



LOOK-ALIKE ANNUAL CERTIFICATION SUBMISSION INSTRUCTIONS

Table of Contents

| | |
|---|----|
| Summary of Changes | 2 |
| I. Technical Assistance | 2 |
| II. General Instructions | 3 |
| III. Instructions for Project Narrative Update | 5 |
| IV. Budget Presentation Instructions | 15 |
| Appendix A: Program Specific Forms Instructions | 18 |

Release Date: July 31, 2019

All submissions started in the HRSA Electronic Handbooks (EHBs) on or after the release date must adhere to the instructions contained herein.

Karen A. Fitzgerald
Office of Policy and Program Development
Contact: [http://bphc.hrsa.gov/programopportunities/lookalike/AC/index.html](https://bphccommunications.secure.force.com/ContactBPHC/BPHC>Contact Form
Telephone: 301-594-4300
Annual Certification Technical Assistance Webpage:
<a href=)

SUBMISSION SCHEDULE

| Certification Period Start Date | HRSA EHBs Access | HRSA EHBs Deadline |
|---------------------------------|------------------|--------------------|
| January 1, 2020 | 8/3/2019 | 10/2/2019 |
| February 1, 2020 | 9/3/2019 | 11/2/2019 |
| March 1, 2020 | 10/2/2019 | 12/1/2019 |
| April 1, 2020 | 11/2/2019 | 1/1/2020 |
| May 1, 2020 | 12/2/2019 | 1/31/2020 |
| June 1, 2020 | 1/2/2020 | 3/2/2020 |

ABOUT THE ANNUAL CERTIFICATION SUBMISSION

The Annual Certification (AC) provides an update on the progress of Health Center Program look-alikes (LAL). The AC reports on progress made from the beginning of your current certification period until the date of AC submission; the expected progress for the remainder of the current certification period; and any projected changes for the upcoming certification period.

SUMMARY OF CHANGES (COMPARED TO THE JULY 3, 2018 AC INSTRUCTIONS)

- The [Clinical Performance Measures](#) section was 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 [AC Technical Assistance \(TA\) webpage](#). The AC TA webpage includes copies of forms, the Electronic Handbooks (EHBs) [AC User Guide](#), and a slide presentation.

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://bphccommunications.secure.force.com/ContactBPHC/BPHC_Contact_Form (complete the BPHC Contact Form, Contact Record, and Organization screens; confirm the Contact Verification; select Health Center, Look-Alike, Look-Alike Annual Certification; then describe your question)

HRSA EHBs system technical assistance is available by contacting:
Health Center Program Support
1-877-464-4772

https://bphccommunications.secure.force.com/ContactBPHC/BPHC_Contact_Form (complete the BPHC Contact Form, Contact Record, and Organization screens; complete and confirm the information in the Contact Verification screens; select Electronic Handbooks (EHBs), Look-Alike, Look-Alike AC; 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 LAL changes including, but not limited to, changes in the project director/chief executive officer (CEO) and the addition or deletion of sites or services from the approved scope of project. These changes must be requested via the Scope Adjustment and/or Change in Scope (CIS) Modules in the HRSA EHBs, as appropriate.

Instructions

The HRSA EHBs system will send an email to your LAL's contacts identified in the system 150 days prior to the end of the certification period to inform them that the submission is accessible in the HRSA EHBs. Once notified that the AC is available within the HRSA EHBs, you will have 60 days to complete and submit it in the HRSA EHBs system. AC submissions are due 90 days prior to the end of the certification period.



AC submissions that fail to include all required documents and information will be considered incomplete or non-responsive. Incomplete or non-responsive AC submissions will be returned through a "Request Change" notification via the HRSA EHBs for the provision of missing information or clarification. You are required to submit an AC by the established deadline within the certification period.

Failure to submit a timely and complete AC may result in termination of the LAL designation and all corresponding benefits. Review your AC to ensure it is both complete and responsive prior to submission.

[Table 1: Submission Components](#) identifies the required AC components. In the Form Type column of [Table 1](#), the word “Form” refers to forms that are completed online in the HRSA EHBs. The word “Document” refers to materials that must be uploaded into the HRSA EHBs. The word “Fixed” refers to forms that cannot be altered but may be “refreshed” based on changes in the scope of project.

