

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

Bureau of Health Professions
Division of Public Health and Interdisciplinary Education
Area Health Education Centers Program

Area Health Education Centers Infrastructure Development Awards

Announcement Type: New and Competing Continuation

Announcement Number: HRSA-12-013

Catalog of Federal Domestic Assistance (CFDA) No. 93.824

Area Health Education Centers Point of Service

Maintenance and Enhancement Awards

Announcement Type: New and Competing Continuation

Announcement Number: HRSA-12-013

Catalog of Federal Domestic Assistance (CFDA) No. 93.107

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2012

Application Due Date: February 15, 2012

Ensure your 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: November 14, 2011

Issuance Date: November 14, 2011

Modified on 12/28. Summary of modifications listed on next page.

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Authority: Title VII, Section 751 of the Public Health Service Act (42 U.S.C. 294a), as amended by Sec. 5403 of the Patient Protection and Affordable Care Act, Public Law 111-148.

Summary of modifications to HRSA-12-013:

Modified on 12/28:

1. Language has been added to page 19 to clarify how applicants should indicate which funding opportunity (CFDA) they are applying for and to indicate the information conveyed below.

Background: This funding opportunity announcement includes two separate types of funding. CFDA 93.824 is for Area Health Education Centers Infrastructure Development Awards. CFDA 93.107 is for Area Health Education Centers Point of Service Maintenance and Enhancement Awards.

Because the Grants.gov forms will pre-populate the CFDA number 93.824, applicants should clearly indicate which opportunity they are applying for. **In item 2 of the SF-424 R&R form (Applicant Identifier), applicants should indicate which CFDA number they are applying for:**

- CFDA 93.824- Area Health Education Centers Infrastructure Development Awards
- CFDA 93.107- Area Health Education Centers Point of Service Maintenance and Enhancement Awards.

HRSA staff will ensure that applications have the correct CFDA before applications are reviewed.

2. Language has been added to page iii and page 47 regarding a third technical assistance call on January 10, 2012 from 2:00 PM to 4:00 PM (EST).

3. Language has been added on page iii and page 10 to indicate the information conveyed below:

Applicants may submit two applications **only if** both Infrastructure Development, (section 751(a)(1)) and Point of Service Maintenance and Enhancement (section 751(a)(2)) funds are being requested in federal fiscal year 2012.

4. Language has been added on page ii and page 9 to indicate the information conveyed below:

A competitive application process for Point of Service Maintenance and Enhancement may be held, based on availability of funds, in federal fiscal years 2013-2016, for AHEC centers transitioning from Infrastructure Development to Point of Service Maintenance and Enhancement.

Modified on 12/6 to specify that applicants may apply for both opportunities listed in this FOA, regardless of the CFDA. Applicants will NOT be able change the CFDA on the application package and should submit using pre-populated CFDA. If funded, HRSA staff will ensure that the correct CFDA number is included on the notice of award.

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act, Public Law 111-148 (Affordable Care Act) emphasizes the ongoing development of a high quality, culturally competent health workforce that meets the primary health care needs of communities. These efforts require collaborating with workforce investment boards and recruiting individuals into health careers from underrepresented minority populations as well as from disadvantaged or rural backgrounds. The Area Health Education Centers (AHEC) Program addresses these issues through a range of community-based training programs intended to increase the number of primary care providers who provide services in rural and other underserved areas.

Section 751 of the Public Health Service Act (PHS Act) authorizes the AHEC Program, which provides awards to public or nonprofit private accredited schools of medicine, either osteopathic (DO) or allopathic (MD), or incorporated consortia made up of such schools or the parent institution(s) of such schools. With respect to states in which no AHEC program is in operation, a school of nursing is eligible to apply. These educational entities must establish and maintain community-based, primary care training programs in off-campus rural and underserved areas. The AHEC Program consists of two sequential programmatic phases: (1) AHEC Infrastructure Development awards for initiating, planning, developing operating and evaluating an AHEC program and (2) AHEC Point of Service Maintenance and Enhancement awards for improving the capacity and effectiveness of the program through ongoing evaluation.

The AHEC program awardees contract with AHEC centers to coordinate and facilitate the training of health professions students, primary care residents, health care providers, and kindergarten through 12th grade students with a more targeted focus on health career students in high school. These partnerships develop community-based training programs at health service delivery sites in rural, underserved, and other areas in the service area of the AHEC centers. Currently, fifty-seven (57) AHEC Program awardees and 253 affiliated AHEC centers provide health professions training in 48 states, the District of Columbia, Guam, Palau and Puerto Rico.

AHEC Required Activities: Applicants are required to carry out activities from the following seven AHEC Program required activities under Section 751(c)(1) A – G that include: A) health careers recruitment; B) community-based training and education, with emphasis on primary care; C) field placements or preceptorships; D) interdisciplinary/interprofessional education and training; E) continuing education; F) evaluation; and G) public health careers exposure to youth. (See Section II Award Information.)

This FY 2012 program funding opportunity announcement (FOA) solicits applications for a five-year project period for AHEC Infrastructure Development awards and AHEC Point of Service Maintenance and Enhancement awards. **A competitive application process for Point of Service Maintenance and Enhancement may be held, based on availability of funds, in federal fiscal years 2013-2016, for AHEC centers transitioning from Infrastructure Development to Point of Service Maintenance and Enhancement.** Funding for FY 2012 is estimated to be \$31,000,000 total to support 60 AHEC Infrastructure Development and AHEC Point of Service Maintenance and Enhancement awards. The actual number and size of awards will depend on the availability of funds. The AHEC Program has a matching funds requirement with a ratio of 1 to 1 federal funds to non-federal contributions. At least 25 percent of the total required non-federal

contributions shall be in cash. (See additional information and instructions in Section III Eligibility Information.)

Applicants may request Infrastructure Development funds under PHS Act Section 751(a)(1) and Point of Service Maintenance and Enhancement funds under PHS Act Section 751(a)(2) if they meet the eligibility criteria (see Section II Award Information). In the case of applicants seeking funds under subsections (a)(1) **and** (a)(2), the applicant **must submit two separate and complete applications with all the required sections and attachments.** Applicants may submit two applications only if both Infrastructure Development, (section 751(a)(1)) and Point of Service Maintenance and Enhancement (section 751(a)(2)) funds are being requested in federal fiscal year 2012.

Technical assistance calls related to the application process for the AHEC program will be held on December 7, 2011 from 2:00 PM - 4:00 PM (EST), December 13, 2011 from 10:00 AM - 12:00 Noon (EST) **and January 10, 2012 from 2:00 PM to 4:00 PM (EST).** All calls will be recorded and will be available until February 15, 2012.

The deadline for all applications is February 15, 2012.

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I. Funding Opportunity Description

1) Purpose

The Area Health Education Center (AHEC) programs consist of interdisciplinary, community-based, primary care training programs wherein academic and community-based leaders work to improve the distribution, diversity, supply, and quality of health personnel, particularly primary care personnel in the health care services delivery system and more specifically in delivery sites in rural and other underserved areas. This funding opportunity announcement (FOA) solicits applications for a **five-year project period** for AHEC Infrastructure Development awards and AHEC Point of Service Maintenance and Enhancement awards. Successful applicants will be awarded cooperative agreements to establish and advance statewide or multi-county AHEC programs.

2) Background

Background on Bureau of Health Professions

The Bureau of Health Professions (BHP) administers these programs as a component of the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS). The mission of BHP is to increase the population's access to health care by providing national leadership in the development, distribution and retention of a diverse, culturally competent health workforce that can adapt to the population's changing health care needs and provide the highest quality care for all. BHP serves as a focal point for those interested in health professions and workforce issues. Additional information about the BHP and its programs is available at <http://bhpr.hrsa.gov/>.

Area Health Education Centers (AHEC) Program

The PHS Act Section 751(c)(1)(A-B) highlight the importance of developing a health care workforce that meets the needs of communities for primary care. Under this law, there are requirements for coordination with applicable one-stop delivery systems under section 134(c) of the Workforce Investment Act of 1998; and working with workforce investment boards to develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas. There is a need to recruit individuals from underrepresented minority populations or from disadvantaged or rural backgrounds into health careers, with an emphasis on health professionals who provide primary health care. For example, participation in interdisciplinary/interprofessional training involving physicians, physician assistants, nurse practitioners, nurse midwives, dentists, psychologists, pharmacists, optometrists, community health workers, public and allied health professionals or other health professionals, as practicable, is not only encouraged, but it is a required activity for the AHEC Program awardees.

The AHEC Program addresses these issues through a range of academic and community-based training activities intended to contribute to an increase in the number of primary care providers, including physicians and other primary care providers who provide services in rural and other underserved areas. The AHEC Program also aims to develop and implement strategies, in coordination with the applicable one-stop delivery system under section 134-(c) of the Workforce Investment Act of 1998, to recruit individuals from underrepresented minority

populations or from disadvantaged or rural backgrounds into health professions, and support such individuals in attaining health professions careers.

The AHEC Program is administratively located in the HHS, HRSA, BHPPr's Division of Public Health and Interdisciplinary Education and further advances the mission and vision of BHPPr. This program supports the strategic plan developed by HRSA and the objectives defined by Healthy People 2020.

The AHEC Program exists in two programmatic phases: AHEC Infrastructure Development programs and AHEC Point of Service Maintenance and Enhancement programs. The two phases collectively embrace the goal of increasing the number of students in the health professions who will pursue careers in primary care and ultimately practice in medically underserved communities. These academic community-based partnerships focus on training programs to improve the supply, distribution, diversity, and quality of health care providers, and to address the goal of increasing access to health care services by consumers in medically underserved areas or for health disparity populations. The AHEC program assists educational systems in developing and operating projects that will initiate recruitment and retention incentives to attract and retain health care personnel in underserved areas.

All AHEC programs start in the AHEC Infrastructure Development phase, where the planning must reflect the projected growth of the project to include the resulting number of anticipated centers at the conclusion of the expansion period. At least one AHEC center shall be operational in the **first** year of Infrastructure Development funding. The awardee program office must have a written contract with each center that it develops. This contractual agreement shall include a statement of work that will be negotiated annually between the AHEC Program awardee and the governing body of each AHEC center. The agreements should clearly define the geographical region of responsibility without overlap and activities anticipated by each center. By linking the academic resources of the university-based health science center with local planning and educational and clinical resources, the AHEC program establishes a network of community-based training sites to provide educational services to students, faculty, and practitioners in medically underserved areas, and ultimately improves the delivery of health care in those identified service locations.

The AHEC Program emphasizes community-based training for health professions students, residents, and all other providers who have a primary care concentration. These programs provide health careers outreach to encourage an early emphasis on enhancing health career activities at the elementary and secondary school levels that will attract and eventually recruit underrepresented minority or disadvantaged or rural students into the health professions. These outreach programs shall include a youth public health program to expose and recruit high school students into health careers with a focus on careers in public health.

In addition, the AHEC Program promotes health career training opportunities to individuals, including adults, seeking health careers, particularly individuals from underrepresented minority populations and from disadvantaged or rural backgrounds in collaboration with other federal, and state health care workforce development programs, the state workforce agency, and local workforce investment boards, and in health care safety net sites.

In FY 2011, approximately \$31M provided support to 60 AHEC Infrastructure Development

awards, PHS Act section 751(a)(1), and AHEC Point of Service Maintenance and Enhancement awards, PHS Act section 751(a)(2).

AHEC PROGRAM REQUIREMENTS

The Secretary shall ensure the following:

- A. An entity that receives an award under PHS Act section 751 shall conduct at least 10 percent of clinical education required for medical students in community settings that are removed from the primary teaching facility of the contracting institution for awardees that operate a school of medicine or osteopathic medicine. In states in which an entity that receives an award under this section is a nursing school or its parent institution, the Secretary shall alternatively ensure that:
 - i. the nursing school conducts at least 10 percent of clinical education required for nursing students in community settings that are remote from the primary teaching facility of the school; and
 - ii. the entity receiving the award maintains a written agreement with a school of medicine or osteopathic medicine to place students from that school in training sites in the area health education center program area.
- B. An entity receiving funds under PHS Act section 751(a)(2) (AHEC Point of Service Maintenance and Enhancement awards) shall not distribute such funding to a center that is eligible to receive funding under PHS Act section 751(a)(1) (AHEC Infrastructure Development awards).

AHEC CENTER REQUIREMENTS

The Secretary shall ensure that each AHEC program includes at least one AHEC center, and that each such center shall meet the following requirements:

- A. is a public or private organization whose structure, governance, and operation is independent from the awardee and the parent institution of the awardee;
- B. is not a school of medicine or osteopathic medicine, the parent institution of such a school, or a branch campus or other subunit of a school of medicine or osteopathic medicine or its parent institution, or a consortium of such entities;
- C. designates an underserved area or population to be served by the center which is in a location removed from the main location of the teaching facilities of the schools participating in the program with such center and does not duplicate, in whole or in part, the geographic area or population served by any other center;
- D. fosters networking and collaboration among communities and between academic health centers and community-based centers;
- E. serves communities with a demonstrated need of health professionals in partnership with academic medical centers;
- F. addresses the health care workforce needs of the communities served in coordination with

the public workforce investment system; **and**

- G. has a community-based governing or advisory board that reflects the diversity of the communities involved.

ADMINISTRATIVE GUIDANCE FOR AHEC PROGRAMS

All qualified applications will be forwarded to an objective review committee. Based on the advice of the objective review committee, the HRSA program official with delegated authority is responsible for final selection and funding decisions. When making final funding decisions regarding Section 751 awards, consideration will be given to the Sense of the Congress “that every state have an area health education center program in effect under this section.”

