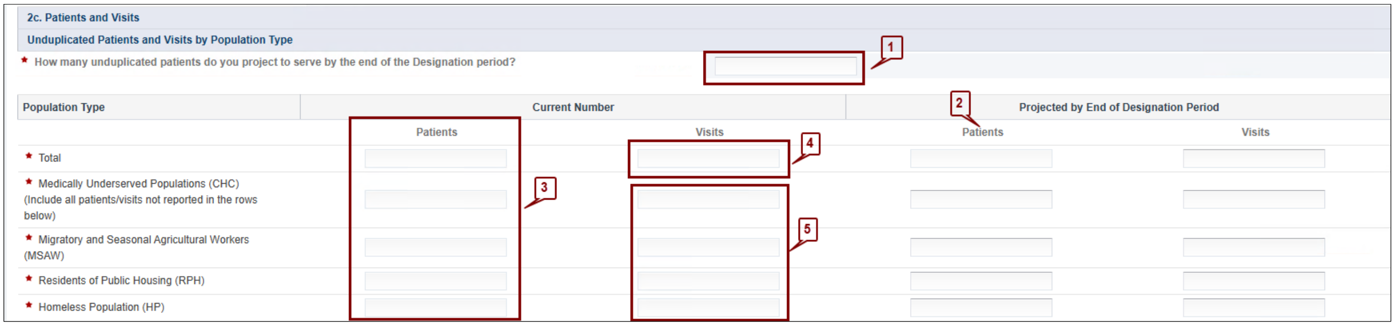
For information about rural populations, visit the Office of Rural Health Policy's website at https://www.hrsa.gov/rural-health/about-us/what-is-rural.

3.1.1.5 Completing 2c. Patients and Visits

There are two required sections:

1. **Unduplicated Patients and Visits by Population Type:**
    a. Answer the question, How many unduplicated patients are projected to be served by End of Designation Period? (**Figure 8**, **1**)
    b. The system will auto-populate the number in the Total row of the Patients column under the Projected by End of Designation Period heading (**Figure 8**, **2**) when the user clicks on the Save or Save and Continue button.
    c. Patient data under the Current Number heading (**Figure 8**, **3**) is pre-populated from the Uniform Data System (UDS) for the Total and the Population Types corresponding to the subprograms selected on the Cover page - Select Target Population(s) section of this application.
    d. The Total Visits under the Current Number heading (**Figure 8**, **4**) is pre-populated from the Uniform Data System (UDS).
    e. You must enter the number of visits for Population Types corresponding to the subprograms selected in the Cover page – Select Target Population(s) section of this application, should be greater than zero (**Figure 8**, **5**). For the remaining Population Types, you may provide zeros if there are no projections. You may also provide data for the Population Types beyond those selected on the Cover page.

Figure 8: Unduplicated Patients and Visits by Population Type


2c. Patients and Visits

Unduplicated Patients and Visits by Population Type

* How many unduplicated patients do you project to serve by the end of the Designation period?

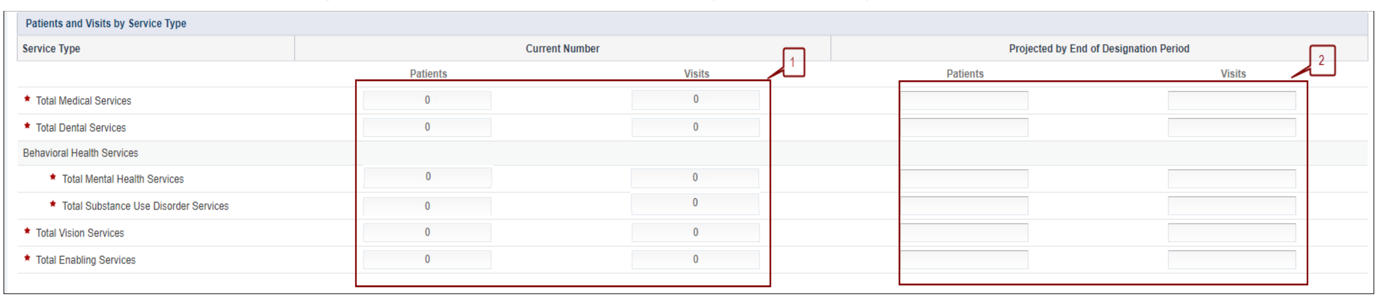
Population Type	Current Number		Projected by End of Designation Period	
	Patients	Visits	Patients	Visits
* Total				
* Medically Underserved Populations (CHC) (Include all patients/visits not reported in the rows below)				
* Migratory and Seasonal Agricultural Workers (MSAW)				
* Residents of Public Housing (RPH)				
* Homeless Population (HP)				

<u>IMPORTANT NOTES</u>:

- The General Underserved Community row should include all patients/visits not captured in other Population Types.
- Across all Population Type categories, an individual can only be counted once as a patient.

2. **Patients and Visits by Service Type**
   a. Patients and Visits under the Current Number heading (**Figure 9**, **1**) are pre-populated from the Uniform Data System (UDS) for each Service type.
   b. Provide the number of patients and visits under the Projected by End of Designation Period heading for each Service Type (**Figure 9**, **2**).
   c. After completing all sections of **Form 1A - General Information Worksheet**, click the **Save and Continue** button to save your work and proceed to the next form.

Figure 9: Patients and Visits by Service Type


Patients and Visits by Service Type

Service Type	Current Number		Projected by End of Designation Period	
	Patients	Visits	Patients	Visits
* Total Medical Services	0	0		
* Total Dental Services	0	0		
Behavioral Health Services				
* Total Mental Health Services	0	0		
* Total Substance Use Disorder Services	0	0		
* Total Vision Services	0	0		
* Total Enabling Services	0	0		

<u>IMPORTANT NOTES</u>:

- 'UDS/Baseline Value' refers to the number of patients and visits for the proposed service area at the time of application.
- Projected Patients and Visits for Medical Services must be greater than 0.
- In the Patients and Visits by Service Type section, Projected Medical Patients (by end of designation period) must be greater than the projected number of patients for each of the other service types.
- Project the number of patients and visits anticipated within each Service Type category by the end of the designation period.

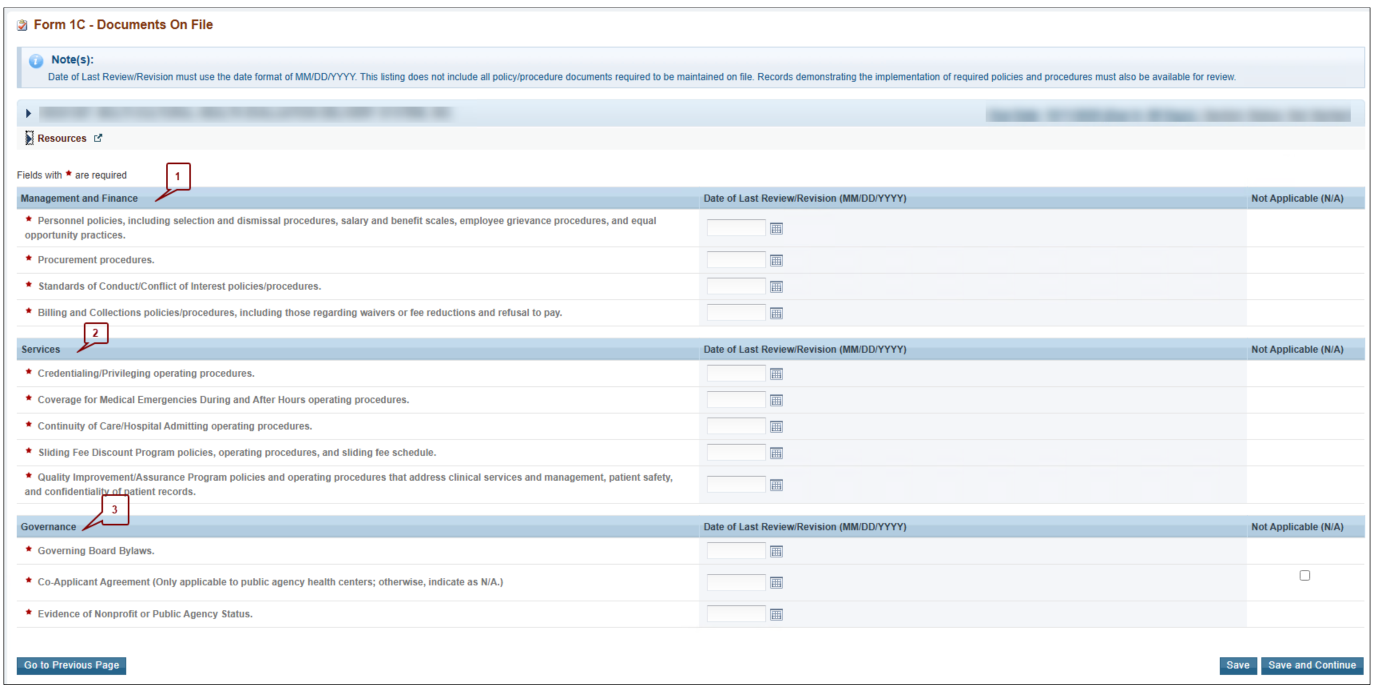
- To maintain consistency with the patients and visits reported in UDS, do not report patients and visits for vision or pharmacy services, or services outside the proposed scope of project.
    - Refer to the Scope of Project (http://bphc.hrsa.gov/about/requirements/scope) policy documents.
- The Patients and Visits by Service Type section does not display total values since an individual patient may be included in multiple Service Type categories.
- Providing numbers for all the Service Types is required. Zeros are acceptable, except Total Medical Services.

3.1.2 Completing Form 1C – Documents on File

Form 1C - Documents on File page displays a list of documents to be maintained by an organization.

To complete Form 1C, provide the date of the last review/revision for each item listed. Select N/A if an item is not applicable, where available (**Figure 10**, **1**, **2**, **3**). Click the **Save and Continue** button to proceed to the next form.

Figure 10: Form 1C – Documents of File



3.2 Completing the Budget Information Section

To complete this section, you must complete the following forms:

3.2.1 Completing Form 2 – Staffing Profile

Form 2 - Staffing Profile reports current and prospective staffing for the look-alike. Report personnel for the **first certification year** of the proposed project. Include only staff for sites included on Form 5B: Service Sites.

