



**Fiscal Year 2021 Health Center Program  
Budget Period Progress Report  
Non-Competing Continuation Instructions**

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**TABLE 1: SUBMISSION SCHEDULE**

<b>Budget Period Start Date</b>	<b>HRSA EHBs Access</b>	<b>HRSA EHBs Deadline (5:00 PM ET)</b>
January 1, 2021	July 17, 2020	September 8, 2020
February 1, 2021	August 3, 2020	September 25, 2020
March 1, 2021	August 17, 2020	October 9, 2020
April 1, 2021	September 14, 2020	November 6, 2020
May 1, 2021	October 19, 2020	December 11, 2020
June 1, 2021	November 16, 2020	January 8, 2021
September 1, 2021	January 4, 2021	February 26, 2021

## About the Budget Period Progress Report

The Budget Period Progress Report Non-Competing Continuation (BPR NCC, hereafter, the BPR) provides an update on the progress of your Health Center Program award. The fiscal year (FY) 2021 BPR reports on progress made from the beginning of your FY 2020 budget period until the date of BPR submission; the expected progress for the remainder of the budget period; and any projected changes for the FY 2021 budget period.

### Important Notice:

On January 31, 2020, the Department of Health and Human Services (HHS) declared a nationwide public health emergency related to severe acute respiratory syndrome coronavirus 2 (COVID-19). The President declared a national emergency related to COVID-19 on March 13, 2020. In an effort to provide maximum flexibility to Health Center Program award recipients, HRSA will extend the period of performance for health centers with a current 2-year or 3-year period of performance scheduled to submit a competitive Service Area Competition (SAC) in FY 2021. These health centers must submit a BPR in FY 2021.

Additionally, health centers whose period of performance end date is not in FY 2021 (October 1, 2020 — September 30, 2021) – those already scheduled to complete an FY 2021 BPR – should submit an FY 2021 BPR.

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

## Summary of Changes (compared to the FY 2020 BPR)

- The Scope Certification Form was removed from the BPR in an effort to streamline the document and reduce awardee burden.
- The Environment, Telehealth, and Clinical/Financial Performance Measures sections of the Project Narrative have been removed.
- The impact of COVID-19 should be reported in all applicable areas of the Project Narrative.
- Table 3: Patient Capacity was updated to include Vision Services.
- Table 4: Supplemental Awards was updated to reflect the most current list of supplemental awards. Supplemental awards released in late FY 2020 or early FY 2021 will be included in the FY 2022 BPR.
- Table 5: [One-Time Funding Awards](#) was updated to reflect the most current list of one-time funding awards. One-time awards released in late FY 2020 or early FY 2021 will be included in the FY 2022 BPR.

## I. TECHNICAL ASSISTANCE

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

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

Travis J. Wright  
Office of Federal Assistance Management  
HRSA Division of Grants Management  
Operations 301-443-0676  
[twright@hrsa.gov](mailto:twright@hrsa.gov)

Technical assistance regarding this instructions document is available by contacting:

Karen A. Fitzgerald, MPH  
Office of Policy and Program  
Development HRSA Bureau of Primary  
Health Care  
301-594-4300  
<https://www.hrsa.gov/about/contact/bphc.aspx> (complete the BPHC Contact Form, Contact Record, and Organization screens; complete and confirm the information in the Contact Verification screen; select Health Center, Non-competing Continuation (NCC) Progress Reports, and Budget Period Progress Report; then describe your question)

HRSA EHBs technical assistance is available by contacting:

Health Center Program Support  
1-877-464-4772

<https://www.hrsa.gov/about/contact/bphc.aspx> (complete the BPHC Contact Form, Contact Record, and Organization screens; complete and confirm the information in the Contact Verification screens; select Electronic Handbooks (EHBs), Non-competing Continuation (NCC) Progress Reports – System Question, and Budget Period Progress Report (BPR); then describe your issue)

## II. GENERAL INFORMATION AND INSTRUCTIONS

### INFORMATION

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

You are required to request prior approval from HRSA for post-award changes including, but not limited to, changes in the project director/chief executive officer (CEO), new or additional sub-awards, significant re-budgeting (i.e., greater than 25%), and the addition or deletion of sites or services from the approved scope of project (in accordance with Uniform Guidance 2 CFR 200 as codified by Health and Human

Services (HHS) at [45 CFR 75.308](#)). These changes must be requested via the Prior Approval, Scope Adjustment, and/or Change in Scope (CIS) Modules in the HRSA EHBs, as appropriate. For further detail on actions and changes requiring prior approval, review the [HHS Grants Policy Statement](#).