The following Administrative Guidance is intended to enhance on-going or new AHEC programs:

- At least one staff member representing the awardee (AHEC program office) and at least one staff member from an AHEC center should attend one HRSA technical assistance meeting in Washington, DC, or elsewhere as deemed by the federal project officer, using staff travel funds as itemized in the proposed budget;
- Confirm through a written submission that a contractual arrangement, which includes a statement of work negotiated, is in place between the AHEC program awardee and the governing body of each AHEC center (submit signed page of each agreement with application);
- The Program Director should hold a faculty appointment in the applicant school and assume responsibility for the overall direction and coordination of the AHEC program;
- The AHEC Center Director should have at least 75 percent time allocated solely to the conduct of center duties and responsibilities;
- The AHEC program awardee should have an advisory board to advise the Program Director on all aspects of the conduct of the program including administration, education, and evaluation. It is suggested that the board meet quarterly with the Program Director to review progress and barriers and collectively plan for further development of the program;
- The AHEC center community-based governing or advisory board should be responsible for the hiring and/or termination of the AHEC Center Director;

The AHEC programs are encouraged to provide a response to Bureau Initiatives specific to developing linkages to Historically Black Colleges and Universities, Hispanic Serving Institutions, and/or Tribal Colleges and Universities and improving the quality of life for African Americans, Latinos, Asian Americans and Pacific Islanders, and American Indians and Alaska Natives as strategies to obtain highly qualified, culturally competent, underrepresented minority health care professionals who will work in medically underserved areas.

II. Award Information

1. Type of Award

Funding will be provided in the form of a cooperative agreement. A cooperative agreement, as

opposed to a grant, is an award instrument of financial assistance where substantial involvement is anticipated between HRSA and the recipient during performance of the contemplated project.

In addition to the usual monitoring and technical assistance provided under the cooperative agreement, **HRSA program responsibilities shall include:**

- Review changes to the composition of the advisory committees and boards;
- Participate in the annual evaluation of the program;
- Assist in planning and implementing project priorities by coordinating and facilitating the interchange of technical and programmatic information;
- Assist project staff in the development, compilation, and dissemination of materials prepared by AHEC and non-AHEC project personnel;
- Review contracts and agreements among recipient medical allopathic or osteopathic schools, other health professions schools, and community-based centers (unless reviews are formally delegated to the recipient cooperating school) for programmatic content; and
- Provide guidance concerning the content, structure, and format of the final project report.

The cooperative agreement recipient's responsibilities shall include:

AHEC Program Required Activities:

To allow applicants to prioritize programming efforts over the five-year project period, the AHEC Program is providing flexibility as it relates to the seven AHEC program required activities. This will enable AHEC Program applicants to focus on responding to identified community needs and developing improved tracking and evaluation of the AHEC program activities, and assess impact over the five-year project period.

Applicants shall identify priority areas within the required activities listed below in alignment with Section 751(c)(1)(A)- (c)(1)(G) for the purpose of focusing their program resources over a five-year period to successfully address specific, identified health workforce issues/problems unique to the applicant's service area. Each AHEC applicant must include evaluation as one of the priority areas and assure that the program addresses the following core AHEC activities:

- **Community-based clinical education.** It is recommended that at least two training sites shall incorporate interdisciplinary/interprofessional education and training. In a program that has both rural and urban AHEC centers, it is recommended that at least one urban and rural interdisciplinary/interprofessional training site be established. Applicants shall collaborate with two or more disciplines as practicable. Participating disciplines shall involve physicians, physician assistants, nurse practitioners, nurse midwives, dentists, psychologists, pharmacists, optometrists, community health workers, public and allied health professionals, or other health professionals, as practicable. Emphasis shall be placed on training in primary care.
- **AHEC pipeline activities.** An AHEC program may include coordination with workforce investment boards or state health care workforce development programs, Health Careers Opportunity Programs (HCOP), other federally supported pipeline programs, and/or establish youth public health careers programs as part of its pipeline activities.

- **Professional education and support.** An AHEC program shall encourage and promote interdisciplinary/interprofessional continuing education for health professionals.

Selection of the priority areas (including evaluation) does not preclude a program from addressing additional or all of the AHEC statutory activities. For AHEC programs with multiple centers, each AHEC center is not expected to carry out all priority areas as long as the AHEC program as a whole with all of its affiliated AHEC centers addresses the selected priority areas.

The following factors should be considered when identifying the priority areas:

- 1) The applicant's **needs assessment** along with available federal, state or local workforce data, which serves to identify a particular health workforce problem/issue in the applicant's service area;
- 2) The applicant's **capacity/resources** to successfully address the specific health workforce problem(s)/issue(s). The applicant may cite past experiences demonstrating success and the current resources available;
- 3) The applicant's **proposed strategy** to address the identified health workforce problem/issue. The extent to which:
 - The approach is based upon a resolution of the identified factors which contribute to the workforce problem/issue;
 - The factors which impact the workforce problem/issue are described, e.g. via logic model; and
 - The proposed strategy represents an evidence-based approach.
- 4) The applicant's **evaluation capabilities**: The extent to which:
 - The staff is capable of carrying out and documenting a short and long term evaluation plan;
 - The potential partnerships or collaborations will be used in the evaluation process;
 - The applicant has articulated performance measures, anticipated outcomes and evidence-based approaches; and
 - The applicant has identified how data will be collected and analyzed to document intermediate progress and ultimate success.
- 5) **The applicant's dissemination plan**: The extent to which the applicant will document success and disseminate evaluation results.

Infrastructure Development programs under PHS Act section 751(a)(1), and Point of Service Maintenance and Enhancement programs under PHS Act section 751(a)(2), shall carry out the following program activities. The examples of activities are provided to give some guidance but do not represent an exhaustive list of activities that would meet the requirements.

- A. Develop and implement strategies, in coordination with the applicable one-stop delivery system under section 134(c) of the Workforce Investment Act of 1998, to recruit individuals from underrepresented minority populations or from disadvantaged or rural

backgrounds into health professions and support such individuals in attaining such careers.

Examples of Activities:

- Collaborate with Workforce Investment Boards (WIBs) to retrain displaced workers in health professions and provide job placement assistance.
- Provide students and displaced workers with educational training requirements in various healthcare occupational areas as well as information and contact with local training programs.
- Work with WIB(s) to have allied health and other disciplines deemed as an apprenticeable trade.
- Establish a community health worker (CHW) training program that leads to certification.

- B. Develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas for the purpose of developing and maintaining a diverse health care workforce that is prepared to deliver high-quality care with an emphasis on primary care, in underserved areas or for health disparity populations, in collaboration with other federal and state health care workforce development programs, the state workforce agency, and local WIB(s), and in health care safety net sites.

Examples of Activities:

- Collaborate with Health Careers Opportunity Program (HCOP) awardees and applicants to recruit underrepresented or disadvantaged or rural individuals into health careers training.
- Provide community-based training opportunities for health professions students to focus on health disparity issues. For example, focusing on educational strategies for diabetes prevention and management in collaboration with local Community Health Centers (CHCs) and Federally Qualified Health Centers (FQHCs).
- Provide students with community-based primary care training, including experience in continuity of care.

- C. Prepare individuals to more effectively provide health services to underserved areas and health disparity populations through field placements or preceptorships in conjunction with community-based organizations, accredited primary care residency training programs, FQHCs, rural health clinics, public health departments, or other appropriate facilities.

Examples of Activities:

- A community-based training experience for health professions students in safety net sites caring for underserved populations.
- Placement of medical students in a rural, underserved clinical rotation that serves not only as a clinical experience, but as a recruitment and retention tool.
- Facilitate training programs in safety-net sites that encourage incumbent workers to complete advanced health professions didactic course work and community-based clinical work.
- Work in partnership with a CHC and/or National Health Service Corps (NHSC) site

- to develop a family practice residency.
- Serve as NHSC Ambassadors to inform eligible students and practitioners about opportunities available through the NHSC.
- Partner with Student/Resident Experiences and Rotations in Community Health (SEARCH) organizations to increase the numbers of primary care providers in underserved areas.

D. Conduct and participate in interdisciplinary/interprofessional training that emphasizes primary care and involves physicians, physician assistants, nurse practitioners, nurse midwives, dentists, psychologists, pharmacists, optometrists, community health workers, public and allied health professionals, or other health professionals, as practicable.

Examples of Activities:

- Provide interdisciplinary/interprofessional didactic presentations and seminars and clinical experiences to medical and health professions students including patient encounters.
- Provide interdisciplinary/interprofessional electives involving students from two or more health professions disciplines and include discussions on the benefits of working with underserved populations.
- Provide interdisciplinary/interprofessional continuing education offerings for health professionals from two or more disciplines.
- Establish interdisciplinary/interprofessional training site.

E. Deliver or facilitate continuing education and information dissemination programs for health care professionals, with an emphasis on individuals providing care in underserved areas and for health disparity populations.

Examples of Activities:

- Provide training to practicing health professionals in primary care, mental health, and other health related topics through continuing education offerings.
- Provide leadership for a state-wide, community-based, community education training program. For example, working with the state health department.
- Provide continuing education programs responsive to the continuing education needs of providers serving health disparity populations or practicing in underserved area sites.

F. Propose and implement effective program and outcomes measurement and evaluation strategies.

Examples of Activities:

- Identify and track health professions students and residents who train in AHEC sites and then enter practice in medically underserved communities and/or practice in primary care.
- Measure change in knowledge and competency after completion of AHEC training program activities, e.g., clinical rotations.
- Track intent and the actual pursuit of health care careers by former AHEC pipeline/enrichment program participants.

- G. Establish a youth public health program to expose and recruit high school students into health careers, with a focus on careers in public health.

Examples of Activities:

- Develop and/or integrate public health career awareness activities for high school students with other health professions career activities.
- Expose high school students to principles of public health through service learning programs in local high schools.
- Involve health professions students and public health professionals in public health careers presentations to high school students.

AHEC PROGRAM INNOVATIVE OPPORTUNITIES

Cooperative agreement recipients may also carry out any of the following activities:

- A. Develop and implement innovative curricula in collaboration with community-based accredited primary care residency training programs, federally qualified health centers, rural health clinics, behavioral and mental health facilities, public health departments, or other appropriate facilities, with the goal of increasing the number of primary care physicians and other primary care providers prepared to serve in underserved areas and health disparity populations.
- B. Coordinate community-based participatory research with academic health centers, and facilitate rapid flow and dissemination of evidence-based health care information, research results, and best practices to improve quality, efficiency, and effectiveness of health care and health care systems within community settings.
- C. Develop and implement other strategies to address identified workforce needs and increase and enhance the health care workforce in the area served by the area health education center program.

2. Summary of Funding

This program will provide funding for federal fiscal years 2012–2016. Approximately \$31,000,000 is expected to be available annually to fund 60 AHEC Infrastructure Development and AHEC Point of Service Maintenance and Enhancement programs for a five-year project period. **A competitive application process for Point of Service Maintenance and Enhancement may be held, based on availability of funds, in federal fiscal years 2013-2016, for AHEC centers transitioning from Infrastructure Development to Point of Service Maintenance and Enhancement.** The legislative language states that an award to an AHEC program shall not be less than \$250,000 annually per AHEC center. If the total amount appropriated to carry out the AHEC Program is not sufficient to comply with the funding amount of \$250,000 per AHEC center, the Secretary may reduce the per center amount as necessary.

Based on the President’s fiscal year 2012 AHEC program request, current estimates of the per-AHEC center funding levels are listed below. These final amounts will be calculated based on the actual appropriation.

- AHEC Infrastructure Development applicants may request up to \$250,000 for each

center, including program office funds.

- AHEC Point of Service Maintenance and Enhancement applicants may request up to \$102,000 per AHEC center, including program office funds. In FY 2011, the amount calculated for approved Point of Service Maintenance and Enhancement awards was \$100,129 per AHEC Center, including program office funds.
- At least 75 percent of the total funds provided to an AHEC program awardee shall be allocated to the AHEC center(s) participating in the program.

Applicants may request AHEC Infrastructure Development funds under PHS Act section 751(a)(1) **and** AHEC Point of Service Maintenance and Enhancement funds under PHS Act section 751(a)(2). Applicants that have AHEC centers that are eligible for Infrastructure Development funds under PHS Act section 751(a)(1), and have other AHEC centers that are eligible for Point of Service Maintenance and Enhancement funds under PHS Act section 751(a)(2), may apply for PHS Act section 751(a)(1) and PHS Act section 751(a)(2) funds. AHEC Point of Service Maintenance and Enhancement funds may not be distributed to a center that receives Infrastructure Development funds. In the case of applicants seeking funds under sections 751(a)(1) and (a)(2), the applicant must **submit two separate and complete applications with all the required sections and attachments.** Applicants may submit two applications only if both Infrastructure Development, (section 751(a)(1)) and Point of Service Maintenance and Enhancement (section 751(a)(2)) funds are being requested in federal fiscal year 2012.

As noted in Section IV *ix. Project Narrative*, an applicant under the Point of Service Maintenance and Enhancement phase proposing to expand the number of AHEC centers must provide a comprehensive justification to include the following:

- 1) there is a geographic area within the state that is not served by an existing AHEC center;
- 2) a needs assessment is completed and documents the need for services of an AHEC center;
- 3) there are available matching funds to support the expansion;
- 4) the proposed center's organization meets the AHEC center requirements; and
- 5) the extent to which the addition of a center(s) will contribute to the outcomes and impact of the existing AHEC program.

The objective review committee will make a specific recommendation on the program as a whole to include approval or disapproval of any new center requested. If the FY 2012 appropriation level for the AHEC Program is the same or less than the FY 2011 appropriation level, the additional new center(s) may not be funded. When making final funding decisions regarding Section 751 awards, consideration will be given to the Sense of the Congress "that every state have an area health education center program in effect under this section." Funding beyond the first year is dependent on the availability of appropriated funds in subsequent fiscal years, grantee satisfactory performance, and a decision that continued funding is in the best interest of the Federal Government.

