FY21 LOOK-ALIKE ANNUAL CERTIFICATION SUBMISSION INSTRUCTIONS

Table of Contents

Release Date: August 3, 2020

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, MPH
Office of Policy and Program Development
Contact: https://bphccommunications.secure.force.com/ContactBPHC/BPHC_Contact_Form
Telephone: 301-594-4300
Annual Certification Technical Assistance Webpage:
http://bphc.hrsa.gov/programopportunities/lookalike/AC/index.html

TABLE 1: SUBMISSION SCHEDULE

Certification Period Start Date	HRSA EHBs Access	HRSA EHBs Deadline
January 1, 2021	8/3/2020	10/2/2020
February 1, 2021	9/3/2020	11/2/2020
March 1, 2021	10/1/2020	11/30/2020
April 1, 2021	11/1/2020	12/31/2020
May 1, 2021	12/1/2020	1/30/2021
June 1, 2021	1/1/2021	3/2/2021

ABOUT THE ANNUAL CERTIFICATION SUBMISSION

The Annual Certification (AC) provides an update on the progress of Health Center Program look-alikes (LALs). 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.

Important Notice:

On January 31, 2020, the Department of Health and Human Services (HHS) declared a nationwide public health emergency related to severe acute respiratory syndrome coronavirus 2 (COVID-19). The President declared a national emergency related to COVID-19 on March 13, 2020. In an effort to provide maximum flexibility to LALs, HRSA will extend the designation period for LALs with a current 3-year designation period scheduled to submit a Renewal of Designation (RD) application in FY 2021.These LALs must submit an AC in FY 2021.

Additionally, LALs whose designation period end date is not in FY 2021 (October 1, 2020 — September 30, 2021) – those already scheduled to complete an FY 2021 AC – should submit an FY 2021 AC.

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

SUMMARY OF CHANGES (COMPARED TO THE JULY 31, 2019 AC INSTRUCTIONS)

- The Scope Certification Form was removed from the AC in an effort to streamline the document and reduce designee burden.
- The Environment, Telehealth, and Clinical/Financial Performance Measures sections of the Project Narrative have been removed.
- The impact of COVID-19 should be reported in all applicable areas of the Project Narrative.
- Table 3: Patient Capacity was updated to include Vision Services.

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, MPH
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; complete and confirm the Contact Verification screen; select Health Center, Look-Alike, Look-Alike Annual Certification; then describe your issue)

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

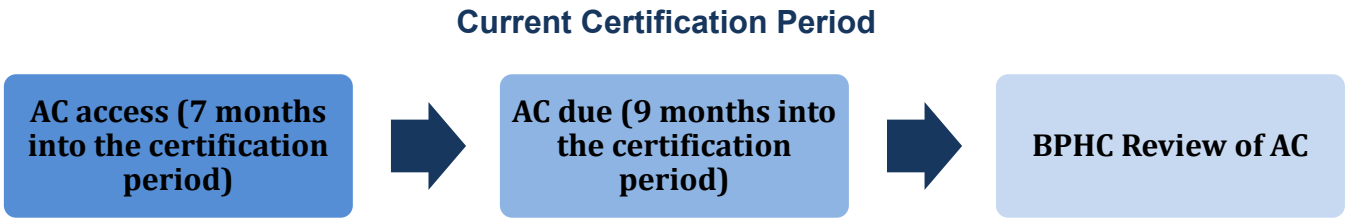
Information

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 2: Submission Components identifies the required AC components. In the Form Type column of Table 2, 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 2: 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, and the Budget Narrative 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 and are only provided for reference only. If any information is incorrect in these forms, submit your request for change via the Scope Adjustment or Change in Scope (CIS) Modules in HRSA EHBs. Contact your Project Officer for guidance.
Project Narrative Update	Form	Refer to Section III for instructions.

III. Instructions for the Project Narrative Update

The Project Narrative Update includes two Key Areas (Organizational Capacity and Patient Capacity) that require narrative reporting (see below). The narrative for each section should address the following:

Project Narrative Update Areas

Each of the two key areas requires a narrative response, and each response section is limited to 2,000 characters, or approximately 1.5 pages.

1. **Organizational Capacity:** Discuss current major changes, since the last certification period, in the organization's capacity that have impacted or may impact the progress of the designated project, including changes in:
    - Staffing, including key vacancies;
    - Operations, including changes in policies and procedures as they relate to COVID-19; and

- Financial status, including the most current audit findings, as applicable.