This form is comprised of the following sections/subsections:

1. Staffing Positions by Major Service Category section including:
    a. Management and Support Personnel (**Figure 11**, **1**)
    b. Facility and Non-Clinical Support Personnel (**Figure 11**, **2**)
    c. Physicians (**Figure 11**, **3**)
    d. Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives (**Figure 11**, **4**)
    e. Medical Care Services (**Figure 11**, **5**)
    f. Dental (**Figure 11**, **6**)
    g. Behavioral Health (Mental Health and Substance Use Disorder Services) (**Figure 12**, **7**)
    h. Professional Services (**Figure 12**, **8**)
    i. Vision Services (**Figure 12**, **9**)
    j. Pharmacy Personnel (**Figure 12, 10**)
    k. Enabling Services (**Figure 12, 11**)
    l. Other Programs and Services (**Figure 12**, **12**)
2. Total FTEs (**Figure 12**, **13**)

Figure 11: Form 2 – Staffing Profile

Form 2 - Staffing Profile

Note(s):
The health center must directly employ its Project Director/CEO. Allocate staff time by function among the positions listed. An individual's full-time equivalent (FTE) should not be duplicated across positions. For example, a provider serving as a part-time family physician and a part-time Clinical Director should be listed in each respective category, with the FTE portion allocated to each position (e.g., Clinical Director 0.3 (30%) FTE and family physician 0.7 (70%) FTE). Do not exceed 1.0 FTE for any individual. Refer to the most recent UDS manual for position descriptions.

[illegible] Due Date: [illegible] (Due In: [illegible]) | Section Status: [illegible]

Resources

View

LAL RD User Guide | LAL RD Instructions | LAL RD TA Webpage

Form 2 - Staffing Profile: Current Staff | Form 2 - Staffing Profile: Prospective Staff

Fields with * are required

Management and Support Personnel 1

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Project Director/Chief Executive Officer (CEO)		N/A
* Finance Director/Chief Financial Officer (CFO)		Yes No
* Chief Operations Officer (COO)		Yes No
* Chief Information Officer (CIO)		Yes No
* Clinical Director/Chief Medical Officer (CMO)		Yes No
* Other Management and Support Personnel		Yes No

Facility and Non-Clinical Support Personnel 2

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Fiscal and Billing Personnel		Yes No
* IT Personnel		Yes No
* Facility Personnel		Yes No
* Patient Support Personnel		Yes No

Physicians 3

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Family Physicians		Yes No
* General Practitioners		Yes No
* Internists		Yes No
* Obstetrician/Gynecologists		Yes No
* Pediatricians		Yes No
* Other Specialty Physicians		Yes No

Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives 4

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Nurse Practitioners		Yes No
* Physician Assistants		Yes No
* Certified Nurse Midwives		Yes No

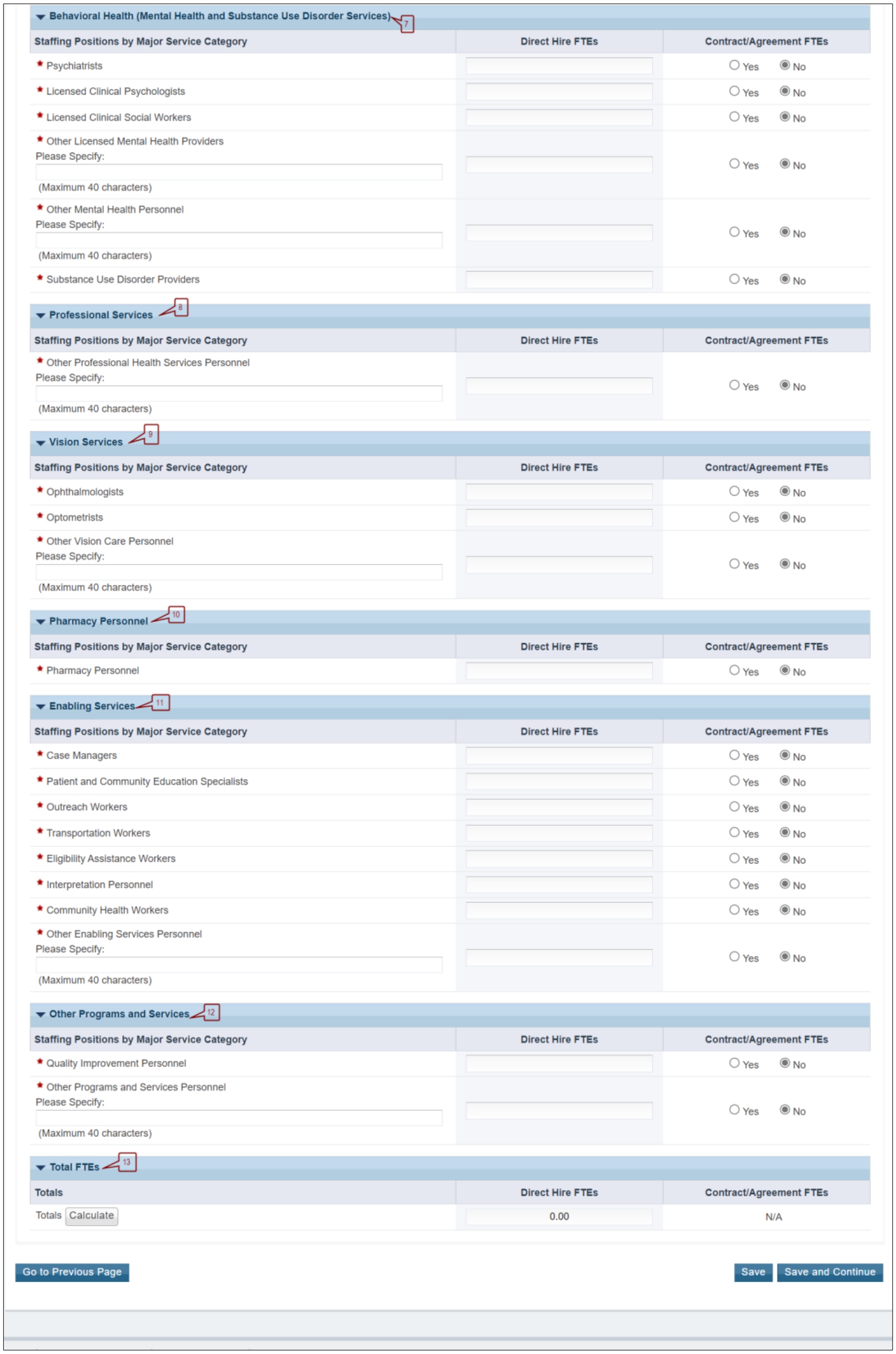
Medical Care Services 5

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Nurses		Yes No
* Other Medical Personnel (e.g. Medical Assistants, Nurse Aides) Please Specify: (Maximum 40 characters)		Yes No
* Laboratory Personnel		Yes No
* X-Ray Personnel		Yes No

Dental 6

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Dentists		Yes No
* Dental Hygienists		Yes No
* Dental Therapists		Yes No
* Other Dental Personnel Please Specify: (Maximum 40 characters)		Yes No

Figure 12: Form 2 - Staffing Profile continued…



Behavioral Health (Mental Health and Substance Use Disorder Services) 7

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Psychiatrists		Yes No
* Licensed Clinical Psychologists		Yes No
* Licensed Clinical Social Workers		Yes No
* Other Licensed Mental Health Providers Please Specify: (Maximum 40 characters)		Yes No
* Other Mental Health Personnel Please Specify: (Maximum 40 characters)		Yes No
* Substance Use Disorder Providers		Yes No

Professional Services 8

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Other Professional Health Services Personnel Please Specify: (Maximum 40 characters)		Yes No

Vision Services 9

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Ophthalmologists		Yes No
* Optometrists		Yes No
* Other Vision Care Personnel Please Specify: (Maximum 40 characters)		Yes No

Pharmacy Personnel 10

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Pharmacy Personnel		Yes No

Enabling Services 11

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Case Managers		Yes No
* Patient and Community Education Specialists		Yes No
* Outreach Workers		Yes No
* Transportation Workers		Yes No
* Eligibility Assistance Workers		Yes No
* Interpretation Personnel		Yes No
* Community Health Workers		Yes No
* Other Enabling Services Personnel Please Specify: (Maximum 40 characters)		Yes No

Other Programs and Services 12

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Quality Improvement Personnel		Yes No
* Other Programs and Services Personnel Please Specify: (Maximum 40 characters)		Yes No

Total FTEs 13

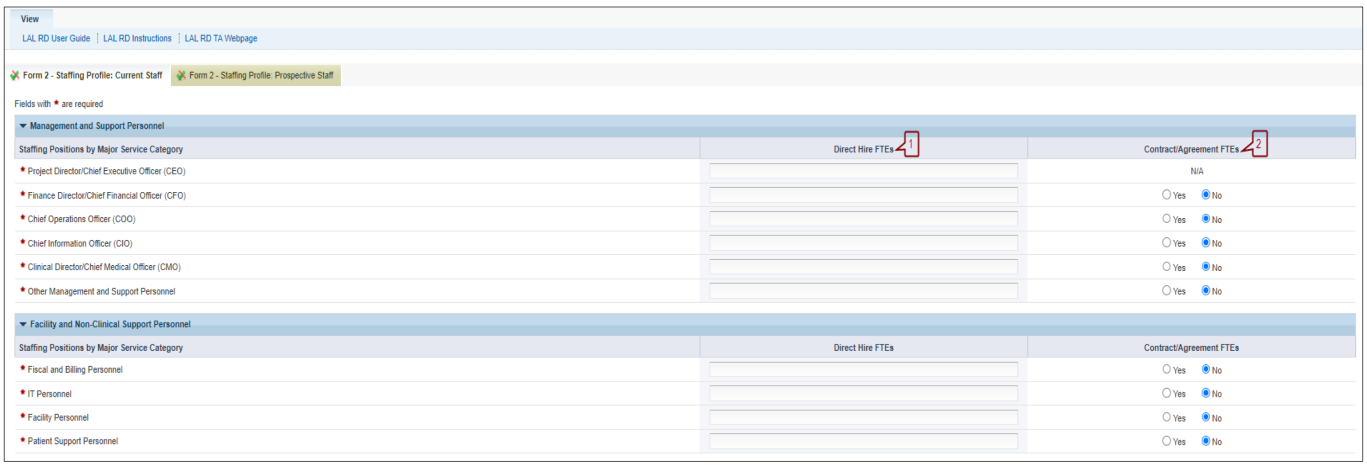
Totals	Direct Hire FTEs	Contract/Agreement FTEs
Totals Calculate	0.00	N/A

Go to Previous Page | Save | Save and Continue

To complete Form 2, follow the steps below:

1. In the Direct Hire FTEs column, provide the number of Full-Time Employees (FTEs) directly hired by the health center for each staffing position. Enter 0 if not applicable. (**Figure 13**, **1**).
2. The Total row of the Total FTEs section displays the sum of 'Direct Hire FTEs' for the Staffing Positions for Major Service Categories. To calculate the totals, click the Calculate button show in (**Figure 12**).
3. In the Contract/Agreement FTEs column, indicate whether contracts are used for each staffing position (**Figure 13**, **2**). Contracted staff should be summarized in **Attachment 7: Summary of Contracts and Agreements** and/or included in contracts uploaded to **Form 8: Health Center Agreements**, as applicable.

