

U.S. Department of Health and Human Services
Health Resources and Services Administration

Bureau of Primary Health Care
Health Center Program

Service Area Competition-Additional Area

Service Area Competition - Additional Area (SAC-AA) – Round Mountain, California and Cheyenne, Wyoming

Announcement Type: Competing Continuation, New, and Supplemental

Announcement Number: HRSA-14-100

Catalog of Federal Domestic Assistance (CFDA) No. 93.224

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2014

Application Due Date in Grants.gov:

September 12, 2013

Supplemental Information Due Date in EHB:

September 26, 2013

Ensure your SAM and Grants.gov registration and passwords are current immediately!

Deadline extensions are not granted for lack of registration.

Registration may take up to one month to complete.

Release Date: August 15, 2013

Issuance Date: August 15, 2013

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Office of Policy and Program Development

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<http://www.hrsa.gov/grants/apply/assistance/sac-aa>

Authority: Public Health Service Act, Section 330, 42 U.S.C. 254b, as amended

EXECUTIVE SUMMARY

This Funding Opportunity Announcement (FOA) details the Service Area Competition-Additional Area (SAC-AA) eligibility requirements, review criteria, and awarding factors for organizations seeking a grant for operational support for an announced service area in fiscal year (FY) 2014 under the Health Center Program, authorized by section 330 of the Public Health Service (PHS) Act, as amended (42 CFR 254b). This includes Community Health Centers (CHC – section 330 (e)), Migrant Health Centers (MHC – section 330 (g)), Health Care for the Homeless (HCH – section 330 (h)), and /or Public Housing Primary Care (PHPC – section 330 (i)).

Eligible Applicants (Refer to [Section III.1](#) for more information.)

Eligible applicants must:

- 1) Be a public or nonprofit private entity, including tribal, faith-based, or community-based organizations; and,
- 2) Be one of the following:
 - Competing Continuation – A current Health Center Program grantee whose project period ends on, or after, October 31, 2013 and before October 1, 2014 that seeks to continue serving its current service area.
 - New – A health center not currently funded through the Health Center Program that seeks to serve an entire announced service area through the proposal of one or more sites.
 - Supplemental – A current Health Center Program grantee that seeks to serve an entire announced service area in addition to its current service area through the proposal of one or more new sites; and,
- 3) Propose to serve a service area and its associated population(s) and patients identified in [Table 6](#).
 - Applicant must propose on Form 1A to serve at least an equivalent number of patients by the end of the project period as listed in [Table 6](#).
 - Applicant must propose on Form 5B the service area zip codes from which at least 75 percent of the current patients come. Applicants may utilize the Patient Origin Map available on the SAC-AA technical assistance site (<http://www.hrsa.gov/grants/apply/assistance/sac-aa>), if applicable, as a resource in determining the zip codes from which the majority of patients originate.
 - Applicant must propose to serve all currently-targeted populations (i.e., CHC, MHC, HCH, PHPC) and maintain the current distribution of funds on the SF-424A as listed in [Table 6](#).

Program Requirements

Refer to [Section I.2: Specific Program Requirements](#) for information on requirements for each health center type (i.e., CHC, MHC, HCH, PHPC). Applicants are expected to demonstrate compliance with the requirements of section 330 of the PHS Act, as amended, and applicable regulations. Program requirements are available at <http://bphc.hrsa.gov/about/requirements>.

Note: Applicants must ensure that all proposed sites located in the service area will be operational within 120 days of the Notice of Award, which may occur up to 60 days prior to the project period start date.

Summary of Changes Compared to the FY 2013 SAC FOA

- The eligibility criteria have been expanded to clarify the requirements for proposed patient numbers, service area zip codes, and target populations.
- The requirements for [Attachment 1](#): Service Area Map and Table have been expanded and direct applicants to use UDS Mapper for maps and accompanying data tables.
- [Attachment 14](#): Implementation Plan is now required for new applicants and current grantees applying to serve a new service area. This plan is designed to outline action steps required for meeting the 120-day operational status requirement.
- The prenatal and perinatal performance measures are now required for all applicants. See [Appendix B](#) for details.
- The childhood immunization and cancer screening performance measures have been updated per Program Assistance Letter 2013-02 available at <http://bphc.hrsa.gov/policiesregulations/policies/pal201302.html>.
- Form 2: Staffing Plan has been updated to include a column to report staff expenses to be charged to the SAC-AA grant (i.e., requested federal dollars).
- Form 3: Income Analysis has been revised to simplify the reporting of projected income.
- Form 6A: Current Board Member Characteristics will be pre-populated and available for edit for current Health Center Program grantees.
- Form 6B: Request for Waiver of Governance Requirements will be not applicable for current grantees receiving CHC (section 330(e)) funding.
- Form 9: Need for Assistance (NFA) Worksheet has been revised to include more current indicators. Core Barriers and Health Indicators have been modified, added, or removed to include the most relevant and current indicators of need for which data are available.
- The Federal Object Class Categories form has been added to capture details on the federal funding request.
- Project period length determining factors have been added, including a stipulation that a current Health Center Program grantee will not be funded if they would be awarded a third, consecutive one-year project period for FY 2014. See [Table 7](#).
- The maximum project period length is three years for all applicants.
- The budget justification must detail the costs of each line item within each object class category from the Federal Object Class Categories form (federal section 330 funding request and non-federal funding). It must also provide detailed information on each staff position to be supported with federal section 330 grant funding. See [Appendix C](#) for details.

Application Submission/Deadlines

HRSA uses a two-tier submission process for SAC-AA applications via Grants.gov and HRSA Electronic Handbooks (EHB).

Phase 1 – Grants.gov: Must be completed and successfully submitted by 11:59 PM ET on September 12, 2013.

Phase 2 – HRSA EHB: Must be completed and successfully submitted by 5:00 PM ET on September 26, 2013.

Pre-Application Technical Assistance Resources

HRSA has posted a pre-application conference call to provide an overview of this FOA at <http://www.hrsa.gov/grants/apply/assistance/sac-aa> . If you have questions after viewing the presentation, contact Katherine McDowell or Vesnier Lugo in the Office of Policy and Program Development at 301-594-4300 or BPHCSAC@hrsa.gov. Refer to <http://www.hrsa.gov/grants/apply> for general (i.e., not SAC-AA-specific) videos and slides on a variety of application and submission components.

Required Registration and Application Procedures

Before an applicant can register in Grants.gov, the organization must be registered in the System for Award Management (SAM) (formerly CCR). See [Section IV](#) for details.

Registration and Phase 1 of the application process in Grants.gov is required. As **registration may take up to a month**, start the process as soon as possible. If the registration process is not completed, an application cannot be submitted. HRSA recommends that applications be submitted in Grants.gov as soon as possible to ensure that maximum time is available for providing the remainder of the application information in HRSA EHB. Visit http://www.grants.gov/applicants/get_registered.jsp or contact the Grants.gov Contact Center at 1-800-518-4726 or support@grants.gov for technical assistance on the registration process. See [Section IV](#) for details.

Registration and Phase 2 of the application process in HRSA EHB is required. For information on registering in HRSA EHB, refer to <http://www.hrsa.gov/grants/apply/userguide.pdf>. Applicants will be able to access EHB approximately seven business days following completing Grants.gov and receipt of a Grants.gov tracking number. **The Authorizing Official (AO) must complete submission of the application in EHB.** Visit <http://www.hrsa.gov/grants/apply> or contact the HRSA Contact Center Monday through Friday, 9:00 a.m. to 5:30 p.m. ET (excluding Federal holidays) at 877-464-4772 or CallCenter@hrsa.gov for technical assistance on the EHB registration process.

Per section 330(k)(3)(H) of the PHS Act, as amended (42 U.S.C. 254b), the health center governing board must approve the health center's annual budget and all grant applications. In addition, the applicant's authorized representative (most often the Executive Director, Program Director, or Board Chair), must electronically submit the SF-424 included in the application package. This form certifies that all application content is true and correct and that the application has been duly reviewed and authorized by the governing board. It also certifies that the applicant will comply with the assurances if a SAC-AA grant is awarded.

The electronic signature in Grants.gov (created when the Grants.gov forms are submitted) is the official signature when applying for a SAC-AA grant and is considered binding. Selection of the responsible person must be consistent with responsibilities authorized by the organization's bylaws. **HRSA requires that for any authorized representative who submits an SF-424 electronically, a copy of the governing board's authorization permitting that individual to submit the application as an official representative must be on file in the applicant's office.**

Application Contacts

If you have questions regarding the FY 2014 SAC-AA application and/or the review process described in this FOA, refer to [Section VII](#) to determine the appropriate agency contact.

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PUBLIC BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 285. Public reporting burden for the applicant for this collection of information is estimated to average 100 hours, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-45, Rockville, Maryland, 20857.

I. Funding Opportunity Description

1. PURPOSE

The Health Resources and Services Administration (HRSA) administers the Health Center Program as authorized by section 330 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254b). Health centers improve the health of the Nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services. Health Center Program grants support a variety of community-based and patient-directed public and private nonprofit organizations that serve an increasing number of the Nation's underserved.

Individually, each health center plays an important role in the goal of ensuring access to services, and combined, they have had a critical impact on the health care status of medically underserved and vulnerable populations throughout the United States and its territories. Targeting the Nation's neediest populations and geographic areas, the Health Center Program currently funds approximately 1,200 health centers that operate nearly 9,000 service delivery sites in every state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. In 2012, more than 21 million patients, including medically underserved and uninsured patients, received comprehensive, culturally competent, quality primary health care services through the Health Center Program.

This Funding Opportunity Announcement (FOA) solicits applications for the Health Center Program's Service Area Competition-Additional Area (SAC-AA). The FOA details the SAC-AA eligibility requirements, review criteria, and awarding factors for organizations seeking a grant for operational support of an announced service area under the Health Center Program, including Community Health Center (CHC – section 330(e)), Migrant Health Center (MHC – section 330(g)), Health Care for the Homeless (HCH – section 330(h)), and/or Public Housing Primary Care (PHPC – section 330(i)). For the purposes of this document, the term "health center" refers to the diverse types of health centers (i.e., CHC, MHC, HCH, and /or PHPC) supported under section 330 of the PHS Act, as amended.

2. BACKGROUND

The SAC-AA application is a competitive request for federal financial assistance to support comprehensive primary health care services for an announced service area (see [Table 6](#)). **All service areas listed in the SAAT are currently served by Health Center Program grantees whose project periods are ending.** It is the intent of HRSA to continue to support health services in these areas given the unmet need inherent in the provision of services to medically underserved populations. Competitive applicants must ensure that services will be available and accessible in a manner that will assure continuity of care to the individuals in the service area.

Note: HRSA will award only one grant for each listed service area.

SPECIFIC PROGRAM REQUIREMENTS

Applicants must document an understanding of the need for primary health care services in the service area and propose a sound plan to meet this need. The plan must ensure the availability and accessibility of essential primary and preventive health services to all individuals in the service area and target population. Further, applicants must demonstrate that the plan maximizes established collaborative and coordinated delivery systems for the provision of health care to the underserved.

Applicants must ensure that all proposed sites located in the service area will be operational within 120 days of the Notice of Award, which may occur up to 60 days prior to the project period start date.

Applicants must demonstrate compliance with the applicable requirements of section 330 of the PHS Act, as amended, including corresponding regulations and policies, based on the announced service area and target population. In addition to these general requirements, there are specific requirements for applicants requesting funding under each health center type (CHC, MHC, HCH, and/or PHPC) authorized under section 330 (see below). Failure to document and demonstrate compliance will significantly reduce the likelihood of funding. Applicants are encouraged to review the Health Center Program requirements at <http://bphc.hrsa.gov/about/requirements>.

It is expected that full operational capacity as outlined in the SAC-AA application will be achieved within three years of receiving federal section 330 grant support, including service to the projected number of patients. **Failure to meet Health Center Program requirements and expectations of this award, including patient projections may jeopardize Health Center Program grant funding** per 45 CFR 74.62(a) and, 45 CFR 92.43(a). Throughout the project period, grantees will be routinely assessed for program compliance. Consistent with current practice, in circumstances where a grantee is determined to be non-compliant with one or more of the Health Center Program requirements, a condition will be placed on the award and will follow the Progressive Action policy and process. The Progressive Action process provides a time-phased approach for resolution of compliance issues. Failure to successfully address conditions and demonstrate compliance via Progressive Action may result in the withdrawal of support through the cancellation of all or part of the grant award. For more information, review the Progressive Action Program Assistance Letter 2010-01: Enhancements to Support Health Center Program Requirements Monitoring available at <http://bphc.hrsa.gov/policiesregulations/policies/pal201001.html>.

COMMUNITY HEALTH CENTER APPLICANTS:

- Ensure compliance with section 330(e) and program regulations.
- Provide a plan that ensures the availability and accessibility of required primary and preventive health services to underserved populations in the service area.

MIGRANT HEALTH CENTER APPLICANTS:

- Ensure compliance with section 330(g), section 330(e), and, as applicable, program regulations.

- Provide a plan that ensures: (1) the availability and accessibility of required primary and preventive health services to migratory and seasonal agricultural workers and their families in the service area; with migratory and seasonal agricultural workers meaning individuals principally employed in agriculture on a seasonal basis within the last 24 months and who establish temporary housing for the purpose of this work; with migratory and seasonal agricultural workers meaning individuals employed in agriculture on a seasonal basis, who are not also migratory; and with agriculture meaning farming in all its branches, as defined by the OMB-developed NAICS under the following codes and all sub-codes within—111, 112, 1151, and 1152.

HEALTH CARE FOR THE HOMELESS APPLICANTS:

- Ensure compliance with section 330(h), section 330(e), and, as applicable, program regulations.
- Provide a plan that ensures the availability and accessibility of required primary and preventive health services to people experiencing homelessness, defined to include residents of permanent supportive housing or other housing programs that are targeted to homeless populations, in the service area. Such a plan may also allow for continuing to provide services for up to 12 months to individuals no longer homeless as a result of becoming a resident of permanent housing.

PUBLIC HOUSING PRIMARY CARE APPLICANTS

- Ensure compliance with section 330(i), section 330(e), and, as applicable, program regulations.
- Provide a plan that ensures the availability and accessibility of required primary and preventive health services to residents of public housing and individuals living in areas immediately accessible to such public housing. Public housing means public housing agency-developed, owned, or assisted low-income housing, including mixed finance projects, but excludes housing units with no public housing agency support other than Section 8 housing vouchers.

II. Award Information

1. TYPE OF AWARD

Funding will be provided in the form of a grant.

2. SUMMARY OF FUNDING

Award amounts will not exceed, in any year of the proposed three-year project period, the projected annual level of section 330 funding for each service area. Information on the projected level of federal section 330 funding can be found in [Table 6](#).

Approximately \$405,070 is expected to be available in FY 2014 to fund one SAC-AA grant in Cheyenne, Wyoming and approximately \$784,496 is expected to be available in FY 2014 to fund one SAC-AA grant in Round Mountain, California. This funding opportunity announcement is subject to availability of appropriated funds. **Funding beyond the first year is dependent upon**

Congressional appropriation, compliance with applicable statutory and regulatory requirements, demonstrated organizational capacity to accomplish the project's goals, and a determination that continued funding would be in the best interest of the federal government.

See [Section IV.2.iii. Budget](#) for further information and instructions on the development of the application budget. Federal funding for new applicants may be adjusted based on an analysis of the budget and cost factors.

III. Eligibility Information

1. ELIGIBLE APPLICANTS

Applicants must meet all of the following eligibility requirements. **Applications that do not demonstrate compliance with all eligibility requirements will be deemed non-responsive and will not be considered for SAC-AA funding.**

- 1) Applicant is a public or nonprofit private entity, such as a tribal, faith-based, or community-based organization.
- 2) Applicant is one of the following:
 - Competing Continuation – A current Health Center Program grantee whose project period ends on, or after, October 31, 2013 and before October 1, 2014 that seeks to continue serving its current service area.
 - New – A health center not currently funded through the Health Center Program that seeks to serve an entire announced service area through the proposal of one or more sites.
 - Supplemental – A current Health Center Program grantee that seeks to serve an entire announced service area in addition to its current service area (select Revision on the SF-424 – see [Section IV.2.i](#) for details) through the proposal of one or more new sites.
- 3) Applicant proposes to serve a service area and its associated population(s) and patients identified in [Table 6](#).
 - Applicant must propose on Form 1A to serve at least an equivalent number of patients by the end of the project period as listed in [Table 6](#).
 - Applicant must propose on Form 5B the service area zip codes from which at least 75 percent of the current patients come.¹ Applicants may utilize the Patient Origin Map available on the SAC-AA technical assistance site

¹ HRSA considers service area overlap when making funding determinations for new applicants and current grantees proposing to serve a new service area if zip codes are proposed beyond those listed on the SAAT. For more information about service area overlap, refer to Policy Information Notice 2007-09 located at <http://bphc.hrsa.gov/policiesregulations/policies/pin200709.html>.

(<http://www.hrsa.gov/grants/apply/assistance/sac-aa>), if applicable, as a resource in determining the zip codes from which the majority of patients originate.

- Applicant must propose to serve all currently-targeted populations (i.e., CHC, MHC, HCH, PHPC) identified through the funding distribution in [Table 6](#). See Item 7 below for details on how this impacts the budget request.

- 4) Applicant submits only one application for consideration under a single SAC announcement number.

Note: An applicant wishing to apply to serve two different service areas announced under a single announcement number **must** contact the Office of Policy and Program Development at 301-594-4300 or BPHCSAC@hrsa.gov for guidance.

- 5) Applicant requests section 330 funds to support the operation of a health center for the provision of required comprehensive primary, preventive, and enabling health care services, either directly on-site or through established arrangements, without regard to ability to pay. An applicant may **not** propose to provide only a single service, such as dental, behavioral, or prenatal services.
- 6) Applicant proposes access to services for all individuals in the service area and target population. In other words, applicant does not propose to exclusively serve a single age group (e.g., children, elderly) or health issue/disease category (e.g., HIV/AIDS). In instances where a sub-population is being targeted within the service area or target population (e.g., homeless children; lesbian, gay, bisexual, and transgender individuals), the applicant must ensure that health care services will be made available to others in need of care who seek services at the proposed site(s).
- 7) Applicant requests annual federal section 330 funding (as listed in [Table 6](#) and presented on the SF-424A, Federal Object Class Categories form, and budget justification/narrative) that **DOES NOT** exceed the established cap of section 330 funding (listed as Total Funding in [Table 6](#)) available to support the announced service area and its designated population(s). Applicant maintains the current funding distribution between target populations as listed in [Table 6](#) (i.e., CHC, MHC, HCH, PHPC).
- 8) Applicant adheres to the 160-page limit on the length of the application when printed by HRSA. See [Tables 1-4](#) for specific information regarding the documents included in the 160-page limit.

Refer to [Table 6](#) for information regarding specific available service areas and their associated population(s), patients, zip codes, and funding distributions.

2. COST SHARING/MATCHING

Cost sharing or matching is not a requirement for this funding opportunity. Under 42 CFR 51c.203, HRSA will take into consideration whether and to what extent an applicant plans to secure and maximize federal, state, local, and private resources to support the proposed project. Please see the budget and budget justification sections ([Section IV.2.iii](#) and [Section IV.2.iv](#), respectively) for clarification and guidelines pertaining to the budget presentation.

3. OTHER

Applications that exceed the ceiling amount for the proposed service area (see [Table 6](#)) will be deemed non-responsive and will not be considered for funding. Additionally, any application that exceeds the page limit referenced in [Section IV.2](#) or fails to satisfy the deadline requirements referenced in [Section IV.3](#) will be deemed non-responsive and will not be considered for funding.

IV. Application and Submission Information

1. ADDRESS TO REQUEST APPLICATION PACKAGE

Application Materials and Required Electronic Submission Information

HRSA *requires* applicants for this funding opportunity announcement to apply electronically through Grants.gov. The registration and application process protects applicants against fraud and ensures that only authorized representatives from an organization can submit an application. Applicants are responsible for maintaining these registrations, which should be completed well in advance of submitting an application. All applicants *must* submit in this manner unless they obtain a written exemption from this requirement in advance of the deadline by the Director of HRSA's Division of Grants Policy. Applicants must request an exemption in writing from DGPWaivers@hrsa.gov, and provide details as to why they are technologically unable to submit electronically through the Grants.gov portal. If requesting a waiver, include the following in the e-mail request: the HRSA announcement number for which the organization is seeking relief; the organization's DUNS number; the name, address, and telephone number of the organization; and the name and telephone number of the Project Director; the Grants.gov Tracking Number (GRANTXXXX) assigned to the submission and a copy of the "Rejected with Errors" notification as received from Grants.gov (if any). HRSA's Division of Grants Policy is the only office authorized to grant waivers. **HRSA and its Digital Services Operation (DSO) will only accept paper applications from applicants that receive prior written approval.** However, the application must still be submitted by the deadline.

Suggestion: Submit application to Grants.gov at least two days before the deadline to allow time to correct errors prior to the deadline.

IMPORTANT NOTICE: CCR moved to SAM effective July 30, 2012

Central Contractor Registration (CCR) transitioned to the System for Award Management

(SAM) on July 30, 2012. For any registrations in process during the transition period, data submitted to CCR migrated to SAM.

If a record was scheduled to expire between July 16, 2012 and October 15, 2012, CCR extended the expiration date by 90 days. The registrant received an e-mail notification from CCR when the expiration date was extended. The registrant then received standard e-mail reminders to update their record based on the new expiration date. Future e-mail notifications will come from SAM.

SAM will reduce the burden on those seeking to do business with the government. Organizations will be able to log into one system to manage their entity information in one record, with one expiration date, through one streamlined business process. Federal agencies will be able to look in one place for entity pre-award information. Everyone will have fewer passwords to remember and see the benefits of data reuse as information is entered into SAM once and reused throughout the system.