2. **Patient Capacity:** See Table 3: Patient Capacity. Discuss trends in unduplicated patients served and report progress in reaching the projected number of patients. In the Patient Capacity Narrative column, explain negative trends or limited progress toward the projected number of patients and plans for achievement.

TABLE 3: PATIENT CAPACITY

	2017 Patient Number	2018 Patient Number	2019 Patient Number	% Change 2017-2019 Trend	% Change 2018-2019 Trend	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
Designation Period: (Pre-populated from most recent Notice of Look-Alike Designation)								
Total Unduplicated Patients	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the most recent LAL application	2,000 character limit
Total Migratory and Seasonal Agricultural Worker Patients	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the most recent LAL application	2,000 character limit
Total People Experiencing Homelessness Patients	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the most recent LAL application	2,000 character limit
Total Public Housing Resident Patients	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the most recent LAL application	2,000 character limit

Notes:
- 2017 – 2019 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.

	2017 Patient Number	2018 Patient Number	2019 Patient Number	% Change 2017-2019 Trend	% Change 2018-2019 Trend	% Progress Toward Goal	Projected Number of Patients	Patient Capacity Narrative
Designation Period: (Pre-populated from most recent Notice of Look-Alike Designation)								
Total Medical Services Patients	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the most recent LAL application	2,000 character limit
Total Dental Services Patients	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the most recent LAL application	2,000 character limit
Total Mental Health Services Patients	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the most recent LAL application	2,000 character limit
Total Substance Use Disorder Services Patients	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the most recent LAL application	2,000 character limit
Total Vision Services	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	N/A*	2,000 character limit
Total Enabling Services Patients	Pre-populated from 2017 UDS	Pre-populated from 2018 UDS	Pre-populated from 2019 UDS	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the most recent LAL application	2,000 character limit

Notes:
- 2017-2019 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.
- (*) The Vision Services category was recently added to the RD, therefore, there is no Projected Number of Patients data available at this time.

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).[1]

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 Costs: 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. 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).

[1] 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. Note that items such as laptops, tablets and desktop computers are classified as a supply if the value is under the $5,000 equipment threshold.

Contractual/Consultant: Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Provide the basis for your cost estimate for the contract rather than line item details. 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. In the budget narrative, 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. 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 are classified as patient service revenue. 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.

Only include patient service revenue associated with sites or services in the approved scope of project. Do not include patient services revenue for sites or services not in the approved scope of project or pending HRSA approval.

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.[2] The value is typically based on assumptions about the amount of available clinician time, average visit time (based on complexity of patient conditions and use of team provider arrangements), and types of billable visits by payer. There may be other exclusions or additions, which, if significant, should be noted in Comment/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column. (See Ancillary Instructions below.)

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, basing it on historical experience. 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.

[2] 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 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. The estimated visits associated with these managed care plans are entered in Column (b).

Payer Categories (Lines 1 – 5): The five payer categories including Medicaid, Medicare, Other Public, Private, and Self-Pay, reflecting 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 (payer billed first). Income is classified by the payer groupings where the income is earned. 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, incentives, 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, risk pool distributions, performance incentives, and case management fee income.

Other Public (Line 3): Income not reported elsewhere from federal, state, or local government programs earned for providing services. 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. 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. Private insurance is earned or paid for by the beneficiary and other public insurance is unearned or based upon meeting the plan's eligibility criteria.

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. This includes other federal, state, local, and other income. This section includes income that is earned but not directly tied to providing visits, procedures, or other specific services. Income is to be classified on the lines below based upon the source from whom the revenue is received. Income from services provided to non-health center patients either in-house or under contract with another entity such as a hospital, nursing home, or other health center is to be reported in Part 2: Other Income (see examples below). This would include income from in-house retail pharmacy sales to individuals who are not patients of the health center.

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 does not include federal funds awarded through intermediaries (see Line 9 below). 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. The CMS Medicare and Medicaid 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; 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, and similar awards. For example: (1) a health center that contracts 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 who in turn make awards to provider organizations. Consequently, Ryan White Part A funding would be classified as income earned from a local government and be shown on this line.

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, a health center operating a 340B pharmacy in part for its own patients and in part, as a contractor to another health center is to report the pharmacy income for your own patients in Part 1 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 applicant funds (retained earnings) are needed to achieve a breakeven budget. Amounts from non-federal sources, combined with the Health Center Program funds should be adequate to support normal operations.

Total Other (Line 14): The sum of lines 7 to 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

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