III. Eligibility Information

1. Eligible Applicants

Entities eligible to apply for **AHEC Infrastructure Development** awards are public or nonprofit private accredited schools of allopathic medicine and osteopathic medicine and incorporated consortia made up of such schools, or the parent institutions of such schools. In states and territories in which no AHEC program is in operation, an accredited school of nursing is an eligible applicant.

An entity eligible to apply for **AHEC Point of Service Maintenance and Enhancement** awards is one that has received funds under section 751 of the PHS Act, is operating an AHEC program, including an AHEC center or centers as defined in section 751, and has a center or centers that are no longer eligible to receive financial assistance under section 751(a)(1).

An academic institution shall use such assistance in collaboration with two or more disciplines.

AHEC Requirements in Sections 751(d)(2)(A) and 751(d)(2)(B) of the PHS Act

For Fiscal Year 2011, the Department of Defense and Full-Year Continuing Appropriations Act (Public Law 112-10) gave the Secretary authority to grant a waiver of the AHEC requirements under sections 751(d)(2)(A) and 751(d)(2)(B) of the Public Health Service Act¹⁽ⁱ⁾ to programs meeting certain requirements. Currently this authority expired on September 30, 2011. Should Congress extend the Secretary's waiver authority and allow applicants to request waivers for Fiscal Year 2012, additional guidance on the waiver process will be made available at that time.

2. Cost Sharing/Matching

Matching Funds: The awardee shall provide documentation that it will make available (directly or through contributions from state, county, or municipal government, or the private sector) recurring non-federal contributions in cash or in kind equal to not less than 50 percent of the operating costs of the AHEC program. Thus, the matching ratio for AHEC awards is 1 to 1 federal funds to non-federal contributions. At least 25 percent of the total required non-federal contributions shall be in cash. If the awardee fails to provide some or all of the required matching, the Grants Management Officer will make a downward adjustment in the federal award.

Examples of match include:

- 1) Non-federal cash match of at least 25 percent of the total match is to be provided in actual dollars.
- 2) Other contributions providing 75 percent of the total match may include:
 - In-kind time and effort (provided by a third-party, non-salaried, individual).
 - Unrecovered indirect costs.

¹ (i) PHS Act sec. 751(d)(2)(A) requires that each area health education center "is a public or private organization whose structure, governance, and operation is independent from the awardee and the parent institution of the awardee." PHS Act sec. 751(d)(2)(B) requires that each area health education center "is not a school of medicine or osteopathic medicine, the parent institution of such a school, or a branch campus or other subunit of a school of medicine or osteopathic medicine or its parent institution, or a consortium of such entities."

- Allowable/allocable third-party donated items of value or services.
- Program Income (if expressly permitted by the Notice of Award).

Guidance on the valuation of cost sharing/matching requirements is found in 45 CFR 74.23 and 45 CFR 92.24.

Waiver 75 Percent of Matching Funds – First Three Years:

An entity may apply to the Secretary for a waiver of not more than 75 percent of the matching fund amount required by the entity for each of the first three years the entity is funded through an award under PHS Act section 751(a)(1) (AHEC Infrastructure Development program). To be considered for a waiver, an applicant must present a written request for a waiver as **Attachment 5**. Unless a waiver of the matching funds requirement is requested and approved, funds awarded may only be expended with the understanding that the matching requirement must be met.

3. Other

Maintenance of Effort

AHEC funding shall not be used to supplant current funding for any activity described in the application. The awardee must agree to maintain non-federal funding for activities at a level that is not less than the level of expenditures for such activities during the fiscal year prior to receiving the cooperative agreement.

Applications that exceed the ceiling amount will be considered non-responsive and will not be considered for funding under this announcement.

Any application that fails to satisfy the deadline requirements referenced in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

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. This robust 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 your application. All applicants *must* submit in this manner unless they obtain a written exemption from this requirement in advance 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. Your email must include the HRSA announcement number for which you are 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 as well as the Grants.gov Tracking Number (GRANTXXXX) assigned to your submission along with a copy of the "Rejected with Errors" notification you received from Grants.gov. **HRSA and its Digital Services Operation (DSO) will only accept paper**

applications from applicants that received prior written approval. However, the application must still be submitted under the deadline. Applicants that fail to allow ample time to complete or update registration with Federal Government's Central Contractor Registration (CCR) and/or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.

Note: Central Contractor Registration (CCR) information must be updated at least every 12 months to remain active (for both grantees and sub-recipients). As of August 9, 2011, Grants.gov began rejecting submissions from applicants with expired Central Contractor Registration (CCR) registrations. Although active CCR registration at time of submission is not a new requirement, this systematic enforcement will likely catch some applicants off guard.

According to the CCR Website it can take 24 hours or more for updates to take effect, so **check for active registration well before your grant deadline.** Applicants will not be eligible for a deadline extension if an application is rejected by Grants.gov for lack of the annual CCR registration.

An applicant can view their CCR Registration Status by visiting <http://www.bpn.gov/CCRSearch/Search.aspx> and searching by their organization's DUNS. The [CCR Website](#) provides user guides, renewal screen shots, FAQs and other resources you may find helpful.

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

All applicants are responsible for reading the instructions included in HRSA's *Electronic Submission User Guide*, available online at <http://www.hrsa.gov/grants/apply/userguide.pdf>. This Guide includes detailed application and submission instructions for both Grants.gov and HRSA's Electronic Handbooks. Pay particular attention to Sections 2 and 5 that provide detailed information on the competitive application and submission process.

Applicants are also responsible for reading the Grants.gov Applicant User Guide, available online at <http://www.grants.gov/assets/ApplicantUserGuide.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 in this FOA in conjunction with Application Form SF-424 Research and Related (SF-424 R&R). The forms contain additional general information and instructions for applications, proposal narratives, and budgets. The forms and instructions may be obtained by:

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

Each funding opportunity contains a unique set of forms and only the specific forms package posted with an opportunity will be accepted for that opportunity. Specific instructions for

preparing portions of the application that must accompany Standard Form 424 Research and Related (SF-424 R&R) 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 80 pages when printed by HRSA. The total file size may not exceed 10 MB. The 80-page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support. Standard forms are NOT included in the page limit. **We strongly urge you to print your application to ensure it does not exceed the 80-page limit. Do not reduce the size of the fonts or margins to save space. When converted to a single PDF, fonts will be changed to the required 12-point size and one-inch margins will be restored (per formatting instructions in Section 5 of the Electronic Submission User Guide referenced above). The 80-page limit will then be imposed.**

Application Format

Applications for funding must consist of the following documents in the following order:

SF-424 R&R Fed/Non-Fed – Table of Contents

-  It is mandatory to follow the instructions provided in this section 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 given any consideration and those particular applicants will be notified.
-  For electronic submissions, applicants only have to 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.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
SF-424 R&R Cover Page	Form	Pages 1 & 2	Not counted in the page limit.
Pre-application	Attachment	Can be uploaded on page 2 of SF-424 R&R - Box 20	Not Applicable to HRSA; Do not use.
SF-424 R&R Senior/Key Person Profile	Form	Supports 8 structured profiles (PD + 7 additional)	Not counted in the page limit.
Senior Key Personnel Biographical Sketches	Attachment	Can be uploaded in SF-424 R&R Senior/Key Person Profile form. One per each senior/key person. The PD/PI biographical sketch should be the first biographical sketch. Up to 8 allowed	Counted in the page limit.
Senior Key Personnel Current and Pending Support	Attachment	Can be uploaded in SF-424 R&R Senior/Key Person Profile form	Not Applicable to HRSA; Do not use.
Additional Senior/Key Person Profiles	Attachment	Can be uploaded in SF-424 R&R Senior/Key Person Profile form. Single document with all additional profiles	Not counted in the page limit.
Additional Senior Key Personnel Biographical Sketches	Attachment	Can be uploaded in the Senior/Key Person Profile form. Single document with all additional sketches	Counted in the page limit.
Additional Senior Key Personnel Current and Pending Support	Attachment	Can be uploaded in the Senior/Key Person Profile form	Not Applicable to HRSA; Do not use.
Project/Performance Site Location(s)	Form	Supports primary and 29 additional sites in structured form	Not counted in the page limit
Additional Performance Site Location(s)	Attachment	Can be uploaded in SF-424 R&R Performance Site Locations form. Single document with all	Not counted in the page limit

Application Section	Form Type	Instruction	HRSA/Program Guidelines
		additional site locations	
Other Project Information	Form	Allows additional information and attachments.	Not counted in the page limit.
Project Summary/Abstract	Attachment	Can be uploaded in SF-424 R&R Other Project Information form, Box 7	Required attachment. Counted in the page limit. Refer to FOA for detailed instructions. Provide table of contents specific to this document only as the first page.
Project Narrative	Attachment	Can be uploaded in SF-424 R&R Other Project Information form, Box 8	Required attachment. Counted in the page limit. Refer to FOA for detailed instructions. Provide table of contents specific to this document only as the first page.
SF-424 R&R Federal & Non-Federal Budget - Section A – B	Form	Supports structured budget for up to 5 periods	Not counted in the page limit.
Additional Senior Key Persons	Attachment	SF-424 R&R Fed & NonFed Budget - Section A-B, of Section A. One for each budget period	Not counted in the page limit.
SF-424 R&R Federal & Non-Federal Budget - Section C – E	Form	Supports structured budget	Not counted in the page limit.
Additional Equipment	Attachment	SF-424 R&R Fed & NonFed Budget - Section C – E, End of Section C.	Not counted in the page limit.
SF-424 R&R Federal & Non-Federal Budget - Section F – K	Form	Supports structured budget	Not counted in the page limit.
SF-424 R&R Cumulative Budget	Form	Total cumulative budget	Not counted in the page limit.
Budget Justification	Attachment	Can be uploaded in SF-424 R&R Budget Period (1-5) - Section F - J form, Box K. Only one consolidated budget justification for the project period.	Required attachment. Counted in the page limit. Refer to FOA for detailed instructions. Provide table of contents specific to this document only as the first page.
SF-424 R&R Subaward Budget	Form	Supports up to 10 budget attachments. This form only contains the attachment list	Not counted in the page limit.
Subaward Budget Attachment 1-10	Attachment	Can be uploaded in SF-424 R&R Subaward Budget form, Box 1 through 10. Extract the form from the SF-424 R&R Subaward Budget form and use it for each	Filename should be the name of the organization and unique. Not counted in the page limit.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
		consortium/contractual/subaward budget as required by the program FOA. Supports up to 10.	
SF-424B Assurances for Non-Construction Programs	Form	Assurances for the SF-424 R&R package	Not counted in the page limit.
Bibliography & References	Attachment	Can be uploaded in Other Project Information form, Box 9.	Optional. Counted in the page limit.
Facilities & Other Resources	Attachment	Can be uploaded in Other Project Information form, Box 10.	Optional. Counted in the page limit.
Equipment	Attachment	Can be uploaded in Other Project Information form, Box 11.	Optional. Counted in the page limit.
Disclosure of Lobbying Activities (SF-LLL)	Form	Supports structured data for lobbying activities.	Not counted in the page limit.
Other Attachments Form	Form	Supports up to 15 numbered attachments. This form only contains the attachment list	Not counted in the page limit.
Attachment 1-15	Attachment	Can be uploaded in Other Attachments form 1-15	Refer to the attachment table provided below for specific sequence. Counted in the page limit.
Other Attachments	Attachment	Can be uploaded in SF-424 R&R Other Project Information form, Box 12. Supports multiple	Not Applicable to HRSA; Do not use.

- 🔔 To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Note that these instructions may vary across programs.
- 🔔 Evidence of Non Profit status and invention related documents, if applicable, must be provided in the other attachment form.
- 🔔 Additional supporting documents, if applicable, can be provided using the available rows. Do not use the rows assigned to a specific purpose in the program funding opportunity announcement.
- 🔔 Merge similar documents into a single document. Where several documents are expected in one attachment, ensure that you place a table of contents cover page specific to the attachment. Table of contents page will not be counted in the page limit.
- 🔔 Limit the file attachment name to under 50 characters. Do not use any special characters (e.g., %, /, #) or spacing in the file name or word separation. (The exception is the underscore (_) character.) Your attachment will be rejected by Grants.gov if you use special characters or attachment names greater than 50 characters.

Attachment Number	Attachment Description (Program Guidelines)
Attachment 1	Staffing Plan.
Attachment 2	Job Descriptions for Key Personnel.
Attachment 3	Letters of Agreement and/or Description of Existing and Proposed Contracts.
Attachment 4	Project Organizational Chart.
Attachment 5	Waiver Request (if applicable) Regarding Matching Funds.
Attachment 6	Waiver Request (if applicable) Regarding 75 Percent/25 Percent Allocation.
Attachment 7	Accomplishments Summary (ACCOMPLISHMENT SUMMARY FOR COMPETING CONTINUATIONS ONLY).
Attachment 8	AHEC Program and Center Requirements.
Attachment 9	Institution Diversity Statement.
Attachment 10	Maintenance of Effort Information
Attachment 11	Other relevant documents, including letters of support.

Application Format

i. Application Face Page

Complete Standard Form 424 Research and Related (SF-424 R&R), provided with the application package. Prepare this page according to instructions provided in the form itself.

For information pertaining to the Catalog of Federal Domestic Assistance, the Catalog of Federal Domestic Assistance Number is **93.824** for the Area Health Education Centers Infrastructure Development Awards and **93.107** for the Area Health Education Centers Point of Service Maintenance and Enhancement Awards. **Because the Grants.gov forms will pre-populate the CFDA number 93.824, applicants should clearly indicate which opportunity they are applying for. In item 2 of the SF-424 R&R form (Applicant Identifier), applicants should indicate which CFDA number they are applying for:**

- CFDA 93.824- Area Health Education Centers Infrastructure Development Awards
- CFDA 93.107- Area Health Education Centers Point of Service Maintenance and Enhancement Awards.