Active SAM registration is a pre-requisite to the successful submission of grant applications!

Items to consider are:

- When does the account expire?
- Does the organization need to complete the annual renewal of registration?
- Who is the eBiz POC? Is this person still with the organization?
- Does anything need to be updated?

To learn more about SAM, please visit <https://www.sam.gov>.

Note: SAM information must be updated at least every 12 months to remain active (for both grantees and sub-recipients).

Grants.gov will reject submissions from applicants with expired registrations. Do not wait until the last minute to update your registration in SAM. According to the SAM Quick Guide for Grantees (https://www.sam.gov/sam/transcript/SAM_Quick_Guide_Grants_Registrations-v1.6.pdf), an entity's registration will become active after 3-5 days. Therefore, *check for active registration well before the application deadline.*

Applicants that fail to allow ample time to complete registration with SAM or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.

Applicants are responsible for reading the instructions included in the *HRSA Electronic Submission User Guide*, available online at <http://www.hrsa.gov/grants/apply/userguide.pdf>. This guide includes application and submission instructions for both Grants.gov and HRSA Electronic Handbooks (EHB). Pay particular attention to Sections 2 and 5 that provide detailed information on the competitive application and submission process. According to the User Guide, applicants should submit single-spaced narrative documents with 12 point, easily readable font (e.g., Times New Roman, Arial, Courier) and 1-inch margins. Smaller font (no less than 10 point) may be used for tables, charts, and footnotes.

Applicants are also responsible for reading the *Grants.gov Applicant User Guide*, available online at http://www.grants.gov/assets/GrantsGov_Applicant_UserGuide_R12.1.0_V2.1.pdf. This guide includes detailed information about using the Grants.gov system and contains helpful hints for successful submission.

Applicants must submit proposals according to the instructions in the Guide and this FOA in conjunction with Application Form SF-424, which contains additional general information and instructions. The forms and instructions may be obtained by:

- (1) Downloading from <http://www.grants.gov> or
- (2) Contacting HRSA Digital Services Operation (DSO) at HRSADSO@hrsa.gov

Specific instructions for preparing portions of the application that must accompany Application Form SF-424 appear in the Application Format Requirements section below.

2. CONTENT AND FORM OF APPLICATION SUBMISSION

Application Format Requirements

The total size of all uploaded files may not exceed the equivalent of 160 pages when printed by HRSA. The total file size may not exceed 20 MB. See [Tables 1-4](#) for information about the application components included in the page limit. Applicants are strongly encouraged to print their applications before submitting electronically to ensure that they do not exceed the 160-page limit. **Electronic submissions are subject to an automated page count, and those exceeding the limit in any way are automatically rejected.** Do not reduce the size of the fonts or margins to save space. See the formatting instructions in Section 5 of the *HRSA Electronic Submission User Guide* referenced above.

Applications must be complete, within the specified limits (160 pages, approximately 20 MB), and submitted prior to the deadline to be considered for SAC-AA funding.

Application Format

The following tables detail the documents required for this funding opportunity and the order in which they must be submitted. In the Form Type column of [Tables 1-4](#), the word “Form” refers to a document that must be downloaded, completed in the template provided, and then uploaded. “E-Form” refers to forms that are completed online in EHB and therefore do not require downloading or uploading. “Document” refers to a document to be uploaded for which no template is provided. “Fixed” refers to forms that cannot be altered.

In [Tables 1-4](#), documents and forms marked as “required for completeness” will be used to determine if an application is complete. Applications that fail to include all forms and documents indicated as “required for completeness” will be considered incomplete or non-responsive, thereby making them ineligible. Ineligible applications will not proceed to Objective Review. Failure to include documents indicated as “required for review” may negatively impact an application’s objective review score. Applications must consist of the following documents in the following order.

Table 1: Step 1–Submission through Grants.gov

<http://www.grants.gov>

- It is mandatory to follow the provided instructions to ensure that your application can be printed efficiently and consistently for review.
- Failure to follow the instructions may make your application non-responsive. Non-responsive applications will not be considered.
- Number the electronic attachment pages sequentially, resetting the numbering for each attachment (i.e., start at page 1 for each attachment). Do not attempt to number standard OMB approved form pages.
- For electronic submissions, no table of contents is required for the entire application. HRSA will construct an electronic table of contents in the order specified.
- Limit file attachment names to 50 or fewer characters. Use only the following characters when naming your attachments: A-Z, a-z, 0-9, underscore (_), hyphen (-), space, and period (.). Attachments that do not follow this rule will cause the entire application to be rejected by Grants.gov.
- The Other Attachments Form (listed as an Optional Document in Grants.gov) is not required and should NOT be submitted.

Application Section	Form Type	Instruction	Counted in Page Limit (Y/N)
Application for Federal Assistance (SF-424)	Form	Complete pages 1, 2, & 3 of the SF-424. See instructions in Section IV.2.i .	N
Project Abstract	Document	Type the title of the funding opportunity and upload the project abstract in Box 15 of the SF-424. See instructions in Section IV.2.viii .	Y
SF-424B: Assurances – Non-Construction Programs	Form	Complete the Assurances form.	N
Additional Congressional District(s) (as applicable)	Document	Upload a list of additional Congressional Districts served by the project if all districts served will not fit in 16b of the SF-424.	N
Project Performance Site Location(s)	Form	Current Health Center Program grantees applying to continue serving their current service area must provide only the administrative site of record. Applicants not currently receiving Health Center Program funds for the proposed service area must provide the administrative site information AND information about all project performance sites. A list of additional sites may be uploaded as necessary.	N
Grants.gov Lobbying Form	Form	Provide the requested contact information at the bottom of the form.	N
SF-LLL: Disclosure of Lobbying Activities (as applicable)	Form	Complete the form only if lobbying activities are conducted.	N

Within seven business days following successful submission of the required items in Grants.gov, you will be notified by HRSA confirming the successful receipt of your application and requiring the Project Director and Authorized Organization Representative to submit additional information in HRSA EHB. Your application will not be considered complete unless you review and validate the information submitted through Grants.gov and submit the additional required portions of the application through HRSA EHB. Refer to <http://www.hrsa.gov/grants/apply> for detailed application and submission instructions.

Table 2: Step 2–Submission through HRSA Electronic Handbooks (EHB)

<https://grants.hrsa.gov/webexternal>

- It is mandatory to follow the provided instructions to ensure that your application can be printed efficiently and consistently for review.
- Failure to follow the instructions may make your application non-responsive. Non-responsive applications will not be considered for funding under this FOA.
- Number the electronic attachment pages sequentially, resetting the numbering for each attachment (i.e., start at page 1 for each attachment). Do not attempt to number standard OMB approved form pages.
- Limit file names for documents to 100 characters or less. Documents will be rejected by EHB if file names exceed 100 characters.

Application Section	Required for Completeness or Review (C/R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Program Narrative	C	Document	Upload the Program Narrative. See instructions in Section IV.2.ix .	Y
SF-424A: Budget Information – Non-Construction Programs	C	E-Form	Complete Sections A, B, and E. Complete Section F if applicable. See instructions in Appendix C .	N
Budget Justification	C	Document	Upload the Budget Justification in the Budget Narrative Attachment Form field. See instructions in Appendix C .	Y
Attachments	Varies	Documents	See Table 3.	Varies
Program Specific Forms	R	Varies	See Table 4.	N
Program Specific Information	R	E-Forms	See Table 4.	N

Table 3: Attachments Submission through HRSA EHB (Step 2 continued)

<https://grants.hrsa.gov/webexternal>

- To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Number the electronic attachment pages sequentially, resetting the numbering (i.e., start at page 1) for each attachment.
- Merge similar documents (e.g., Letters of Support) into a single document. Add a table of contents page specific to the attachment. This page will **not** count toward the page limit.
- Limit file names for attachments to 100 characters or less. Attachments will be rejected by EHB if file names exceed 100 characters.
- If the attachments marked “required for completeness” are not uploaded, the application will be considered incomplete and non-responsive, thereby making it ineligible. Ineligible applications will not proceed to Objective Review.
- If the attachments marked “required for review” are not uploaded, the application’s Objective Review score may be negatively impacted.

Attachment	Required for Completeness or Review (C/R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Attachment 1: Service Area Map and Table	R	Document	Upload a map of the service area for the proposed project, indicating the organization’s proposed health center site(s) listed in Form 5B. The map must clearly indicate the proposed service area zip codes, any medically underserved areas (MUAs) and/or medically underserved populations (MUPs), and Health Center Program grantees, look-alikes, and other health care providers serving the proposed zip codes. Maps should be created using UDS Mapper (http://www.udsmapper.org). Please note that you will have to manually place markers for the locations of other major private provider groups serving low income/uninsured populations. Include a corresponding table that lists each zip code tabulation area (ZCTA) in the service area, the number of Health Center Program grantees serving each ZCTA, the dominant grantee serving the ZCTA and its share of Health Center Program patients, total population, total low-income population, total Health Center Program grantee patients, and patient penetration levels for each ZCTA and for the overall proposed service area. This table will be automatically created in UDS Mapper when the map is created. See http://www.hrsa.gov/grants/apply/assistance/sac-aa for samples and instructions on creating maps using UDS Mapper. For a tutorial on how to create a map, see How To’s: Create a Service Area Map and Data Table at http://www.udsmapper.org/tutorials.cfm .	Y

Attachment	Required for Completeness or Review (C/R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Attachment 2: Corporate Bylaws	C	Document	Upload (in entirety) the applicant organization's most recent bylaws. See the GOVERNANCE section of the Program Narrative for more details.	Y
Attachment 3: Project Organizational Chart	R	Document	Upload a one-page document that depicts the applicant's current organizational structure, including the governing board, key personnel, staffing, and any sub-recipients or affiliated organizations.	Y
Attachment 4: Position Descriptions for Key Management Staff	R	Document	Upload current position descriptions for key management staff: Chief Executive Officer (CEO), Clinical Director (CD), Chief Financial Officer (CFO), Chief Information Officer (CIO), and Chief Operating Officer (COO). Indicate on the position descriptions if key management positions are combined and/or part time (e.g., CFO and COO roles are shared). Each position description should be limited to one page and must include, at a minimum, the position title; description of duties and responsibilities; position qualifications; supervisory relationships; skills, knowledge, and experience requirements; travel requirements; salary range; and work hours.	Y
Attachment 5: Biographical Sketches for Key Management Staff	R	Document	Upload current biographical sketches for key management staff: CEO, CD, CFO, CIO, and COO. Biographical sketches should not exceed two pages each. When applicable, biographical sketches must include training, language fluency, and experience working with the cultural and linguistically diverse populations to be served. In the event that an identified individual is not yet hired, include a letter of commitment from that person with the biographical sketch.	Y

Attachment	Required for Completeness or Review (C/R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Attachment 6: Co-Applicant Agreement required for public center ² applicants that have a co-applicant board)	C (as applicable)	Document	Public center applicants that have a co-applicant board must submit, in its entirety, the formal co-applicant agreement signed by both the co-applicant governing board and the public center. See the RESOURCES/CAPABILITIES and GOVERNANCE sections of the Program Narrative for more details.	Y
Attachment 7: Summary of Contracts and Agreements (as applicable)	R	Document	<p>Upload a BRIEF SUMMARY describing current or proposed patient service-related contracts and agreements. The summary must address the following items for each contract or agreement:</p> <ul style="list-style-type: none"> • Name and contact information for each affiliated agency. • Type of contract or agreement (e.g., contract, affiliation agreement). • Brief description of the purpose and scope of each contract or agreement (i.e., type of services provided, how/where services are provided). • Timeframe for each contract or agreement. <p>If a contract or agreement will be attached to Form 8 (e.g., contract for a substantial portion of the proposed project), denote this with an asterisk (*).</p>	Y

² Public centers were referred to as “public entities” in the past.

Attachment	Required for Completeness or Review (C/R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Attachment 8: Independent Financial Audit	C	Document	Upload the most recent audit. The audit must include all balance sheets, profit and loss statements, audit findings, management letter (or a signed statement that no letter was issued with the audit), and noted exceptions. Organizations that have been operational less than one year and do not have an audit may submit monthly financial statements for the most recent six-month period. Organizations with no audit or financial statements (e.g., organization formed for the purposes of this grant application) must provide a detailed explanation of the situation, including supporting documentation.	N
Attachment 9: Articles of Incorporation – Signed Seal Page	R	Document	Upload the official signatory page (seal page) of the organization's Articles of Incorporation. A public center with a co-applicant should upload the co-applicant's Articles of Incorporation.	Y
Attachment 10: Letters of Support	R	Document	Upload current dated letters of support addressed to the appropriate organization contact (e.g., board, CEO) to document commitment to the project. See the COLLABORATION section of the Program Narrative for details on required letters of support. Letters of support that are not submitted with the application will not be considered by reviewers.	Y
Attachment 11: Sliding Fee Discount Schedule(s)	R	Document	Upload the current or proposed sliding fee discount schedule(s). See the RESPONSE section of the Program Narrative for details.	Y
Attachment 12: Evidence of Nonprofit or Public Center Status (as applicable)	R	Document	Upload evidence of nonprofit or public center status only if evidence is not already on file with HRSA. Private Nonprofit: A private, nonprofit organization must submit any one of the following as evidence of its nonprofit status: <ul style="list-style-type: none"> A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS 	Y

Attachment	Required for Completeness or Review (C/R)	Form Type	Instruction	Counted in Page Limit (Y/N)
			<p>Code.</p> <ul style="list-style-type: none"> • A copy of a currently valid Internal Revenue Service Tax exemption certificate. • A statement from a state taxing body, state Attorney General, or other appropriate state official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals. • A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization. • Any of the above proof for a state or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate. <p>Public Center: Consistent with Policy Information Notice 2010-10 (http://bphc.hrsa.gov/policiesregulations/policies/pin201001.html), applicants must provide documentation demonstrating that the organization qualifies as a public agency (e.g., health department, university health system) for the purposes of section 330 of the PHS Act, as amended. Any of the following is acceptable:</p> <ol style="list-style-type: none"> 1. Affirm Instrumentality Letter (4076C) from the IRS or a letter of authority from the federal, state, or local government granting the entity one or more sovereign powers. 2. A determination letter issued by the IRS providing evidence of a past positive ruling by the IRS or other documentation demonstrating that the organization is an instrumentality of government, such as documentation of the law that created the organization or documentation showing that the state or a political subdivision of the state controls the organization. 3. Formal documentation from a sovereign state's taxing authority equivalent to the IRS granting the entity one or more governmental powers. 	

Attachment	Required for Completeness or Review (C/R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Attachment 13: Floor Plans (as applicable)	R	Document	New applicants and current grantees applying to serve a new service area must provide copies of floor plans for all sites within the proposed scope of project. Current grantees applying to continue serving their current service area do not need to provide floor plans unless there has been a change in layout of any site(s).	Y
Attachment 14: Implementation Plan (as applicable)	C	Document	New applicants and current grantees applying to serve a new service area must upload the Implementation Plan. Refer to Appendix D for detailed instructions and see http://www.hrsa.gov/grants/apply/assistance/sac-aa for a sample.	Y
Attachment 15: Other Relevant Documents (as applicable)	R	Document	If desired, include other relevant documents to support the proposed project (e.g., charts, organizational brochures, lease agreements).	Y

Table 4: Program Specific Forms and Information Submission through HRSA EHB (Step 2 continued)

<https://grants.hrsa.gov/webexternal>

- With the exception of Form 3, all Program Specific Forms will be completed online in HRSA EHB. All Program Specific Forms are required unless otherwise noted.
- Limit the file name for Form 3 to 100 characters or less. Attachments will be rejected by EHB if file names exceed 100 characters.
- All Program Specific Information is required and will be completed online in HRSA EHB.
- Refer to [Appendix A](#) for detailed instructions for the Program Specific Forms.
- Refer to [Appendix B](#) for Program Specific Information detailed instructions and Clinical and Financial Performance Measures samples.
- The Program Specific Forms and Program Specific Information forms DO NOT count against the page limit.

Program Specific Form/Information	Form Type
Form 1A : General Information Worksheet	E-Form
Form 1C : Documents on File	E-Form
Form 2 : Staffing Profile	E-Form

Program Specific Form/Information	Form Type
Form 3 : Income Analysis	Form
Form 4 : Community Characteristics	E-Form
Form 5A : Services Provided	Fixed form for current grantees applying to continue serving their current service area. E-Form for new applicants and current grantees applying to serve a new service area.
Form 5B : Service Sites	Fixed form for current grantees applying to continue serving their current service area. E-Form for new applicants and current grantees applying to serve a new service area.
Form 5C : Other Activities/Locations (if applicable)	Fixed form for current grantees applying to continue serving their current service area. E-Form for new applicants and current grantees applying to serve a new service area.
Form 6A : Current Board Member Characteristics	E-Form
Form 6B : Request for Waiver of Governance Requirements	E-Form
Form 8 : Health Center Agreements	E-Form
Form 9 : Need for Assistance Worksheet	E-Form
Form 10 : Annual Emergency Preparedness Report	E-Form
Form 12 : Organization Contacts	E-Form
Federal Object Class Categories Form	E-Form
Clinical Performance Measures	E-Forms
Financial Performance Measures	E-Forms

Applicants are reminded that failure to include in the application all forms and documents indicated as “required for completeness” may result in an application being considered incomplete or non-responsive thereby making it ineligible. Ineligible applications will not proceed to Objective Review. Failure to include documents indicated as “required for review” may negatively impact an application’s objective review score.

Application Preparation

The SAC-AA technical assistance Web site (<http://www.hrsa.gov/grants/apply/assistance/sac-aa>) provides essential resources for application preparation. Throughout the application development and preparation process, applicants are encouraged to work with the appropriate Primary Care Associations (PCAs), Primary Care Offices (PCOs), and/or National Cooperative Agreements (NCAs) to prepare quality, competitive applications. For a complete listing of PCAs, PCOs, and NCAs, refer to <http://www.bphc.hrsa.gov/technicalassistance/partnerlinks>.

Applicants must provide all required information in the sequence and format described. Information and data must be accurate and consistent. Instructions must be followed carefully and completely. **Applications that fail to meet all requirements may not be accepted for review or may receive a low rating from the Objective Review Committee (ORC).**

Only materials included with an application submitted by the announced deadlines will be considered. Supplemental materials submitted after the application deadlines will not be considered. Letters of support sent directly to HHS, HRSA, or BPHC will **not** be added to an application or considered by the ORC.

Application Format

i. Application for Federal Assistance SF-424

In Grants.gov, complete Application Form SF-424 provided with the application package. Prepare according to instructions provided in the form itself (mouse over fields for specific instructions) and the following guidelines. For additional guidance, current grantees should refer to *How to Read your Notice of Award Handout: A Guide for Current Grantees* available at <http://www.hrsa.gov/grants/apply/assistance/sac-aa>.

- *Box 2: Type of Application:* Select one. **Incorrect selection may delay EHB access.**
 - Continuation – Current Health Center Program grantees applying to continue serving their current service area (include your H80 grant number in Box 4)

Figure 1: SF-424 for Competing Continuation Applicants

Application for Federal Assistance SF-424		
* 1. Type of Submission: <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	* 2. Type of Application: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision	* If Revision, select appropriate letter(s): <input type="text"/> * Other (Specify): <input type="text"/>
* 3. Date Received: <input type="text" value="Completed by Grants.gov upon submission."/>	4. Applicant Identifier: <input type="text" value="H80CSXXXXXX"/>	

- New – Applicants not currently funded through the Health Center Program (leave Box 4 blank)

Figure 2: SF-424 for New Applicants

Application for Federal Assistance SF-424		
<p>* 1. Type of Submission:</p> <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	<p>* 2. Type of Application:</p> <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision	<p>* If Revision, select appropriate letter(s):</p> <input type="text"/> <p>* Other (Specify):</p> <input type="text"/>
<p>* 3. Date Received:</p> <input type="text"/> <p>Completed by Grants.gov upon submission.</p>	<p>4. Applicant Identifier:</p> <input type="text"/>	

- Revision – Current grantees applying to serve a new service area (select Other and type Supplement and your H80 grant number); include your H80 grant number in Box 4

Figure 3: SF-424 for Supplemental Applicants

Application for Federal Assistance SF-424		
<p>* 1. Type of Submission:</p> <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	<p>* 2. Type of Application:</p> <input type="checkbox"/> New <input type="checkbox"/> Continuation <input checked="" type="checkbox"/> Revision	<p>* If Revision, select appropriate letter(s):</p> <input type="text" value="E: Other (specify)"/> <p>* Other (Specify):</p> <input type="text" value="Supplement: H80CSXXXXX"/>
<p>* 3. Date Received:</p> <input type="text"/> <p>Completed by Grants.gov upon submission.</p>	<p>4. Applicant Identifier:</p> <input type="text" value="H80CSXXXXX"/>	

- *Box 5a: Federal Entity Identifier:* Leave blank.
- *Box 5b: Federal Award Identifier:* 10-digit grant number (H80...) found in box 4b from the most recent Notice of Award for current section 330 grantees. New applicants should leave this blank.
- *Box 8c: Organizational DUNS:* Applicant organization's DUNS number (see below).
- *Box 8f: Name and Contact Information of Person to be Contacted on Matters Involving this Application:* Provide the Project Director's name and contact information.
Note: If, for any reason, the Project Director will be out of the office between the Grants.gov submission date and the project period start date, ensure that the email Out of Office Assistant is set so HRSA will be aware of whom to contact if issues arise with the application and a timely response is required.
- *Box 11: Catalog of Federal Domestic Assistance Number:* 93.224
- *Box 14: Areas Affected by Project:* Provide a summary of the areas to be served (e.g., if entire counties are served, cities do not need to be listed) and upload it as a Word document. This document will NOT count toward the page limit.
- *Box 15: Descriptive Title of Applicant's Project:* Service Area Competition-Additional Area and upload the project abstract. The abstract WILL count toward the page limit.
- *Box 16: Congressional Districts:* Provide the congressional district where the administrative office is located in 16a and the congressional districts to be served by the proposed project in 16b. If information will not fit in the boxes provided, attach a Word document. This document will NOT count toward the page limit.
- *Box 17: Proposed Project Start and End Date:* Provide the start and end dates for the proposed three-year project period (e.g., December 1, 2013 – November 30, 2016)
- *Box 18: Estimated Funding:* Complete the required information based on the funding request for the **first year** of the proposed project period (e.g., December 1, 2013 – November 30, 2014).

