

**HRSA Electronic Handbooks (EHBs)**

# **Fiscal Year (FY) 2025 New Access Points (NAP)**

**HRSA-25-085**

**User Guide for Applicants**

Last updated on May 2, 2024



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This user guide describes the steps to submit a FY 2025 New Access Points (NAP) application in the HRSA Electronic Handbooks (EHBs). This user guide does not replace the Notice of Funding Opportunity (NOFO), which details NAP requirements and instructions for the application. See the [NAP technical assistance webpage](#) for additional resources. Go to [HRSA EHBs](#) to create a login.gov account and register for EHBs, if you don't already have a username. If you have log in issues or forget your password, use the [BPHC Contact Form](#) or call (877) 464-4772.

## 1. Starting the FY 2025 NAP Application

Complete and submit the application by following a two-phase process:

1. Find the NOFO announcement number (HRSA-25-085) in Grants.gov, access the application package, and submit the completed forms in Grants.gov.
2. Validate, complete, and submit this application in EHBs.

To validate the Grants.gov application, log into EHBs and click on the [Grant Applications](#) link under the Tasks tab (**Figure 1, 1**) and then click on the **Grants.Gov Application Pending Validation: Validate** link (**Figure 1, 2**). You will need your Grants.gov and EHB tracking numbers (**emailed after successful Grants.gov submission**) (**Figure 2**).

Figure 1: Grant Applications Link



**Figure 2: Validating Your Grants.gov Application**

**Grants.Gov Application - Validate**

**Note(s):**  
In order to ensure that the correct persons are given permissions to work on this Grants.gov application, you must enter the following validation information from the submitted Grants.gov application

Fields with \* are required

**Announcement Information**

\* Announcement Number  
(From submitted Grants.gov application)  (e.g. HRSA-04-061 or 04-061)

**Grants.gov Application Information**

\* Grants.gov Tracking Number  
(From submitted Grants.gov application)  (e.g. GRANT00059900)

**EHBs Application Information**

\* EHBs Application Tracking Number  
(From email notification)  (e.g. 00025328)

**IMPORTANT NOTE:** Refer to the HRSA SF-424 Two Tier Application Guide (<http://www.hrsa.gov/grants/apply/applicationguide/sf424programspecificappguide.pdf>) for details related to submitting the application in Grants.gov and validating it in EHBs.

Once the application is validated in EHBs, click the Tasks tab on the EHB homepage to go to the **Pending Tasks – List** page. Locate the FY 2025 NAP application using the EHBs application tracking number and click the **Start** link to begin working on the application in EHBs. If you have previously accessed the application, the **Start** link will be replaced with **Edit**.

- The system opens the **Application - Status Overview** page of the application (**Figure 3**).

**Figure 3: Application - Status Overview Page**

List of forms that are part of the application package		
Section	Status	Options
Basic Information		
SF-424	Not Started	
Part 1	Not Started	Update
Part 2	Not Started	Update
Project/Performance Site Location(s)	Not Started	Update
Project Narrative	Not Started	Update
Budget Information		
Section A-C	Not Complete	Update
Section D-F	Not Started	Update
Budget Narrative	Not Started	Update
Other Information		
Disclosure of Lobbying Activities	Not Started	Update
Appendices	Not Started	Update
Program Specific Information		
Program Specific Information	Not Complete	Update

The application consists of a standard section and a program specific section. Complete both sections to submit your application to HRSA. Click Update to access each section.

## 2. Completing the Standard SF-424 Section of the Application

The standard SF-424 section of the application consists of the following main sections:

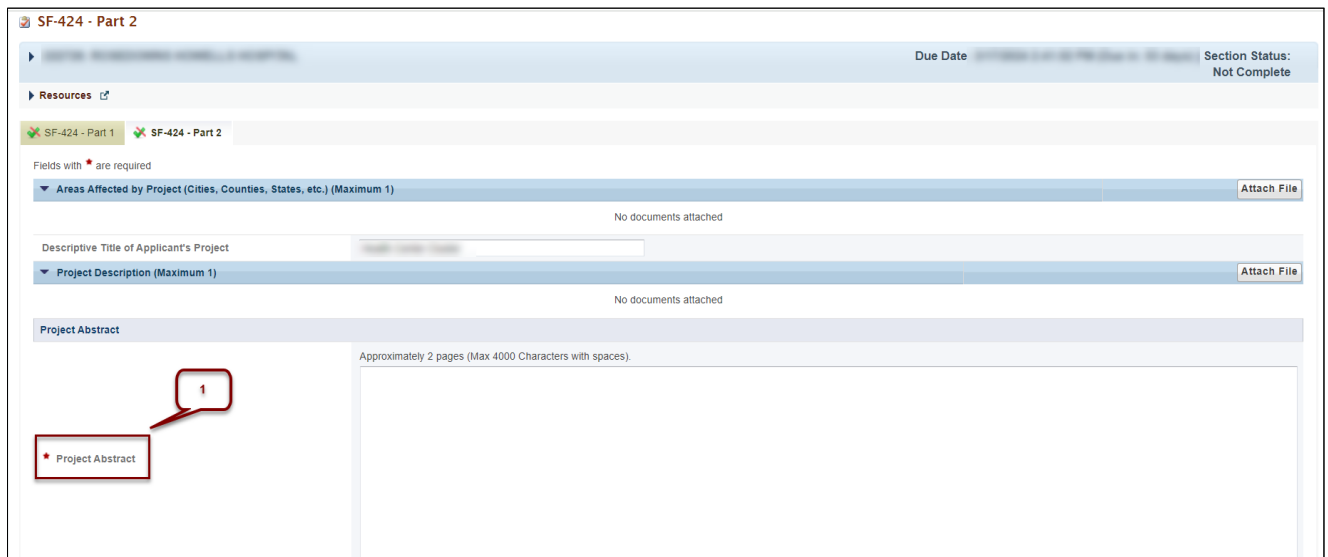
- Basic Information (**Figure 3, 1**)
- Budget Information (**Figure 3, 2**)
- Other Information (**Figure 3, 3**)

## 2.1 Completing the Basic Information

The Basic Information has been imported from Grants.gov and has undergone a data validation check. You may edit this information if necessary. Only the fields marked with an asterisk (\*) are required. This section has the following forms:

- The **SF-424 Part 1** displays basic information about the application and the applicant organization.
- The **SF-424 Part 2** displays information about the proposed project, including the project title, project period, and cities, counties, and Congressional districts affected by the project. The text entered in the abstract provided in Grants.gov can be updated in this section (**Figure 4, 1**).

**Figure 4: Project Abstract on the SF-424 Part 2**



The screenshot shows the SF-424 Part 2 form interface. At the top, it displays 'SF-424 - Part 2' and 'Section Status: Not Complete'. Below this, there are tabs for 'SF-424 - Part 1' and 'SF-424 - Part 2'. A section titled 'Fields with \* are required' contains several dropdown menus: 'Areas Affected by Project (Cities, Counties, States, etc.) (Maximum 1)', 'Descriptive Title of Applicant's Project', and 'Project Description (Maximum 1)'. Each dropdown has an 'Attach File' button and a note 'No documents attached'. The 'Project Abstract' field is a large text area with a red asterisk and a red box around it. A callout bubble with the number '1' points to this field. The text area contains the placeholder text 'Approximately 2 pages (Max 4000 Characters with spaces)'.

- In the Congressional Districts field, select the congressional district where the new access point is located.
- For the Proposed Project Period, enter 6/01/2025 to 5/31/2026.
- The Estimated Funding section will update automatically when edits are made to the Budget Information section.
- In the **Project/Performance Site Location(s)** form, enter the location that you consider to be your main service delivery site.

- In the **Project Narrative** form, attach the Project Narrative by clicking the Attach File button (**Figure 5, 1**). See the FY 2025 NAP NOFO for detailed requirements for the Project Narrative.

**Figure 5: Project Narrative**

## 2.2 Completing the Budget Information (SF-424A) and Budget Narrative

Complete the **Budget Information** form and provide a **Budget Narrative**.

### 2.2.1 Budget Information – Section A-C

The **Budget Information – Section A-C** form consists of the following three sections:

- Section A – Budget Summary
- Section B – Budget Categories
- Section C – Non-Federal Resources

To complete this form, follow the steps below:

1. Click the **Update** link for Section A-C on the **Application - Status Overview** page (**Figure 6**).



**Figure 6: Budget Information Section A-C Update Link**

List of forms that are part of the application package		
Section	Status	Options
Basic Information		
SF-424	Not Started	
Part 1	Not Started	Update
Part 2	Not Started	Update
Project/Performance Site Location(s)	Not Started	Update
Project Narrative	Not Started	Update
Budget Information		
Section A-C	Not Complete	Update
Section D-F	Not Started	Update
Budget Narrative	Not Started	Update
Other Information		
Disclosure of Lobbying Activities	Not Started	Update
Appendices	Not Started	Update
Program Specific Information		
Program Specific Information	Not Complete	Update

- The system opens the **Budget Information – Section A-C** form (Figure 7).
2. Under **Section A – Budget Summary**, click the Update Sub Program button (Figure 7, 1) to go to the **Sub Program – Update** page (Figure 8).

**Figure 7: Budget Information – Section A-C Page**

3. Select or unselect the sub programs. Only select the programs for which you are requesting funding.
4. Click the Save and Continue button and the **Budget Information – Section A-C** page re-opens showing the selected sub program(s) under the Section A – Budget Summary (**Figure 9, 1**).

**Figure 8: Sub Programs – Update Page**

**Figure 9: Section A – Budget Summary Showing Addition of Sub Program**

- To enter or update the budget amount for each sub program, click the Update button in the top right corner of the Section A – Budget Summary header (**Figure 9, 2**) and the **Section A – Update** page will open.
- Under the **New or Revised Budget** section, in the Federal column, enter the amount of federal funds you are requesting for the 12-month NAP period of performance for each requested sub program (CHC, MHC, HCH, and/or PHPC) (**Figure 10, 1**). In the Non-Federal column, enter the non-federal funds in the budget (**Figure 10, 2**). Do not enter amounts in the Estimated Unobligated Funds columns.

**Figure 10: Section A - Update Page**

The screenshot shows the 'Section A - Update' page. At the top right, it says 'Due Date: [blank] (Due in: [blank] | Section Status: Not Complete)'. Below this is a 'Resources' link. A note says 'Fields with \* are required'. The main table is titled 'Section A - Budget Summary' and has the following structure:

Grant Program Function or Activity	CFDA Number	Estimated Unobligated Funds		New or Revised Budget		Total
		Federal	Non-Federal	Federal	Non-Federal	
Community Health Centers	93.224	\$0.00	\$0.00	\$	\$	
<b>Total</b>		\$0.00	\$0.00	\$	\$0.00	

Red boxes labeled '1' and '2' highlight the input fields for Federal and Non-Federal funding in the 'New or Revised Budget' section. A 'Cancel' button is on the bottom left and a 'Save and Continue' button is on the bottom right.

**IMPORTANT NOTE:** The federal amount refers only to the NAP funding request, not all federal grant funding that an applicant receives. The total federal amount cannot exceed \$650,000.

- Click the Save and Continue button to go back to the **Budget Information – Section A-C** page. It will display the updated New or Revised Budget under Section A – Budget Summary (**Figure 11**).

**Figure 11: Section A - Budget Summary Page after Update**

The screenshot shows the 'Section A - Budget Summary' page after the update. The table now displays the updated values:

Grant Program Function or Activity	CFDA Number	Estimated Unobligated Funds		New or Revised Budget		Total
		Federal	Non-Federal	Federal	Non-Federal	
Community Health Centers	93.224	\$0.00	\$0.00	\$250,000.00	\$0.00	\$250,000.00
<b>Total</b>		\$0.00	\$0.00	\$250,000.00	\$0.00	\$250,000.00

An 'Update' button is visible in the top right corner, and an 'Update Sub Program' button is located below the 'Total' row.

- In Section B – Budget Categories, provide the federal and non-federal funds across object class categories for the 12-month period. Click the Update button at the top right corner of the Section B header (**Figure 12**) to open the **Section B – Update** page (**Figure 13**).

**Figure 12: Section B- Budget Categories**

* Section B - Budget Categories <span style="float: right;">Update</span>			
Object Class Categories	Grant Program Function or Activity		Total
	Federal	Non-Federal	
Personnel			
Fringe Benefits			
Travel			
Equipment			
Supplies			
Contractual			
Construction			
Other			
<b>Total Direct Charges</b>			
Indirect Charges			
<b>Total</b>			

9. Enter the federal amount for each object class category under the Federal column (**Figure 13, 1**).

- Enter “0” in the Federal or Non-Federal columns of the Object Class Categories that are not applicable.
- You may request funding for equipment (enter on the Equipment row) and/or minor alteration/renovation (enter on the Construction row). The combined one-time funding request cannot exceed \$250,000. Your one-time funding selection and amount will show on **Form 1B: Funding Request Summary**.

10. Enter the non-federal amount for each applicable object class category under the Non-Federal column (**Figure 13, 2**). Enter the total budget for the NAP project, including both program income and all other non-grant funding sources that support the NAP scope of project.

**Figure 13: Section B – Update Page**

**Section B - Update**

**Note(s):**  
 Total federal amount in Section B must be equal to the total new or revised budget, federal amount specified in budget summary (section A) \$250,000.00.  
 Total non-federal amount in Section B must be equal to the total new or revised budget, non-federal amount specified in budget summary (section A) \$0.00.

Due Date: ( ) (Due in: ) | Section Status: Not Complete

Resources

Fields with \* are required

Object Class Categories	Grant Program Function or Activity		Total
	Federal	Non-Federal	
Personnel	\$	\$	
Fringe Benefits	\$	\$	
Travel	\$	\$	
Equipment	\$	\$	
Supplies	\$	\$	
Contractual	\$	\$	
Construction	\$	\$	
Other	\$	\$	
Indirect Charges	\$	\$	
<b>Total</b>			

Total Budget specified in Budget Summary (Section A)

Calculate Total

Cancel Save and Continue

**IMPORTANT NOTES:**

- The total federal amount in Section B – Budget Categories must be equal to the total new or revised federal budget amount specified in Section A – Budget Summary (no greater than \$650,000).
- The total non-federal amount in Section B – Budget Categories must be equal to the total new or revised non-federal budget amount specified in Section A – Budget Summary.

11. Click the Save and Continue button (**Figure 13, 3**) to go back to the **Budget Information – Section A-C** page (**Figure 7**).
12. In Section C – Non-Federal Resources, enter the non-federal amount specified in Section A – Budget Summary across the applicable non-federal resources by clicking the Update button in the top right corner of Section C header (**Figure 14, 1**). Program Income should be consistent with the Total Program Income (patient service revenue) in Form 3: Income Analysis.
13. Click the Save and Continue button to proceed to the next form (**Figure 14, 2**).

**Figure 14: Section C - Non-Federal Resources**

Grant Program Function or Activity	Applicant	State	Local	Other	Program Income	Total
Community Health Centers	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>Total</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

**IMPORTANT NOTE:** The total non-federal amount in Section C – Non-Federal Resources must be equal to the total new or revised non-federal budget amount specified in Section A – Budget Summary.