HRSA staff will ensure that applications have the correct CFDA before applications are reviewed.

DUNS Number

All applicant organizations (and subrecipients of HRSA award funds) are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a unique nine-character identification number 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 at <http://fedgov.dnb.com/webform> or call 1-866-705-5711. Please include the DUNS number in item 5 on the application face page. 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 should take care in entering the DUNS number in the application.

Additionally, the applicant organization (and any subrecipient of HRSA award funds) is required to register annually with the Central Contractor Registration (CCR) in order to do electronic business with the Federal Government. CCR registration must be maintained with current, accurate information at all times during which an entity has an active award or an application or plan under consideration by HRSA. It is extremely important to verify that your CCR registration is active and your Marketing Partner ID Number (MPIN) is current. Information about registering with the CCR can be found at <http://www.ccr.gov>.

ii. Table of Contents

The application should be presented in the order of the Table of Contents provided earlier. Again, for electronic applications no table of contents is necessary as it will be generated by the system. (Note: the Table of Contents will not be counted in the page limit.)

iii. Budget

Complete the required Research and Related (R&R) Federal & Non-Federal Budget, adhering to the instructions provided for that specific form. Complete all sections and provide a line

item budget for each award year using the budget categories in the R&R budget. Indicate the **names, numbers, and addresses** of centers that will contract with the awardee.

Please complete Sections A – J and the Cumulative Budget for each budget period. Upload the Budget Justification Narrative for the entire five-year project period in Section K of the Research & Related Budget Form. Following completion of Budget Period 1, you must click on the “NEXT PERIOD” button on the final page to allow for completion of Budget Period 2. You will repeat this instruction to complete Budget Periods 3, 4 and 5.

The Cumulative Budget is automatically generated and provides the total budget information for the five-year award request. Errors found in the Cumulative Budget must be corrected within the incorrect field(s) in Budget Period 1, 2, 3, 4, or 5; corrections cannot be made to the Cumulative Budget itself.

iv. Budget Justification

Provide a narrative that explains the federal and non-federal amounts on each line in the budget. Indicate the source of non-Federal funds including cash (state, county, or municipal government or private sector funds), in-kind contributions, and other forms of match. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year. However, the applicant **must** submit one-year budgets for each year of the five-year project period. Line item information must be provided to explain the costs entered in the Research and Related budget form. Be very careful about showing how each item in the “other” category is justified. The budget justification **MUST** be concise. Do **NOT** use the justification to expand the project narrative.

Budget for Multi-Year Award

This announcement is inviting applications for project periods up to five (5) years. Awards, on a competitive basis, will be for a one-year budget period; although the project period may be for up to five (5) years. Submission and HRSA approval of Progress Report(s) and any other required submission or reports is the basis for the budget period renewal and release of subsequent year funds. Funding beyond the one-year budget period but within the five-year project period is subject to availability of funds, satisfactory progress of the awardee, and a determination that continued funding would be in the best interest of the Federal Government.

For **AHEC Infrastructure Development**, applicants may apply for costs totaling up to \$250,000 per AHEC center, including program office funds, recognizing that not less than 75 percent is made available for the contracting AHEC center(s). For **AHEC Point of Service Maintenance and Enhancement**, applicants may apply for costs totaling up to \$102,000 per AHEC center, including program office funds, recognizing not less than 75 percent must be made available for the contracting AHEC center(s).

Limitation: A Waiver associated with 75 Percent Allocation to Centers

At least 75 percent of the total funds provided to an AHEC program awardee shall be allocated to the AHEC center(s) participating in the program. To provide flexibility to newly funded AHEC programs (AHEC Infrastructure Development programs), the Secretary/HRSA may waive the requirement for the first two years of a new AHEC program funded under subsection 751(a)(1). The waiver request must be submitted as **Attachment 6**.

Include the following in the Budget Justification narrative:

Personnel Costs: Personnel costs should be explained by listing each staff member who will be supported from federal and non-federal funds, name (if possible), position title, percent full time equivalency, and annual salary. Reminder: As noted in the Administrative Guidance, the AHEC Center Director should have at least 75 percent time allocated solely to the conduct of center duties and responsibilities.

Fringe Benefits: List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project.

Travel: List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops. Attendance of at least one staff member from the Program Office and the attendance of at least one staff member from a participating AHEC center in the AHEC program at one HRSA technical assistance meeting is encouraged.

Equipment: List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of \$5000 or more and a useful life of one or more years).

Supplies: List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, and the like; medical supplies are syringes, blood tubes, plastic gloves, etc., and educational supplies may be pamphlets and educational videotapes. Remember, they must be listed separately.

Contractual: Applicants are responsible for ensuring that their organization or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Reminder: recipients must notify potential subrecipients that entities receiving subawards must be registered in the Central Contractor Registration (CCR) and provide the recipient with their DUNS number.

Applicants should complete subawardee budget(s) in accordance with the R&R Fed/Non-Fed budget instructions and attach them to the R&R Subaward Budget Attachment(s) Form included with the application kit. In the budget justification, include a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Letters of Agreement and/or existing or proposed contracts should be included in **Attachment 3**. See further instructions under Section xi – Attachments.

Other: Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. In some cases, awardee's rent; utilities and insurance fall under this category if they are not included in an approved indirect cost rate.

Applicants may include the cost of access accommodations as part of their project's budget, including sign interpreters, plain language and health literate print materials in alternate formats (including Braille, large print, etc.); and cultural/linguistic competence modifications such as use of cultural brokers, translation or interpretation services at meetings, clinical encounters, and conferences, etc.

Trainee Expenses: Funds for trainee travel are necessary for the training experience and must include the purpose, number of trips involved, travel allowance used, destinations, and number of individuals requesting funds. Daily commuting and/or routine local travel costs are not allowable.

Data Collection Activities: Funds may be used to support appropriate and justifiable costs directly related to meeting evaluation and data reporting requirements. Identify and justify how these funds will be used under the appropriate budget category; Personnel, Contracts or Other.

Indirect Costs: Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. Dues for institutional membership in business, technical and professional organizations may be allowable under indirect costs with justification for the request provided. Membership dues that are paid through grant funds cannot be used to support lobbying activities. For institutions subject to OMB Circular A-21, the term "facilities and administration" is used to denote indirect costs. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may wish to obtain one through HHS's Division of Cost Allocation (DCA). Visit DCA's website at: <http://rates.psc.gov/> to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.

Indirect costs under training grants to organizations other than state, local or Indian tribal governments will be budgeted and reimbursed at 8 percent of modified total direct costs rather than on the basis of a negotiated cost agreement, and are not subject to upward or downward adjustment. Direct cost amounts for equipment (capital expenditures), tuition and fees, and subgrants and subcontracts in excess of \$25,000 are excluded from the actual direct cost base for purposes of this calculation.

v. Staffing Plan and Personnel Requirements

Applicants must present a staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the amount of time being requested for each staff position as **Attachment 1**. Position descriptions that include the roles, responsibilities, and qualifications of proposed project staff must be included in **Attachment 2**. Copies of biographical sketches for any key employed personnel that will be assigned to work on the proposed project are required as part of the Research and Related application kit. When applicable, job descriptions and biographical sketches should include training, language

fluency and experience working with the cultural and linguistically diverse populations that are served by their programs.

vi. Assurances

Complete Application Form SF-424B Assurances – Non-Construction Programs provided with the application package.

vii. Certifications

Use the certifications and Disclosure of Lobbying Activities form provided with the application package. Any organization or individual that is indebted to the United States, and has a judgment lien filed against it for a debt to the United States, is ineligible to receive a federal grant. By signing the SF-424 R&R, the applicant is certifying that they are not delinquent on federal debt in accordance with OMB Circular A-129. (Examples of relevant debt include delinquent payroll or other taxes, audit disallowances, guaranteed and direct student loans, benefits that were overpaid, etc.) If an applicant is delinquent on federal debt, they should attach an explanation that includes proof that satisfactory arrangements have been made with the Agency to which the debt is owed. This explanation should be uploaded as Attachment 11.

viii. Project Abstract

Provide a summary of the application. Because the abstract is often distributed to provide information to the public and Congress, please prepare this section so that it is clear, accurate, concise, and without reference to other parts of the application.

The project abstract must be single-spaced and limited to one page in length.

The abstract should provide the following:

- 1) A brief overview of the project as a whole, and its special focus, including the AHEC program's purpose, disciplines, and number of students involved;
- 2) Specific, measurable objectives which the project will accomplish;
- 3) How the proposed project for which funding is requested will be accomplished, *i.e.*, the "who, what, when, where, why and how" of a project.

In addition, please provide the number of counties and the population size served by the AHEC Program. Include the name of each AHEC center, and for each AHEC center, include the number of counties served, and the population size covered. Include a map that details the geographical areas served by the AHEC centers and program collectively. .

The abstract might be best prepared after the completion of the program narrative.

Please place the following at the top of the abstract:

- *Project Title*
- *Applicant Organization Name*
- *Address*
- *Project Director Name*
- *Contact Phone Numbers (Voice, Fax)*
- *E-Mail Address*
- *Web Site Address, if applicable*

ix. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

Use the following section headers for the Narrative:

▪ **INTRODUCTION**

Applicants should briefly describe the purpose of the proposed project.

▪ **NEEDS ASSESSMENT**

Applicants should develop the response to this requirement with the goal of assisting the reviewers with understanding the community to be served by outlining its needs. Describe the background and critically evaluate the health workforce demand/need that the project proposes to address on a national, regional, state and/or local level. Identify the gaps that the project intends to fill and provide demographic data to support and validate identified needs. Applicants should indicate **the demographics of the population served in the area covered by the AHEC center(s)** and its physical distance from the awardee school. Applicants should correlate the importance of the need by relating the specific objectives to the project's potential to meet the priority areas identified from the legislative purposes of the AHEC Program. The needs assessment should include current healthcare workforce data (not more than two years old). Applicants should describe how the project will address the healthcare workforce distribution, diversity, and quality issues of the state or region to be served by the project.

An applicant under the Point of Service Maintenance and Enhancement phase proposing to expand the number of AHEC centers must provide a comprehensive justification to include the following:

- 1) there is a geographic area within the state that is not served by an existing AHEC center;
- 2) a needs assessment is completed and documents the need for services of an AHEC center;
- 3) there are available matching funds to support the expansion;
- 4) the proposed center's organization meets the AHEC center requirements; and
- 5) the extent to which the addition of a center(s) will contribute to the outcomes and impact of the existing AHEC program.

The plan for carrying out the project must be consistent with at least one federal, state or regional plan to assure a competent health care workforce. The federal workforce objectives are stated in several chapters of the HHS publication Healthy People 2020, available by calling 1-800-367-4725 or from the website:

<http://www.healthypeople.gov/2020/default.aspx> .

▪ **METHODOLOGY**

Applicants should propose methods that will be used to meet each of the described program requirements and expectations in this announcement. List specific objectives that contain measures that will assist reviewers in evaluating the application. The objectives must be measurable with specific outcomes for each project year and attainable within the

stated timeframe. Describe the nature and structure of the academic partnerships that will be developed and include information specific to community-based linkages (see below). Applicants should present a chart with the timeline of the major project objectives, using the framework of distribution, diversity, and quality issues. Describe the activities, methods, and techniques proposed to accomplish the project objectives. Use a time line that includes each activity and identifies responsible staff. Applicants must provide data regarding the medical school 10 percent requirement in response to the statutory requirement that AHEC Programs conduct at least 10 percent of the required medical student clinical education training at sites remote to the primary teaching facility of the contracting institution.

Community-Based Partnerships and Linkages

To the extent possible, awardees are required to establish linkages with community-based organizations including providers of health care services to underserved communities and populations.

Linkages to Community

Clearly identify any collaboration or planned collaboration/linkage with Health Careers Opportunity Program (HCOP) grantees (as applicable) in the application. A list of currently funded HCOP grantees can be found at:

<http://bhpr.hrsa.gov/grants/diversity/index.html>.

In addition, the applicant must describe the current and/or anticipated relationships with entities that provide health care or education of health care providers. Please describe how the proposed project will address community-based linkages with the following entities, as applicable:

- Federally Qualified Health Centers
- Rural Health Clinics
- Indian Health Service Sites
- AIDS Education Training Centers
- Ryan White Centers
- Center of Excellence Program grantees
- Geriatric Education Centers
- Two and four-year colleges and universities, identifying HBCUs, HSIs and TCs
- Elementary, middle and high schools
- Health Care for the Homeless sites
- Health department (state/local government) sites
- Community hospitals
- Nurse-managed care centers/clinics; free clinics
- Primary care Health Professional Shortage Areas (HPSAs)
- National Health Service Corps sites
- Public/elderly/low-income housing
- Prisons
- Faith-based organizations and other community-based organizations

The description should focus on the use of shared facilities, personnel, services, funding, or other resources and coordination of activities and related strategic planning to achieve common objectives for effective and efficient project operation.

Linkages to Improve Health of the Underserved

To the extent practicable, awardees must establish linkages with organizations that deliver health care to underserved communities and populations and describe the underserved community or population and any current linkages to organizations providing care.

Applicants should indicate the extent to which letters of agreement have been established with training sites serving underserved populations, e.g., list name of site, city, state and date of letter of agreement.

Applicants should describe how the proposed project will address Healthy People 2020 and National HIV/AIDS Strategy (NHAS) objectives (see Section VI.2 for more information).

