Health Center Program Site Visit Protocol:

Consolidated Documents Checklist

Last updated: April 13, 2023
Technical Revision: March 20, 2025

NOTE: This resource complements the Site Visit Protocol (SVP), which is the primary tool for assessing compliance with Health Center Program requirements during Operational Site Visits (OSVs). Refer to the Health Center Program Compliance Manual as the principal resource to assist health centers in understanding and demonstrating compliance with Health Center Program requirements and the SVP for complete guidance on OSVs.

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NEEDS ASSESSMENT

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Service area reports or analysis documentation.
- Most recent needs assessment and documentation (for example, studies, resources, reports) used to develop the needs assessment.

REQUIRED AND ADDITIONAL HEALTH SERVICES

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Sample of key health center documents translated for patients with limited English proficiency (for example, forms and materials used to assess eligibility for the health center's sliding fee discount program, intake forms for clinical services, instructions for accessing after-hours services).
- **FORM 5A, COLUMN I:**
    - For services delivered via **Column I** of the health center's current Form 5A:
        - A list of Form 5B service sites to be toured. Select sites where a variety of **Column I** services are provided.
        - If the health center has more than one service site, the list must include at least two health center service sites.
    - If a **Column I** service cannot be verified through a site tour: Documentation of service provision in a current patient record.[1]
      Note: *Use live navigation of the Electronic Health Record (EHR), screenshots from the EHR, or other patient record formats.*
- **FORM 5A, COLUMN II:** For services delivered via **Column II (whether or not the service is also delivered via Column I and/or Column III):**
    - For health centers with **Column II** services that occur at any locations that are not Form 5B service sites: Health center internal procedures that address how information in patient health center records is documented (for example, lab results, x-ray results).
    - *Contracts/Agreements:*
        - **At least one but no more than three** written contracts/agreements for EACH Required and EACH Additional Service: For any required or additional service noted as a **Column II** service on Form 5A, at least one written contract. If there is more than one contract for the same service, each contract would be included in the sample, up to a maximum of three contracts. For example:
            - Primary Care Services is listed in **Column II**. The health center maintains four separate contracts for individual contracted

[1] Health centers may choose to provide samples of patient records before or during the site visit. If patient records will be provided during the site visit, this should be communicated to the site visit team before the site visit to avoid any disruption or delay in the site visit process.

providers. The sample would include a maximum of three of these contracts for Primary Care Services.
        - Preventive Dental is listed in **Column II**. The health center maintains one contract for its preventive dental services. The sample would include one contract for Preventive Dental.
    - To assist in the review, the health center should flag all relevant provisions within contracts/agreements related to:
        - How the service will be documented in the patient's health center record; and
        - How the health center will pay for the service.

    Note: *Use the same sample of contracts/agreements for the review of Required and Additional Health Services*, *Clinical Staffing, and Sliding Fee Discount Program. The sampling methodologies for Required and Additional Health Services* are different from *Contracts and Subawards* and *Conflict of Interest, even though they may result in some overlap in the contracts/agreements reviewed.*
  - *Patient Records:*
    - Based on three Required Services and two Additional Services: A total of three to five health center patient records for patients who have received required and additional health services in the past 24 months from contracted providers or contracted organizations.
        - If the same patient has received more than one of these services, the same record can be used for assessing those services.
        - If a health center delivers services through subrecipient agreements:
            - For a health center with five or fewer subrecipients, select a total of three to five patient records from each subrecipient.
            - For a health center with more than five subrecipients, select patient records from the five subrecipients that receive the largest amounts of Health Center Program subaward funds, for a total of three to five patient records from each subrecipient.

    Notes:
    - For **Column II** Services provided by individual contractors who work at a health center Form 5B site, documentation in the patient record of the services provided would occur in the health center's own patient record system.
    - Use live navigation of the EHR, screenshots from the EHR, or other patient record formats.
- **FORM 5A, COLUMN III:** For services delivered via **Column III (whether or not the service is also delivered via Column I and/or Column II):**
  - For health centers with **Column III** services: Health center operating procedures for tracking and managing referred services.