### 2.2.2 Budget Information – Section D-F

The **Budget Information – Section D-F** page consists of the following three sections:

- Section D – Forecasted Cash Needs
- Section E – Federal Funds Needed for Balance of the Project
- Section F – Other Budget Information

To complete this form, follow the steps below:

1. Section D – Forecasted Cash Needs is optional and may be left blank. However, you may enter the amount of cash needed by each quarter of the year by clicking the Update button in the top right corner of Section D (**Figure 15, 1**).
2. Section E – Federal Funds Needed for Balance of the Project is not applicable and should be left blank.
3. In Section F – Other Budget Information, click the Update button provided in the top right corner of Section F to enter the type of indirect rate, if applicable (**Figure 15, 2**). This section is optional.
4. Click the Save and Continue button to proceed to the next form (**Figure 15, 3**).

**Figure 15: Budget Information - Section D-F**

Due Date: [ ] Section Status: Not Complete

Resources [ ]

**Section D - Forecasted Cash Needs** [Update]

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Federal	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Non-Federal	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>Total</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

**Section E - Federal Funds Needed for Balance of the Project** [Update]

Grant Program	Future Funding Periods (Years)			
	First	Second	Third	Fourth
Community Health Centers	\$0.00	\$0.00	\$0.00	\$0.00
Health Care for the Homeless	\$0.00	\$0.00	\$0.00	\$0.00
Migrant Health Centers	\$0.00	\$0.00	\$0.00	\$0.00
<b>Total</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

**Section F - Other Budget Information** [Update]

Direct Charges: No information added.

Indirect Charges: No information added.

Remarks: No information added.

Go to Previous Page [ Save Save and Continue ]

- Section D – Forecasted Cash Needs is optional and may be left blank. However, you may enter the amount of cash needed by each quarter of the year by clicking the Update button in the top right corner of Section D (Figure 15, 1).
- In Section F – Other Budget Information, click the Update button provided in the top right corner of Section F to enter the type of indirect rate, if applicable (Figure 15, 2). This section is optional.

**2.2.3 Budget Narrative**

Upload the budget narrative by clicking the Attach File button (Figure 16, 1). Then click the Save and Continue button to proceed to **Disclosure of Lobbying Activities** form.

**Figure 16: Budget Narrative**

Budget Narrative

Due Date: [ ] PM (Due in: [ ]) | Section Status: Not Complete

Resources [ ]

Fields with \* are required

\* Budget Narrative (Minimum 1) (Maximum 2) [Attach File]

No documents attached

Go to Previous Page [ Save Save and Continue ]

**IMPORTANT NOTE:** If using Excel or other spreadsheet documents, do not use multiple pages (sheets). Make sure that the information that needs to be viewed is set in the “Print Area” of the document if the Budget Narrative is presented as a spreadsheet.

## 2.3 Completing the Other Information Section

The Other Information section consists of the Disclosure of Lobbying Activities and Appendices forms.

### 2.3.1 Completing the Disclosure of Lobbying Activities Form

Answer the question regarding lobbying activities. If yes, complete all sections of the **Disclosure of Lobbying Activities** form. If no, you may skip the rest of the form. Click the Save and Continue button to proceed to the **Appendices** form.

**IMPORTANT NOTE:** If you certify that you do NOT currently receive more than \$100,000 in federal funds and engage in lobbying activities, you are not required to complete the Disclosure of Lobbying Activities form.

### 2.3.2 Completing the Appendices Form

Upload the following attachments by clicking the Attach File button for each:

- Attachment 1: Service Area Map and Table – required (maximum 3 attachments)
- Attachment 2: Bylaws – required (maximum 1 attachment)
- Attachment 3: Project Organizational Chart – required (maximum 1 attachment)
- Attachment 4: Position Description(s) – required (maximum 1 attachment)
- Attachment 5: Biographical Sketch(es) – required (maximum 1 attachment)
- Attachment 6: Co-Applicant Agreement – required for public agencies that have a co-applicant board (maximum 1 attachment)
- Attachment 7: Summary of Contracts and Agreements – as applicable (maximum 1 attachment)
- Attachment 8: Sliding Fee Discount Schedule(s) – required (maximum 1 attachment)
- Attachment 9: Collaboration Documentation – required (maximum 1 attachment)
- Attachment 10: Articles of Incorporation – required for new applicants (maximum 1 attachment)
- Attachment 11: Evidence of Nonprofit or Public Center Status – required (maximum 1 attachment)
- Attachment 12: Other Relevant Documents (Extra documentation required if your service area meets any of the geographic considerations of need or service area expansion criteria in the NAP NOFO Section V.2. Distribution of Awards) – as applicable (maximum 2 attachments)

**IMPORTANT NOTE:** See Section 5.2 of HRSA's SF-424 Two-Tier Application Guide at <http://www.hrsa.gov/grants/apply/applicationguide/sf424programspecificappguide.pdf> for attachment formatting Guidelines.

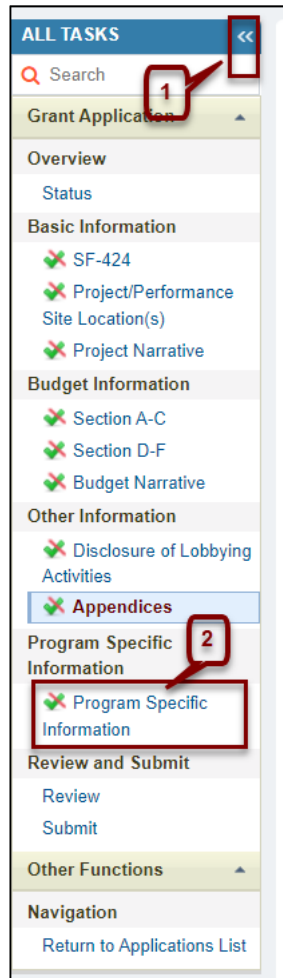
After completing the **Appendices** form, click the Save and Continue button to proceed to the **Program Specific Information – Status Overview** page.

### 3. Completing the Program Specific Forms

1. See the NAP NOFO and the sample forms on the [NAP TA webpage](#) for more details about application requirements.
2. Expand the left navigation menu if not already expanded by clicking the double arrows displayed near the form name at the top of the page (**Figure 17, 1**). Click the **Program Specific Information** link (**Figure 17, 2**) under the Program Specific Information section in the left menu to open the **Status Overview** page for the Program Specific Information forms (**Figure 18**).
3. Click the **Update** link to edit a form (**Figure 18, 1**).

**IMPORTANT NOTE:** Your session remains active for 30 minutes after your last activity. Save your work every five minutes to avoid losing data.

Figure 17: Left Navigation Menu





**Figure 18: Status Overview Page for Program Specific Forms**

The screenshot shows the 'Status Overview' page for Program Specific Forms. At the top, it displays 'Due Date: [blank]' and 'Program Specific Status: Not Complete'. Below this, there are navigation links for 'Resources' and 'View'. The main content is a table with columns for 'Section', 'Status', and 'Options'. The 'Status' column for all rows shows 'Not Started'. The 'Options' column contains an 'Update' button for each row. A red box highlights the 'Update' button for the 'Project Overview' row, and a red callout bubble with the number '1' points to it.

Section	Status	Options
<b>Project Information</b>		
Project Overview	Not Started	Update
<b>General Information</b>		
Form 1A - General Information Worksheet	Not Started	Update
Form 1C - Documents On File	Not Started	Update
Form 4 - Community Characteristics	Not Started	Update
<b>Budget Information</b>		
Form 1B - Funding Request Summary	Not Started	Update
Form 2 - Staffing Profile	Not Started	Update
Form 3 - Income Analysis	Not Started	Update
<b>Sites and Services</b>		
Form 5A - Services Provided	Not Started	Update
Required Services	Not Started	Update
Additional Services	Not Started	Update
Form 5B - Service Sites	Not Started	Update
Form 5C - Other Activities/Locations	Not Started	Update
Alteration/Renovation (A/R) Information	Not Started	Update
<b>Other Forms</b>		
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
<b>Other Information</b>		
Equipment List	Not Started	Update
Summary Page	Not Started	Update

### 3.1 Project Overview

The **Project Overview** form has a work plan to show the NAP activities that you will conduct over the 1-year period of performance (**Figure 19**). The work plan must be specific to the proposed NAP project, with reasonable time-framed action steps necessary to:

- Begin operations at all sites (as noted on Form 5B: Service Sites and described in the Project Narrative) within 120 days of release of the notice of award, with staff and systems in place to begin delivering primary care services to the proposed population(s).
- Provide all required and additional services as proposed on Form 5A: Services Provided for the number of hours per week indicated on Form 5B: Service Sites. If required services are provided by contract or referral, include action steps and timeframes for finalizing these formal arrangements.

#### 3.1.1 Adding an activity

1. To complete the Work Plan, click the Add button (**Figure 19, 1**).
2. Select a **Focus Area** (**Figure 20, 1**). All **Focus Areas** are required except “Other”.
3. After you select a **Focus Area**, select an activity from the list of activities for that Focus Area (**Figure 21, 1**). Each activity with an asterisk (\*) is required. You may also select additional activities or

develop your own as needed to fully outline your work plan. You can only describe one activity at a time, so you will need to select a focus area and/or activity multiple times to fully describe all planned activities in that area.

4. Provide descriptions in the boxes for Key Action Step(s) (Figure 22, 1), Timeframe (Figure 22, 2), and Key Person Responsible (Figure 22, 3).
5. Click Save and Continue (Figure 22, 4) to see the updated information in the Project Overview Form (Figure 23, 1).
6. Repeat steps 1-5 until you have entered all required and planned activities. The Project Overview form will not be complete until you add all required\* activities.
7. To edit an activity, click the Edit button in the Options Column (Figure 23, 2).
8. Click Save and Continue (Figure 23, 3) to proceed to the next form.

**IMPORTANT NOTE:** Ensure that the work plan outlines activities that demonstrate your compliance with Health Center Program requirements. Use the [Compliance Manual](#) and [Site Visit Protocol](#) to assess your compliance with Health Center Program requirements. Describe actions you need to take to become compliant. If you are currently operational and compliant with Health Center Program requirements, state your compliance status in the Key Action Step(s) column and describe any new action steps.

Figure 19: Add button for Add Activity

The screenshot displays the 'Project Overview' form. At the top, there is a header with 'Project Overview' and a 'Due Date' field. Below this is a 'Resources' section. The main content area is titled 'Work Plan' and contains instructions for creating a work plan, including bullet points about beginning operations and providing services. At the bottom of the 'Work Plan' section, there is an 'Add' button with a plus sign icon. A red box highlights the 'Add' button, and a red callout bubble with the number '1' points to it. Below the 'Add' button, the text 'No Activities Added' is visible.

Figure 20: Focus Area Selection

**Add Activity**

**Note(s):**

- You must select all activities with an asterisk under each of the focus areas. You may also select additional activities or develop your own as needed to fully outline your work plan.
- You can only describe one activity at a time, so you will need to select a focus area and/or activity multiple times to fully describe all planned activities in that area.

Fields with \* are required

\* Focus Area

- Coverage for Medical Emergencies During and After Hours
- Workforce, including compliance with the following Health Center Program requirements:
  - Clinical Staffing
  - Key Management Staff
- Quality and Reporting, including compliance with the following Health Center Program requirements:
  - Quality Improvement/Assurance
  - Program Monitoring and Data Reporting Systems
- Governance, including compliance with the following Health Center Program requirements:
  - Board Authority
  - Board Composition
  - Conflict of Interest

Figure 21: Activity Selection

**Add Activity**

**Note(s):**

- You must select all activities with an asterisk under each of the focus areas. You may also select additional activities or develop your own as needed to fully outline your work plan.
- You can only describe one activity at a time, so you will need to select a focus area and/or activity multiple times to fully describe all planned activities in that area.

Fields with \* are required

\* Activity

- Getting site(s) ready to open (e.g., lease, mobile unit, minor A/R, equipment purchases) \*\*\*
- Providing required clinical services \*\*\*
- Providing required enabling services \*\*\*
- Increasing access for low income, uninsured people \*\*\*
- Providing additional services, if any are proposed
- Identifying and addressing access barriers
- Securing admitting privileges and developing procedures for follow-up \*\*\*
- Responding to patient emergencies during and after hours \*\*\*
- Other: Please specify

(Up to 300 characters with spaces)

1000 characters with spaces (Approximately 1/4 page)

**Figure 22: Key Action Steps, Timeframe and Key Person Responsible**

1000 characters with spaces (Approximately 1/4 page)

500 characters with spaces (Approximately 1/4 page)

500 characters with spaces (Approximately 1/4 page)

Cancel Save and Continue

**Figure 23: Project Overview with updated activity**

Project Overview

Due Date: | Section Status: Not Started

Resources of

Work Plan

The work plan must be specific to the proposed NAP project, with reasonable time-framed action steps necessary to:

- Begin operations at all proposed sites (as noted on Form 5B: Service Sites and described in the Project Narrative) within 120 days of the notice of award, with staff and systems in place to begin delivering primary care services to the proposed population(s).
- Provide all required and additional services as proposed on Form 5A: Services Provided for the number of hours per week indicated on Form 5B: Service Sites. If required services are provided by contract or referral, include action steps and timeframes for finalizing these formal arrangements.

Ensure that the work plan outlines activities that demonstrate your compliance with Health Center Program requirements. Use the Compliance Manual and Site Visit Protocol to assess your compliance with Health Center Program requirements. Describe actions you need to take to become compliant. If you are currently operational and compliant with Health Center Program requirements, state your compliance status in the Key Action Step(s) column and describe any new action steps.

See the NAP Technical Assistance webpage for a sample work plan.

Click on "Add" to select your activities under each focus area. The work plan should include activities over the 1-year period of performance.

Add

Focus Area	Activity	Key Action Step(s)	Time Frame	Key Person Responsible	Options
Operational Service Delivery, including compliance with the following Health Center Program requirements:	<ul style="list-style-type: none"> <li>Required and Additional Health Services</li> <li>Accessible Locations and Hours of Operation</li> <li>Continuity of Care and Hospital Admitting</li> <li>Coverage for Medical Emergencies During and After Hours</li> </ul>	Getting site(s) ready to open (e.g., lease, mobile unit, minor AR, equipment purchases)?			Edit

Go to Previous Page Save Save and Continue

### 3.2 Form 1A: General Information Worksheet

**Form 1A - General Information Worksheet** provides information related to the applicant, proposed service area, and patient and visit projections. This form has the following sections:

- Applicant Information (**Figure 24, 1**)
- Proposed Service Area (**Figure 24, 2**)

Figure 24: Form 1A: General Information Worksheet

**Form 1A - General Information Worksheet** Due Date: | Section Status: Not Started

**Resources**

Fields with \* are required

**1. Applicant Information**

Applicant Name: SHRIBMAN DAVENPORT HOSPITAL DISTRICT

\* Fiscal Year End Date:

Application Type: New

Grant Number: NIA

If you are a designated look-alike, enter your LAL number:

\* Business Entity (Select one option that aligns with the type entered in SAM.gov):

\* Organization Type:

- Community based organization
- Faith based
- Hospital
- City/County/Local Government or Municipality
- State government
- University
- Other

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

**2. Proposed Service Area**

**Note(s):**  
Applicants applying for Community Health Center (CHC) funding in Section A of the SF-424A: Budget Information form 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**

**Note(s):**  
You must select Urban or Rural. If you select Rural, Sparsely Populated may also be selected, if applicable.

