



Fiscal Year 2027 Look-Alike Renewal of Designation Form Instructions

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Form 1A: General Information Worksheet

Instructions

This form collects general information about your organization and proposed project. Some of the data you enter in this form will pre-populate in other forms in your application.

1. Applicant Information

- Enter the Applicant name as it appears on your SAM.gov registration.
- Select the Fiscal Year End Date for your organization, such as January 31.
- Check one category in the Business Entity section. Make sure your selection aligns with the entity type entered in [SAM.gov](https://sam.gov).
 - If you are a Tribal or Urban Indian entity, always select the Tribal or Urban Indian category.
- You may select more than one Organization Type.

2. Proposed Service Area

a. Service Area Designation

- Use HRSA's shortage designation tools¹ to determine whether all or part of your proposed service area is located in a designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP).
- Select the MUA and/or MUP designations for your proposed service area and enter the corresponding identification number(s).
- To learn more about MUAs and MUPs, see [What is Shortage Designation?](#) or email sdb@hrsa.gov.

HRSA will use the MUA/MUP IDs provided on Form 1A to determine whether you propose to serve at least one medically underserved area or population within the proposed service area.

b. Service Area Type

- HRSA defines the service area as rural if 40 percent or more of the area's ZIP codes are designated rural by the Federal Office of Rural Health Policy (FORHP). Visit [FORHP's website](#) for more information about rural designations.
- Select the type, urban or rural, that best describes the proposed service area.

c. Patients

General Guidance for Patient Counts: When providing the number of patients for each service type and population type, note the following:

- The period of performance for your proposed service area is 4 years.
 - For a 4-year period of performance, patient projections should be for calendar year (CY) 2029, January 1 through December 31, 2029.
- A patient is someone who had at least one visit in 2025, for the UDS/Baseline Value, or is projected to have at least one visit during the assessment period (January 1 through December 31).
- Provide combined data for all service sites in your proposed project.
- See the [UDS Manual](#) for reporting details about patients and services.
- Do not include patients for pharmacy services or services outside your proposed scope of project.
- Ensure your projections are consistent throughout the application.

Unduplicated Patients by Population Type: The population types in this section do **not** refer only to the designated

¹ <https://data.hrsa.gov/tools/shortage-area/mua-find> or <https://data.hrsa.gov/tools/shortage-area/by-address>

Population Type on the Cover Page. For example, if your designated Population Type is Medically Underserved Populations (CHC), but some patients fall into other special medically underserved population type categories, you should still enter those patients in the appropriate categories.

All patients who do not fall within the Migratory and Seasonal Agricultural Workers (MSAW), Residents of Public Housing (RPH), or Homeless Population (HP) categories must be included in the Medically Underserved Populations (CHC) category.

1. Project the number of unduplicated patients to be served during the assessment period, CY 2029, for a 4-year period of performance. This value will pre-populate in the corresponding cell within the table below this field.
2. The number of current patients for each population type will pre-populate from available 2025 UDS data. You will not be able to edit or enter data in the applicable fields.
3. Project the total number of patients for each population type category during the assessment period, CY 2029, for a 4-year period of performance.

Patients by Service Type: A person who receives multiple types of services should be counted once for each service type. For example, a person who receives both medical and dental services should be counted once for medical and once for dental. This section does not include a row for total patients since a patient may be included in more than one service type category.

1. The number of current patients for each service type will pre-populate from available 2025 UDS data. You will not be able to edit or enter data in the applicable fields.
2. Project the total number of patients for each service type category in the assessment period, CY 2029, for a 4-year period of performance.

Form 1C: Documents On File

Instructions

This form lists selected items that support compliance with Health Center Program requirements, as outlined in the [Health Center Program Compliance Manual](#). It does not include all documents, such as policies and procedures, protocols, or legal documents, that your health center must maintain on file.

Provide the date each document was last reviewed or revised. Select N/A if the item does not apply to your organization.

Your organization's board must evaluate your policies on Billing and Collections, Sliding Fee Discount Program, and Quality Improvement/Assurance at least once every 3 years as required in element d of [Chapter 19: Board Authority](#) in the [Compliance Manual](#).

Do not submit listed documents with the application unless requested in the Instructions. If your application is re-designated, HRSA will review these documents as part of an [Operational Site Visit](#) or may request to review them post-designation.

