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

Bureau of Primary Health Care
Health Center Program

Affordable Care Act – Mental Health Service Expansion – Behavioral Health Integration (BHI)

Announcement Type: Supplemental
Announcement Number: HRSA-14-110

Catalog of Federal Domestic Assistance (CFDA) No. 93.527

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2014

Application Due Date in Grants.gov:
March 3, 2014

Supplemental Information Due Date in EHB:
April 3, 2014

Ensure your SAM.gov and Grants.gov registrations 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: January 31, 2014
Issuance Date: January 31, 2014

Revision (February 10): Clarified project start date as August 1, 2014 (pages i, 9, 25, and 38)

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http://www.hrsa.gov/grants/apply/assistance/bhi

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

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Bureau of Primary Health Care, is accepting applications for fiscal year (FY) 2014 Mental Health Service Expansion – Behavioral Health Integration (BHI). The purpose of this grant opportunity is to improve and expand the delivery of behavioral health services through the establishment/enhancement of an integrated primary care/behavioral health model at existing health centers. The source of funding for this competitive, supplemental opportunity is the Patient Protection and Affordable Care Act (P.L. 111-148), Section 10503.

Funding Opportunity Title:	(FY) 2014 Mental Health Service Expansion – Behavioral Health Integration (BHI)
Funding Opportunity Number:	HRSA-14-110
Application Due Dates/Times:	In Grants.gov: March 3, 2014 by 11:59 PM ET In EHB: April 3, 2014 by 5:00 PM ET
Anticipated Total Annual Available Funding:	$50 million
Estimated Number and Type of Awards:	200 grants
Estimated Award Amount:	Up to $250,000 per year
Cost Sharing/Match Required:	No
Length of Project Period:	Two years
Project Start Date:	August 1, 2014
Eligible Applicants: (See Section III-1 of this FOA for complete eligibility information, including exclusionary criteria.)	Existing Health Center Program grantees that currently receive operational funding under section 330 of the Public Health Service Act (e.g., sections 330(e), (g), (h) and/or (i)). Applicants **must** propose a plan for achieving or enhancing a fully-integrated primary care and behavioral health services model of care. The plan **must** include: 1. Use of screening, brief intervention, and referral to treatment (SBIRT) and other evidence-based practices, including tracking of the new *Depression Screening and Follow Up* performance measure; 2. Addition of at least one onsite, full-time equivalent (FTE) licensed behavioral health provider; 3. Use of a team-based, integrated model of care.

To ensure adequate time to successfully submit the application, HRSA recommends that applicants immediately verify/renew registrations in SAM, Grants.gov and HRSA EHB. The SAM and Grants.gov registration process can take up to one month. See Section IV.1 for registration details. Please note that the HRSA EHB portion of the application will not be accessible until February 26, 2014.

Per section 330(k)(3)(H) of the PHS Act, as amended (42 U.S.C. 254b(k)(3)(H), as amended), the health center governing board must approve the health center's annual budget and all grant applications. In addition, the applicant's authorized representative (most often the Executive Director, Program Director, or Board Chair), must electronically submit the SF-424 included in the application package. This form certifies that:

- The application has been reviewed and authorized by the governing board;
- All application content, including the federal and non-federal budget presentation, accurately supports the project; and
- The applicant will comply with the required assurances and resulting terms if a BHI grant is awarded.

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

Pre-Application Conference Call

HRSA will hold a pre-application conference call to provide an overview of this FOA and offer an opportunity for organizations to ask questions. For the date, time, dial-in number, and other information for the call, visit http://www.hrsa.gov/grants/apply/assistance/bhi.

Application Contacts

If you have questions regarding the FY 2014 BHI application and/or the review process described in this FOA, refer to Section VII to determine the appropriate agency contact.

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Public burden statement: an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 285. Public reporting burden for the applicant for this collection of information is estimated to average 100 hours, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to hrsa reports clearance officer, 5600 fishers lane, room 14-45, Rockville, Maryland, 20857.

I. Funding Opportunity Description

1. Purpose

This announcement solicits applications for Mental Health Service Expansion – Behavioral Health Integration (BHI). The goal of the fiscal year (FY) 2014 BHI funding is to increase the coordination, collaboration, and integration of primary and behavioral health care services[1] at existing health centers funded under Section 330 of the Public Health Service Act. Specifically, this funding opportunity will:

1. Increase access to behavioral health services, and
2. Increase the number of health centers with integrated primary care and behavioral health models of care.

Applicants must demonstrate a high level of need for behavioral health services in their community/target population, a sound proposal to meet this need, and readiness to rapidly implement the proposal. In addition, applicants must show that BHI grant funds will increase access to comprehensive, culturally competent, collaborative, and integrated behavioral health services. Applicants are expected to explain how services will be made available to all individuals in the service area while maximizing collaboration with existing behavioral health providers in the community.

2. Background

This program is authorized by Section 330 of the Public Health Service Act, as amended, 42 U.S.C. 254b and supported by the Affordable Care Act, §10503 (Public Law 111-148).

Research has shown that more than 70 percent of primary care visits stem from behavioral health issues[2]. Depression is the most common type of mental illness, currently affecting more a quarter of the U.S. adult population, and it is predicted to be the second leading cause of disability in the United States by 2020.[3] With depression currently the third most common condition diagnosed by health centers, it is clear that primary care settings have become an important access point for addressing both physical and behavioral health care needs.[4]

Many individuals seek behavioral health services in health centers due to familiarity with the setting/provider along with lack of other accessible treatments options in many communities. Recognizing that behavioral and physical health problems are often interwoven, delivery of behavioral health services in primary care settings reduces stigma and discrimination, and the

[1] For the purpose of this funding opportunity, behavioral health includes both substance use and mental health disorders.
[2] Robinson, P., and Reiter, J. (2007). Behavioral Consultation and Primary Care: A Guide to Integrating Services. *New York*: Springer.
[3] Centers for Disease Control and Prevention. *Mental Health Basics.* (HHS Publication http://www.cdc.gov/mentalhealth/basics.htm.) Atlanta, Georgia.
[4] Ibid, Robinson, P., and Reiter, J. (2007). Behavioral Consultation and Primary Care: A Guide to Integrating Services. *New York*: Springer.

majority of people with behavioral health disorders treated in integrated primary care have improved outcomes.

In 2012, over 1.1 million people received behavioral health services at Health Center Program grantee sites (hereafter referred to as health centers), including over 100,000 patients treated for substance use disorders. This represents a greater than 30 percent increase in patients seeking behavioral health services at health centers over the past three years. While over 70 percent of health centers provide at least some onsite mental health services, and nearly 20 percent of health centers provide onsite substance use disorders services, there is still significant unmet need for behavioral health services in health centers.[5]

Integration Model

Integrated care combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to their primary care providers. Primary care settings have become an important gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with both behavioral and general health care needs.

Integrating behavioral health care (mental health and substance use prevention services) with primary care services produces improved health outcomes and provides a cost-effective approach to caring for people with multiple health care needs by closely coordinating their behavioral health and primary care services. Primary and behavioral health care delivery models range from minimal collaboration to fully integrated.[6] New models of integration are evolving, yet most include the following points (or their equivalents) along an integration continuum: minimal, basic at a distance, basic on-site, partly integrated and the fully integrated.

Collaboration Continuum

- **Minimal collaboration**. Providers work in separate facilities, have separate records systems, and communicate sporadically.
- **Basic collaboration at a distance**. Providers have separate systems at separate facilities, but engage in periodic communication about shared patients, typically via telephone or email.
- **Basic collaboration on-site.** Providers from separate organizations have separate systems but are co-located/share a facility.

[5]Health Resources and Services Administration, Bureau of Primary Health Care. (2012). *2012 UDS Data* (HHS Publication) Rockville, MD

[6] Doherty, McDaniel, & Baird (1996). Five levels of primary care/behavioral healthcare collaboration. Behavioral Healthcare Tomorrow. Also appears as Doherty (1995), The why's and levels of collaborative family healthcare. *Family Systems Medicine, 13*(3/4).

- **Close collaboration in a partly integrated system**. Providers within one organization share a facility, have regular face-to-face communication, and have some common systems (e.g., scheduling, medical records).
- **Close collaboration in a fully integrated system.** Providers within one organization are part of the same team with regular treatment meetings and shared systems. The patient experiences behavioral health treatment as part of his/her regular primary care.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)
An important component of integrated care is the ability of the primary care provider to properly screen patients for behavioral health conditions. Screening, brief intervention, and referral to treatment (SBIRT) has provided universal screening, secondary prevention, early intervention, and treatment within primary care and other health care settings.[7] Based on the Substance Abuse and Mental Health Services Administration (SAMHSA) model, SBIRT is unique in its universal screening of all patients, allowing health care professionals to address a spectrum of behavioral health problems.[8] A primary aspect of SBIRT is the integration and coordination of screening and treatment into a service system that provides a needed intersection between specialty treatment and prevention.