\* Choose Service Area Type

Select Urban or Rural. If you select Rural, you may also select Sparsely Populated, if applicable.

Urban

Rural

Sparsely Populated - Provide the number of people per square mile:  (Provide a value ranging from 0.01 to 7)

**2c. Patients and Visits**

**Unduplicated Patients and Visits by Population Type**

\* How many unduplicated patients do you project to serve at your proposed site(s) in 2026 (January 1, 2026 - December 31, 2026)?

Population Type	Projected by December 31, 2026 (January 1 - December 31, 2026)	
	Patients	Visits
* Total	<input type="text"/>	<input type="text"/>
* General Underserved Community (Include all patients/visits not reported in the rows below)	<input type="text"/>	<input type="text"/>
* Migratory and Seasonal Agricultural Workers and Families	<input type="text"/>	<input type="text"/>
* Public Housing Residents	<input type="text"/>	<input type="text"/>
* People Experiencing Homelessness	<input type="text"/>	<input type="text"/>

**Patients and Visits by Service Type**

Service Type	Projected by December 31, 2026 (January 1 - December 31, 2026)	
	Patients	Visits
* Total Medical Services	<input type="text"/>	<input type="text"/>
* Total Dental Services	<input type="text"/>	<input type="text"/>
<b>Behavioral Health Services</b>		
* Total Mental Health Services	<input type="text"/>	<input type="text"/>
* Total Substance Use Disorder Services	<input type="text"/>	<input type="text"/>
* Total Vision Services	<input type="text"/>	<input type="text"/>
* Total Enabling Services	<input type="text"/>	<input type="text"/>

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

### 3.2.1 Completing the Applicant Information Section

Part of this section is pre-populated. Complete this section by providing information in the following fields (Figure 25):

1. For the 'Fiscal Year End Date', select the month and day of the applicant organization's fiscal year end date (e.g., June 30) to inform HRSA of the expected audit submission timeline in the Federal Audit Clearinghouse (<https://www.fac.gov/>).
2. If you are a designated look-alike, enter your LAL number (Figure 25, 1).
3. Select one category in the 'Business Entity' field. Your selection should match the type entered in SAM.gov. 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.
4. Select your 'Organization Type.' Specify the organization type if you select 'Other' (Figure 25, 2).

Figure 25: Applicant Information Section

Fields with \* are required

1. Applicant Information

Applicant Name XCHANGE RHEOLOGIES COMMUNITY COLLEGE

\* Fiscal Year End Date Select Option

Application Type New

Grant Number N/A

If you are a designated look-alike, enter your LAL number

\* Business Entity (Select one option that aligns with the type entered in SAM.gov) Select Option

- Community based organization
- Faith based
- Hospital
- City/County/Local Government or Municipality
- State government
- University
- Other

\* Organization Type

If 'Other' please specify:

(maximum 100 characters)

### 3.2.2 Completing the Proposed Service Area Section

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

- 2a. Service Area Designation
- 2b. Service Area Type
- 2c. Patients and Visits

### 3.2.2.1 Service Area Designation

In the **Select MUA/MUP** field (**Figure 26, 1**), enter ID number(s) for the MUA and/or MUP in the proposed service area. To find out if a designated MUA or MUP is located in your proposed service area, see <https://data.hrsa.gov/tools/shortage-area/mua-find>.

**IMPORTANT NOTE:** If you are applying for Community Health Centers funding, you must provide an ID number for at least one of the line items listed in this field. Otherwise, providing an MUA or MUP ID number is optional.

**Figure 26: Service Area Designation**

2. Proposed Service Area

Note(s):  
Applicants applying for Community Health Center (CHC) funding in Section A of the SF-424A: Budget Information form 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 #

### 3.2.2.2 Service Area Type

In the **Service Area Type** section (**Figure 27**), indicate whether the service area is Urban or Rural. If you select Rural, then you may select Sparsely Populated if applicable. If you select Sparsely Populated, specify the population density by providing the number of people per square mile (values ranging from 0.01 to 7).

**IMPORTANT NOTE:** For information about rural populations, visit the Office of Rural Health Policy's website ([http://www.hrsa.gov/ruralhealth/policy/definition\\_of\\_rural.html](http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html)).

**Figure 27: Service Area Type Section**

2b. Service Area Type

Note(s):  
You must select Urban or Rural. If you select Rural, Sparsely Populated may also be selected, if applicable.

Choose Service Area Type

Urban

Rural

Sparsely Populated - Specify population density by providing the number of people per square mile:  (Provide a value ranging from 0.01 to 7)

### 3.2.2.3 Patients and Visits

To complete this section, follow the steps below:

1. In the **Unduplicated Patients and Visits by Population Type** section, answer the question, “How many unduplicated patients do you project to serve at your proposed site(s) in 2026 (January 1, 2025 – December 31, 2026)?” (**Figure 28, 1**). The system will auto-populate this number in the Total row of the Patients column under the ‘Projected by December 31, 2026 (January 1 - December 31, 2026)’ heading (**Figure 28, 3**) when you click the Save button.
2. Provide the number of patients and visits that you project to serve in 2026 under the ‘Projected by December 31, 2026 (January 1 - December 31, 2026)’ heading for each listed population type (**Figure 28, 2**). An individual can only be counted once as a patient, so do not duplicate patients across the population types.

**Figure 28: Unduplicated Patients and Visits by Population Type**

The screenshot shows a web form titled "2c. Patients and Visits" with a sub-section "Unduplicated Patients and Visits by Population Type". A red callout '1' points to a text input field for the total number of patients. A red callout '3' points to the "Projected by December 31, 2026 (January 1 - December 31, 2026)" column header. A red callout '4' points to the "Visits" column header. A red callout '2' points to the table rows for population types: Total, General Underserved Community, Migratory and Seasonal Agricultural Workers and Families, Public Housing Residents, and People Experiencing Homelessness.

#### **IMPORTANT NOTES:**

- Only include the number of new patients who are projected to receive services at the NAP site(s) from January 1, 2026 – December 31, 2026. Patient projections from this section will be added to the applicant’s overall Patient Target, if funded.
- You must enter a patient number greater than zero for each population type selected in [Section A – Budget Summary](#) (**Figure 28, 3**). For the remaining population types, you may enter a projected number or zero, as applicable.
- The number of projected visits (**Figure 28, 4**) must be greater than or equal to the number of projected patients (**Figure 28, 3**).
- The ‘General Underserved Community’ row should include all patients and visits not captured in the special populations rows.



- In the **Patients and Visits by Service Type** section, provide the number of patients and visits that you project to serve from January 1, 2026 to December 31, 2026 for each applicable service type (**Figure 29, 1**). An individual who receives multiple types of services should be counted once for each service type (e.g., once for medical and once for dental).

**Figure 29: Patients and Visits by Service Type**

Patients and Visits by Service Type		
Service Type	Projected by December 31, 2026 (January 1 - December 31, 2026)	
	Patients	Visits
* Total Medical Services	<input type="text"/>	<input type="text"/>
* Total Dental Services	<input type="text"/>	<input type="text"/>
Behavioral Health Services		
* Total Mental Health Services	<input type="text"/>	<input type="text"/>
* Total Substance Use Disorder Services	<input type="text"/>	<input type="text"/>
* Total Vision Services	<input type="text"/>	<input type="text"/>
* Total Enabling Services	<input type="text"/>	<input type="text"/>

Go to Previous Page Save Save and Continue

**IMPORTANT NOTES:**

- For 'Total Medical Services' (**Figure 29, 2**), the number of patients must be greater than the number of patients you provide for each of the other service types.
- The number of projected visits (**Figure 29, 4**) must be greater than or equal to the number of projected patients (**Figure 29, 3**).
- The Patients and Visits by Service Type section does not have a row for total numbers, since an individual patient may be included in multiple service type categories.

- After completing all sections of **Form 1A**, click the Save and Continue button to save your work and proceed to the next form.

### 3.3 Form 1C: Documents on File

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

1. To complete Form 1C, enter the review/revision dates for each document listed on this form (Figure 30). Select N/A if an item is not applicable.

Figure 30: Form 1C: Documents on File

**Form 1C - Documents On File**

**Note(s):**  
This listing does not include all policy/procedure documents required to be maintained on file. Records demonstrating implementation of required policies and procedures must also be available for review.

**Resources**

Fields with \* are required

Management and Finance	Date of Last Review/Revision (MM/DD/YYYY)	Not Applicable (N/A)
* Personnel policies, including selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices.	<input type="text"/>	<input type="checkbox"/>
* Procurement procedures.	<input type="text"/>	<input type="checkbox"/>
* Standards of Conduct/Conflict of Interest policies/procedures.	<input type="text"/>	<input type="checkbox"/>
* Financial Management/Accounting and Internal Control policies and/or procedures to ensure awarded Health Center Program federal funds are not expended for restricted activities.	<input type="text"/>	<input type="checkbox"/>
* Financial Management/Accounting and Internal Control policies/procedures related to restrictions on the use of federal funds for the purchase of sterile needles or syringes for the hypodermic injection of any illegal drug. (Only applicable if your organization provides syringe exchange services or is otherwise engaged in syringe service programs; otherwise, indicate as N/A.)	<input type="text"/>	<input type="checkbox"/>
* Financial Management/Accounting and Internal Control policies/procedures related to restrictions on the use of federal funds to provide abortion services, except in cases of rape or incest or where there is a threat to the life of the mother. (Only applicable if your organization provides abortion services; otherwise, indicate as N/A.)	<input type="text"/>	<input type="checkbox"/>
* Billing and Collections policies/procedures, including those regarding waivers or fee reductions and refusal to pay.	<input type="text"/>	<input type="checkbox"/>
Services	Date of Last Review/Revision (MM/DD/YYYY)	Not Applicable (N/A)
* Credentialing/Privileging operating procedures.	<input type="text"/>	<input type="checkbox"/>
* Coverage for Medical Emergencies During and After Hours operating procedures.	<input type="text"/>	<input type="checkbox"/>
* Continuity of Care/Hospital Admitting operating procedures.	<input type="text"/>	<input type="checkbox"/>
* Sliding Fee Discount Program policies, operating procedures, and sliding fee schedule.	<input type="text"/>	<input type="checkbox"/>
* Quality Improvement/Assurance Program policies and operating procedures that address clinical services and management, patient safety, and confidentiality of patient records.	<input type="text"/>	<input type="checkbox"/>
Governance	Date of Last Review/Revision (MM/DD/YYYY)	Not Applicable (N/A)
* Governing Board Bylaws.	<input type="text"/>	<input type="checkbox"/>
* Co-Applicant Agreement (Only applicable to public agency health centers; otherwise, indicate as N/A.)	<input type="text"/>	<input type="checkbox"/>
* Evidence of Nonprofit or Public Agency Status	<input type="text"/>	<input type="checkbox"/>

Go to Previous Page Save Save and Continue

**IMPORTANT NOTE:** This listing does not include all required policy/procedure documents. Records demonstrating implementation of required policies and procedures must also be available for review.

2. After completing all sections of Form 1C, click the Save and Continue button to save your work and proceed to the next form.

### 3.4 Form 4: Community Characteristics

**Form 4: Community Characteristics** reports current service area and target population data for the NAP scope of the project (including all NAP sites). Service Area Population is the number of people in the proposed service area. The Target Population number is less than the Service Area Population, and in most cases, is greater than the number of patients projected on Form 1A. Patient data should not be used for target population data since patients are typically a subset of all individuals targeted for service.

To complete **Form 4**, follow the steps below:

1. Enter the Service Area Population (Figure 31, 6) and Target Population Numbers (**Figure 27, 7**) for each of the following categories. Because these categories provide data for the same population in different ways, the total Service Area Population Numbers for each of these categories must match. Similarly, the total Target Population Numbers for Race, Hispanic or Latino Ethnicity, Income as a Percent of Poverty Level, and Primary Third-Party Payment Source categories must match.
  - a. Race and Ethnicity (**Figure 31, 1**)
  - b. Hispanic or Latino Ethnicity (**Figure 31, 2**)
  - c. Income as a Percent of Poverty Level (**Figure 31, 3**)
  - d. Principal Third Party Payment Source (**Figure 31, 4**)

**IMPORTANT NOTE:** Information provided regarding race and/or ethnicity will be used only to ensure compliance with statutory and regulatory Governing Board requirements. Data on race and/or ethnicity collected on this form will not be used as an awarding factor.

2. To automatically calculate the Totals for all four categories, click on the Save and Calculate Total button (**Figure 31, 8**) under any of the sections. The system will also auto-calculate the population percentages.
3. Under **Special Populations and Select Population Characteristics (Figure 31, 5)**, enter the Service Area Population and the Target Population Numbers for each population group. Individuals may be counted in multiple population groups, so the numbers in this section do not have to match those in the other sections of this form.

**Figure 31: Form 4: Community Characteristics**

**Form 4 - Community Characteristics**

**Note(s):**  
The total numbers for the first four sections of this form (i.e., Race, Hispanic or Latino Ethnicity, Income as a Percent of Poverty Level, and Primary Third Party Payment Source) must match. Data on race and/or ethnicity collected on this form will not be used as an awarding factor, but will be used to assess compliance of new applicants with current board composition (element c) in [Chapter 20](#), Board Composition of the Compliance Manual.

Due Date: (Due In: ) | Section Status: Not Started

Fields with \* are required

**1**

Race and Ethnicity	Service Area Population	Service Area Percent	Target Population Number	Target Population Percent
Asian		0.00%		0.00%
Native Hawaiian		0.00%		0.00%
Other Pacific Islander		0.00%		0.00%
Black/African American		0.00%		0.00%
American Indian/Alaska Native		0.00%		0.00%
White		0.00%		0.00%
More than One Race		0.00%		0.00%
Unreported/Chose Not to Disclose Race (if applicable)		0.00%		0.00%
<b>Total</b>	0		0	

Click the 'Save and Calculate Total' button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form.

**2**

Hispanic or Latino/a Ethnicity	Service Area Population	Service Area Percent	Target Population Number	Target Population Percent
Hispanic or Latino/a		0.00%		0.00%
Non-Hispanic or Latino/a		0.00%		0.00%
Unreported/Chose Not to Disclose Race (if applicable)		0.00%		0.00%
<b>Total</b>	0		0	

Click the 'Save and Calculate Total' button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form.

**3**

Income as a Percent of Poverty Level	Service Area Population	Service Area Percent	Target Population Number	Target Population Percent
100% and below		0.00%		0.00%
101-200%		0.00%		0.00%
Over 200%		0.00%		0.00%
<b>Total</b>	0		0	

Click the 'Save and Calculate Total' button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form.