TABLE 1: SUBMISSION COMPONENTS

- The Budget Narrative is the only document that should be uploaded within the HRSA EHBs.
- Samples of Form 1C, Form 3: Income Analysis, Form 3A: Look-Alike Budget Information, the Project Narrative Update, the Budget Narrative, and the Scope Certification Form are available on the [AC TA webpage](#).
- Refer to [Appendix A: Program Specific Forms Instructions](#) for detailed instructions on completing the forms listed in the table, unless otherwise noted.

| AC Section | Form Type | Instructions |
|--|-----------|---|
| Cover Page | Form | Provide a summary of information related to the project |
| Budget Narrative | Document | Provide a line-item budget for the upcoming certification period |
| 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 certification period |
| Form 3A: Look-Alike Budget Information | Form | Provide the budget for the upcoming certification 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 CIS Modules in the HRSA EHBs. Contact your Project Officer for guidance. |

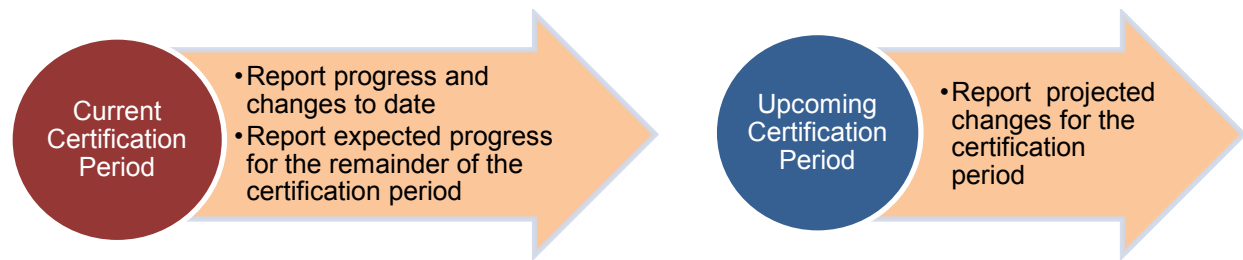
| AC Section | Form Type | Instructions |
|--|-----------|--|
| Scope Certification Form | Form | Certify that the sites and services in scope (listed on Forms 5A and 5B) are accurate or that a Scope Adjustment or CIS request has been submitted to correct inaccurate information. Contact your Project Officer for guidance. |
| Project Narrative Update | Form | Refer to Section III for instructions |

III. INSTRUCTIONS FOR PROJECT NARRATIVE UPDATE

The Project Narrative Update includes five Key Areas (Environment; Organizational Capacity; Telehealth; Patient Capacity; 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 changes that have impacted the community/patient population and your organization from the beginning of the current certification period until the date of the AC submission;
2. Expected progress for the remainder of the certification period; and
3. Projected changes for the upcoming certification period.

Reporting Your Certification Period Progress



Project Narrative Update Areas

Each of the five 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 over the past year that have directly impacted and/or have the potential to impact the progress of the designated project, including changes in:
 - Service area demographics and shifting patient population needs;
 - Major health care providers in the service area;
 - Key program 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 over the past year, in the organization’s capacity that have impacted or may impact the progress of the designated project, including changes in:
- Staffing, including key vacancies;
 - Board membership;
 - 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:**¹ Describe how you use telehealth 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, mHealth²); and
 - Provide virtual health care services (list all services that are or will be provided via telehealth).
- 4. Patient Capacity:** See [Table 2: Patient Capacity](#). Discuss the 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. Clinical/Financial Performance Measures:** See [Table 3: Performance Measures](#). Referencing the % Change 2016-2018 Trend, % Change 2017-2018 Trend, and % Progress Toward Goal columns, discuss the trends for:
- HRSA Priority Clinical Performance Measure: Diabetes: Hemoglobin A1c Poor Control
 - The measures within each of the remaining sections 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
- b. Plans for improving progress and/or overcoming barriers to ensure goal achievement.

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>.

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 measure.
- Narrative regarding performance trend is required for the priority measure (Diabetes) regardless of trend data.

