HRSA
Health Center Program

Program-Specific Forms Instructions

Program-Specific Forms must be completed electronically in HRSA EHBs. All forms are required, except Form 5C: Other Activities/Locations. Sample forms are available at the SAC Technical Assistance website.

The forms that HRSA will utilize, in part or in full, in its assessment of compliance are noted with a bolded, underlined asterisk (*****).

Note: If you are a competing supplement applicant, you must utilize the Program-Specific Forms to describe ONLY the project in the proposed service area.

Form 1A: General Information Worksheet

1. Applicant Information

- Use the Fiscal Year End Date field to note the month and day in which your organization's fiscal year ends (e.g., January 31).
- Check only one category in the Business Entity section. If you are a Tribal or Urban Indian entity and meet the definition for a public or private entity, select the Tribal or Urban Indian category.
- You may select one or more categories for the Organization Type section.

2. Proposed Service Area

2a. Service Area Designation

- If you are applying for CHC funding, you MUST serve at least one Medically Underserved Area (MUA) or Medically Underserved Population (MUP).
- Select the MUA and/or MUP designations for the proposed service area and enter the identification number(s).
- For inquiries regarding MUAs or MUPs, visit the Shortage Designation website at https://bhw.hrsa.gov/shortage-designation or email sdb@hrsa.gov.

2b. Service Area Type

- Select the type (urban or rural) that describes the majority of the service area. If rural is selected, you may further choose sparsely populated, if applicable, and provide the number of people per square mile (values must range from .01 to 7). For information about rural populations, visit the Office of Rural Health Policy's website at http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html.

2c. Patients and Visits

General Guidance for Patient and Visit Numbers:

When providing the count of patients and visits within each service type category, note the following (see the UDS Manual for detailed information):

- A visit is a face-to-face contact between a patient and a licensed or credentialed provider who exercises independent, professional judgment in providing services. To be included as a visit, services must be paid for by your organization (Form 5A: Services Provided, Columns I and/or II) and documented in a written or electronic form in a system that permits ready retrieval of current data for the patient.
- A patient is an individual who had at least one visit in 2018 (current data) or is projected to have at least one visit in 2021 (projected data).
- Since a patient must have at least one documented visit, the number of patients cannot exceed the number of visits.
- Report aggregate data for all service sites in the proposed project.
- If you are a new or competing supplement applicant, report calendar year baseline values for services your organization is currently providing in the proposed service area. If your organization is not currently operational in the proposed service area, report baseline values as zero.

Unduplicated Patients and Visits by Population Type:

The population types in this section do NOT refer only to the requested funding categories in Section A of the SF-424A: Budget Information form. For example, if you are applying for only CHC funding (General Underserved Community), you may still have patients/visits reported in the other population type categories. **All patients/visits that do not fall within the Migratory and Seasonal Agricultural Workers and Families, Residents of Public Housing, or the People Experiencing Homelessness categories must be included in the General Underserved Community category.**

1. Project the number of unduplicated patients to be served in 2021 (January 1 through December 31, 2021). This value will pre-populate in the corresponding cell within the table below.

   HRSA will use the number of unduplicated patients projected to be served in calendar year 2021 to determine compliance with Eligibility Requirement 3a, which requires the patient projection to be at least 75 percent of the SAAT Patient Target. If a health center is unable to meet the total unduplicated patient target in 2021 (the patient projection from this application, plus other patient projections from funded supplemental applications for which the projections can be monitored in 2021), funding for the service area may be reduced when the service area is next competed through SAC (assuming a 3-year project period).

2. If you are a new or competing supplement applicant: Provide the number of current unduplicated patients and visits for each population type category to establish a

baseline. **Across all population type categories, an individual can only be counted once as a patient.**

If you are a competing continuation applicant, current patients will pre-populate from the 2018 UDS data. Provide the number of visits across the population type categories to establish a baseline. To maintain consistency with the patients and visits reported in UDS, do not include patients and visits for pharmacy services or other services outside the proposed scope of project.

3. The total number of unduplicated patients projected in 2021 (January 1 through December 31, 2021) will pre-populate from Item 1 above. Project the **total** number of visits in 2021 (January 1 through December 31, 2021). Then categorize these projected numbers for each population type category. **Across all population type categories, an individual can only be counted once as a patient.**

Patients and Visits by Service Type:

1. If you are a new or competing supplement applicant: Provide the number of current patients and visits within each service type category to establish a baseline. **An individual who receives multiple types of services should be counted once for each service type** (e.g., an individual who receives both medical and dental services should be counted once for medical and once for dental).