A research-based comprehensive behavioral health SBIRT model implemented in a primary care setting reflects the five following characteristics:

- The initial screening is brief (5-10 minutes), and the intervention and treatment components are completed in significantly less time than traditional specialty care.
- The screening is universal – all patients are screened as part of the standard intake process.
- One or more specific problematic or pre-conditional behaviors are targeted.
- Behavioral health services occur in a primary care setting.
- It is comprehensive, with a seamless transition between brief universal screening, brief intervention and/or treatment, and referral to specialty care.

Program Requirements

Applicants must propose a plan for achieving increased access to behavioral health services and successful implementation of a fully-integrated primary care and behavioral health services model of care by the end of a two-year period. Applicants must demonstrate:

- Ongoing compliance with the requirements of section 330 of the PHS Act, as amended and applicable regulations. Program requirements are available at http://bphc.hrsa.gov/about/requirements. See Grant Status for details.

[7] Madras, B.K., Compton, W.M., Avula, D., Stegbauer, T., Stein, J.B., & Clark, H.W. (2010). Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and six months. *Drug and Alcohol Dependence, 99,* (1-3):280-295. doi:10.1016/j.drugalcdep.2008.08.003
[8] Substance Abuse and Mental Health Services Administration. (2011). *Screening, brief intervention and referral to treatment (SBIRT) in behavioral healthcare* (HHS Publication http://www.samhsa.gov/prevention/sbirt/SBIRTwhitepaper.pdf). Rockville, Maryland.

- An increase in the number of patients screened for a range of behavioral health concerns and connected with treatment via SBIRT (and other evidence-based practices, as appropriate).

- A realistic and achievable plan to ensure a fully-integrated primary care – behavioral health care system.

- Responsiveness to the community health care environment through coordinated provision of behavioral health care to the underserved via partnerships and collaborative activities with other organizations/programs addressing the behavioral health care needs of the target population.

- A budget for establishing or expanding BHI activities that augments current Section 330 funds and other resources.

- Readiness to initiate the proposed project with at least one new onsite, full-time equivalent (FTE) licensed behavioral health care provider in place within 120 days of a grant award.

II. Award Information

1. Type of Award

Funding will be provided in the form of a grant.

2. Summary of Funding

This program will provide funding during Federal fiscal years 2014-2016. Approximately $50 million is expected to be available to fund 200 grantees. Applicants may apply for a ceiling amount of up to $250,000 per year. The proposed project goals are to be achieved within two years. Funding beyond the first year is dependent on the availability of appropriated funds in subsequent fiscal years, grantee satisfactory performance, and a determination that continued funding is in the best interest of the Federal government.

III. Eligibility Information

1. Eligible Applicants

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

1. Applicant is an existing Health Center Program grantee funded under Section 330(e), (g), (h) and/or (i) of the Public Health Service Act.

2. Applicant DID NOT receive initial Health Center Program funding as a new start/new grantee in FY 2013 or FY 2014 (via a New Access Point, Service Area Competition, or Service Area Competition – Additional Area grant award).

3. Applicant DOES NOT request more than $250,000 in BHI Federal funding in Year 1 or Year 2.

4. Applicant adheres to the 80-page limit on the length of the total application when printed by HRSA. See Tables 1-4 for specific information regarding the documents included in the 80-page limit.

5. Applicant demonstrates on Form 5A: Service Provided that onsite behavioral health services are either currently provided or will be added to scope via the proposed BHI project.

6. Applicant demonstrates that at least one new onsite full-time equivalent (FTE) licensed behavioral health care provider will be in place within 120 days of notice of award. The new FTE can be a single new staff member or contracted provider, or a combination of new part-time staff members/contracted providers equaling at least one FTE. Eligible licensed providers include, but are not limited to, mental health and substance abuse professionals. HRSA encourages staffing expansion under this award to begin with licensed mental health professionals.

2. Cost Sharing/Matching

Cost sharing or matching is not a requirement for this funding opportunity. Under 42 CFR 51c.203, HRSA will take into consideration whether and to what extent an applicant plans to secure and maximize Federal, state, local, and private resources to support the proposed project. See Appendix E for guidelines pertaining to the budget presentation.

3. Other

Multiple applications from an organization are not allowable. If more than one BHI application is submitted, HRSA will accept only the last application submitted prior to the deadline in Grants.gov, and its corresponding application components submitted prior to the EHB deadline.

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. Applicants must download the SF-424 application package associated with this funding opportunity (HRSA-14-110) and follow the directions provided at Grants.gov and

included in *HRSA Electronic Submission User Guide*, available online at http://www.hrsa.gov/grants/apply/userguide.pdf.

Grants.gov
To submit an application electronically, use the APPLICANTS section at http://www.grants.gov. To download a copy of the application package and FOA, search grant opportunities using the funding opportunity number HRSA-14-110. See Table 1 for the required Grants.gov application components.

2. Content and Form of Application Submission

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

> **Phase 1 – Grants.gov:** Must be completed and successfully submitted by 11:59 PM ET on March 3, 2014.
>
> **Phase 2 – HRSA EHB:** Must be completed and successfully submitted by 5:00 PM ET on April 3, 2014. Applications will not be accessible in HRSA EHB before February 26, 2014.

Applicants are responsible for reading the instructions included in *HRSA 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 Electronic Handbooks. Pay particular attention to Section IV that provides detailed information on the competitive application and submission process.

Application Page Limit
The total size of all uploaded files may not exceed the equivalent of 80 pages when printed by HRSA. See Tables 1-4 for information about the application components included in the page limit. Standard OMB-approved forms are NOT included in the page limit. **Electronic submissions are subject to an automated page count, and those exceeding the limit are automatically rejected.**

Applications must be complete, within the specified page limit, and submitted prior to the deadline to be considered under this announcement.

HRSA EHB
To submit the application in HRSA EHB, the Authorizing Official (AO) and other application preparers must register in EHB at https://grants.hrsa.gov/webexternal/home.asp. See **Section 4: Validating and/or Completing an Application in the HRSA EHB** in the *HRSA Electronic Submission User Guide* (http://www.hrsa.gov/grants/apply/userguide.pdf) for additional information regarding the Phase 2 registration and submission process.

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

- 1-877-464-4772
- TTY for hearing impaired: 1-877-897-9910
- CallCenter@hrsa.gov

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

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

Application Format and Completeness/Review

The following tables detail the two-tier submission process, the documents required, and the order in which they must be submitted. In the Form Type column of Tables 1-4, the word "Form" refers to a document that must be downloaded, completed in the template provided, and then uploaded. "E-Form" refers to forms that are completed online in EHB and therefore do not require downloading or uploading. "Document" refers to a document to be uploaded as an attachment.

Documents and forms marked "C" (required for completeness) will be used to determine if an application is complete. Applications that fail to include all forms and documents indicated as required for completeness will be considered incomplete or non-responsive and will not be considered for funding. Failure to include documents marked "R" (required for review) may negatively impact an application's objective review score.

Table 1: Step 1–Submission through Grants.gov
http://www.grants.gov

- Complete and submit the following application components by the Grants.gov deadline. These forms are available in the Grants.gov application package.
- 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 considered under this funding opportunity announcement.
- 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.
- Use only the following characters when naming your attachments: A-Z, a-z, 0-9, underscore (_), hyphen (-), space, and period. Limit the file name to 50 fewer. Attachments that do not follow this instruction will cause the entire application to be rejected or cause issues during processing.
- The Other Attachments Form (listed as an Optional Document in Grants.gov) is not required and should NOT be submitted.