- *Box 19: Review by State:* See [Section IV.4](#) for guidance in determining applicability.
- *Box 21: Authorized Representative:* The electronic signature in Grants.gov (created when the Grants.gov forms are submitted) is the official signature when applying for a SAC-AA grant. The form should NOT be printed, signed, and mailed to HRSA.

DUNS Number

Applicant organizations (and sub-recipients of HRSA award funds) are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant from the federal government. The DUNS number is a unique nine-character identification number for each applicant organization provided by the commercial company Dun and Bradstreet. There is no charge to obtain a DUNS number. Information about obtaining a DUNS number can be found by visiting <http://fedgov.dnb.com/webform> or calling 1-866-705-5711. Applications *will not* be reviewed without a DUNS number.

Note: A missing or incorrect DUNS number is the number one reason for applications being “Rejected for Errors” by Grants.gov. HRSA will not extend the deadline for applications with a missing or incorrect DUNS number. Applicants must take care in entering the DUNS number in the application.

Additionally, applicant organizations (and sub-recipients of HRSA award funds) are required to register annually with the System for Award Management (SAM) in order to conduct electronic business with the federal government. SAM registration must be maintained with current, accurate information at all times during which an entity has an active award from or an application under consideration by HRSA. It is extremely important to verify that the applicant organization’s SAM registration is active and the Marketing Partner ID Number (MPIN) is current. Information about registering with SAM can be found at <https://www.sam.gov>. Please see [Section IV](#) of this funding opportunity announcement for SAM registration requirements.

ii. Table of Contents

The application components should be submitted in the order presented in [Tables 1-4](#). For electronic applications, no table of contents is necessary as it will be generated by the EHB system. **Note:** The table of contents will not count in the page limit.

iii. Budget

In HRSA EHB, complete Application Form SF-424A: Budget Information – Non-Construction Programs. Complete Sections A, B, E, and F if applicable. See [Appendix C](#) for detailed instructions.

Salary Limitation

The Consolidated and Further Continuing Appropriations Act, 2013 (P. L. 113-6), enacted March 26, 2013, continues provisions enacted in the Consolidated Appropriations Act, 2012 (P.L. 112-74). The law limits the salary amount that may be awarded and charged to HRSA grants. SAC-AA federal grant funds may not be used to pay the salary of an individual at a rate in excess of Federal Executive Level II of the Federal Executive Pay scale (currently \$179,700). This amount reflects an individual’s base salary **exclusive of fringe benefits** and income that an individual may be permitted to earn outside of the duties to the applicant organization (i.e., the

rate limitation only limits the amount that may be awarded and charged to HRSA grants). This salary limitation also applies to subawards/subcontracts under a HRSA grant.

Example of Application of this Limitation

If an individual’s base salary is \$350,000 per year plus fringe benefits of 25 percent (\$87,500), and that individual is devoting 50 percent of his/her time to this award, the base salary must be adjusted to \$179,700 plus fringe benefits of 25 percent (\$44,925) when calculating what may be charged to the SAC-AA grant. This results in a total of \$112,312 that may be included in the project budget and charged to the award in salary/fringe benefits for this individual. See the breakdown below:

Table 5: Actual versus Claimed Salary

Current Actual Salary	
Individual's actual base full time salary: \$350,000 (50% of time will be devoted to project)	
Direct Salary	\$175,000
Fringe (25% of salary)	\$ 43,750
Total	\$218,750
Amount of Actual Salary Eligible to be Claimed on the Application Budget due to the Legislative Salary Limitation	
Individual's base full time salary adjusted to Executive Level II: \$179,700 (50% of time will be devoted to the project)	
Direct Salary	\$ 89,850
Fringe (25% of salary)	\$ 22,462
Total	\$112,312

iv. Budget Justification

Provide a justification in HRSA EHB that provides a line-item budget for each year of the proposed project period and explains in line-item format the amounts requested for each object class category as presented on the [Federal Object Class Categories](#) form. **The budget justification must provide a breakdown of federal and non-federal funding and clearly describe how each cost element contributes to meeting the project’s objectives/goals.** The budget period is for ONE year. However, the applicant **must** submit one-year budget justifications for each budget period within the proposed project period (3 years) at the time of application. For subsequent budget years, the justification narrative should highlight the changes from year one or clearly indicate that there are no substantive changes during the project period. See [Appendix C](#) for a detailed explanation of object class categories information to be included.

Budget for Multi-Year Award

This announcement is inviting applications for project periods up to three (3) years. Competitive awards will be for a budget period of one year, although the project period may be for up to three (3) years. Submission and HRSA approval of the yearly Federal Financial Report (FFR) and Budget Period Progress Report (BPR) is the basis for the budget period renewal and release of subsequent year funds. Funding beyond the one-year budget period but within the three-year project period is subject to availability of funds, satisfactory grantee progress, and a determination that continued funding is in the best interest of the federal government.

v. *Staffing Plan and Personnel Requirements*

In HRSA EHB, staffing and personnel information will be provided through [Form 1A](#): General Information Worksheet, [Form 2](#): Staffing Profile, [Attachment 3](#): Organizational Chart, [Attachment 4](#): Position Descriptions, and [Attachment 5](#): Biographical Sketches. Position descriptions must include the roles, responsibilities, and qualifications of proposed project staff. When applicable, biographical sketches should include training, language fluency, and experience working with the cultural and linguistically diverse populations served.

vi. *Assurances*

In Grants.gov, complete Application Form SF-424B: Assurances – Non-Construction Programs.

vii. *Certifications*

In Grants.gov, complete the Certification Regarding Lobbying. Complete the SF-LLL: Disclosure of Lobbying Activities in Grants.gov only if the organization engages in lobbying.

viii. *Project Abstract*

In Grants.gov, upload a single-spaced, one-page summary of the application in Box 15 of the SF-424. Because the abstract is distributed to the public and Congress, please ensure that it is clear, accurate, concise, and without reference to other parts of the application.

Place the following at the top of the abstract:

- Project Title: Service Area Competition-Additional Area.
- Applicant Name.
- Address.
- Project Director Name.
- Phone Numbers (voice, fax).
- E-Mail Address.
- Web Site Address (if applicable).
- Congressional District(s) for the Applicant Organization and Proposed Service Area (if different).
- Types of Section 330 Funding Requested (i.e., CHC, MHC, HCH, and/or PHPC).
- Current Federal Funding (including HRSA funding), if applicable.

The abstract must include a brief description of the proposed project, including the applicant organization, target population, needs to be addressed, and proposed services. Include the following in the body of the abstract:

- A brief history of the organization, the community to be served, and the target population.
- A summary of the major health care needs and barriers to care to be addressed by the proposed project, including the needs of special populations (migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing).
- How the proposed project will address the need for comprehensive primary health care services in the community and target population.
- Number of current and proposed patients, visits, providers, service delivery sites and locations, and services to be provided.

ix. Program Narrative

In HRSA EHB, provide a comprehensive description of all aspects of the proposed SAC-AA project. The Program Narrative must be succinct, consistent with other application components, and well organized so that reviewers can fully understand the proposed project. The Program Narrative should:

- Demonstrate the applicant's compliance with Health Center Program Requirements (applicants should review <http://bphc.hrsa.gov/about/requirements>).
- Address the specific Review Criteria elements (see [Section V](#)) in the areas specified (i.e., Program Narrative, form, or attachment). Unless specified, the attachments should not be used to extend the Program Narrative.
- Reference attachments and forms as needed to clarify information about sites, geographic boundaries, demographic data, and proposed key management staff. Referenced items must be part of the HRSA EHB submission.

A **new applicant** (not currently funded through the Health Center Program) must ensure that the Program Narrative reflects the entire proposed scope of project (all proposed services and sites).

A **current Health Center Program grantee applying to continue serving its current service area** must ensure that the Program Narrative reflects the current approved scope of project. Any change in scope **must** be submitted separately through HRSA EHB. Refer to the Scope of Project policy documents at <http://bphc.hrsa.gov/policiesregulations/policies> (search for Scope of Project under Sub-topic or Keyword search) for information on scope of project.

A **current Health Center Program grantee applying to serve a new service area** must ensure that the Program Narrative reflects only the proposed scope of project for the new service area. However, reference may be made in the Program Narrative to current sites, services, policies, procedures, and capacity as they relate to the new service area (e.g., experience, transferrable procedures).

The following provides a framework for the Program Narrative. The Program Narrative must be organized by section headers (***NEED, RESPONSE, COLLABORATION, EVALUATIVE MEASURES, RESOURCES/CAPABILITIES, GOVERNANCE, SUPPORT REQUESTED***), with the requested information appearing in the appropriate section of the Program Narrative or the designated forms and attachments.

NEED

- 1) Describe the characteristics of the target population within the proposed service area by:
 - Completing [Form 9](#): Need for Assistance Worksheet (see Appendix A) to quantitatively establish target population health care needs. National median benchmark data will appear when available to facilitate comparisons to national data to fully demonstrate target population need.

- Describing the following factors in narrative format and how they impact access to primary health care, health care utilization, and health status, citing data resources, including local target population needs assessments when available:
 - a) Geographical/transportation barriers (consistent with [Attachment 1](#)).
 - b) Unemployment, income level, or educational attainment.
 - c) Health disparities.
 - d) Unique health care needs of the target population not previously addressed (e.g., cultural/ethnic factors such as sexual orientation, language, attitudes, and beliefs).
- 2) **Applicants requesting special population funding** to serve migratory and seasonal agricultural workers (MHC), people experiencing homelessness (HCH), and/or residents of public housing (PHPC): Describe the specific health care needs and access issues of the proposed special population(s).
 - a) Migratory and seasonal agricultural workers (MHC) needs/access issues, including agricultural environment (e.g., crops and growing seasons, demand for labor, number of temporary workers), approximate period(s) of residence of migratory and seasonal agricultural workers and their families and the availability of local providers to provide primary care services during these times, migrant occupation-related factors (e.g., working hours, housing, hazards including pesticides and other chemical exposures), and significant increases or decreases in migratory and seasonal agricultural workers.
 - b) People Experiencing Homelessness (HCH) needs/access issues, such as the number of providers treating people experiencing homelessness, availability of homeless shelters and affordable housing, and significant increases or decreases in people experiencing homelessness.
 - c) Residents of Public Housing (PHPC) needs/access issues, such as the availability of public housing, the impact of the availability of public housing on the residents in the targeted public housing communities served, and significant increases or decreases in residents of public housing.

Applicants not requesting special population funding but that currently serve or may serve these populations in the future: Describe the current or future planned services for and specific health care needs and access issues of the targeted special populations (i.e., migratory and seasonal agricultural workers (MHC), people experiencing homelessness (HCH), and/or residents of public housing (PHPC)).

- 3) Describe other primary health care services currently available in the service area (consistent with [Attachment 1](#)) and the location of the providers/organizations that provide these services, including whether they also serve the applicant's target population. Justify the need for Health Center Program support by highlighting gaps in services that the applicant currently fills (current grantees applying to continue serving their current service area) or will fill (new applicants or current grantees applying to serve a new service area).
- 4) Describe the health care environment and its impact on the applicant organization's current and future operations, including any significant changes that affect the availability of health care services. Include external factors within the service area and internal factors specific to the applicant's fiscal stability, including:

- a) Changes in insurance coverage, including Medicaid, Medicare, and Children’s Health Insurance Program (CHIP). Specifically discuss changes that could result from the implementation of the Affordable Care Act.
- b) Changes in state/local/private uncompensated care programs.
- c) Economic or demographic shifts (e.g., influx of immigrant/refugee population; closing of local hospitals, community health care providers, or major local employers).
- d) Natural disasters or emergencies (e.g., hurricanes, flooding, terrorism).
- e) Changes affecting special populations.

Information provided in NEED section must serve as the basis for, and align with, the proposed activities and goals described throughout the application.

RESPONSE

- 1) Describe the service delivery model(s) proposed to address the health care needs identified in the ***NEED*** section and how the model(s) are appropriate and responsive to the identified health care needs, including the specific needs of any special populations for which funding is sought (MHC, HCH, and/or PHPC). The description must address the following:
 - a) Site(s)/location(s) where services will be provided (consistent with [Attachment 1](#), [Form 5B](#), and [Form 5C](#)).
 - b) Service site type (e.g., fixed site, mobile van, school-based clinic) for each site (consistent with [Form 5B](#)), including how the type and location of sites will assure that services are accessible and available at times that meet the needs of the target population.
 - c) Hours of operation, including how the scheduled hours will assure that services are accessible and available at times that meet the needs of the target population (consistent with [Forms 5B](#) and [5C](#)).
 - d) Arrangements for professional after-hours coverage for medical emergencies during hours when service sites or locations are closed. Specifically discuss how these arrangements are appropriate for the size and needs of the patient population served and provisions for follow-up by the health center for patients accessing after hours coverage.

- 2) Describe how the proposed primary health care services (consistent with [Form 5A](#)) and other activities (consistent with [Form 5C](#)) are appropriate for the needs of the target population. The description must include:
 - a) The provision of required and additional clinical and non-clinical services, including whether these are provided directly or through established written arrangements and referrals.
 - b) How services will be culturally and linguistically appropriate (e.g., availability of interpreter/translator services).
 - c) Method by which enabling services such as case management, outreach, and transportation are integrated into the primary health care delivery system. Highlight enabling services designed to increase access for targeted special populations, if any.

Note:

- Health Care for the Homeless (HCH) applicants must document how substance abuse services will be made available either directly or via a formal written referral arrangement.
 - Migrant Health Center (MHC) applicants must document how they will address any occupational health or environmental health hazards or conditions identified in the [NEED](#) section, as well as any necessary translation services in the case of serving limited English proficiency population(s).
 - Public Housing Primary Care (PHPC) applicants must document that the service plan was developed in consultation with residents of the targeted public housing.
- 3) Describe how the service delivery model(s) assure continuity of care and access to a continuum of care. The description must address:
- a) Arrangements for admitting privileges for health center physicians at one or more hospitals (consistent with [Form 5C](#)). In cases where hospital privileges are not possible, describe other established arrangements to ensure continuity of care (i.e., timely follow-up) for patient hospitalizations.
 - b) How these arrangements ensure a continuum of care, including discharge planning, post-hospitalization tracking, patient tracking (e.g., shared electronic health records).
- 4) Describe the proposed clinical team staffing plan (consistent with [Form 2](#)), including the mix of provider types and support staff necessary for:
- a) Providing services for the projected number of patients (consistent with [Form 1A](#)).
 - b) Assuring appropriate linguistic and cultural competence (e.g., bilingual/multicultural staff, training opportunities).
 - c) Carrying out required and additional health care services (as appropriate and necessary), either directly or through established formal written arrangements and referrals (consistent with [Form 5A](#)).

Note: Contracted providers should not be included on the clinical team staffing plan ([Form 2](#)). Such providers should be included on the summary of current or proposed contracts/agreements in [Attachment 7](#). If a contract/agreement for core primary care providers is for a substantial portion of the proposed scope of project, include the contract/agreement as an attachment to [Form 8](#).

- 5) Describe how the established schedule of charges is consistent with locally prevailing rates and designed to cover the reasonable cost of service operation (consistent with [Form 5A](#)).
- 6) Describe the sliding fee discount schedule(s) (consistent with [Attachment 11](#)), including:
- a) The process utilized to develop the sliding fee discount schedule(s).
 - b) The policies and procedures used to implement the sliding fee discount schedule(s), including provisions that assure that no patient will be denied service based on an inability to pay.
 - c) How the sliding fee discount schedule(s):

- Are applied only for individuals and families with an annual income at or below 200 percent of the most current Federal Poverty Guidelines (available at <http://aspe.hhs.gov/poverty>).
 - Provide a full discount (no charge) or only a nominal fee for individuals and families with an annual income at or below 100 percent of the Federal Poverty Guidelines.
- d) How any nominal fees are determined. (Nominal fees may be collected from patients at and below 100 percent of the Federal Poverty Guidelines only if the imposition of a nominal fee is consistent with project goals and **does not** pose a barrier to receiving care.)
- e) How often the governing board reviews and updates the sliding fee discount schedule(s) to reflect the most recent Federal Poverty Guidelines.
- f) How often the governing board evaluates and updates (as needed) the policies and procedures that support the implementation of the sliding fee discount schedule(s).
- g) How patients are made aware of available discounts (e.g., signs posted in accessible and visible locations, registration materials, brochures, verbal messages delivered by staff).
- 7) Describe the organization's quality improvement/quality assurance (QI/QA) and risk management plan(s) including:
- a) The parties responsible for accountability and communication throughout the organization for systematically assuring and improving the provision of quality health care. Specifically address the role and responsibilities of the Clinical Director in providing oversight of the QI/QA program.
 - b) The process and parties responsible for developing, updating, and obtaining board approval for policies and procedures that support the QI/QA and risk management plan(s).
 - c) Current risk management policies and procedures, including those related to patient grievance procedures and incident reporting and management.
 - d) Current policies and procedures for maintaining the confidentiality of patient records.
 - e) Current policies and procedures for periodic assessment of appropriateness of service utilization, quality of services delivered, and patient outcomes, conducted by physicians or other licensed health professionals under the supervision of physician. Specifically address the following areas:
 - The process and parties responsible for ensuring providers (e.g., employed, contracted, volunteers, locum tenens) are appropriately licensed, credentialed, and privileged to perform proposed services (consistent with [Form 5A](#)) at proposed sites/locations (consistent with [Forms 5B](#) and [5C](#)).
 - The process and parties responsible for peer review and systematic evaluation of patient records to identify areas for improvement in documentation of services.
 - Utilization of appropriate information systems measures (e.g., electronic health records, payment management systems) for tracking, analyzing, and reporting key performance data, including data necessary for 1) required clinical and financial performance measures and 2) tracking of diagnostic tests and other services provided to health center patients to ensure appropriate follow up and documentation in the patient record.
 - Utilization of QI results to improve performance.

Note: Clinical Directors may be full or part-time staff and should have appropriate credentials (e.g., MD, NP, PA) to support the QI/QA plan as determined by needs and size of the health center.

- 8) Describe plans for assisting individuals in determining their eligibility for, and enrolling in, health insurance options that will be available starting in January 2014 as a result of the Affordable Care Act.³ Specifically describe how potentially-eligible individuals (both current patients and other individuals in the service area) will be identified and informed of the new options; what type of assistance will be provided for determining eligibility; and what type of assistance will be provided for completion of the relevant enrollment process.
- 9) **NEW APPLICANTS AND CURRENT GRANTEEES APPLYING TO SERVE A NEW SERVICE AREA ONLY:** Within [Attachment 14](#) (see [Appendix D](#)), outline a plan with appropriate and reasonable time-framed tasks (i.e., infrastructure development, including developing operational policies/procedures, applying for billing numbers, and formalizing referral agreements; provider/staff recruitment and retention; facility development/operational planning; information system acquisition/integration; risk management/quality assurance procedures; and governance), that ensure compliance with Health Center Program Requirements (see <http://bphc.hrsa.gov/about/requirements>) and assure that within 120 days of the Notice of Award, which may occur up to 60 days prior to the project period start date, proposed site(s) will:
 - Be open and operational.
 - Have appropriate staff and providers in place.
 - Begin to deliver services as proposed (consistent with [Forms 5A](#) and [5C](#)) to the proposed target population(s).

COLLABORATION

- 1) Describe both formal and informal collaboration and coordination of services⁴ with other health care providers. Specifically describe collaboration and coordination with the following:
 - a) Existing health centers (Health Center Program grantees and look-alikes).
 - b) Rural health and free clinics.
 - c) Critical access hospitals.
 - d) Other federally-supported grantees (e.g., Ryan White programs, Title V Maternal and Child Health programs).
 - e) State and local health departments.
 - f) Private providers.

³ Medicaid coverage for individuals up to 133% of the FPL in states choosing to provide this coverage; the ability to purchase insurance through an Exchange; the availability of Advanced Premium Tax Credits for insurance purchased through an Exchange for individuals with incomes up to 400% FPL; and the availability of Cost-Sharing Reductions for insurance purchased through an Exchange for persons up to 250% FPL.

⁴ Refer to <http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html> for information on maximizing collaborative opportunities.

- g) Programs serving the same target population (e.g., social services; job training; Women, Infants, and Children (WIC); coalitions; community groups; school districts).
- h) If applicable, organizations that provide services or support to the special population(s) for which funding is sought (e.g., Migrant Head Start, Public Housing Authority, homeless shelters).
- i) If applicable, neighborhood revitalization initiatives such as the Department of Housing and Urban Development's Choice Neighborhoods, the Department of Education's Promise Neighborhoods, and/or the Department of Justice's Byrne Criminal Justice Innovation Program.

Note: Formal collaborations (e.g., contracts, memoranda of understanding or agreement) should also be summarized in [Attachment 7](#).

- 2) Document support for the proposed project through current dated letters of support⁵ that reference specific coordination or collaboration from all of the following in the service area:
 - a) Health centers (Health Center Program grantees and look-alikes).
 - b) Rural health clinics.
 - c) Critical access hospitals.
 - d) Health departments.
 - e) Major private provider groups serving low income and/or uninsured populations.

If such organizations do not exist in the service area (as defined in [Attachment 1](#)), state this. If such letters cannot be obtained from organizations in the service area, include documentation of efforts made to obtain the letters along with an explanation for why such letters could not be obtained. Letters of support should be consistent with [Attachment 1](#).