- *Referral Arrangements:*
  - At **least one but no more than three** written referral arrangements for EACH Required and EACH Additional Service: For any required or additional service noted as a **Column III** service on Form 5A, at least one written referral arrangement. If there is more than one referral arrangement for the same service, each written arrangement would be included in the sample, up to a maximum of three written arrangements. For example:
    - Intrapartum Services is listed in **Column III**. The health center maintains four separate arrangements for these services in its service area. The sample would include a maximum of three of these written arrangements for Intrapartum Care Services.
    - Diagnostic Laboratory Services is listed in **Column III**. The health center maintains one referral arrangement with a local hospital to provide these services. The sample would include one written arrangement for Diagnostic Laboratory Services.
  - To assist in the review, the health center should flag all relevant provisions within referral arrangements related to:
    - The manner by which referrals will be made and managed; and
    - The process for tracking and referring patients back to the health center for appropriate follow-up care (for example, exchange of patient record information, receipt of lab results).

    If these provisions are not present within the referral arrangements, provide additional documentation (for example, health center procedures) that contain those provisions.

  Note: *Use the same sample of referral arrangements for the review of Required and Additional Health Services, Clinical Staffing, and Sliding Fee Discount Program.*
- *Patient Records:*
  - Based on three Required Services and two Additional Services: A total of three to five health center patient records for patients who have received required and additional services in the past 24 months from referral providers or referral organizations. Ensure each record clearly documents the patient's entire referral process, from initial referral to receipt of care and follow-up by the health center.
    - If the same patient has received more than one of these services, the same record can be used for assessing those services.

  Note: *Use live navigation of the EHR, screenshots from the EHR, or other patient record formats.*

Note: *Refer to the Sampling Review Resource Guide to help select the samples for Required and Additional Health Services.*

CLINICAL STAFFING

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Credentialing and privileging procedures for licensed independent practitioners (LIP), other licensed or certified practitioners (OLCP), or other clinical staff.
  Note: *Credentialing and privileging procedures may be included in Human Resource procedures.*
- If the health center has a website: The website URL.
- Most recent needs assessment.
- Current clinical staffing profile that lists:
  - Name,
  - Position,
  - FTE,
  - Credential (for example, RN, MD),
  - Hire date,
  - Provider type: LIP, OLCP, or other clinical staff (for example, non-certified medical/dental assistants, community health representatives, case managers),
  - Staff who are bilingual or multilingual.
- Files for current clinical staff that contain credentialing and privileging information: four to five LIP files; four to five OLCP files; and, if the health center has other clinical staff, two to three files for those other clinical staff. For the selected files, include:
  - Representation from different clinical disciplines and service sites.
  - Employees, contractors, and volunteers.
  - Providers who do procedures beyond core privileges for their clinical disciplines.
  - Providers who have been initially credentialed.
  - Providers who have been re-credentialed/re-privileged.
- Any contracts or agreements with outside entities, such as Credentialing Verification Organizations (CVOs), that perform credentialing functions (such as primary source verification).
- If clinical services are provided via **Column II or III**:
  - **No more than three** written contracts/agreements with provider organizations. Prioritize contracts for any clinical services that are only offered via **Column II**.
  - **No more than three** written referral arrangements. Prioritize referral arrangements for any clinical services that are only offered via **Column III**.
  - Any additional documentation showing the health center has ensured credentialing and privileging of the contracted and referral providers. For example, documentation showing the health center has reviewed:
    - The contracted organization's credentialing and privileging processes for

providers, such as physicians, pharmacists, and dentists;
- The contracted organization's documentation from a nationally recognized accreditation organization; or
- The contracted laboratory's documentation of Clinical Laboratory Improvement Amendments (CLIA) compliance.

Notes:

- Select contracts and referral arrangements that support clinical services (for example, general primary medical care, preventive dental). HRSA recognizes that contracts or referral arrangements for enabling services (for example, transportation, translation, outreach) may not contain provisions for credentialing and privileging.
- Use the same sample of contracts/agreements and referral arrangements for the review of Required and Additional Health Services, Clinical Staffing, and Sliding Fee Discount Program.
- The sampling methodologies for Clinical Staffing are different from Contracts and Subawards and Conflict of Interest, even though they may result in some overlap in the contracts/agreements reviewed.