Application Component	Form Type	Instruction	Counted in Page Limit (Y/N)
Application for Federal Assistance (SF-424)	Form	Prepare according to instructions provided in the form itself (mouse over fields for specific instructions) and the following guidelines: • *Box 2: Type of Applicant: Select Revision, then choose Other and type Supplement and your H80 grant number* • *Boxes 4 and 5a:* Leave blank • *Box 5b: Federal Award Identifier:* 10-digit grant number (H80…) found in box 4b from the most recent Notice of Award • *Box 8f: Name and Contact Information of Person to be Contacted on Matters Involving this Application:* Provide the Project Director's name and contact information. If, for any reason, the Project Director will be out of the office between the Grants.gov submission date and the project period start date, ensure that the email Out of Office Assistant is set so HRSA will be aware of whom to contact if issues arise with the application and a timely response is required. • *Box 11: Catalog of Federal Domestic Assistance Number:* 93.527 • *Box 14: Areas Affected by Project:* Provide a summary of the areas to be served (e.g., if entire counties are served, cities do not need to be listed) and	N

Application Component	Form Type	Instruction	Counted in Page Limit (Y/N)
		upload it as a Word document. • *Box 15: Descriptive Title of Applicant's Project:* Type **Behavioral Health Integration** and upload the project abstract. The abstract WILL count toward the page limit. • *Box 16: Congressional Districts:* Provide the congressional district where the administrative office is located in 16a and the congressional districts to be served by the proposed project in 16b. If information will not fit in the boxes provided, attach a Word document. • *Box 17: Proposed Project Start and End Date:* Provide the start date (August 1, 2014) and end date (July 31, 2016) for the proposed two-year project. • *Box 18: Estimated Funding:* Complete the required information based on the funding request for the **first year** of the proposed project. • *Box 19: Review by State:* See Section IV.6 for guidance in determining applicability. • *Box 21: Authorized Representative:* The electronic signature in Grants.gov (created when the Grants.gov forms are submitted) is the official signature when applying for a grant. The form should NOT be printed, signed, and mailed to HRSA.	
Project Summary/Abstract	Document	Type the title of the funding opportunity and upload the project abstract in Box 15 of the SF-424. See instructions in Section IV.2.i.	Y
SF-424B: Assurances – Non-Construction Programs	Form	Complete the Assurances form.	N
Additional Congressional District(s) (as applicable)	Document	Upload a list of additional Congressional Districts served by the project if all districts served will not fit in 16b of the SF-424.	Y
Project Performance Site Location(s)	Form	Provide administrative site information AND information about all sites where BHI activities will occur. A list of additional sites may be uploaded as necessary.	N
Grants.gov Lobbying Form	Form	Provide the requested contact information at the bottom of the form.	N
SF-LLL: Disclosure of Lobbying Activities (as applicable)	Form	Complete the form only if lobbying activities are conducted.	N

After successful submission of the required items in Grants.gov, you will be notified by HRSA confirming the successful receipt of your application and requiring the Project Director and Authorized Organization Representative to submit additional information in HRSA EHB. Applications will not be accessible in HRSA EHB before February 26, 2014. Your application will not be considered complete unless you review and validate the information submitted through Grants.gov and submit the additional required portions of the application through HRSA EHB.

Table 2: Step 2–Submission through HRSA Electronic Handbooks (EHB)
https://grants.hrsa.gov/webexternal

- Complete and submit the following application components in EHB.
- It is mandatory to follow the provided instructions to ensure that your application can be printed efficiently and consistently for review.
- Failure to follow the instructions may make your application non-responsive. Non-responsive applications will not be considered for funding.
- Limit file names for documents to 100 characters or less. Documents will be rejected by EHB if file names exceed 100 characters.

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

Table 3: Attachments Submission through HRSA EHB (Step 2 continued)
https://grants.hrsa.gov/webexternal

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

Attachment	Required for Completeness (C)/Review(R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Attachment 1: Work Plan	C	Document	Upload a comprehensive two-year work plan. Refer to Appendix C for detailed instructions and see http://www.hrsa.gov/grants/apply/assistance/bhi for a sample.	Y
Attachment 2: Position Descriptions for Key Project Staff	R	Document	Upload position descriptions for key project staff. Each position description should be limited to one page and must include the following: position title; description of duties and responsibilities; position qualifications; supervisory relationships; skills, knowledge, and experience requirements; travel requirements; salary range; and work hours. Indicate if positions are part-time, combined, or shared. Note: A description must be submitted for, at a minimum, the BHI project coordinator and any new onsite licensed behavioral health care staff to be supported with BHI funding.	Y

Attachment	Required for Completeness (C)/Review(R)	Form Type	Instruction	Counted in Page Limit (Y/N)
Attachment 3: Biographical Sketches and Licenses/Certifications for Key Project Staff	R	Document	Upload biographical sketches for key project staff. Each biographical sketch should not exceed **two** pages in length and must include training, language fluency, and experience working with the cultural and linguistically diverse populations to be served. **Include licenses/certifications for onsite provider(s).** In the event that an identified individual is not yet hired, include a letter of commitment from that person with the biographical sketch. Note: A biographical sketch must be submitted for, at a minimum, the BHI project coordinator.	Y
Attachment 4: Service Area Map	R	Document	Upload a service area map indicating the applicant's sites along with the locations of other behavioral health providers in the service area, including other Health Center Program grantees and look-alikes, critical access hospitals, health departments, rural health clinics, and community behavioral health centers. Maps should be created using UDS Mapper (http://www.udsmapper.org). See http://www.hrsa.gov/grants/apply/assistance/bhi for instructions on creating maps using UDS Mapper.	Y
Attachment 5: Letters of Support	R	Document	Upload current dated letters of support addressed to the appropriate organizational contact (e.g., board, CEO) to document commitment to the project. See the *COLLABORATION* section of the Project Narrative for details on required letters of support. Letters of support that are not submitted with the application will not be considered by reviewers.	Y
Attachment 6: Other Relevant Documents	R	Document	If desired, include other relevant documents to support the proposed project (e.g., charts, summary of contracts/agreements, organizational brochures).	Y

Table 4: Program Specific Forms and Information Submission through HRSA EHB (Step 2 continued)
https://grants.hrsa.gov/webexternal

- All Program Specific Forms will be completed online in HRSA EHB. Refer to Appendix A for instructions.
- The Clinical Performance Measures Forms will be completed online in HRSA EHB. Refer to Appendix B for instructions.
- The Program Specific Forms and Program Specific Information forms DO NOT count against the page limit.

Program Specific Form/Information	Form Type
Form 1A: General Information Worksheet	E-Form
Form 2: Staffing Profile	E-Form
Form 5A: Services Provided	E-Form
Federal Object Class Categories	E-Form
Supplemental Information Form	E-Form
Equipment List (as applicable)	E-Form
Clinical Performance Measure	E-Form

Failure to include all forms and documents indicated as "required for completeness" will result in an application being considered incomplete or non-responsive and will not be considered for BHI funding. Failure to include documents indicated as "required for review" may negatively impact an application's objective review score.

Application Preparation

The BHI technical assistance website (http://www.hrsa.gov/grants/apply/assistance/bhi) provides essential resources for application preparation. Throughout the application development and preparation process, applicants are encouraged to work with the appropriate Primary Care Associations (PCAs), Primary Care Offices (PCOs), and/or National Cooperative Agreements (NCAs) in determining their readiness to develop a competitive application. For a complete listing of PCAs, PCOs, and NCAs, refer to http://www.bphc.hrsa.gov/technicalassistance/partnerlinks.

Only materials included with an application submitted by the announced deadlines will be considered. Supplemental materials submitted after the application deadlines, and letters of support sent directly to HHS, HRSA, or BPHC will **not** be added to an application for consideration by the Objective Review Committee.

Program-Specific Instructions

i. Project Abstract

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

Place the following at the top of the abstract:

- Project Title: Mental Health Service Expansion – Behavioral Health Integration (BHI)
- Applicant Name
- Address
- Project Director Name
- Phone Numbers (voice, fax)
- E-Mail Address
- Web Site Address (if applicable)
- Congressional District(s) for the Applicant Organization and Proposed Service Area
- Amount of Health Center Program Funding Requested in this Application

Include the following in the body of the abstract:

- A brief overview/history of the organization, the community to be served, and the target population.
- How the proposed project will address the need for integrated behavioral health care services in the community and target population.

ii. Project Narrative

In HRSA EHB, upload a Project Narrative that provides a comprehensive description of all aspects of the proposed BHI project. The Project Narrative must be succinct, consistent with other application components, and well organized so that reviewers can fully understand the proposed project. The Project Narrative should:

- Address the Review Criteria (see Section V) in the areas specified (i.e., Project Narrative, form, or attachment). Unless specified, attachments should not be used to extend the Project Narrative.
- Reference attachments and forms as needed to clarify information about patients, goals, and proposed key staff. Referenced items must be part of the HRSA EHB submission.
- Discuss required activities and any additional activities that will be included in the BHI project.

The Project Narrative must be organized using the following section headers (***NEED***, ***RESPONSE***, ***COLLABORATION***, ***EVALUATIVE MEASURES***, ***RESOURCES/CAPABILITIES***, ***SUPPORT REQUESTED***).

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

1. Describe the service area/target population, including special populations targeted with Health Center Program funding, providing data on the prevalence of behavioral health disorders in the community. Prevalence data must be provided, at a minimum, on depression.

2. Describe the unique characteristics of the service area/target population that impact access to or utilization of behavioral health care, inclusive of treatment for substance use and mental health disorders.