Distance Learning

Applicants are encouraged to propose collaborative approaches for increasing the number of students in rural and underserved areas who can access educational opportunities through the use of electronic distance learning methodologies. These methodologies are defined as a continuum of audiovisual media for presenting educational content. The interaction communication continuum ranges from television with full-motion video and audio interaction to interaction with either visual or audio media with the midpoint of this continuum being the use of computers as an interactive medium for learning. When used for a significant part of student learning activities, the following information should be included:

- Discussion of the application of distance learning with the outcomes of the proposed project;
- On campus requirements for distance learning students;
- Plans to maintain and foster scholarly dialogue and interaction between faculty and students;
- Scheduling of courses for distance learning students compared to that of students in traditional settings;
- Technical, human, and administrative resources available to support distance learning;
- Financing for distance learning courses;
- Sustainability of the distance learning methodology with plans for continued use and updating hardware and software following the project period;
- Specific coursework information related to:
 - course design and learning experiences; number, length and frequency of courses; plan for evaluating student clinical experience; the relationship between the methodology and the project objectives; anticipated number of clinical experiences and how clinical learning for distance learning students will be guided; plan for assessing computer skills of students and providing training as needed; and
 - description of teaching expertise of the faculty with the proposed distance learning methodologies; and the plan to further develop faculty;
- Identification of other programs using similar methodologies in close proximity to the proposed program;
- Number of students expected to utilize the methodology (per course); and

- Evaluation of student outcomes comparing students taking on-campus courses to those using the distance learning methodology related to this proposal.

Linkages to other Federal & State Departments or Agencies

To the extent practicable, applicants are expected to establish linkages with Federal Departments or Agencies to provide the trainings in their centers. Please describe how the proposed project will address collaborations and linkages as stated in the PHS Act section 751(c)(1)(B) with state health care workforce development programs, state workforce agency and local WIBs, and with health care safety net sites.

It is anticipated that applicants will work with Department of Labor and WIBs as specified in PHS Act section 751(c)(1)(A). Additionally, applicants are encouraged to collaborate with the Citizen Soldier Support Program and other entities that provide training (e.g., on mental health issues) to providers serving veterans and their families.

Self-sufficiency plan: The applicant must include plans for self-sufficiency by providing specific information that describes the extent and means by which the program plans to become autonomous within a defined period of time. The documentation should specify other sources of income, future funding initiatives and strategies, timetable for becoming self-sufficient, and a description of barriers to be overcome in order to become self-sufficient.

- **WORK PLAN**

Describe the activities or steps that will be used to achieve each of the activities proposed in the methodology section. Use a time line that includes each activity and identifies responsible staff. Applicants are encouraged to use a chart that includes project objectives, activities, resources, personnel, timeframes, and evaluation outcome measures, using the suggested format below.

Objectives/ Sub Objectives Listed in Measurable Terms	Methodology/ Activities	Resources Personnel Responsible For Program Activity	Time/ Milestones	Evaluation Measure/ Process Outcome
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- **RESOLUTION OF CHALLENGES**

Discuss challenges that are likely to be encountered in designing and implementing the activities described in the Work Plan, and approaches that will be used to resolve such challenges.

- **EVALUATION AND TECHNICAL SUPPORT CAPACITY**

Program evaluation will demonstrate if the program is functioning according to program purpose and objectives. Applicants must present an evaluation plan that at a minimum addresses the following elements:

- Evaluation Technical Capacity: describe current evaluation experience, including skills and knowledge of individual(s) responsible for conducting and reporting evaluation efforts;
- Logic Model: demonstrate the relationship among resources, activities, outputs, target population, short-and long-term outcomes;

- Performance Measures: provide detailed description of how the required BHP performance measures for this program will be collected; BHP Performance Measures may be accessed from the following website: <http://bhpr.hrsa.gov/grants/reporting/>
- Evaluation Methods: provide examples of the evaluation questions; instruments/tools used; primary/secondary data sources; include milestones; timeline.
- Quality Assurance Plan: explain the process to validate data collection and results;
- Evaluation Report: describe how the evaluation activities, results, challenges, and recommendations will be analyzed and reported.

When current awardees apply for competing continuation funding, summary evaluation information for the entire previous project period must be submitted as part of the application in the Accomplishment Summary (Attachment 7).

▪ ORGANIZATIONAL INFORMATION

Provide information on the current mission, scope of current activities, and organizational chart. Describe how these components all contribute to the ability of the organization to conduct the AHEC program requirements and meet expectations. If an applicant already has an Advisory Board, describe the board and its composition, its function, the number of proposed meetings per year, and how the board members will provide guidance to the Principal Investigator of the project. Applicants should include an organizational chart as **Attachment 4**.

x. Program Specific Forms

Medical/Nursing School 10 Percent Requirement: Applicants must present data to demonstrate compliance with the legislative mandate that recipients-awardees conduct at least 10 percent of required medical student clinical education at community settings remote from the primary teaching facility of the contracting institution for awardees that operate a school of medicine or osteopathic medicine. In states in which a school of nursing, or its parent institution, is the recipient the nursing school or its parent institution shall submit data documenting that at least 10 percent of clinical education for nursing students is conducted in community settings that are remote from the primary teaching facility of the school.

In preparing the data, applicants should consider the number of students in each class (First Year, 2nd Year, 3rd Year and 4th Year), as appropriate, multiplied by the number of required clinical weeks for each class to get the total number of student required clinical weeks. The 10 Percent (AHEC) Requirement will be based on ten percent (10%) of the total number of the student required clinical weeks. (Please see the worksheet example below).

EXAMPLE							
Academic Year	# of Required Clinical Weeks	X	# of Students	Total Student Weeks	X	10%	AHEC Student Weeks
1	0	X	100	0	X	10%	0
2	20	X	95	1900	X	10%	190
3	30	X	91	2730	X	10%	273
4	50	X	98	4900	X	10%	490
	100	X	384	9530	X	10%	953
MINIMUM AHEC STUDENT WEEKS = 953							

NOTE: A student week of clinical education totals 40 hours, completed in either five consecutive days or cumulatively over time.

Applicants may use any format to submit the above requested data. A table format has been submitted to the Office of Management and Budget (OMB) for clearance. If approved, this table will be made available for applicants to submit the Medical/Nursing School 10 Percent Requirement Data.

xi. Attachments

Please provide the following items to complete the content of the application. Please note that these are supplementary in nature, and are not intended to be a continuation of the project narrative. Be sure each attachment is clearly labeled. Note that all attachments are included in the page limit.

Attachment 1: Staffing Plan

Education and experience qualifications and a rationale for the amount of time requested for project staff positions (e.g., Program Director, Associate Program Director, and Center Director(s)).

Attachment 2: Job Descriptions for Key Personnel

Include the roles, responsibilities, and qualifications of proposed project staff. Keep each to one page in length.

Attachment 3: Letters of Agreement and/or Description of Existing and Proposed Contracts.

Include documents that describe working relationships between the applicant agency and other agencies and programs cited in the proposal. Documents that confirm actual or pending contractual agreements should clearly describe the roles of the subcontractors and the deliverables. Letters of agreement must be dated. An applicant school of nursing or its parent institution shall provide a written agreement with a school of medicine or osteopathic medicine to place students from that school in training sites in the area health education center program area.

Attachment 4: Project Organizational Chart

Provide a one-page figure that depicts the organizational structure of the project, including subcontractors and other significant collaborators.

Attachment 5: Waiver Request (if applicable) regarding Matching Funds

To be considered for a waiver of 75% of the matching requirements for the first three years of the project period, an applicant must present a written request. The request for a waiver shall include a description of the extent to which the applicant school has attempted to meet this requirement and include a description of the reasons why the requirement cannot be met. The written request must demonstrate that the applicant school made a good faith attempt, but factors beyond its control caused its efforts to be unsuccessful. An acceptable plan and timetable for meeting this requirement shall be submitted by the applicant school and should reflect a gradual increase in the annual contribution of non-federal funds.

Attachment 6: Waiver Request (if applicable) regarding 75 percent/25 percent allocation to Centers

At least 75 percent of the total funds provided to an AHEC program awardee shall be allocated to the AHEC center(s) participating in the program. To provide flexibility to newly funded AHEC programs (AHEC Infrastructure Development programs), the Secretary/HRSA may waive the requirement for the first two years of a new AHEC program funded under subsection 751(a)(1). To be considered for a waiver of the 75 Percent Allocation requirement, an applicant must present a written request for a waiver as an attachment to a competing application in which AHEC Infrastructure Development funds are requested for a new start AHEC Infrastructure Development program. The applicant shall provide a rationale for the waiver request including an explanation of the reason(s) why the applicant may not meet the 75 percent allocation requirement.

Attachment 7: ACCOMPLISHMENT SUMMARY FOR COMPETING CONTINUATION APPLICATIONS ONLY

All currently funded awardees must include a brief (3 page maximum) accomplishment summary as **Attachment 7**. It is an important source of material for HRSA in preparing annual reports, planning programs, and communicating program specific accomplishments. A well-presented accomplishment summary provides a description of the degree to which the applicant met previous project objectives. The progress of an AHEC competing continuation application is carefully considered during the review process; therefore, competing continuation applicants are advised to include previously stated goals and objectives in their application and emphasize the progress made in attaining these goals and objectives. Because the accomplishment summary is considered when applications are reviewed and scored, **applicants who do not include an accomplishment summary may not receive as high a score as applicants who do**. The accomplishment summary will be considered in Review Criterion 4 – Impact. (See Section V, “Application Review Information.” for an explanation of review criteria.)

The accomplishment summary is for the purpose of objective review only and does not replace the need for currently funded awardees to submit their annual progress report.

New applicants may, but are not required to, submit a summary of AHEC related accomplishments in the Program Narrative.

The accomplishment summary should be a brief presentation of the accomplishments, in relation to the objectives of the training program during the current project period. The report should include:

- 1) The period covered (dates) and addition of any centers if applicable.
- 2) Specific Objectives - Briefly summarize the specific objectives of the project as actually funded. Because of objective review recommendations and/or budgetary modifications made by the awarding unit, these objectives may differ in scope from those stated in the competing application. Include the quantitative and qualitative measures used to evaluate the project in the context of each funded objective. Include performance and evaluation information used to develop the project for which funding is being requested.
- 3) Results- Describe the program activities conducted for each objective. Include both positive and negative results or technical problems that may be important. Include the results obtained for each funded objective including the number of trainees. Include a

list of articles published in peer-reviewed journals presenting the outcomes of activities supported by award funds.

Attachment 8: AHEC Program and Center Requirements

Applicants are requested to complete the AHEC Program and Center requirements by indicating the pages in the narrative that describe how each of the selected priority areas and any additional areas have been satisfied or will be satisfied. Suggested format follows in the form of a table; however, applicants may use any format as long as it is indicated where in the application each requirement is addressed. Applicants are encouraged to provide this information in **Attachment 8** as it will help reviewers during the application review process.

AHEC Program Requirements*	Identified priority area addressed	
<p>*Applicants have the flexibility to identify priority areas, in order to focus programming efforts. For the identified priority areas, please put “Priority” next to the requirement and indicate if the priority area has been addressed.</p>	<p>YES Indicate the page number(s) where the requirement has already been satisfied.</p>	<p>NO Indicate the page number(s) where the plan to satisfy the requirement is described.</p>
<p>1. Develop and implement strategies, in coordination with the applicable one-stop delivery system under section 134(c) of the Workforce Investment Act of 1998, to recruit individuals from underrepresented minority populations or from disadvantaged or rural backgrounds into health professions, and support such individuals in attaining such careers.</p>		
<p>2. Develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas for the purpose of developing and maintaining a diverse health care workforce that is prepared to deliver high-quality care, with an emphasis on primary care, in underserved areas or for health disparity populations, in collaboration with other federal and state health care workforce development programs, the state workforce agency, local workforce investment boards, and in health care safety-net sites.</p>		
<p>3. Prepare individuals to more effectively provide health services to underserved areas and health disparity populations through field placements or preceptorships in conjunction with community-based organizations, accredited primary care residency training programs, federally qualified health centers, rural health clinics, public health departments, or other appropriate facilities.</p>		

4. Conduct and participate in interdisciplinary training that involves physicians, physician assistants, nurse practitioners, nurse midwives, dentists, psychologists, pharmacists, optometrists, community health workers, public and allied health professionals, or other health professionals, as practicable.		
5. Deliver or facilitate continuing education and information dissemination programs for health care professionals, with an emphasis on individuals providing care in underserved areas and for health disparity populations.		
6. Propose and implement effective program and outcomes measurement and evaluation strategies. (Required for all applicants)		
7. Establish a youth public health program to expose and recruit high school students into health careers, with a focus on careers in public health.		
General Provision: Applicants shall collaborate with 2 or more disciplines.		
AHEC CENTER REQUIREMENTS	YES Indicate the page number(s) where each requirement has already been satisfied.	NO Indicate the page number(s) where the plan to satisfy each requirement is described.
1. Is a public or private organization whose structure, governance, and operation is independent from the awardee and the parent institution of the awardee;		
2. Is not a school of medicine or osteopathic medicine, the parent institution of such a school, or a branch campus or other subunit of a school of medicine or osteopathic medicine or its parent institution, or a consortium of such entities;		
3. Designates an underserved area or population to be served by the center which is in a location removed from the main location of the teaching facilities of the schools participating in the program with such center and does not duplicate, in whole or in part, the geographic area or population served by any other center;		
4. Fosters networking and collaboration among communities and between academic health centers and community-based centers;		
5. Serves communities with a demonstrated need of health professionals in partnership with academic medical centers;		
6. Addresses the health care workforce needs of the communities served in coordination with the public workforce investment system; and		
7. Has a community-based governing or advisory board that reflects the diversity of the communities involved.		

Attachment 9: Institution Diversity Statement.

1. Describe the institution’s approach to increasing the number of diverse health professionals through an established strategic plan, policies, and program initiatives.
2. Describe the health professions school and/or program’s recent performance in recruiting and graduating students from underrepresented minority groups and/or students from educationally and economically disadvantaged backgrounds.
3. Describe future plans to recruit, retain, and graduate students from underrepresented minority groups and students from educationally and economically disadvantaged backgrounds.