- 3) Provide current dated letters of support that reference specific coordination or collaboration with community organizations in support of the proposed project beyond those required in Item 2 above (e.g., social service agencies, school districts, homeless shelters).

Note: Merge all letters of support from Items 2 and 3 into a single document and submit it as [Attachment 10](#).

EVALUATIVE MEASURES

- 1) Within the Clinical Performance Measures form (see detailed instructions in [Appendix B](#)), outline time-framed and realistic goals that are responsive to the needs identified in the **NEED** section. **NOTE:** *For new applicants and current grantees applying to serve a new service area, if baselines are not yet available, state when data will be available.* Goals should be limited to the proposed three-year project period. Specifically include:
 - a) Goals for improving quality of care and health outcomes in the required areas of Diabetes, Cardiovascular Disease, Cancer, Prenatal Health, Perinatal Health, Child Health, Weight Assessment and Counseling for Children and Adolescents, Adult Weight

⁵ Letters of support should be addressed to the organization's board, CEO, or other appropriate key management staff member (e.g., Medical Director), not HRSA staff.

Screening and Follow-Up, Tobacco Use Assessment, Tobacco Cessation Counseling, Asthma – Pharmacological Therapy, Coronary Artery Disease – Lipid Therapy, Ischemic Vascular Disease – Aspirin Therapy, Colorectal Screening, Behavioral Health, and Oral Health.

- b) Goals relevant to the needs of migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing for applicants seeking targeted special population funding. An applicant that is not requesting targeted funding but currently serves or plans to serve special population(s) is encouraged to include relevant goals reflecting the needs of these populations.
 - c) Measures (numerator and denominator) and data collection methodology for all goals.
 - d) A summary of at least one key factor anticipated to contribute to and one key factor anticipated to restrict progress toward the stated performance measure goals, and action steps planned for addressing described factors.
- 2) Within the Financial Performance Measures form (see detailed instructions in [Appendix B](#)), outline time-framed and realistic goals that are responsive to the organization’s financial needs. *NOTE: For new applicants and current grantees applying to serve a new service area, if baselines are not yet available, state when data will be available.* Goals should be limited to the proposed three-year project period. Specifically include:
- a) Goals for improving the organization’s status in terms of controlling costs and sustaining financial viability.
 - b) Measures (numerator and denominator) and data collection methodology for all goals.
 - c) A summary of at least one key factor anticipated to contribute to and one key factor anticipated to restrict progress toward the stated performance measure goals, and action steps planned for addressing described factors.
- 3) Provide a brief description of any additional evaluation activities planned to enhance the assessment of progress and project improvement throughout the project period, including tools utilized to collect and analyze relevant data (e.g., patient satisfaction surveys).

RESOURCES/CAPABILITIES

- 1) Describe how the organizational structure (including any sub-recipients) is appropriate for the operational needs of the project (consistent with [Attachments 2](#) and [3](#), and, as applicable, [Attachments 6⁶](#) and [7](#)), including how lines of authority are maintained from the governing board to the CEO/Executive Director down through the management structure.
- 2) Describe how the organization maintains appropriate oversight and authority in accordance with Health Center Program requirements over all contracted/sub-awarded sites and services, including (as applicable):

⁶ Public centers that receive section 330 funding must comply with all applicable governance requirements and regulations. When a public center has a co-applicant board, the public center and co-applicant board must have a formal co-applicant agreement that stipulates roles, responsibilities, and the delegation of authorities of each party in the oversight and management of the public health center, detailing any shared roles and the responsibilities of each party in carrying out governance functions.

- a) Current or proposed contracts and agreements summarized in [Attachment 7](#).
 - b) Sub-recipient arrangements⁷ referenced in [Form 8](#) (any negative response to the Governance Checklist in [Form 8](#) must be explained).
- 3) Describe how the organization's management team (CEO, CD, CFO, CIO, and COO, as applicable):
- a) Is appropriate and adequate for the operational and oversight needs, scope, and complexity of the proposed project.
 - b) Has appropriately defined roles as outlined in [Attachment 4](#), in particular the responsibilities of the CEO or Executive Director for programmatic aspects of the health center, including day-to-day management of health center activities.
 - c) Possesses needed skills and experience for the defined roles as demonstrated in [Attachment 5](#) and ensures consistency of the staffing information provided across Attachments 2-5.

If applicable, describe any changes in key management staff in the last year, including recruitment plans for vacancies or any significant changes in roles and responsibilities.

Note: Current Health Center Program grantees must receive prior approval from HRSA via the EHB Prior Approval Module when there is a change in the Project Director/CEO or when the Project Director/CEO will be absent for more than three months or have a 25 percent reduction in time devoted to the project.

- 4) Describe the plan for recruiting and retaining health care providers necessary for achieving the proposed staffing plan (consistent with [Form 2](#)).
- 5) Describe how the proposed service site(s) (consistent with [Form 5B](#)) are appropriate for implementing the service delivery plan in terms of the projected number of patients and visits (consistent with [Form 1A](#)). New applicants and current grantees applying to serve a new service area must attach floor plans for all proposed sites in [Attachment 13](#). If desired, lease/intent to lease documents may be included in [Attachment 15](#).
- 6) Describe expertise in the following areas:
 - a) Working with the target population.
 - b) Developing and implementing systems and services appropriate for addressing the target population's identified health care needs.

⁷ A sub-recipient is an organization that receives a subaward from a Health Center Program grantee to carry out a portion of the grant-funded scope of project. Sub-recipients must be compliant with all Health Center Program statutory and regulatory requirements, as well as applicable grant requirements specified in 45 CFR Part 74. As a sub-recipient of section 330 funding, such organizations are eligible to receive FQHC benefits, including reimbursement as an FQHC, 340b drug pricing, and FTCA coverage. All sub-recipient arrangements must be documented through a formal written contract/agreement, and a copy must be provided to HRSA as an attachment to [Form 8](#). The grantee must demonstrate that it has systems in place to provide reasonable assurances that the sub-recipient organization complies with – and will continue to comply with – all statutory and regulatory requirements throughout the period of award.

Note: Public Housing Primary Care (PHPC) applicants must specifically describe how residents of public housing were involved in the development of the application and will be involved in administration of the proposed project.

- 7) Describe the organization's ongoing strategic planning process, including:
 - a) The role of the governing board in strategic planning.
 - b) The role of key management staff and any other relevant individuals in strategic planning.
 - c) The frequency of strategic planning meetings (e.g., annually, bi-annually).
 - d) Strategic planning products (e.g., strategic plan, operational plan).
 - e) How often and when health care needs of the target population were last assessed.
 - f) How the target population's health care needs and the related program evaluation plans have been or will be incorporated into the organization's ongoing strategic planning process.
 - g) How the applicant organization's clinical quality needs/performance are addressed.
 - h) How the applicant organization's financial needs/performance are addressed.
- 8) Describe any national quality recognition the organization has received or is in the process of achieving (e.g., Patient-Centered Medical Home, Accreditation Association for Ambulatory Health Care, Joint Commission, state-based or private payer initiatives) as well as any current or planned acquisition and implementation of certified EHR systems—including the number of sites and utilization by providers (i.e., number and types of providers that receive Medicare and Medicaid EHR Incentive Payments)—used for tracking patient and clinical data to achieve meaningful use. Information about meaningful use is available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html.
- 9) Describe the current status or plans for participating in FQHC-related benefits (e.g., Federal Torts Claim Act (FTCA) coverage, FQHC Medicare/ Medicaid /CHIP reimbursement, 340 Drug Pricing Program, Vaccine for Children's Program, National Health Service Corp Providers).
- 10) Describe the processes in place to maximize collection of payments and reimbursement for services, including written policies and procedures for billing, credit, and collection.
- 11) Describe how the financial accounting and control systems, as well as related policies and procedures:
 - a) Are appropriate for the size and complexity of the organization.
 - b) Reflect Generally Accepted Accounting Principles (GAAP).
 - c) Separate functions/duties appropriate to the organization's size to safeguard assets and maintain financial stability.
 - d) Enable the collection and reporting of the organization's financial status as well as tracking of key financial performance data (e.g., visits, revenue generation, aged accounts receivable by income source or payor type, aged accounts payable, lines of credit, debt to equity ratio, net assets to expenses, working capital to expenses).
 - e) Support management decision making.

- 12) Describe the organization's annual independent auditing process performed in accordance with federal audit requirements and submit the most recent financial audit and management letter (or a signed statement that no letter was issued with the audit) as [Attachment 8](#).⁸ Organizations that have been operational for less than one year and do not have an audit may submit monthly financial statements for the most recent six-month period. Organizations with no audit/financial information (i.e., organization formed to apply for this grant) must provide a detailed explanation of the situation, including supporting documentation.
- 13) Describe the status of emergency preparedness planning and development of emergency management plan(s), including efforts to participate in state and local emergency planning. Any negative response on [Form 10](#) must be addressed.

GOVERNANCE

Note: Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups should respond to ONLY Items 5 and 6 below.⁹

- 1) Describe how the Corporate Bylaws ([Attachment 2](#))¹⁰, Articles of Incorporation ([Attachment 9](#)), and/or Co-Applicant Agreement ([Attachment 6](#))¹¹ demonstrate that the organization has an independent governing board that retains (i.e., does not delegate) the following authorities, functions, and responsibilities:
- a) Meets at least once a month (this requirement may be waived for eligible applicants; see [Form 6B](#)).
 - b) Ensures that minutes that document the board's functioning are maintained.
 - c) Selects the services to be provided.
 - d) Determines the hours during which services will be provided.
 - e) Measures and evaluates the organization's progress and develops a plan for the long-range viability of the organization through strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational performance and assets.
 - f) Approves the health center's annual budget.
 - g) Approves the health center's grant applications.

⁸ Current grantees are reminded that the annual audit must also be provided to the Federal Audit Clearinghouse and submitted via EHB. For more information, see <http://bphc.hrsa.gov/policiesregulations/policies/pal200906.html>.

⁹ Per section 330(k)(3)(H), of the PHS Act, Health Center Program governance requirements do not apply to health centers operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or urban Indian organizations under the Indian Health Care Improvement Act.

¹⁰ Bylaws must be signed and dated by the appropriate individual indicating review and approval by the governing board.

¹¹ Public center applicants whose board cannot directly meet health center governance requirements are permitted to establish a separate co-applicant health center governing board that meets all the section 330 governance requirements. In the co-applicant arrangement, the public center receives the section 330 grant and the co-applicant board serves as the health center board. Together, the two are collectively referred to as the health center. The public center and health center board must have a formal co-applicant agreement in place (see [footnote 6](#) for details).

- h) Approves the selection/dismissal and conducts the performance evaluation of the organization's Executive Director/CEO.
 - i) Establishes general policies for the organization. **Note:** In the case of public centers with co-applicant governing boards, the public center is permitted to retain authority for establishing general fiscal and personnel policies for the health center.
- 2) Document that the structure of the board (co-applicant board for a public center) is appropriate in terms of size, composition, and expertise by describing how the following criteria are met:
- a) At least 51 percent of board members are individuals who are/will be patients of the health center (this requirement may be waived for eligible applicants¹²; see [Form 6B](#)).
 - b) As a group, the patient board members reasonably represent the individuals served by the organization in terms of race, ethnicity, and gender (consistent with [Forms 4](#) and [6A](#)).
 - c) Non-patient board members are representative of the community in which the health center's service area is located and selected for their expertise in areas that include but are not limited to community affairs, local government, finance and banking, legal affairs, trade unions and other commercial and industrial concern, or social services.
 - d) Board has a minimum of nine but no more than 25 members, as appropriate for the complexity of the organization and diversity of the community served.
 - e) No more than half of the non-patient board members derive more than 10 percent of their annual income from the health care industry.
 - f) No board member is an employee of the health center or an immediate family member of an employee. (The CEO may serve only as a non-voting *ex officio* board member.)

Note: An applicant requesting funding to serve general community (CHC) AND special populations (MHC, HCH, and/or PHPC) must have appropriate board representation from these populations. At minimum, there must be at least one representative from/for each of the special population groups for which funding is requested. Board members representing a special population should be individuals that can clearly communicate the needs/concerns of the target populations to the board (e.g., advocate for migratory and seasonal agricultural workers, formerly homeless individual, current resident of public housing).

- 3) Document the effectiveness of the governing board by describing how the board:
- a) Operates, including the organization and responsibilities of board committees (e.g., Executive, Finance, Quality Improvement/ Assurance, Risk Management, Personnel, Planning).
 - b) Monitors and evaluates its own (the board's) performance (e.g., identifies and develops processes for assessing and addressing board weaknesses, challenges, training needs).
 - c) Provides board training, development, and orientation for **new members** to ensure that they have sufficient knowledge to make informed decisions regarding the strategic direction, general policies, and financial position of the organization.

¹² Eligible applicants requesting a waiver of the 51% patient majority board composition requirement must list the applicant's board members on [Form 6A](#): Current Board Member Characteristics, NOT the members of any advisory councils.

Note: In the case of a public center with a co-applicant governing board, the public center is permitted to retain authority for establishing general fiscal and personnel policies for the health center.

- 4) **Applicants requesting a waiver of governance requirements ONLY** (only applicants not currently receiving or applying for CHC funding are eligible to request a waiver): Justify the need for a waiver of the governance requirements of patient majority board composition and/or monthly meetings, consistent with [Form 6B](#).
- a) If the 51% patient majority is requested to be waived, justify why this requirement cannot be met and describe in [Form 6B](#) the alternative mechanism(s) for gathering and utilizing patient input (e.g., separate advisory boards, patient surveys, focus groups), including:
- Specific types of patient input to be collected.
 - Methods for documenting input in writing.
 - Process for formally communicating the input directly to the governing board (e.g., quarterly presentations of the advisory group to the full board, quarterly summary reports from patient surveys).
 - How the patient input will be used by the governing board in areas such as: 1) selecting services; 2) setting operating hours; 3) defining strategic priorities; 4) evaluating the organization's progress in meeting goals, including patient satisfaction; and 5) other relevant areas of governance that require and benefit from patient input.
- b) If monthly meetings are requested to be waived, discuss why this requirement cannot be met and describe in [Form 6B](#) the alternative meeting schedule and how it will assure that the board will maintain appropriate oversight of the project.

Note: An approved waiver does not relieve the governing board from fulfilling all other board authorities, functions, and responsibilities required by statute.

- 5) Document that the health center's bylaws and/or other board-approved policy document(s) specifically include provisions that prohibit real or apparent conflict of interest by board members, employees, consultants, and those who furnish goods (e.g., supplies and other expendable property, equipment, real property) or services to the health center with federal funds.
- 6) **INDIAN TRIBES OR TRIBAL, INDIAN, OR URBAN INDIAN GROUPS ONLY:** Describe the applicant organization's governance structure and how it will assure adequate (1) input from the community/target population on health center priorities and (2) fiscal and programmatic oversight of the proposed project.

SUPPORT REQUESTED

- 1) Provide a complete, consistent, and detailed budget presentation through the submission of the following: SF-424A, budget justification, [Form 2](#): Staffing Profile, [Form 3](#): Income Analysis, and the Federal Object Class Categories form.

- 2) Describe how the total budget is aligned and consistent with the proposed service delivery plan and number of patients to be served (consistent with [Form 1A](#): General Information Worksheet).
- 3) Describe how the proportion of requested federal grant funds is appropriate given other sources of funding, including those specified in [Form 3](#): Income Analysis, the Federal Object Class Categories form, and the budget justification.
- 4) Describe expected shifts in payer mix and potential impact on the overall budget (e.g., as a result of the Affordable Care Act).

x. Program Specific Forms

See [Appendix A](#) for Program Specific Forms instructions.

xi. Program Specific Information

See [Appendix B](#) for Program Specific Information instructions.

xii. Attachments

Attachments are supplementary in nature and are not intended to be a continuation of the Program Narrative. Attachments must be clearly labeled and uploaded in the appropriate place within HRSA EHB. See [Table 3](#) for a complete listing of required attachments, including instructions for completing them.

3. SUBMISSION DATES AND TIMES

Application Due Date

[Table 6](#) indicates the due dates for applications under this FOA. Applications completed online are considered formally submitted when: (1) the application has been successfully transmitted electronically to the correct HRSA funding opportunity number by the Authorized Organization Representative (AOR) through Grants.gov and has been validated by Grants.gov on or before the Grants.gov deadline date and time; and (2) the Authorizing Official (AO) has submitted the additional information in HRSA EHB on or before the EHB deadline date and time.

Receipt Acknowledgement

Upon receipt of an application, Grants.gov will send a series of email messages regarding the progress of the application through the system.

1. The first will confirm receipt in the system.
2. The second will indicate whether the application has been successfully validated or has been rejected due to errors.
3. The third will be sent when the application has been successfully downloaded at HRSA.
4. The fourth will notify the applicant of the Agency Tracking Number assigned to the application.

The applicant will receive an “Application successfully transmitted to HRSA” message in HRSA EHB upon successful application submission within the EHB system.

The Chief Grants Management Officer (CGMO) or designee may authorize an extension of published deadlines when justified by circumstances such as natural disasters (e.g., floods, hurricanes) or other service disruptions such as prolonged blackout. The CGMO or designee will determine the affected geographic area(s). For more details, refer to HRSA Electronic Submission User Guide at <http://www.hrsa.gov/grants/apply/userguide.pdf>.

Table 6: Service Area Details

Project Period Start Date	Service Area (Current Grantee's Administrative Site Location)	State	Target Population	Grants.gov Deadline (11:59 PM ET)	EHB Deadline (5:00 PM ET)	Projected Funding (CHC)	Projected Funding (HCH)	Service Area Zip Codes (as of August 2, 2013)	Number of Patients in 2012*
December 1, 2013	Cheyenne	WY	HCH	September 12, 2013	September 26, 2013	\$0	\$405,070	82001	692
December 1, 2013	Round Mountain	CA	CHC	September 12, 2013	September 26, 2013	\$784,496	\$0	96008 96011 96013 96016 96028 96056 96065 96069 96084	3,691

*Number of patients with known zip codes served in 2012. Please visit <http://www.hrsa.gov/grants/apply/assistance/sac-aa> for a patient origin map (if applicable).

Late Applications

Applications that do not meet the deadline criteria above are considered late applications and will not be considered for SAC-AA funding.

4. INTERGOVERNMENTAL REVIEW

State System Reporting Requirements

The Health Center Program is subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. Executive Order 12372 allows states the option of setting up a system for reviewing applications from within their states for assistance under certain federal programs. The Single Point of Contact (SPOC) for review within each participating state can be found at http://www.whitehouse.gov/omb/grants_s poc. Information may also be obtained from the Grants Management Specialist listed in [Section VII](#).

All applicants other than federally recognized Native American Tribal Groups must contact their SPOCs as early as possible to alert them to the prospective applications and receive any necessary instructions on the process used under this Executive Order. For proposed projects serving more than one state, the applicant is advised to contact the SPOC of each affected state.

Letters from the SPOC in response to Executive Order 12372 are due sixty days after the application due date. Letters should be sent electronically to the points of contact listed in [Section VII](#).

Public Health System Reporting Requirements

Under the requirements approved by the Office of Management and Budget, 0937-0195, community-based non-governmental applicants must prepare and submit a Public Health System Impact Statement (PHSIS) to the heads of the appropriate state or local health agencies in the areas to be impacted by the proposed project no later than the federal application due date.

The PHSIS must include: (1) a copy of the SF-424 and (2) a summary of the project, not to exceed one page, which provides:

- A description of the target population whose needs would be met under the proposal.
- A summary of the services to be provided.
- A description of coordination planned with the appropriate state or local health agencies.

If applicants are unclear on where to send the PHSIS, they should contact their SPOC (see contact information above) or PCO at <http://www.bphc.hrsa.gov/technicalassistance/partnerlinks>.

5. FUNDING RESTRICTIONS

Funds under this announcement may not be used for fundraising or the construction of facilities. The HHS Grants Policy Statement (HHS GPS) available at <http://www.hrsa.gov/grants> includes information about allowable expenses.

Pursuant to existing law and consistent with Executive Order 13535 (75 FR 15599), health centers are prohibited from using federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered). This includes all grants awarded under this announcement and is consistent with past practice and long-standing requirements applicable to grant awards to health centers.

Salary Limitation

The Consolidated and Further Continuing Appropriations Act, 2013 (P. L. 113-6), enacted March 26, 2013, continues provisions enacted in the Consolidated Appropriations Act, 2012 (P.L. 112-74). The law limits the salary amount that may be awarded and charged to HRSA grants. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II of the Federal Executive Pay scale. The Executive Level II salary is \$179,700. This amount reflects an individual's base salary **exclusive** of fringe benefits and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to sub-awards/subcontracts for a substantial portion of the project under a HRSA grant.

Per Section 503 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) and continued through the Consolidated and Further Continuing Appropriations Act, 2013 (P. L. 113-6):

- (a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any state or local legislature or legislative body, except in presentation to the Congress or any

state or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any state or local government, except in presentation to the executive branch of any state or local government itself.

(b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any state government, state legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a state, local or tribal government in policymaking and administrative processes within the executive branch of that government.

(c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future federal, state or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

Per Section 523 of the Consolidated Appropriations Act, 2012 (P.L. 112-74), and continued through the Consolidated and Further Continuing Appropriations Act, 2013 (P. L. 113-6), no funds appropriated in this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

6. OTHER SUBMISSION REQUIREMENTS

As stated in [Section IV.1](#), except in very rare cases, HRSA will no longer accept applications in paper form. Applicants are **required** to submit **electronically** through Grants.gov and HRSA EHB.

Grants.gov

To submit an application electronically, use the APPLY FOR GRANTS section at <http://www.grants.gov>. When using Grants.gov, download a copy of the application package, complete it off-line, and then upload and submit the application via Grants.gov.