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

Form 2: Staffing Profile

Instructions

List personnel for the **first certification period** of your proposed project. Include all personnel that will support your look-alike project, whether they will be paid with program funds or not. Include only personnel that support sites included on Form 5B: Service Sites. For position descriptions, refer to the [UDS Manual](#). Do not exceed 1.0 (100 percent) FTE for any individual.

Direct Hire FTEs Column:

- The project director (PD)/chief executive officer (CEO) must be a direct employee of the health center.
- Enter the full-time equivalent (FTE) staff total for each position in the Direct Hire FTEs column.
- Record volunteers in the Direct Hire FTEs column.

Contract/Agreement FTEs Column:

- Enter the FTE staff total for each position that is provided through a formal written contract/agreement in the Contract/Agreement FTEs column.

Form 3: Income Analysis

Instructions

Form 3 collects the projected income from all sources other than this Health Center Program funding request for the **first budget year** of the **proposed project**.

- **Look-Alike Initial Designation applicants** enter projected income for your entire proposed scope of project.
- **Look-Alike Renewal of Designation and Look-Alike Annual Certification applicants** enter projected income for your current scope of project.

Form 3 is divided into two parts: (1) Patient Service Revenue and (2) Other Income - Other Federal, State, Local, and Other Income.

Part 1: Patient Service Revenue

Patient service revenue includes income earned from Medicaid and Medicare rate settlements and wrap reconciliations designed to make up the difference between the approved FQHC rate and the interim amounts received. It includes risk pool and other incentive income, as well as primary care case management fees. If you do not have an FQHC cost reimbursement rate from Medicaid and Medicare, contact your Primary Care Association (PCA) for help with your application.

This section groups patients and income into the same five payer groupings used in the [UDS Manual](#). Each payer (lines 1-5) is described below. All patient service revenue is reported in this section of the form. Only include patient service revenue associated with sites and services proposed in your application.

Count of Patients by Primary Medical Insurance – Column (a): Includes the projected number of unduplicated patients categorized by payer based on the patient's primary medical insurance (payer billed first) as of their last visit. Patients are categorized in the same way as in the [UDS Manual](#), Table 4, lines 7 – 12.

For example:

- Categorize a patient with both Medicare and Medicaid coverage as a Medicare patient on line 2.
- Categorize a Medicaid patient with no dental coverage who is only seen for dental services as a Medicaid patient on line 1 and report the estimated income (columns b and c) and costs (column d) based on the dental service being a self-pay visit on line 5.

Non-Federal Income per Patient – Column (b): Includes all income associated with patient care including Fee for Service (FFS), capitated payments, Prospective Payment System (PPS) rate settlements, cost report settlements, incentive payments, and shared costs savings. These amounts are expressed as an average amount per patient. While many payments to FQHCs are transitioning to value-based care models, HRSA recognizes that many payments are still based on a per visit basis. In these situations, health centers may utilize an average number of visits per patient to calculate a payment per patient amount. [For example, for your health center, the average number of Medicaid patient visits is 5 visits per year and these visits are paid at \$150 per visit. Thus, the calculated amount per patient for the year would be \$750.]

Note: DO NOT include pharmacy-related revenue in calculating the Non-Federal Income per Patient. All pharmacy-related revenue (e.g., 340B, in-house retail pharmacy, etc.) is reported in Part 2: Other Income, Line 12.

Non-Federal Projected Income – Column (c): Calculated by multiplying the patient count in Column (a) by Income per patient in Column (b).

Total All Projected Costs – Column (d): Report the total of all projected accrued costs associated with the delivery of services to the patients identified in Column (a).

- Report the portion of total estimated accrual-based budget costs for the Total All Projected Costs (d) column for each Payer Category on Lines 1 through 5. The costs by Payer Category should be determined utilizing standard cost accounting methods, including:
 - Identification of the direct costs for each service (e.g., medical, dental, mental health, substance use disorder, etc.) provided by the applicant within the proposed scope of project.
 - Allocation of indirect costs including central support, overhead, and other administrative costs to each service based on relevant statistics (e.g., number of patients, number of visits, square footage, number of FTEs, etc.) for each type of cost being allocated.
 - Consider the estimated visits by service for each Payer Category to derive the average cost per visit. The estimated visits for each service should consider patient utilization of the service for each Payer Category.
 - Total estimated visits by service by Payer Category multiplied by the average cost per visit for each service will derive the Total All Projected Costs (d) for each Payer Category.
- The value in the Total All Projected Costs (d) column for the Totals on Line 6 and Line 16 should equal the value of the total estimated budget costs in Year 1 of the Budget Justification Narrative, Total (g) column, Line 5.