Attachment 10: Maintenance of Effort chart

Applicants must complete and submit the following information:

NON-FEDERAL EXPENDITURES

FY 2011 (Actual)	FY 2012 (Estimated)
Actual FY 2011 non-federal funds, including in-kind, expended for activities proposed in this application. If proposed activities are not currently funded by the institution, enter \$0.	Estimated FY 2012 non-federal funds, including in-kind, designated for activities proposed in this application.
Amount: \$ _____	Amount: \$ _____

Attachment 11: Other Relevant Documents

Include here any other documents that are relevant to the application, including explanation of delinquent debt (if applicable), letters of support, which specifically describe a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.) List all letters of support on one page.

3. Submission Dates and Times

Application Due Date

The due date for applications under this announcement is **February 15, 2012 at 8:00 P.M. EST**. Applications completed online are considered formally submitted when the application has been successfully transmitted electronically by your organization’s Authorized Organization Representative (AOR) through Grants.gov and has been validated by Grants.gov on or before the deadline date and time.

Receipt acknowledgement: Upon receipt of an application, Grants.gov will send a series of email messages advising you of the progress of your application through the system. The first will confirm receipt in the system; the second will indicate whether the application has been successfully validated or has been rejected due to errors; the third will be sent when the application has been successfully downloaded at HRSA; and the fourth will notify the applicant of the Agency Tracking Number assigned to the application.

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 or hurricanes) or widespread disruptions of service, such as a prolonged blackout. The CGMO or designee will determine the affected geographical area(s).

Late applications:

Applications which do not meet the criteria above are considered late applications and will not be considered in the current competition.

4. Intergovernmental Review

The AHEC Program - Area Health Education Centers Point of Service Maintenance and Enhancement Awards (CFDA # 93.107) and AHEC Program - Infrastructure Development Awards (CFDA # 93.824) are both 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. Application packages made available under this funding opportunity will contain a listing of states which have chosen to set up such a review system, and will provide a State Single Point of Contact (SPOC) for the review. Information on states affected by this program and State Points of Contact may also be obtained from the Grants Management Specialist listed in the Agency Contact(s) section, as well as from the following Web site:
http://www.whitehouse.gov/omb/grants_spoc.

All applicants other than federally recognized Native American Tribal Groups should contact their Single Point of Contact (SPOC) as early as possible to alert them to the prospective applications and receive any necessary instructions on the state's process used under this Executive Order.

Letters from the SPOC in response to Executive Order 12372 are due sixty days after the application due date.

5. Funding Restrictions

The following funding requirements apply to the AHEC Program:

- (a) *75 Percent Allocation and Waiver:* Not less than 75 percent of the total amount provided to an AHEC program under (a)(1) or (a)(2) shall be allocated to the area health education centers participating in the program.

Waiver: To provide flexibility to newly funded AHEC programs (Infrastructure Development programs), the Secretary/HRSA may waive the requirement (stated in the sentence above) for the first two years of a new AHEC program funded under (a)(1). To be considered for a waiver of the 75 Percent Allocation requirement, an applicant must present a written request for a waiver (see Section IV. 2. xi. Attachment 6).

- (b) *Limitation:* An entity receiving funds under subsection 751(a)(2) shall not distribute such funding to a center that is eligible to receive funding under subsection 751(a)(1).

(c) *Carryover Funds*: An entity that receives an award under this section may carry over funds from one fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than three years. The recipient must notify the Grants Management Specialist and Project Officer in writing of the intended use of the carryover funds, and must report the amount carried over on the Federal Financial Report for the period in which the funds remain unobligated.

(d) *Matching Funds and Waiver*: With respect to the costs of operating a program through an award under section 751, to be eligible for financial assistance under section 751, an entity shall make available (directly or through contributions from state, county or municipal governments, or the private sector) recurring non-federal contributions in cash or in kind toward such costs in an amount that is equal to not less than 50 percent of such costs. Thus, the matching ratio for AHEC awards is 1:1 (federal funds to non-federal contributions). At least 25 percent of the total required non-federal contributions shall be in cash.

Waiver: An entity may apply to the Secretary for a waiver of not more than 75 percent of the matching fund amount required by the entity for each of the first three years the entity is funded through an award under (a)(1) AHEC Infrastructure Development program. To be considered for a waiver of not more than 75 percent of the AHEC Infrastructure Development matching fund amount, an applicant must present a written request (see Section IV. 2. xi. Attachment 5).

(e) ***Indirect costs under training grants to organizations other than state, local or Indian tribal governments will be budgeted and reimbursed at 8 percent of modified total direct costs rather than on the basis of a negotiated cost agreement, and are not subject to upward or downward adjustment.*** Direct cost amounts for equipment (capital expenditures), tuition and fees, and subgrants and subcontracts in excess of \$25,000 are excluded from the actual direct cost base for purposes of this calculation.

(f) *Project Terms*: The period during which payments may be made under an award under PHS Act section 751(a)(1) (AHEC Infrastructure Development awards) may not exceed – (A) in the case of a program, 12 years; or (B) in the case of a center within a program, 6 years.

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 submitting for this funding opportunity are **required** to submit **electronically** through Grants.gov. To submit an application electronically, please use the APPLY FOR GRANTS section at <http://www.grants.gov>. When using Grants.gov you will be able to download a copy of the application package, complete it off-line, and then upload and submit the application via the Grants.gov site.

It is essential that your organization **immediately register** in Grants.gov and become familiar with the Grants.gov site application process. If you do not complete the registration process, you will be unable to submit an application. The registration process can take up to one month.

To be able to successfully register in Grants.gov, it is necessary that you complete all of the following required actions:

- Obtain an organizational Data Universal Numbering System (DUNS) number
- Register the organization with Central Contractor Registration (CCR)
- Identify the organization's E-Business POC (Point of Contact)
- Confirm the organization's CCR "Marketing Partner ID Number (M-PIN)" password
- Register and approve an Authorized Organization Representative (AOR)
- 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>. Assistance is also available 24 hours a day, 7 days a week (excluding federal holidays) from the Grants.gov help desk at support@grants.gov or by phone at 1-800-518-4726. Applicants should ensure that all passwords and registration are current well in advance of the deadline.

It is incumbent on applicants to ensure that the AOR is available to submit the application to HRSA by the published due date. HRSA will not accept submission or re-submission of incomplete, rejected, or otherwise delayed applications after the deadline. Therefore, you are urged to submit your application in advance of the deadline. If your application is rejected by Grants.gov due to errors, you must correct the application and resubmit it 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 deadline.

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 application due date as the final and only acceptable submission of any competing application submitted to Grants.gov.

Tracking your application: It is incumbent on the applicant to track their application status by using the Grants.gov tracking number (GRANTXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking your application can be found at <https://apply07.grants.gov/apply/checkApplStatus.faces>. Be sure your 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 for an objective review of applications and to assist the applicant 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 related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

Review Criteria are used to review and rank applications. The AHEC Program has six (6) review criteria:

Criterion 1: NEED (10 points)

Involves the extent to which the application describes the problem(s) to be addressed and the target population(s) and geographic area(s) to be served by the AHEC(s). Applicants shall address needs that relate to their proposed focus/priority areas. Applicants are not required to address needs in areas they have not selected as focus/priority areas.

The extent to which the application:

- Demonstrates an understanding of the purpose and requirements of the AHEC Program.
- Demonstrates an understanding of the identified need(s) as evidenced by the description of target population(s) with supporting data, demographics, health status of the target population(s), and associated contributing factors that the proposed AHEC project intends to address in the area(s) to be served by the AHEC(s). Data provided are not older than two years.
- Identifies proposed centers and geographic areas to be served.
- In the event an applicant is requesting a new center, the extent of justification provided for adding a new center will be considered.
- Provides data to substantiate the need to recruit individuals from underrepresented minority populations or from disadvantaged or rural backgrounds into health professions.
- Provides data and literature references to demonstrate the need to prepare individuals to more effectively provide care in underserved areas and for health disparity populations.
- Provides data to describe the current and projected primary care workforce in a state or region served, and estimates the number of students to be trained in the field of primary care, and the number of primary care providers to be recruited.
- Demonstrates how data provided in the needs assessment may serve as a baseline for evaluation of specific project objectives.

Criterion 2: RESPONSE (27 points)

Involves the degree to which the proposal responds to AHEC legislative and programmatic requirements. The extent to which:

- The proposed activities address the AHEC program and center requirements.
- The application provides clarity of the project objectives and their relationship to the identified need(s).
- The project objectives are measurable and attainable within the stated timeframe.
- The clarity of the proposed work plan and mechanisms to assure that satisfactory progress is attained.
- The project fulfills the cost sharing/matching requirements.
- The project challenges and plans to overcome barriers are indicated.
- The project meets the 10 percent clinical education requirement of the applicant medical school or applicant nursing school.
- The application demonstrates interdisciplinary/interprofessional training opportunities are provided or expanded to involve physicians, physician assistants, nurse practitioners, nurse midwives, pharmacists, dentists, optometrists, public and

allied health professionals, psychologists, community health workers, or other health professionals, as practicable.

- The application has established collaborations with an HCOP, if there is one in the applicant's service area.
- The program has established linkages with community-based entities and programs listed under "Community-Based Partnerships and Linkages" – such as FQHCs, two and four-year colleges and universities.
- Innovative opportunities are proposed and/or are on-going – such as innovative community-based primary care curricula, community-based participatory research.
- Collaboration with federal and state health care workforce development programs and WIB(s) are established.
- The proposed health careers recruitment programs include or emphasize public health.
- The applicant addresses the BHP Diversity Guiding Principles.

Criterion 3: EVALUATIVE MEASURES (25 points)

Involves the adequacy of the evaluation strategy to monitor and evaluate the project results and the extent to which:

- The overall quality of the evaluation plan is reflected as an integral part of the overall project.
- The outcomes evaluation measures are being developed or implemented.
- The potential of evaluative measures to assess the extent to which project objectives are met and can be attributed to the project.
- The clarity of methods and techniques that will be used to measure, analyze and report the outcomes of each objective. Provide examples of the evaluation questions; instruments/tools used; primary/secondary data sources; include milestones and timeline.
- The application includes a logic model demonstrating the relationship among resources, activities, outputs, target population, short and long-term outcomes.
- The proposed project adequately responds to AHEC Program performance measures and outcome indicators.
- Appropriate data are identified and collected as it relates to measurable objectives.
- There is a quality assurance plan that describes the process to validate data collection and results.
- Baseline data provided in the needs assessment are utilized in the evaluation strategies.

Criterion 4: IMPACT (22 points)

This area reviews the degree to which the project activities are replicable, and/or the sustainability of the program as federal funding decreases. Involves the extent and effectiveness of meeting the primary care workforce needs of the population and geography/region identified for AHEC services and programs, and potential for replication of project activities.

Involves the extent to which:

- The project demonstrates past performance success.
 - The potential of the proposed AHEC program and participating center(s) to continue on a self-sustaining basis is demonstrated.

- The plans for effective, efficient dissemination of project results to other AHEC entities are identified.
- The potential of project results to be of state or national significance are noted.
- The potential for replication of project activities is described.
- Students are exposed to primary care in community settings and are exposed to service to underserved populations.
- Community-based participatory research activities are conducted with academic partners, and results are shared.
- The program specific accomplishments, successful outcomes, and other relevant information demonstrate meeting identified community workforce needs.
- The program provides examples of the impact of training program activities from collaborations with the following federal and non-federal partners:
 - HCOP
 - CHC(s)/FQHC(s)
 - NHSC
 - WIB(s), State Health Care Workforce Development Programs

For **Competing Continuation** applications only, the extent to which the program specific accomplishments, successful outcomes, and other relevant information that demonstrate the history of achieving statutory and programmatic requirements.

Criterion 5: RESOURCES/CAPABILITIES (11 points)

This criterion involves the qualifications of personnel by training and/or experience to implement and carry out the proposal. The capabilities of the applicant organization and quality and availability of facilities and personnel fulfill the needs and requirements of the proposed project. For competing continuation applications, past performance will also be considered.

Performance will be considered, along with the extent to which:

- There is evidence of qualifications of personnel (review of bio-sketches for key personnel).
- There is evidence of adequate staffing plan for the proposed project (Project organizational chart).
- The application provides evidence of ability to implement and evaluate programs with the following characteristics: interdisciplinary, community-based, primary care oriented, and activities that enhance workforce diversity.
- The application documents institutional support, e.g., resources and letters of support (commitment to provide financial or in-kind resources).
- The proposal includes evidence of successful partnerships and linkages with academic and community-based organizations.
- Successful partnerships with WIB(s) are substantiated.

Criterion 6: SUPPORT REQUESTED (5 points)

Involves the reasonableness of the proposed budget and resources in relation to the objectives, scope of the project, complexity of activities, and anticipated results.

The extent to which:

- The application presents a reasonable detailed annual budget for the program and contracting AHEC centers, with rationale to accomplish the project objectives.
- The application demonstrates the fiscal capability to successfully manage cooperative agreements and contracts.
- The application demonstrates efforts to obtain other sources of income, income generation plans, and future funding strategies.

2. Review and Selection Process

The Division of Independent Review is responsible for managing objective reviews within HRSA. Applications competing for federal funds receive an objective and independent peer 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 above. The committee provides expert advice on the merits of each application to program officials responsible for final selections for award.

Applications that pass the initial HRSA eligibility screening will be reviewed and rated by a panel based on the program elements and review criteria presented in relevant sections of this funding opportunity announcement. 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.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of September 1, 2012.

VI. Award Administration Information

1. Award Notices

Each applicant 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 who are selected for funding may be required to respond in a satisfactory manner to Conditions placed on their application before funding can proceed. Letters of notification do not provide authorization to begin performance.