**4**

Principal Third Party Payment Source	Service Area Population	Service Area Percent	Target Population Number	Target Population Percent
Medicaid		0.00%		0.00%
Medicare		0.00%		0.00%
Other Public Insurance		0.00%		0.00%
Private Insurance		0.00%		0.00%
None/Uninsured		0.00%		0.00%
<b>Total</b>	0		0	

Click the 'Save and Calculate Total' button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form.

**5**

Special Populations and Select Population Characteristics	Service Area Population	Service Area Percent	Target Population Number	Target Population Percent
Migratory/Seasonal Agricultural Workers and Families		0.00%		0.00%
People Experiencing Homelessness		0.00%		0.00%
Residents of Public Housing		0.00%		0.00%
School Age Children		0.00%		0.00%
Veterans		0.00%		0.00%
Lesbian, Gay, Bisexual and Transgender		0.00%		0.00%
People Living with HIV		0.00%		0.00%
Individuals Best Served in a Language Other Than English		0.00%		0.00%
<b>Other</b>		0.00%		0.00%
Please specify: Approximately 1/3 page (Max 200 Characters with spaces)				

**6**

**7**

**8**

**9**

Go to Previous Page | Save | Save and Continue

**IMPORTANT NOTES:**

- If you select any sub program related to special populations (MHC, HCH, and/or PHPC) in [Section A – Budget Summary](#), you must enter a number greater than zero (0) for the corresponding ‘Migratory/Seasonal Agricultural Workers and Families,’ ‘Homeless,’ and/or ‘Residents of Public Housing’ line item(s), under **Special Populations and Select Population Characteristics (Figure 31, 5)**.
- In the ‘**Other**’ row (**Figure 31, 9**), you may specify a population group that is not listed (if desired), and then enter the Service Area Population and the Target Population Numbers for that group.

4. After completing all the sections on **Form 4**, click the Save and Continue button to save your work and proceed to the next form.

### 3.5 Form 1B: Funding Request Summary

**Form 1B: Funding Request Summary** summarizes the funding request for the NAP application and is pre-populated from the **Budget Information** – Sections A and B (**Figure 7**).

1. Review the information that has been pre-populated for the NAP Federal Funding Request (**Figure 32, 1**). The NAP Federal Funding Request must not exceed \$650,000. Go to **Section A – Budget Summary** to edit the New or Revised, Federal total, if needed.
2. Review the information pre-populated for One-Time Funding (**Figure 32, 2**). To change your One-Time Funding Request, go to **Section B – Budget Categories**.
  - **“N/A”** will be selected (**Figure 32, 4**) if both the **Equipment** line item and **Construction** line item have zero (0) in the Federal column in Section B - Budget Categories.
  - **“Equipment Only”** will be selected (**Figure 32, 4**) if the **Equipment** line item has a dollar value and **Construction** line item does not in the Federal column in Section B - Budget Categories.
  - **“Minor A/R with equipment”** will be selected (**Figure 32, 4**) if both the **Equipment** line item and **Construction** line item have a dollar value in the Federal column in Section B - Budget Categories.
  - **“Minor A/R without equipment”** will be selected (**Figure 32, 4**) if the **Construction** line item has a dollar value and **Equipment** line item does not in the Federal column in Section B - Budget Categories.
3. Review the NAP one-time funding request for minor A/R and equipment (**Figure 32, 3**). The NAP one-time funding request must not exceed \$250,000 for minor A/R and equipment combined. To edit the one-time funding request, go to **Section B – Budget Categories**.

#### **IMPORTANT NOTES:**

- For this form to be complete, you must complete the [SF-424A: Budget Information](#) form in the standard section of this NAP application.
- In **Form 1B**, you will not be able to edit the pre-populated information. If you need to edit this information, go to the [SF-424A: Budget Information](#) form in the standard section of this application.
- Based on your one-time funding request, the system will require you to complete the applicable equipment and/or minor A/R forms. If you change the equipment or construction line items in the Budget Information Form, the system will update this form. If you remove the equipment or construction line items from the Budget Information Form, the system will delete any forms that are no longer applicable.

**Figure 32: Form 1B: Funding Request Summary**

**Form 1B - Funding Request Summary**

Due Date: [Redacted] Section Status: Not Started

Resources

Note the following when completing this form:

- Before completing Form 1B, the SF-424A, Budget Information form must be completed.
- The NAP Federal Funding Request below matches the Total Federal Funds requested on the SF-424A. Go to Section A – Budget Summary in the Budget Information form to edit the Total Federal Funds requested, not to exceed \$650,000.
- The one-time funding request below totals the Equipment and Construction (minor A/R) federal line items on the SF-424A. Go to Section B – Budget Categories in the Budget Information form to edit the federal funds requested for Equipment and Construction (minor A/R).

NAP Federal Funding Request

One-Time Funding Request

You indicated on the Budget Information form, Section B that you are requesting NAP one-time funding for:

N/A (no funding requested for equipment or minor A/R)

Equipment (no minor A/R)

Minor alteration/renovation with equipment

Minor alteration/renovation without equipment

NAP one-time funding request for minor A/R and equipment:

Note(s):

- If no funding is requested for equipment or minor A/R in the Budget Information form, the following forms will not be available in your application: Equipment List, A/R Project Cover Page, and Other Requirements for Sites.
- If 'Equipment (no minor A/R)' is indicated above, you must complete the Equipment List form.
- If 'Minor A/R with equipment' is indicated above, you must complete the Equipment List, A/R Project Cover Page, and Other Requirements for Sites forms.
- If 'Minor A/R without equipment' is indicated above, you must complete the A/R Project Cover Page and Other Requirements for Sites forms.

Based on your one-time funding request, the system will require you to complete the applicable equipment and/or minor A/R forms. After providing required information in the relevant forms, if you change the Budget Information Form to remove the equipment or construction line items, the system will delete information from all forms that are no longer applicable.

Go to Previous Page Save Save and Continue

5. Click the Save and Continue button at the bottom of the screen to save your work and proceed to the next form.

### 3.6 Form 2: Staffing Profile

**Form 2: Staffing Profile** shows the personnel supported by the total budget (federal and non-federal funds) for the 12-month period of the proposed project for all sites included on Form 5B: Service Sites. This form has the following sections to enter staffing positions by service categories:

- Management and Support Personnel
- Facility and Non-Clinical Support Personnel
- Physicians
- Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives
- Medical Care Services
- Dental
- Behavioral Health (Mental Health and Substance Use Disorder)
- Professional Services
- Vision Services
- Pharmacy Personnel
- Enabling Services
- Other Programs and Services

Figure 33: Staffing Profile

**Form 2 - Staffing Profile**

Fields with \* are required

**Management and Support Personnel**

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)		<input type="radio"/> Yes <input checked="" type="radio"/> No
Chief Operating Officer (COO)		<input type="radio"/> Yes <input checked="" type="radio"/> No
Chief Information Officer (CIO)		<input type="radio"/> Yes <input checked="" type="radio"/> No
Clinical Director/Chief Medical Officer (CMO)		<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Management and Support Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No

**Facility and Non-Clinical Support Personnel**

Staffing Positions by Major Service Category

	Direct Hire FTEs	Contract/Agreement FTEs
Recal and Billing Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No
IT Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No
Facility Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No
Patient Support Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No

**Physicians**

Staffing Positions by Major Service Category

	Direct Hire FTEs	Contract/Agreement FTEs
Family Physicians		<input type="radio"/> Yes <input checked="" type="radio"/> No
General Practitioners		<input type="radio"/> Yes <input checked="" type="radio"/> No
Internists		<input type="radio"/> Yes <input checked="" type="radio"/> No
Obstetrician/Gynecologists		<input type="radio"/> Yes <input checked="" type="radio"/> No
Pediatricians		<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Specialty Physicians		<input type="radio"/> Yes <input checked="" type="radio"/> No

**Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives**

Staffing Positions by Major Service Category

	Direct Hire FTEs	Contract/Agreement FTEs
Nurse Practitioners		<input type="radio"/> Yes <input checked="" type="radio"/> No
Physician Assistants		<input type="radio"/> Yes <input checked="" type="radio"/> No
Certified Nurse Midwives		<input type="radio"/> Yes <input checked="" type="radio"/> No

**Medical Care Services**

Staffing Positions by Major Service Category

	Direct Hire FTEs	Contract/Agreement FTEs
Nurses		<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Medical Personnel (e.g. Medical Assistants, Nurse Aides) Please Specify: _____ (Maximum 40 characters)		<input type="radio"/> Yes <input checked="" type="radio"/> No
Laboratory Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No
X-Ray Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No

**Dental**

Staffing Positions by Major Service Category

	Direct Hire FTEs	Contract/Agreement FTEs
Dentists		<input type="radio"/> Yes <input checked="" type="radio"/> No
Dental Hygienists		<input type="radio"/> Yes <input checked="" type="radio"/> No
Dental Therapists		<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Dental Personnel Please Specify: _____ (Maximum 40 characters)		<input type="radio"/> Yes <input checked="" type="radio"/> No

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

Staffing Positions by Major Service Category

	Direct Hire FTEs	Contract/Agreement FTEs
Psychiatrists		<input type="radio"/> Yes <input checked="" type="radio"/> No
Licensed Clinical Psychologists		<input type="radio"/> Yes <input checked="" type="radio"/> No
Licensed Clinical Social Workers		<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Licensed Mental Health Providers Please Specify: _____ (Maximum 40 characters)		<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Mental Health Personnel Please Specify: _____ (Maximum 40 characters)		<input type="radio"/> Yes <input checked="" type="radio"/> No
Substance Use Disorder Providers		<input type="radio"/> Yes <input checked="" type="radio"/> No

**Professional Services**

Staffing Positions by Major Service Category

	Direct Hire FTEs	Contract/Agreement FTEs
Other Professional Health Services Personnel Please Specify: _____ (Maximum 40 characters)		<input type="radio"/> Yes <input checked="" type="radio"/> No

**Vision Services**

Staffing Positions by Major Service Category

	Direct Hire FTEs	Contract/Agreement FTEs
Ophthalmologists		<input type="radio"/> Yes <input checked="" type="radio"/> No
Otolaryngologists		<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Vision Care Personnel Please Specify: _____ (Maximum 40 characters)		<input type="radio"/> Yes <input checked="" type="radio"/> No

**Pharmacy Personnel**

Staffing Positions by Major Service Category

	Direct Hire FTEs	Contract/Agreement FTEs
Pharmacy Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No

**Enabling Services**

Staffing Positions by Major Service Category

	Direct Hire FTEs	Contract/Agreement FTEs
Case Managers		<input type="radio"/> Yes <input checked="" type="radio"/> No
Patient and Community Education Specialists		<input type="radio"/> Yes <input checked="" type="radio"/> No
Outreach Workers		<input type="radio"/> Yes <input checked="" type="radio"/> No
Transportation Workers		<input type="radio"/> Yes <input checked="" type="radio"/> No
Eligibility Assistance Workers		<input type="radio"/> Yes <input checked="" type="radio"/> No
Interpretation Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No
Community Health Workers		<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Enabling Services Personnel Please Specify: _____ (Maximum 40 characters)		<input type="radio"/> Yes <input checked="" type="radio"/> No

**Other Programs and Services**

Staffing Positions by Major Service Category

	Direct Hire FTEs	Contract/Agreement FTEs
Quality Improvement Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Programs and Services Personnel Please Specify: _____		<input type="radio"/> Yes <input checked="" type="radio"/> No

**Total FTEs**

Totals	Direct Hire FTEs	Contract/Agreement FTEs
Totals <input type="button" value="Calculate"/>	12.00	N/A

### 3.6.1 Completing Form 2: Staffing Profile

1. In the Direct Hire FTEs column, provide the number of Full Time Employees (FTEs) directly hired by the health center and volunteers for each staffing position (**Figure 33, 1**). Enter zero (0) if not applicable.
2. In the Contract/Agreement FTEs column, indicate whether you contract for each staffing position (**Figure 33, 2**). Positions marked Yes should align with Attachment 7: Summary of Contracts and Agreements and Form 5A: Services Provided, Column II.
3. If both direct hire staff and contracts are used, provide the number of Direct Hire FTEs only and check Yes in the Contract/Agreement FTEs column.

#### **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 parttime family physician and a part-time Clinical Director should be listed in each respective category with the FTE percentage allocated to each position (e.g., 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 at <https://bphc.hrsa.gov/data-reporting/uds-training-and-technical-assistance>.
- The Project Director/CEO must be a Direct Hire and cannot be contracted.

4. To add up the total Direct Hire FTEs, click the Calculate button (**Figure 34**).

**Figure 34: Total FTEs**

Total FTEs		
Totals	Direct Hire FTEs	Contract/Agreement FTEs
Totals <input type="button" value="Calculate"/>	<input type="text"/>	N/A

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

### 3.7 Form 3: Income Analysis

**Form 3: Income Analysis** collects the projected patient services and other income from all sources (other than the Health Center Program grant funds) for the 12-month period of the proposed project. This form has the following sections:

- Payer Category (**Figure 35, 1**)
- Comments/Explanatory Notes (**Figure 35, 2**)



**Figure 35: Form 3: Income Analysis**

**Form 3 - Income Analysis**

**Note(s):**  
The value in the Projected Income (d) column should equal the value in the Billable Visits (b) column multiplied by the value in the Income per Visit (c) column. If not, explain in the Comments/Explanatory Notes box. In the Prior FY Income (e) column, enter the income data from the health center's most recent fiscal year audit or interim financial statement.

Due Date: 01/15/2025 | Section Status: [ ]

Resources [ ]

Fields with \* are required [ ]

Payer Category	Patients By Primary Medical Insurance (a)	Billable Visits (b)	Income Per Visit (c)	Projected Income (d)	Prior FY Income (e) [ ]
<b>Part 1: Patient Service Revenue - Program Income</b>					
* 1. Medicaid					
* 2. Medicare					
* 3. Other Public					
* 4. Private					
* 5. Self Pay					
6. Total (Lines 1 to 5)			N/A		
<b>Part 2: Other Income - Other Federal, State, Local and Other Income</b>					
* 7. Other Federal	N/A	N/A	N/A		
* 8. State Government	N/A	N/A	N/A		
* 9. Local Government	N/A	N/A	N/A		
* 10. Private Grants/Contracts	N/A	N/A	N/A		
* 11. Contributions	N/A	N/A	N/A		
* 12. Other	N/A	N/A	N/A		
* 13. Applicant (Retained Earnings)	N/A	N/A	N/A		
14. Total Other (Lines 7 to 13)	N/A	N/A	N/A		
<b>Total Non-Federal (Non-Health Center Program) Income (Program Income Plus Other)</b>					
15. Total Non-Federal Income (Lines 6+14)	N/A	N/A	N/A		\$12

Comments/Explanatory Notes (if applicable)  
Approximately 2 pages (Max 2500 Characters with spaces)

### 3.7.1 Completing the Payer Category 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

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

1. In column (a), project the number of Patients by Primary Medical Insurance for each Payer Category in Part 1. Enter 0 if not applicable (**Figure 35, 3**).
2. In column (b), project the number of Billable Visits for each Payer Category in Part 1. Billable Visits should be greater than or equal to the number of Patients by Primary Medical Insurance in column (a). Enter zero (0) if not applicable (**Figure 35, 4**).
3. In column (c), provide the amount of Income per Visit for each Payer Category in Part 1. Enter zero (0) if not applicable. (**Figure 35, 5**).
4. In column (d), calculate the amount of Projected Income for each Payer Category in Parts 1 and 2. Enter zero (0) if not applicable (**Figure 35, 6**).
5. In column (e), provide the amount of Prior FY Income for each Payer Category in Parts 1 and 2. Enter zero (0) if not applicable (**Figure 35, 7**).
6. Click the Calculate Total and Save button to calculate and save the values for each Payer Category in Parts 1 and 2. (**Figure 35, 8**).