Figure 13: Direct Hire and Contract/Agreement FTE Columns



4. Click the **Save and Continue** button to save your work and proceed to the next form.

IMPORTANT NOTES:

- Allocate staff time in the Direct Hire FTE column by function among the staff positions listed. An individual's FTE should not be duplicated across positions. For example, a provider serving as a part- time family physician and a part-time Chief Medical Officer should be listed in each respective category with the FTE allocated to each position (e.g., CMO 0.3 FTE and family physician 0.7 FTE). Do not exceed 1.0 FTE for any individual. For position descriptions, refer to the UDS Reporting Manual (http://bphc.hrsa.gov/datareporting/reporting/index.html).
- If a staffing position is not listed, you may specify in the "Other" section, up to 40 characters, and provide value for Direst Hire FTEs (zeros are acceptable) or specify if it is Contract/Agreement FTEs.
- Volunteers should be recorded in the Direct Hire FTEs column.

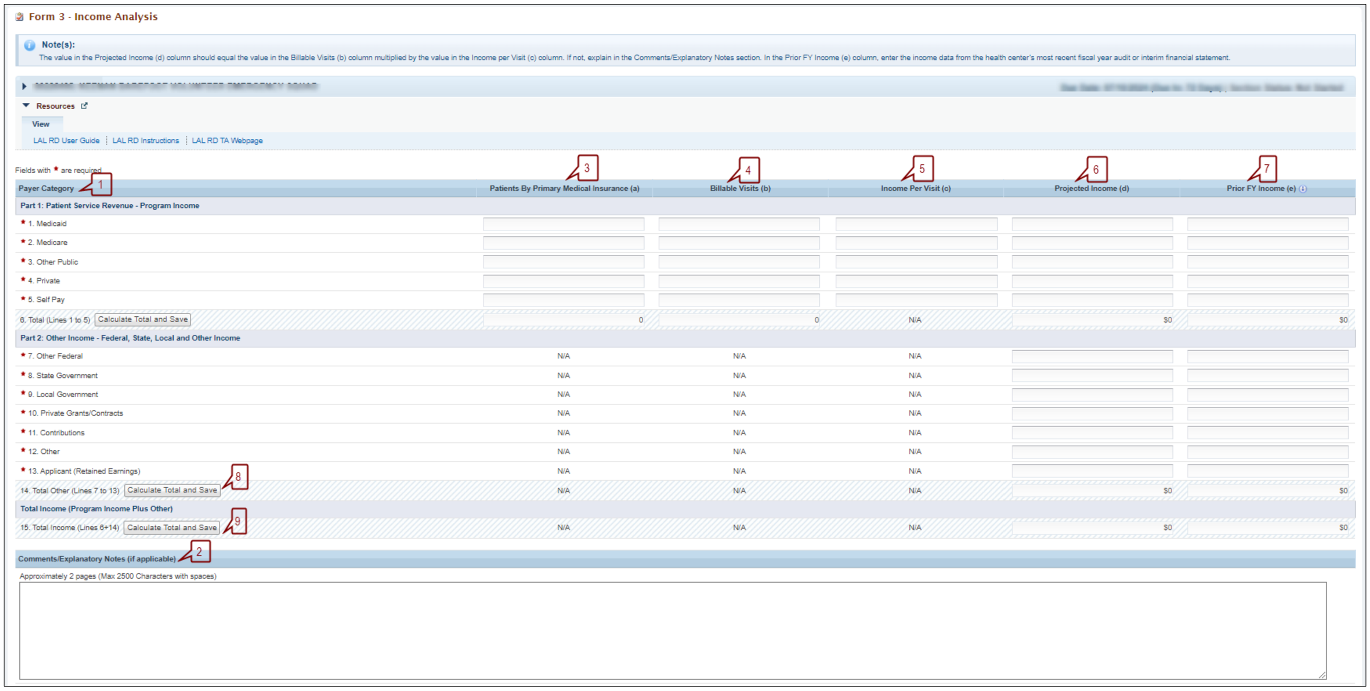
3.2.2 Completing Form 3 – Income Analysis

Form 3: Income Analysis projects program income, by source, for Year 1 of the proposed period of performance. This form comprises the following sections:

1. Payer Category (**Figure 14**, **1**)

2. Comments/Explanatory Notes (**Figure 14**, **2**)

Figure 14: Form 3 – Income Analysis



3.2.2.1 Completing the Payer Categories Section

The Payer Category section has the following parts:

- Part 1: Patient Service Revenue - Program Income
- Part 2: Other Income - Other Federal, State, Local, and Other Income
- Total Income (Program Income Plus Other)

To complete the Payer Category section, follow the steps below:

1. In column (a), provide the number of Patients by Primary Medical Insurance for each Payer Category in Part 1. Enter 0 if not applicable (Figure 14, **3**).
2. In column (b), provide the number of Billable Visits that are greater than or equal to the number of Patients by Primary Medical Insurance (column (a)) for each Payer Category in Part 1. Enter 0 if not applicable (Figure 14, **4**).
3. In column (c), provide the amount of Income per Visit for each Payer Category in Part 1. Enter 0 if not applicable. (**Figure 14**, **5**).
4. In column (d), provide the amount of Projected Income for each Payer Category in Parts 1 and 2. Enter 0 if not applicable (Figure 14, **6**).
5. In column (e), provide the amount of Prior FY Income in Parts 1 and 2. Refer to the Fiscal Year End Date selected in Form 1A of this application to provide this information. Enter 0 if not applicable (**Figure 14**, **7**).
6. Click the Calculate Total and Save button to calculate and save the values for each Payer Categories in Part 1. (**Figure 14**, **8**).

7. Click the Calculate Total and Save button in the Total Income (Program Income Plus Other) section to calculate and save the values for each Payer Category in Part 1 & 2. (**Figure 14**, **9**).

IMPORTANT NOTES:

- The number of Billable Visits in column (b) should be Zero if the number of Patients by Primary Medical Insurance in column (a) for a Payer Categories is Zero.
- The value for the Total Program Income (line 6, column (d)) should equal the value for the Total Program Income on **Form 3A**, line (f) under section 2. Revenue.
- The Patients by Primary Medical Insurance (a), Billable Visits (b) and Income Per Visit (c) columns in Part 2 are disabled and set to 'N/A'.

3.2.2.2 Completing the Comments/Explanatory Notes Section

In this section, enter any comments/explanations related to this form.

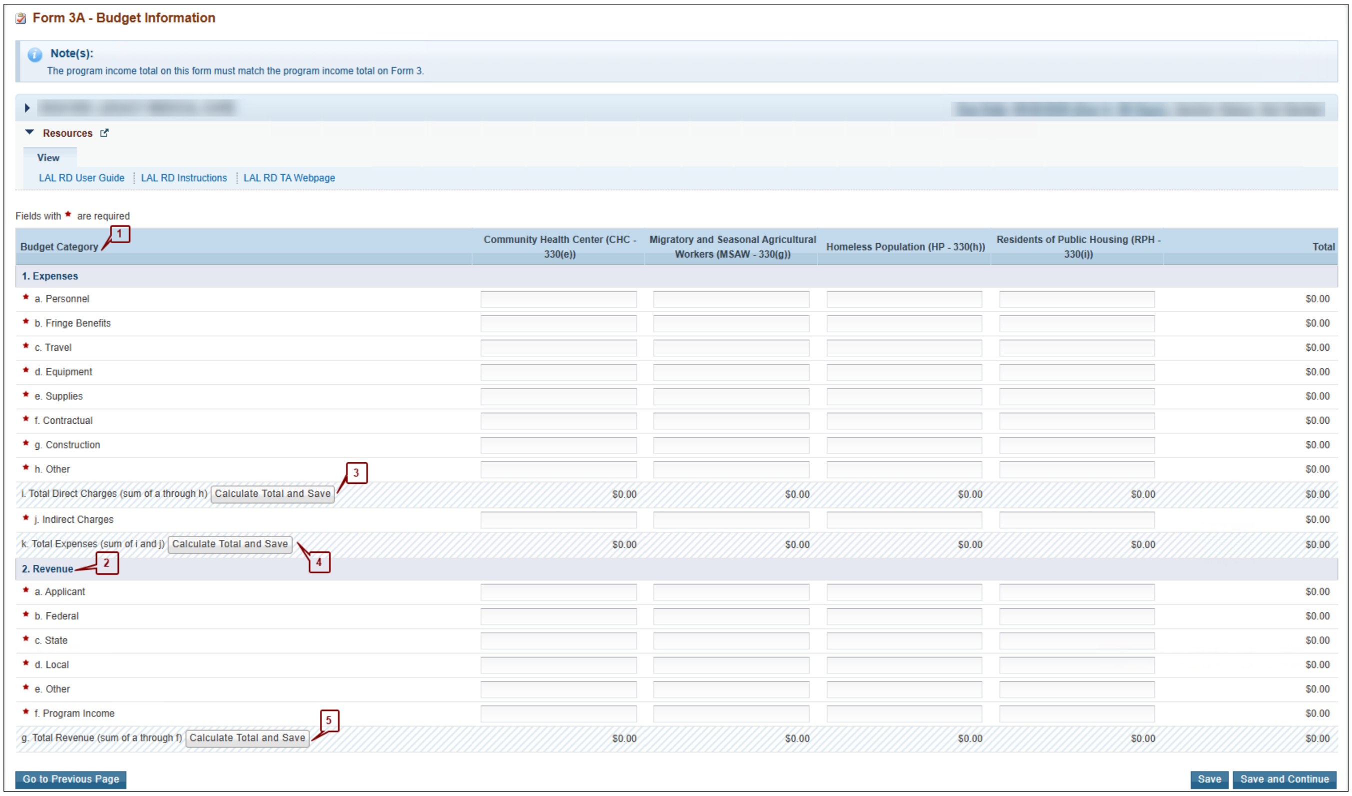
1. For each of the Payer Categories in Part 1, the value in the Projected Income (d) column should equal the value obtained by multiplying Billable Visits (b) and Income per Visit (c). If these values are not equal, explain in this section. If these numbers are equal for all the Payer Categories, providing comments in this section is optional.
2. Click the **Save and Continue** button to save your work and proceed to the next form.