Note: Do not include costs associated with in-kind donations.

Difference between Projected Income and Costs – Column (e): Projected Income Column (c) less Projected Costs Column (d):

- The values for the Difference between Projected Income and Costs (e) column are expected to be negative values for each Payer Category, Lines 1 through 5, reflecting the need for other sources of support after applying Patient Services Revenues generated from the provision of services (Column c minus Column d).
- The value for the Total on Line 6 for the Difference between Projected Income and Costs (e) column should equal the value of the total estimated budget costs in Year 1 of the Budget Justification Narrative; less the value of Part 2: Other Income for Non-Federal Projected Income (c), Total on Line 15; less the value of the Health Center Program funding request.
- The value for the Total on Line 16 for the Difference between Projected Income and Costs (e) column should equal the value of the Health Center Program funding request for new applicants or continued funding amount.

Payer Categories (Lines 1 – 5): The five payer categories (Medicaid, Medicare, Other Public, Private, and Self-Pay) reflect the five payer groupings in UDS. The [UDS Manual](#) includes definitions for each payer category.

Patient Service Revenue is reported on the line of the primary payer (payer billed first). When a single visit involves more than one payer, assign each portion of the visit income to the payer group from which it is earned. In cases where there are deductibles and co-payments that the patient pays, report that income on the self-pay line. If the co-payment is to be paid by another payer, report that income on the other payer's line. If you cannot accurately associate the income to secondary and subsequent sources, you may include that income on the primary payer line.

Ancillary Revenue Instructions: All service revenue is to be categorized by payer, including other ancillary service revenue. Ancillary services are supportive services that supplement primary care and are typically categorized as diagnostic services (e.g., lab, radiology, testing), therapeutic services (e.g., weight loss, improve well-being), or custodial services (e.g., home health). If you do not normally categorize the projected ancillary or other service revenue by payer, assign the projected income by payer group using a reasonable method, such as the proportion of medical visits or charges. The method used should be noted in the Comments/Explanatory Notes section at the bottom of the form.

Medicaid (Line 1): Income from all Medicaid payment sources including services paid directly by the State and from Medicaid managed care plans. This includes Early Periodic Screening, Diagnosis, and Treatment (EPSDT);

Children's Health Insurance Program (CHIP); and other reimbursement arrangements administered either directly by the state Medicaid agency or by a fiscal intermediary. It includes all projected revenue from managed care capitation, settlements from FQHC cost reimbursement reconciliations, wrap-around payments, performance incentives, and primary care case management.

Medicare (Line 2): Income from all Medicare sources including services paid through a Medicare fiscal intermediary and from Medicare managed care plans (e.g., Medicare Advantage plans). It includes all projected income from managed care, settlements from the FQHC cost reimbursement reconciliations, risk pool distributions, performance incentives, and case management fee income.

Other Public (Line 3): Income not reported elsewhere from federal, state, or local government programs for providing services that is paid based upon delivery of service and patient meeting the plan's eligibility criteria. For example:

- Income from CHIP operated independently from Medicaid.
- Other Public income also includes income from categorical grant programs when the grant income is earned by providing services (e.g., Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program).

Private (Line 4): Income earned from private insurance plans, managed care plans, Marketplace Qualified Health Plans, self-insured employer plans, group contracts with unions and employers, service contracts with employers, Veterans Health Administration Community Care Network (CCN) agreements and other private contracts for services. Also categorize as private insurance: revenue from health benefit plans that are earned by government employees, veterans, retirees, and dependents, such as TRICARE, the federal employee health benefits program, state employee health insurance benefit programs, teacher health insurance, and similar plans.

Self-Pay (Line 5): Income from patients, including full-pay, self-pay, and sliding fee patients, as well as the portion of the visit income for which an insured patient is personally responsible.