It is essential that each organization **immediately register** in Grants.gov and become familiar with the Grants.gov application process. The registration process must be complete in order to submit an application. The registration process can take up to one month. To successfully register in Grants.gov, complete all of the following required actions:

- Obtain an organizational Data Universal Number System (DUNS) number.
- Register the organization with the System for Award Management (SAM) —See [Section IV](#) for SAM details.
- Identify the organization's E-Business Point of Contact (E-Biz POC).
- Confirm the organization's SAM Marketing Partner ID Number (M-PIN) password.
- Register and approve at least one Authorized Organization Representative (AOR)—HRSA recommends registering multiple AORs.
- Obtain a username and password from the Grants.gov Credential Provider.

Instructions on how to register, tutorials, and FAQs are available on the Grants.gov Web site at http://www.grants.gov/applicants/app_help_reso.jsp. Assistance is also available from the Grants.gov Contact Center 24 hours a day, 7 days a week (excluding federal holidays) at support@grants.gov or 1-800-518-4726. Applicants must ensure that all passwords and registrations are current well in advance of the deadline.

HRSA EHB

To submit the application in HRSA EHB, the Authorizing Official (AO) and other application preparers must register in EHB. The purpose of the registration process is to collect consistent information from all users, avoid collection of redundant information, and allow for the unique identification of each system user. Registration within HRSA EHB is required only **once for each user**.

User registration within HRSA EHB is a two-step process:

- a. Individuals who participate in the grants process create individual system accounts.
- b. Individual users associate themselves with the appropriate grantee organization(s).

Once an individual is registered, the user can search for an existing organization using the **10-digit grant number** from the **Notice of Award** or the **EHB Tracking Number provided via e-mail within seven business days of successful Grants.gov submission**. The organization's HRSA EHB record is created based on information provided in Grants.gov.

To complete the registration quickly and efficiently, HRSA recommends that applicants identify EHB roles for all participants in the grants management process. HRSA EHB offers three functional roles for individuals from applicant organizations:

- Authorizing Official (AO).
- Business Official (BO).
- Other Employee (for project directors, assistant staff, AO designees, and others).

For more information on functional responsibilities, refer to the HRSA EHB online help feature available at <https://grants.hrsa.gov/webexternal/help/hlpTOC.asp>. Please note that following registration, EHB users must complete a validation step before they can complete the application.

For assistance with HRSA EHB registration, refer to <http://www.hrsa.gov/grants/apply> or contact the HRSA Contact Center Monday through Friday, 9:00 a.m. to 5:30 p.m. ET (excluding federal holidays) at:

- 877-464-4772
- TTY for hearing impaired: 877-897-9910
- CallCenter@hrsa.gov

For assistance with completing and submitting an application in HRSA EHB, contact the BPHC Helpline Monday through Friday, 8:30 a.m. to 5:30 p.m. ET (excluding federal holidays) at:

- 877-974-2742
- BPHCHelpline@hrsa.gov

Formal Submission of the Electronic Application

It is incumbent on applicants to ensure that the AOR is available to submit the application in Grants.gov and the AO is available to submit the application in HRSA EHB by the published due dates and times. HRSA will not accept submission or re-submission of incomplete, rejected, or otherwise delayed applications after the deadlines. Therefore, an organization is urged to submit an application in advance of the deadlines. If an application is rejected by Grants.gov due to errors, the application must be corrected and resubmitted to Grants.gov before the deadline date and time. Deadline extensions will not be provided to applicants who do not correct errors and resubmit before the posted deadlines. Please note that unlike Grants.gov, which allows for revision submissions before the Grants.gov deadline, applicants will **not** be allowed to correct and resubmit applications in HRSA EHB.

If, for any reason, an application is submitted more than once prior to the application due date, HRSA will only accept the applicant's last validated electronic submission prior to the Grants.gov application due date and time, and the corresponding HRSA EHB submission (submitted prior to the EHB application due date and time), as the final and only acceptable application.

Tracking an application: It is incumbent on the applicant to track their application by using the Grants.gov tracking number (GRANTXXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking an application can be found at <https://apply07.grants.gov/apply/checkApplStatus.faces>. Be sure the application is validated by Grants.gov prior to the application deadline.

V. Application Review Information

1. REVIEW CRITERIA

Procedures for assessing the technical merit of grant applications have been instituted to provide an objective review of applications and assist applicants in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information and provide the reviewer with a standard for evaluation. Review criteria, with scoring points, are outlined below. Reviewers will use the HRSA Scoring Rubric as a guideline when assigning scores to each criterion. The HRSA Scoring Rubric may be found at <http://www.hrsa.gov/grants/apply/assistance/sac-aa>. Information presented in the application will also impact the project period if funding is awarded. See [Table 7 for more information](#).

In the event that a current grantee applying to continue serving its current service area submits the only application for the service area, HRSA will conduct a comprehensive internal review of the application in lieu of an external objective review. Applications receiving internal HRSA review will be subject to the same completeness and eligibility screening as those receiving external review and will be reviewed for compliance with all Health Center Program requirements and projected performance goals.

Review criteria are used to review and rank applications. Applicants must ensure that the review criteria are fully addressed within the Program Narrative, except where indicated, and supported by supplementary information in the other sections of the application. Each application will be evaluated on the following seven review criteria:

Criterion 1: NEED (15 Points)

- The extent to which the applicant demonstrates the health care needs in the service area/target population, including any targeted special populations as documented by quantitative and qualitative data provided in the Need for Assistance Worksheet - Form 9 and listed in [Item 1 of the *NEED* section of the Program Narrative](#).
- The extent to which the applicant clearly describes the existing primary health care services and service gaps in the service area, the factors affecting the broader health care environment, and the role that the applicant organization currently plays or will play in the local health care landscape through SAC-AA grant support.

Criterion 2: RESPONSE (20 Points)

- The extent to which the applicant demonstrates that the proposed service delivery model(s), sites, services, staffing plan, and coordination with other providers/institutions in the community will provide continuity of care while ensuring that the target population's continuum of health care needs (as outlined in the *NEED* section) are met.
- The extent to which the applicant establishes that the schedule of charges: is reasonable and consistent with local rates and that the corresponding sliding fee discount schedule(s), including any justified nominal fees; ensures that services are available and accessible to all without regard to ability to pay; applies discounts based on a patient's income; and is appropriately promoted.
- The extent to which the applicant establishes that the QI/QA and risk management plans are or will be integrated into the health center's routine management efforts and will be utilized to ensure ongoing improvement of services and practices.
- The extent to which the application defines reasonable plans for assisting individuals (both current patients **and** other service area residents) in determining their eligibility for, and enrolling in, health insurance options that will be available starting in January 2014 as a result of the Affordable Care Act.
- The extent to which the applicant demonstrates compliance with requirements for targeted special populations, including demonstrating that services targeting residents of public housing (PHPC) are immediately accessible to the targeted public housing communities and that services targeting people experiencing homelessness (HCH) will include the provision of substance abuse services (either directly or through referral).

- New applicant or current grantee applying to serve a new service area: The extent to which the applicant outlines a clear and reasonable implementation plan in [Attachment 14](#) that ensures that within 120 days of the Notice of Award, which may occur up to 60 days prior to the project period start date, proposed site(s) will be open and operational with appropriate staff and providers in place to deliver services at the same or a comparable level as presently provided to the entire announced service area.

Criterion 3: COLLABORATION (10 points)

- The extent to which the applicant establishes that other health care providers in the service area support the proposed project through detailed descriptions of specific commitment, collaboration and/or coordinated activities. Descriptions are supported by the provision of specific letters of support as [Attachment 10](#) from, at a minimum, the organizations listed in [Item 2 of the COLLABORATION section of the Program Narrative](#) and community organizations to be involved in the proposed project.

Criterion 4: EVALUATIVE MEASURES (15 points)

- The extent to which the applicant establishes Clinical and Financial Performance Measures that include realistic contributing and restricting factors, plans for addressing such factors, and goals for the length of the project period that address the required elements as well as unique special population needs identified in the *NEED* section.
- The extent to which the applicant establishes that additional planned evaluation activities are methodologically sound and will lead to project improvements.

Criterion 5: RESOURCES/CAPABILITIES (20 points)

- The extent to which the applicant establishes that the organizational structure, proposed sites, management staff, and policies/procedures are appropriate for the operational and oversight needs of the proposed project, including any contractors and sub-recipients.
- The extent to which the applicant establishes that its experience and expertise working with and addressing the target population's health care needs have well prepared the applicant organization to successfully implement the proposed project.
- The extent to which the applicant establishes a commitment to sustainability by documenting: plans to effectively recruit and retain key management staff and health care providers; policies and procedures for maximizing collection of payments and reimbursement for costs; plans for emergencies; and a strategic planning process that incorporates the target population's needs and related performance measure goals.
- The extent to which the applicant describes current or planned acquisition/development and implementation of certified EHR technology systems as well as any national quality recognition the organization has received or is working towards.

- The extent to which the applicant establishes that appropriate financial accounting and control systems, policies, and procedures are in place to enable data tracking and reporting of the organization's financial status in accordance with Generally Accepted Accounting Principles (GAAP). Applicant provides: (1) an annual independent financial audit that demonstrates the organization's financial stability and compliance with federal laws and regulations, or lack thereof; (2) most recent six months of financial statements; or (3) a detailed explanation of why no audit or financial statement is available.
- The extent to which the applicant demonstrates compliance with requirements for targeted special populations, including involvement of residents of public housing in application development and proposed project implementation.

Criterion 6: GOVERNANCE (10 points)

- The extent to which the applicant establishes that the independent governing board appropriately oversees the proposed project through: compliance with Health Center Program requirements; appropriateness in terms of size, composition, expertise; effective operations; and establishment and review of policies and procedures
- Applicant targeting only special populations and requesting a waiver: The extent to which the applicant justifies the waiver request by providing a reasonable statement of need for the request and describing sufficient alternative procedures for ensuring patient input and/or appropriate project oversight by the governing board.
- Indian tribe or tribal, Indian, or urban Indian group applicant: The extent to which the applicant documents that policy documents specifically prohibit real or apparent conflict of interest and establishes that the governance structure will assure adequate input from the community/target population as well as fiscal and programmatic oversight of the proposed project.

Criterion 7: SUPPORT REQUESTED (10 points)

- The extent to which the applicant provides a detailed and reasonable budget presentation that will reasonably support the proposed project, including planned service delivery and patient/visit projections.
- The extent to which the applicant establishes that the federal request for funds is appropriate given other sources of project income.
- The extent to which the applicant predicts and describes expected shifts in payer mix and potential impact on the overall budget (e.g., as a result of the Affordable Care Act).

2. REVIEW AND SELECTION PROCESS

HRSA's Division of Independent Review is responsible for managing objective reviews. With the exception of situations in which a current grantee submits the only application for its current service area, applications competing for federal funds receive an objective independent review performed by a committee of experts qualified by training and experience in particular fields or disciplines related to the program being reviewed. In selecting review committee members, other factors in addition to training and experience may be considered to improve the balance of the committee (e.g., geographic distribution). Each reviewer is screened to avoid conflicts of interest and is responsible for providing an objective, unbiased evaluation based on the review criteria noted in [Section V.1](#). The committee provides expert advice on the merits of each application to program officials responsible for final award selections.

All applications will be reviewed initially for eligibility (see [Section III](#)), completeness (see [Section IV.2](#)), and responsiveness. **Applications determined to be ineligible, incomplete, or non-responsive to this FOA will not be considered for funding.**

Applications that pass the initial HRSA completeness and eligibility screening, with the exception of situations in which a current grantee submits the only application for a its current service area, will be reviewed and rated by a panel based on the program elements and review criteria presented in this FOA. The review criteria are designed to enable the review panel to assess the quality of a proposed project and determine the likelihood of its success. The criteria are closely related to each other and are considered as a whole in judging the overall quality of an application.

Additional Review Information

Factors such as past performance, including unsuccessful progressive action condition resolution (see <http://bphc.hrsa.gov/policiesregulations/policies/pal201001.html> for more information), and current compliance with section 330 program requirements and regulations will be considered when selecting applications for funding (see [Table 7](#)). HRSA will review fundable applicants for compliance with HRSA program requirements through site visits, audit data, UDS or similar reports, Medicare/Medicaid cost reports, external accreditation, or other performance reports, as applicable. HRSA also reserves the right to conduct onsite verification of compliance prior to any final funding decision. The results of this review and/or any onsite verification may impact final funding or project period decisions.

If a current grantee had one-year project periods awarded via SAC or SAC-Additional Area in FY 2012 and FY 2013 and meets the criteria for a one-year project period for FY 2014 (see [Table 7](#) below for Project Period Length factors), a SAC-AA award will not be made to this grantee.

Project Period Determining Factors

The criteria in [Table 7](#) below will be utilized to determine the project period for all FY 2014 SAC-AA awards.

Table 7: Project Period Length Factors

Criteria	Project Period Length
<p>0 to 4 Health Center Program requirement conditions</p> <p><i>New applicants:</i> Conditions related to Health Center Program requirements to be placed on award based on information included in this application and review of Additional Review information</p> <p><i>Current grantees:</i> Current unresolved conditions related to Health Center Program requirements carried over into the new project period combined with any new conditions related to Health Center Program requirements to be placed on award based on information included in this application and review of Additional Review information</p>	<p>3 Year Project Period</p>
<p>One or more of the following:</p> <ul style="list-style-type: none"> • 5 or more Health Center Program requirement conditions • Most recent audit called into question whether the organization is able to continue as a "going concern" (without the threat of liquidation for the foreseeable future, usually regarded as a period of at least 12 months). • Current grantee with an unresolved condition related to Health Center Program requirements in the 30-day phase of Progressive Action carried over into the new project period <p><i>New applicants:</i> Conditions related to Health Center Program requirements to be placed on award based on information included in this application and review of Additional Review information</p> <p><i>Current grantees:</i> Current unresolved conditions related to Health Center Program requirements carried over into the new project period combined with any new conditions related to Health Center Program requirements to be placed on award based on information included in this application and review of Additional Review information</p> <p>Reminder: If a current grantee had one-year project periods awarded via SAC or SAC-Additional Area in FY 2012 and FY 2013 and meets the criteria for a one-year project period for FY 2014, a SAC-AA award will not be made to this grantee</p>	<p>1 Year Project Period*</p>

* All NoAs issued for a one-year project period will include the term for restricted drawdown. When a grantee is placed on restricted drawdown, all drawdown of federal funds must have approval from the Division of Grants Management Operations.

Special Funding Considerations

Other factors such as geographic distribution, past performance, and compliance with section 330 program requirements and applicable regulations may be considered as part of the selection of applications for funding. HRSA will consider the following factors in making awards:

- **RURAL/URBAN DISTRIBUTION OF AWARDS:** Aggregate awards in FY 2014 will be made to ensure that no more than 60 percent and no fewer than 40 percent of centers serve people from either rural or urban areas.

- *PROPORTIONATE DISTRIBUTION*: Aggregate awards in FY 2014 to support the various types of health centers (CHC, MHC, HCH, and/or PHPC) will be made to ensure continued proportionate distribution of funds across the Health Center Program as set forth in section 330(r)(2)(B) of the PHS Act.

3. ANTICIPATED ANNOUNCEMENT AND AWARD DATES

It is anticipated that awards will be announced prior to the applicable project period start date (see [Table 6](#)).

VI. Award Administration Information

1. AWARD NOTICES

For applications that receive external objective review, applicants will receive written notification of the outcome of the objective review process, including a summary of the expert committee's assessment of the application's strengths and weaknesses, and whether the application was selected for funding. Applicants selected for funding may be required to respond in a satisfactory manner to conditions placed on their award before funding can proceed. Letters of notification do not provide authorization to begin performance.

The Notice of Award sets forth the funding amount of funds granted, the terms and conditions of the award, the effective date of the award, the budget period for which initial support will be given, the non-federal share to be provided (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant's Authorized Organization Representative, and is the only authorizing document. It will be sent prior to the project period start date (see [Table 6](#)).

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

Successful applicants must comply with the administrative requirements outlined in [45 CFR Part 74](#): Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations or [45 CFR Part 92](#): Uniform Administrative Requirements for Grants And Cooperative Agreements to State, Local, and Tribal Governments, as appropriate.

HRSA grant awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable based on recipient type and purpose of award. This includes any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at <http://www.hrsa.gov/grants/hhsgrantspolicy.pdf>. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award).

Standards for Financial Management

Recipients are required to meet the standards and requirements for financial management systems set forth in 45 CFR 74.21 or 92.20, as applicable. The financial systems must enable the recipient to maintain records that adequately identify the sources of funds for federally assisted activities and the purposes for which the award was used, including authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and any program income. The system must also enable the recipient to compare actual expenditures or outlays with the approved budget for the award.

HRSA funds must retain their award-specific identity—they may not be commingled with state funds or other federal funds. [“Commingling funds” typically means depositing or recording funds in a general account without the ability to identify each specific source of funds for any expenditure.]

See the “Financial Management” section in the HHS Grants Policy Statement available at <http://www.hrsa.gov/grants> for additional information.

Non-Discrimination Requirements

To serve persons most in need and to comply with federal law, services must be widely accessible. Services must not discriminate on the basis of age, disability, sex, race, color, national origin or religion. The HHS Office for Civil Rights provides guidance to grant and cooperative agreement recipients on complying with civil rights laws that prohibit discrimination on these bases. Please see <http://www.hhs.gov/ocr/civilrights/understanding>. HHS also provides specific guidance for recipients on meeting their legal obligation under Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin in programs and activities that receive federal financial assistance (P. L. 88-352, as amended and 45 CFR Part 80). In some instances a recipient’s failure to provide language assistance services may have the effect of discriminating against persons on the basis of their national origin. Please see <http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html> to learn more about the Title VI requirement for grant and cooperative agreement recipients to take reasonable steps to provide meaningful access to their programs and activities by persons with limited English proficiency.

Integrating Primary Care and Public Health

Integration of primary care and public health links people, policy, programs and activities to increase efficiency and effectiveness and ultimately improve population health. Both primary care and public health emphasize prevention as a key driver of better health, and integration of the two fields can transform our focus on disease and treatment to health and wellness, as well as maximize our health care system investment. Integration occurs on a continuum and includes mutual awareness, cooperation, collaboration and partnership. Successful integration requires primary care and public health to work together along this continuum and address social and environmental determinants of health, engage communities, align leadership, develop the healthcare workforce, sustain systems, and share and collaborate on the use of data and analysis – all with an eye toward achieving a shared goal of population health improvement. Integration of primary care and public health is a major focus for HRSA and HHS, and to the extent

possible, applicants should consider ways to integrate primary care and public health in the activities they pursue. More information can be found at <http://www.hrsa.gov/publichealth/>.

Trafficking in Persons

Awards issued under this FOA are subject to the requirements of Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to <http://www.hrsa.gov/grants/trafficking.html>.

Smoke-Free Workplace

The Public Health Service strongly encourages all award recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. Further, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care, or early childhood development services are provided to children.

Affordable Care Act (ACA) Outreach and Education

It is important to note that a healthier country is one in which more Americans are able to access the care they need to prevent the onset of disease and manage disease when it is present. Insurance coverage is strongly related to better health outcomes for both children and adults. Access to insurance improves health outcomes by helping people obtain preventive and screening services, prescription drug benefits, mental health and other services, and by improving continuity of care.

The Affordable Care Act (ACA), the health care law of 2010, creates new state-based marketplaces, also known as exchanges, to offer millions of Americans new access to affordable health insurance coverage. Individuals with incomes between 100 to 400 percent FPL may be eligible to receive advance payments of premium tax credits and/or cost-sharing reductions to help pay for the cost of enrolling in a qualified health insurance plan and paying for coverage of essential health benefits. In states that choose to participate in the ACA expansion of Medicaid to non-disabled adults with incomes of up to 133 percent of Federal Poverty Level (FPL), this provision will provide new coverage options for many individuals who were previously ineligible for Medicaid. In addition, the law helps make prevention affordable and accessible for Americans by requiring health plans to cover certain recommended preventive services without cost sharing.

Outreach efforts would ensure that families and communities understand these new developments and would provide eligible individuals the assistance they need to secure and retain coverage as smoothly as possible during the transition and beyond. You are expected to share information with your service area/target population about these options and to assist them, to the extent it is an appropriate activity under your grant, in enrolling in available insurance plans or in finding other available sources of payment for the services you provide.

For more information on the marketplaces and the health care law, visit <http://www.healthcare.gov>.

Cultural and Linguistic Competence

HRSA programs serve culturally and linguistically diverse communities and multiple cultures. Although race and ethnicity are often thought to be dominant elements of culture, HRSA-funded programs embrace a broader definition to incorporate diversity within specific cultural groups including but not limited to cultural uniqueness within Native American populations, Native Hawaiian, Pacific Islanders, and other ethnic groups, language, gender, socio-economic status, sexual orientation and gender identity, physical and mental capacity, age, religion, housing status, and regional differences. Organizational behaviors, practices, attitudes, and policies across all HRSA-supported entities respect and respond to the cultural diversity of communities, clients and students served. HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, materials delivered by competent providers in a manner that factors in the language needs, cultural richness, and diversity of populations served. Quality also means that, where appropriate, data collection instruments used should adhere to culturally competent and linguistically appropriate norms. For additional information and guidance, refer to the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) published by HHS and available online at <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>. Additional cultural competency and health literacy tools, resources and definitions are available online at <http://www.hrsa.gov/culturalcompetence> and <http://www.hrsa.gov/healthliteracy>.

Healthy People 2020

Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The initiative has four overarching goals: (1) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote quality of life, healthy development, and healthy behaviors across all life stages. The program consists of over 40 topic areas containing measurable objectives. HRSA has actively participated in the work groups of all topic areas and is committed to the achievement of the Healthy People 2020 goals. More information about Healthy People 2020 may be found at <http://www.healthypeople.gov>.