## INSTRUCTIONS

Progress reports that fail to include all required documents and information will be considered incomplete or non-responsive. Incomplete or non-responsive progress reports will be returned through a “Request Change” notification via HRSA EHBs for the provision of missing information or clarification.

**Failure to submit the BPR by the established deadline or the submission of an incomplete or non-responsive BPR may result in a delay in Notice of Award (NoA) issuance or a lapse in funding. Review your BPR to ensure that it is both complete and responsive prior to submission.**

[Table 2: Submission Components](#) identifies the required BPR components. In the Form Type column, the word “Form” refers to forms that are completed online in HRSA EHBs. The word “Document” refers to materials that must be uploaded into HRSA EHBs.

**TABLE 2: SUBMISSION COMPONENTS**

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

BPR Section	Form Type	Instructions
SF-PPR and SF-PPR-2	Form	Provide basic organizational information. Refer to instructions in the HRSA EHBs user guide available at the <a href="#">BPR TA webpage</a> .
<a href="#">Budget Information: Budget Details</a>	Form	Provide the budget for the upcoming budget period broken down by object class categories and federal/nonfederal funding.
<a href="#">Budget Narrative</a>	Document	Provide a line-item budget for the upcoming budget period that corresponds with the Budget Information: Budget Details form.

<b>BPR Section</b>	<b>Form Type</b>	<b>Instructions</b>
<a href="#">Form 1C: Documents on File</a>	Form	Provide the dates when the listed documents were last updated, if applicable.
<a href="#">Form 3: Income Analysis</a>	Form	Provide projected program income for the upcoming budget period.
<a href="#">Forms 5A, 5B, and 5C</a>	Fixed	These forms are pre-populated to reflect the current scope of project and are only provided for reference only. If any information is incorrect in these forms, submit your request for change via the Scope Adjustment or Change in Scope (CIS) Modules in HRSA EHBs. Contact your Project Officer for guidance.
<a href="#">Project Narrative Update</a>	Form	See <a href="#">Section III</a> for detailed instructions.

### III. INSTRUCTIONS FOR THE PROJECT NARRATIVE UPDATE

The Project Narrative Update includes four Key Areas (Organizational Capacity, Patient Capacity, Supplemental Awards, and One-Time Funding Awards) that require narrative reporting (see below). The narrative for each section should address the following:



#### Project Narrative Update Areas

Each of the four Key Areas requires a narrative response, and each response section is limited to 2,000 characters, or approximately 1.5 pages.

- 1. Organizational Capacity:** Discuss current major changes, since the last budget period, in the organization's capacity that have impacted or may impact the progress of the funded project, including changes in:
  - Staffing, including key vacancies;
  - Operations, including changes in policies and procedures as they relate to COVID-19; and
  - Financial status, including the most current audit findings, as applicable.
- 2. Patient Capacity:** See [Table 3: Patient Capacity](#). Discuss trends in unduplicated patients served and report progress in reaching the projected number of patients. In the Patient Capacity Narrative column, explain negative trends or limited progress toward the projected number of patients and plans for achievement.
- 3. Supplemental Awards:** See [Table 4: Supplemental Awards](#). In the Supplemental Award Narrative column, describe the following:
  - Implementation status and progress toward achieving goals, including your progress toward meeting projected outcomes (including actual versus projected patients) and implementing newly proposed sites/services, as applicable;
  - Key factors impacting progress toward achieving goals, including an explanation of the impact of any new or changing environmental factors (state/local/community) on supplemental award progress; and
  - Plans for sustaining progress and/or overcoming barriers (including environmental barriers) to ensure goal achievement.
- 4. One-Time Funding Awards:** See [Table 5: One-Time Funding Awards](#). Use the checkboxes in the Allowable Activities column to indicate the allowable activities that are taking place or have taken place in your health center. In the Activities column, discuss those activities (identified via checkmark) and their impact.