3. Describe existing behavioral health care providers in the service area, including identified gaps in behavioral health care services that the applicant can address via BHI funds (refer to Attachment 4: Service Area Map).

4. Describe the behavioral health care services the applicant currently provides directly as well as those provided through formal written contracts, agreements, and formal written referral arrangements. Describe how the organization maintains appropriate oversight and authority in accordance with Health Center Program requirements over all services provided via contracts/agreements or sub-recipient arrangements.[9]

5. Describe the applicant's stage of behavioral health integration along the collaboration continuum (refer to the Integration Model and Appendix D: Integration Behavioral Health Model).

6. Describe the training needs of current staff in preparation for providing integrated care (e.g., team-based care, SBIRT).

[9] All sub-recipient arrangements must be documented through a formal written contract/agreement. The grantee must demonstrate that it has systems in place to provide reasonable assurances that the sub-recipient organization complies with—and will continue to comply with—all statutory and regulatory requirements throughout the period of award.

7. Describe the behavioral health care reimbursement environment.

RESPONSE

1. Describe the proposed integrated care model, including:
    a. Integration of primary medical and behavioral health care.
    b. Use of a team-based, integrated model of care that incorporates behavioral health services within the primary care delivery system.
    c. Use of SBIRT and other evidence based practices to support universal screening, including tracking of the new *Depression Screening and Follow Up* performance measure.
    d. Referral arrangements for specialty treatment, as needed.
    e. After-hours and and involuntary/emergency psychiatric services.
    f. Consumer involvement in integrated behavioral health services.

2. As Attachment 1, provide a comprehensive two-year work plan (see Appendix C). The work plan should be detailed and logical, and describe how increased integrated behavioral health services will be responsive to the needs of the target population, including timeframes for the accomplishment of key tasks. Address how the following will be accomplished:
    a. Adoption or enhancement of primary and behavioral health care integration.
    b. Close collaboration in a fully integrated system (refer to the Integration Model and Appendix D: Integrated Behavioral Health Model) where a team-based, integrated model of care is employed using a predetermined protocol that incorporates behavioral health services within the primary care delivery system.
    c. Addition of at least one new, onsite licensed behavioral health FTE (new staff or contractor, or any combination of new part-time staff or contractor positions). Eligible licensed providers include, but are not limited to, mental health and substance abuse professionals. HRSA encourages staffing expansion under this award to begin with licensed mental health professionals.
    d. Training to support integration of primary medical and behavioral health care and use of SBIRT and other evidence based practices.

3. Describe how the following core competencies of behavioral health integration will be achieved by the end of the two-year period: shared patient scheduling, shared treatment planning, shared service provision, and shared record keeping. Refer to Attachment 1: Work Plan as appropriate.

4. Describe how the target population will be informed of available behavioral health services and the benefits of such services. Describe any enabling services (e.g., transportation, case management) that will be utilized to support the proposed project.

5. Describe how the quality improvement/quality assurance (QI/QA) program currently supports or will be enhanced to support the proposed BHI project, including:
    a. Inclusion of behavioral health data.
    b. Process for problem identification and resolution.
    c. How QA/QI reports will be used for BHI program improvement.

d. Process of assessing BHI staff through board-approved peer and chart review policies.
e. Process and parties responsible for provider licensure, credentials, and privileges – ensuring that all providers (e.g., employed, contracted) are appropriately licensed, credentialed, and privileged to perform proposed services (consistent with Form 5A).[10]

COLLABORATION

1. Describe formal and informal collaborations with community behavioral health organizations/providers and how, if needed, these collaborations will be strengthened in support of the proposed BHI project. Applicants serving special populations (MCH, HCH, and/or PHPC) must describe existing or proposed collaboration with other organizations providing behavioral health services to the same population(s).

2. Include current signed and dated letters of support in Attachment 5: Letters of Support, referencing specific support for the proposed BHI project from other organizations in the area providing behavioral health services to the target population. At a minimum, letters of support are required from Health Center Program grantees and look-alikes, critical access hospitals, health departments, rural health clinics, and community behavioral health centers in the service area (consistent with Attachment 4: Service Area Map). Letters of support are also required from specialty behavioral health organizations/providers that will provide care via referral agreement for severe/complex cases.

EVALUATIVE MEASURES

1. Using the Clinical Performance Measure form in EHB, outline a plan for tracking the following predetermined measure: *Depression Screening and Follow Up*. For this measure, outline a realistic two-year goal given the baseline (if baseline data are not yet available, state when data will be available). See Appendix B: Program Specific Information Instructions for more information.

2. Using the Supplemental BHI Information form in EHB, provide current and goal values for the percentage of patients receiving SBIRT services. See Appendix A: Program Specific Forms Instructions for more information.

3. Describe the process by which progress toward full onsite BHI will be tracked and any measures other than those cited in Items 1 and 2 above that will be utilized in these assessments.

[10] See PIN 2002-22 and PIN 2001-16 for further details on Health Center Program requirements regarding credentialing and privileging: http://bphc.hrsa.gov/policiesregulations/policies/index.html.

RESOURCES/CAPABILITIES

1. Describe the experience and expertise that qualify the organization to carry out the proposed two-year BHI plan, including readiness to implement integrated care. See Attachment 1: Work Plan for more information.

2. Describe how the organizational structure, including the capability and commitment of administration, management and governing board, is appropriate for the operational and oversight needs necessary to implement onsite integrated services.

3. Describe the recruitment and retention plan for behavioral health staff, including at least one onsite FTE licensed behavioral health care provider and any new behavioral health professional or paraprofessional staff proposed to support the BHI project.

4. Describe current or proposed systems to:
    a. Ensure a single integrated medical and behavioral health care record (e.g., EHR).
    b. Track patients referred for complex/specialty behavioral health care to ensure continuity of care.
    c. If applicable, make behavioral health services available through telebehavioral health.[11]

SUPPORT REQUESTED

1. Provide a budget presentation that appropriately supports the proposed project via the SF-424A, Federal Object Class Categories form, and budget justification, consistent with Form 1A, Form 2, and the ***RESPONSE*** section of the Project Narrative, including Attachment 1.

2. Describe how the proposed BHI Service Expansion is a cost-effective approach for meeting the behavioral health needs of the target population given the level of behavioral health care resources currently available in the service area. Highlight plans for how the health center proposes to maximize collections and reimbursement for providing behavioral health care services consistent with its sliding fee and billings and collections policies and procedures.

iii. Program Specific Forms

See Appendix A for Program Specific Forms instructions.

iv. Program Specific Information

See Appendix B for Program Specific Information instructions.

[11] See the SAMHSA-HRSA Center for Integration Health Solutions (CIHS) for learning modules on how determine if tele-behavioral health is the right choice for your community, and if so, how to build a tele-behavioral health program (see http://www.integration.samhsa.gov/operations-administration/telebehavioral-health).

v. Attachments

Attachments must be clearly labeled and uploaded in the appropriate place within HRSA EHB. See Table 3 for a complete listing of required attachments, including instructions for completing them.

3. Submission Dates and Times

Application Due Dates

The Grants.gov deadline for applications under HRSA-14-110 is **11:59 p.m. ET on March 3, 2014** and the deadline to complete all required information in HRSA EHB is **5:00 p.m. ET on April 3, 2014.** For more details regarding application submission and receipt acknowledgement, refer to HRSA Electronic Submission User Guide at http://www.hrsa.gov/grants/apply/userguide.pdf.

Late Applications

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

4. Intergovernmental Review

State System Reporting Requirements

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

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

Letters from the SPOC in response to Executive Order 12372 are due 60 days after the application due date. Letters should be sent electronically to the points of contact listed in Section VII: *Agency Contacts*.

Public Health System Reporting Requirements

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

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

- A description of the target population whose needs would be met under the proposal.

- A summary of the services to be provided.
- A description of coordination planned with the appropriate state or local health agencies.

Applicants should contact their SPOC to determine how and where to submit the PHSIS (see contact information above).

5. Funding Restrictions

Funds must be requested and utilized by the applicant organization identified on the SF-424 submitted in Grants.gov. Applicants are expected to perform the activities indicated in the BHI application and may not apply on behalf of another organization.
Funds under this announcement may not be used for fundraising, alteration/renovation, or construction. HRSA grant awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS); for more information on allowable costs and other grant requirements see the HHS GPS at http://www.hrsa.gov/grants/hhsgrantspolicy.pdf. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award).

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

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of grant applications have been instituted to provide an objective review of applications and assist applicants in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information and provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points. Reviewers will also use the HRSA Scoring Rubric as a guideline when assigning scores for each criterion. The HRSA Scoring Rubric may be found at http://www.hrsa.gov/grants/apply/assistance/bhi.