   If you are a competing continuation applicant: Current patients and visits for each service type category will pre-populate from the 2018 UDS data.

2. Project the number of patients and visits anticipated within each service type category in 2021 (January 1 through December 31, 2021).

   If you are a competing supplement applicant, include only the new patients you propose to serve via the proposed project.

3. To maintain consistency with the patients and visits reported in UDS, do not report patients and visits for vision or pharmacy services or other services outside the proposed scope of project.

   Note: The Patients and Visits by Service Type section does not have a row for total numbers since an individual patient may be included in multiple service type categories (i.e., a single patient should be counted as a patient for each service type received).

Form 1C: Documents on File

This form provides a summary of documents that support the implementation of Health Center Program requirements, as outlined in the Health Center Program Compliance Manual; 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 2: Staffing Profile

Report personnel for the **first budget year** of the proposed project. Include only staff for sites included on Form 5B: Service Sites.

- The project director (PD)/chief executive officer (CEO) must be a direct employee of the health center.
- Allocate staff time in the Direct Hire FTEs column by function among the staff positions listed. An individual's full-time equivalent (FTE) should not be duplicated across positions. For example, a provider serving as a part-time family physician and a part-time Clinical Director should be listed in each respective category with the FTE portion allocated to each position (e.g., clinical director 0.3 (30%) FTE and family physician 0.7 (70%) FTE). Do not exceed 1.0 (100%) FTE for any individual. For position descriptions, refer to the UDS Manual.
- Record volunteers in the Direct Hire FTEs column.
- If you propose to provide services through formal written contracts/agreements (Form 5A, Column II), select Yes for contracted staff.
- Contracted staff are indicated by answering Yes or No only. **Do not quantify contracted staff in the Direct Hire column.** Contracted staff should be summarized in Attachment 7: Summary of Contracts and Agreements.

* Form 3: Income Analysis

Form 3 collects the projected income from all sources other than this Health Center Program funding request for the **first budget year** of the proposed project. 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 health center 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, 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 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.[1]

Only include patient service revenue associated with sites and services proposed 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. 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.[2] 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 under Payer Categories 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 on 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).

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

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

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 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 on 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, wrap-around 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 Health Administration Community Based Outpatient Clinic (CBOC) contracts. Income from health benefit plans that are earned by government employees, veterans, retirees, and dependents, such as TRICARE, the federal employee health benefits program, state employee health insurance benefit programs, teacher health insurance, and similar plans 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 & Medicaid Services (CMS), and Department of Health and Human Service 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 this Health Center Program funding request

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

Local Government (Line 9): Income from local government grants, contracts, and programs, including local indigent care income, community development block grants, capital improvement

project funding, federal funding awarded through intermediaries, and similar awards. For example, include: (1) income earned under a contract with the local Department of Health to provide services to the Department's patients, and (2) Ryan White Part A 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 this Health Center Program funding request, 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 this Health Center Program funding request).

Note*:* In-kind donations are not included on Form 3. You may discuss in-kind donations in the SUPPORT REQUESTED section of the Project Narrative. Additionally, such donations may be included on the SF-424A (Section A: Budget Summary—Non-Federal Resources under New or Revised Budget).

Form 4: Community Characteristics

Report current service area and target population data. Data on race and/or ethnicity collected on this form will **not** be used as an awarding factor. If you compile data from multiple data sources, the total numbers may vary across sources. If this is the case, make adjustments as needed to ensure that the total numbers for the first four sections of this form match. Adjustments must be explained in the NEED section of the Project Narrative.

Service area data must be specific to the proposed project and include the total number of individuals for each characteristic (percentages will automatically calculate in HRSA EHBs). If information for the service area is not available, extrapolate data from the U.S. Census Bureau,

local planning agencies, health departments, and other local, state, and national data sources. Estimates are acceptable.