**TABLE 3: PATIENT CAPACITY**

	2017 Patient Number	2018 Patient Number	2019 Patient Number	% Change 2017-2019 Trend	% Change 2018-2019 Trend	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
<b>Period of Performance: (Pre-populated from most recent Notice of Award)</b>								
<b>Total Unduplicated Patients</b>	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit
<b>Notes:</b> <ul style="list-style-type: none"> <li>• 2017–2019 Patient Number data are pre-populated from Table 3a in the UDS Report.</li> <li>• The Projected Number of Patients value is pre-populated from the Patient Target noted in the Patient Target Management Module in HRSA EHBs. If you have questions related to your Patient Target, contact the <a href="#">Patient Target Response Team</a>. To formally request a change in your Patient Target, you <b>must</b> submit a request via the Patient Target Management Module in HRSA EHBs.</li> </ul>								

	2017 Patient Number	2018 Patient Number	2019 Patient Number	% Change 2017-2019 Trend	% Change 2018-2019 Trend	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
<b>Period of Performance: (Pre-populated from most recent Notice of Award)</b>								
<b>Total Migratory and Seasonal Agricultural Worker Patients</b>	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit
<b>Total People Experiencing Homelessness Patients</b>	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit
<b>Total Public Housing Resident Patients</b>	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit
<b>Notes:</b> <ul style="list-style-type: none"> <li>• 2017-2019 Patient Number data are pre-populated from Table 4 in the UDS Report.</li> <li>• The Projected Number of Patients values is pre-populated from the patient projections in the Service Area Competition (SAC) that initiated your current period of performance plus the patient projections from selected supplemental funding awarded after the start of the current period of performance. See the frequently asked questions on the <a href="#">BPR TA webpage</a> for details on the selected supplemental funding patient projections included.</li> <li>• The Projected Number of Patients values cannot be edited during the BPR submission. If these values are not accurate, provide adjusted projections and an explanation in the Patient Capacity Narrative section.</li> </ul>								

	2017 Patient Number	2018 Patient Number	2019 Patient Number	% Change 2017-2019 Trend	% Change 2018-2019 Trend	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
<b>Period of Performance: (Pre-populated from most recent Notice of Award)</b>								
<b>Total Medical Services Patients</b>	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit
<b>Total Dental Services Patients</b>	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit
<b>Total Mental Health Services Patients</b>	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit
<b>Total Substance Use Disorder Services Patients</b>	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit
<b>Total Vision Services</b>	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	N/A*	2,000 character limit
<b>Total Enabling Services Patients</b>	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit

**Notes:**

- 2017-2019 Patient Number data are pre-populated from Table 5 in the UDS Report.
- The Projected Number of Patients column is pre-populated from the patient projections in the SAC that initiated your current period of performance plus the patient projections from selected supplemental funding awarded after the start of the current period of performance. See the frequently asked questions on the [BPR TA webpage](#) for details on the selected supplemental funding patient projections included.
- The Projected Number of Patients values cannot be edited during the BPR submission. If these values are not accurate, provide adjusted projections and an explanation in the Patient Capacity Narrative section.
- (\*)The Vision Services category was recently added to SAC, therefore, there is no Projected Number of Patients data available at this time.

