HRSA
Health Center Program

Fiscal Year 2020 Health Center Program
Budget Period Progress Report
Non-Competing Continuation Instructions

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TABLE 1: SUBMISSION SCHEDULE

Budget Period Start Date	HRSA EHBs Access (Mondays)	HRSA EHBs Deadline (Fridays at 5:00 PM ET)
January 1, 2020	June 24, 2019	August 16, 2019
February 1, 2020	July 15, 2019	September 6, 2019
March 1, 2020	August 19, 2019	October 11, 2019
April 1, 2020	September 16, 2019	November 8, 2019
May 1, 2020	October 21, 2019	December 13, 2019
June 1, 2020	November 18, 2019	January 10, 2020

About the Budget Period Progress Report

The Budget Period Progress Report (BPR) Non-Competing Continuation provides an update on the progress of your Health Center Program award. The fiscal year (FY) 2020 BPR reports on progress made from the beginning of your FY 2019 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 2020 budget period.

Complete the BPR if you **do not** have a project period end date in FY 2020 (October 1, 2019 – September 30, 2020).

Note: The BPR is available in the HRSA Electronic Handbooks (EHBs) according to your 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 2019 BPR)

- The Supplemental Awards section was updated to reflect the most current list of supplemental awards. Supplemental awards released in late FY 2019 or early FY 2020 will be included in the FY 2021 BPR.
- The One-Time Funding Awards section was updated to reflect the most current list of one-time funding awards. One-time awards released in late FY 2019 or early FY 2020 will be included in the FY 2021 BPR.
- The Clinical and Financial Performance Measures sections were updated to reflect the most current list of Uniform Data System (UDS) clinical performance measures. Additionally, a narrative explanation is required for each performance measure for which you have experienced a negative trend of 5 percent or greater.
- Form 1C: Documents on File was added to collect the dates when a subset of documents were last updated that support the implementation of Health Center Program requirements, Federal grants regulations, and legislative mandates.

I.   TECHNICAL ASSISTANCE

Technical assistance resources are available on the BPR technical assistance (TA) webpage. The webpage includes copies of forms, 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

Technical assistance regarding this instructions document is available by contacting:

Karen A. Fitzgerald
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, Progress Reports, and Budget Period Progress Report (BPR); 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), Progress Reports, 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, 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 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. The word "Fixed" refers to forms that cannot be altered but may be refreshed from scope.

TABLE 2: SUBMISSION COMPONENTS

- The Budget Narrative and the Indirect Cost Rate Agreement are the only documents that should be uploaded within HRSA EHBs.
- Samples of Form 3: Income Analysis, the Project Narrative Update, the Budget Narrative, and the Scope Certification Form 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 BPR TA webpage.
Budget Information: Budget Details	Form	Provide the budget for the upcoming budget period broken down by object class categories and federal/nonfederal funding.
Budget Narrative	Document	Provide a line-item budget for the upcoming budget period that corresponds with the Budget Information: Budget Details form.
Form 1C: Documents on File	Form	Provide the dates when the listed documents were last updated, if applicable.
Form 3: Income Analysis	Form	Provide projected program income for the upcoming budget period.
Forms 5A, 5B, and 5C	Fixed	These forms are pre-populated to reflect the current scope of project. Changes must be requested via the Scope Adjustment or Change in Scope (CIS) Modules in HRSA EHBs. Contact your Project Officer for guidance.
Scope Certification Form	Form	Certify that the sites and services in scope (listed on Forms 5A and 5B) are accurate or that a Scope Adjustment or CIS request has been submitted to correct inaccurate information. Contact your Project Officer for guidance.

BPR Section	Form Type	Instructions
[Project Narrative Update](#)	Form	See [Section III](#) for detailed instructions.

III. INSTRUCTIONS FOR THE PROJECT NARRATIVE UPDATE

The Project Narrative Update includes seven Key Areas (Environment, Organizational Capacity, Telehealth, Patient Capacity, Supplemental Awards, One-Time Funding Awards, and Clinical/Financial Performance Measures) that require narrative reporting (see below). The narrative for each section should address the following:

1. Progress toward goals and/or and changes that have impacted the community/patient population and your organization from the beginning of the FY 2019 budget period until the date of the BPR submission;
2. Expected progress for the remainder of the FY 2019 budget period; and
3. Projected changes for the FY 2020 budget period.

