



# Program-Specific Forms Instructions

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**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 [LAL RD 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 (\*).

## Form 1A: General Information Worksheet

### 1. Applicant Information

- Complete all relevant information that is not pre-populated.
- Enter the Fiscal Year End Date field to note the month and day in which your organization's fiscal year ends (e.g., December 31) to help HRSA know when to expect the audit submission in the Federal Audit Clearinghouse, available at <https://harvester.census.gov/facweb/default.aspx/>.
- 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

- You must continue to serve a defined geographic area that is currently federally designated, in whole or in part, as a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP). The exception to this requirement is an application with designation for the sole service of special populations (e.g., MHC, HCH, and/or PHPC).
- 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 <http://www.hrsa.gov/shortage> or email [sdb@hrsa.gov](mailto: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 population, 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](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 interaction between a patient and a licensed or credentialed provider who exercises independent judgment in providing services. To be included as a visit, services rendered must be paid for by your organization (Form 5A: Services Provided, Columns I and/or II) and documented in a chart that stays in the possession of the health center.
- A patient is an individual who had at least one visit in 2017 (current data), or is projected to have at least one visit in 2020 (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 LAL service sites in the designated project.
- Baseline patient data will pre-populate from the most recent UDS. If UDS data does not accurately reflect current numbers (e.g., due to change in scope or shifting service area characteristics such as influx of new populations), indicate the accurate current data and describe the discrepancy between UDS and current data in the NEED section of the Project Narrative.
- Do not report patients and visits for services outside of the LAL scope of project. Specifically, the scope of project defines the service sites, providers, service area, and target population for which look-alike designation may be applicable. For more information, see PIN 2008-01 [Defining Scope of Project and Policy for Requesting Changes](#) and other [Scope of Project](#) documents.

**Unduplicated Patients and Visits by Population Type:** The population types in this section do NOT refer only to the requested designation categories (i.e., CHC, MHC, HCH, and/or PHPC). For example, if you are a LAL designated for only CHC (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, Public Housing Residents, 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 the last year of the three-year designation period. This value will pre-populate in the corresponding cell within the table below..
2. Current patients will pre-populate from the most recent 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 services outside the proposed scope of project.

Refer to the Scope of Project policy documents. **Across all population type categories, an individual can only be counted once as a patient.**

3. The total number of unduplicated patients projected by the end of the 3-year designation period will pre-populate from Item 1 above. Project the **total** number of visits by the end of the three-year designation period, 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.** Refer to the Scope of Project policy documents

***Patients and Visits by Service Type:***

1. Current patients and visits for each service type category will pre-populate from the most recent UDS data.
2. Project the number of patients and visits anticipated within each service type category by the end of the 3-year designation period. **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).
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 certification 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 patient services and other income from all sources for the **first year** of the proposed designation period. Form 3 income is divided into two parts: (1) Patient Service Revenue - Program Income and (2) Other Income - Other Federal, State, Local, and Other Income.

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

Patient service revenue is income directly tied to the provision of services to the health center's patients. 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 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 service 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.<sup>1</sup> 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 the 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 that do not generate

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<sup>1</sup> These visits will correspond closely with the visits reported on the [UDS Manual](#) Table 5, excluding enabling service visits.

reportable visits, such as income from laboratory or pharmacy services, capitated-managed care, performance incentives, wrap payments, and cost report settlements. You may 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.

**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):** There are 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 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. An example of this is the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program.

**Private (Line 4):** Income from private insurance plans, managed care plans, and other private contracts for service. 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. 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 – Other 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.

**Other Federal (Line 7):** Income from direct federal funds (where your organization is the recipient of a NoA 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), and Department of Health and Human Service funding under the Ryan White HIV/AIDS Program Part C. The CMS Medicare and Medicaid EHR incentive program income is reported here in order 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 is to report all the income earned under this contract on this line, and (2) Ryan White Part A funds are federal funds awarded to 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 its 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 fund raising.

**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.

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

## [\\*](#) **Form 3A: Look-Alike Budget Information**

### **Part 1: Expenses**

For each of the expense categories (personnel, fringe benefits, travel, equipment, supplies, contractual, construction, other, and indirect charges – see the Budget Narrative section for a definition of each expense category), enter the projected expenses for the first year of the proposed new designation period for each Health Center Program type for which you are designated (i.e., CHC, MHC, HCH, PHPC). 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 first year of the proposed new designation 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.