**TABLE 4: SUPPLEMENTAL AWARDS**

Type of Supplemental Award	Programmatic Goal	Supplemental Award Narrative
<b>FY 2019 Integrated Behavioral Health Services (IBHS)</b>	Increase access to high quality integrated behavioral health services, including prevention or treatment of mental health conditions and or substance use disorders (SUDs), including opioid use disorder (OUD) by December 31, 2020	2,000 character limit
<b>FY 2019 New Access Points (NAP) Satellite</b>	Achieve operational status and increase the number of patients by December 31, 2020	2,000 character limit
<b>FY 2020 Ending HIV Epidemic - Primary Care HIV Prevention (PCHP)</b>	Expand HIV prevention services that decrease the risk of HIV transmission by December 31, 2020	2,000 character limit
<p><b>Notes:</b></p> <ul style="list-style-type: none"> <li>• If you did not receive a Supplemental Award, the system will not require narrative in the Supplemental Award Narrative column.</li> <li>• Supplemental awards released late in FY 2020 or early in FY 2021 will be included in the FY 2022 BPR.</li> </ul>		

**TABLE 5: ONE-TIME FUNDING AWARDS**

Type of One-Time Funding Award	Allowable Activities*	Activities
<b>FY 2019 Health Center Quality Improvement</b>	<p>Developing and improving health center systems and infrastructure:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Training staff</li> <li><input type="checkbox"/> Developing policies and procedures</li> <li><input type="checkbox"/> Enhancing health information technology, certified electronic health record, and data systems</li> <li><input type="checkbox"/> Data analysis</li> <li><input type="checkbox"/> Implementing targeted QI activities (including hiring consultants)</li> </ul> <p>Developing and improving care delivery systems:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Supporting care coordination, case management, and medication management</li> <li><input type="checkbox"/> Developing and implementing contracts and formal agreements with other providers</li> <li><input type="checkbox"/> Laboratory reporting and tracking</li> <li><input type="checkbox"/> Training and workflow redesign to support team-based care</li> <li><input type="checkbox"/> Clinical integration of behavioral health, oral health, HIV care, and other services</li> <li><input type="checkbox"/> Patient engagement activities</li> </ul>	2,000 character limit
<b>FY 2019 Oral Health Infrastructure</b>	<p>Support infrastructure enhancements to provide new or enhance existing high quality, integrated oral health services:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Minor alteration and renovation (A/R) to modernize existing facilities</li> <li><input type="checkbox"/> Purchase and installation of dental and radiology equipment</li> <li><input type="checkbox"/> Training, consultation and health IT to increase oral health integration</li> <li><input type="checkbox"/> Purchase of mobile dental units</li> </ul>	2,000 character limit
<p><b>Notes:</b></p> <ul style="list-style-type: none"> <li>• If you did not receive a One-Time Funding Award, the system will not require narrative in the Activities column.</li> <li>• One-time awards released late in FY 2020 or early in FY 2021 will be included in the FY 2022 BPR.</li> <li>• (*) Use the checkboxes to indicate your allowable one-time funding activities.</li> </ul>		

## **IV. BUDGET PRESENTATION INSTRUCTIONS**

**Continuation funding is based on progress toward accomplishing the project's goals, congressional appropriation, and a determination that continued funding would be in the best interest of the federal government.**

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

You must present the total budget for the project, including Health Center Program federal grant funds and all non-Health Center Program grant funds that support the health center scope of project. The Total Project or Program Costs are the total allowable costs (inclusive of direct and indirect costs) you incur to carry out a HRSA-supported project or activity. Total project or program costs include costs charged to the award and costs borne by you.

The total budget represents all proposed expenditures that directly relate to and support in-scope activities. Therefore, the total budget must reflect projections from all anticipated revenue sources. In addition, the Health Center Program requires the following for formulation of the budget presentation, per section 330(e)(5)(A) of the PHS Act, as amended.

### **Notes:**

The amount of funds awarded in any fiscal year may not exceed the costs of health center operations for the budget period less the total of state, local, and other operational funding provided to the center and the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in the fiscal year. Nongrant funds may be used for purposes that are not specifically prohibited if such use: (1) furthers the objectives of the health center project, and (2) is not specifically prohibited.<sup>1</sup>

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

45 CFR Part 75 and the HHS Grants Policy Statement (HHS GPS) include information about allowable expenses. Please note that funds under this notice may not be used for fundraising or the construction of facilities.

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

You are required to have the necessary policies, procedures, and financial controls in

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<sup>1</sup> Section 330e(5)(D) of the PHS Act.

place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding, including statutory restrictions on use of funds for lobbying, executive salaries, gun control, abortion, etc. Like those for all other applicable grants requirements, the effectiveness of these policies, procedures, and controls is subject to audit.