ACCESSIBLE LOCATIONS AND HOURS OF OPERATION

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- List of health center sites with the following information for each site:
  - Address
  - Hours of operation
  - Services offered (for example, medical, oral health, behavioral health).
- Health Center Program GeoCare Navigator Map (if updated since last application submission to HRSA).
- Patient satisfaction surveys or other forms of patient input.
- Most recent needs assessment or related studies or resources.

COVERAGE FOR MEDICAL EMERGENCIES DURING AND AFTER HOURS

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Operating procedures for addressing medical emergencies during health center's hours of operation.
- Operating procedures for responding to patient medical emergencies after hours.
- Staffing schedules for up to five service delivery sites that identify at least one individual with current certification in basic life support at each site. Include a copy of those individuals' current certifications (for example, credentialing file for licensed independent practitioner or other licensed or certified practitioner, certification of training if non-clinical staff).
- If the health center uses its providers for after-hours coverage: Health center provider on-call schedules.
- If the health center uses non-health center providers for after-hours coverage: After-hours written arrangements with non-health center providers/entities (for example, formal agreements with other community providers, nurse call lines).
- Information provided to patients for accessing after-hours coverage.
- Three samples of after-hours clinical advice documentation in patient records.[1] Include associated documentation of follow-up.
  Notes:
  - Select a sample based on after-hours calls that necessitated follow-up by the health center. If the health center has fewer than three after-hours calls that required follow-up, make up the difference with after-hours call documentation that did not require follow-up.
  - Use live navigation of the Electronic Health Record (EHR), screenshots from the EHR, or other patient record formats.
- Procedures for tracking, recording, and storing of after-hours coverage interactions and any follow-up (for example, log of patient calls).
  Note: *Alternatively, a health center can use live navigation of its system.*

[1] Health centers may choose to provide samples of patient records before or during the site visit. If patient records will be provided during the site visit, this should be communicated to the site visit team before the site visit to avoid any disruption or delay in the site visit process.

CONTINUITY OF CARE AND HOSPITAL ADMITTING

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Health center's internal operating procedures and documentation of any arrangements with non-health center providers or entities for tracking of patient hospitalization and continuity of care.
- Documentation of EITHER:
    - Health center provider hospital admitting privileges (for example, hospital staff membership, provider employee contracts) that address delivery of care in a hospital setting to health center patients; OR
    - All formal arrangements that address health center patient hospital admissions (for example, provisions in hospitalist contract, transfer agreements, supporting procedures, or other documentation of inpatient care coordination with the health center).
- Sample of 5–10 health center patient records[1] for patients who were hospitalized or who had Emergency Department (ED) visits within the past 12 months. Ensure each record clearly documents the health center's entire hospitalization tracking process, from admission and follow-up through closure.
  Note: *Use live navigation of the Electronic Health Record (EHR), screenshots from the EHR, or other patient record formats.*

[1] Health centers may choose to provide samples of patient records before or during the site visit. If patient records will be provided during the site visit, this should be communicated to the site visit team before the site visit to avoid any disruption or delay in the site visit process.

SLIDING FEE DISCOUNT PROGRAM

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Sliding fee discount program (SFDP) policies.
- SFDP procedures.
- Sliding fee discount schedule (SFDS), including any SFDSs that differ by service or service delivery method.
- Any related policies, procedures, forms, and materials that support the SFDP (for example, registration and scheduling, financial eligibility, screening, enrollment, patient notifications, billing, and collections).
- For health centers that choose to have a nominal charge for patients with incomes at or below 100 percent of the FPG:
    - Documentation that the nominal charge was set at a level that would be nominal from the perspective of patients with incomes at or below 100 percent of the FPG. For example, based on input from patient board members, patient surveys, advisory committees, or a review of co-pay amounts associated with Medicare and Medicaid for patients with comparable incomes.
    - Documentation that shows each nominal charge does not reflect the actual cost of the service being provided.
    - If the board-approved SFDP policy does not state a specific amount for each nominal charge or how each nominal charge is determined: Other documentation of board involvement in setting the amount of each nominal charge (for example, board minutes, reports).
- Sample of 5–10 records, files, or other forms of documentation of patient income and family size. Ensure the sample includes records for:
    - Uninsured and insured patients; and
    - Initial assessments for income and family size as well as re-assessments.
- For any service delivered via **Column II (whether or not the service is also delivered via Column I and/or Column III)**: At least one but no more than three written contracts/agreements for EACH Required and EACH Additional Service. Provide any other supporting documentation showing how the health center ensures sliding fee discounts for those selected services.
  Note: *Use the same sample of contracts/agreements for the review of Required and Additional Health Services, Clinical Staffing, and Sliding Fee Discount Program. The sampling methodologies for Sliding Fee Discount Program are different from Contracts and Subawards and Conflict of Interest, even though they may result in some overlap in the contracts/agreements reviewed.*