Reporting Your Budget Period Progress

Project Narrative Update Areas

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

1. **Environment:** Discuss current major community, state, and/or regional changes, since the last budget period, that have directly impacted and/or have the potential to impact the progress of the funded project, including changes in:
   - Service area demographics and shifting patient population needs;
   - Major health care providers in the service area;
   - Key community partnerships and collaborations; and
   - Changes in insurance coverage, including Medicaid, Medicare, and the Children's Health Insurance Program (CHIP).

2. **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;
   - Board membership changes;

- Operations, including changes in policies and procedures since the last operational site visit;
- Systems, including financial, clinical, and/or practice management systems; and
- Financial status, including the most current audit findings, as applicable.

3. **Telehealth:** Describe how you use telehealth[1] to:
   - Communicate with patients at other clinical locations;
   - Communicate with providers and staff at other clinical locations;
   - Receive or perform clinical consultations;
   - Send and receive health care information from mobile devices to remotely monitor patients (i.e., mobile health, mHealth[2]); and
   - Provide virtual health care services (list all services that are provided via telehealth).

4. **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 any negative trends or limited progress toward the projected patient goals.

5. **Supplemental Awards:** See Table 4: Supplemental Awards. In the Supplemental Award Narrative column, describe the following:
   - Implementation status and progress toward achieving goals;
   - Key factors impacting progress toward achieving goals; and
   - Plans for sustaining progress and/or overcoming barriers to ensure goal achievement.

6. **One-Time Funding Awards:** See Table 5: One-Time Funding Awards. In the Activities column, discuss activities for which one-time funds were used and the impact on your organization.

7. **Clinical/Financial Performance Measures:** See Table 6: Performance Measures. Referencing the % Change 2016-2018 Trend, % Change 2017-2018 Trend, and % Progress Toward Goal columns, discuss the trends for:
   - HRSA Priority Clinical and Financial Performance Measures:
     o Diabetes: Hemoglobin A1c Poor Control
     o Health Center Program Grant Cost Per Patient (Grant Costs)
   - The measures for which you have experienced a negative trend of 5 percent or greater.

   When discussing trends, include:
   a. Key contributing and restricting factors affecting progress toward achieving goals; and

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[1]Telehealth is defined as the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

[2] For more information, see http://www.telehealthtechnology.org/toolkits/mhealth.

b. Plans for improving progress and/or overcoming barriers to ensure goal achievement.

If you have no measures for which you have experienced a negative trend of 5 percent or greater, state this in the Measure Narrative field for the relevant measure(s).

- Use the % Change 2017-2018 Trend data to determine if narrative is required for each measure other than the priority measures.
- Narrative regarding performance trend is required for the two priority measures (Diabetes and Grant Cost per Patient) regardless of trend data.

TABLE 3: PATIENT CAPACITY

	2016 Patient Number	2017 Patient Number	2018 Patient Number	% Change 2016-2018 Trend	% Change 2017-2018 Trend	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
Project Period: (Pre-populated from most recent Notice of Award)								
Total Unduplicated Patients	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit

Notes:
- 2016–2018 Patient Number data are pre-populated from Table 3a in the UDS Report.
- 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 Patient Target Response Team at BPHCPatientTargets@hrsa.gov. To formally request a change in your Patient Target, you **must** submit a request via the Patient Target Management Module in HRSA EHBs.

	2016 Patient Number	2017 Patient Number	2018 Patient Number	% Change 2016-2018 Trend	% Change 2017-2018 Trend	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
Project Period: (Pre-populated from most recent Notice of Award)								
Total Migratory and Seasonal Agricultural Worker Patients	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit
Total People Experiencing Homelessness Patients	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit
Total Public Housing Resident Patients	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit

Notes:
- 2016-2018 Patient Number data are pre-populated from Table 4 in the UDS Report.
- The Projected Number of Patients values is pre-populated from the patient projections in the submission that initiated your current project period (Service Area Competition (SAC)) plus the patient projections from selected supplemental funding awarded after the start of the current project period. 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.

	2016 Patient Number	2017 Patient Number	2018 Patient Number	% Change 2016-2018 Trend	% Change 2017-2018 Trend	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
Project Period: (Pre-populated from most recent Notice of Award)								
Total Medical Services Patients	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit
Total Dental Services Patients	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit
Total Mental Health Services Patients	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit
Total Substance Use Disorder Services Patients	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit
Total Enabling Services Patients	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated (see note for explanation)	2,000 character limit

Notes:
- 2016-2018 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 submission that initiated your current project period (SAC) plus the patient projections from selected supplemental funding awarded after the start of the current project period. 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.