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

As per the requirements in 45 CFR §75.205, HRSA performs risk assessments of organizations to be funded, which includes a financial review. HRSA may apply special conditions to the award that correspond to the degree of risk assessed.

### **A. Budget Information: Budget Details Form**

In **Section A: Budget Summary**, verify the pre-populated list of Health Center Program funding types (CHC, MHC, HCH, PHPC).<sup>2</sup> If the funding types are incorrect, make necessary adjustments using the **Update Sub-Program** button. In the Federal column, provide the grant request for each Health Center Program funding type (CHC, MHC, HCH, PHPC). The total federal funding requested across all Health Center Program funding types must equal the Recommended Federal Budget figure that is pre-populated at the top of the Budget Information: Budget Details form. This figure should correspond with the recommended future support figure (Item 13 or Box 13) on the most recent Notice of Award.

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

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

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

Indirect costs may only be claimed with an approved indirect cost rate (see details in the

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<sup>2</sup> Community Health Center – CHC, Migrant Health Center – MHC, Health Care for the Homeless – HCH, and/or Public Housing Primary Care – PHPC

[Budget Narrative](#) section below).

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

**Salary Limitation**

The Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Division A, § 202, states “None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of [Executive Level II](#),” which is currently \$197,300. See Section 5.1.iv Budget – Salary Limitation of HRSA’s [SF-424 Two-Tier Application Guide](#) for additional information. Note that these or other salary limitations will apply in the following fiscal years, as required by law.

**Example of Application of this Limitation:**

If an individual’s base full time salary is \$255,000 per year plus fringe benefits of 25 percent, and that individual is devoting **50 percent of his/her time to this award**, the base salary must be adjusted to \$197,300, plus fringe benefits of 25 percent, when calculating the amount that may be charged to the Health Center Program grant. This results in a total of \$123,313 that may be included in the project budget and charged to the award in salary/fringe benefits for this individual. See the breakdown below.

**TABLE 6: SALARY LIMITATION – ACTUAL VS. CLAIMED**

<b>Current Actual Salary:</b> Individual’s actual base full time salary: \$255,000 (50% of time will be devoted to project)	
Direct Salary	\$127,500
Fringe (25% of salary)	\$31,875
Total Salary	\$159,375
<b>Amount of Actual Salary Eligible to be Claimed on the Submission Budget due to the Legislative Salary Limitation:</b> Individual’s base full time salary adjusted to Executive Level II: \$197,300 (50% of time will be devoted to the project)	
Direct Salary	\$98,650
Fringe (25% of salary)	\$24,663
Total Salary claimed	\$123,313

**B. Budget Narrative**

The Budget Narrative must explain the amounts requested for each line item within each object class category from Section B of the Budget Information: Budget Details form. The Budget Narrative should specifically describe how each item will support the achievement of proposed objectives. Carefully show how each item in the “other” category is justified.

The Budget Narrative is for **one year based on your upcoming 12-month budget period (this period will follow immediately after the current budget period listed on your most recent Notice of Award).**

The one-year Budget Narrative must itemize both your federal request and your non-federal contribution. Ensure that the Budget Narrative contains detailed calculations explaining how each line-item expense within each cost category is derived (e.g., number of visits, cost per unit). Refer to the Uniform Guidance [2 CFR 200](#) as codified by HHS at [45 CFR 75](#) for information on allowable costs.

Upload the completed document in the Budget Narrative Form section in HRSA EHBs. Include the following:

**Personnel Costs:** Explain personnel costs by listing each staff member who will be supported from Health Center Program funds, name (if possible), position title, percentage of full-time equivalency, and annual salary. **Reminder:** Award funds may not be used to pay the salary of an individual at a rate in excess of Federal Executive Level II or \$197,300.<sup>3</sup> An individual's base salary, per se, is **NOT** constrained by the legislative provision for a limitation of salary. The rate limitation simply limits the amount that may be awarded and charged to the HRSA grant. Provide an individual's actual base salary if it exceeds the cap. See Table 7.