- For any service delivered via **Column III (whether or not the service is also delivered via Column I and/or Column II)**: At least one but no more than three written referral arrangements for EACH Required and EACH Additional Service. Provide any other supporting documentation showing how the health center ensures sliding fee discounts for those selected services.
  Note: *Use the same sample of referral arrangements for the review of Required and Additional Health Services, Clinical Staffing, and Sliding Fee Discount Program.*
- If the health center is subject to legal or contractual restrictions applicable to sliding fee discounts for patients with third-party coverage: Documentation of such restrictions.
- Data, reports, or any other relevant materials used to evaluate the SFDP.

QUALITY IMPROVEMENT/ASSURANCE

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Policies that establish the Quality Improvement/Quality Assurance (QI/QA) program.
- QI/QA-related operating procedures or processes that address:
    - Clinical guidelines, standards of care, and standards of practice;
    - Patient safety and adverse events, including implementation of follow-up actions;
    - Patient satisfaction;
    - Patient grievances;
    - Periodic QI/QA assessments; and
    - QI/QA report generation and oversight.
- Job or position descriptions of individuals who oversee the QI/QA program.
- Sample of patient satisfaction results.
- Documentation of any related systems that support QI/QA (for example, event reporting system, tracking resolutions and grievances, dashboards).
- QI/QA assessment schedule or calendar.
- Sample of two QI/QA assessments from the past 12 months and any related reports resulting from these assessments.
- Sample of 5–10 health center patient records[1] that include clinic visit notes or summary of care.
  Notes:
    - The same sample of patient records used for reviewing other program requirement areas may also be used for this sample.
    - Use live navigation of the Electronic Health Record (EHR), screenshots from the EHR, or other patient record formats.
- Systems (for example, certified EHRs) and record-keeping procedures for maintaining and monitoring the confidentiality, privacy, and security of protected health information (PHI).

[1] Health centers may choose to provide samples of patient records before or during the site visit. If patient records will be provided during the site visit, this should be communicated to the site visit team before the site visit to avoid any disruption or delay in the site visit process.

KEY MANAGEMENT STAFF

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Health center organization charts with names and titles of key management staff (if updated since last application submission to HRSA).
- Position descriptions of key management staff (if updated since last application submission to HRSA).
- Any contracts for key management staff.
- If the health center has key management staff vacancies:
    - Human Resources procedures relevant to recruiting and hiring of key management staff.
    - Documentation associated with filling key management staff vacancies (for example, job advertisements or revised position descriptions).
- Project Director/CEO employment agreement.
- Project Director/CEO's W-2 or, if a W-2 has not yet been issued, documentation of receipt of salary directly from the health center (for example, pay stub).
- Any additional documentation of key management reporting structures.
- If the health center has a co-applicant: Co-applicant agreement (if updated since last application submission to HRSA).
- If the current Project Director/CEO has changed *since the start of the current period of performance*:
    - The Notice of Award (NOA)/Notice of Look-Alike Designation (NLD) approving the current Project Director/CEO; OR
    - If the prior approval request for the current Project Director/CEO is still under review by HRSA, the documentation of the request.