TABLE 4: SUPPLEMENTAL AWARDS

Type of Supplemental Award	Programmatic Goal	Supplemental Award Narrative
FY 2017 Access Increases in Mental Health and Substance Abuse Services (AIMS)	Increase the number of patients with access to mental health services, and substance use disorder services focusing on the treatment, prevention, and awareness of opioid abuse by December 31, 2018	2,000 character limit
FY 2017 New Access Points (NAP) Satellite	Achieve operational status and increase the number of patients by December 31, 2018	2,000 character limit
FY 2018 Expanding Access to Quality Substance Use Disorder and Mental Health Services (SUD-MH)	Increase patients receiving substance use disorder and/or mental health services by December 31, 2019*	2,000 character limit

Notes:
- If you did not receive a Supplemental Award, the system will not require narrative in the Supplemental Award Narrative column.
- Supplemental awards released late in FY 2019 or early in FY 2020 will be included in the FY 2021 BPR.
- (*) SUD-MH recipients should report on the number of patients accessing SUD and/or mental health services, and, if you requested additional MAT funding, the number of patients receiving MAT for opioid use disorder (OUD).

TABLE 5: ONE-TIME FUNDING AWARDS

Type of One-Time Funding Award	Allowable Activities	Activities
FY 2017 Access Increases in Mental Health and Substance Abuse Services (AIMS)	Implementing health information technology (health IT) and/or training investments to: • Expand mental health services, and substance use disorder services focusing on the treatment, prevention, and awareness of opioid abuse • Integrate expanded services into primary care Funding must be used for health IT and/or training investments in one or more of the following Activity Categories: • Medication Assisted Treatment • Telehealth • Prescription Drug Monitoring Program • Clinical Decision Support • EHR Interoperability • Quality Improvement • Cybersecurity • Other Training • Other IT	2,000 character limit
FY 2017 Quality Improvement Assistance (August 2017) **FY 2018 Quality Improvement Assistance (August 2018)**	Developing and improving health center quality improvement (QI) systems and infrastructure: • Training staff • Purchasing medically accessible clinical equipment • Enhancing health information technology, certified electronic health record, and data systems • Data analysis • Implementing targeted QI activities (including hiring consultants) Developing and improving care delivery systems: • Purchasing supplies to support care coordination, case management, and medication management • Laboratory reporting and tracking • Training and workflow redesign to support team-based care • Clinical integration of behavioral health, oral health, HIV care, and other services	2,000 character limit

Type of One-Time Funding Award	Allowable Activities	Activities
FY 2018 Enhancing Behavioral Health Workforce	Increase access to quality opioid use disorder (OUD) and other substance use disorder (SUD) treatment by increasing the number of professionals and paraprofessionals trained to deliver behavioral health and primary care services as part of integrated, interprofessional team. Funds must be used to fulfill the following requirements throughout the 2 year funding period: • Provide mental health and SUD services either directly or through formal or written agreement for which the health center pays. • Have physicians, certified nurse practitioners, and/or physician assistants, on-site or with whom the health center has contracts, who have obtained a Drug Addiction Treatment Act (DATA) of 2000 waiver to treat OUD with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication. • Have patients who receive medication-assisted treatment (MAT) for OUD from a physician, certified nurse practitioner, or physician assistant with a DATA 2000 waiver working on behalf of the health center. • Develop, host in academic years 2018-2019 and 2019-2020, and evaluate at least annually, experiential rotations for individuals preparing to become social workers, psychologists, counselors, addiction counselors, paraprofessionals, community workers, or other approved professionals that will teach integrated behavioral health and primary care services, and OUD and other SUD treatment, including MAT.	2,000 character limit

FY 2018 Expanding Access to Quality Substance Use Disorder and Mental Health Services (SUD-MH)	Implementation of evidence-based SUD-MH integration and expansion strategies to:
	• Expand access to quality integrated SUD prevention and treatment services, including those addressing OUD and other emerging SUD issues.
	• Expand access to quality integrated mental health services, with a focus on conditions that increase risk for, or co-occur with SUD, including OUD.
	
	Funding may be used for infrastructure enhancements that support the expansion of SUD and/or mental health services, which may include:
	     • equipment,
	     • minor alternation and renovations (A/R), and
	     • other one-time costs.
		2,000 character limit

Notes: • If you did not receive a One-Time Funding Award, the system will not require narrative in the Activities column. • One-time awards released late in FY 2019 or early in FY 2020 will be included in the FY 2021 BPR.		