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

CRTIERION 1: NEED (20 POINTS)

1. The degree to which the applicant's description of the service area/target population, including special populations targeted with Health Center Program funding, demonstrates the need for new/increased integrated primary health care/behavioral health services. Prevalence data must be provided, at a minimum, on depression.

2. How well the applicant describes the unique characteristics of the service area/target population that impact access to or utilization of behavioral health care.

3. How well the applicant describes existing behavioral health care providers in the service area (refer to Attachment 4: Service Area Map), including identified gaps in behavioral health care services that the applicant can address via BHI funds.

4. How well the applicant describes the behavioral health care services currently provided directly as well as those provided through agreements/referral arrangements, including an assessment of the applicant's stage of primary health care/behavioral health integration along the collaboration continuum (refer to the Integration Model and Appendix D: Integration Behavioral Health Model). If behavioral health care services provided via contracts/agreements or sub-recipient arrangements, how well the applicant describes how the organization maintains appropriate oversight and authority over such contracts/agreements/sub-recipient arrangements.

5. How well the applicant describes the training needs of current staff in preparation for providing integrated care (e.g., primary care staff training needs in the provision of SBIRT, behavioral health staff in the provision of integrated primary health care/behavioral health care services).

6. How well the applicant describes the behavioral health care reimbursement environment.

CRITERION 2: RESPONSE (25 POINTS)

1. How well the applicant describes a proposed care model that will ensure integrated care, including:
    a. Integration of primary medical and behavioral health care.
    b. Use of a team-based, integrated model of care that incorporate behavioral health services within the primary care delivery system.
    c. Use of SBIRT and other evidence based practices to support universal screening, including tracking of the new *Depression Screening and Follow Up* performance measure.
    d. Referral arrangements for specialty treatment, as needed.
    e. After- hours and involuntary/emergency psychiatric services.
    f. Consumer involvement in integrated primary health care/behavioral health services.

2. How well Attachment 1: Work Plan provides a detailed and logical two-year BHI work plan that is responsive to the needs of the target population, as identified in the ***NEED*** section.

The work plan must include timeframes for the accomplishment of key tasks in the following areas and demonstrate that full integration will occur within the two-year project:

a. Adoption or enhancement of current primary and behavioral health care integration.
b. Collaboration in a fully integrated system (refer to the Integration Model and Appendix D: Integrated Behavioral Health Model).
c. Addition of at least one new, onsite licensed behavioral health FTE (new staff or contractor, or any combination of new part-time staff or contractor positions). Eligible licensed providers include, but are not limited to, mental health and substance abuse professionals. HRSA encourages staffing expansion under this award to begin with licensed mental health professionals.
d. Training to support integration of primary medical and behavioral health care and use of SBIRT and other evidence based practices.

3. How well the applicant describes a realistic process for ensuring that the following core competencies of primary health care/behavioral health integration will be achieved through the two-year project: shared patient scheduling, shared treatment planning, shared service provision, and shared record keeping.

4. How well the applicant describes how the target population will be informed of available behavioral health services and educated about the benefits of such services. The degree adequate and appropriate enabling services have been proposed to support the two-year integration project.

5. How well the applicant describes how the quality improvement/quality assurance (QI/QA) program currently supports or will be enhanced to support the proposed BHI project, including:
   a. Inclusion of behavioral health data.
   b. Process for problem identification and resolution.
   c. How QA/QI reports will be used for BHI program improvement.
   d. Process of assessing BHI staff through board-approved peer and chart review policies.
   e. Process and parties responsible for provider licensure, credentials, and privileges – ensuring that all providers (e.g., employed, contracted) are appropriately licensed, credentialed, and privileged to perform proposed services (consistent with Form 5A).

CRITERION 3: COLLABORATION (15 POINTS)

1. The degree to which the proposed formal and informal collaborations with community behavioral health organizations/providers will support the proposed project and increase the overall behavioral health of the target population. How well the applicant describes how collaborations will be strengthened, if needed, in support of the proposed BHI project. Applicants serving special populations (MCH, HCH, and/or PHPC) must describe collaboration with other organizations providing behavioral health services to the same population(s).

2. How well the letters of support in Attachment 5 demonstrate specific support for the proposed BHI project from other organizations in the service area providing behavioral

health services to the target population through detailed descriptions of collaboration and coordination. **The letters of support must be specific to the nature of the support and the BHI project.** If letters are not included from all required organizations, how well the applicant justifies why such letters could not be obtained, including documentation of efforts made to obtain the letters. At a minimum, letters of support are required from Health Center Program grantees and look-alikes, critical access hospitals, health departments, rural health clinics, and community behavioral health centers in the service area (refer to Attachment 4: Service Area Map).

CRITERION 4: EVALUATIVE MEASURES (15 POINTS)

1. How realistic and achievable the presented two-year goal for the *Depression Screening and Follow Up* clinical performance measure is given the cited baseline data and information provided in the ***NEED*** and ***RESPONSE*** sections. See Appendix B: Program Specific Information Instructions for more information.

2. How realistic and achievable the presented two-year goal for the percentage of patients receiving SBIRT services is given the cited baseline data and information provided in the ***NEED*** and ***RESPONSE*** sections. See Appendix A: Program Specific Forms Instructions for more information.

3. How well the applicant describes appropriate plans for tracking progress toward full onsite BHI, including listing any measures other than those cited in Items 1 and 2 above that will be utilized in these assessments.

CRITERION 5: RESOURCES/CAPABILITIES (15 POINTS)

1. How well the described experience and expertise qualify the organization to carry out the proposed two-year BHI plan, including readiness to implement integrated care. See Attachment 1: Work Plan for more information.

2. The extent to which the applicant's organizational structure, including the capability and commitment of administration, management, and the governing board, is appropriate for the operational and oversight needs necessary to implement onsite integrated services.

3. The appropriateness of the applicant's recruitment and retention plan for behavioral health staff, including the requirement for at least one onsite FTE licensed behavioral health care provider and any new behavioral health professional or paraprofessional staff proposed to support the BHI project, is for enabling a successful BHI project.

4. How well the applicant demonstrates that current or proposed systems will:
    a. Ensure a single integrated medical and behavioral health care record (e.g., EHR).
    b. Track patients referred for complex/specialty behavioral health care to ensure continuity of care.

CRITERION 6: SUPPORT REQUESTED (10 POINTS)

1. How well the applicant demonstrates, with consistent and complete information, a detailed and appropriate budget presentation that supports the proposed project via the SF-424A, Federal Object Class Categories form, and budget justification, consistent with Form 1A, Form 2, and the ***RESPONSE*** section of the Project Narrative, including Attachment 1.

2. The extent to which the applicant demonstrates that the proposed BHI Service Expansion is a realistic and cost-effective approach for meeting the behavioral health care needs of the target population given the level of behavioral health care resources currently available in the service area. How well the applicant demonstrates a plan for maximizing collections and reimbursement for providing behavioral health care services consistent with its sliding fee and billings and collections policies and procedures.

2. Review and Selection Process

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

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

Applications that pass the initial HRSA completeness and eligibility screening will be reviewed and rated by a panel of experts based on the program elements and review criteria presented in this FOA. The review criteria are designed to enable the review panel to assess the quality of a proposed project and determine the likelihood of its success. The criteria are closely related to each other and are considered as a whole in judging the overall quality of an application. HRSA reserves the right to review fundable applicants for compliance with HRSA program requirements through reviews of site visits, audit data, UDS reports, Medicare/Medicaid cost reports, external accreditation, or other performance reports, as applicable. The results of such review may impact final funding decisions.

Grant Status

Prior to the award date, HRSA will assess the grant status of all applicants. Applicants within the fundable range will not receive a BHI award if they have one or more of the following:

- Five or more 60-day Health Center Program requirement progressive action conditions
- One or more 30-day Health Center Program requirement progressive action conditions

Special Funding Considerations
HRSA will consider the following factors in making FY 2014 BHI awards:

- RURAL/URBAN DISTRIBUTION OF AWARDS: Aggregate awards in FY 2014 will be made to ensure that no more than 60 percent and no fewer than 40 percent of health centers serve people from urban areas and no more than 60 percent and no fewer than 40 percent serve people from rural areas as set forth in section 330(k)(4)(B) of the PHS Act. In order to ensure this distribution, HRSA may award grants to applications out of rank order.

- PROPORTIONATE DISTRIBUTION: Aggregate awards in FY 2014 to support the various types of health centers will be made to ensure continued proportionate distribution of funds across the Health Center Program as set forth in section 330(r)(2)(B) of the PHS Act. In order to meet this distribution, HRSA may award grants to applications out of rank order.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced on or around the start date of August 1, 2014.