3.3 Completing Form 3A – Look-Alike Budget Information

Form 3A: Budget Information shows the program budget, by category, for the upcoming certification period. This form has the following sections:

1. Expenses (**Figure 15**, **1**)
2. Revenue (**Figure 15**, **2**)

Figure 15: Form 3A – Budget Information



Form 3A - Budget Information

Note(s):
The program income total on this form must match the program income total on Form 3.

Resources

View

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Fields with * are required

Budget Category	Community Health Center (CHC - 330(e))	Migratory and Seasonal Agricultural Workers (MSAW - 330(g))	Homeless Population (HP - 330(h))	Residents of Public Housing (RPH - 330(i))	Total
1. Expenses					
* a. Personnel					$0.00
* b. Fringe Benefits					$0.00
* c. Travel					$0.00
* d. Equipment					$0.00
* e. Supplies					$0.00
* f. Contractual					$0.00
* g. Construction					$0.00
* h. Other					$0.00
i. Total Direct Charges (sum of a through h) Calculate Total and Save	$0.00	$0.00	$0.00	$0.00	$0.00
* j. Indirect Charges					$0.00
k. Total Expenses (sum of i and j) Calculate Total and Save	$0.00	$0.00	$0.00	$0.00	$0.00
2. Revenue					
* a. Applicant					$0.00
* b. Federal					$0.00
* c. State					$0.00
* d. Local					$0.00
* e. Other					$0.00
* f. Program Income					$0.00
g. Total Revenue (sum of a through f) Calculate Total and Save	$0.00	$0.00	$0.00	$0.00	$0.00

Go to Previous Page | Save | Save and Continue

3.3.1 Completing the Expenses Section

In the Expenses section, enter the projected expenses for the upcoming certification period for each of the applicable categories.

1. If the categories in the form do not describe all expenses, enter expenses in the other category.
2. Click the Calculate Total and Save button to calculate and save the values for each of the Budget Categories in Part 1. (**Figure 15**, **3**, **4**).

3.3.2 Completing the Revenue Section

In the Revenue section, enter the projected revenue for the upcoming certification period from each category.

1. If you are a state agency, leave the State row blank and include state funding in the Applicant row.
2. If revenue is collected from sources other than those listed, indicate the additional sources in the other category.
3. Click the Calculate Total and Save button to calculate and save the values for each of the Budget Categories in Part 2. (**Figure 15**, **5**).
4. Click the **Save and Continue** button to save your work and proceed to the next form.

IMPORTANT NOTE:

- The value for the Total Program Income in the Revenue section (line (f)) should equal the value for the Total Program Income on Form 3, line 6, column (d).

3.4 Completing the Sites and Services Section

To complete this section, you must complete the following forms:

3.4.1 Completing Form 5A – Services Provided

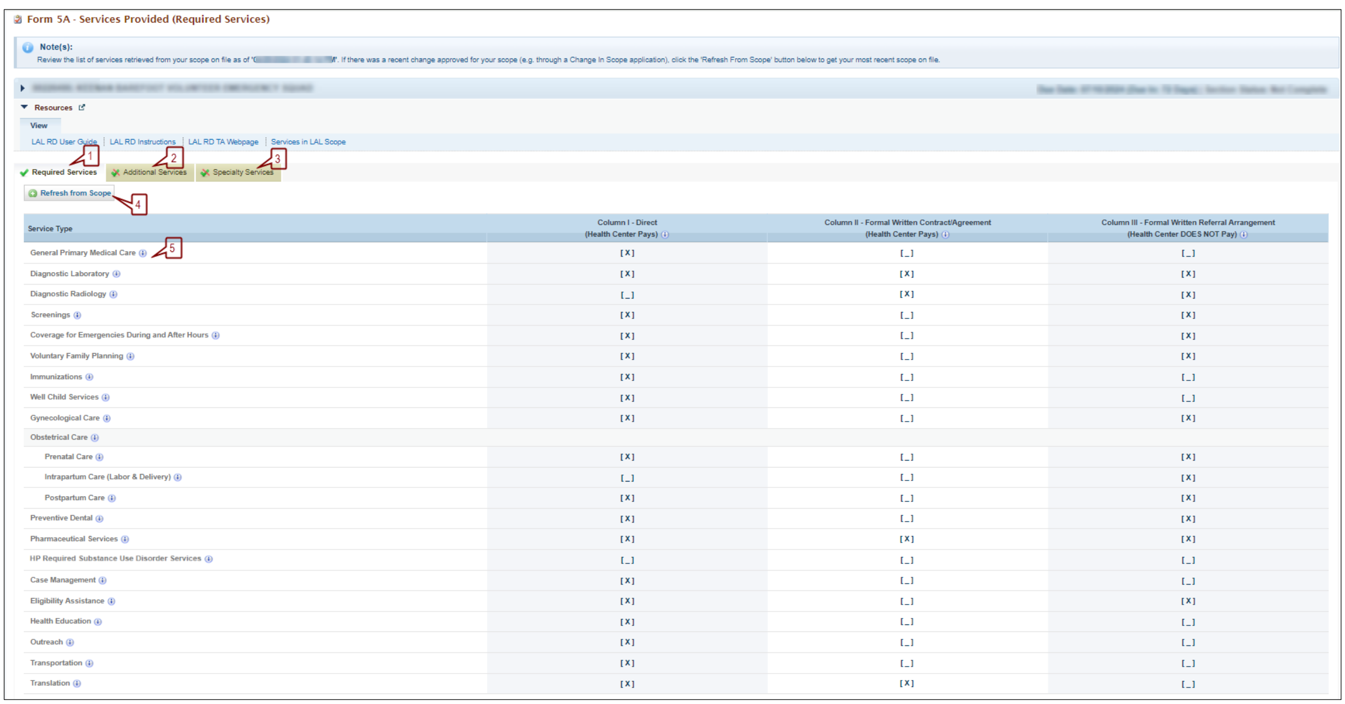
Form 5A – Services Provided identifies the services to be provided, and how they will be provided by the applicant organization. For Renewal of Designation applications, Form 5A – Services Provided has the following sections:

1. Required Services (**Figure 16**, **1**)
2. Additional Services (**Figure 16**, **2**)
3. Specialty Services (**Figure 16**, **3**)

The **Form 5A: Services** Provided is pre-populated with the services in your current Health Center Program scope that HRSA has on file for your organization and is non-editable.

If the pre-populated data on Form 5A does not reflect any recently approved scope changes, click the **Refresh from Scope** button to refresh the data and display the approved changes. (**Figure 16**, **4**)

Figure 16: Form 5A – Services Provided (Required Services)


Form 5A - Services Provided (Required Services)

Note(s):
Review the list of services retrieved from your scope on file as of '[illegible]'. If there was a recent change approved for your scope (e.g. through a Change In Scope application), click the 'Refresh From Scope' button below to get your most recent scope on file.

Resources

View

LAL RD User Guide | LAL RD Instructions | LAL RD TA Webpage | Services in LAL Scope

1 Required Services | 2 Additional Services | 3 Specialty Services

Refresh from Scope 4

Service Type	Column I - Direct (Health Center Pays)	Column II - Formal Written Contract/Agreement (Health Center Pays)	Column III - Formal Written Referral Arrangement (Health Center DOES NOT Pay)
General Primary Medical Care 5	[X]	[_]	[_]
Diagnostic Laboratory	[X]	[X]	[X]
Diagnostic Radiology	[_]	[X]	[X]
Screenings	[X]	[_]	[X]
Coverage for Emergencies During and After Hours	[X]	[_]	[X]
Voluntary Family Planning	[X]	[_]	[X]
Immunizations	[X]	[_]	[_]
Well Child Services	[X]	[_]	[_]
Gynecological Care	[X]	[_]	[X]
Obstetrical Care			
Prenatal Care	[X]	[_]	[X]
Intrapartum Care (Labor & Delivery)	[_]	[_]	[X]
Postpartum Care	[X]	[_]	[X]
Preventive Dental	[X]	[_]	[X]
Pharmaceutical Services	[X]	[X]	[X]
HP Required Substance Use Disorder Services	[_]	[_]	[_]
Case Management	[X]	[_]	[_]
Eligibility Assistance	[X]	[_]	[X]
Health Education	[X]	[_]	[_]
Outreach	[X]	[_]	[_]
Transportation	[X]	[_]	[_]
Translation	[X]	[X]	[_]

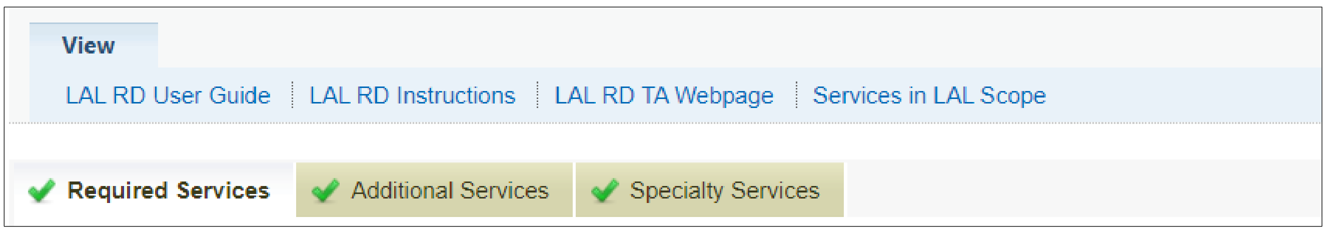
3.4.1.1 Completing Form 5A: Required Services, Additional Service & Specialty Services Section Tabs

The **Form 5A: Service Provided** is pre-populated with the services in the current Health Center Program scope that HRSA has on file for your organization and is not editable. If the pre-populated data on **Form 5A** does not reflect any recently approved scope changes, click the Refresh from Scope button (**Figure 16**, **4**) to refresh the data and display the approved changes. You will be required to visit the Required Services, Additional Services, and Specialty Services sections (**Figure 16**, **1**, **2**, **3**) at least once by clicking the Continue button on each section to change the status of the form to Complete.

Form 5A: Services Provided will be complete when each of the Required Services, Additional Services, and Specialty Services sections are complete, indicated with a green tick mark in the section tabs (**Figure 17**).