National HIV/AIDS Strategy (NHAS)

The National HIV/AIDS Strategy (NHAS) has three primary goals: (1) reducing the number of people who become infected with HIV; (2) increasing access to care and optimizing health outcomes for people living with HIV; and (3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of early entrance into care for people living with HIV to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention, care and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to identify people who are HIV-positive but do not know their serostatus and reduce stigma and discrimination against people living with HIV.

To the extent possible, program activities should strive to support the three primary goals of the NHAS. As encouraged by the NHAS, programs should seek opportunities to increase

collaboration, efficiency, and innovation in the development of program activities to ensure success of the NHAS. Programs providing direct services should comply with federally-approved guidelines for HIV Prevention and Treatment (see <http://www.aidsinfo.nih.gov/guidelines> as a reliable source for current guidelines). More information can also be found at <http://www.whitehouse.gov/administration/eop/onap/nhas>.

Health IT

Health information technology (Health IT) provides the basis for improving the overall quality, safety and efficiency of the health delivery system. HRSA endorses the widespread and consistent use of health IT, which is the most promising tool for making health care services more accessible, efficient and cost effective for all Americans.

Related Health IT Resources:

- [Health Information Technology \(HHS\)](#)
- [What is Health Care Quality and Who Decides? \(AHRQ\)](#)

3. REPORTING

Successful applicants under this FOA must comply with the following reporting and review activities:

a. Audit Requirements

Comply with audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at http://www.whitehouse.gov/omb/circulars_default. Organizations should refer to the submission process described in Program Assistance Letter 2009-06: New Electronic Process for Submitting Required Annual Financial Audits located at <http://bphc.hrsa.gov/policiesregulations/policies/pal200906.html>.

b. Payment Management Requirements

Submit a quarterly electronic Federal Financial Report (FFR) Cash Transaction Report via the Payment Management System. The report identifies cash expenditures against the authorized funds for the grant or cooperative agreement. The FFR Cash Transaction Reports must be filed within 30 days of the end of each calendar quarter. Failure to submit the report may result in the inability to access award funds. Go to <http://www.dpm.psc.gov> for additional information.

c. Status Reports

1) **Federal Financial Report** – The Federal Financial Report (SF-425) is required according to the following schedule: <http://www.hrsa.gov/grants/manage/technicalassistance/federalfinancialreport/ffrschedule.pdf>. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through HRSA EHB. More specific information will be included in the Notice of Award.

2) **Uniform Data System (UDS) Report** – The UDS is an integrated reporting system used to collect data on all health center programs to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments. All grantees are required to submit a Universal Report and, if applicable, a Grant Report annually. The Universal Report provides data on patients, services, staffing, and financing across all section 330 health centers. The Grant Report provides data on patients and services for special populations served (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing).

3) **Progress Report** – Submission and HRSA approval of an annual BPR non-competing continuation application will trigger the budget period renewal and release of each subsequent year of funding (dependent upon Congressional appropriation, program compliance, organizational capacity, and a determination that continued funding would be in the best interest of the federal government). The BPR documents grantee progress on program-specific goals and collects core performance measurement data to track the progress and impact of the project. Grantees will receive an email message via HRSA EHB when it is time to begin working on their progress reports.

4) **Tangible Personal Property Report.** If applicable, the awardee must submit the Tangible Personal Property Report (SF-428) and any related forms. The report must be submitted within 90 days after the project period ends. Awardees are required to report all federally-owned property and acquired equipment with an acquisition cost of \$5,000 or more per unit. Tangible personal property means property of any kind, except real property, that has physical existence. It includes equipment and supplies. Property may be provided by HRSA or acquired by the recipient with award funds. Federally-owned property consists of items that were furnished by the federal government. Tangible personal property reports must be submitted electronically through EHB. More specific information will be included in the NoA.

d. Transparency Act Reporting Requirements

New awards issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252, and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier subaward of \$25,000 or more in federal funds and executive total compensation for the recipient’s and sub-recipient’s five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170. (FFATA details are available online at <http://www.hrsa.gov/grants/ffata.html>). Competing continuation awardees, etc. may be subject to this requirement and will be so notified in the Notice of Award.

VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this FOA by contacting:

Donna Marx
Office of Federal Assistance Management
HRSA Division of Grants Management Operations
301-594-4245
dm Marx@hrsa.gov

Additional information related to overall program issues and/or technical assistance regarding this FOA may be obtained by contacting:

Katherine McDowell or Vesnier Lugo
Office of Policy and Program Development
HRSA Bureau of Primary Health Care
301-594-4300
BPHCSAC@hrsa.gov
<http://www.hrsa.gov/grants/apply/assistance/sac-aa>

Additional technical assistance regarding this FOA may be obtained by contacting the appropriate PCAs, PCOs, or NCAs. For a list of contacts, see <http://www.bphc.hrsa.gov/technicalassistance/partnerlinks>.

Applicants may need assistance when working online to submit their application forms electronically. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726
E-mail: support@grants.gov
iPortal: <http://grants.gov/iportal>

Note: Applicants should always obtain a case number when calling Grants.gov for support.

For assistance with submitting the remaining information in HRSA EHB, contact HRSA's Bureau of Primary Health Care, Monday through Friday, 8:30 a.m. to 5:30 p.m. ET, excluding federal holidays:

BPHC Helpline
1-877-974-2742
BPHCHelpline@hrsa.gov

VIII. Other Information

Technical Assistance Page

A technical assistance Web site has been established to provide applicants with copies of forms, FAQs, and other resources that will help organizations submit competitive applications. To review available resources, visit <http://www.hrsa.gov/grants/apply/assistance/sac-aa>. Refer to <http://www.hrsa.gov/grants/apply> for general (i.e., not SAC-AA specific) videos and slides on a variety of application and submission components.

Federal Tort Claims Act Coverage/Medical Malpractice Insurance

Organizations that receive grant funds under section 330 are eligible for protection from suits alleging medical malpractice through the Federally Supported Health Centers Assistance Act of 1992 (Act). The Act provides that health center employees may be deemed federal employees and afforded the protections of the Federal Tort Claims Act (FTCA).

Organizations must be aware that **participation in the FTCA program is not guaranteed**. Applicants are encouraged to review the requirements that are outlined in the FTCA Policy Manual, Policy Information Notice 2011-01 available at <http://bphc.hrsa.gov/policiesregulations/policies/pin201101.html> and the most current FTCA Deeming Application Program Assistance Letter (search <http://bphc.hrsa.gov/policiesregulations/policies> for keyword FTCA). If an applicant is not currently deemed, the costs associated with the purchase of malpractice insurance must be included in the proposed budget. The search for malpractice insurance, if necessary, should begin as soon as possible. Applicants interested in FTCA will need to submit a new application annually. Applicants are encouraged to review the FTCA Health Center Policy Manual noted above and contact 877-974-BPHC (877-974-2742) for additional information.

340B Drug Pricing Program

The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, codified as Section 340B of the Public Health Service Act, as amended (see <http://www.hrsa.gov/opa/programrequirements/phsactsection340b.pdf>). The program limits the cost of covered outpatient drugs for certain federal grantees, FQHC Look-Alikes, and qualified disproportionate share hospitals. Covered entities may realize a cost savings of 20-50 percent on outpatient drug purchases and additional savings on other value-added services through participation in the 340B Prime Vendor Program (PVP). Pharmacy related technical assistance is available at 866-PharmTA (866-742-7682). There is no cost to participate in the 340B program or the 340B Prime Vendor Program, and eligible entities are not required to have an established in-house pharmacy to participate. For additional information, please contact the Office of Pharmacy Affairs (OPA) at 888-340-2787 or visit the OPA Web site at <http://www.hrsa.gov/opa>.

IX. Tips for Writing a Strong Application

HRSA has designed a technical assistance webpage to assist applicants in preparing applications. Resources include help with system registration, finding and applying for funding opportunities, writing strong applications, understanding the review process, and many other topics which applicants will find relevant topics. The website can be accessed online at: <http://www.hrsa.gov/grants/apply/index.html>.

In addition, a concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at: <http://dhhs.gov/asfr/ogapa/grantinformation/apptips.html>.

Appendix A: Program Specific Forms Instructions

Program Specific Forms must be completed electronically in EHB. Use only the forms approved by the U.S. Office of Management and Budget. To preview the forms, visit <http://www.hrsa.gov/grants/apply/assistance/sac-aa>. Portions of the forms that are “blocked/grayed” out are not relevant to the application and DO NOT need to be completed.

Note: Current grantees applying to serve a new service area must utilize the Program Specific Forms to describe ONLY the proposed project in the new service area.

FORM 1A – GENERAL INFORMATION WORKSHEET (REQUIRED)

Complete Form 1A based on the proposed project.

1. APPLICANT INFORMATION

- Complete all relevant information that is not pre-populated.
- Grant numbers are only applicable for current grantees.
- Use the Fiscal Year End Date field to note the month and day in which the applicant organization’s fiscal year ends (e.g., June 30) to help HRSA know when to expect your audit submission.
- Applicants may check only one category in the Business Entity section. If an applicant is a Tribal or Urban Indian entity and also meets the definition for a public or private entity, then the applicant should select the Tribal or Urban Indian category.
- Applicants may select more than one category for the Organization Type section.

2. PROPOSED SERVICE AREA

2a. Target Population and Service Area Designation

Population Type:

- Population types for which funding is requested will be pre-populated based on information provided in Section A (Budget Summary) of the SF-424A.
- If the population types are not pre-populated or if changes are required, make them on the SF-424A using the **Change Sub-Program** link.

Service Area Designation:

- Applicants seeking CHC funding **MUST** provide **Medically Underserved Area (MUA)** and/or **Medically Underserved Population (MUP)** designation information.
- Select the MUA **and/or** MUP designations that best describe the proposed service area. **For inquiries regarding MUAs or MUPs, call 1-888-275-4772 (option 2) or** contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816. For additional information, visit the Shortage Designation Web site at <http://bhpr.hrsa.gov/shortage>.

2b. Service Area Type:

Select the type (rural, urban, or sparsely populated) that describes the majority of the target population. If sparsely populated is selected, provide the number of people per square mile (must be 7 or less).

2c. Target Population and Provider Information: For all portions of this section:

- Applicants with more than one service site must report aggregate data for all sites in the proposed project.
- **A current grantee applying to continue serving its current service area may report current numbers that are consistent with the most recent data submitted in UDS.** If UDS data does not accurately reflect current numbers (due to additional funding received, change in scope, or shifting service area characteristics such as influx of new populations), please indicate the accurate current data and describe the discrepancy between UDS and current data in [Item 5 of the RESOURCES/CAPABILITIES section of the Program Narrative](#).
- A new applicant or current grantee applying to serve a new service area should report current numbers based on services the applicant is currently providing in the proposed service area (report annualized data) or, if not currently operational in the service area, list the current numbers as zero.
- Data should be consistent across all tables.

Service Area and Target Population:

Provide the estimated number of individuals currently composing the service area and target population. **Note:** Target population numbers must be less than or equal to service area numbers since the target population is generally a subset of the service area population.

Provider FTEs by Type:

1. Provide a count of current provider full-time equivalents (FTEs), paid and voluntary, by staff type. Current grantees should ensure that the FTEs reported are consistent with the reporting of FTEs in UDS (see the 2012 UDS Manual available at <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting>). **Include only provider FTEs** (e.g., physician, nurse practitioner, certified nurse midwife, dentist, dental hygienist, psychiatrist, psychologist, social worker, case manager, patient educator, outreach worker).
2. Project the number of provider FTEs anticipated by the end of the three-year project period based on maintaining the current level of funding.

Do **not** report provider FTEs providing vision or pharmacy services or functioning outside the proposed scope of project.

Patients and Visits by Service Type:

1. Provide the number of current patients and visits within each service type category: medical, dental, behavioral health, substance abuse, and enabling. Within each category, an individual can only be counted once as a patient. An

individual who receives multiple types of services should be counted once for each service type (e.g., once for medical and once for dental).

2. Project the number of patients and visits anticipated within each service type category by the end of the three-year project period at the current level of funding. **Note: HRSA does not expect the number of patients and visits to decline over time.**
 - Applicant must propose to serve at least an equivalent number of patients by the end of the three-year project period as listed in [Table 6](#).
 - Current grantees applying to continue serving the current service area must project a realistic number of patients to be served at the end of the three-year project period, considering all additional/supplemental funding received that should impact this projection (e.g., NAP satellite grant, Capital Development Building Capacity grant).
3. To maintain consistency with the patients and visits reported in UDS, do not report patients and visits for vision services or services outside the proposed scope of project.

When providing the count of patients and visits within each service type category, note the following (see the 2012 UDS Manual available at <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting> for detailed information):

- A visit is a documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services rendered must be paid for by the applicant organization and documented in the patient's record.
- A patient is an individual who had at least one visit in the previous year.
- Since a patient must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.

Unduplicated Patients and Visits by Population Type:

1. Provide the current number of patients and visits within each population type category: general community, migratory and seasonal agricultural workers, public housing residents, and homeless persons. Within each category, an individual can only be counted once as a patient.

Note: The population types in this section of the form do NOT refer only to the requested funding for special populations (i.e., CHC, MHC, HCH, and/or PHPC). An applicant applying for only CHC funding (general underserved community) may still have patients/visits reported in the other population type categories.

2. Follow instructions 2-3 under ***Patients and Visits by Service Type***.

FORM 1C – DOCUMENTS ON FILE (REQUIRED)

Provide the date that each document listed was last reviewed and, if appropriate, revised. This form provides a summary of documents that support the implementation of Health Center Program requirements and key areas of health center operations. The requirements numbers

listed on the form correspond to the list of Health Center Program requirements found at <http://bphc.hrsa.gov/about/requirements>; reference this list for more detailed information about each requirement. Please note that Form 1C is not intended to provide an exhaustive list of all types of health center documents (e.g., policies and procedures, protocols, legal documents).

All documents noted on Form 1C should be maintained and updated by key management staff and, as appropriate, approved and monitored by the health center's governing board. Keep these documents on file, making them available to HRSA **upon request** within 3-5 business days. **DO NOT** submit these documents with the application.

Note: Beyond Health Center Program requirements, other federal and state requirements may apply to health centers. Applicants are encouraged to seek legal advice from their own counsel to ensure that organizational documents accurately reflect all applicable requirements.

Under "Malpractice Coverage Plan" in the "Services" section, new applicants should indicate that malpractice coverage will be in effect as soon as services become operational. Once funded, new grantees can apply for FTCA coverage upon meeting the FTCA eligibility requirements, but they must maintain malpractice coverage in the interim. FTCA participation is not guaranteed. Funded health centers who opt out of FTCA (e.g., Public Entity-Health Centers) must maintain malpractice insurance coverage at all times. See [Section VIII](#) for more information about FTCA.

FORM 2 – STAFFING PROFILE (REQUIRED)

Report personnel salaries supported by the total budget and federal request (i.e., requested Health Center Program section 330 funds) for the **first budget year** of the proposed project, including those that are part of an indirect cost rate. Include only Health Center Program staff for the entire scope of project (i.e., all sites). Anticipated staff changes within the proposed project period must be addressed in [Item 4 of the RESOURCES/CAPABILITIES section of the Program Narrative](#).

- Salaries in categories representing multiple positions (e.g., LPN, RN) must be averaged. To calculate the average annual salary, sum the salaries within the category and divide that amount by the total number of FTEs.
- Do not report portions of salaries that support activities outside the proposed scope of project.
- Do not include contracted staff or volunteers on this form.

Note: The amount for total salaries (this figure will auto-calculate in EHB) may not match the amount allocated for the Personnel cost category of the SF-424A due to the inclusion of salaries charged to indirect costs on the Staffing Profile.

FORM 3 – INCOME ANALYSIS (REQUIRED)

Form 3 will show the projected patient services and other income from all sources (other than the section 330 federal grant) for the first year of the proposed project period. The sum of the requested section 330 federal grant and the projected total income on Form 3 must equal the total budget as presented on the SF-424A. Form 3 income is divided into two parts: (1) program income (known as patient service revenue) and (2) all other income.

Patient service revenue is revenue that is 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 (MCOs), categorical grant programs (e.g., family planning), employers, and health provider organizations are classified as patient service revenue. Reimbursements may be based upon visits, procedures, member months, enrollees, the achievement of performance goals, or other service related measures. All income not classifiable as program income is classified as other income.

Please note that in-kind donations are not included as income on Form 3. Applicants may discuss in-kind donations in the [**SUPPORT REQUESTED**](#) section of the Program Narrative.

Part 1: Program Income

The program income section groups billable visits and income into the same five payer groupings used in the Uniform Data System (UDS – see the UDS Manual available at <http://bphc.hrsa.gov/healthcenterdatastatistics> for details). All patient service revenue is reported in this section of the form. This includes all income from medical, dental, behavioral health, substance abuse, other professional, vision, and other clinical services as well as income from ancillary services such as laboratory, pharmacy, and imaging services.

Patient service revenue includes income earned from Medicaid and Medicare rate settlements and wrap reconciliations which 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.

Patient service revenue associated with sites or services not in the approved scope of project including those pending approval is to be excluded.

Column (a) Patients: These are the projected number of unduplicated patients classified by payer based upon the patient's *primary medical insurance*. The primary insurance is the payer that is billed first. The patients are classified in the same way as found in UDS Table 4, lines 7 – 12. This column should 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.

Column (b): Billable Visits: These include all billable/reimbursable visits.¹³ 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).

¹³ These visits will correspond closely with the visits reported on the UDS Table 5, excluding enabling service visits.

Column (c): Income per Visit: This is the quotient arrived at by dividing projected income by billable visits.

Column (d): Projected Income: This is the projected accrued net revenue, including an allowance for bad debt from all patient services for each pay grouping in the first year of the proposed project period.

Column (e): Prior FY Income Mo/Yr: This is the income data from the most recent fiscal year, which will be either interim statement data or audit data. The fiscal year was specified because the interim data can eventually be compared to actual audit data.

(Lines 1 – 5) Payer Categories: There are five payer categories including Medicaid, Medicare, Other Public, Private, and Self-Pay, reflecting the five payer groupings used in Table 9d of the UDS. The UDS instructions are to be used to define each payer category (see the UDS Manual available at <http://bphc.hrsa.gov/healthcenterdatastatistics>).

Visits are reported on the line of the primary payer (payer billed first). The income is classified by the payer groupings where the income is earned. When a single visit involves more than one payer, attribute that 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, that income is to be shown on the self-pay line. If the co-payment is to be paid by another payer, that income should be shown on the other payer's line. It is acceptable if the applicant cannot accurately associate the income to secondary and subsequent sources.

All service income is to be classified by payer, including pharmacy and other ancillary service revenue. In the event the applicant does not normally classify the projected ancillary or other service revenue by payer category, the projected income is to be allocated by payer group using a reasonable allocation 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.

(Line 1) Medicaid: This includes 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.

(Line 2) Medicare: This includes 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 care management fee income from the ACA Medicare Demonstration Program.

(Line 3) Other Public: This includes income from federal, state, or local government programs earned for providing services that is not reported elsewhere. A CHIP operated independently

from the Medicaid program is an example of other public insurance. Other public also includes income from categorical grant programs when the grant income is earned by providing services. Examples of these include CDC's National Breast and Cervical Cancer Early Detection Program and the Title X Family Planning Program.

(Line 4) Private: This includes income from private insurance plans, managed care plans, insurance plans from the ACA marketplaces/exchanges, 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, and service contracts with employers. Income from health benefit plans which are earned by government employees, 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.

(Line 5) Self-Pay: This includes 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.

(Line 6) Total: This is the sum of lines 1-5.

Part 2: Other Income

This section includes all income other than the patient service revenue shown in Part 1 (exclusive of the section 330 SAC-AA grant request). It includes other federal, state, local, and other income. It is 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 (patients of an entity with which the health center is contracting) 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. See Lines 9 and 10 for examples of services provided to non-health center patients (patients of an entity with which the health center is contracting).

(Line 7) Other Federal: This is income from federal grants where the SAC-AA applicant is the recipient of a Notice of Award from a federal agency. It does not include the section 330 SAC-AA grant request or federal funds awarded through intermediaries (see Line 9 below). It includes grants from federal sources such as the Centers for Disease Control (CDC), Housing and Urban Development (HUD), Centers for Medicaid and Medicare Services (CMS), and others.

(Line 8) State Government: This is income from state government grants, contracts, and programs, including uncompensated care grants; emergency preparedness grants; mortgage assistance; capital improvement grants; school health grants; Women, Infants, and Children (WIC); immunization grants; and similar awards.

(Line 9) Local Government: This is income from local government grants, contracts, and programs, including indigent care grants, community development block grants, capital improvement project grants, 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, so Ryan White Part A grants would be classified as income earned from a local government and be shown on this line.

(Line 10) Private Grants/Contracts: This is income from private sources such foundations, non-profit entities, 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.

(Line 11) Contributions: This is income from private entities and individual donors which may be the result of fund raising.

(Line 12) Other: This is incidental income not reported elsewhere and includes 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.

(Line 13) Applicant (Retained Earnings): This is the amount of funds needed from the applicant's retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why the applicant funds are needed and provide an assurance that the reserves are sufficient to meet the amount budgeted and that the remaining reserves are adequate to support normal operations.

(Line 14) Total Other: This is the sum of lines 7 – 13.

(Line 15) Total Non-Federal: This is the sum of Lines 6 and 14 and is the total non-federal (non-section 330) income. When this value is added to the section 330 grant, the total equals the applicant's total budget for the first year of the proposed project period.

FORM 4 – COMMUNITY CHARACTERISTICS (REQUIRED)

The Community Characteristics form reports service area and target population data for the entire scope of the project for the most recent period for which data are available. 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 an awarding factor.

Service area data must be specific to the proposed SAC-AA project and include the total number of persons for each characteristic (percentages will automatically calculate in 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 is most often a subset of service area data and must include the number of persons for each characteristic within the target population (percentages will automatically calculate in EHB). ***Patient data should not be used to report target population data since patients are typically a subset of all individuals targeted for service.*** Estimates are acceptable.