**IMPORTANT NOTES:**

- The value in the Projected Income (d) column should equal the value in the Billable Visits (b) column multiplied by the value in the Income per Visit (c) column. If not, provide an explanation in the Comments/Explanatory Notes box.
- Do not include in-kind donations on Form 3.
- 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'.

7. Click the Calculate Total and Save button in the **Total Non-Federal (Non-Health Center Program) Income (Program Income Plus Other)** section to calculate and save Total Non-Federal Income (**Figure 35, 9**).

**3.7.2 Completing the Comments/Explanatory Notes section**

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

1. As applicable, provide an explanation for each Payer Category for which Projected Income (d) is not equal to the value obtained by multiplying Billable Visits (b) with Income per Visit (c).
2. Note significant exclusions and/or additions to the Billable Visits data in the comments box.
3. Click Save and Continue to save your work and proceed to **Form 5A: Services Provided**.

**3.8 Form 5A: Services Provided**

**Form 5A – Services Provided** identifies the services to be provided and how they will be provided by the applicant organization. You may provide required and additional services directly, by contracting with another provider, or by referral to another provider. These service delivery methods differ according to the service provider and the payment source (**Table 1**). See the Form 5A Column Descriptors at <https://bphc.hrsa.gov/sites/default/files/bphc/compliance/form-5a-column-descriptors.pdf> for descriptions and requirements for each of the three service delivery methods. All referral arrangements for services noted on Form 5A as provided via Column III must be formal written arrangements/agreements.

**Table 1: Service Delivery Methods**

<b>Service Delivery Method</b>	<b>Your Organization Provides the Service</b>	<b>Your Organization Pays for the Service</b>
1. Column I – Service provided directly by health center ( <b>Figure 36, 3</b> )	Yes	Yes
2. Column II – Service provided by formal written contract/agreement ( <b>Figure 36, 4</b> )	No	Yes
3. Column III – Service provided by formal written referral arrangement ( <b>Figure 36, 5</b> )	No	No

You will complete only one Form 5A, regardless of the number of proposed sites. **Form 5A – Services Provided** has the following two sections:

- Required Services (**Figure 36, 1**)
- Additional Services (**Figure 36, 2**)

**Figure 36: Form 5A – Services Provided (Required Services)**

**Form 5A - Services Provided (Required Services)**

**Note(s):**

- Select service delivery methods for services as applicable to the proposed NAP project.
- For more information, refer to the [Service Descriptors for Form 5A: Services Provided](#) and the [Column Descriptors for Form 5A: Services Provided](#).

Due Date: \_\_\_\_\_ (Due In: \_\_\_\_\_) | Section Status: \_\_\_\_\_

Resources

Fields with \* are required

Required Services Additional Services

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic Laboratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic Radiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Screenings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coverage for Emergencies During and After Hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Voluntary Family Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Well Child Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gynecological Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obstetrical Care			
Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intrapartum Care (Labor & Delivery)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Postpartum Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preventive Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharmaceutical Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HCH Required Substance Use Disorder Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eligibility Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outreach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Translation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Go to Previous Page Save Save and Continue

### 3.8.1 Completing the Required Services Section

To complete this section of **Form 5A**, follow the steps below:

1. Check one or more boxes to indicate the service delivery method(s) for each of the required services as applicable to the proposed NAP project (**Figure 36, 3-5**). See the [Form 5A Service Descriptors](#) for descriptions of required and additional services.
2. Click the Save and Continue button to go to the **Additional Services** section OR click the Save button on the **Required Services** section and select the **Additional Services** tab (**Figure 36, 2**).

### IMPORTANT NOTES:

- You must provide General Primary Medical Care (**Figure 36, 7**) directly (Column I) and/or through formal written contractual agreements in which the health center pays for the service (Column II).
- If you selected “Health Care for the Homeless” (HCH) as a sub program in the Budget Information: Section A - Budget Summary form, then you must select at least one service delivery method for ‘HCH Required Substance Use Disorder Services’ (**Figure 36, 6**) in the Required Services section. If you are not requesting HCH sub program funding, this row will be disabled.

### 3.8.2 Completing the Additional Services Section

To complete this section of **Form 5A**, follow the steps below:

1. Check one or more boxes to indicate the service delivery method(s) for additional services that will be available at the proposed NAP site(s) (**Figure 37**). Leave the row blank if the service will not be available at the NAP site(s).

**IMPORTANT NOTE:** You must select service delivery method(s) for Mental Health and Substance Use Disorder services (**Figure 37, 1**).

**Figure 37: Form 5A – Services Provided (Additional Services)**

Service Type	Column 1 - Direct (Health Center Pays) :	Column 2 - Formal Written Contract/Agreement (Health Center Pays) :	Column 3 - Formal Written Referral Arrangement (Health Center DOES NOT Pay) :
Additional Dental Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use Disorder Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Optometry	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Re recuperative Care Program Services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Environmental Health Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech-Language Pathology/Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Complementary and Alternative Medicine	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Additional Enabling/Supportive Services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. After completing **Form 5A**, click the Save and Continue button to save your work and proceed to the next form.

### 3.9 Form 5B: Service Sites

**Form 5B: Service Sites** identifies the NAP sites where you will provide services.

- ALL APPLICANTS must propose at least one site that will operate for at least 40 hours per week (full-time).
- NEW START and LOOK-ALIKE APPLICANTS must propose a full-time, fixed (not mobile), service delivery site.
  - If you apply for only MHC funding, this site may be permanent or seasonal.
  - If you apply for any other type of funding (CHC, HCH, PHPC), this site must be permanent, operating year-round.

- You may also propose sites open fewer hours per week or a mobile site.
- SATELLITE APPLICANTS must propose a full-time service delivery site. This site may be fixed or mobile.
  - If you apply for only MHC funding, this site may be permanent, seasonal, or mobile.
  - If you apply for any other type of funding (CHC, HCH, PHPC), this site may be permanent or mobile, operating year-round.
  - You may also propose sites open fewer hours per week.

To propose a new site, follow the steps below:

1. Click the Add New Site button (**Figure 38, 1**).

**Figure 38: Form 5B: Service Sites**

2. The **Service Site Checklist** page will open. Answer the questions in the **Service Site Checklist**.

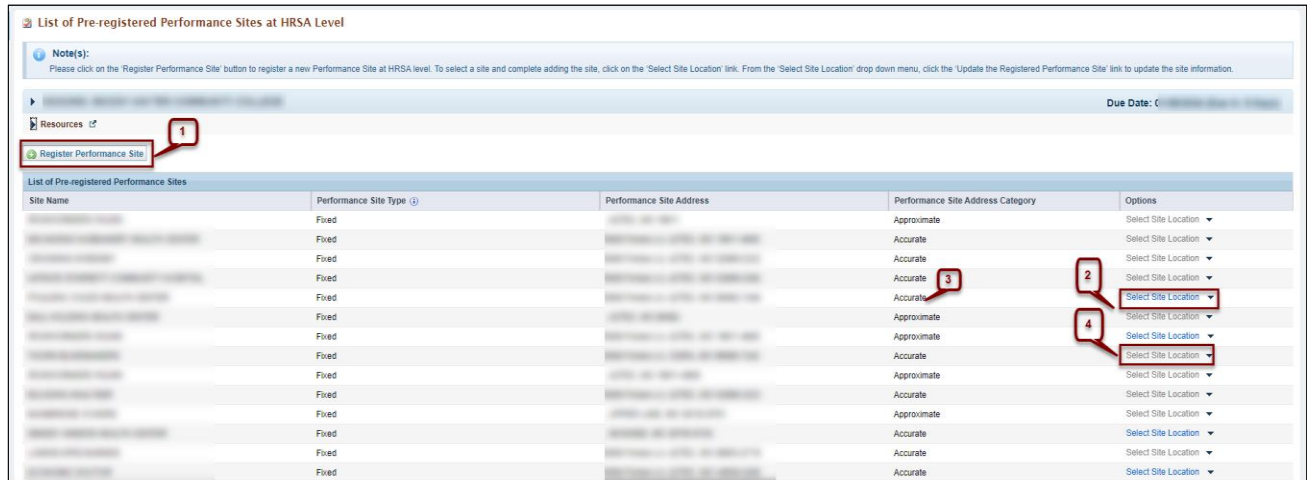
**IMPORTANT NOTES:**

- You cannot propose an ‘Admin-only’ site in your NAP application. The answer to question 1 must be ‘No’ (**Figure 39, 1**) since you will provide services at the NAP site.
- To qualify as a service site, you must select ‘Yes’ for questions ‘a’ through ‘d’.
- Only select ‘Yes’ for question 2 if the site being added is a confidential site serving victims of domestic violence and the site address cannot be published due to the necessity to protect the location of the domestic violence shelter (**Figure 39, 2**).

Figure 39: Service Site Checklist page

3. Click the Verify Qualification button (**Figure 39, 3**).
  - The system navigates to the **List of Pre-Registered Performance Sites at HRSA Level** page displaying all the sites that are registered by your organization within EHB.
4. To use a new location for the site you are proposing in **Form 5B**, click the Register Performance Site button (**Figure 40, 1**) and register your site using the Enterprise Site Repository (ESR) system by following the steps below:
  - On the Basic Information – Enter page, provide a site name and select a site type from the following options: Fixed or Mobile. Click the Next Step button.
  - On the Address – Enter page, enter the physical address of the site. The site must have a valid street address. Click the Next Step button.
  - On the Register – Confirm page, the system shows the address you entered on the Address – Enter page along with the standardized format of the address. Select the option you want and click the Confirm button.
  - On the Register – Result page, click the Finish button to register the site to your organization.
5. Once the site is registered, click its **Select Site Location** link (**Figure 40, 2**) from the list of pre-registered performance sites. Standardized addresses will be listed as “Accurate” (**Figure 40, 3**). If the address is “Approximate,” ensure that the site address is a valid street address.

**Figure 40: List of Pre-Registered Performance Sites at HRSA Level page**

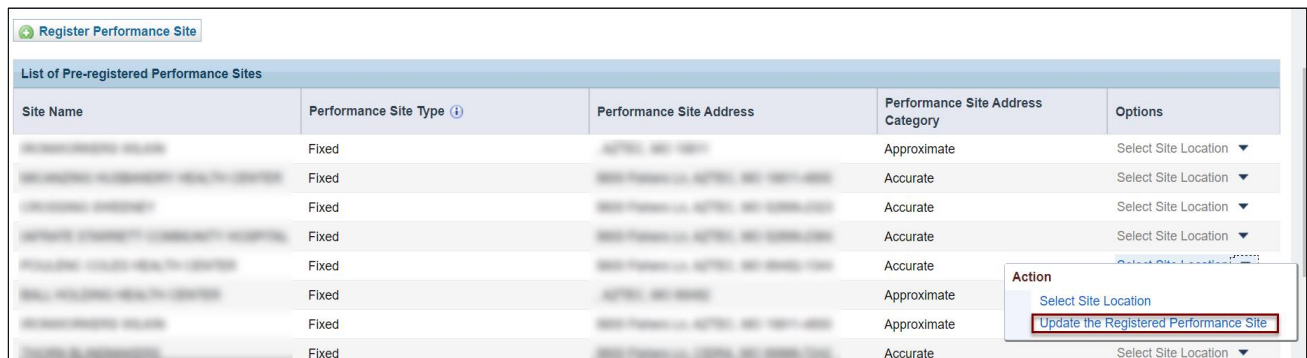


**IMPORTANT NOTE:** If the **Select Site Location** link (Figure 40, 4) is disabled, you can hover over the link to see the reason. You will not be able to select the site if it is:

- Already included in your application.
- Already active or pending verification in an award recipient’s Health Center Program scope of project.
- A confidential site and you selected ‘No’ that the proposed site is not a confidential domestic violence site for question 2 in the **Service Site Checklist (Figure 39, 2)**.
- A non-confidential site and you selected ‘Yes’ that the proposed site is a confidential/domestic violence site for question 2 in the **Service Site Checklist (Figure 39, 2)**.

6. If you wish to update the name of any site on the list of pre-registered performance sites, click the **Update the Registered Performance Site** link (Figure 41) and update the site name.

**Figure 41: Update the Registered Performance Site link**



7. When you click the **Select Site Location** link of a site, the system opens the **Form 5B: Edit** page where you must provide all the required information for the site (Figure 42). Fields marked with an asterisk (\*) are required.

Figure 42: Form 5B: Edit page

**Form-5B : Edit**

**Note(s):**  
It is recommended that you save your work often (e.g., every 5 minutes) to avoid a loss of data due to unforeseeable technical issues.

Fields with \* are required for all site types.

**Site Information** Status: Not Started

\* Site Name  Change Site Name \* Physical Site Address

\* Site Type  \* Site Phone Number ( ) - Ext.

\* Web URL

The following fields are required for "Service Delivery" and "Administrative/Service Delivery" site types, other than where exceptions are noted:

\* Location Type  \* Site Setting

Date Site was Added to Scope  \* Site Operational Date

\* FQHC Site Medicare Billing Number Status  FQHC Site Medicare Billing Number  
(Required if "This site has a Medicare billing number" is selected in "FQHC Site Medicare Billing Number Status" field.) e.g. 12345-OR-123456

FQHC Site National Provider Identification (NPI) Number  
(Optional field.) e.g. 1234567890

Months of Operation  \* Total Hours of Operation  
(when Patients will be Served per Week)

Saved Months of Operation

Number of Contract Service Delivery Locations  
(Required only for "Migrant Voucher Screening" Site Type)  Number of Intermittent Sites  
(Required only for "Intermittent" Site Type)

\* Site Operated by

**Add Subrecipient/Contractor**

Subrecipient or Contractor Information (Required only if "Subrecipient or Contractor" is selected in "Site Operated By".... (\* View More))

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN	Options
No Subrecipient or Contractor information to be displayed			

**Service Area Zip Code** (Include only those from which the majority of the patient population will come)

\* Service Area Zip Codes

Saved Service Area Zip Code(s)

8. Complete Form 5B for each proposed NAP site by following the steps below:

- The site name and address populate from the list of pre-registered performance sites.
- Select the Site Type (Service Delivery Site or Administrative/Service Delivery Site).
- Select a Location Type (**Figure 42, 1**). If you select Permanent, or if you are a satellite applicant proposing only a mobile site, all the months of operation should be checked (**Figure 42, 2**).
- Select a Site Setting. Select 'all other clinic types' if the site is not located at a hospital or school.
- Enter the date that the site will be or became operational. The date should be no more than 120 days after the project start date.
- Select the Medicare billing status and enter Medicare billing number, if applicable.
- Enter the total hours of operation per week for the site. At least one proposed site must operate for at least 40 hours per week.