After completing all the sections on **Form 5A**, click the Save and Continue button to save your work and proceed to Form 5B.

Figure 17: Completed Form 5A



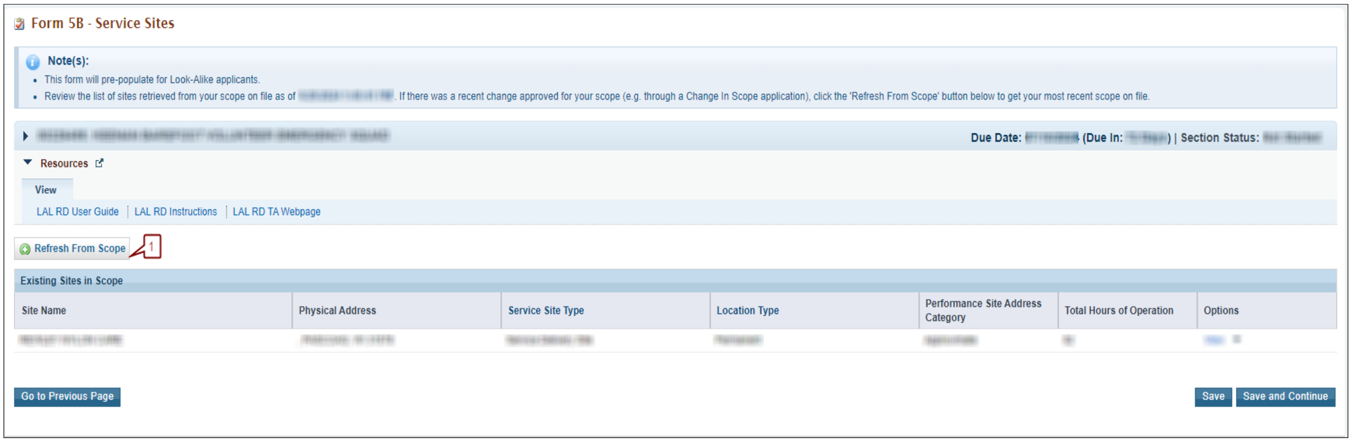
3.4.2 Completing Form 5B – Service Sites

Form 5B – Service Sites identifies the sites in your scope of the project. **Form 5B** is pre-populated with the sites in the current Health Center Program scope that HRSA has on file for your organization. Form 5B is not editable. You will be required to visit the form at least once to change the status of the form to Complete.

If the pre-populated data on Form 5B does not reflect any recently approved scope changes, click the **Refresh from Scope** button to refresh the data and display the approved changes (**Figure 18**, **1**).

After providing complete information on **Form 5B – Edit** page, click the **Save and Continue** button.

Figure 18: Form 5B – Service Sites



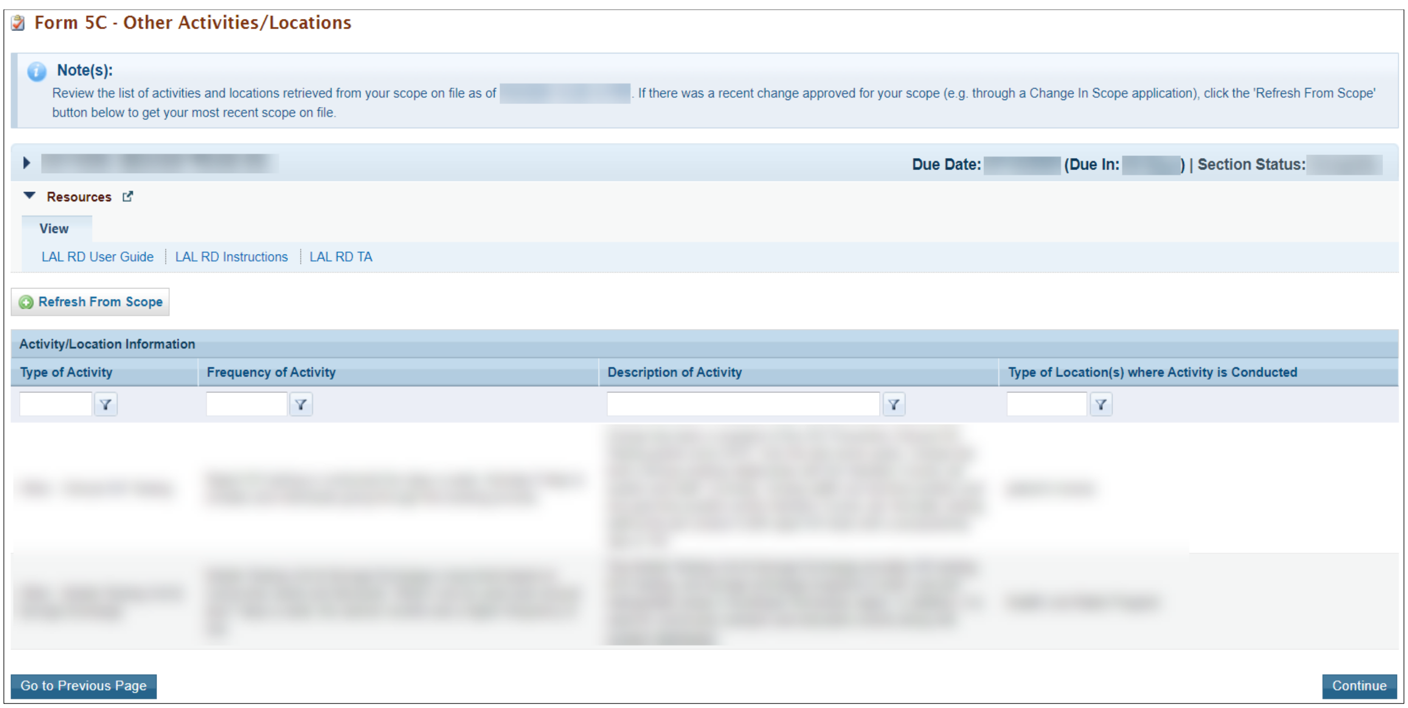
3.4.3 Completing Form 5C – Other Activities / Locations

Form 5C - Other Activities/Locations are pre-populated with the activities/locations Information in the current Health Center Program scope that HRSA has on file for your organization and is not editable.

You will be required to visit this form at least once to change the status of the form to Complete. If the pre-populated data on Form 5B does not reflect any recently approved scope changes, click the Refresh from Scope button to refresh the data and display the approved changes (**Figure 19**).

After completing Form 5C, click the Continue button to save your work and proceed to the next form.

Figure 19: Form 5C – Other Activities / Locations



3.4.4 Completing Scope Certification

Scope Certification allows you to certify if the scope of your organization, displayed in Form 5A: Services Provided and Form 5B: Service Sites of this Renewal of Designation, is correct.

To complete this form, follow the steps below:

1. Select an option in section 1: **Scope of Project Certification - Services** to certify that the Form 5A: Services Provided form of this Renewal of Designation accurately reflects all services and service delivery methods included in your current approved project scope or that it requires changes that you submitted through the change in scope process (**Figure 20**, **1**).
2. Select an option in section 2: **Scope of Project Certification -** Sites to certify that the Form 5B: Service Sites form of this Renewal of Designation accurately reflects all sites included in your current approved project scope or that it requires changes that you submitted through the change in scope process (**Figure 20**, **2**).

Figure 20: Scope Certification

3. Click the **Save and Continue** button to save the information and proceed to the next form.

3.5 Completing the Other Forms Section

To complete this section, you must complete the following forms:

3.5.1 Completing Form 6A – Current Board Member Characteristics

Form 6A - Current Board Member Characteristics provides information about your organization's current board members.

<u>**IMPORTANT NOTES**</u>:

- This form is optional if you selected 'Tribal Indian' or 'Urban Indian' as the **Business Entity** in **Form 1A: General Information Worksheet**. Click the Save and Continue button at the bottom of the page to proceed to the next form.
- If you chose a **Business Entity** other than 'Tribal Indian' or 'Urban Indian,' you must enter all required information on **Form 6A.**
- The minimum number of board members to be entered on **Form 6A** is **9** and the maximum number is **25**.
- If **Form 6A** is optional for you, but you choose to enter information, then you must enter all required information.

To complete this form, follow the steps below:

1. To add the board member information, click the Add New Board Member button (**Figure 21**, **1**). You must provide a minimum of 9 and a maximum of 25 board members. The system navigates to the Current Board Member – Add page (**Figure 22**).
2. Provide the required board member information on this page. Click the **Save and Continue** button to save the information and navigate back to the Form 6A list page (**Figure 22**, **1**), or the Save and Add New button to save the information and add a new board member (**Figure 22**, **2**).
3. To update or to delete information for any board member, click on the **Update** or **Delete** link under the options column in the List of All Board Members section (**Figure 21**, **2**).
4. If you selected Public (non-Tribal or Urban Indian) as the business entity in Form 1A of this application, then select 'Yes' or 'No' for the public organization/center-related question. If you selected a different business entity in Form 1A, then select 'N/A' for this question. If you answer 'Yes' to this question, ensure that the co-applicant agreement is included as Attachment 6 in the **Appendices** form of this application.
5. After providing complete information on Form 6A, click the **Save and Continue** button to save the information and proceed to the next form.