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 objective review 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 award before funding can proceed. Letters of notification do not provide authorization to begin performance.

The NoA sets forth the amount of funds granted, the terms and conditions of the grant, the effective date of the grant, the budget period for which initial support will be given, the non-Federal funding (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 project period start date.

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 any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at http://www.hrsa.gov/grants/hhsgrantspolicy.pdf. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the NoA).

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

HRSA funds must retain their award-specific identity – they may not be commingled with state funds or other Federal funds. Commingling funds typically means depositing or recording funds in a general account without the ability to identify each specific source of funds for any expenditure. See "Financial Management" in the HHS GPS for additional information.

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

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.

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

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

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

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

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

Cultural and Linguistic Competence
HRSA programs serve culturally and linguistically diverse communities. Although race and ethnicity are often thought to be dominant elements of culture, HRSA-funded programs embrace a broader definition to incorporate diversity within specific cultural groups, including but not limited to, cultural uniqueness within Native American populations; Native Hawaiian, Pacific Islanders, and other ethnic groups; language; gender; socio-economic status; sexual orientation and gender identity; physical and mental capacity; age; religion; housing status; and regional differences. Organizational behaviors, practices, attitudes, and policies across all HRSA-supported entities respect and respond to the cultural diversity of communities, clients, and students served. HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, and materials delivered by competent providers in a manner that factor 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 as well as the free online training resources on https://www.thinkculturalhealth.hhs.gov/. 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/.

Integrating Primary Care and Public Health
Integration of primary care and public health links people, policy, programs and activities to increase efficiency and effectiveness and ultimately improve population health. Both primary care and public health emphasize prevention as a key driver of better health, and integration of the two fields can transform our focus on disease and treatment to health and wellness, as well as maximize our health care system investment. Integration occurs on a continuum and includes mutual awareness, cooperation, collaboration and partnership. Successful integration requires primary care and public health to work together along this continuum and address social and environmental determinants of health, engage communities, align leadership, develop the healthcare workforce, sustain systems, and share and collaborate on the use of data and analysis – all with an eye toward achieving a shared goal of population health improvement. Integration of primary care and public health is a major focus for HRSA and HHS and to the extent possible, applicants should consider ways to integrate primary care and public health in the activities they pursue. More information can be found at http://www.hrsa.gov/publichealth/.

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.

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 a promising tool for making health care services more accessible, efficient and cost effective for all Americans.

Related Health IT Resources:

- Health Information Technology (HHS): http://www.healthit.gov/
- What is Health Care Quality and Who Decides? (AHRQ): http://www.ahrq.gov

Pilot Program for Enhancement of Contractor Employee Whistleblower Protections
Grantees will be subject to a term and condition of award based on 48 CFR section 3.908 that requires grantees inform their employees in writing of employee whistleblower rights and protections under 41 U.S.C. 4712 in the predominant native language of the workforce. Note: Regarding 48 CFR section 3.908, the terms "contract," "contractor," "subcontract," and "subcontractor" for the purpose of this term and condition, should read as "grant," "grantee," "subgrant," and "subgrantee".

3. Reporting

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

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

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

c. **Status Reports**

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

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

3) **Progress Report –** A progress report must be submitted to HRSA on an annual basis. Submission and HRSA approval of the Budget Period Progress Report (BPR) non-competing continuation application will trigger the budget period renewal and release of each subsequent year of funding. The BPR documents progress on program-specific goals and collects core performance measurement data to track the progress and impact of the project. Grantees will receive an email message via HRSA EHB when it is time to begin working on the progress report.

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

d. Transparency Act Reporting Requirements

Supplemental awards (Type 3) issued under this funding opportunity announcement may be 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 and will be so notified in the NoA. Grant recipients must report information for each first-tier subaward of $25,000 or more in Federal funds and executive total compensation for the recipient's and sub-recipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (FFATA details are available online at http://www.hrsa.gov/grants/ffata.html).

VII. Agency Contacts

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

Brian Feldman
Office of Federal Assistance Management
301-443-3190
bfeldman@hrsa.gov

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

René Herbert
Office of Policy and Program Development
301-594-4300
BPHCBHI@hrsa.gov
http://www.hrsa.gov/grants/apply/assistance/bhi

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

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

Grants.gov Contact Center
1-800-518-4726
support@grants.gov
http://grants.gov/iportal

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

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

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

VIII. Other Information

Technical Assistance Page
A technical assistance Web site has been established to provide applicants with copies of forms, FAQs, and other resources that will help organizations submit competitive applications. To review available resources, visit http://www.hrsa.gov/grants/apply/assistance/bhi.

Federal Tort Claims Act Coverage/Medical Malpractice Insurance
Organizations that receive operational grants under the Health Center Program (sections 330(e), (g), (h), and/or (i)) are eligible for protection from claims or suits alleging medical malpractice through the Federally Supported Health Centers Assistance Act of 1992 (Act). The Act provides that health center employees may be deemed as Public Health Service (PHS) employees and thereby afforded protections of the Federal Tort Claims Act (FTCA) for the performance of medical, dental, surgical, and related functions.

Once funded, new grantees can apply for FTCA coverage upon meeting the FTCA eligibility requirements, but they must maintain malpractice coverage in the interim. **FTCA participation is not guaranteed**. Funded health centers who opt out of FTCA (e.g., Public Entity-Health Centers) must maintain malpractice insurance coverage at all times. Applicants are encouraged to review the FTCA Health Center Policy Manual available at http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin201101manual.pdf and contact 866-FTCA-HELP (866-382-2435) for additional information.

340B Drug Pricing Program
The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, codified as Section 340B of the Public Health Service Act, as amended (see http://www.hrsa.gov/opa/programrequirements/phsactsection340b.pdf). The program limits the cost of covered outpatient drugs for certain Federal grantees, look-alikes, and qualified disproportionate share hospitals. Covered entities may realize a cost savings of 20-50 percent on outpatient drug purchases and additional savings on other value-added services through participation in the 340B Prime Vendor Program (PVP). Pharmacy related technical assistance is available at 866-PharmTA (866-742-7682). There is no cost to participate in the 340B program or the 340B Prime Vendor Program, and eligible entities are not required to have an established in-house pharmacy to participate. For additional information, please contact the Office of Pharmacy Affairs (OPA) at 800-628-6297 or visit the OPA Web site at http://www.hrsa.gov/opa/index.html.

IX. Tips for Writing a Strong Application

HRSA has designed a technical assistance Web site to assist applicants in preparing applications. Resources include help with system registration, finding and applying for funding opportunities, writing strong applications, understanding the review process, and many other topics which applicants will find relevant. The Web site can be accessed online at http://www.hrsa.gov/grants/apply/index.html. In addition, a concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at http://dhhs.gov/asfr/ogapa/grantinformation/apptips.html.

Appendix A: Program Specific Forms Instructions

Program Specific Forms must be completed electronically in HRSA EHB. Use only the forms approved by the U.S. Office of Management and Budget and available via the online application. Portions of the forms that are blocked/grayed-out are not relevant to the BHI application and should not be completed. To preview the forms to be completed online, visit http://www.hrsa.gov/grants/apply/assistance/bhi.

FORM 1A – GENERAL INFORMATION WORKSHEET (REQUIRED)

1. APPLICANT INFORMATION

- Complete all relevant information that is not pre-populated.
- Applicants may check only one category in the Business Entity section. If an applicant is a Tribal or Urban Indian entity and also meets the definition for a public or private entity, then the applicant should select the Tribal or Urban Indian category.
- Applicants may select more than one category for the Organization Type section.

2. PROPOSED SERVICE AREA

2a. Target Population and Service Area Designation

- The type of funding requested (i.e., section 330(e)-CHC, section 330(g)-MHC, section 330(h)-HCH, and/or section 330(i)-PHPC) will be pre-populated from the Budget Summary form. Refer to Section I.3 for definitions of the MHC, HCH, and PHPC populations. To change the population type, go to the Budget Summary page of the standard forms and click on Change Sub-Program.
  NOTE: Applicants must apply for funding under all population types, and in the same proportion, for which they currently receive funding.

2b. Service Area Type

- Classify the proposed target population (consistent with the current target population and service area) type as Urban, Rural, or Sparsely Populated. To be determined sparsely populated, the entire proposed service area must have seven or fewer people per square mile. Visit the Office of Rural Health Policy's Web site at http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html for information about rural populations.

2c. Target Population and Provider Information[12]

Provider FTEs by Type:

- Provide a count of current provider full-time equivalents (FTEs) by type (i.e., behavioral (mental) health, substance abuse, and enabling services).
- Project the number of provider FTEs anticipated by the end of the two-year project.