**TABLE 7: PERSONNEL JUSTIFICATION TABLE**

Name	Position Title	% of FTE	Base Salary	Adjusted Annual Salary*	Federal Amount Requested
J. Smith	Physician	50%	\$255,000	\$197,300	\$98,650
R. Doe	Nurse Practitioner	100%	\$75,950	no adjustment needed	\$75,950
D. Jones	Data/AP Specialist	25%	\$33,000	no adjustment needed	\$8,250
D. Green	Outreach Coordinator	50%	\$65,000	no adjustment needed	\$32,500
N. Merchant	Dentist	100%	\$200,000	\$197,300	\$197,300
<b>Total</b>	<b>N/A</b>	<b>N/A</b>	<b>\$628,950</b>	<b>N/A</b>	<b>\$412,650</b>

\*Used when the base salary is over the limitation of \$197,300

Ensure that personnel costs are supported by official records that accurately reflect the work performed and that internal controls provide reasonable assurance that the

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<sup>3</sup> While the BPR NCC focuses on the application of the salary limitation to the federal Health Center Program grant funds, the salary limitation applies across all HRSA funding. In other words, if a full-time staff member is paid from several HRSA grants, the total federal contribution to that staff person's salary cannot exceed \$197,300.

personnel costs are accurate, allowable, and allocable to the HRSA award.

**Fringe Benefits:** List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plans, and tuition reimbursement. The fringe benefits should be directly proportional to the portion of personnel costs that are allocated for the project. If an individual's base salary exceeds the legislative salary cap (i.e., \$197,300), adjust fringe proportionally.

**Travel:** List travel costs according to local and long distance travel. For local travel, outline the mileage rate, number of miles, reason for travel, and staff members/patients completing the travel. The budget should also reflect the travel expenses (e.g., airfare, lodging, parking, per diem) for each person and trip associated with participating in meetings and other proposed trainings or workshops. Name the traveler(s) if possible, describe the purpose of the travel, and provide the number of trips involved, the destinations, and the number of individuals for whom funds are requested.

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

**Supplies:** List the items that will be used to implement the proposed project. Separate items into three categories: office supplies, medical supplies, and educational supplies. Items must be listed separately.

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

**Contractual/Subawards/Consultant:** Provide a clear explanation as to the purpose of each contract/subaward, how the costs were estimated, and the specific contract/subaward deliverables. Provide the basis for your cost estimate for the contract rather than line item details. You are responsible for ensuring that your organization or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts/subawards. Recipients must notify potential subrecipients that entities receiving subawards must be registered in SAM and provide the recipient with their DUNS number (see [2 CFR part 25](#)). For consultant services, list the total costs for all consultant services. In the budget narrative, identify each consultant, the services he/she will perform, total number of days, travel costs, and total estimated costs.

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

Per the Suspension and Debarment rules in the Uniform Administrative Requirements, as implemented by HRSA under [45 CFR § 75.212](#), non-federal entities and contractors are subject to the non-procurement debarment and suspension regulations

implementing Executive Orders 12549 and 12689, 2 CFR parts 180 and 376. These regulations restrict awards, subawards, and contracts with certain parties that are debarred, suspended, or otherwise excluded from or ineligible for participation in federal assistance programs or activities.

**Other:** Include all costs that do not fit into any other category and provide an explanation of each cost (e.g., EHR provider licenses, audit, legal counsel). In some cases, rent, utilities, and insurance fall under this category if they are not included in an approved indirect cost rate.

You may include the cost of access accommodations as a part of your project's budget, including sign interpreters; plain language and health literacy print materials in alternate formats (e.g., Braille, large print); and linguistic competence modifications (e.g., translation or interpretation services).

**Indirect Charges:** Indirect costs are costs incurred for common or joint objectives which cannot be readily and specifically identified with a particular project or program, but are necessary to the operations of the organization (e.g., the cost of operating and maintaining facilities, depreciation, administrative salaries). For some institutions, the term "facilities and administration" (F&A) is used to denote indirect costs.