Figure 21: Form 6A – Current Board Member Characteristics

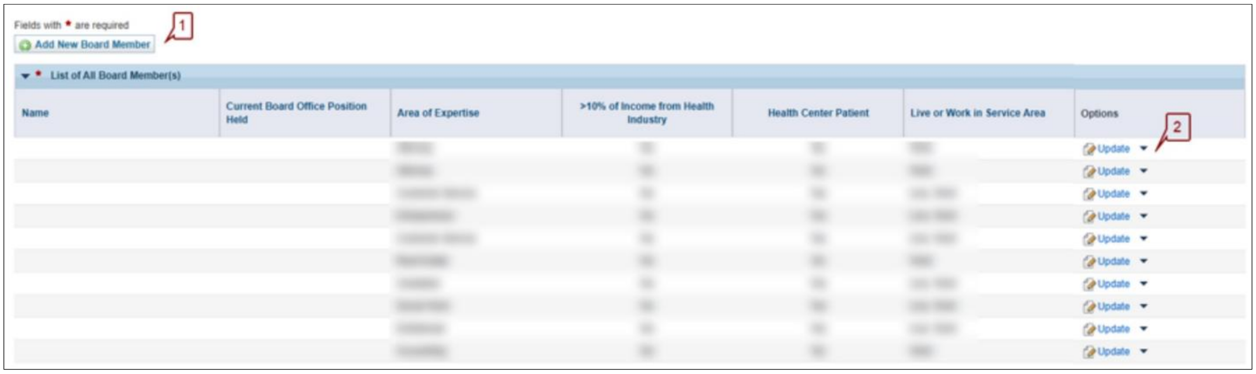
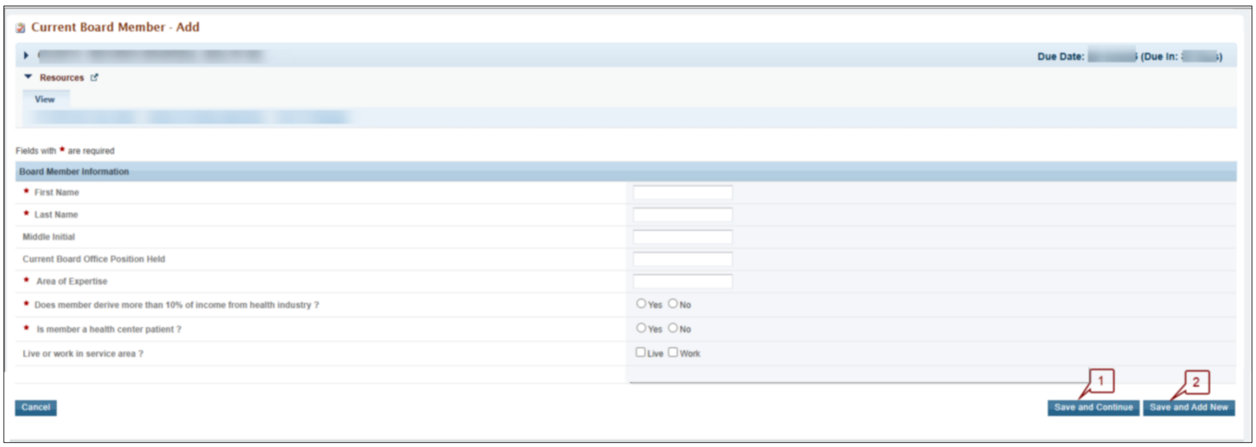


Figure 22: Current Board Member – Add Page



3.5.2 Completing Form 6B – Request for Waiver of Board Member Requirements

Form 6B - Request for Waiver of Board Member Requirements If you are proposing to serve only Migratory and Seasonal Agricultural Workers, Homeless Population, and/or Residents of Public Housing, Form 6B is used to request a waiver of the patient majority governance requirement. HRSA will not grant a waiver request if your organization is applying to serve the underserved community (Community Health Center (CHC)).

3.5.2.1 Completing Form 6B When It is Not Applicable

Form 6B is not applicable and you will only see the message depicted (**Figure 23**) if any of these reasons are true:

- You have selected Community Health Centers (CHC) as the Target Population in the Cover Page form of this application.
- You selected “Tribal” or “Urban Indian” as the Business Entity in Form 1A.

You can complete this form and proceed to the next form by clicking the **Continue** button at the bottom of the page.

Figure 23: Form 6B – Not Applicable

3.5.2.2 Completing Form 6B When it is Applicable

To complete **Form 6B** when it is applicable, follow the steps provided below**:**

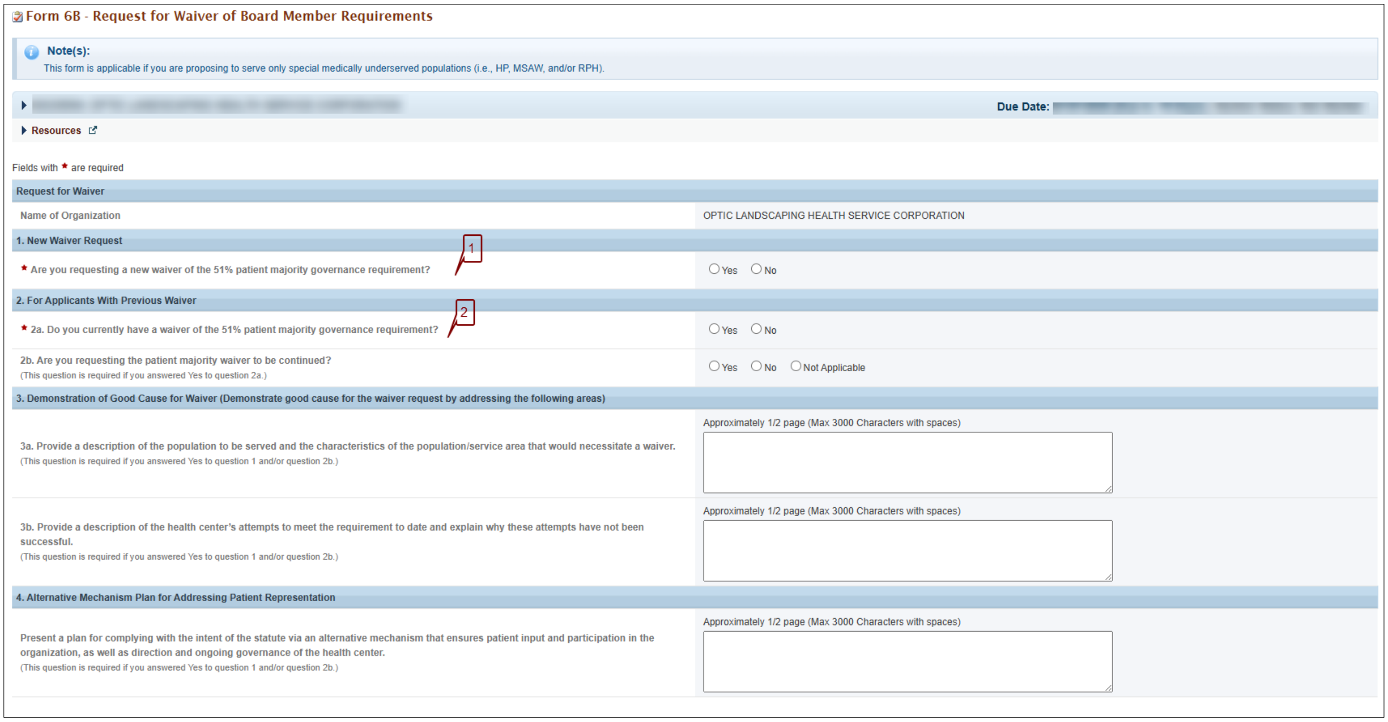
1. Indicate whether you are requesting a new waiver of the 51% patient majority governance requirement under the New Waiver Request section (**Figure 24**, **1**) or if you currently have a waiver in the For Applicants With Previous Waiver section (**Figure 24**, **2**).
2. Answer the remaining questions on the form, as applicable.

IMPORTANT NOTES:

- Question 1 and Question 2a both cannot be marked ‘Yes’.
- Select ‘Yes’ or ‘No’ for question 2a if you answered ‘No’ to question 1.
- Select ‘Yes’ or ‘No’ for question 2b if you answered ‘Yes’ to question 2a. Select ‘N/A’ for this question if you answered ‘No’ to question 2a.
- Questions 3a, 3b, and 4 are required if you answered 'Yes' to question 1 and/or question 2b.

3. After completing **Form 6B**, click the Save and Continue button to save your work and proceed to the next form.

Figure 24: Form 6B - Applicable


Form 6B - Request for Waiver of Board Member Requirements

Note(s):
This form is applicable if you are proposing to serve only special medically underserved populations (i.e., HP, MSAW, and/or RPH).

Due Date:

Resources

Fields with * are required

Request for Waiver

Name of Organization	OPTIC LANDSCAPING HEALTH SERVICE CORPORATION
1. New Waiver Request	
* Are you requesting a new waiver of the 51% patient majority governance requirement?	○Yes ○No
2. For Applicants With Previous Waiver	
* 2a. Do you currently have a waiver of the 51% patient majority governance requirement?	○Yes ○No
2b. Are you requesting the patient majority waiver to be continued? (This question is required if you answered Yes to question 2a.)	○Yes ○No ○Not Applicable
3. Demonstration of Good Cause for Waiver (Demonstrate good cause for the waiver request by addressing the following areas)	
3a. Provide a description of the population to be served and the characteristics of the population/service area that would necessitate a waiver. (This question is required if you answered Yes to question 1 and/or question 2b.)	Approximately 1/2 page (Max 3000 Characters with spaces)
3b. Provide a description of the health center's attempts to meet the requirement to date and explain why these attempts have not been successful. (This question is required if you answered Yes to question 1 and/or question 2b.)	Approximately 1/2 page (Max 3000 Characters with spaces)
4. Alternative Mechanism Plan for Addressing Patient Representation	
Present a plan for complying with the intent of the statute via an alternative mechanism that ensures patient input and participation in the organization, as well as direction and ongoing governance of the health center. (This question is required if you answered Yes to question 1 and/or question 2b.)	Approximately 1/2 page (Max 3000 Characters with spaces)

3.5.3 Completing Form 8 – Health Center Agreements

Form 8 - Health Center Agreements indicates whether you have 1) any agreements with a parent, affiliate, or subsidiary organization; and/or 2) any agreements that will constitute a substantial portion of the proposed scope of the project, including a proposed site operated by a contractor, as identified in Form 5B: Service Sites. This form has the following sections:

- Part I: Health Center Agreements (**Figure 25**, **1**)
- Part II: Attachments (**Figure 25**, **2**)