Total (Line 6): Sum of lines 1-5.

Part 2: Other Income – Other Federal, State, Local, and Other Income

This section includes all income other than the patient service revenue shown in Part 1 that **supports the scope of project**. It includes other federal, state, local, and other income. It is revenue that is not directly tied to services, visits, procedures, or other specific services. It may only include income from non-health center patients in limited circumstances. For example, all pharmacy-related income that supports the scope of project would be included as part of in-house retail pharmacy sales to individuals who are not health center patients. Categorize income based on the source you receive it from and not the source it originates from.

Other Federal (Line 7): Income from direct federal funds, where your organization is the recipient of a notice of award (NOA) directly from a federal agency. It includes funds from federal sources such as the CDC, Housing and Urban Development (HUD), Centers for Medicare & Medicaid Services (CMS), Health Center Program capital awards, and others. The CMS EHR incentive program income is reported here to be consistent with the [UDS Manual](#). Exclude this Health Center Program operational (H80) funding request.

State Government (Line 8): Income from state government funding, contracts, and programs, including uncompensated care funding; state indigent care income; emergency preparedness funding; mortgage assistance; capital improvement funding; school health funding; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); immunization funding; and similar awards.

Local Government (Line 9): Income from local government grants, contracts, and programs, including local indigent care income, community development block grants, capital improvement project funding, federal funding awarded through intermediaries, and similar awards. For example, include: (1) income earned under a contract with the local Department of Health to provide services to the Department's patients, and (2) grants that are awarded through municipalities.

Private Grants/Contracts (Line 10): Income from private sources, such as foundations, non-profits, hospitals, nursing homes, drug companies, employers, other health centers, and similar entities. For example, if you operate a pharmacy in part for your own patients and in part as a contractor to another health center, report the pharmacy income for your own patients in Part 1 Line 12 and the income from the health center contract on this line.

Contributions (Line 11): Income from private entities and individual donors that may be the result of fundraising.

Pharmacy (Line 12): Income from pharmacy services including 340B pharmacy and in-house retail pharmacy sales.

Other (Line 13): Income not reported elsewhere, including items such as interest income, patient record fees, vending machine income, dues, and rental income. Do not include pharmacy revenue on line 13, all pharmacy-related revenue is reported on Line 12. Applicants typically have at least some “other” income to report on Line 13.

Applicant (Retained Earnings) (Line 14): The amount of funds needed from your retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why this is necessary. Amounts from non-federal sources, combined with this Health Center Program funding request, should typically be able to cover operations.

Total Other (Line 15): The sum of lines 7 – 14.

Total Non-Federal (Line 16): The sum of Lines 6 and 15 (the total income aside from this Health Center Program funding request). The value for the Total on Line 16 for the Difference between Projected Income and Costs (e) column should equal the value of the Health Center Program funding request for new applicants or continued funding amount, although the value will be reported as a negative number on Form 3.

For example: If the Health Center Program funding request or continued funding amount is \$1,000,000; the value on Form 3, Column e, Line 16 should be (\$1,000,000) – a negative number.

Note: Do not include in-kind donations on Form 3 (income or cost) You may also include in-kind donations on the Budget Justification Narrative

Form 5A: Services Provided

Instructions

This form will pre-populate from your current scope of project and cannot be modified through this application.

Changes in services require prior approval through a Change in Scope request submitted in EHBs. Click the **Refresh from Scope** button in EHBs if the pre-populated data does not reflect recently approved changes. Refer to the [Scope of Project](#) documents and resources for details about defining and changing your scope.

Form 5B: Service Sites

Instructions

This form will pre-populate from your current scope of project and cannot be modified through this application.

Changes to sites require prior approval through a Change in Scope request submitted in EHBs. Click the **Refresh from Scope** button in EHBs if the pre-populated data does not reflect recently approved changes. Refer to the [Scope of Project](#) documents and resources for details about defining and changing your scope.

Form 6A: Current Board Member Characteristics

Instructions

When completing this form, refer to [Chapter 20: Board Composition](#) of the [Compliance Manual](#). The list of board members will pre-populate for Renewal of Designation applicants. **Update pre-populated information as appropriate.** Public agencies with co-applicant health center governing boards must list the co-applicant board members.