The Notice of Award sets forth the 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 reflects the only authorizing document. It will be sent prior to the start date of September 1, 2012.

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 and cooperative agreement 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, as applicable, 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/>. 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).

Trafficking in Persons

Awards issued under this funding opportunity announcement 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>. If you are unable to access this link, please contact the Grants Management Specialist identified in this funding opportunity to obtain a copy of the Term.

Smoke-Free Workplace

The Public Health Service strongly encourages all award recipients to provide a smoke-free workplace and to 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.

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 include 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, and 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 the topic areas and is committed to the achievement of the Healthy People 2020 goals. More information about Healthy People 2020 may be found online 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/Default.aspx> as a reliable source for current guidelines). More information can also be found at <http://www.whitehouse.gov/administration/eop/onap/nhas>.

Diversity

The Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHP) is committed to increasing diversity in health professions programs and the health workforce across the Nation. This commitment extends to ensuring that the U.S. has the right clinicians, with the right skills, working where they are needed. In FY 2011, BHP adopted Diversity Guiding Principles for all its workforce programs that focus on increasing the diversity of the health professions workforce.

All health professions programs should aspire to --

- recruit, train, and retain a workforce that is reflective of the diversity of the nation;
- address all levels of the health workforce from pre-professional to professional;
- recognize that learning is life-long and should be supported by a continuum of educational opportunities;
- help health care providers develop the competencies and skills needed for intercultural understanding, and expand cultural fluency especially in the areas of health literacy and linguistic competency; and
- recognize that bringing people of diverse backgrounds and experiences together facilitates innovative strategic practices that enhance the health of all people.

To the extent possible, program grant activities should strive to support the guiding principles identified by BHP to increase diversity in the health professions workforce.

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? \(AHRO\)](#)

3. Reporting

The successful applicant under this funding opportunity announcement 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;

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

- **Federal Financial Report.** The Federal Financial Report (SF-425) is required within 90 days of the end of the project period. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through EHB. More specific information will be included in the award notice.
- **The BHP_r Performance Report.** All BHP_r awardees are required to submit a performance report to HRSA on an annual basis. They are due in August each year and must be submitted on-line by awardees in the Electronic Handbooks system at <https://grants.hrsa.gov/webexternal/home.asp>. The BHP_r Performance Report for Grants and Cooperative Agreements is designed to provide the Bureau of Health Professions (BHP_r) with information about awardee activities. As such, it is an important management tool, contributing to data BHP_r uses to report success achieving programmatic and crosscutting goals and in setting new goals for the future. The report also gives program officers information that helps them provide technical assistance to individual projects.

The *BHP_r Performance Report for Grants and Cooperative Agreements* contains two components, as follows:

- Part I - Program-Specific Information: Collects data on activities specific to your project.
- Part II – Core Measures Information: Collects data on overall project performance related to the BHP_r's strategic goals, objectives, outcomes and

indicators. The purpose is to incorporate accountability and measurable outcomes into BHPPr's programs, and to develop a framework that encourages quality improvement in its programs and projects.

All applicants are required to submit their report online using the Electronic Handbooks (EHBs). More information about the Performance Report can be found at <http://bhpr.hrsa.gov/grants/reporting/>.

- **Final Report(s).** All BHPPr awardees are required to submit a final report **within 90 days after the project period ends**. The Final Report must be submitted on-line by awardees in the Electronic Handbooks system at <https://grants.hrsa.gov/webexternal/home.asp>.

The Final Report is designed to provide the Bureau of Health Professions (BHPPr) with information required to close out an award after completion of project activities. As such, every awardee is required to submit a final report after the end of their project. The Final Report includes the following sections:

- Project Objectives and Accomplishments - Description of major accomplishments on project objectives.
- Project Barriers and Resolutions - Description of barriers/problems that impeded project's ability to implement the approved plan.
- Summary Information
 - Project overview.
 - Project impact.
 - Prospects for continuing the project and/or replicating this project elsewhere.
 - Publications produced through this grant activity.
 - Changes to the objectives from the initially approved award.

d. Transparency Act Reporting Requirements

New awards ("Type 1") 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 subrecipient'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 funding opportunity announcement by contacting:

Curtis Colston, Grants Management Specialist
Division of Grants Management Operations
OFAM/HRSA
Parklawn Building, Room 11A-02
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-3438; Fax: (301) 443-6343
Email: ccolston@hrsa.gov

William Weisenberg, Grants Management Specialist
Division of Grants Management Operations
OFAM/HRSA
Parklawn Building, Room 11A-02
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-8056; Fax: (301) 443-6343
Email: [wwaisenberg@hrsa.gov](mailto:wweisenberg@hrsa.gov)

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

Lou Coccodrilli, Branch Chief
AHEC Branch, Division of Diversity and Interdisciplinary Education
BHPr/HRSA
Parklawn Building, Room 9C-05
5600 Fishers Lane
Rockville, Maryland 20857
Telephone: (301) 443-6950; Fax: (301) 443-0157
Email: lcoccodrilli@hrsa.gov

Norma J. Hatot, CAPT, Senior Nurse Consultant/Senior Program Officer
Telephone: (301) 443-2681; Fax: (301) 443-0157
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Meseret Bezuneh, Program Officer
Telephone: (301) 594-4149; Fax: (301) 443-0157
Email: mbezuneh@hrsa.gov

Michelle Menser, Program Officer
Telephone: (301) 443-6853; Fax: (301) 443-0157
Email: mmenser@hrsa.gov

Applicants may need assistance when working online to submit their application forms electronically. Applicants should always obtain a case number when calling for support. 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
Phone: 1-800-518-4726
E-mail: support@grants.gov
iPortal: <http://grants.gov/iportal>

VIII. Other Information

Technical Assistance Calls

The program staff will host **three** technical assistance calls of two hours each, on December 7, 2011 from 2:00 PM - 4:00 PM (EST), December 13, 2011 from 10:00 AM - 12:00 Noon (EST) and January 10, 2012 from 2:00 PM to 4:00 PM (EST). All calls will be recorded and will be available until February 15, 2012.

No prior registration is necessary to participate in the January 10, 2012 technical assistance session. Participants may access audio for the session via conference line at: 1-888-604-9364; passcode: 8691149. To view presentation slides during the technical assistance session, please visit the following URL: <https://hrsa.connectsolutions.com/r86139542/>. An audio recording of the January 10, 2012 session will be available until February 15, 2012 at 1-800-835-8067.

Definitions

“Adult learner/Adult students” – are typically identified with a larger group characterized as “nontraditional students”. The National Center for Education Statistics (NCES), U.S. Department of Education, has identified seven characteristics that typically define nontraditional students. According to the NCES, adult students often:

- Have delayed enrollment into postsecondary education
- Attend part-time
- Are financially independent of parents
- Work full-time while enrolled
- Have dependents other than a spouse
- Are a single parent
- Lack a standard high school diploma.ⁱ

“Allied Health Professional” – is defined in section 799b of the Public Health Service Act (42 U.S.C. 295). Further, Allied Health (or Health Related Professions) is used to identify a cluster of health professions, encompassing approximately 80 different professions. The allied health professions fall into two broad categories: technicians (assistants) and therapists/technologists. Technicians are trained to perform procedures, and their education lasts less than two years. They are required to work under the supervision of technologists or therapists. Therapists/technologists include physical therapy assistants, medical laboratory technicians, radiological technicians, occupational therapy assistants, recreation therapy assistants, and respiratory therapy technicians.ⁱⁱ

Allied Health Disciplines have been classified in the following categories/groups:

- Assistants refer to: Home Health Aides and Medical Assistants.
- Clinical Laboratory Sciences refers to: Cytotechnologists, Histologic Technicians/Technologists, Medical Laboratory Technicians, Medical Technologists and Phlebotomists.
- Dental refers to: Dental Hygienists, Dental Assistants and Dental Laboratory Technicians.
- Food and Nutrition Services refers to: Dietetic Technicians, Dietitians, and Nutritionists.
- Health Information refers to: Health Information Administrators and Health Information Technicians.
- Rehabilitation refers to: Occupational Therapists, Occupational Therapy Assistants, Orthotists or Prosthetists, Physical Therapists, Physical Therapy Assistants, Recreation Therapists and Speech Pathologist/Audiologists.
- Technicians and Technologists refers to: Clinical Perfusionists, Cardiopulmonary Technologists, Diagnostic Medical Sonographers, Electrocardiograph Technicians (EKG), Electroencephalograph Technicians (EEG), Medical Imaging Technologists, Nuclear Medicine Technologists, Ophthalmic Medical Technicians/ Technologists, Radiation Therapy Technologists, Radiology Technologists, Respiratory Therapists, Respiratory Therapy Technicians, Surgical Technologists, and Emergency Medical Technicians or EMT Paramedics.
- Unspecified refers to any Allied Health discipline not included in the categories/groups as defined.

“Area Health Education Center Program” – is a cooperative program consisting of an entity that has received an award under PHS Act section 751(a)(1) or section 751(a)(2) for the purpose of planning, developing, operating, and evaluating an area health education center program and one or more area health education centers, which carries out the required activities described in section 751(c), satisfies the program requirements in such section, has as one of its principal functions identifying and implementing strategies and activities that address health care workforce needs in its service area, in coordination with the local workforce investment boards.

“Area Health Education Center” – is a public or nonprofit private organization that has a cooperative agreement or contract in effect with an entity that has received an award under PHS Act section 751(a)(1) or section 751(a)(2), satisfies the requirements in section 751(d)(1), and has as one of its principal functions the operation of an area health education center. Appropriate organizations may include hospitals, health organizations with accredited primary care training programs, accredited physician assistant educational programs associated with a college or university, and universities or colleges not operating a school of medicine or osteopathic medicine.

“Clinical training” – is the patient-care component of health professions education, including but not limited to clinical rotations, preceptorships, and clerkships. For purposes of BHP reporting, include hands-on field training with patient encounters (not didactic or observations).

“Continuing Education Program” – a formal, post-licensure education program designed to increase knowledge and/or skills of health professionals. Continuing education programs may

include: workshops, institutes, clinical conferences, staff development courses and individual studies. It does not include study for an academic degree, post-master's certificate or other evidence of completing such a program.

“Cooperative Agreement” – a support mechanism used when there will be substantial Federal programmatic involvement. Substantial involvement means that HRSA program staff will collaborate or participate in project or program activities as specified in Section II of this funding opportunity announcement.

“Disadvantaged” – an individual who: (1) educationally comes from an environment that has inhibited the individual from obtaining the knowledge, skill, and abilities required to enroll in and graduate from a health professions school; or (2) economically comes from a family with an annual income below a level based on low income thresholds according to family size published by the U.S. Bureau of Census, adjusted annually for changes in the Consumer Price Index, and adjusted by the Secretary of HHS, for use in all health professions programs.ⁱⁱⁱ

Examples of criteria for educationally disadvantaged are below:

- (1) The individual graduated from (or last attended) a high school with low SAT score based on most recent data available:
- (2) The individual graduated from (or last attended) a high school from which, based on most recent data available:
 - (a) low percentage of seniors receive a high school diploma; or
 - (b) low percentage of graduates go to college during the first year after graduation.
- (3) The individual graduated from (or last attended) a high school with low per capita funding.
- (4) The individual graduated from (or last attended) a high school at which based on most recent data available, many of the enrolled students are eligible for free or reduced price lunches.
- (5) The individual comes from a family that receives public assistance (e.g., Aid to Families with Dependent Children, food stamps, Medicaid, public housing).
- (6) The individual comes from a family that lives in an area that is designated under section 332 of the Act as a health professional shortage area.
- (7) The individual would be the first generation in a family to attend college.

“Dislocated worker” – refers to an individual who (A) (i) has been terminated or laid off, or who has received a notice of termination or layoff, from employment; (ii) (I) is eligible for or has exhausted entitlement to unemployment compensation; or (II) has been employed for a duration sufficient to demonstrate, to the appropriate entity at a one-stop center referred to in section 134(c), attachment to the workforce, but is not eligible for unemployment compensation due to insufficient earnings or having performed services for an employer that were not covered under a State unemployment compensation law; and (iii) is unlikely to return to a previous industry or occupation; (B)(i) has been terminated or laid off, or has received a notice of termination or layoff, from employment as a result of any permanent closure of, or any substantial layoff at, a plant, facility, or enterprise; (ii) is employed at a facility at which the employer has made a general announcement that such facility will close within 180 days; or (iii) for purposes of eligibility to receive services other than training services described in section 134(d)(4), intensive services described in section 134(d)(3), or supportive services, is employed at a facility at which the employer has made a general announcement that such facility will close; (C) was self-employed (including employment as a farmer, a rancher, or a fisherman) but is unemployed

as a result of general economic conditions in the community in which the individual resides or because of natural disasters; or (D) is a displaced homemaker.^{iv}

“Disparity” – refers to a pattern of differences in health outcomes that occurs by age, gender, race, ethnicity, education or income, disability, geographic location, or sexual orientation.

“Diversity” – as defined by BHP: Diversity is most often viewed as the proportion and number of individuals from groups underrepresented among students, faculty, administrators, and staff (i.e., structural diversity). Diversity, however, can also be conceptualized as the diversity of interactions that take place on campus (e.g., the quality and quantity of interactions across diverse groups and the exchange of diverse ideas), as well as campus diversity-related initiatives and pedagogy (e.g., the range and quality of curricula and programming pertaining to diversity, such as cultural activities and cultural awareness workshops).”

“Enrollee” – is a trainee who is receiving training in a program, but has not finished the program during a given grant year. Enrollees do not include graduates or program completers.

“Ethnicity” - refers to two categories: “Hispanic or Latino” and “Not Hispanic and Not Latino.” “Hispanic or Latino” refers to an individual of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

“Federally Qualified Health Centers” - means an entity which:

- (A)(i) is receiving a grant under section 330 of the Public Health Service Act, or (ii) (I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 of such Act;
- (B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant;
- (C) was treated by the Secretary, for purposes of part B, as a comprehensive federally funded health center as of January 1, 1990; or
- (D) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act.