3.5.3.1 Completing Part I of Form 8

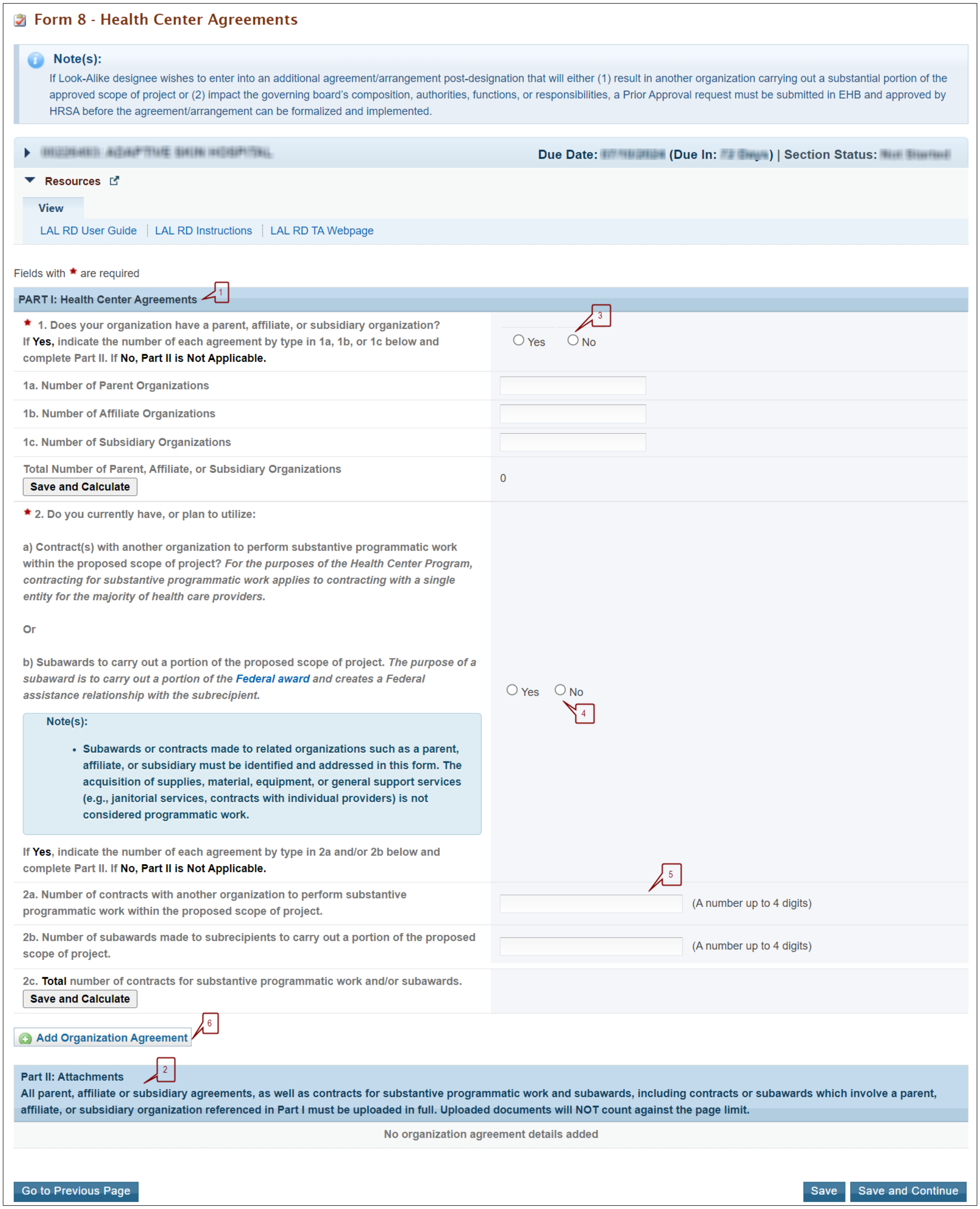
To complete Part I of Form 8, follow the steps below:

1. In Part I, question 1 (**Figure 25**, **3**), answer if your organization has a parent, affiliate, or subsidiary organization and provide number of Parent, Affiliate and/or Subsidiary organizations.
2. Select 'Yes' in question 2 (**Figure 25**, **4**) if any current or proposed agreements exist with another organization to conduct a substantial portion of your organization's approved scope of the project. If 'Yes' is selected, complete 2a (**Figure 25**, **5**).

   <u>**IMPORTANT NOTES**</u>:

   If any of the sites in **Form 5B: Service Sites** are being operated by a contractor, the system will auto-select 'Yes' for question 2 and make it non-editable.

Figure 25: Form 8, Part I



Form 8 - Health Center Agreements

Note(s):
If Look-Alike designee wishes to enter into an additional agreement/arrangement post-designation that will either (1) result in another organization carrying out a substantial portion of the approved scope of project or (2) impact the governing board's composition, authorities, functions, or responsibilities, a Prior Approval request must be submitted in EHB and approved by HRSA before the agreement/arrangement can be formalized and implemented.

[illegible] **Due Date:** [illegible] **(Due In:** [illegible]**) | Section Status:** [illegible]

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Fields with * are required

PART I: Health Center Agreements 1

* 1. Does your organization have a parent, affiliate, or subsidiary organization? If **Yes**, indicate the number of each agreement by type in 1a, 1b, or 1c below and complete Part II. If **No, Part II is Not Applicable.**	3 ○ Yes ○ No
1a. Number of Parent Organizations	
1b. Number of Affiliate Organizations	
1c. Number of Subsidiary Organizations	
Total Number of Parent, Affiliate, or Subsidiary Organizations **Save and Calculate**	0
* 2. Do you currently have, or plan to utilize: a) Contract(s) with another organization to perform substantive programmatic work within the proposed scope of project? *For the purposes of the Health Center Program, contracting for substantive programmatic work applies to contracting with a single entity for the majority of health care providers.* Or b) Subawards to carry out a portion of the proposed scope of project. *The purpose of a subaward is to carry out a portion of the Federal award and creates a Federal assistance relationship with the subrecipient.* **Note(s):** • Subawards or contracts made to related organizations such as a parent, affiliate, or subsidiary must be identified and addressed in this form. The acquisition of supplies, material, equipment, or general support services (e.g., janitorial services, contracts with individual providers) is not considered programmatic work. If **Yes**, indicate the number of each agreement by type in 2a and/or 2b below and complete Part II. If **No, Part II is Not Applicable.**	○ Yes ○ No 4
2a. Number of contracts with another organization to perform substantive programmatic work within the proposed scope of project.	5 (A number up to 4 digits)
2b. Number of subawards made to subrecipients to carry out a portion of the proposed scope of project.	(A number up to 4 digits)
2c. **Total** number of contracts for substantive programmatic work and/or subawards. **Save and Calculate**	

Add Organization Agreement 6

Part II: Attachments 2
All parent, affiliate or subsidiary agreements, as well as contracts for substantive programmatic work and subawards, including contracts or subawards which involve a parent, affiliate, or subsidiary organization referenced in Part I must be uploaded in full. Uploaded documents will NOT count against the page limit.

No organization agreement details added

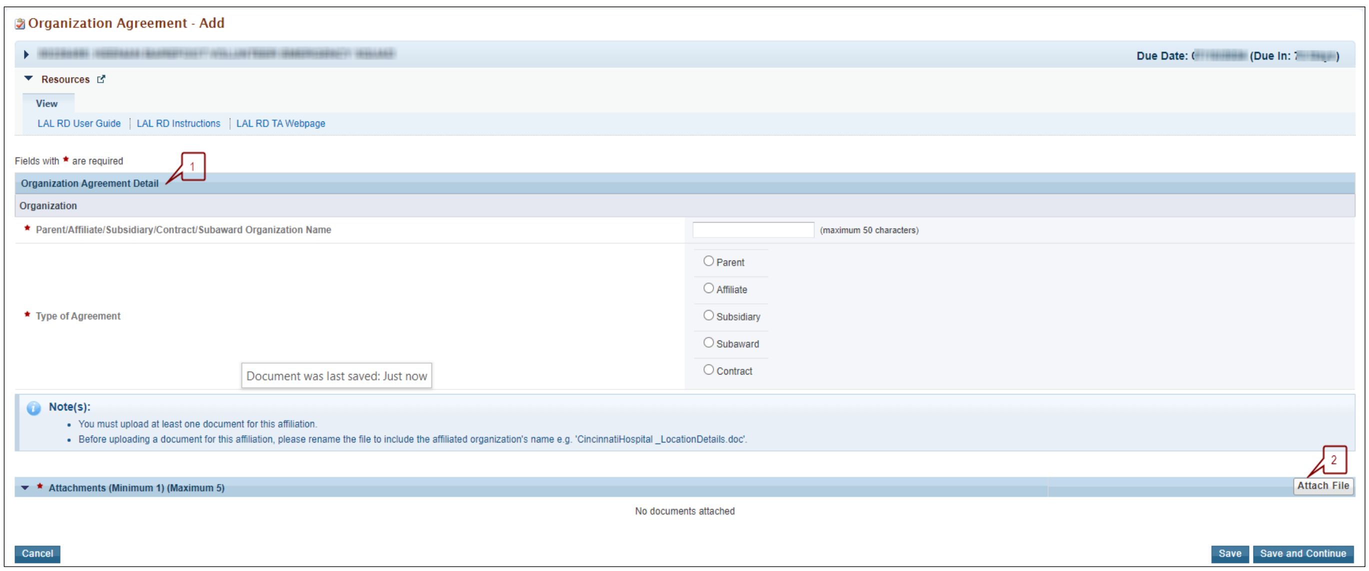
Go to Previous Page | Save | Save and Continue

3.5.3.2 Completing Part II of Form 8 – Adding Organization Agreement Details

If you answer 'Yes' to questions 1 and/or 2 in Part II, provide each agreement with external organizations as noted in Part I. If you select 'No' in questions 1 and 2, Part II is Not Applicable. The agreements will be organized by each organization. To add agreements, follow these steps:

1. Click the **Add Organization Agreement** button located above Part II (**Figure 25**, **6**) and the system navigates to the Organization Agreement - Add page (**Figure 26**).
2. Provide the required information for the agreement in the Organization Agreement Detail (**Figure 26**, **1**) section on this page (Upload at least one document related to the agreement in the Attachments section at the bottom of this page by clicking the Attach File (**Figure 26**, **2**) button.