- Enter the months of operation (**Figure 42, 2**). At least one proposed site must operate year-round, unless you are proposing MHC only.
- Select whether the site is operated by the health center/applicant, contractor, or subrecipient.
- If the site is operated by a contractor or subrecipient, you must enter information about the operating organization.
- Enter the zip codes for the NAP service area. After each five zip codes entered, click Save Zip Codes, to save and add more, if applicable (**Figure 42, 3**). For fixed sites, you must include the zip code of the site’s physical address.

**IMPORTANT NOTE:** The zip codes entered in **Form 5B** will be used to calculate the Unmet Need Score (UNS) for your application. Explore the [UNS Map Tool](#) to see the data that make up the UNS.

9. After completing **Form 5B**, click the save and continue button.
  - **Form 5B – Service Sites** list page opens with the newly added site in the **Proposed Sites** section (**Figure 43**).

**Figure 43: Newly added site displayed under Proposed Sites Section**

Site Name	Physical Address	Service Site Type	Location Type	Site Status	Performance Site Address Category	Options
[Dropdown]	[Dropdown]	All [Dropdown]	All [Dropdown]	All [Dropdown]	[Dropdown]	[Update]
[Dropdown]	4521 Hammett St West Richmond, VA 23220-7000	Administrative/Service Delivery Site	Permanent	Complete	Accurate	[Update]

10. To add additional sites, follow the steps 1-9 above. Once you have completed **Form 5B** for each NAP site, click the Save and Continue button to save your work and proceed to the next form.

### 3.10 Form 5C: Other Activities/Locations

**IMPORTANT NOTE:** This is an optional form. If you do not want to propose any other activities or locations in your application, you can click the Save and Continue button at the bottom of the form to complete it.

**Form 5C – Other Activities/Locations** identifies other activities or locations associated with your NAP project. To add activities or locations, follow the steps below:

1. Click the Add New Activity/Location button (**Figure 44**). The system opens the **Activity/Location – Add** page (**Figure 45**).

**Figure 44: Add New Activity/Location button**

Form 5C - Other Activities/Locations

Due Date: [Date] | Section Status: [Status]

Resources

**Add New Activity/Location**

Type of Activity	Frequency of Activity	Description of Activity	Type of Location(s) where Activity is Conducted	Status	Options
No other activities/locations added.					

Go to Previous Page Save and Continue

**Figure 45: Activity/Location – Add page**

Fields with \* are required

Activity/Location Information

\* Type of Activity: Select Option (dropdown), If Other, Please Specify (text input)

\* Frequency of Activity: [Dropdown menu] (Approximately 1/2 page(s) (Max 600 Characters): 600 Characters left)

\* Description of Activity: [Text input] (Approximately 1/2 page(s) (Max 600 Characters): 600 Characters left)

\* Type of Location(s) where Activity is Conducted: [Dropdown menu] (Approximately 1/2 page(s) (Max 600 Characters): 600 Characters left)

Cancel Save Save and Continue

2. Complete all the fields on this page and click the Save and Continue button.

- The system goes to the **Form 5C** list page displaying the newly added activity (**Figure 46**). Once the activity is added, it can be updated or deleted as needed.

**Figure 46: Activity/Location added**

Add New Activity/Location

Activity Type	Description	Frequency	Type of Location	Status	Options
Hospital Admitting	Admitting patients to hospitals	Daily	Permanent	Complete	Update

Go to Previous Page Save and Continue

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

### 3.11 Alteration/Renovation (A/R) Information

If you did not request funding for minor alteration/renovation (shown on Form 1B: Funding Request Summary), this form will not apply to you (**Figure 47**). Click the Continue button to proceed to the next form.

**Figure 47: A/R Information Page – “Not Applicable” Message**

The screenshot shows the 'Alteration/Renovation (A/R) Information' page. At the top, there is a header with 'Due Date: [blank] | Section Status: [blank]'. Below the header, there is a 'Resources' section. A yellow alert box contains the following text: 'Alert: As indicated on Form 1B, this form is not applicable to you because minor alteration/renovation was not included in the federal construction line item on the SF424A: Budget Information form, Section B, in this application.' At the bottom of the page, there are two buttons: 'Go to Previous Page' on the left and 'Continue' on the right.

If you requested funding for minor alteration/renovation, you must complete the **Alteration/Renovation (A/R) Information**, by indicating the site(s) where A/R will occur and completing the **Alteration/Renovation (A/R) Project Cover Page** and **Other Requirements for Sites** forms. On the **Alteration/Renovation (A/R) Information** page, the system populates your proposed site(s) from **Form 5B – Service Sites** (**Figure 48, 1**). Follow the steps below to complete this form:

1. Answer whether you are requesting funding for minor A/R at each site (**Figure 48, 2**).
2. For each site answered “Yes”, click the Update button (**Figure 48, 3**) to complete the **Alteration/Renovation (A/R) Project Cover Page** and **Other Requirements for Sites** forms.

**Figure 48: A/R Information Page when Applicable**

The screenshot shows the 'Alteration/Renovation (A/R) Information' page when applicable. It features a table with the following columns: 'Site Name', 'Physical Address', 'Are you requesting federal one-time funding for minor alteration/renovation at this site?', 'Status', and 'Options'. The 'Site Name' column has a red box labeled '1' around it. The 'Are you requesting federal one-time funding for minor alteration/renovation at this site?' column has a red box labeled '2' around the 'Yes' radio button. The 'Options' column has a red box labeled '3' around the 'Update' button. At the bottom of the page, there are three buttons: 'Go to Previous Page', 'Save', and 'Save and Continue'.

#### 3.11.1 Alteration/Renovation (A/R) Project Cover Page

1. On the **A/R Project Cover Page** (**Figure 49**), answer all the questions and attach the documents as requested. Fields and attachments marked with an asterisk (\*) are required.

- After you have completed the **A/R Project Cover Page**, click the Save and Continue button at the bottom of the screen to save your work and proceed to **Other Requirements for Sites (Figure 50)**.

**IMPORTANT NOTE:** For the Environmental Information Documentation (EID) checklist, download the template to your computer, complete the form, and attach it to your application in the form.

**Figure 49: A/R Project Cover Page**

**Alteration/Renovation (A/R) Project Cover Page**

**Note(s):**

- Please provide A/R information for the site below.
- To save the information entered in this page, click on the "Save" button or use the "Save and Continue" button to go to the next section. To return to the previous section, click on the "Go to Previous Page" button. The form will not be marked as COMPLETE if any information required below is missing or is incorrect.

Due Date: [Redacted] Section Status: Complete

Resources [Icon]

Fields with \* are required

Alteration/Renovation (A/R) Project Cover Page ✔ Other Requirements for Sites ✔

**\* 1. Site Information**

Name of Service Site:

Site Address:

Improved Project Square Footage:

**\* 2. Project Description**

- Provide a detailed description of the scope of work of the minor A/R project. Identify the major clinical and non-clinical spaces that will result from or be improved by the project.
- List key improvements, such as permanently affixed equipment to be installed; modifications and repairs to the building exterior (including windows); HVAC modifications (including the installation of climate control and duct work); electrical upgrades; and plumbing work.
- Describe how potential adverse impacts on the environment will be minimized. Indicate whether, and if so, how the project will implement green/sustainable design practices/principles (e.g., using project materials, design/renovation strategies).

Maximum 4000 characters counting spaces:

**\* 3. Project Management/Resources/Capabilities**

- Explain the oversight for the minor A/R project, including the Project Manager and the Project Team, if applicable, responsible for managing the project.
- Describe how the Project Team has the expertise and experience necessary to successfully manage and complete the project within the timeframe and achieve the goals and objectives established for this project.

Maximum 4000 characters counting spaces:

**\* 4. Is the proposed minor alteration/renovation project part of a larger scale renovation, construction, or expansion project?**

Yes  No

**\* Attachments**

Provide following documents related to this site:

**A/R Budget Justification (Minimum 1) (Maximum 1)** Max 1 Allowed

Document Name	Size	Date Attached	Description	Options
AR Budget Justification docx	11 kB	12/19/2023		Update Description

**Environmental Information Documentation (EID) Checklist**

Download Template

Name	Description	Options
EID Checklist	Template for EID Checklist	Download

**\* Environmental Information Documentation (EID) Checklist (Minimum 1) (Maximum 1)** Max 1 Allowed

Document Name	Size	Date Attached	Description	Options
EID Checklist docx	11 kB	12/19/2023		Update Description

**\* Floor Plans/Schematic Drawings (Minimum 1) (Maximum 2)** Attach File

Document Name	Size	Date Attached	Description	Options
Floor Plan docx	11 kB	12/19/2023		Update Description

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

### 3.11.2 Other Requirements for Sites

This form addresses site control, federal interest, and cultural resources and historic preservation considerations related to the minor A/R project. Follow the steps below to complete this form:

1. Answer all the questions on the form.
2. Attach property information, such as the lease or deed.
3. If you do not own the property, attach a Landlord Letter of Consent.
4. Click the Save and Continue button at the bottom of the form.
  - You will be returned to the **A/R Information Page** with the list of proposed sites.

Figure 50: Other Requirements for Sites

**Other Requirements for Sites**

**Notes(s):**

- Please provide A/R information for the site below.
- To save the information entered in this page, click on the "Save" button or use the "Save and Continue" button to go to the next section. To return to the previous section, click on the "Go to Previous Page" button. The form will not be marked as COMPLETE if any information required below is missing or is incorrect.

**Resources**

Fields with \* are required

Alteration/Renovation (A/R) Project Cover Page  Other Requirements for Sites

**Site Information**

Name of Service Site  
Site Address

**1. Site Control and Federal Interest**

\* 1a. Identify current status of property site (If "Leased", please answer Question 1b)

Owned  Leased

\* 1b. If Leased, please check the following:

The applicant certifies the following:

- The existing lease will provide you reasonable control of the project site.
- The existing lease is consistent with the proposed scope of project.
- We understand and accept the terms and conditions regarding federal interest in the property.

**2. Cultural Resource Assessment and Historic Preservation Considerations**

\* 2a. Was the project facility constructed prior to 1975?

Yes  No

\* 2b. Is the project facility 50 years or older?

Yes  No

\* 2c. Does any element of the overall work at the project site include:

- Any renovation/modifications to the exterior of the facility (e.g., roof, HVAC, windows, siding, signage, exterior painting, generators, etc.) or
- Ground disturbance activity (e.g., expansion of building footprint, parking lot, sidewalks, utilities, etc.)?

Yes  No

\* 2d. Does the project involve renovation to a facility that is, or near a facility that is, architecturally, historically, or culturally significant?

Yes  No

\* 2e. Is the site located on or near Native American, Alaskan Native, Native Hawaiian, or equivalent culturally significant lands?

Yes  No

**Attachments**

Provide a copy of the title, deed, or lease for the project.

Property Information (Minimum 1) (Maximum 1) Max 1 Allowed

Document Name	Size	Date Attached	Description	Options
Property Information.doc	22 kB	12/19/2023		Update Description ▼

If property status is "Leased", applicant must provide Landlord Letter of Consent.

Landlord Letter of Consent (Maximum 1) Max 1 Allowed

Document Name	Size	Date Attached	Description	Options
Landlord Letter Of Consent.docx	11 kB	12/19/2023		Update Description ▼

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

5. After you have completed the A/R Information, click the Save and Continue button at the bottom of the page to save your work and proceed to the next form.

**IMPORTANT NOTES:**

- If you add a new site in Form 5B: Service Sites after completing the A/R Information form, you will be required to revisit the A/R Information page to answer the one-time funding question for that site and provide the A/R information for the site, as applicable.
- If you remove a site from Form 5B: Service Sites, then the site will be removed from the A/R Information page.

### 3.12 Form 6A: Current Board Member Characteristics

This form collects information about your board members.

**IMPORTANT NOTES:**

- This form is optional if you select “Tribal” or “Urban Indian” as the Business Entity in Form 1A: General Information Worksheet. You can click the Save or the Save and Continue button at the bottom of the page to proceed to the next form.
- If **Form 6A** is optional for you, but you choose to enter information, then you must enter all required information.

You are required to list all current board members and provide the requested details. For existing award recipients submitting a satellite NAP application, the system will pre-populate the board member information from the last awarded Health Center Program application. You may update or delete the pre-populated information and add board members, as applicable.

To complete **Form 6A**, follow the steps below:

- To add information for a board member, click the Add New Board Member button (**Figure 51, 1**). You must provide a minimum of 9 and maximum of 25 board members. The system opens the **Current Board Member - Add** page (**Figure 52**).

Figure 51: Form 6A Current Board Member Characteristics

Form 6A - Current Board Member Characteristics

Resources

Fields with \* are required

**1** Add New Board Member

Provide a minimum of 9 and maximum of 25 board members. (v)

List of All Board Member(s)

Name	Current Board Office Position Held	Area of Expertise	>10% of income from health industry	Health Center Patient	Live or Work in Service Area	Special Population Representative (if yes, specify Special Population)	Options
							Update <b>2</b>

The totals of each Patient Board Member Classification section must be equal. (v)

PATIENT BOARD MEMBER CHARACTERISTICS

Note(s):  
Only include board members that are patients of the health center in the Patient Board Member Characteristics section.

	Number of Patient Board Members
Gender	<p><b>3</b></p> <p>The total number of patient board members under the 'Gender' section should be less than or equal to the total number of board members listed above.(v)</p> <ul style="list-style-type: none"> <li>Male</li> <li>Female</li> <li>Unreported/Declined to Report</li> </ul>
Ethnicity	<p>The total number of patient board members under the 'Ethnicity' section should be less than or equal to the total number of board members listed above.(v)</p> <ul style="list-style-type: none"> <li>Hispanic or Latino/a</li> <li>Non-Hispanic or Latino/a</li> <li>Unreported/Declined to Report</li> </ul>
Race	<p>The total number of patient board members under the 'Race' section should be less than or equal to the total number of board members listed above.(v)</p> <ul style="list-style-type: none"> <li>Native Hawaiian</li> <li>Other Pacific Islander</li> <li>Asian</li> <li>Black/African American</li> <li>American Indian/Alaska Native</li> <li>White</li> <li>More Than One Race</li> <li>Unreported/Declined to Report</li> </ul>

Note(s):  
An answer to the question below is required if you selected Public (non-Tribal or Urban Indian) as the Business Entity on Form 1A of this application. In all other cases, select N/A.

If you are a public agency, do the board members listed above represent a co-applicant board?

Yes  No  N/A

If yes, ensure that the co-applicant agreement is included as Attachment 6 in the Appendices form of this application.

Go to Previous Page Save Save and Continue

1. Provide the required board member information. Click the Save and Continue button to save the information and go back to the **Form 6A** list page (**Figure 52, 1**), or click the Save and Add New button to save the information and add a new board member (**Figure 52, 2**).

