Summary Page

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration **SUMMARY PAGE**	**FOR HRSA USE ONLY**	
	Grant Number	**Application Tracking Number**

1) Select your applicant type:	**Select One Option:**
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 Code(s)**
Will pre-populate from Form 5B					

[_] 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): *Will auto-calculate in EHBs* **UNS Converted Score (up to 20 points):** *Will auto-calculate in EHBs*

[_] 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: 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.

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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.
[_] 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	*Will pre-populate from SF-424A, section A*	*Will pre-populate from Form 1A*	*Will auto-calculate in EHBs*
Health Care for the Homeless	*Will pre-populate from SF-424A, section A*	*Will pre-populate from Form 1A*	*Will auto-calculate in EHBs*
Migrant Health Centers	*Will pre-populate from SF-424A, section A*	*Will pre-populate from Form 1A*	*Will auto-calculate in EHBs*
Public Housing Primary Care	*Will pre-populate from SF-424A, section A*	*Will pre-populate from Form 1A*	*Will auto-calculate in EHBs*
Total	*Will auto-Calculate in EHBs*	*Will pre-populate from Form 1A*	*Will auto-calculate in EHBs*

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: *Will pre-populate from SF-424A, section B*

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

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

Will pre-populate from Form 2

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)

Instructions

Use this form to verify key application data. If the pre-populated data are incorrect, verify that you entered the correct data in the SF-424A: Budget Information form and program-specific forms (1A, 1B, 2, and 5B).

Proposed NAP site(s) and service area ZIP codes will pre-populate from Form 5B: Service Sites. Review to make sure the site address and service area ZIP codes are correct. We use the ZIP codes listed on Form 5B to determine the NAP service area, unmet need score (UNS), and priority points.

The UNS represents unmet need across all proposed service area ZIP codes. You can enter the ZIP codes from Form 5B into the Unmet Need Score Map Tool to see the UNS for your service area as you develop your application. You should know how your service area ZIP codes impact your UNS, since it is worth up to 20 points in your application score. The NAP TA webpage has more resources about UNS.

The number of patients that you project to serve at your proposed site(s) in 2026 pre-populates from Form 1A: General Information Worksheet (from the Total line under Unduplicated Patients and Visits by Population Type). Make sure that your unduplicated patient projection is realistic and appropriate based on the proposed NAP project. If funded, your progress toward this number may impact future funding. We will use your 2026 UDS report to assess your progress.

Your NAP federal funding request pre-populates from the SF-424A: Budget Information form, section A. Make sure your NAP funding request is accurate and reasonable for the number of projected patients. The federal dollars per patient are calculated by dividing the federal request by projected unduplicated patients (entered by CHC, MHC, HCH, and/or PHPC on Form 1A). You will explain why these values are reasonable in the Project Narrative.

You must certify that:

- You plan for all proposed sites (from Form 5B) to be operational within 120 days of Notice of Award.

- The main purpose of your NAP project is to provide primary medical care for underserved people in the service area.

- You have consulted with appropriate State and local government agencies and health care providers about the need for the proposed NAP site(s).

- You have reviewed the UDS resources and understand that you will be required to report data on patients, services, staffing, and financing each year.

- You 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.

You must acknowledge that:

- The service area ZIP codes used for the UNS are accurate (from Form 5B).

- Your converted UNS score (up to 20 points) will be included as part of your overall NAP application score.

- HRSA will assess progress toward the 2026 patient projection (from Form 1A), which may impact future funding.

- You will maintain compliance with all Health Center Program requirements.

- If you are non-compliant with any Health Center requirements or a new start health center, you must submit a Compliance Achievement Plan that outlines steps you will take to meet requirements.

- You will address areas of noncompliance within the specified timeframes.