CONTRACTS AND SUBAWARDS

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

Contracts: Procurement and Monitoring

- Policies or procedures for purchasing, procurement, and contract management.
- Provide a complete list of health center contracts that support the HRSA-approved scope of project, including contracts for health center clinical services or other goods and services (for example, tech support, janitorial, payroll). Specifically, include all active contracts and all contracts that had a period of performance that ended less than 3 years ago. In the list, include all of the following information for each contract:
    - Whether the health center uses federal award funds to pay in whole or in part for the contract (not applicable to look-alikes);
    - Contractor/contract organization;
    - Value of the contract (if there is a federal share, state the federal share amount);
    - Brief description of the goods or services provided;
    - Period of performance/timeframe (for example, ongoing contractual relationship, specific duration); and
    - Whether the contract supports substantive programmatic work.[1]
- Based on the list of contracts that support the HRSA-approved scope of project:
    - Five contracts AND related supporting procurement documentation for actions that **use federal award funds.** Choose the contracts that use the largest amounts of federal award funds.
      Note: *Use the same sample of contracts/agreements for the review of both Contracts and Subawards and Conflict of Interest. The sampling methodologies for Contracts and Subawards are different from Required and Additional Health Services, Clinical Staffing, and Sliding Fee Discount Program, even though they may result in some overlap in the contracts/agreements reviewed.*
    - Sample of five contracts that **do NOT use federal award funds**.
- From the sample of selected contractors: Two to three reports or records of the contractor's health center-related activities. For example, monthly invoices or billing reports, data on patients served or visits provided.

[1] For the purposes of the Health Center Program, contracting for substantive programmatic work applies to contracting with a single entity for the majority of health care providers. The acquisition of supplies, material, equipment, or general support services is not considered programmatic work. Substantive programmatic work may be further defined within HRSA Notices of Funding Opportunity (NOFOs) and applications.

- Documentation of HRSA prior approval for any contracts for the performance of substantive programmatic work (i.e., contracting with a single entity for the majority of health care providers) under the federal award.

Subawards: Monitoring and Management

ONLY APPLICABLE FOR AWARDEES WITH AT LEAST ONE SUBRECIPIENT

NOT APPLICABLE TO LOOK-ALIKES

- Most recent annual audit and management letter.
- Policies or procedures for subrecipient monitoring.
- All subrecipient agreements (if updated since last application submission to HRSA) that support the awardee's HRSA-approved Health Center Program scope of project.
  Note: *Per 45 CFR 75.351(c), "In determining whether an agreement between a pass-through entity [(Health Center Program awardee)] and another non-federal entity casts the latter as a subrecipient or a contractor, the substance of the relationship is more important than the form of the agreement. All of the characteristics listed above [(see 45 CFR 75.351(a) and (b))] may not be present in all cases, and the pass-through entity [(Health Center Program awardee)] must use judgment in classifying each agreement as a subaward or a procurement contract."*
- Documentation of HRSA prior approval of subrecipient arrangements.

NOTE: *For a health center with five or fewer subrecipients, provide the following documentation from all subrecipients. For a health center with more than five subrecipients, provide the documentation from the five subrecipients that receive the largest amounts of Health Center Program subaward funds.*

- Sample of financial and performance reports from within the current period of performance from the subrecipient, including the subrecipient's annual audit.
- Documentation of subrecipient monitoring by the health center through audits, on-site reviews, and other means, that occurred during the current period of performance.
- If there have been subrecipient deficiencies identified by the health center through its monitoring process: Documentation ensuring that the subrecipient took corrective action.
- The following documentation used by the health center to confirm subrecipient compliance:
  - Subrecipient articles of incorporation, bylaws (either for the subrecipient's board or the co-applicant board of a public agency subrecipient), or other corporate documents (for example, co-applicant agreement);
  - Subrecipient sliding fee discount program (SFDP) policy;
    - If the subrecipient board-approved SFDP policy does not state a specific amount for each nominal charge or how each nominal charge is determined: Other documentation (for example, subrecipient board

minutes, subrecipient reports) of subrecipient board involvement in setting the amount of each nominal charge;

- Current subrecipient board roster or completed Form 6A indicating current board member characteristics as follows:
  - For all board members: patient status, area of expertise, and percentage income from the healthcare industry; and
  - For patient board members: sex, race, and ethnicity;
- Subrecipient billing records from within the past 24 months to confirm the patient status of subrecipient board members; and
- Subrecipient's portion of the Uniform Data System (UDS) data for an overview of subrecipient patient population demographic factors (race, ethnicity, and sex).