Target population data are most often a subset of service area population data. Report the number of individuals for each characteristic (percentages will automatically calculate in HRSA EHBs). Estimates are acceptable. **Patient data should not be used to report target population data since patients are typically a subset of this number.**

If the target population includes a large number of transient individuals that are not included in the data set used for service area population data (e.g., census data), adjust the service area population numbers accordingly to ensure that the target population numbers are always less than or equal to the service area population numbers.

Note: The total numbers for the first four sections of this form **must match**.

Guidelines for Reporting Race

- Classify all individuals in one of the racial categories, including individuals who also consider themselves Hispanic or Latino. If the data source does not separately classify Hispanic or Latino individuals by race, report them as Unreported/Declined to Report.
- Utilize the following race definitions:

    - Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Indonesia, Thailand, and Vietnam.
    - Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
    - Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, Tonga, Palau, Truk, Yap, Saipan, Kosrae, Ebeye, Pohnpei, or other Pacific Islands in Micronesia, Melanesia, or Polynesia.
    - American Indian/Alaska Native – Persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
    - More Than One Race – Persons who are choosing two or more races.

Guidelines for Reporting Hispanic or Latino Ethnicity

- If ethnicity is unknown, report individuals as Unreported/Declined to Report.
- Utilize the following ethnicity definition: Hispanic or Latino – Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Guidelines for Reporting Special Populations and Select Population Characteristics

The Special Populations section of Form 4 does not have a row for total numbers. Individuals that represent multiple special population categories should be counted in all applicable categories.

Forms 5A, 5B, and 5C

General Notes

- **Competing continuation applicants**: These forms will be pre-populated and cannot be modified to ensure that they reflect the current scope of project. Changes in services, sites, and other activities/locations require prior approval through a Change in Scope request submitted in HRSA EHBs. If the pre-populated data do not reflect recently approved scope changes, click the **Refresh from Scope** button in HRSA EHBs to display the latest scope of project.

  Note: In order for forms to accurately pre-populate, you must correctly complete the SF-424 in Grants.gov by selecting **Continuation** for Box 2 and providing the grant number for Box 4. **Failure to apply in this manner may result in delayed HRSA EHBs application access.**

- **New or competing supplement applicants**: Complete these forms based only on the scope of project included in this application for the proposed service area.
- If the application is funded, only the services, sites, and other activities/locations listed on these forms will be in the approved scope of project, regardless of what is described elsewhere in the application.
- 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, target population).

Form 5A: Services Provided

Identify how services will be provided (i.e., direct by health center, formal written contract (health center pays for service), formal written referral arrangement).

- You must provide all required services without regard to ability to pay and on a sliding fee discount schedule.
- Additional services are not required. However, in order to be considered in-scope services, additional services be must be listed on this form and provided without regard for ability to pay and on a sliding fee discount schedule.

For more information, refer to Chapter 4: Required and Additional Health Services of the Compliance Manual. Only one form is required regardless of the number of sites proposed.

Refer to the Form 5A Service Descriptors for descriptions of the required and additional services. Also see the Form 5A Column Descriptors for descriptions of the three service delivery methods used by health centers. All contracts/referral arrangements for services noted on Form 5A as provided via Column II and/or III must be formal written contracts/referral arrangements.

Competing supplement applicants:

- All services in your current scope of project must be accessible to patients in the newly proposed service area.
- If new services are proposed on Form 5A and this application is funded, these services must be accessible to both current and proposed patients.

Form 5B: Service Sites

Provide requested data, including a **verifiable street address**, for each proposed service site.

New or competing supplement applicants: You must propose **at least one new** full-time permanent service delivery, or administrative/service delivery site,[3] located in the proposed service area.

Competing supplement applicants: After proposing **at least one new** full-time permanent service delivery site[4] located in the proposed service area, current sites in scope may be selected to the extent that they will provide services to the proposed new patients.

Zip codes entered in the Service Area Zip Codes field for service delivery sites and administrative/service delivery sites[5] will **determine compliance with Eligibility Requirement 3b and therefore must** include: 1) a combination of SAAT zip codes where zip code patient percentages total at least 75 percent, or 2) all SAAT zip codes for the proposed service area, if the sum of all zip code patient percentages is less than 75 percent. Zip codes entered for administrative-only sites will not be considered when determining eligibility.

Note*:* Sites described in the Project Narrative that are not listed on Form 5B will not be considered for compliance with the eligibility requirements or by the Objective Review Committee when reviewing and scoring the application.