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

Any non-federal entity that has never received a negotiated indirect cost rate (except a governmental department or agency unit that receives more than \$35 million in direct federal funding) may elect to charge a de minimis rate of 10 percent of modified total direct costs (MTDC), which may be used indefinitely. If this methodology is chosen, it must be used consistently for all federal awards until such time as a non-federal entity chooses to negotiate for a rate, which the non-federal entity may apply to do at any time.

## **APPENDIX A: PROGRAM SPECIFIC FORMS INSTRUCTIONS**

### **Form 1C: Documents on File**

Form 1C collects a summary of documents that support the implementation of Health Center Program requirements, Federal grants regulations, and legislative mandates; however, it does not provide an exhaustive list of all types of health center documents (e.g., policies and procedures, protocols, legal documents).

You must provide the date that each document was last reviewed/revised or select Not Applicable (N/A).

DO NOT submit these documents with the application. HRSA will review these documents as part of an Operational Site Visit and/or may request these for review post-award.

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

### **Form 3: Income Analysis**

Form 3 collects the projected income from all sources other than the Health Center Program grant for the upcoming budget period. Form 3 is divided into two parts: (1) Patient Service Revenue - Program Income and (2) Other Income - Other Federal, State, Local, and Other Income.

#### **Part 1: Patient Service Revenue — Program Income**

Patient service revenue is income directly tied to the provision of services to the health center's patients. This includes services reimbursed by health insurance plans, managed care organizations, categorical grant programs (e.g., breast and cervical cancer screening), employers, and health provider organizations. Reimbursements may be based upon visits, procedures, member months, enrollees, the achievement of performance goals, or other service related measures.

The program income section groups billable visits and income into the same five payer groupings used in the [UDS Manual](#). All patient service revenue is reported in this section of the form.

Patient service revenue includes income earned from Medicaid and Medicare rate settlements and wrap reconciliations that are designed to make up the difference between the approved Federally Qualified Health Center (FQHC) rate and the interim amounts received. It includes risk pool and other incentive income as well as primary care case management fees. If you do not have an FQHC cost reimbursement rate from Medicaid and Medicare, contact your PCA for help with the application process. Only include patient service revenue associated with sites and services in this application.

**Patients by Primary Medical Insurance — Column (a):** The projected number of unduplicated patients classified by payer based upon the patient’s primary medical insurance (payer billed first). The patients are classified in the same way as in the [UDS Manual](#), Table 4, lines 7 – 12. Do not include patients who are only seen for non-billable or enabling service visits. Examples for determining where to count patients include:

- A crossover patient with Medicare and Medicaid coverage is to be classified as a Medicare patient on line 2.
- A Medicaid patient with no dental coverage who is only seen for dental services is to be classified as a Medicaid patient on line 1 with a self-pay visit on line 5.

**Billable Visits — Column (b):** Includes all billable/reimbursable visits. The value is typically based on assumptions about the amount of available clinician time, clinician productivity (visits per unit of time), and mix of billable visits by payer. Do not include billable services related to laboratory, pharmacy, imaging, and other ancillary services in this column (see [Ancillary Instructions](#) below). Note other significant exclusions or additions in the Comment/Explanatory Notes box at the bottom of the form.

**Note:** The patient service income budget is primarily based upon income per visit estimates. However, some forms of patient service income do not generate reportable visits, such as income from laboratory or pharmacy services, capitated managed care, performance incentives, wrap payments, and cost report settlements. Based on historical experience, you may choose to include some or all of this income in the income per visit assumption. You may also choose to separately budget for some or all of these sources of patient service income.

**Income per Visit — Column (c):** Calculated by dividing projected income in Column (d) by billable visits in Column (b).

**Projected Income — Column (d):** Projected accrued net revenue, including an allowance for bad debt, from all patient services for each pay grouping. Pharmacy income may be estimated using historical data to determine the number of prescriptions per medical visit and the average income per prescription. All separate projections of income are consolidated and reported here.

**Prior Fiscal Year (FY) Income — Column (e):** The income data from the health center’s most recent fiscal year, which will be either interim statement data or audit data, when available.