CONFLICT OF INTEREST

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Two most recent annual audits and management letters.
- Documents containing the health center's standards of conduct (for example, articles of incorporation, bylaws, board manual, employee manual, policies and procedures, disclosure forms).
- For contracts that support the HRSA-approved scope of project:
    - Five contracts AND related supporting procurement documentation for actions that **use federal award funds.** Choose the contracts that use the largest amounts of federal award funds.

  Note: *Use the same sample of contracts/agreements for the review of both Contracts and Subawards and Conflict of Interest. The sampling methodologies for Conflict of Interest are different from Required and Additional Health Services, Clinical Staffing, and Sliding Fee Discount Program, even though they may result in some overlap in the contracts/agreements reviewed.*
- Agreements with any parent corporation, affiliate, subsidiary, or subrecipient organizations.
- For look-alikes that have parent, affiliate, or subsidiary organizations that are not a state, local government, or Indian tribe:
    - Five contracts AND related supporting procurement documentation for procurements involving the related parent, affiliate, or subsidiary organizations.

  Note: *Contracts in the sample are either active or have a period of performance which ended less than 3 years ago.*
- If a real or apparent conflict of interest was identified in a procurement action that occurred within the last 3 years: All related written disclosures that were completed by employees, officers, board members, and agents of the health center (for example, board minutes documenting disclosures, standard forms to report disclosures).

COLLABORATIVE RELATIONSHIPS

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- Documentation of established collaboration with other providers and organizations in the health center service area to provide access to services not available through the health center, including:
    - Local hospitals;
    - Specialty providers;
    - Social service organizations; and
    - Organizations that serve special populations.

  Examples of documentation may include memoranda of agreement (MOAs), memoranda of understanding (MOUs), letters, evidence of membership in a city-wide community health planning council, or evidence of participation in an emergency room diversion program.
- Documentation of coordination with other federally-funded, as well as state and local, health services delivery projects and programs serving similar patient populations in the service area.
    - If coordination is not established, documentation of efforts to establish coordination.
    - Documentation must include one or more health centers in the service area.
    - Examples of documentation may include minutes or agendas from meetings, emails, or other correspondence.
- Health Center Program GeoCare Navigator Map documentation showing other health centers with sites in the service area.

FINANCIAL MANAGEMENT AND ACCOUNTING SYSTEMS

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Two most recent annual audits and management letters.
- Financial management, accounting, and internal control procedures. These procedures may be in the form of financial/accounting policies, manuals, or other related documents.
- Procedures for drawdown, disbursement, and expenditure of federal award funds. These procedures may be separate or part of the financial management and internal control procedures.
- Policies or procedures that govern and track the use of non-grant funds.
- Any manuals or documentation that support the financial management system used by the health center (for example, financial accounting software, practice management system).
  Note: *Some or all of the financial management system may be contracted out or carried out via a Health Center Controlled Network.*
- Two financial reports selected from the past 6 months that were provided to the board and key management staff.
- The most recent interim financial statement.
- Aged Accounts Receivable, as of most recent interim financial statement.
- Aged Accounts Payable, as of most recent interim financial statement.
- Sample of source documentation for expenditures made under the federal Health Center Program award for the last quarter:
  - Drawdowns under the Health Center Program award with supporting documentation (for example, financial records, receipts, invoices);
  - Last non-payroll drawdown under the Health Center Program award with supporting documentation;
  - If there was a capital-related Health Center Program award drawdown within the last 3 years, the last capital drawdown with supporting documentation; and
  - Copy of the journal entry that records these drawdowns in the general ledger under the Health Center Program award.