Form 5C: Other Activities/Locations (As Applicable)

Provide requested data for other activities/locations (e.g., home visits, health fairs). List only activities/locations that 1) do not meet the definition of a service delivery site, 2) are conducted

[3] MHC-only applicants may propose at least one full-time seasonal rather than permanent site.

[4] MHC-only applicants may propose at least one full-time seasonal rather than permanent site.

[5] HRSA considers service area overlap when making funding determinations for new and competing supplement applicants if zip codes are proposed on Form 5B: Service Sites beyond those listed in the SAAT. For more information about service area overlap, refer to Policy Information Notice 2007-09.

on an irregular timeframe/schedule, and/or 3) offer a limited activity from within the full complement of health center activities in the scope of project.[6]

* Form 6A: Current Board Member Characteristics

The list of board members will be pre-populated for competing continuation and competing supplement applicants. **Update pre-populated information as appropriate.**[7] Public centers with co-applicant health center governing boards must list the co-applicant board members.

Complete or update the following information:

- List all current board members (minimum of 9 and maximum 25). Do not list non-voting board members (e.g., PD, advisory board members).
- List each board member's office held, if applicable (e.g., Chair, Treasurer) and area of expertise (e.g., finance, education, nursing).
- For non-patient board members, indicate if more than 10 percent of their annual income is from the health care industry.
- Indicate if each board member is a health center patient. For the purposes of board composition, a patient is an individual who received at least one service in the past 24 months that generated a health center visit, where both the service and the site where the service was received are within the HRSA-approved (or proposed in this application) scope of project.
- Indicate if each board member lives and/or works in the service area.
- Indicate if each board member is a representative from/for a special population (i.e., people experiencing homelessness, migratory and seasonal agricultural workers and families, residents of public housing).
- Indicate the total gender, ethnicity, and race of board members who are patients of the health center.

Note:

- Indian tribes or tribal, Indian, or urban Indian organizations are not required to complete this form, but may do so if desired.
- If you are requesting a waiver of the 51 percent patient majority board composition requirement (see qualifications in the Form 6B instructions below), you must list your board members, NOT the members of any advisory council.

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[6] Refer to Scope of Project for more information.

[7] Refer to Chapter 20: Board Composition of the Compliance Manual.

* Form 6B: Request for Waiver of Board Member Requirements

New applicants: You may use this form to request a waiver of the patient majority board composition requirement if you are requesting funding to serve only special populations (i.e., you are not requesting CHC funding).

Competing continuation and competing supplement applicants: You may use this form to request a waiver of the patient majority board composition requirement if you currently receive and are requesting funding to serve only special populations. In other words, if you currently receive or are applying to receive CHC funding, you are not eligible for a waiver and cannot enter information on this form.

Indian tribes or tribal, Indian, or urban Indian groups are not required to complete this form and cannot enter information.

If you are a competing continuation applicant that wishes to continue an existing waiver, or a new applicant that wishes to request a waiver of the 51 percent patient majority board composition requirement, you must complete this form. Present a "good cause" justification describing the need for a waiver of the patient majority board composition requirement, including:

- The unique characteristics of the special population or service area that create an undue hardship in recruiting a patient majority.
- Attempts to recruit a majority of special population board members within the last 3 years and why these attempts have not been successful.
- Strategies that will ensure patient participation and input in the direction and ongoing governance of the organization by addressing the following:
  - Collection and documentation of input from the special population(s).
  - Communication of special population(s) input directly to the health center governing board.
  - Incorporation of special population(s) input into key areas, including but not limited to: selecting health center services; setting hours of operation of health center sites; defining budget priorities; evaluating the organization's progress in meeting goals, including patient satisfaction; and assessing the effectiveness of the sliding fee discount program.

* Form 8: Health Center Agreements

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

1) A parent, affiliate, or subsidiary organization; and/or

2) A current or proposed subaward that will constitute a substantial portion of the proposed scope of project (e.g., a site that is or will be operated by a subrecipient or contractor, as identified on Form 5B: Service Sites).[8]

Refer to Uniform Guidance 2 CFR part 200 as codified by HHS at 45 CFR part 75 for more information on the characteristics of a subrecipient or contractor agreement. You must determine whether an individual agreement that will result in disbursement of federal funds will be carried out through a contract or a subaward and structure the agreement accordingly.