[12] For the purposes of the funding opportunity, "behavioral health" (BH) implies mental health or emotional issues, as well as substance abuse or chemical dependency. For the purposes of Form 1A only, behavioral health references only mental health providers/services.

Patients and Visits by Service Type:

- Project the number of ***NEW*** patients and visits anticipated within the relevant service type categories by the end of the two-year project. Within each relevant service type category (i.e., behavioral (mental) health, substance abuse, and enabling services), an individual can only be counted once as a patient. An individual who receives multiple types of services should be counted once for each service type (e.g., once for behavioral health and once for substance abuse services).
- For this section of the form only, ***NEW*** is defined as both new patients to the health center as well current patients who have not previously received behavioral health services via the health center.

Unduplicated Patients and Visits by Population Type:

- Project the number of ***NEW*** patients and visits anticipated within each population type category by the end of the two-year project.
- Data reported for patients and visits should not be duplicated within or across the four target population categories (i.e., General Community, Migratory and Seasonal Agricultural Workers, Public Housing Residents, Homeless Persons). Note that Population Type in this table refers to the population being served, not the funding type (i.e., section 330(g), section 330(h), section 330(i)).

FEDERAL OBJECT CLASS CATEGORIES FORM (REQUIRED)

Before completing the Federal Object Class Categories form, the SF-424A must be completed. See Appendix E for instructions on completing both budget forms.

FORM 2 – STAFFING PROFILE (REQUIRED)

Report staff that will support the proposed BHI project by the end of the two-year project, including those that are part of an indirect cost rate. Include salaried staff for the entire scope of the BHI project.

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

The Staffing Profile should be consistent with the amounts for personnel costs included in the budget justification. However, the amount for total salaries (this figure will auto-calculate in EHB) may not match the amount allocated for the Personnel cost category of the SF-424A due to the inclusion of salaries charged to indirect costs on the Staffing Profile.

FORM 5A – SERVICES PROVIDED (REQUIRED)

Identify the services that will be available through the proposed BHI project and how the services will be provided (i.e., Applicant, Formal Written Contract/Agreement (Applicant Pays for Service), Formal Written Referral Arrangement/Agreement). Onsite behavioral health services must be indicated on Form 5A (Column I) for the application to be considered eligible.

Information presented on Form 5A will be used by HRSA to determine Health Center Program changes in scope. Any BHI-related changes will result in verification conditions on the Notice of Award. New services described or detailed in other portions of the application (e.g., narratives, attachments) are not considered to be included in the approved scope of project if the application is funded.

Allowable Services/Providers for Behavioral Health Integration

Eligible Services	Eligible Changes to Form 5A	Eligible Staff
• Substance Abuse Services: o Detoxification o Outpatient Treatment o Residential Treatment o Rehabilitation (Non-Hospital Settings) • Mental Health Services o Treatment/ Counseling o Developmental Screening o 24-Hour Crisis • Psychiatry	• Applicants **must** propose to provide behavioral health services directly (Column I) if they are not already doing so. • Applicants may also propose to: o Provide a behavioral health service directly (Column I) that is currently offered through an agreement in which the grantee pays for the service (Column II). o Provide a behavioral health service directly (Column I) or pay for the service through an agreement (Column II) that was previously offered through a referral arrangement in which the grantee does NOT pay (Column III). o Add a ***new*** behavioral health service (this application will serve as the Change in Scope request if BHI funding is received).	• Psychiatrists • Licensed Clinical Psychologists • Licensed Clinical Social Workers • Other licensed mental health/substance abuse providers (e.g., Licensed Professional Counselors) • Other mental health/substance abuse staff • Non-clinical staff, including: o Case Managers o Patient/Community Education Specialists o Transportation Staff o Interpretation Staff

SUPPLEMENTAL INFORMATION FORM (REQUIRED)

1. SBIRT

Report baseline and goal data for the percentage of patients receiving SBIRT. Refer to the most recent UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics for more information about reporting SBIRT data (UDS Table 6a). For developing the baseline, refer to your most recent UDS Report or utilize more current health center data, as available. If SBIRT is not currently provided, baseline data can be 0. The goals should be realistic and attainable, as well as responsive to the proposed target population, identified community behavioral health needs, and key proposed activities discussed in the Project Narrative and included in Attachment 1. Goal data cannot be equal to or less than baseline data.

2. NEW LICENSED BEHAVIORAL HEALTH STAFF

Report the number of onsite FTE licensed behavioral health provider(s) to be added through BHI funding, listing providers by two categories: staff and contractors. The total for these two categories must be equal to or greater than 1 for the application to be eligible for BHI funding.

EQUIPMENT LIST (AS APPLICABLE)

Applicants requesting to utilize up to $40,000 in funding in Year 1 ONLY for the purchase of moveable equipment must complete this form detailing the equipment to be purchased in support of the proposed BHI project.

For each item on the equipment list, the following fields must be completed:

- **Type** – Select clinical or non-clinical.
- **Item Description** – Provide a description of each item.
- **Unit Price** – Enter the price of each item.
- **Quantity** – Enter of the number of each item to be purchased.
- **Total Price** – EHB will calculate the total price by multiplying the unit price by the quantity entered.

Any equipment purchased with grant funds must be pertinent to health center operations. Further, equipment purchased with grant funds must be procured through a competitive process (see 45 CFR 74.43) and maintained, tracked, and disposed of in accordance with 45 CFR Parts 74.34 and 92.32.

Allowable equipment purchases are limited to moveable items that are non-expendable, tangible personal property having a useful life of more than one year and an acquisition cost which equals or exceeds the lesser of (a) the capitalization level established by the applicant for its financial statement purposes, or (b) $5,000. Furniture, administrative equipment (i.e., computers, servers, telephones, fax machines, copying machines, software), and special purpose equipment used for medical activities (e.g., tele-behavioral health equipment) with a useful life of one year or more and a unit cost of less than $5,000 may also be included. Moveable equipment can be readily shifted from place to place without requiring a change in the utilities or structural characteristics of the space.

The selection of all equipment should be based on a preference for recycled content, non-hazardous substances, non-ozone depleting substances, energy and water efficiency, and consideration of final disposal (disposed in a manner that is safe, protective of the environment, and compliant with all applicable regulations), unless there are conflicting health, safety, and performance considerations. Applicants are strongly encouraged to employ the standards established by either the Electronic Product Environmental Assessment Tool (EPEAT) or Energy Star, where practicable, in the procurement of equipment. Following these standards will mitigate the negative effects on human health and the environment from the proliferation, rapid obsolescence, low recycling rate, high energy consumption, potential to contain hazardous materials, and increased liability from improper disposal. Additional information for these standards can be found online at http://www.epeat.net and http://www.energystar.gov.

Appendix B: Program Specific Information Instructions

CLINICAL PERFORMANCE MEASURE

The Clinical Performance Measure set a goal for the two-year project (8/1/2014 – 7/31/2016) for the new Depression Screening and Follow Up Measure performance measure that will be collected in early 2015 as part of the Calendar Year (CY) 2014 UDS Report. The goal should be responsive to the proposed target population, identified community behavioral health needs, and key proposed activities discussed in the Project Narrative and included in Attachment 1.

Report the **Depression Screening and Follow Up Measure** as follows:

- Set the goal as the percentage of patients age 12 years and older that will be screened for depression and, if identified as depressed, have a follow-up plan documented.
- Set the baseline data as follows, or provide zero as the baseline data if baseline (current) data is not available:
  - For the numerator, report the number of patients age 12 years and older who were (1) screened for depression with a standardized tool during the measurement year and, if considered to be depressed, (2) had a follow-up plan documented.
  - For the denominator, report the number of patients age 12 years and older that were seen as medical patients during the measurement year.

Table 5: Overview of Measures Form Fields

Field Name	Notes
Focus Area	This field contains the content area description for the performance measure.
Performance Measure	This field defines the performance measure.
Performance Measure Applicability	The measure may not be marked *Not Applicable*.
Target Goal Description	This field provides a description of the target goal. Applicants must specify this field.
Numerator Description	The numerator is the number of patients that meet the criteria identified by the measure (e.g., patients in a specified age range that received a specified service).
Denominator Description	The denominator is all patients to whom the measure applies (e.g., patients in a specified age range, regardless of whether they received a specified service).