TABLE 6: PERFORMANCE MEASURES

	2016 Measure	2017 Measure	2018 Measure	% Change 2016-2018 Trend	% Change 2017-2018 Trend	% Progress Toward Goal	Measure Goal	Measure Narrative
HRSA Priority Clinical and Financial Performance Measures								
Clinical Measure								
Diabetes: Hemoglobin A1c Poor Control	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-population calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
Financial Measure								
Health Center Program Grant Cost Per Patient (Grant Costs)	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
Perinatal Health*								
Early Entry into Prenatal Care	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
Low Birth Weight	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit

	2016 Measure	2017 Measure	2018 Measure	% Change 2016-2018 Trend	% Change 2017-2018 Trend	% Progress Toward Goal	Measure Goal	Measure Narrative
Preventive Health Screenings and Services*								
Dental Sealants for Children between 6 – 9 Years	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
Body Mass Index (BMI) Screening and Follow-Up Plan	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
Tobacco Use: Screening and Cessation Intervention	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit

	2016 Measure	2017 Measure	2018 Measure	% Change 2016-2018 Trend	% Change 2017-2018 Trend	% Progress Toward Goal	Measure Goal	Measure Narrative
Colorectal Cancer Screening	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
Cervical Cancer Screening**	Data not available	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Data not available	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
Childhood Immunization Status (CIS)	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
Chronic Disease Management*								
Use of Appropriate Medications for Asthma	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit

	2016 Measure	2017 Measure	2018 Measure	% Change 2016-2018 Trend	% Change 2017-2018 Trend	% Progress Toward Goal	Measure Goal	Measure Narrative
Coronary Artery Disease (CAD): Lipid Therapy	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet**	Data not available	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Data not available	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
Controlling High Blood Pressure	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
HIV Linkage to Care	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
Screening for Depression and Follow-Up Plan	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit

	2016 Measure	2017 Measure	2018 Measure	% Change 2016-2018 Trend	% Change 2017-2018 Trend	% Progress Toward Goal	Measure Goal	Measure Narrative
Financial Measures*								
Total Cost Per Patient (Costs)	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
Medical Cost Per Medical Visit (Costs)	Pre-populated from 2016 UDS	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current project period	1,000 character limit
Additional Measures***								
Additional Measures (if applicable)	Provide data if available	Provide data if available	Provide data if available	Pre-populated calculation (if data are provided)	Pre-populated calculation (if data are provided)	Pre-populated calculation (if data are provided)	Pre-populated from the application that initiated the current project period	1,000 character limit

Notes:
- 2016 – 2018 Measure fields will prepopulate from UDS, if available.
- Performance measure goals cannot be edited during the BPR submission. If pre-populated performance measure goals are not accurate, provide an adjusted goal and explanation in the appropriate Measure Narrative field (e.g., goal for the low birth weight measure has decreased based on improved patient tracking via a new EHR).
- If you were previously a look-alike, your look-alike UDS data will not pre-populate.
- (*) If there are measures within this section that have not experienced a negative trend of 5 percent or greater (reference the % Change 2017-2018 Trend Column), state this in the appropriate Measure Narrative fields.
- (**) Due to the fact that Cervical Cancer and IVD goals were set and reported in UDS based on different measure definitions, data will not display for some fields.
- (***) If you receive funds to serve special populations (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing), you must ensure that at least one additional clinical performance measure that addresses the health care needs of each funded special population is included, as established in your most recent SAC application.

Refer to the UDS Manual and the UDS TA Site for assistance with analyzing performance measure progress.

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, 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 budget represents projected operational costs for the health center scope of project where all proposed expenditures directly relate to and support in-scope activities. Therefore the total budget must reflect projections from all anticipated revenue sources from program income (e.g., fees, premiums, third party reimbursements, payments) that is generated from the delivery of services, and from "other non-Health Center Program grant sources" such as state, local, other federal, and non-federal sources. Health centers have discretion regarding how they propose to allocate the total budget between Health Center Program grant funds and other funding that supports the project, provided that the projected budget complies with all applicable HHS policies and other federal requirements. See Chapter 17: Budget of the Compliance Manual for additional information.

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. Further, as stated in section 330 of the PHS Act, the federal cost principles apply only to federal funds. In other words, Health Center Program funds are to be used for authorized health center operations and may not be used for profit.

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 place to ensure that your organization complies with all federal funding requirements and prohibitions such as lobbying, gun control, abortion, etc. The effectiveness of these policies, procedures, and controls is subject to audit.