If the target population includes a large number of transient individuals (e.g., the county has an influx of migratory and seasonal agricultural workers during the summer months) that are not included in the dataset used for service area data (e.g., census data), the applicant should 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 (i.e., Race, Hispanic or Latino Identity, Income as a Percent of Poverty Level, and Primary Third Party Payment Source) **must match**. These total numbers should also be consistent with the service area and target population totals reported on [Form 1A](#). The Special Populations section of Form 4 does not have a row for total numbers; individuals that represent multiple special population categories should be counted in all applicable categories.

Guidelines for Reporting Race

- All individuals must be classified in one of the racial categories, including individuals who also consider themselves Hispanic or Latino. If the data source does not separately classify Hispanic or Latino individuals by race, report them as Unreported/Declined to Report.
- Utilize the following race definitions:
 - 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, Palau, Truk, Yap, or other Pacific Islands in Micronesia, Melanesia or Polynesia.
 - 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, Thailand, and Vietnam.
 - 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 – Patient who chooses 2 or more races.

Guidelines for Reporting Hispanic or Latino Identity

- 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.

Note:

- Applicants compiling data from multiple data sources may find that the total numbers vary across sources. Such applicants should make adjustments as needed to ensure that the total numbers for the first four sections of this form match. Adjustments must be explained in [Item 1 of the NEED section of the Program Narrative](#).
- When completing Form 4, please note that all information provided regarding race and/or ethnicity will be used only to ensure compliance with statutory and regulatory Governing Board requirements. Data on race and/or ethnicity collected on this form will not be used as an awarding factor.

FORMS 5A, 5B, AND 5C—GENERAL NOTES

- Current grantees applying to continue serving their current service area: These forms will be pre-populated with no opportunity for modification. The SAC-AA application should reflect only the current scope of project. Changes in services, sites, and other activities/locations require prior approval through a Change in Scope request submitted in EHB.

Note: In order for pre-population to occur, a current grantee applying to continue serving its current service area must select **Continuation** for Box 2 and provide the grant number for Box 4 on the SF-424 (submitted in Grants.gov – see screen shot in [Section IV.2.i](#)).

Failure to apply in this manner will result in delayed EHB application access.

- New applicants (not currently funded through the Health Center Program) and current grantees applying to serve a new service area: Complete these forms based only on the scope of project for the proposed service area.

FORM 5A – SERVICES PROVIDED (REQUIRED) – NEW APPLICANTS AND CURRENT GRANTEE APPLYING TO SERVE A NEW SERVICE AREA ONLY

Identify how the required and optional additional services will be provided. Only one form is required regardless of the number of proposed sites. All referral arrangements/agreements for required services must be formal written arrangements/agreements. Refer to the Scope of Project policy documents available at <http://bphc.hrsa.gov/policiesregulations/policies> (search for Scope of Project under Sub-topic or Keyword search) for more information on services and modes of service delivery. If the project is funded, only the services included on this form will be considered to be in the approved scope of project regardless of what is described or detailed in other portions of the application.

FORM 5B – SERVICE SITES (REQUIRED) – NEW APPLICANTS AND CURRENT GRANTEE APPLYING TO SERVE A NEW SERVICE AREA ONLY

Provide requested data for each proposed service site. Current grantees applying to serve a new service area will be able to select sites from their current scope, but they must also propose at least one new service or service/administrative site located in the new service area. Refer to the Scope of Project policy documents available at <http://bphc.hrsa.gov/policiesregulations/policies> (search for Scope of Project under Sub-topic or Keyword search) for information on defining sites, including special instructions for recording mobile, intermittent, and other site types. If the project is funded, only the service sites listed on this form will be considered to be in the

approved scope of project regardless of what is described or detailed in other portions of the application.

FORM 5C – OTHER ACTIVITIES/LOCATIONS (AS APPLICABLE) – NEW APPLICANTS AND CURRENT GRANTEES APPLYING TO SERVE A NEW SERVICE AREA ONLY

Provide requested data for other activities/locations (e.g., home visits, health fairs). Only activities 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 should be listed on this form. Refer to the Scope of Project policy documents available at <http://bphc.hrsa.gov/policiesregulations/policies> (search for Scope of Project under Sub-topic or Keyword search) for information on the types of activities/locations that should be included. If the project is funded, only the other activities/locations listed on this form will be considered to be in the approved scope of project regardless of what is described or detailed on other portions of the application.

FORM 6A – CURRENT BOARD MEMBER CHARACTERISTICS (REQUIRED)

For grantees that currently receive Health Center Program funding (current grantees applying to serve their own or a new service area), the data will be pre-populated from their latest SAC/NAP/BPR submission. **Applicants are expected to update pre-populated information as appropriate.**

NOTE: Indian tribes or tribal, or urban Indian organizations are not required to complete this form. When the applicant selects Tribal or Urban Indian as the business entity in Form 1A, Form 6A will automatically show as complete. However, such applicants may include information on this form as desired.

- List all current board members.
- List the current board office held for each board member, if applicable (e.g., Chair, Treasurer).
- List each board member's area of expertise (e.g., finance, education, nursing).
- Indicate if each board member derives more than 10 percent of income from the health care industry.
- Indicate if each board member is a health center patient.
- Indicate if each board member lives and/or works in the service area.
- List how long each individual has been on the board.
- Indicate if each board member is a representative of a special population (i.e., homeless, agricultural, public housing).
- Classify board members in terms of gender, ethnicity, and race.

NOTE: Public centers with co-applicant health center governing boards must list the co-applicant board members.

NOTE: Applicants requesting a waiver of the 51 percent patient majority requirement must list the health center's board members, not the members of any advisory council(s).

FORM 6B – REQUEST FOR WAIVER OF GOVERNANCE REQUIREMENTS (REQUIRED)

Only MHC, HCH and/or PHPC applicants are eligible to request a waiver.

- An applicant that currently receives or is applying to receive CHC (section 330(e)) funding is not eligible for a waiver. Form 6B will not permit the applicant to enter information on this form.
- Indian tribes or tribal, Indian, or urban Indian groups are not required to complete this form. Form 6B will not permit the applicant to enter information on this form.
- Current health center program grantees with an existing waiver must reapply for governance waiver approval as part of the SAC-AA application.
- Eligible applicants may request a waiver of the patient majority board composition and/or board monthly meetings. When completing Form 6B, applicants requesting a waiver must briefly justify why the applicant cannot meet the statutory requirements requested to be waived and summarize the alternative strategies that will assure consumer/patient participation/input (if board is not 51 percent consumers/patients) and/or regular oversight in the direction and ongoing governance of the organization (if no monthly meetings). The text boxes are limited to 500 characters in this section. See [Item 4 of the GOVERNANCE section of the Program Narrative](#) for details on the type of information to include in the strategies section.

FORM 8 – HEALTH CENTER AGREEMENTS (REQUIRED)

Complete Part I, indicating whether current or proposed agreements constitute a substantial portion of the proposed scope of project. If a proposed site is operated by a sub-recipient or contractor, as identified in Form 5B, the answer must be yes. If **Yes**, indicate the number of each type in the appropriate field. If **No**, skip to the Governance Checklist in Part II.

Complete the Governance Checklist. If the response to any of the Governance Checklist items is **No**, the response to the question regarding agreements/arrangements affecting the governing board's composition, authorities, functions, or responsibilities must be **Yes**, and the number of such agreements/arrangements must be indicated. Additionally, **No** responses for the Governance Checklist must be explained in [Item 2 of the RESOURCES/CAPABILITIES section of the Program Narrative](#). Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups may select **Yes** for all items on the Governance Checklist.

Part III should be completed only by applicants that responded **Yes** to Part I.1 or Part II.2. In Part III, use the Organization Agreement Details section to provide the contact information for each organization (up to 10) with which an agreement/arrangement either (1) constitutes a substantial portion of the proposed scope of project (as described in Part I) or (2) impacts the governing board's composition, authorities, functions, or responsibilities (as described in Part II). If a proposed site is operated by a sub-recipient or contractor, as identified in Form 5B, the applicant must attach the agreement or contract. **Upload each agreement/arrangement** (up to 5 for each organization) in full. Agreements/arrangements that exceed these limits should be included in [Attachment 15](#). As a reminder, a summary of all sub-recipient arrangements, contracts, and affiliation agreements must be included in [Attachment 7](#).

Note: Items attached to Form 8 will **not** count against the page limit. Items included in [Attachment 15](#) will count against the page limit.

FORM 9 – NEED FOR ASSISTANCE WORKSHEET (REQUIRED)

The worksheet is presented in three sections: Core Barriers, Core Health Indicators, and Other Health and Access Indicators.

Please note that the following changes have been made to the worksheet since the FY 2013 SAC:

- Core Barrier: Percent of Population below 200 Percent Federal Poverty Level (FPL): Applicants are required to report the percentage of the **service area** population below 200 percent of the FPL. Only applicants applying to serve special populations exclusively (MHC, HCH, and/or PHPC) may use this barrier to report the percentage of the target population in poverty. See the [Data Reporting Guidelines Table](#) for additional clarification.
- Core Barrier: Percent of Population Uninsured: Applicants are required to report the percentage of the **service area** population that is uninsured. Only applicants applying to serve special populations exclusively (MHC, HCH, and/or PHPC) may use this barrier to report the percentage of the target population that is uninsured. See the [Data Reporting Guidelines Table](#) for additional clarification.
- Indicators in Section 2: Core Health Indicators and Section 3: Other Health and Access Indicators have been added, removed, or modified to include the most current indicators for which data are readily available at the sub-state level. In addition, corresponding benchmarks for each indicator have been updated.

GENERAL INSTRUCTIONS

Only one NFA Worksheet will be submitted per applicant. If an applicant proposes multiple sites, the NFA Worksheet responses should represent the total combined population for all sites. Data values for different sites should be combined. **Only one response may be submitted for each barrier or health indicator.**

Guidelines for Completing the NFA Worksheet:

- All responses must be expressed as a finite number (e.g., 212.5) and cannot be presented as a range (e.g., 31-35).
- The data sources used should be those identified in the Data Resource Guide located at <http://www.hrsa.gov/grants/apply/assistance/sac-aa> or alternative sources. Alternative sources must have the same parameters for each indicator as the source in the Data Resource Guide. For example, any source used for diabetes prevalence must provide age-adjusted rates. See the Data Resource Guide for more information.
- Responses to all indicators must be expressed in the same format/unit of analysis identified on the worksheet (e.g., a mortality ratio cannot be used to provide a response to age-adjusted death rate). The following table provides examples of the unit and format of responses:

Format/Unit of Analysis	Example Format	Example Description
Percent	25%	25 percent of target population is uninsured
Prevalence expressed as a percent	8.5%	8.5 percent of population has asthma
Prevalence expressed as a rate	9 per 1,000 population	9 of every 1,000 infants die
Rate	50 per 100,000	50 hospital admissions for hypertension per 100,000 population
Ratio	3,000:1	3,000 people per every 1 primary care physician

Note: When entering rate or ratio data in EHB, provide only the variable number, not the entire ratio (i.e., 3,000:1 would be entered as 3,000).

POPULATION BASIS FOR DATA

Provide data for three of four Core Barriers in Section 1, one Core Health Indicator for each of six categories in Section 2, and two of the 13 Other Health and Access Indicators in Section 3.

Data Reporting Guidelines Table

Applicants should report data for the NFA Worksheet measures based on the population groups specified in the table below. In cases where data are not available for the specific service area or target population, applicants are encouraged to explore the use of extrapolation techniques to make valid estimates using data available for related areas and population groups. See the Data Resource Guide located at <http://www.hrsa.gov/grants/apply/assistance/sac-aa> for further information on the use of extrapolation. Where data are not directly available and extrapolation is not feasible, applicants should use the best available data describing the area or population to be served. In such a case, applicants must explain the data provided.

Form Sections	General Community 330(e) ONLY	General Community 330(e) plus one or more Special Populations (330(g), (h), and/or (i))	One or more Special Populations 330(g), (h), and/or (i) ONLY
Core Barrier: Population to One FTE Primary Care Physician	Target Population	Target Population	Target Population
Core Barrier: Percent of Population below 200% of Poverty	Service Area	Service Area	Target Population
Core Barrier: Percent of Population Uninsured	Service Area	Service Area	Target Population
Core Barrier: Distance (miles) or Travel Time (minutes) to Nearest Primary Care Provider Accepting New Medicaid	N/A	N/A	N/A
Core Health Indicators	Target Population	Target Population	Target Population
Other Health and Access Indicators	Target Population	Target Population	Target Population

Note: Core Barrier: Distance (miles) or Travel Time (minutes) to Nearest Primary Care Physician Accepting New Medicaid and Uninsured Patients is not calculated based on population. For this core barrier, distance/time is measured from the proposed site to the nearest physician accepting new Medicaid and uninsured patients.

Extrapolation

For detailed instructions for each indicator and information on using and documenting acceptable extrapolation techniques, refer to the Data Resource Guide (available at <http://www.hrsa.gov/grants/apply/assistance/sac-aa>). Extrapolation to the service area, target population, or both may be needed. The need for extrapolation will depend on:

- Which Core Barrier or Health Indicator is being reported.
- Whether the applicant is targeting the entire population within the service area or a specific subset of the population.
- The availability and specificity of data for each Core Barrier and Health Indicator.

Note: Applicants must document how extrapolation was conducted and what data sources were used. The Data Resource Guide provides additional detail on using and documenting acceptable extrapolation techniques. If data are not available to conduct a valid extrapolation to the specific service area and/or target population, the applicant should use data pertaining to the immediately surrounding geographic area/population (e.g., if target population data are not available, service area data may be used; if county level data are available, state level data cannot be used).

DATA RESPONSE AND SOURCES

The Data Resource Guide provides a listing of recommended data sources and instructions on utilizing these sources to report each indicator. Applicants may use these sources or other alternate publicly available data sources if the data is collected and analyzed in the same way as the suggested data source. Applicants must use the following guidelines when reporting data:

- (a) All data must be from a reliable and independent source, such as a state or local government agency, professional body, foundation, or other well-known organization using recognized, scientifically accepted data collection and/or analysis methods. Applicants must assure that any alternate sources used collect and report data in the same manner as the suggested data source.
- (b) Applicants must provide the following information:
 - **Data Response**—The data reported for each indicator on which the NFA score will be based.
 - **Year to which Data Apply**—Provide the year of the data source. If the data apply to a period of more than one year, provide the most recent year for the data reported.
 - **Data Source/Description**—If a data source other than what is included in the Data Resource Guide is utilized, name the data source and provide a rationale (e.g., more current, more geographically specific, more population specific). For example, if a county-level survey which meets all the required criteria was used, name that survey and provide a rationale for using it.
 - **Methodology Utilized/Extrapolation Method**—Provide the following information:

- Extrapolation methodology used – State whether extrapolation was from one geographic area to another, one population to another, both, or none.
- Differentiating factor used – Describe the demographic factor upon which the extrapolation was based (e.g., rates by age, gender, race/ethnicity) and data source.
- Level of geography – State geographic basis for the data (e.g., the data source may be a national survey, but the geographic basis for extrapolation was at the county level).
- **Identify Geographic Service Area or Target Population for Data**—Define the service area and/or target population used (e.g., zip codes, Census tracts, MUA or MUP designation, population type).

SECTION 1: CORE BARRIERS

A response is required for **3 of the 4 Core Barriers**. The table below provides the national median (50th percentile) benchmark for three of the four core barriers as a point of reference.

SECTION 1: CORE BARRIERS	National Median Benchmark
A: Population to One FTE Primary Care Physician	1,641
B: Percent of Population below 200% of Poverty	36.6%
C: Percent of Population Uninsured	14.1%
D: Distance or Travel Time to Nearest Primary Care Provider Accepting New Medicaid and Uninsured Patients	N/A

SECTION 2: CORE HEALTH INDICATORS

Applicant must provide a response to **1 core health indicator from each of the 6 categories:** Diabetes, Cardiovascular Disease, Cancer, Prenatal and Perinatal Health, Child Health, and Behavioral Health. The table below provides the national median (50th percentile) benchmark for each indicator within the six categories as a point of reference.

If an applicant determines that none of the specified indicators represent the applicant’s service area or target population, the applicant may propose to use an “Other” alternative for that core health indicator category. In such a case, the National Median Benchmark field will display n/a. See the Data Resource Guide for detailed instructions on providing documentation for an “Other” indicator.

SECTION 2: CORE HEALTH INDICATOR CATEGORIES	National Median Benchmark
1. Diabetes	
1(a) Age-adjusted diabetes prevalence	8.1%
1(b) Adult obesity prevalence	27.6%

SECTION 2: CORE HEALTH INDICATOR CATEGORIES	National Median Benchmark
1(c) Age-adjusted diabetes mortality ¹³ rate (per 100,000)	22.5
1(d) Percent of diabetic Medicare enrollees not receiving a hemoglobin A1c (HbA1c) test	18.0%
1(e) Percent of adults (18 years and older) with no physical activity in the past month	24.0%
1(f) <i>Other</i>	N/A
2. Cardiovascular Disease	
2(a) Hypertension hospital admission rate (18 years and older; per 100,000)	61.4
2(b) Congestive heart failure hospital admission rate (18 years and older; per 100,000)	361.7
2(c) Age-adjusted mortality from diseases of the heart ¹⁴ (per 100,000)	179.4
2(d) Proportion of adults reporting diagnosis of high blood pressure	28.7%
2(e) Percent of adults who have not had their blood cholesterol checked within the last 5 years	23.1%
2(f) Age-adjusted cerebrovascular disease mortality (per 100,000)	41.4
2(g) <i>Other</i>	N/A
3. Cancer	
3(a) Cancer screening – percent of women 18 years and older with no Pap test in past 3 years	18.4%
3(b) Cancer screening – percent of women 50 years and older with no mammogram in past 2 years	22.2%
3(c) Cancer screening – percent of adults 50 years and older with no fecal occult blood test (FOBT) within the past 2 years	83.3%
3(d) Percent of adults who currently smoke cigarettes	17.3%
3(e) Age-adjusted colorectal cancer mortality (per 100,000)	14.0
3(f) Age-adjusted breast cancer mortality (per 100,000) among females	22.1
3(g) <i>Other</i>	N/A
4. Prenatal and Perinatal Health	
4(a) Low birth weight (<2500 grams) rate (5 year average)	7.9%
4(b) Infant mortality rate (5 year average; per 1,000)	6.6
4(c) Births to teenage mothers (ages 15-19; percent of all births)	8.4%
4(d) Late entry into prenatal care (entry after first trimester; percent of all births)	16.4%
4(e) Cigarette use during pregnancy (percent of all pregnancies)	14.1%
4(f) Percent of births that are preterm (<37 weeks gestational age)	12.0%
4(g) <i>Other</i>	N/A
5. Child Health	
5(a) Percent of children (19-35 months) not receiving recommended immunizations: 4-3-1-3-3-1-4 ¹⁵	30.0%
5(b) Percent of children not tested for elevated blood lead levels by 72 months of age	84.1%

SECTION 2: CORE HEALTH INDICATOR CATEGORIES	National Median Benchmark
5(c) Pediatric asthma hospital admission rate (2-17 year olds; per 100,000)	116.0
5(d) Percent of children (10-17 years) who are obese	15%
5(e) Other	N/A
6. Behavioral Health	
6(a) Percent of adults with at least one major depressive episode in the past year	6.6%
6(b) Suicide rate (per 100,000)	13.5
6(c) Binge alcohol use in the past month (percent of population 12 years and older)	24.1%
6(d) Age-adjusted drug poisoning (i.e., overdose) mortality rate per 100,000 population	12.3
6(e) Other	N/A

¹³ Number of deaths per 100,000 reported as due to diabetes as the underlying cause or as one of multiple causes of death (ICD-10 codes E10-E14).

¹⁴ Total number of deaths per 100,000 reported as due to heart disease (includes ICD-10 codes I00-I09, I11, I13, and I20-I51).

¹⁵ 4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B, 1 varicella, and 4 Pneumococcal conjugate.

SECTION 3: OTHER HEALTH AND ACCESS INDICATORS

Applicants must provide responses to **2 of the 13** Other Health and Access Indicators. The table below provides the national median (50th percentile) benchmark for each Other Health and Access Indicator as a point of reference.

SECTION 3: OTHER HEALTH AND ACCESS INDICATORS	National Median Benchmark
(a) Age-adjusted death rate (per 100,000)	764.8
(b) HIV infection prevalence	0.2%
(c) Percent elderly (65 and older)	15.2%
(d) Adult asthma hospital admission rate (18 years and older; per 100,000)	130.7
(e) Chronic Obstructive Pulmonary Disease hospital admission rate (18 years and older; per 100,000)	227.2
(f) Influenza and pneumonia death ¹⁶ rate (3 year average; per 100,000)	18.6
(g) Adult current asthma prevalence	9.0%
(h) Age-adjusted unintentional injury deaths (per 100,000)	40.0
(i) Percent of population linguistically isolated (people 5 years and over who speak a language other than English at home)	10.3%
(j) Percent of adults (18+ years old) that could not see a doctor in the past year due to cost	13.4%
(k) Percentage of adults 65 years and older who have not had a flu shot in the past year	32.6%
(l) Chlamydia (sexually transmitted infection) rate (per 100,000)	389.5
(m) Percent of adults without a visit to a dentist or dental clinic in the past year for any reason	30.4%

¹⁶ Three year average number of deaths per 100,000 due to influenza and pneumonia (ICD 10 codes J09-J18).

FORM 10 – ANNUAL EMERGENCY PREPAREDNESS REPORT (REQUIRED)

Select the appropriate responses regarding emergency preparedness. Explain negative responses in [Item 12 of the RESOURCES/CAPABILITIES section of the Program Narrative](#). This form will be used to assess the status of emergency preparedness planning and progress towards developing and implementing an emergency management plan.