## Form 4: Community Characteristics

Report current service area and target population data. 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 LAL project and include the total number of individuals for each characteristic (percentages will automatically calculate in HRSA EHB). 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 data. Report the number of individuals for each characteristic (percentages will automatically calculate in HRSA EHB). Estimates are acceptable. **Patient data should not be used to report target population data since patients are typically a subset of all individuals targeted for service.**

If the target population includes a large number of transient individuals that are not included in the dataset used for service area data (e.g., census data), adjust the service area numbers accordingly to ensure that the target population numbers are always less than or equal to the service area 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. Information provided regarding race and ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements and will not be used as a designation factor.
- 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 – Person who chooses 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. Count individuals representing multiple special population categories in all applicable categories.

## Forms 5A, 5B, and 5C

**General Notes**

- 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 Scope Adjustment or Change in Scope request submitted in HRSA EHB. If the pre-populated data do not reflect recently approved scope changes, click the **Refresh from Scope** button in the HRSA EHB to display the latest scope of project.

- 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).

Data will pre-populate from your official scope of project. Services identified elsewhere in the application (e.g., Project Narrative) that are not identified on Form 5A will not be considered to be in the approved scope of project.

**NOTE:** *If your organization has a pending Scope Adjustment or Change in Scope application to add a service, it will not be included in Form 5A until the Scope Adjustment or Change in Scope has been approved.*

## 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 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.

## Form 5B: Service Sites

Data will pre-populate from your official scope of project. Sites identified elsewhere in the application (e.g., Project Narrative) and not identified on Form 5B will not be considered to be in the approved scope of project.

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

Data will pre-populate from your official scope of project. This form includes activities/locations that: 1) do not meet the definition of a service site; 2) are conducted

on an irregular timeframe/schedule; and/or 3) offer a limited activity from within the full complement of health center activities included within the scope of project. Refer to PIN 2008-01: [Defining Scope of Project and Policy for Requesting Changes](#) for more details.

## \* Form 6A: Current Board Member Characteristics

The list of board members will be pre-populated from your last LAL submission. **Update pre-populated information as appropriate.**<sup>2</sup> Public centers with co-applicant health center governing boards must list the co-applicant board members.

- 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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<sup>2</sup> Refer to [Chapter 20: Board Composition of the Compliance Manual](#).

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

- If you currently receive or are applying to receive CHC designation, you are not eligible for a waiver and cannot enter information.
- Indian tribes or tribal, Indian, or urban Indian groups are not required to complete this form and cannot enter information.
- If you wish to continue an existing waiver, you must complete this form.
- When requesting a waiver, 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 (migratory and seasonal agricultural workers advocate, former homeless individual, current resident of public housing) 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 three 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) any current or proposed agreements that will constitute a substantial portion of the proposed scope of project, including a proposed site to be operated by a contractor, as identified in Form 5B: Service Sites.

Refer to [Uniform Guidance 2 CFR part 200 as codified by HHS at 45 CFR part 75](#) for the definition of “substantial” and characteristics of a contractor agreement. If there are

current/proposed agreements that will constitute a substantial portion of the project, indicate the number of each type in the appropriate field and attach the complete agreements in Part II.

Note: Items attached to Form 8 will **not** count against the page limit; however, documents included in Attachment 12 **will** count against the page limit.

## Form 12: Organization Contacts

As necessary, revise the pre-populated data.

## Scope Certification Form

This form requires two certifications. First, certify that the scope of project for services (including service delivery methods) is accurate, as presented on Form 5A: Services Provided in the RD application. Second, certify that the scope of project for sites is accurate, as presented on Form 5B: Service Sites in the RD application. **If you cannot certify the accuracy of Form 5A and/or Form 5B, you must certify that you have submitted a Change in Scope (CIS) request to HRSA to correct the presented information.**

### **120 Day Compliance Achievement Plan Certification (As Applicable)**

Certify that if your organization is funded and is noncompliant with any Health Center Program requirements, within 120 days of receipt of your Notice of Look-Alike Designation (NLD), 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 NLD.