Figure 52: Current Board Member – Add Page

The screenshot shows a web form titled "Current Board Member - Add". At the top right, there is a "Due Date:" field with a dropdown arrow and "(Due In: 5)". Below this is a "Resources" link. A note states "Fields with \* are required". The form is divided into a "Board Member Information" section. It contains the following fields and questions:

- \* First Name (text input)
- \* Last Name (text input)
- Middle Initial (text input)
- Current Board Office Position Held (text input)
- \* Area of Expertise (text input)
- \* Does member derive more than 10% of income from health industry? (radio buttons: Yes, No)
- \* Is member a health center patient? (radio buttons: Yes, No)
- Live or work in service area? (checkboxes: Live, Work)
- \* Is member a special population representative (MHC, HCH, PHPC)? (radio buttons: Yes, No)

Below the "Is member a special population representative" question, there is a sub-section: "If Yes, please specify Special Population:" with three checkboxes: "Migrant Health (MHC)", "Homeless Health (HCH)", and "Public Housing (PHPC)". At the bottom left is a "Cancel" button. At the bottom right are two buttons: "Save and Continue" (highlighted with a red box labeled '1') and "Save and Add New" (highlighted with a red box labeled '2').

3. To update or to delete information for any board member, click the **Update** or **Delete** link under the options column in the **List of All Board Members** section (Figure 51, 2).
4. Enter the gender, ethnicity, and race of board members who are patients of the health center in the **Patient Board Member Characteristics** section (Figure 51, 3). The total number of patient board members for each of these sections must match.
5. If you selected Public as the business entity in **Form 1A: General Information Worksheet**, answer the public agency question at the bottom of the form. If you selected a different business entity in **Form 1A**, select 'N/A' for this question. If you answer 'Yes' to this question, ensure that the Co-Applicant Agreement is included in **Attachment 6** in the **Appendices** form.
6. After completing **Form 6A**, click the Save and Continue button to save the information and proceed to the next form.

### 3.13 Form 6B: Request for Waiver of Governance Requirements

If you are requesting funding for special populations only (MHC, HCH, and/or PHPC), you may use **Form 6B** to request a waiver of the 51% patient majority governance requirement. HRSA will not grant a waiver request if your organization currently receives or is applying for Community Health Center (CHC) funding.

#### 3.13.1 Completing Form 6B when it is not applicable

**Form 6B** is not applicable if:

- You currently receive Community Health Centers (CHC) funding, or you selected the CHC sub program in the Budget Information form: **Section A – Budget Summary**.
- You selected "Tribal" or "Urban Indian" as the Business Entity in **Form 1A: General Information Worksheet**.

If the form is not applicable, click the Continue button to proceed to the next form (Figure 53, 1).



**Figure 53: Form 6B: Request for Waiver of Governance Requirements – Not Applicable**

### 3.13.2 Completing Form 6B when it is applicable.

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

1. Indicate whether you are requesting a new waiver of the 51% patient majority governance requirement under the **New Waiver Request** section (**Figure 54, 1**) or if you currently have a waiver in the **For Applicants With Previous Waiver** section (**Figure 54, 2**).

**Figure 54: Form 6B: Request for Waiver of Governance Requirements – Applicable**

2. If you answered 'Yes' to question 2a, you must answer 'Yes' or 'No' for question 2b. Select 'N/A' for question 2b if you answered 'No' to question 2a.
3. If you answered 'Yes' to question 1 or question 2b, you must answer the remaining questions on the form.
4. After completing **Form 6B**, click the Save and Continue button to save your work and proceed to the next form.

### 3.14 Form 8: Health Center Agreements

**Form 8** indicates whether 1) you have a parent, affiliate, or subsidiary organization; and/or 2) you have or plan to use:

- Contract(s) with another organization to perform substantive programmatic work within the proposed scope of project; or
- Subaward(s) 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.

This form has the following sections:

- Part I: Health Center Agreements (**Figure 55, 1**)
- Part II: Attachments – Organization Agreement(s) (**Figure 55, 2**)

**Figure 55: Form 8 – Health Center Agreements**

**Form 8 - Health Center Agreements**

**Notes:**  
If a Health Center Program award recipient wishes to enter into an agreement/arrangement post-award 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.

Resources 17

Fields with \* are required

**PART I: Health Center Agreements**

\* 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.  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**

\* 2. Do you currently have, or propose 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.  Yes  No

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.  Yes  No

**Notes:**  
• 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 substantive programmatic work.

If **Yes**, indicate the number of each agreement by type in 2a and/or 2b below and complete Part II.

2a. Number of contracts with another organization to perform substantive programmatic work within the proposed scope of project.  (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)

Total number of contracts for substantive programmatic work and/or subawards.

**Save and Calculate**

**Add Organization Agreement** 2

**Part II: Attachments**  
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](#)

#### 3.14.1 Completing Part I: Health Center Agreements

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

1. Answer question 1 (**Figure 56, 1**). If you select 'Yes' for question 1, enter the number each agreement type in 1a, 1b, and 1c.
2. Answer question 2 (**Figure 56, 2**). Select 'Yes' for question 2 if any current or proposed agreements exist with another organization to perform substantive programmatic work within the scope of project. For the purposes of the Health Center Program, contracting for substantive programmatic work applies to contracting with a single entity for most of health care providers.

**IMPORTANT NOTE:** If you proposed a site in Form 5B: Service Sites that will be operated by a “Subrecipient” or a “Contractor”, the system will set the answer for question 2 to ‘Yes’.

Figure 56: Form 8, Part I

3. If you select ‘Yes’ for question 2, enter the number of each agreement type in 2a and 2b (Figure 56, 3-4).
4. Click Save and Calculate to show the total number of agreements, contracts, and subawards (Figure 56, 5).

### 3.14.2 Completing Part II: Attachments – Organization Agreement(s)

If you answered ‘Yes’ to questions 1 or 2, provide each agreement with the organizations as noted in Part I. To add agreements for each organization, follow the steps below:

1. Click the Add Organization Agreement button located above Part II (Figure 57, 1). The system opens the Organization Agreement - Add page (Figure 58).

Figure 57: Form 8, Part II

Figure 58: Organization Agreement – Add page

2. Provide the required information for the agreement in the **Organization Agreement Detail** section (**Figure 58, 1**).
3. Under the **Attachments** section, click the **Attach File** button (**Figure 58, 2**) to upload at least one document related to the organization (the complete affiliation agreement, contract, and/or subaward).

**IMPORTANT NOTE:** Before uploading a document for Form 8, rename the file to include the affiliated organization's name (e.g., "CincinnatiHospital\_MOA.doc").

4. Click **Save and Continue** to return to the **Form 8: Health Center Agreements** list page. Following the steps described above, click the **Add Organization Agreement** button to enter details and attach agreements for each organization referenced in Part I. This form will accept a maximum of five attachments for 10 organizations.
5. After completing **Form 8**, click the **Save and Continue** button to save your work and proceed to the next form.

### 3.15 Form 12: Organization Contacts

Use **Form 12: Organization Contacts** to provide contact information for the proposed project.

New applicants will provide the requested contact information. For existing award recipients submitting a satellite application, the system will pre-populate the contact information from the latest awarded Health Center Program application. Fields marked with an asterisk (\*) are required.

To complete this form, follow the steps below:

1. Click the **Add/Update** link to add or update the information for each type of contact (**Figure 59, 1, 2, 3, 4, 5**). For example, click **Add Chief Executive Officer** link to add a Chief Executive Officer. The system directs you to the data entry page for the corresponding contact (**Figure 60**).

**Figure 59: Form 12 – Organization Contacts**

The screenshot shows the 'Form 12 - Organization Contacts' page. At the top, there is a 'Note(s):' section stating: 'For satellite applicants, the system will pre-populate this form. Update as applicable.' Below this, there are tabs for 'Resources' and 'Section Status: Not Started'. The main content area is titled 'Fields with \* are required' and contains a table with the following columns: Role, Name, Highest Degree, Email, and Phone Number. The roles listed are: Chief Executive Officer, Contact Person, Chief Medical Officer, Dental Director, and Behavioral Health Director. To the right of each row, there is a dropdown menu labeled 'Option' with a plus icon and the role name. Numbered callouts (1-5) point to these dropdown menus. At the bottom of the page, there are buttons for 'Go to Previous Page', 'Save', and 'Save and Continue'.

2. To delete the contact information already provided, click on the **Delete** link under the options column.

**IMPORTANT NOTE:** The **Update** and the **Delete** links will display after you add the contact information.

3. Enter the required information on this page.

**Figure 60: Chief Executive Officer – Add page**

The screenshot shows the 'Chief Executive Officer - Add' page. At the top, there is a 'Note(s):' section stating: 'For satellite applicants, the system will pre-populate this form. Update as applicable.' Below this, there are tabs for 'Resources' and 'Section Status: Not Started'. The main content area is titled 'Fields with \* are required' and contains a form for adding a new contact. The form has a 'Position Title' dropdown menu set to 'Chief Executive Officer'. The fields include: Prefix (dropdown), First Name (text), Last Name (text), Middle Initial (text), Suffix (dropdown), Highest Degree (dropdown), Email (text), and Phone Number (text with Ext. field). At the bottom of the page, there are buttons for 'Cancel', 'Save', and 'Save and Continue'.

4. Click Save and Continue to save the information and proceed to the **Form 12: Organization Contacts** page to add information for the next contact.
5. After completing **Form 12**, click the Save and Continue button to save the information and proceed to the next form.

### 3.16 Equipment List

The **Equipment List** form provides a line-item list of proposed equipment to be purchased with grant funds. If you did not request funding for equipment (shown on **Form 1B: Funding Request Summary**), this form will not apply to you (**Figure 61**). Click the Continue button to proceed to the next form.

**Figure 61: Equipment List Page – Not Applicable**

The screenshot shows the 'Equipment List' page with a yellow alert box. The alert text reads: 'Alert: As indicated on Form 1B, this form is not applicable to you because equipment was not included in the federal line item on the SF424A, Budget Information form, Section B, in this application.' Below the alert are two buttons: 'Go to Previous Page' and 'Continue'.

If you requested funding for equipment, you must complete the **Equipment List** form. To complete this form, follow the steps below:

1. Click the Add button to add equipment (**Figure 62**).
2. The system opens the **Equipment Information - Add Page** (**Figure 63**).

**Figure 62: Equipment List Page**

The screenshot shows the 'Equipment List' page with a 'Note(s)' section at the top. Below the note is a table with columns for 'Type', 'Description', 'Unit Price', 'Quantity', and 'Total Price | Options'. The text 'No equipment added' is displayed in the table. A red box highlights the 'Add' button in the 'Resources' section. At the bottom right, there are 'Save' and 'Save and Continue' buttons.

**Figure 63: Equipment Information - Add Page**

The screenshot shows the 'Equipment Information - Add' page. It features a form with the following fields: 'Type' (a dropdown menu with 'Select Option' selected), 'Description' (a text input field with a '(Maximum 50 Characters)' label), 'Unit Price (\$)' (a text input field), and 'Quantity' (a text input field). There are 'Cancel', 'Save', and 'Save and Continue' buttons at the bottom.

3. Select an equipment Type and enter the Description, Unit Price (\$), and Quantity.
4. Click the Save and Continue button at the bottom of the screen. You will be returned to the **Equipment List** page (**Figure 64**).

**Figure 64: Equipment List Page with Equipment Added**

Type	Description	Unit Price	Quantity	Total Price	Options
Clinical	Testing Equipment	\$10,000.00	1	\$10,000.00	Action Update Delete
Total			1	\$10,000.00	

5. To edit an equipment list item, click the **Update** link under the Options menu (**Figure 64, 1**). To delete an equipment item, click the **Delete** link under the Options menu (**Figure 64, 2**).

**IMPORTANT NOTE:** Include equipment that is \$5,000 or more per unit. Equipment items that cost less than \$5,000 each should be listed under supplies in the budget.

6. When you have finished entering the equipment, click the Save and Continue button at the bottom of the screen to save your work and proceed to the next form.

### 3.17 Summary Page

This form displays information provided in the following forms of the NAP application: **Form 1A**, **Form 1B**, **Form 2** and **Form 5B**. You will not be able to complete this form until these related forms are complete. To complete this form, follow the steps below:

1. Select your applicant type (satellite, new start, or look-alike).
2. Review the data displayed on the **Summary page (Figure 65)**. If changes are required, edit the forms by clicking on the form name in the left navigation panel. Be advised that the information in the forms should be consistently identified throughout the entire application.
3. The site table under #2 lists site information for the proposed NAP sites, including the service area zip codes. (**Figure 65, 1**). If changes are needed, go to Form 5B: Service Sites. Check the box to certify this information.
4. The “Unmet Need Score” (UNS) is based on data from all the service area zip codes listed in the table, from Form 5B. These zip codes correspond to Zip Code Tabulation Areas (ZCTAs) to determine the UNS. The **Summary Page** will display the UNS Score (out of 100) and the UNS Converted Score (**Figure 65, 2**). The UNS Converted Score (out of 20 points) will be included as part of your NAP application overall score. Check the box to acknowledge this information. Use the [UNS Map Tool](#) to determine the ZCTAs for your proposed service area (enter your Form 5B service area zip codes), view the unmet need data for each ZTCA, and see how that data makes up the service area UNS.
5. Check the box under #4 to verify your patient projection for 2026. If changes are needed, go to **Form 1A**.
6. The funding table under #5 displays budget information, the patient projection for calendar year 2026, and calculates the funding amount per patient (**Figure 65, 3**).
7. Review your one-time funding selection from **Form 1B** and the funding request for equipment and/or minor A/R under #6.
8. Review your proposed FTEs for the NAP project under #7. If changes are needed, go to **Form 2**.

9. Read the certifications under #8 and compliance requirements under #9. Check the boxes to certify and acknowledge.
10. If you are requesting HCH or PHPC funding on the **SF-424A Budget Information** form, you must respond to #10 and describe how you will use federal funds to add new or expand existing services to people experiencing homelessness and/or public housing residents in your proposed service area. If you are not requesting HCH or PHPC funding, N/A will be selected for you.
11. When the form is complete, click the Save and Continue button (**Figure 65, 4**).

**IMPORTANT NOTE:** If you update the information in any of the related forms after completing the **Summary Page**, you will be required to revisit the **Summary Page** to review and acknowledge the updated information.



Figure 65: Summary Page

**Summary Page**

**Note(s):**  
The information below is pre-populated based on data that you provided in the forms of this NAP application. If any information is incorrect, please edit the forms by clicking on the form name in the Menu on the left of the screen. Be advised that the information in the forms should be consistently identified throughout the entire application.

**Warning:**  
One or more details displayed below may have been updated in one of the forms (Form 1A, Form 1B, Form 2 or Form 5B) of this NAP Application. Please review the information on this form and click 'Save' button displayed at the bottom of this page.

Due Date: 12/31/2025 09:00 AM (ET) | Section Status: Not Started

**Resources**

**Summary Information**

1. Select your applicant type:

I am a current Health Center Program award recipient with an H80 grant (I am a satellite applicant)  
 I am not an H80 award recipient, and I am not a designated look-alike (I am a new start applicant)  
 I am a designated look-alike, and I am not an H80 award recipient (I am a look-alike applicant)

2. I am proposing the following site(s), which will be open within 120 days of award:

These are the proposed NAP site(s) and service area. If changes are required, revisit Form 5B

Site Name	Physical Street Address for Site	Service Site Type	Location Type	Hours per Week	Service Area Zip Codes
No Site Added.					