TABLE 2: 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 |
|--|-----------------------------|-----------------------------|-----------------------------|---------------------------|---------------------------|---------------------------|--|----------------------------|
| Designation Period: (Pre-populated from most recent Notice of Look-Alike Designation) | | | | | | | | |
| 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 from the most recent LAL application | 2,000 character limit |
| 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 from the most recent LAL application | 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 from the most recent LAL application | 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 from the most recent LAL application | 2,000 character limit |
| Notes: <ul style="list-style-type: none"> • 2016 – 2018 Patient Number data are pre-populated from Tables 3a and 4 in the UDS Report. • The Projected Number of Patients values cannot be edited during the AC 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 |
|---|-----------------------------|-----------------------------|-----------------------------|---------------------------|---------------------------|---------------------------|--|----------------------------|
| Designation Period: (Pre-populated from most recent Notice of Look-Alike Designation) | | | | | | | | |
| 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 from the most recent LAL application | 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 from the most recent LAL application | 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 from the most recent LAL application | 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 from the most recent LAL application | 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 from the most recent LAL application | 2,000 character limit |
| Notes: <ul style="list-style-type: none"> • 2016-2018 Patient Number data are pre-populated from Table 5 in the UDS Report. • The Projected Number of Patient values cannot be edited during the AC submission. If these values are not accurate, provide adjusted projections and an explanation in the Patient Capacity Narrative section. | | | | | | | | |

TABLE 3: 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 Performance 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 most recent LAL application | 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 most recent LAL application | 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 most recent LAL application | 1,000 character limit |
| 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 most recent LAL application | 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 |
|--|-----------------------------|-----------------------------|-----------------------------|---------------------------------|---------------------------------|-------------------------------|--|--------------------------|
| 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 most recent LAL application | 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 most recent LAL application | 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 most recent LAL application | 1,000 character limit |
| 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 most recent LAL application | 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 most recent LAL application | 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 |
|--|-----------------------------|-----------------------------|-----------------------------|---------------------------------|---------------------------------|-------------------------------|--|--------------------------|
| 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 most recent LAL application | 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 most recent LAL application | 1,000 character limit |
| 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 most recent LAL application | 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 most recent LAL application | 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 most recent LAL application | 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 |
|--|-----------------------------|-----------------------------|-----------------------------|--|--|--|--|-----------------------|
| 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 most recent LAL application | 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 most recent LAL application | 1,000 character limit |
| 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 most recent LAL application | 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 most recent LAL application | 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 most recent LAL application | 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 |
|--|--------------|--------------|--------------|--------------------------|--------------------------|------------------------|--------------|-------------------|
|--|--------------|--------------|--------------|--------------------------|--------------------------|------------------------|--------------|-------------------|

Notes:

- 2016 – 2018 Measure fields will prepopulate from UDS, if available.
- Performance measure goals cannot be edited during the AC submission. If pre-populated performance measure goals are not accurate, provide an adjusted goal and explanation in the appropriate Measure Narrative section (e.g., goal for the low birth weight measure has decreased based on improved patient tracking via a new electronic health record (EHR)).
- (*) If you have no measures for which you have experienced a negative trend of 5 percent or greater within one or more of these sections state this in the Measure Narrative field.
- (**) 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 are designated 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 designated special population is included, as established in your most recent Renewal of Designation application.

Refer to the [UDS Manual](#) and the [UDS TA Site](#) for assistance with analyzing performance measure progress.

IV. BUDGET PRESENTATION INSTRUCTIONS

LAL designation is based on progress toward accomplishing the project's goals and a determination that continued designation would be in the best interest of the federal government.

A complete budget presentation includes [Form 3: Income Analysis](#), [Form 3A: Look-Alike Budget Information](#) (see instructions for Forms 3 and 3A in [Appendix A: Program Specific Forms Instructions](#)), and the submission of the budget narrative.

Note: The AC may not be used to request changes in the designation type(s).³

Budget Narrative

Provide a detailed budget narrative in line-item format for the upcoming certification period. An itemization of revenues and expenses is necessary. Upload the budget narrative in the Appendices section in the HRSA EHBs. Definitions for the expense categories are as follows:

Personnel: Explain personnel costs by listing each staff member who will be directly employed by the LAL, name (if possible), position title, percentage of full-time equivalency, and annual salary.