BILLING AND COLLECTIONS

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Current fee schedule for each service (for example, medical, dental, behavioral health).
- Data used to develop and update fee schedules based on health center costs and locally prevailing rates. For example, operating costs for service delivery, relative value units (RVUs) or other relevant data sources, Medicare and Medicaid cost reports.
- Sliding fee discount schedule (SFDS), including any SFDSs that differ by service or service delivery method.
- List of provider, program, or site billing numbers for Medicaid, CHIP, Medicare, or any other documentation of participation (for example, individual provider NPIs).
- Documentation of participation in any other public or private program or health insurance plans (for example, list or copy of third-party payor contracts including any managed care contracts).
- Billing and Collections policies or procedures and systems, including:
    - Provisions to waive or reduce fees owed by patients;
    - Third-party payor billing procedures and contracts;
    - Any policies on patients' refusal to pay; and
    - Procedures for notifying patients of any additional costs for supplies and equipment related to but not included in the service.
- Contracts with any outside organizations that conduct billing or collections on behalf of the health center.
- Eligibility, outreach, and enrollment procedures (for example, new patient registration and screening procedures).
- Current data on the following revenue cycle management metrics, if available:
    - Collection ratios;
    - Bad debt write-off as a percentage of total billing;
    - Collections per visit;
    - Charges per visit;
    - Percentage of accounts receivable (A/R) less than 120 days; and
    - Days in A/R (for context on billing and collections efforts).
- Sample of at least 21 claims submissions and resubmissions to the health center's major third-party payors:
    - Randomly choose 7 claims submissions and resubmissions for patient visits from across at least 3 unique services (for example, routine primary care, preventive dental, behavioral health, obstetrics); and
    - Within this sample, include at least 7 rejected claims.

- Report showing the last 6 months of claims data, specifically: the average filing time for the last 6 months of claims as well as the individual claims numbers, dates of service, dates claims were first billed, and filing times.
- Sample of at least 15 billing and payment records related to the health center's charges to patients:
    - Randomly choose 5 records for patient visits from across at least 3 unique services (for example, routine primary care, preventive dental, behavioral health, obstetrics);
    - Ensure the sample includes patients with incomes at or below 200 percent of the Federal Poverty Guidelines (FPG); and
    - If the health center has patients with incomes above 200 percent of the FPG include records for those patients.
- Sample of two to three billing records where patient fees or payments were waived or reduced.
- Documentation of methods for notifying patients of any additional costs for supplies and equipment related to but not included in the service.
- If the health center has a refusal to pay policy: Documentation of any cases in the past 24 months when the health center applied this policy.

BUDGET

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Updated annual budget for the health center project (if updated since last application submission to HRSA).
- Budget to actual comparison report for the current fiscal year.
- Budget to actual comparison report for the prior fiscal year.
- For context and background on budget development process: Financial management procedures.
- As a reference for any other lines of business: Most recent annual audit and management letter or audited financial statements.
- If the health center has an organizational budget that is separate from the health center project budget: All separate organizational budgets for the current fiscal year.

PROGRAM MONITORING AND DATA REPORTING SYSTEMS

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- One to two data-based reports generated by the health center for the governing board or key management staff from the past 12 months. For example, dashboards, board packets, reports provided to the Finance or Quality Improvement Committee, routine reports generated by the health center for key management staff. The reports must include information on:
    - Patient service utilization;
    - Trends and patterns in the patient population; and
    - Overall health center clinical, financial, or operational performance.

BOARD AUTHORITY

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Health center organization charts with names of key management staff.
- For public agencies or for organizations with a parent or subsidiary: Corporate organization charts.
- Articles of Incorporation.
- Bylaws (if updated since last application submission to HRSA).
- Any additional corporate or governing documents.
- For public agencies with a co-applicant: Co-applicant agreement (if updated since last application submission to HRSA).
- Any agreements with a parent corporation, affiliate, subsidiary, or subrecipient organizations.
- Any collaborative or contractual agreements with outside entities that impact the health center board's authorities or functions.
- Board calendar or other related scheduling documents for the most recent 12 months.
- Board agendas and minutes for:
    - The most recent 12 months.
    - Any other relevant meetings from the past 3 years that demonstrate board authorities were clearly exercised, including approving key policies on:
        - Sliding Fee Discount Program;
        - Quality Improvement/Quality Assurance Program;
        - Billing and Collections, specifically policies for waiving or reducing patient fees and any policies on patients' refusal to pay;
        - Financial Management and Accounting Systems; and
        - Personnel.