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). If the funding types are incorrect, make necessary adjustments using the **Update Sub-Program** button. (As a reminder, the BPR may **not** be used to request changes in the total award, funding type(s)[3], or allocation of Health Center Program funds between funding types.) 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.

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 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 Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245), Division B, Section 202 provides a salary rate limitation. The law limits the salary amount that may be awarded and charged to HRSA grants. Award funds may not be used to pay the salary of an individual (either through direct hire or a contractual arrangement) at a rate in excess of Executive Level II, which is currently $192,300. See

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[3] Community Health Center – CHC, Migrant Health Center – MHC, Health Care for the Homeless – HCH, and/or Public Housing Primary Care – PHPC

Section 5.1.iv Budget – Salary Limitation of HRSA's [SF-424 Two-Tier Application Guide](#) for additional information. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to your organization. This salary limitation also applies to subrecipients under a HRSA grant. Note that these or other salary limitations will apply in FY 2020, 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 $192,300, 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 $120,188 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 7: SALARY LIMITATION – ACTUAL VS. CLAIMED

Current Actual Salary: 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
Amount of Actual Salary Eligible to be Claimed on the Submission Budget due to the Legislative Salary Limitation: Individual's base full time salary adjusted to Executive Level II: $192,300 (50% of time will be devoted to the project)	
Direct Salary	$96,150
Fringe (25% of salary)	$24,038
Total Salary claimed	$120,188

B. Budget Narrative

The Budget Narrative must detail the costs of each line item within each object class category from the Budget Information: Budget Details form. The Budget Narrative must contain sufficient detail to enable HRSA to determine if costs are allowable.

Include a line item Budget Narrative that explains the amounts requested for each row of Section B: Budget Categories of the Budget Information: Budget Details form. 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 **revenues AND expenses** of your federal request and 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 $192,300.[4] 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 8.

TABLE 8: PERSONNEL JUSTIFICATION TABLE

Name	Position Title	% of FTE	Base Salary	Adjusted Annual Salary*	Federal Amount Requested
J. Smith	Physician	50%	$255,000	$192,300	$96,150
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	$192,300	$192,300
Total	**N/A**	**N/A**	**$628,950**	**N/A**	**$405,150**

*Used when the base salary is over the limitation of $192,300

Ensure that personnel costs are supported by official records that accurately reflect the work performed and that internal controls provide reasonable assurance that the 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., $192,300), 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,

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[4] While the BPR 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 $192,300.

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 to carry out the program's goals. 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 (tangible personal property (including information technology systems), with a useful life of more than one year and a per-unit cost of $5,000 or more). 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 (e.g., paper, pencils), medical supplies (e.g., syringes, blood tubes, gloves), and educational supplies (e.g., brochures, videos).

Per 45 CFR § 75.321, property will be classified as supplies if the acquisition cost is under $5,000 (e.g., laptops, tablets, desktop computers).

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. For proposed contracts, provide the basis for your cost estimate for the contract. You are responsible for ensuring that your organization 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, and 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, describe how you will 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 chosen, this must be used consistently for all federal awards until you negotiate for an indirect cost rate, which you may 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.[5]

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[5] For a listing of HRSA-supported PCAs, refer to HRSA's Strategic Partnerships website.

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.[6] 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

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[6] These visits will correspond closely with the visits reported on the UDS Manual Table 5, excluding enabling service visits.

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

Only services, sites, and other activities/locations included on Forms 5A, 5B, and 5C respectively are included in your approved scope of project. Data will pre-populate from the official scope of project and cannot be modified. If the pre-populated data do not reflect recently approved scope changes, click the '**Refresh from Scope'** button to update scope data in the BPR.

Note*:* In order for forms to accurately pre-populate, you must take action to correct this information **before** BPR submission. Refer to the Scope of Project documents and resources for details pertaining to defining and changing scope (i.e., services, sites, service area zip codes, and patient population). For more information, review Chapter 4: Required and Additional Health Services and Chapter 6: Accessible Locations and Hours of Operation of the Compliance Manual. You may contact your Project Officer for additional assistance.

Scope Certification Form

The Scope Certification Form requires certifications for Form 5A: Services Provided and Form 5B: Service Sites. First, certify that the scope of project for services (including

service delivery methods) is accurate, as presented on Form 5A: Services Provided in the BPR. Second, certify that the scope of project for sites is accurate, as presented on Form 5B: Service Sites in the BPR.

If you cannot certify the accuracy of Form 5A and/or Form 5B, you must certify that you have submitted a Scope Adjustment or CIS request to HRSA to correct the presented information.