Figure 26: Organization Agreement – Add Page



IMPORTANT NOTES:

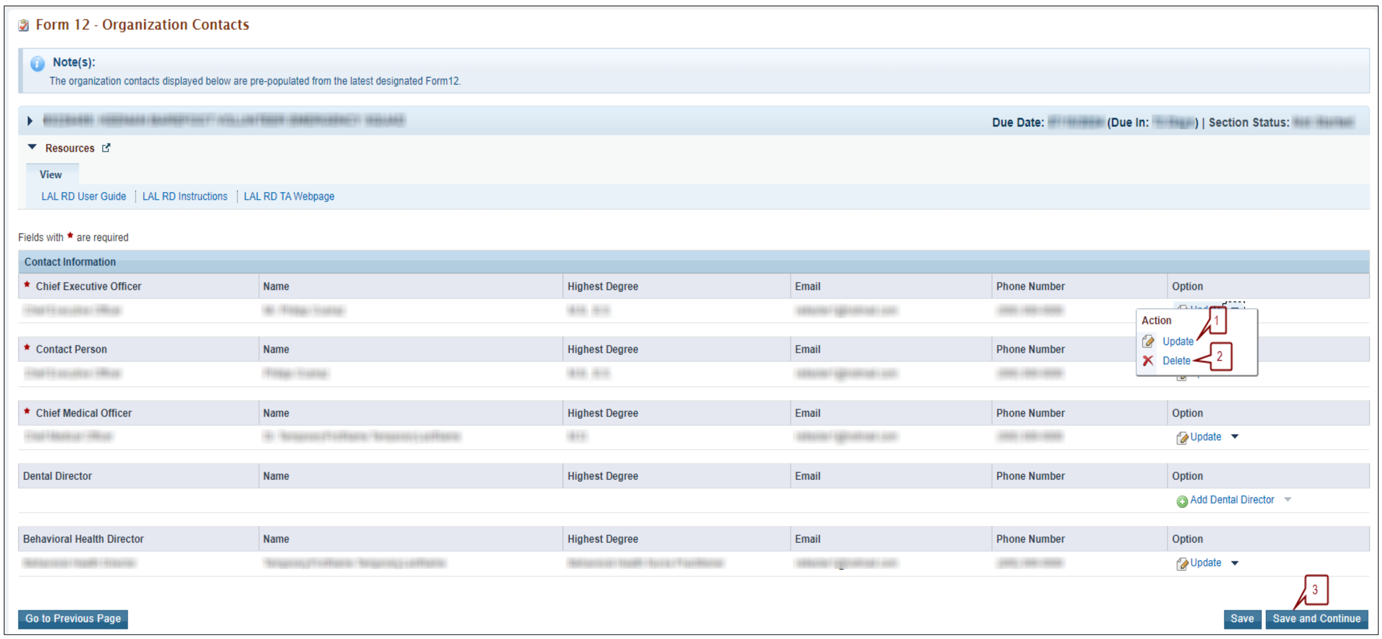
- Before uploading a document for this agreement, rename the file to include the applicable organization's name (e.g., **CincinnatiHospital_MOA.docx**.')
- Part II will accept a maximum of five document uploads for each of up to 10 organizations listed. Additional documentation that exceeds this limit should be included in Attachment 14: Other Relevant Documents.
- Attachments to Form 8 will not count toward the application page limit of 160 pages.
- A warning will be displayed if the number of attachments attached in Part II does not match with the number of Parent, Affiliate or Subsidiary organizations. However, this won't stop you from completing the form.

1. Click the Save and Continue button to return to the **Form 8: Health Center Agreements** list page. Following the steps described above, add organizations and corresponding agreements referenced in Part 1 up to the noted maximum.
2. After completing **Form 8**, click the Save and Continue button to save your work and proceed to the next form.

3.5.4 Completing Form 12 – Organization Contacts

Form 12 - Organization Contacts will be pre-populated within this form. If you wish to update or delete any of the contact information, follow the following steps (**Figure 27**).

Figure 27: Form 12 – Organization Contacts



To update this form:

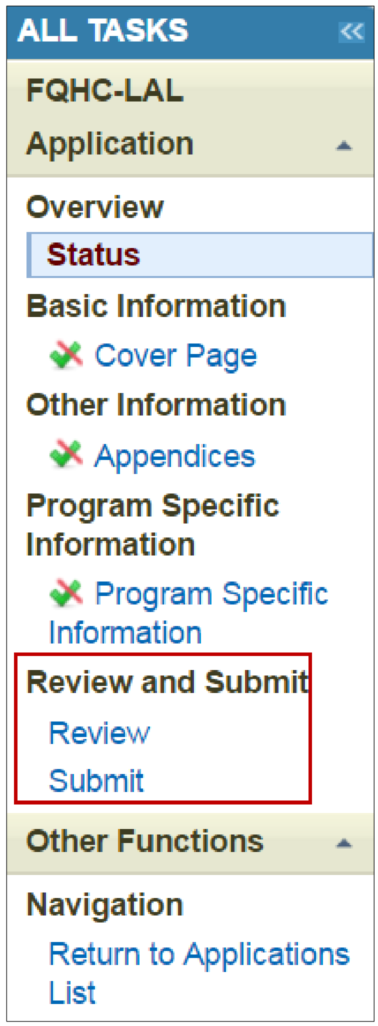
1. To update the contact information provided, click on the Update link under the options column (**Figure 27**, **1**)
2. To delete the contact information already provided, click on the **Delete** link under the options column (**Figure 27**, **2**)
3. After providing updated information on **Form 12**, click the **Save and Continue** button to save the information and proceed to Reviewing and Submitting the Look-Alike Renewal of Designation Application.

4. Reviewing and Submitting the Look-Alike Renewal of Designation Application to HRSA

To review your application, follow the steps below:

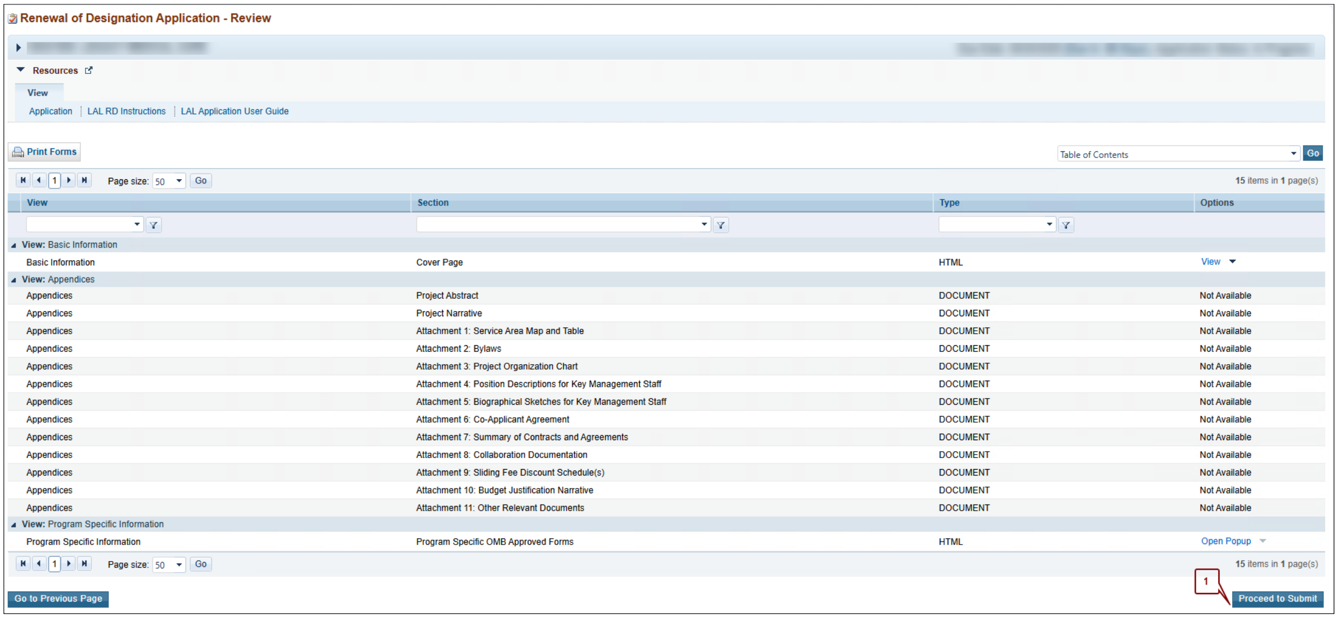
1. Click on the **Status** link on the Left Menu.
2. On the **Application – Status Overview page**, click the **Review** link in the **Review and Submit** section of the left menu. The system navigates to the Review page (**Figure 28**)

Figure 28: Review Link



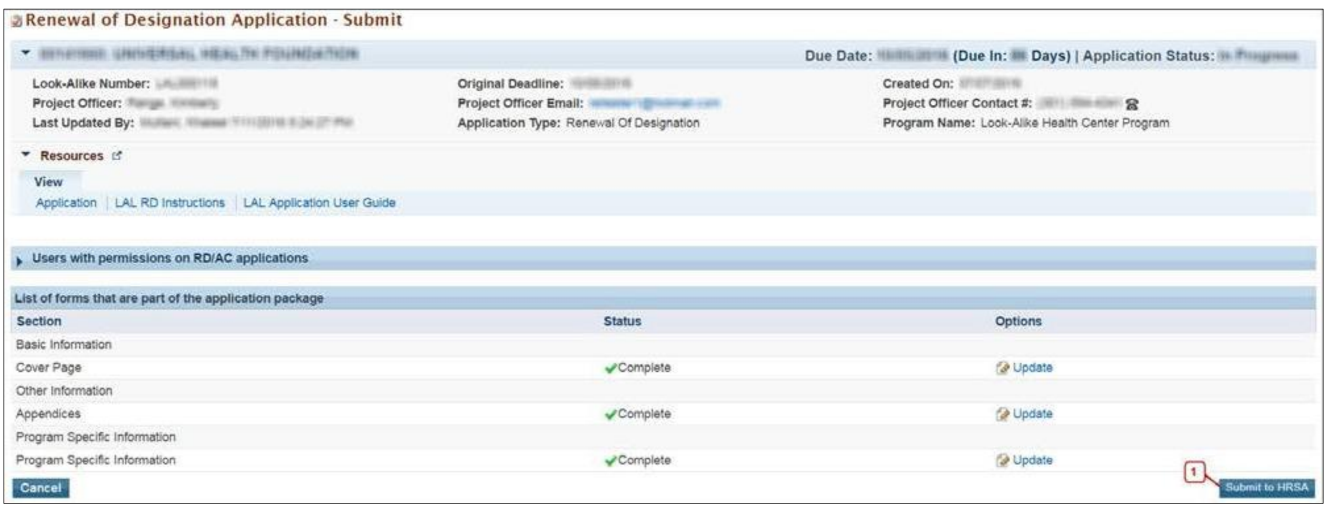
3. Verify the information displayed on the Review page (**Figure 29**).
4. If you are ready to submit the application to HRSA, click the Proceed to Submit button at the bottom of the Review page (**Figure 29**, **1**). The system navigates to the Submit page (**Figure 30**).

Figure 29: Review Page – Proceed to Submit



5. Click the Submit to HRSA button at the bottom of the Submit page (**Figure 30**, **1**). The system navigates to a confirmation page.

Figure 30: Submit to HRSA



6. Check the Application Certification to electronically sign the application and click the **Submit to HRSA** button.
7. If you experience any problems with submitting the application in EHB, contact Health Center Program Support at 1-877-464-4772 or https://hrsa.force.com/support/s/