**Alternative Instructions for Capitated Managed Care:**

Health centers may use their own methods for budgeting patient service income other than those noted above, but must report the consolidated result in the Projected Income Column (d), along with the related data requested in Columns (a) through (e). Income for each service may be estimated by multiplying the projected visits by assumed income per visit. For example, capitated managed care income may be based upon member-month enrollment projections and estimated capitation rates for each plan, grouped by payer and added to the projected income. Enter the estimated visits associated with these managed care plans in Column (b).

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

includes definitions for each payer category.

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

**Ancillary Instructions:** All service income is to be classified by payer, including pharmacy and other ancillary service revenue. If you do not normally classify the projected ancillary or other service revenue by payer category, allocate the projected income by payer group using a reasonable method, such as the proportion of medical visits or charges. The method used should be noted in the Comments/Explanatory Notes section at the bottom of the form.

**Medicaid (Line 1):** Income from FQHC cost reimbursement; capitated managed care; fee-for-service managed care; Early Periodic Screening, Diagnosis, and Treatment (EPSDT); Children's Health Insurance Program (CHIP); and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from FQHC cost reimbursement reconciliations, wraparound payments, performance incentives, pharmaceutical reimbursements, and primary care case management income.

**Medicare (Line 2):** Income from the FQHC cost reimbursement, capitated managed care, fee-for-service managed care, Medicare Advantage plans, and other reimbursement arrangements administered either directly by Medicare or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from the FQHC cost reimbursement reconciliations, risk pool distributions, performance incentives, pharmaceutical reimbursements, and case management fee income.

**Other Public (Line 3):** Income not reported elsewhere from federal, state, or local government programs earned for providing services or pharmaceuticals that is unearned or based upon meeting the plan's eligibility criteria. A CHIP operated independently from the Medicaid program is an example of other public insurance. 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 or paid for by private insurance plans, managed care plans, and other private contracts for services or pharmaceuticals. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, service contracts with employers, and Veterans Administration Community Based Outpatient Clinic (CBOC) contracts. Income from health benefit plans which are earned by government employees, veterans, retirees, and dependents, such as TRICARE, the federal employee health benefits program, state employee health insurance benefit programs, teacher health insurance, and similar plans are to be classified as private insurance.

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

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

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

This section includes all income other than the patient service revenue shown in Part 1 (exclusive of this Health Center Program funding request). It includes other federal, state, local, and other income. It is income that is earned but not directly tied to visits, procedures, or other specific services. It includes income from services provided to non-health center patients (see examples below). This would include income from in-house retail pharmacy sales to individuals who are not patients of the health center. Income is to be classified based on the source.

**Other Federal (Line 7):** Income from direct federal funds, where your organization is the recipient of an NoA directly from a federal agency. It includes funds from federal sources such as the CDC, Housing and Urban Development (HUD), Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services funding under the Ryan White HIV/AIDS Program Part C, School-Based Health Center Capital grants, and others. The CMS EHR incentive program income is reported here to be consistent with the [UDS Manual](#). Exclude your Health Center Program funding.

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

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

**Private Grants/Contracts (Line 10):** Income from private sources, such as foundations, 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 under the appropriate payer categories and the income from the contracted health center on this line.

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

**Other (Line 12):** Incidental income not reported elsewhere, including items such as interest income, patient record fees, vending machine income, dues, and rental income. Applicants typically have at least some "other" income to report on Line 12.

**Applicant (Retained Earnings) (Line 13):** The amount of funds needed from your retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why your funds (retained earnings) are needed for this purpose. Amounts from non-federal sources, combined with the Health Center Program funds, should typically be adequate to support operations.

**Total Other (Line 14):** The sum of lines 7 – 13.

**Total Non-Federal (Line 15):** The sum of Lines 6 and 14 (the total income aside from the Health Center Program funds).

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

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

Forms 5A-C are being provided for reference only. If any information is incorrect, submit your request for change via the Scope Adjustment or Change in Scope (CIS) Modules in HRSA EHBs. Contact your Project Officer for guidance.