FORM 12 – ORGANIZATION CONTACTS (REQUIRED)

For grantees that currently receive Health Center Program funding (current grantees applying to serve their own or a new service area), the data will be pre-populated from their latest SAC/NAP/BPR submission. It can be revised as necessary.

New applicants, provide the requested contact information. For the Contact Person field, provide an individual who can represent the organization in communication regarding the SAC-AA application.

FEDERAL OBJECT CLASS CATEGORIES FORM (REQUIRED)

This form will collect details about the federal section 330 funding request and the total non-federal (non-section 330) funding for the first year of the proposed project period. This information will enable HRSA to review the proposed use of federal grant dollars to ensure that all applicable requirements described in 45 CFR 74 or 45 CFR 92 are met.

In the Budget Summary section, the federal section 330 funding request and the total non-federal (non-section 330) funding amounts will pre-populate from the total column of the Section A of the SF-424A: Budget Information – Non-Construction Programs. If the pre-populated values are incorrect, adjustments must be made in Section A (Budget Summary) of the SF-424A: Budget Information – Non-Construction Programs.

In the Budget Categories section, break down the federal section 330 funding request by the object class categories (see the [Budget Justification](#) section for details regarding these categories). The Total column should match the equivalent Total column of the SF-424A: Budget Information – Non-Construction Programs.

Appendix B: Program Specific Information Instructions

CLINICAL AND FINANCIAL PERFORMANCE MEASURES

The Clinical and Financial Performance Measures set the clinical and financial goals for the project period. The goals must be responsive to identified community health and organizational needs and correspond to key service delivery activities and organizational capacity discussed in the Program Narrative. The Clinical and Financial Performance Measures goals must be inclusive of all sites and services within scope. Further detail on the Clinical and Financial Performance Measures can be found at <http://www.hrsa.gov/grants/apply/assistance/sac-aa> and <http://www.hrsa.gov/data-statistics/health-center-data/reporting> (refer to the UDS Reporting Manual for specific measurement details such as exclusionary criteria).

Important Details about the Performance Measures Forms

- Applicants **must include** one **behavioral health** (e.g., mental health/substance abuse screening, treatment, or referral) and one **oral health** (e.g., screenings and exams, referrals, dental caries) Clinical Performance Measure of their choice.
- Current grantees applying to serve their current service area should report on their previously developed, pre-populated behavioral and oral health performance measures as long as such measures remain relevant to the project.
- For new applicants and Health Center Program grantees applying to serve a new service area, baselines for performance measures should be developed from data that are valid, reliable, and whenever possible, derived from currently established management information systems.
- Applicants applying for funds to target special populations (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing), **must include** additional performance measures that address the health care needs of these populations. In providing additional performance measures specific to a special population, applicants must reference the target group in the performance measure. For example, if an applicant seeks funds to serve migratory and seasonal agricultural workers, then the applicant must propose to measure “*the percentage of migratory and seasonal agricultural workers who...*” **rather than** simply “*the percentage of patients who...*”.
- Applicants that have identified unique issues (e.g., populations, age groups, health issues, risk management efforts) in the **NEED** section of the Program Narrative are encouraged to include additional related performance measures.
- All performance measure must include a numerator and denominator that can be tracked over time.
- Applicants are required to report prenatal and perinatal performance measures. Please refer to Program Assistance Letter 2013-07 located at

<http://bphc.hrsa.gov/policiesregulations/policies/pal201307.html>. Applicants reporting these measures for the first time can enter 0 for the baseline data and provide a date by which baseline data will be gathered. The projected data field must be completed with a predicted three-year goal (estimates are acceptable).

Special Instructions for Existing Performance Measures

Report the **Diabetes Clinical Performance Measure** as follows:

- Report adult patients with HbA1c levels ≤ 9 percent in the Baseline Data (numerator and denominator subfields) and Projected Data fields.
- If desired, report the additional measurement thresholds (i.e., < 7 percent, < 8 percent, > 9 percent) in the Comments field.

The **Child Health Performance Measure** has been modified to include the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 2 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumococcal conjugate vaccines by age 3.

The **Cancer Screening Performance Measure** has been modified to include the following: Number of female patients age 24 - 64 years of age who received one or more documented Pap tests during the measurement year or during the two years prior to the measurement year OR, for women over 30, received a Pap test accompanied with an HPV test done during the measurement year or the four years prior who had at least one medical visit during the reporting year.

Overview of the Performance Measures Form Fields

In Table 8, YES in the **Is this Field Pre-Populated?** column notes an item that is pre-populated for current grantees applying to continue serving their current service area. A single asterisk (*) in this column denotes a field pre-populated from the latest SAC/NAP/BPR submission. A double asterisk (**) denotes a field pre-populated from the 2012 UDS submission.

Table 8: Overview of Measures Form Fields

Field Name	Is this Field Pre-Populated?	Can I Edit this Field?	Notes
Focus Area	YES	NO	This field contains the content area description for each required performance measure. Applicants may specify additional focus areas for Oral Health and Behavioral Health measures and when adding a non-required Other performance measure.
Performance Measure	YES	NO	This field defines each measure and is editable for Oral Health, Behavioral Health, and Other performance measures. Applicants are required to provide a justification for each edit in the Comments field.
Performance Measure Applicability	YES	YES	Audit-related Financial Performance Measures (Change in Net Assets to Expense Ratio, Working Capital to Monthly Expense Ratio, and Long Term Debt to Equity Ratio) may be marked <i>Not Applicable</i> ONLY by tribal and public center applicants. As desired, these applicants may choose to include

Field Name	Is this Field Pre-Populated?	Can I Edit this Field?	Notes
			substitute measures.
Target Goal Description	NO	YES	This field provides a description of the target goal.
Numerator Description	YES*	NO	In the case of the Clinical Performance Measures, the numerator is the number of patients that meet the criteria identified by the measure (e.g., patients in a specified age range that received a specified service). In the Financial Performance Measures, the numerator field must be specific to the organizational measure. This field can be edited for only Oral Health, Behavioral Health, and Other performance measures. All edits require justification in the Comments field.
Denominator Description	YES*	NO	In the case of the Clinical Performance Measures, the denominator is all patients to whom the measure applies (e.g., patients in a specified age range, regardless of whether they received a specified service). In the Financial Performance Measures, the denominator field must be specific to the organizational measure. This field can be edited for only Oral Health, Behavioral Health, and Other performance measures. All edits require justification in the Comments field.
Baseline Data Baseline Year Measure Type Numerator Denominator	YES** YES* YES** YES**	NO NO NO NO	This field contains subfields that provide information regarding the initial threshold used to measure progress over the course of the project period. The Baseline Year subfield identifies the initial data reference point. The Measure Type subfield provides the unit of measure (e.g., percentage, ratio). The Numerator and Denominator subfields specify patient or organizational characteristics (see rows above). Current grantees applying to continue serving their current service area will not be able to edit this data for the required measures. If such applicants would like to report more current baseline data, this information should be included in the Comments field.
Projected Data	NO	YES	This field provides the goal for the end of the three-year project period. Current grantees applying to continue serving their current service area should ensure that this goal is a three-year projection from the 2012 UDS baseline data.

Field Name	Is this Field Pre-Populated?	Can I Edit this Field?	Notes
Data Source and Methodology	NO	YES	<p>This field provides information about the data sources used to develop the performance measures. Applicants are required to identify data sources and discuss the methodology used to collect and analyze data (e.g., electronic health records (EHR), disease registries). Data must be valid, reliable, and derived from established management information systems.</p> <p>For Clinical Performance Measures, applicants must select the data source—EHR, Chart Audit, or Other (please specify)—before describing the methodology.</p> <p>For Financial Performance Measures, note if data are based on the most recent audit.</p>
Key Factors and Major Planned Actions			
Key Factor Type	NO	YES	<p>The Key Factor Type subfield requires applicants to select Contributing and/or Restricting factor categories. Applicants must specify at least one key factor of each type.</p> <p>The Key Factor Description subfield provides a description of the factors predicted to contribute to and/or restrict progress toward stated goals.</p>
Key Factor Description	NO	YES	<p>The Major Planned Action Description subfield provides a description of the major actions planned for addressing key factors. Applicants must use this subfield to provide detailed major action steps and strategies for achieving each performance measure. This field has a 1,000-character limit.</p>
Major Planned Action Description	NO	YES	
Comments	NO	YES	<p>This open text field, limited to 1,000 characters, enables applicants to provide additional information. Current grantees applying to continue serving their current service area MUST use this field to provide information regarding the past year's progress. Additionally, justifications required from changes made to other form fields must be included here. Information exceeding the character limit should be placed in the EVALUATIVE MEASURES section of the Program Narrative.</p>

Other Performance Measures

In addition to the required Clinical and Financial Performance Measures, applicants may identify other measures relevant to their health center and/or target population. Each additional measure must be defined by a numerator and denominator, and progress must be tracked over time. If a Health Center Program grantee applying to continue serving its current service area no longer tracks a self-defined Other measure, the grantee must note this by marking the measure *Not Applicable* and including a justification in the Comments field as to why reporting is no longer possible and/or relevant.

Resources for the Development of Performance Measures

Current grantees are encouraged to use their UDS Health Center Trend Report and/or Summary Report available in EHB when considering how improvements to past performance can be achieved. Instructions for accessing these reports can be found at <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting> under the **UDS Website and Reports** heading. Applicants may also find it useful to do the following:

- Consider that many UDS clinical performance measures are aligned with the meaningful use measures specified at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_MeasuresTable_Posting_CQMs.pdf.
- Examine the performance measures of other health centers that serve similar target populations.
- Consider state and national performance UDS benchmarks and comparison reports (available <http://www.hrsa.gov/data-statistics/health-center-data/reporting>).
- Use the Healthy People 2020 goals as a guide when developing their organization's performance measures. Healthy People 2020 objectives are at <http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf>. Six of these objectives can be compared directly to UDS clinical performance measures (high blood pressure under control, diabetes HbA1c readings less than or equal to nine, low and very low birth weight infants, access to prenatal care in the first trimester, tobacco use assessment, and tobacco cessation counseling). A table outlining the Healthy People 2020 objectives related to these performance measures can be found at <http://www.hrsa.gov/grants/apply/assistance/sac-aa>.

Appendix C: Budget Presentation Instructions

Applicants must note that in the formulation of their budget presentation, per section 330(e)(5)(A) of the PHS Act (42 U.S.C. 254b), the amount of grant funds awarded in any fiscal year may not exceed the costs of health center operation in such fiscal year less the total of: state, local, and other operational funding provided to the center; and the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in such fiscal year. Further, as stated in section 330 of the PHS Act, the federal cost principles apply only to federal grant funds.

STANDARD FORM 424A

Complete Sections A, B, E, and F (if F is applicable) of the SF-424A: Budget Information – Non-Construction Programs. The budget must be entered separately for each type of Health Center Program (CHC, MHC, HCH, and/or PHPC). The budget must clearly indicate the cost for each program and should be prepared for a **12-month period based on the project period start date**. The budget must be based on the projected level of support for the service area. Current grantees applying to continue serving their current service area should reference Item 13 (Recommended Future Support) or Item 19 (Future Recommended Funding) on the most recent Notice of Award for the appropriate funding amount. This amount will match the amount listed in [Table 6](#) to be referenced by other applicants. Budget amounts must be rounded to the nearest whole dollar.

Use the following guidelines to complete the SF-424A. In addition, please review the sample SF-424A located on the SAC TA website (<http://www.hrsa.gov/grants/apply/assistance/sac-aa>).

SECTION A – BUDGET SUMMARY

Under New or Revised Budget, provide the proposed federal and non-federal budget for the first 12-month budget period broken down by each section 330 program for which funding is requested (CHC, MHC, HCH, and/or PHPC, as applicable). The federal amount refers to only the federal section 330 Health Center Program grant funding requested, not all federal grant funding that an applicant receives. Provide non-federal resources by funding source. Program Income must be consistent with the Total Program Income presented in [Form 3](#): Income Analysis. If the applicant is a state agency, state funding should be included in the applicant field. As a reminder, matching funds are not required for this grant program.

SECTION B – BUDGET CATEGORIES

Update the budget for the first 12-month budget period broken down by each section 330 program for which funding is requested. Each line represents a distinct object class category that must be addressed in the budget justification. Each column should reflect the total budget by object class category for each section 330 program for which funding is requested (use a separate column for CHC, MHC, HCH, and/or PHPC, as applicable). Note that row 7 (Program Income) must be consistent with the Total Program Income presented in [Form 3](#): Income Analysis.

The amounts in the Total Direct Charges row and the Total column will be calculated automatically. Indirect costs may only be claimed with an approved indirect cost rate (see details in the Budget Narrative section below),

SECTION E – BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR THE BALANCE OF THE PROJECT

Enter the federal section 330 funds requested for Year 2 in column (b) and Year 3 in column (c) only for each section 330 program for which funding is requested. **The requested amount for each future year of the project period must not exceed the requested level of funding for the first year.**

SECTION F – OTHER BUDGET INFORMATION (IF APPLICABLE)

Direct Charges: Explain amounts for individual direct object class categories that may appear to be out of the ordinary.

Indirect Charges: Enter the type of indirect rate (provisional, predetermined, final, or fixed) that will be in effect during the project period, the estimated amount of the base to which the rate is applied, and the total indirect expense.

Remarks: Provide other explanations as necessary.

BUDGET JUSTIFICATION

A detailed budget justification in line-item format must be provided for **each requested 12-month period** of federal funding. A three-year budget justification is required. **An itemization of revenues and expenses is necessary only for the first year of the budget justification.** All years of the budget justification should be broken down into federal and non-federal resources. See <http://www.hrsa.gov/grants/apply/assistance/sac-aa> for a sample budget justification.

If there are budget items for which costs are shared with other programs (e.g., other HRSA programs), the basis for the allocation of costs between the programs must be explained. Attach the budget justification in the Budget Narrative Attachment Form section in EHB. The budget justification must be concise and should not be used to expand the Program Narrative. Please be aware that Excel or other spreadsheet documents with multiple pages (sheets) may not print out in their entirety.

New for FY 2014: The budget justification must detail the costs of each line item within each object class category from the [Federal Object Class Categories](#) form (federal section 330 request and non-federal (non-section 330) funding). The budget justification must contain sufficient detail to enable HRSA to determine if costs are allowable.

It is important to **ensure that the budget justification contains detailed calculations explaining how each line-item expense is derived** (e.g., number of visits, cost per unit). Refer to the HHS Grants Policy Statement available at <http://www.hrsa.gov/grants> for information on allowable costs.

Include the following in the budget justification:

Personnel Costs: Personnel costs must be explained by listing the exact amount requested each year. **Reminder:** Award (federal section 330 grant) funds may not be used to pay the salary of an individual at a rate in excess of Federal Executive Level II or \$179,700.¹⁴ An individual's base salary, per se, is **not** constrained by the legislative provision (see [Section IV.2.iii](#)); the rate limitation restricts the amount of the salary that may be charged to the Health Center Program grant. Provide all base salaries at the full amount even if they exceed the salary limit.

See Table 9 below for the information that **must** be included for each staff position supported in whole or in part with federal section 330 grant funds. This level of information is **not** required for staff positions supported entirely with non-federal section 330 grant funds; applicants should reference [Form 2: Staffing Profile](#) in the justification for such staff positions.

Table 9: Budget Justification Sample for Salary Adjustment

Name	Position Title	% of FTE	Base Salary	Adjusted Annual Salary	Federal Amount Requested
J. Smith	Physician	50	\$225,000	\$179,700	\$89,850
R. Doe	Nurse Practitioner	100	\$ 75,950	no adjustment needed	\$75,950
D. Jones	Data/AP Specialist	25	\$ 33,000	no adjustment needed	\$ 8,250

Fringe Benefits: List the components of the fringe benefit rate (e.g., health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement). Fringe benefits must be directly proportional to the portion of personnel costs allocated for the SAC-AA grant.

Travel: List travel costs categorized by local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel, and staff members/patients/board members completing the travel must be outlined. The budget must also reflect travel expenses associated with participating in proposed meetings, trainings, or workshops.

Equipment: Identify the cost per item and justify the need for each piece of equipment to carry out the proposed project. Equipment includes moveable items that are non-expendable, tangible personal property having a useful life of more than 1 year and an acquisition cost that equals or exceeds the lesser of (a) the capitalization level established by the applicant for its financial statement purposes, or (b) \$5,000. Furniture, administrative equipment (i.e., computers, servers, telephones, fax machines, copying machines, software) and special

¹⁴ While this FOA focuses on application of the salary limitation to the federal section 330 grant funds, the salary limitation applies across all HRSA funding. In other words, if a full-time staff member is paid from several HRSA grants, the total federal contribution to that staff person's salary cannot exceed \$179,700.

purpose equipment used for medical activities (e.g., stethoscopes, blood pressure monitors, scales, electronic thermometers) with a useful life of one year or greater and a unit cost of less than \$5,000 may also be included.

Supplies: List the items necessary for implementing the proposed project, separating 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).

Contractual: Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. List both patient care (e.g., laboratory) and non-patient care (e.g., janitorial) contracts. Each applicant is responsible for ensuring that its organization/institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring contracts.

Other: Include all costs that do not fit into any other category and provide an explanation of each cost (e.g., audit, legal counsel). In some cases, rent, utilities, organizational membership fees, and insurance fall under this category if they are not included in an approved indirect cost rate. This category can also include the cost of access accommodations, including sign language interpreters, plain language materials, health-related print materials in alternate formats (e.g., Braille, large print), and cultural/linguistic competence modifications (e.g., use of cultural brokers, translation, or interpretation services at meetings, clinical visits, and conferences).

Indirect Charges: Costs incurred for common or joint objectives that cannot be readily identified but are necessary to organizational operation (e.g., facility operation and maintenance, depreciation, administrative salaries). If an organization does not have an indirect cost rate, the applicant may wish to obtain one through the HHS Division of Cost Allocation (DCA). Visit <https://rates.psc.gov> to learn more about rate agreements, including the process for applying for them.

If an organization does not have a Federally Negotiated Indirect Costs (IDC) Rate Agreement, all costs will be considered direct costs until a rate agreement is negotiated with a federal cognizant agency and provided to HRSA as part of the budget request. If the application is funded, HRSA will reallocate any amount identified under the Indirect Charges cost category to the Other cost category. If the grantee can provide an approved IDC Rate Agreement within 90 days of award, the funds can be moved back to the Indirect Charges cost category. **Organizations with previously negotiated federal indirect cost rates must provide the current federal indirect cost rate agreement in [Attachment 15: Other Relevant Documents](#).**

Appendix D: Implementation Plan

New applicants and current grantees applying to serve a new service area must provide a plan with appropriate and reasonable time-framed tasks (including infrastructure/organizational development, developing operational policies/procedures, applying for billing numbers, and formalizing referral agreements; provider/staff recruitment and retention; facility development/operational planning; information system acquisition/integration; risk management/quality assurance procedures; and governance), that ensure compliance with Health Center Program Requirements (see <http://bphc.hrsa.gov/about/requirements>) and assure that within 120 days of the Notice of Award, which may occur up to 60 days prior to the project period start date, all proposed sites will be operational. The Implementation Plan (as noted in [Item 9 of the *RESPONSE* section of the Program Narrative](#)) is the applicant's opportunity to outline the action steps that it will take to achieve operational status within the 120-day timeframe. Instructions for developing the Implementation Plan are provided below. A sample Implementation Plan is provided on the SAC technical assistance Web site at <http://www.hrsa.gov/grants/apply/assistance/sac-aa>.

In the Implementation Plan, outline goals and action steps necessary to ensure that within 120 days of the Notice of Award, proposed site(s) will:

- Be open and operational;
- Have appropriate staff and providers in place; and
- Deliver services (consistent with Forms 5A and 5C) to the proposed target population.

The Implementation Plan must be specific to the proposed project. Applicants may choose from the following list of focus areas and goals within each area, or may include other goals as desired. The Implementation Plan will be reviewed in conjunction with the Program Narrative, Program Specific Forms, and required attachments to evaluate the application.

Focus Area: Operational Service Delivery Program

- A.1. Provision of Required & Additional Services (Form 5A)
- A.2. Core Provider Staff Recruitment Plan
- A.3. System for Professional Coverage for After Hours Care
- A.4. Admitting Privileges

Focus Area: Functioning Key Management Staff/Systems/Arrangements

- B.1. Appropriate Management Team Recruitment
- B.2. Documented Contractual/Affiliation Agreements
- B.3. Financial Management and Control Policies
- B.4. Data Reporting System

Focus Area: Operational Site(s) within 120 Days

- C.1. Physical Location Ready to Receive Patients
- C.2. Readiness to Serve the Target Population

Focus Area: Implementation of a Sliding Fee Discount Program and Billings and Collections System

- D.1. Implementation of a Compliant Sliding Fee Scale
- D.2. SFDP and Billing and Collections Policies and Procedures

Focus Area: Quality Improvement/Quality Assurance (QI/QA) Program

- E.1. Leadership and Accountability
- E.2. QI/QA Policies and Procedures
- E.3. QI/QA Plan and Process to Evaluate Performance

Focus Area: Governing Board

- F.1. Required Composition Recruitment
- F.2. Required Authority & Functions
- F.3. Conflict of Interest Policies and Procedures

Key Elements of the Project Work Plan

1. Focus Area: Applicants may choose a focus area based on the list above or provide a different focus area based on the action steps necessary to achieve the required operational status.
2. Goal: For each Focus Area, provide at least one goal. Goals should describe measureable results.
3. Key Action Steps: Identify the action steps that must occur to accomplish each goal. For each goal, provide at least one action step. For each action step, identify at least one person/area responsible and time frame.
4. Person/Area Responsible: Identify who will be responsible and accountable for carrying out each action step.
5. Time Frame: Identify the expected time frame for carrying out each action step.
6. Comments: Provide supplementary information as desired.