By checking this box, I certify that all sites described in my application are included on Form 5B (as summarized above) and that all service sites included on Form 5B (as summarized above) will be open and operational within 120 days of receipt of the Notice of Award.

3. The Unmet Need Score (UNS) is based on data from all the service area zip codes entered on Form 5B. The UNS converted score is up to 20 points of the 30 available points in the Need section.

Unmet Need Score (out of 100 points): 0  
 UNS Converted Score (up to 20 points): 0

By checking this box, I understand that the UNS converted score (up to 20 points) will be included as part of my NAP application overall score, and I acknowledge that the service area zip codes used to calculate the Unmet Need Score are accurate (as listed above and on Form 5B). In addition, I understand that these zip codes correspond to ZCTAs to determine the UNS.

**Note(s):**  
Visit the NAP TA webpage for UNS Resources and see the Unmet Need Score Map Tool to view the unmet need data for each ZCTA.

4. Total number of unduplicated patients projected to be served in calendar year 2026 (January 1, 2026 through December 31, 2026) entered on Form 1A:

If changes are required, revisit Form 1A

0

By checking this box, I acknowledge that HRSA will assess my progress toward serving this number of patients in calendar year 2026, and that assessment may impact future funding. For new start and look-alike applicants, this becomes your Patient Target. For satellite applicants, this figure may be added to your Patient Target.

5. I am requesting the following types of Health Center Program funding:

This is the NAP federal funding request. If changes are required, revisit the Budget Information Form and/or Form 1A

Type of Health Center Funding	Federal Funds Requested (a)	CY 2026 Patient Projection (b)	Federal Dollars per Patient (c=a/b)
Community Health Centers	\$0.00	-	
Health Care for the Homeless	\$0.00	-	
Migrant Health Centers	\$0.00	-	
Public Housing Primary Care	\$0.00	-	
<b>Total</b>	<b>\$0.00</b>	<b>0</b>	<b>\$0.00</b>

6. I am requesting one-time funding for the following type of project:

If changes are required, revisit the Budget Information Form (populated from SF-424A Section B) and Form 1B

N/A (no funding requested for equipment or minor A/R)  
 Equipment (no minor A/R)  
 Minor alteration/renovation with equipment  
 Minor alteration/renovation without equipment

NAP one-time funding request for minor A/R and equipment: \$0.00

7. Total number of full time equivalent (FTE) staff:

This is the proposed FTE staff for the NAP project. If changes are required, revisit Form 2

0

**8. Certifications**

By checking this box, I certify that:

- The main purpose of this NAP project is to provide comprehensive primary medical care for medically underserved populations in the service area.
- I have consulted with appropriate State and local government agencies, and health care providers regarding the need for the health services to be provided at the proposed NAP site(s).
- I have reviewed the UDS resources, including the most recent UDS Manual, and understand that my organization will be required to report data on patients, services, staffing, and financing annually. I acknowledge that failure to submit a complete report by the specified deadline may result in conditions or restrictions being placed on the Health Center Program award.

**9. Compliance**

By checking this box, I acknowledge that, in accordance with Section 330(e)(1)(B):

- My health center must maintain compliance with all Health Center Program requirements.
- I must address areas of noncompliance within the timeframes specified in applicable conditions.
- If my organization is noncompliant with any Health Center Program requirements or a new start health center, I must submit a Compliance Achievement Plan within 120 days of Notice of Award which outlines steps the health center will take to meet the Health Center Program requirements.

**10. Applicants for HCH and PHPC Funding: Supplement and Not Supplant Certification**

Not Applicable. My organization is NOT requesting HCH and/or PHPC funding on the SF-424A. Budget Information Form

By checking this box, I certify that my organization will utilize HCH and/or PHPC grant funding to supplement and not supplant, the expenditures of the health center and the value of in-kind contributions for the delivery of services to these populations (individuals experiencing homelessness and residents of public housing).

Describe, with specific examples, how you will utilize the requested federal funds to add new or expand existing services to individuals experiencing homelessness and/or residents of public housing within your proposed service area. Specifically address how this is an increase or expansion of the services your organization was providing previously for these populations. (maximum 1,000 characters)

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## 4. Reviewing and Submitting the FY 2025 NAP Application to HRSA

To review your application, follow the steps below:

1. Go to the standard section of the application using the **Grant Application** link next to **You are here:** at the top of the page (**Figure 66, 1**).
2. On the **Application - Status Overview** page, sections that are incomplete or have errors will have a status of 'Not Complete.' Click the **Update** link under the Options menu to access each section needing revision. Update until the status is 'Complete' for all. Once all sections indicate 'Complete', click the **Review** link in the Review and Submit section of the left menu (**Figure 66, 2**).

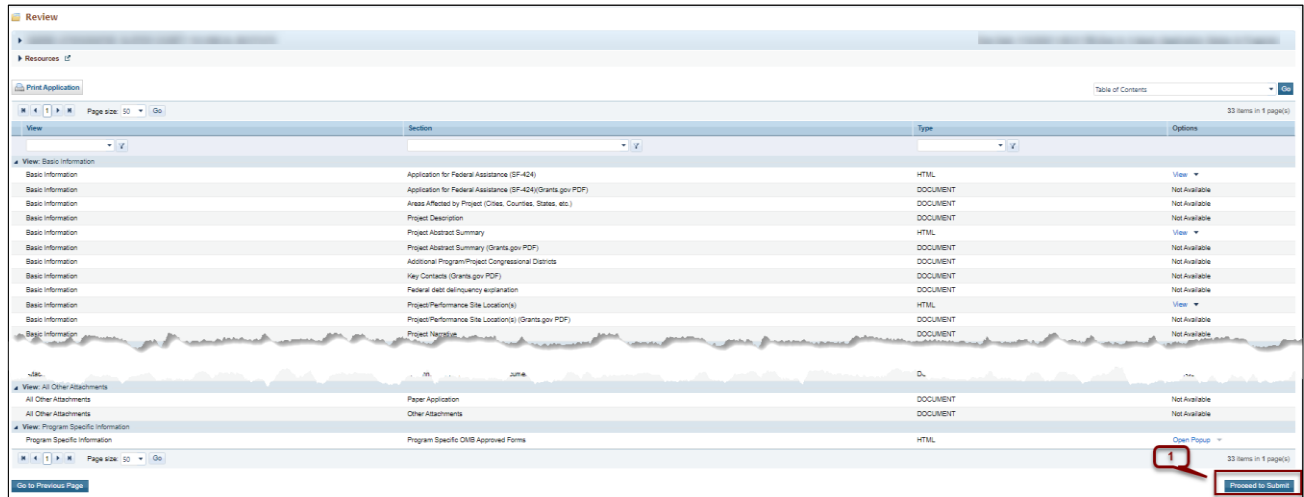
Figure 66: Review Link

The screenshot displays the 'Application - Status Overview' page. At the top, the breadcrumb navigation shows 'You are here: Home » Tasks » Browse » Grant Applications » 225819'. A red box labeled '1' highlights the 'Grant Application' link in the top navigation bar. The main content area shows application details: Announcement Number: HRSA-25-085, Application Type: New, Application Package: SF424, Announcement Name: New Access Points, Grant Number: N/A, Application FY: 2025, Created by: [redacted], Last Updated By: [redacted], Program Type: Non-Construction. Below this is a 'Resources' section with links for Application, Action History, Funding Opportunity Announcement, FOA Guidance, and Application User Guide. A 'Users with permissions on this application (1)' section is also present. The main table, 'List of forms that are part of the application package', has columns for Section, Status, and Options. The table lists various sections, all with a status of 'Complete' and an 'Update' link in the Options column. A left-hand navigation menu includes sections like Overview, Status, Basic Information, Budget Information, Other Information, Program Specific Information, and Review and Submit. A red box labeled '2' highlights the 'Review' link in the 'Review and Submit' section of the left menu.

Section	Status	Options
Basic Information	Complete	
SF-424	Complete	
Part 1	Complete	Update
Part 2	Complete	Update
Project/Performance Site Location(s)	Complete	Update
Project Narrative	Complete	Update
Budget Information		
Section A-C	Complete	Update
Section D-F	Complete	Update
Budget Narrative	Complete	Update
Other Information		
Disclosure of Lobbying Activities	Complete	Update
Appendices	Complete	Update
Program Specific Information		
Program Specific Information	Complete	Update

3. The system opens the **Review** page (**Figure 67**). Click the **View** link in the Options column to see each part of your application. Click the Open Popup link at the bottom of the Options column to see all the program-specific forms. Click the Print Application button at the top of the page to print the forms.
4. When you are ready to submit the application to HRSA, click the Proceed to Submit button at the bottom of the **Review** page (**Figure 67, 1**).
5. The system opens the **Submit** page.

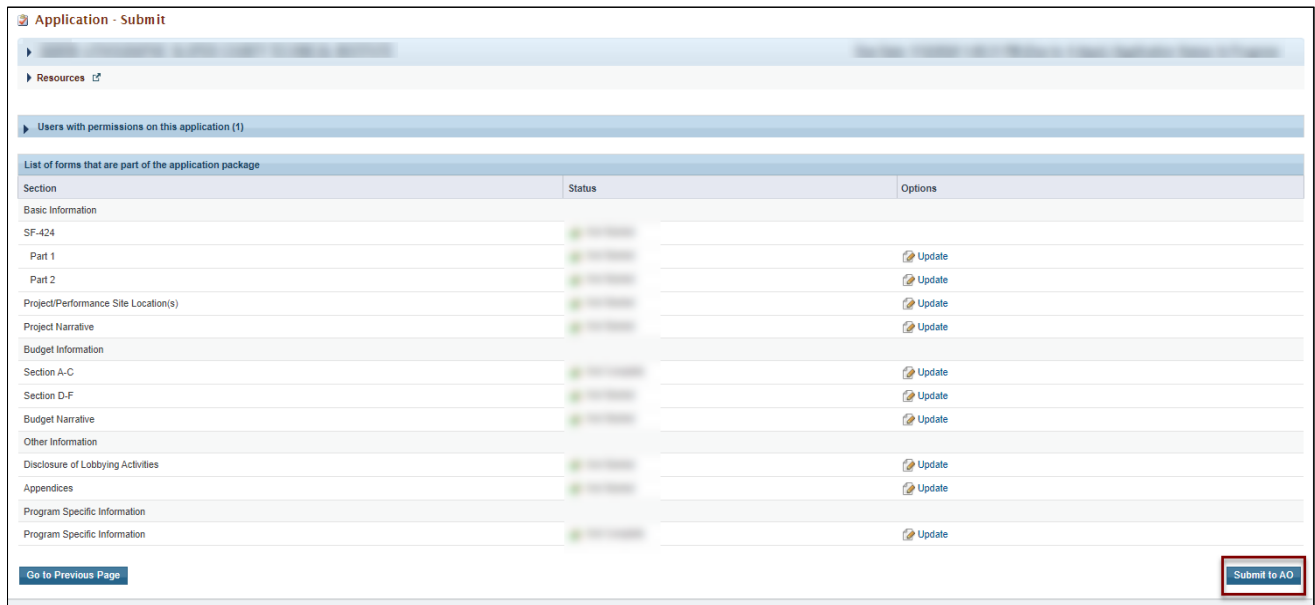
**Figure 67: Review Page – Proceed to Submit**



**IMPORTANT NOTES:**

- To apply, you must have the 'Submit' privilege. This privilege must be given by the Project Director (PD) to the Authorizing Official (AO).
- If you are not the AO, a **Submit to AO** button will be displayed at the bottom of the **Submit** page. Click the button to notify the AO that the application is ready to submit to HRSA (**Figure 68**).
- The AO must click the **Submit to HRSA** button before the due date. Make sure to leave time for this step!

**Figure 68: Submit to AO**



5. Click the Submit to AO button at the bottom of the **Submit** page (**Figure 68**). If you are the AO, click the Submit to HRSA button at the bottom of the **Submit** page (**Figure 69**).
6. You're not done yet! The system goes to a confirmation page.

Figure 69: Submit Page

The screenshot shows the 'Application - Submit' page. The sidebar on the left contains navigation options: Grant Application, Overview, Status, Basic Information (SF-424, Project/Performance Site Location(s), Project Narrative), Budget Information (Section A-C, Section D-F, Budget Narrative), Other Information (Disclosure of Lobbying Activities, Appendices), Program Specific Information (Program Specific Information), Review and Submit (Review, Submit), Other Functions, and Navigation (Return to Applications List). The main content area shows 'Resources' with links for Application, Action History, Funding Opportunity Announcement, FOA Guidance, and Application User Guide. Below that, it shows 'Users with permissions on this application (1)'. The primary section is a table titled 'List of forms that are part of the application package'.

Section	Status	Options
Basic Information		
SF-424	Complete	
Part 1	Complete	Update
Part 2	Complete	Update
Project/Performance Site Location(s)	Complete	Update
Project Narrative	Complete	Update
Budget Information		
Section A-C	Complete	Update
Section D-F	Complete	Update
Budget Narrative	Complete	Update
Other Information		
Disclosure of Lobbying Activities	Complete	Update
Appendices	Complete	Update
Program Specific Information		
Program Specific Information	Complete	Update

At the bottom left of the main content area is a 'Go to Previous Page' button. At the bottom right is a 'Submit to HRSA' button, which is highlighted with a red box and a callout bubble containing the number 1.

7. Check the box to certify and electronically sign the application. Then click the Submit to HRSA button (Figure 70) to submit your application to HRSA.

Figure 70: Submit to HRSA

The screenshot displays the 'Application - Submit Certify' interface. On the left, a sidebar lists various sections: Grant Application, Overview, Basic Information (with sub-items SF-424, Project/Performance, Site Location(s), Project Narrative), Budget Information (with sub-items Section A-C, Section D-F, Budget Narrative), Other Information (with sub-items Disclosure of Lobbying Activities, Appendices), Program Specific Information (with sub-item Program Specific Information), Review and Submit (with sub-item Review), Submit, Other Functions, and Navigation (with sub-item Return to Applications List). The main content area features a yellow 'Confirmation:' header with a note: 'Note: This is a confirmation page! You must click the appropriate button to complete your action.' Below this, there's a 'Resources' section with a 'View' button and links to 'Application', 'Action History', 'Funding Opportunity Announcement', 'FOA Guidance', and 'Application User Guide'. The 'Application Certification' section contains a text area with a certification statement and a checkbox labeled 'Please check the box to electronically sign the Application.' A 'Cancel' button is on the left, and a 'Submit to HRSA' button is on the right, highlighted with a red callout box containing the number '1'. The top of the page shows the breadcrumb 'You are here: Home » Tasks » Browse » Grants [ ] » Grant Applications »' and the title 'Application - Submit Certify'.

8. If you have any problems submitting the application in EHBs, contact **Health Center Program Support** at 1-877-464-4772 (Monday – Friday, 8:30 AM - 5:30 PM ET) or through the [BPHC Contact Form](#):
  - Under *Technical Support*, select *EHBs Tasks/EHBs Technical Issues*
  - Select *Grant Applications Technical Question*