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.

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 travel expenses (e.g., airfare, lodging, parking, per diem) for each person and trip associated with participating in meetings and other proposed trainings or workshops.

Equipment: List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Equipment includes moveable items that are non-expendable, 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. Any items that do not meet the threshold for equipment are considered supplies (see definition below).

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

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 and desktop computers).

Contractual/Consultant: Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract 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. For consultant services, list the total costs for all consultant services. Identify each consultant, the services he/she will perform, total number of days, travel costs, and total estimated costs.

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 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 language 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 maintenance, depreciation, administrative salaries). For some institutions, the term "facilities and administration" (F&A) is used to denote indirect costs. Visit HHS's Cost Allocation Services (CAS) (formerly the Division of Cost Allocation's (DCA)) website at [Program Support Center](#) (PSC) to learn more about rate agreements, including the process for applying for them.

Note: If your organization receives any federal funding, you are required to have the necessary policies, procedures, and financial controls in place to ensure that you comply with all federal funding requirements and prohibitions such as

lobbying, gun control, abortion, etc. The effectiveness of these policies, procedures, and controls may be subject to audit.

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 AC submission. HRSA will review these documents as part of an Operational Site Visit and/or may request these for review post-designation.

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 (Required)

Form 3 collects the projected income from all sources for the upcoming certification period (one year). Form 3 income is divided into two parts: (1) Patient Service Revenue - Program Income and (2) Other Income - 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 to patients that are 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 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 reimbursement rate for services provided to Medicaid and Medicare beneficiaries, you may contact your

Primary Care Association (PCA) to inquire about FQHC rates for service delivery programs that are similar in size.⁴

Only include patient service revenue associated with sites or 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. 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.⁵ 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 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 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.

⁴ For a listing of HRSA-supported PCAs, refer to HRSA's [Strategic Partnerships website](#).

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

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 Projected Income Column (d), along with the related data requested in Columns (a) through (e). Income for each service may be estimated by multiplying the projected visits by assumed income per visit. For example, capitated managed care income may be based upon member-month enrollment projections and estimated capitation rates for each plan, grouped by payer and added to the projected income. Enter the estimated visits associated with these managed care plans in Column (b).

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

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

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

Medicaid (Line 1): Income from FQHC cost reimbursement; capitated managed care; fee-for-service managed care; Early Periodic Screening, Diagnosis, and Treatment (EPSDT); 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 Veteran's 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 –Federal, State, Local, and Other Income

This section includes all income other than the patient service revenue shown in Part 1. It includes 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.

Federal (Line 7): Income from direct federal funds, where your organization is the recipient of a Notice of Award 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](#).

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-profit entities, 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 organization's 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 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).

Note: In-kind donations are not included as income on Form 3.

Form 3A: Look-Alike Budget Information (Required)

Part 1: Expenses

For each of the expense categories (personnel, fringe benefits, travel, equipment, supplies, contractual, other, and indirect charges – see the [Budget Narrative](#) section for a definition of each expense category), enter the projected expenses for the upcoming certification period for each of the applicable categories. If the categories in the form do not describe all possible expenses, enter expenses in the Other category. The total fields are calculated automatically as you move through the form.

Part 2: Revenue

For each of the revenue categories (applicant, federal, state, local, other, and program income), enter the projected revenue for the upcoming certification period from each category. If you are a state agency, leave the State row blank and include state funding in the Applicant row. If revenue is collected from sources other than those listed, indicate the additional sources in the Other category. The total fields are calculated automatically as you move through the form.

Form 3A should be consistent with amounts described 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 a LAL's 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 recent scope changes, click the 'Refresh from Scope' button to update scope data in the AC.

Note: If the information presented in the AC on Forms 5A and 5B is not accurate after it has been refreshed, you must take action to correct this information **before** AC submission. Review the [Scope of Project](#) resources. 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 also contact your Project Officer for 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 AC. Second, certify that the scope of project for sites is accurate, as presented on Form 5B: Service Sites in the AC.

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