  Note: *For look-alike initial designation applicants and newly-funded health centers that do not have 12 months of board agendas and minutes, all of the available board agendas and minutes from within the past 12 months.*
- Sample of board packets from two board meetings that occurred during the most recent 12 months.
- Board committee minutes OR committee documents from the most recent 12 months that support board functions and activities.
- Strategic plan or long-term planning documents from within the past 3 years.
- Position description for the Project Director/CEO.
- Project Director/CEO employment agreement, highlighting the provisions that address Project Director/CEO selection, evaluation, and dismissal or termination.
- Most recent evaluation of Project Director/CEO.

BOARD COMPOSITION

Note: *HRSA provides the documents included in your last application (Service Area Competition (SAC), Renewal of Designation (RD), New Access Point (NAP), or Initial Designation). Health centers do not need to submit these documents again unless the documents changed.*

- Health center organization charts with names of key management staff.
- For public agencies or for organizations with a parent or subsidiary: Corporate organization charts.
- Articles of Incorporation.
- Bylaws (if updated since last application submission to HRSA).
- Any additional corporate or governing documents.
- For public agencies with a co-applicant: Co-applicant agreement (if updated since last application submission to HRSA).
- Updated Form 6A (PDF) or board roster (if board composition has changed since last application submission to HRSA) indicating current board member characteristics as follows:
    - For all board members: patient status, area of expertise, and percentage income from the healthcare industry; and
    - For patient board members: sex, race, and ethnicity.
- Additional documentation about current board member characteristics (for example, applications, bios, disclosure forms).
- Billing records from within the past 24 months that verify board member patient status.
- For health centers with approved waivers: Examples of the use of special populations input (for example, board minutes, board meeting handouts, board packets).

ELIGIBILITY REQUIREMENTS FOR LOOK-ALIKE INITIAL DESIGNATION APPLICANTS

Note: *HRSA provides the documents included in your Initial Designation application. Health centers do not need to submit these documents again unless the documents changed.*

- Patient Services Utilization Report (for example, from the Electronic Health Records (EHR)) from within the past 6 months. Data should include patient demographics, type of services, and how the service was provided (**Column I, II, or III**).
- Five health center patient records[1] that document the provision of various required and additional health services.
  Notes:
  - The same sample of patient records used for reviewing other program requirement areas may also be used for this sample.
  - Use live navigation of the EHR, screenshots from the EHR, or other patient record formats.
- Applicant's current organization charts with names of key management staff.
- For public agencies or for organizations with a parent or subsidiary: Corporate organization charts.
- Project Director/CEO position description.
- Project Director/CEO employment agreement.
- Most recent annual audit and management letter. If audits are not available: Audited financial statements.
- Sample of up to three Medicare or Medicaid claims or other billing documents. The sample should show the organizational entity or unit that conducts the billing.
- Bylaws (if updated since last application submission to HRSA).
- For public agencies with a co-applicant: Co-applicant agreement (if updated since last application submission to HRSA).
- If the applicant has contracts or memoranda of understanding (MOUs) that support the proposed Health Center Program scope of project (i.e., to provide health center services or to acquire other goods and services), provide a complete list of these contracts and MOUs that includes:
  - All active contracts and MOUs;
  - All contracts and MOUs that had a period of performance that ended less than 3 years ago; and

[1] Health centers may choose to provide samples of patient records before or during the site visit. If patient records will be provided during the site visit, this should be communicated to the site visit team before the site visit to avoid any disruption or delay in the site visit process.

    - The following information for each contract and MOU:
        - Contractor or contract/MOU organization;
        - Brief description of all goods and services provided;
        - Period of performance/timeframe (for example, specific duration, ongoing contractual/MOU relationship); and
        - Whether the contract or MOU indicates a third party plays a substantive role in the Health Center Program project (for example, a contract or MOU with a single entity for the majority of: health care providers and services, key management staff, or administrative functions).
- Any and all contracts or MOUs that indicate a third party plays a substantive role in the Health Center Program project (for example, a contract for the majority of health care providers and services, a contract for the majority of key management staff, an administrative services agreement for the majority of administrative functions).
- If the applicant has a parent corporation, affiliate, subsidiary, or other controlling organization: All related agreements or other documentation.
- Documentation (for example, employment contracts) that shows the organization is not owned, operated, or controlled by another entity.