If either question 1 or 2 is answered "Yes", you must upload the associated agreement(s). You may list a maximum of 10 Contract or Subaward Organizations with five document uploads each. Additional documentation that exceeds this limit should be included in Attachment 13: Other Relevant Documents, which will count against the page limit.

Contracts attached to Form 8 must support the HRSA-approved scope of project and include provisions that address:

- Specific activities or services to be performed, or goods to be provided.
- Mechanisms for the health center to monitor contractor performance.
- Requirements for the contractor to provide data necessary to meet applicable Federal financial and programmatic reporting requirements, as well as provisions addressing records retention and access, audits, and property management.[9]

Subawards attached to Form 8 must support the HRSA-approved scope of project and include provisions that address:

- Specific portions of the project to be performed by the subrecipient.
- Applicability of all Health Center Program requirements to the subrecipient.
- Applicability to the subrecipient of any distinct statutory, regulatory, and policy requirements of other federal programs associated with the proposed project.
- Mechanisms for you to monitor subrecipient compliance and performance.
- Requirements for the subrecipient to provide data necessary to meet applicable Federal financial and programmatic reporting requirements, as well as provisions addressing records retention and access, audits, and property management.

[8] For the purposes of the Health Center Program, contracting for substantive programmatic work applies to contracting with a single entity for the majority of health care providers. The acquisition of supplies, material, equipment, or general support services is not considered programmatic work.

[9] For further guidance on these requirements, see the HHS Grants Policy Statement.

- Requirements that all costs paid for by the federal subaward are allowable, consistent with Federal Cost Principles.[10]

Form 12: Organization Contacts

Data will pre-populate for competing continuation and competing supplement applicants to revise as necessary.

If you are a new applicant, provide the requested contact information. For the Contact Person field, provide an individual who can represent the organization in communication regarding the application.

Summary Page

This form enables you to verify key application data. If pre-populated data appear incorrect, verify that the pertinent data in the SF-424A and Forms 1A: General Information Worksheet and 5B: Service Sites were entered correctly.

Service Area

Enter the proposed service area identification number (ID), city, and State, as indicated in the SAAT.

Patient Projection

The total number of unduplicated patients projected to be served in 2021 (January 1 through December 31, 2021) will pre-populate from Form 1A: General Information Worksheet. Enter the Patient Target for the proposed service area from the SAAT. The percentage of patients to be served in 2021 will auto-calculate. **Applications with an auto-calculated percentage below 75 percent will be deemed ineligible.**

Federal Request for Health Center Program Funding

To ensure eligibility, the total Health Center Program funding request must not exceed the Total Funding available in the SAAT for the proposed service area. Additionally, ensure that the funding requested for each population aligns with the values in the SAAT. If the unduplicated patient projection on Form 1A General Information Worksheet is less than 95 percent of the SAAT Patient Target, ensure the annual Health Center Program funding request is adjusted based on the auto-calculated percentage of patients to be served in calendar year 2021 from the Patient Projection section of this form. If the total Health Center Program funding request is

[10] See 45 CFR 75 Subpart E: Cost Principles.

reduced, funding requested for each targeted population (e.g., CHC, MHC) must maintain the same distribution as in the SAAT.

Note: If a required funding reduction based on the unduplicated patient projection is not made in the application, HRSA will make the funding reduction before issuing the award.

Scope of Project: Sites and Services

New or competing supplement applicants: To ensure continuity of services in areas already being served by the Health Center Program, you must certify that **all sites** described in the application are included on Form 5B: Service Sites and will be open and operational within 120 days of receipt of the NoA.

Competing continuation applicants: To ensure an accurate scope of project, certify that:

- Form 5A: Services Provided accurately reflects all services and service delivery methods included in the current scope of project OR Form 5A: Services Provided requires changes that **you have already submitted** through the change in scope process.
- Form 5B: Service Sites accurately reflects all sites included in the current scope of project OR Form 5B: Service Sites requires changes that **you have already submitted** through the change in scope process.

120 Day Compliance Achievement Plan Certification

Certify that if your organization is funded and is noncompliant with any Health Center Program requirements, within 120 days of receipt of your NoA, you will submit for HRSA approval a Compliance Achievement Plan which outlines a plan to meet the Health Center Program requirements within the timeframes required by the conditions on your NoA.