“Frontier” - is an area where remote clinic sites are located and where weather and distance can prevent patients who experience severe injury or illness from obtaining immediate transport to an acute care hospital.^v

“Graduate” –refers to a trainee who has successfully completed all educational requirements for a specified academic program of study culminating in a degree or diploma, as in a university, college, or health professions school.

“Health Care Workforce” - includes all health care providers with direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, dental hygienists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals

(including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, certified nurse midwives, podiatrists, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), licensed complementary and alternative medicine providers, integrative health practitioners, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.

“Health Disparity Population” – has the meaning given such term in PHS Act section 903(d)(1), as amended, and referenced in PHS Act section 799B(20). The term “health disparity population” has the meaning given such term in section 464z-3: “A population is a health disparity population if, as determined by the Director of the Center after consultation with the Director of the Agency for Healthcare Research and Quality, there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population.”

“Health Professionals” - include-

- (A) dentists, dental hygienists, primary care providers, specialty physicians, nurses, nurse practitioners, physician assistants, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, public health professionals, clinical pharmacists, allied health professionals, doctors of chiropractic, community health workers, school nurses, certified nurse midwives, podiatrists, licensed complementary and alternative medicine providers, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), and integrative health practitioners;
- (B) national representatives of health professionals;
- (C) representatives of schools of medicine, osteopathy, nursing, dentistry, optometry, pharmacy, chiropractic, allied health, educational programs for public health professionals, behavioral and mental health professionals (as so defined), social workers, pharmacists, physical and occupational therapists, oral health care industry dentistry and dental hygiene, and physician assistants;
- (D) representatives of public and private teaching hospitals, and ambulatory health facilities, including federal medical facilities; and
- (E) any other health professional the Comptroller General of the United States determines appropriate.^{vi}

Additionally, the term “Health Professional” refers to an individual who has received a certificate, an associate’s degree, a bachelor’s degree, a master’s degree, a doctorate degree, or post-baccalaureate training in a field related to health care and who shares in the responsibility for the delivery of health care or related services.

“Health professional shortage area (HPSA)” – refers to an area designated as having a shortage of primary medical care, dental, or mental health providers. The area may be geographic (a county or service area), demographic (low income population), or institutional (comprehensive health center, federally qualified health center, or other public facility). More information about HPSAs is available on the BHP’s Web sites: <http://bhpr.hrsa.gov/shortage> and <http://muafind.hrsa.gov/>.

“Interprofessional/Interdisciplinary education” - occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve quality of care and health outcomes.^{vii}

“Low Income Individual, State Workforce Investment Board, and Local Workforce Investment Board” –

(A) Low-Income Individual - The term ‘low-income individual’ has the meaning given that term in section 101 of the Workforce investment Act of 1998 (29 U.S.C. 2801).

(B) State Workforce Investment Board, and Local Workforce Investment Board - The terms ‘State workforce investment board’ and ‘local workforce investment board’, refer to a State workforce investment board established under section 111 of the Workforce Investment Act of 1998 (29 U.S.C. 2821) and a local workforce investment board established under section 117 of such Act (29 U.S.C. 2832), respectively.

“Medically Underserved Areas/Populations” (MUA/P) - are areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population. Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility). Medically Underserved Areas (MUAs) may be a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services. Medically Underserved Populations (MUPs) may include groups of persons who face economic, cultural or linguistic barriers to health care.^{viii}

“Medically Underserved Community” - Section 799B(6) of the PHS Act this term refers to an urban or rural area or population that:

- (A) is eligible for designation under Section 332 of the PHS Act as a health professional shortage area (HPSA);
- (B) is eligible to be served by a migrant health center under Section 329 [now section 330(g)] of the PHS Act, a community health center under Section 330 of the PHS Act, a grantee under Section 330(h) of the PHS Act (relating to individuals who are homeless), or a grantee under Section 340A [now 330(i)] of the PHS Act (relating to residents of public housing);
- (C) has a shortage of personal health services, as determined under criteria issued by the Secretary under Section 1861(a)(2) of the Social Security Act (relating to rural health clinics); or
- (D) is designated by a State Governor (in consultation with the medical community) as a shortage area or medically underserved community.^{ix}

Examples of work settings that serve medically underserved communities include the following: Community Health Centers, Migrant Health Centers, Health Care for the Homeless grantees, Public Housing Primary Care grantees, Federally Designated Rural Health Clinics, National Health Service Corps sites, Indian Health Service sites, Federally Qualified Health Centers, Primary Medical Care and Dental HPSAs, City or County Health Departments. Additional information is available on the BHPr or the Bureau of Primary Health Care Web sites: <http://bhpr.hrsa.gov> or <http://bhpc.hrsa.gov> (select “Key Program Areas” and “Resources”).

“One-Stop Delivery System” - means a one-stop delivery system described in section 134(c) of the Workforce Investment Act of 1998 (29 U.S.C. 2864(c). Reference is made to the general definitions section in PHS Act section 799B (23): “One-Stop Delivery System Center”.

“Primary Care” – is the provision of **integrated, accessible health care services by clinicians** who are **accountable** for addressing a large **majority of personal health care needs**, developing a **sustained partnership** with **patients**, and practicing in the **context of family and community**. The term **clinician** refers to an individual who uses a recognized scientific knowledge base and has the authority to direct the delivery of personal health services to patients. A clinician has direct contact with patients and may be a physician, nurse practitioner, or physician assistant.^x

“Program Completer” - refers to a trainee who has successfully met the didactic and/or clinical requirements of a course of study or training program designed to improve their knowledge or skills. This term differs from graduates since an official degree or diploma is not conferred. Contact your project officer to clarify if your trainees should be considered completers or graduates. (See also definition of ‘graduate’).

An individual receiving a degree in nursing at the associate, bachelor, master or doctorate level should be classified as a graduate. A physician who completes a residency program should be classified as a program completer. A health care provider who completes a continuing education course for credit, or a high school student who completes a summer health careers program of 20-hours, should be classified as program completer. A local resident who completes initial training as a Community Health Worker (CHW) should be considered a program completer; a CHW who completes a continuing education course should also be considered a program completer.

“Public health” – is the science and art of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention.

“Quality of Care” – is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.^{xi}

“Race” - according to standards for the classification of federal data on race and ethnicity from OMB, five minimum categories on race exist: American Indian or Alaska Native, Asian, Black or African-American, Native Hawaiian or Other Pacific Islander, and White.^{xii} The minimum categories for data on race and ethnicity for Federal statistics, program administrative reporting, and civil rights compliance reporting are defined as follows:

- American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African-American. A person having origins in any of the Black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African-American.”

- Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Note: See “Ethnicity” for definitions of Hispanic or Latino ethnicity.

“Racial and Ethnic Minority Group” - means American Indians (including Alaska Natives, Eskimos, and Aleuts); Asian Americans; Native Hawaiians and other Pacific Islanders; Blacks; and Hispanics.^{xiii}

Minority/Minorities - refer to individual(s) from a racial and ethnic minority group.

Underrepresented Minority/Minorities, with respect to a health profession, means racial and ethnic populations that are underrepresented in the health profession relative to the number of individuals who are members of the population involved. This includes Blacks or African-Americans, American Indians or Alaska Natives, Native Hawaiians or Other Pacific Islanders, Hispanics or Latinos, and certain Asian subpopulations (other than Chinese, Filipino, Japanese, Asian Indian, or Thai).^{xiv}

“Rural” - describes all counties that are not part of a Metropolitan Statistical Area (MSA). For more information on Metropolitan areas, see:

<http://www.census.gov/population/www/estimates/metroarea.html>

There is an additional method of determining rurality that HRSA uses called the Rural-Urban commuting area (RUCA) codes. Like the MSAs, these are based on Census data which is used to assign a code to each Census Tract. Tracts inside Metropolitan counties with the codes 4-10 are considered rural. While use of the RUCA codes has allowed identification of rural census tracts in Metropolitan counties, among the more than 60,000 tracts in the U.S. there are some that are extremely large and where use of RUCA codes alone fails to account for distance to services and sparse population. In response to these concerns, HRSA’s Office of Rural Health Policy has designated 132 large area census tracts with RUCA codes 2 or 3 as rural. These tracts are at least 400 square miles in area with a population density of no more than 35 people.

For more information on RUCAs, see:

<http://www.ers.usda.gov/briefing/Rurality/RuralUrbanCommutingAreas/>

Please see the HRSA website where a complete list of eligible areas can be downloaded.

<http://datawarehouse.hrsa.gov/RuralAdvisor/>.^{xv}

“Rural Health Clinic” – means a facility which, as referenced by Social Security Act section 1861, 42 U.S.C. 1395x,—

(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1) [see Social Security Act section 1861 (aa)(1)];

(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of state and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians of physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability

of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and, in the case of a physician-directed clinic, has one or more of its staff physicians perform the activities accomplished through such an arrangement;

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under Social Security Act section 1866, for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic's services;

(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this title;

(H) in compliance with state and federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify;

(J) has a nurse practitioner, a physician assistant, or a certified nurse-midwife (as defined in subsection (gg)) available to furnish patient care services not less than 50 percent of the time the clinic operates; and

(K) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

“Underserved Area/Population” - includes:

- The Elderly, Individuals with HIV-AIDS, Substance Abuse, Homeless, and Victims of Domestic Violence
- Homeless Populations
- Health Professional Shortage Areas/Populations
- Medically Underserved Areas/Populations
- Migrant and Seasonal Farm workers
- Nurse Shortage Areas
- Residents of Public Housing
- Rural Communities
- Rural Health Clinic

The HRSA website has a page where you can search for eligible counties, or eligible census tracts inside Metro counties, at <http://datawarehouse.hrsa.gov/RuralAdvisor/>. A complete list of eligible areas can be downloaded from that page.^{xvi}

“Underrepresented Minorities” - means, with respect to a health profession, racial and ethnic populations that are underrepresented in the health profession relative to the number of individuals who are members of the population involved.^{xvii}

“Urban” - is classified by the U.S. Census Bureau as all territory, population, and housing units located within urbanized areas (UA) and urban clusters (UC), both defined using the same criteria. The U.S. Census Bureau delineates UA and UC boundaries that represent densely developed territory, encompassing residential, commercial, and other nonresidential urban land uses. In general, this territory consists of areas of high population density and urban land use resulting in a representation of the “urban footprint.”

According to the U.S. Census Bureau, an UA is:

“An area consisting of a central place(s) and adjacent territory with a general population density of at least 1,000 people per square mile of land area that together have a minimum residential population of at least 50,000 people. The U.S. Census Bureau uses published criteria to determine the qualification and boundaries of UAs” (U.S. Census Bureau Web site).^{xviii} The agency goes on to further clarify this definition with the following additional information:

“...a densely settled area that has a census population of at least 50,000. A UA generally consists of a geographic core of block groups or blocks that have a population density of at least 1,000 people per square mile, and adjacent block groups and blocks with at least 500 people per square mile. A UA may consist of all or part of one or more incorporated places or census designated places, and may include area adjacent to the place(s).”

IX. Tips for Writing a Strong Application

A concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at:

<http://www.hhs.gov/asrt/og/grantinformation/apptips.html>.

ⁱ Horn, L. (1996). Nontraditional Undergraduates, Trends in Enrollment From 1986 to 1992 and Persistence and Attainment Among 1989–90 Beginning Postsecondary Students ([NCES 97–578](#)). U.S. Department of Education, NCES. Washington, DC: U.S. Government Printing Office.
<http://nces.ed.gov/programs/coe/analysis/2002a-sa09.asp>

ⁱⁱ Definition retrieved from http://explorehealthcareers.org/en/Field/1/Allied_Health_Professions.

ⁱⁱⁱ As defined by the U.S. Department of Health and Human Services. Definition used by the Scholarships for Disadvantaged Students Program. <http://www.hrsa.gov/loanscholarships/scholarships/disadvantaged.html>

^{iv} Workforce Investment Act, Title I, Subsection A, Section 101.

^v Definition provided in the Office of Rural Health Policy 2009 Annual Report, retrieved from <http://www.hrsa.gov/ruralhealth/pdf/annualreport2009.pdf>

^{vi} Pursuant to 42 USCS § 294q Title 42. The Public Health And Welfare; Chapter 6A

^{vii} World Health Organization. (2010). Framework for Action on Interprofessional Education and Collaborative Practice. Geneva: WHO

^{viii} Definition retrieved from the Health Resources and Services Administration. <http://muafind.hrsa.gov/>.

^{ix} Section 799B(6) of the PHS Act

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- ^x Definition adapted from Donaldson, M.S. [et al.], editors (1996), *Primary care: America's health in a new era*, Committee on the Future of Primary Care Services, Division of Health Care Services, Institute of Medicine.
- ^{xi} Retrieved from Institute of Medicine, Measuring the Quality of Health Care
<http://www.nap.edu/catalog/6418.html>
- ^{xii} OMB guidance on aggregation and allocation of data on race can be retrieved from:
http://www.whitehouse.gov/omb/bulletins_b00-02
- ^{xiii} Public Health Service Act, Section 1707.
- ^{xiv} Public Health Service Act, Section 799b.
- ^{xv} Retrieved from the HRSA, Office of Rural Health Policy:
http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html
- ^{xvi} Retrieved from the HRSA, Office of Rural Health Policy:
http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html
- ^{xvii} Section 799B(10)
- ^{xviii} Definition was retrieved from the Office of Rural Health Policy Web site:
<http://www.hrsa.gov/ruralhealth/pdf/rhcmanual1.pdf> The U.S. Census Bureau Web site can be retrieved from
<http://www.census.gov/>