Complete or update the following information:

- List all current board members (minimum of 9 and maximum of 25). Do not list non-voting board members (e.g., Project Director (PD), advisory board members).
- List each board member's office held, if applicable (e.g., Chair, Treasurer) and expertise in areas such as community affairs, local government, finance and banking, legal affairs, trade unions, other commercial and industrial concerns, social services, or other relevant expertise (for example, working with the medically underserved) within the community.
- For non-patient board members, indicate if more than 10 percent of their annual income is from the health care industry.
- Indicate if each board member is a health center patient. For the purposes of board composition, a patient is an individual who received at least one service in the past 24 months that generated a health center visit, where both the service and the site where the service was received are in the HRSA-approved (or proposed in this application) scope of project.
- Indicate if each board member lives and/or works in the service area.

Note:

- Native American tribal or urban Indian organizations are not required to complete this form, but they may do so if desired.
- If you are requesting a waiver of the 51 percent patient majority board composition requirement, you must list your board members, NOT the members of any advisory council.

Form 6B: Request For Waiver Of Board Member Requirements

Instructions

If you wish to request a waiver of the 51 percent patient majority board composition requirement, you will only be able to complete this form if you are proposing to serve **only** special medically underserved populations: Migratory and Seasonal Agricultural Workers (MSAW), Homeless Population (HP), and/or Residents of Public Housing (RPH), as indicated on the Cover Page. You cannot complete this form if you currently receive CHC (Community Health Center) designation, since you are not eligible for a waiver of the patient majority board requirement. **Note:** Native American tribal and urban Indian organizations are not required to complete this form and cannot enter information.

Complete this form if you are a Renewal of Designation applicant who wants to continue an existing waiver. Provide a “good cause” justification and a plan for patient representation. Describe the following:

- The special medically underserved population(s) you will serve.
- The characteristics of the special medically underserved population(s) in the proposed service area that make it hard to recruit patient board members.
- Your attempts to recruit a majority of special medically underserved population board members within the last 3 years, and why your attempts have not been successful.
- Your planned strategies to ensure patient participation and input in the direction and ongoing governance of the organization. Address the following:
 - Collection and documentation of input from the special medically underserved population(s).
 - Communication of special medically underserved population(s) input directly to the health center governing board.
 - How you will incorporate special medically underserved population input into key areas, such as:
 - Selecting health center services.
 - Setting hours of operation of health center sites.
 - Defining budget priorities.
 - Evaluating progress in meeting goals, including patient satisfaction.
 - Assessing the effectiveness of the sliding fee discount program.

Form 8: Health Center Agreements

Instructions

Complete Part I by selecting **Yes** if you have:

1. A parent, affiliate,¹ or subsidiary organization; and/or
2. A current or proposed contract or subaward that will be a substantial portion of the proposed scope of project.² For example, select **Yes** if you have a site that is or will be operated by a subrecipient as noted on [Form 5B: Service Sites](#).

Refer to [2 CFR part 200](#) for more information on the provisions applicable to subrecipient and/or contractor agreements. Structure agreements that will be carried out through a contract or subaward according to these provisions. See [Chapter 12: Contracts and Subawards](#) in the Compliance Manual for more information.

You must upload the agreement(s) if either question 1 or 2 is answered **Yes**. If you contract with one organization for the majority of health care providers or have a subrecipient agreement, include an asterisk (*) next to those organizations. You may list a maximum of 10 organizations with five document uploads each. Include agreements that exceed this limit in Attachment 14: Other Relevant Documents, which counts in the page limit.

Contracts attached to this form must support the HRSA-approved scope of project and include the following:

- Specific activities or services to be performed, or goods to be provided.
- How you will monitor contractor performance.
- Requirements for the contractor to provide data necessary for meeting applicable federal financial and programmatic reporting requirements, as well as provisions for records retention and access, audits, and property management.³

¹ For the purposes of this form, “affiliate” refers to a separate corporate entity with which the health center applicant organization shares a parent or subsidiary.

² 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. The acquisition of supplies, material, equipment, or general support services is not considered programmatic work.

³ For further guidance on these requirements, see the [HHS Grants Policy Statement](#).

Form 12: Organization Contacts

Instructions

All applicant types must provide the requested contact information. The secondary contact person should be someone who can represent your organization if we have questions about your application.