Field Name	Notes
Baseline Data Baseline Year Measure Type Numerator Denominator	This field contains subfields that provide information regarding the initial threshold used to measure progress over the course of the 2-year project. The Baseline Year subfield identifies the initial data reference point. The Measure Type subfield provides the unit of measure (e.g., percentage, ratio). The Numerator and Denominator subfields specify patient or organizational characteristics (see above). For applicants with no baseline data, the numerator and denominator can be zero. Use the Comments field to provide details on when baseline data will be available.
Projected Data	This field provides the goal for the end of the 2-year project.
Data Source and Methodology	This field provides information about the data sources used to develop the performance measure. Applicants are required to select the data source—EHR, Chart Audit, or Other (please specify)—and describe the methodology used to collect and analyze data. Data must be valid, reliable, and derived from established management information systems.
Key Factors and Major Planned Actions Key Factor Type Key Factor Description Major Planned Action Description	The Key Factor Type subfield requires applicants to select Contributing and/or Restricting factor categories. Contributing factors are those that are predicted to positively impact goal attainment, while restricting factors are those predicted to negatively impact goal attainment. Applicants must specify at least one key factor of each type. In the Key Factor Description subfield, applicants provide a narrative description of the factors predicted to contribute to and restrict progress toward stated goals. In the Major Planned Action Description subfield, applicants provide a description of the major actions planned for addressing the identified key factors. Applicants must use this subfield to outline major action steps and strategies for achieving the performance measure. This field has a 1,000-character limit.
Comments	This open text field, limited to 1,000 characters, enables applicants to provide additional information. Information exceeding the character limit should be placed in the *EVALUATIVE MEASURES* section of the Project Narrative.

Appendix C: Work Plan

As noted in the ***RESPONSE*** section of the Program Narrative (Section IV.2.ix), applicants are required to develop a comprehensive work plan for the proposed BHI project. A sample work plan and guidance for completion can be downloaded from http://www.hrsa.gov/grants/apply/assistance/bhi. It can be completed in Mircosoft Word and uploaded into EHB as a Microsoft Word document or PDF file.

Work Plan Guidance
In the work plan, outline goals, objectives, action steps, and additional required information related to the accomplishment of BHI. **The work plan should span the proposed two-year project and WILL count against the page limit.** When completing the work plan, utilize the following definitions.

Key Elements of the Project Work Plan

1) **Focus Area:** Applicants must organize their work plans under the following focus areas:
    a. Adoption or enhancement of current primary and behavioral health care integration
    b. Collaboration in a fully integrated system (refer to the Integration Model and Appendix D: Integrated Behavioral Health Model)
    c. Addition of a total of at least one new, onsite licensed behavioral health FTE (staff or contractor, or any combination of part-time staff or contractor positions)
    d. Training to support integration of primary medical and behavioral health care and use of SBIRT and other evidence based practices

2) **Goal:** For each focus area, provide at least one goal. Goals should describe measureable results.

3) **Key Action Steps:** Identify the action steps that must occur to accomplish each goal. For each goal, provide at least one action step. For each action step, identify at least one person/area responsible and time frame.

4) **Person/Area Responsible:** Identify who will be responsible and accountable for carrying out each action step.

5) **Time Frame:** Identify the expected time frame for carrying out each action step.

6) **Comments:** Provide supplementary information as desired.

When defining goals and action steps, applicants should ensure that the work plan review criteria (Item 2 in ***CRITERION 2: RESPONSE***) are fully addressed. For information that cannot be adequately explained in the work plan, **provide detail in the Program Narrative** (Item 2 in ***RESPONSE***).

Appendix D: Integrated Behavioral Health Model

New models of Primary Health Care/Behavioral Health Integration are evolving as the unique needs of each care setting impacts the needs for that population. Historically, model of full integration include the below characteristics.[13]

	Fully Integrated
Access to Care	One reception area One health record Typically one visit to address all needs Integrated provider model
Clinical Service Provision	One treatment plan All services provided onsite Ongoing consultation and involvement in services One provider prescribing or close collaboration among prescribing providers One set of lab work
Funding	Maximization of billing and support staff
Use of Evidence Based Practices (EBPs)	EBPs are standard services (e.g., motivational interviewing, depression screening, diabetes management)
Data/Information Technology	Fully integrated, electronic health record with information available to all providers Data collection from one source

[13] Adapted from Doherty, McDaniel, & Baird (1996). Five levels of primary care/behavioral healthcare collaboration. Behavioral Healthcare Tomorrow, October 1996. Also appears as Doherty (1995), The why's and levels of collaborative family healthcare. Family Systems Medicine, 1995, Vol 13, No.3/4.

Appendix E: Budget Presentation Instructions

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

STANDARD FORM 424A
Complete Sections A, B, D, E, and F (if F is applicable) of the SF-424A: Budget Information – Non-Construction Programs. The budget must be entered separately for each type of section 330 funding (CHC, MHC, HCH, and/or PHPC). The budget must clearly indicate the cost for each program type and must provide detailed information on the first **12-month period**. The maximum amount that may be requested in each year cannot exceed $250,000.

Use the following guidelines to complete the SF-424A. Budget amounts must be rounded to the nearest whole dollar. In addition, please review the sample SF-424A located on the BHI technical assistance Web site at http://www.hrsa.gov/grants/apply/assistance/bhi.

Section A – Budget Summary
Under New or Revised Budget, provide the proposed budget (Federal and non-Federal) for the first 12-month budget period broken down by each section 330 program type for which funding is requested (CHC, MHC, HCH, and/or PHPC). Funding must be requested proportionately for all population types for which the applicant currently receives Health Center Program funding. The Federal amount refers to only the Federal section 330 grant funding requested, not all Federal grant funding that an applicant receives. Provide non-Federal Resources by funding source. If the applicant is a state agency, state funding should be included in the applicant field. As a reminder, matching funds are not required for this grant program.

Section B – Budget Categories
Update the budget for the first 12-month budget period for each type of section 330 program for which funding is requested (CHC, MHC, HCH, and/or PHPC in separate columns). Enter the budget amount for each object class category. Each line represents a distinct object class category that must be addressed in the budget justification. Applicants may request Federal section 330 grant funding up to $40,000 in Year 1 only for equipment (see Appendix F).

Section D – Forecasted Cash Needs
Enter the amount of cash needed by quarter during the first year for both the Federal request and all other sources, if desired.

Section E – Budget Estimates of Federal Funds Needed For the Balance of the Project
Enter the Federal funds requested for Year 2 in column (b) broken down by each proposed section 330 program type (CHC, MHC, HCH, and/or PHPC). The maximum amount that may be requested cannot exceed $250,000.

Section F – Other Budget Information (if applicable)
Direct Charges: Explain amounts for individual direct object class categories that may appear to be out of the ordinary.
Indirect Charges: Enter the type of indirect rate (provisional, predetermined, final, or fixed) that will be in effect during the project period, the estimated amount of the base to which the rate is applied, and the total indirect expense.
Remarks: Provide other explanations as necessary.

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

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

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

BUDGET JUSTIFICATION
A detailed budget justification in line-item format must be provided for **each 12-month period of the two-year project**.

Attach the budget justification in the Budget Narrative Attachment Form section in EHB. Please be aware that Excel or other spreadsheet documents with multiple pages (sheets) may not print out in their entirety. The budget justification must be concise and should not be used to expand the Project Narrative. See http://www.hrsa.gov/grants/apply/assistance/bhi for a sample budget justification.

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

It is important to **ensure that the budget justification contains detailed calculations explaining how each line-item expense is derived** (e.g., number of visits, cost per unit). Refer to the HHS Grants Policy Statement available at http://www.hrsa.gov/grants for information on allowable costs. If there are budget items for which costs are shared with other programs (e.g., other HRSA programs), the basis for the allocation of costs between the programs must be explained. Include the following in the budget justification:

Personnel Costs: Personnel costs must be explained by listing the exact amount requested each year. Reference Form 2: Staffing Profile as justification for dollar figures, noting that the total dollar figures will not match if any salaries are charged as indirect costs.

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

Table: Budget Justification Sample for Staff

Name	Position Title	% of FTE	Base Salary	Federal Amount Requested
J. Smith	Physician	50	$225,000	$112,500
R. Doe	Nurse Practitioner	100	$ 75,950	$75,950
D. Jones	Data/AP Specialist	25	$ 33,000	$ 8,250

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

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

Equipment: Identify the cost per item and justify the need for each piece of equipment to carry out the proposed project. Equipment includes moveable items that are non-expendable, tangible personal property having a useful life of more than 1 year and an acquisition cost that equals or exceeds the lesser of (a) the capitalization level established by the applicant for its financial statement purposes, or (b) $5,000. Furniture, administrative equipment (i.e., computers, servers, telephones, fax machines, copying machines, software) and special purpose equipment used for medical activities (e.g., stethoscopes, blood pressure monitors, scales, electronic thermometers) with a useful life of one year or greater and a unit cost of less than $5,000 may also be included.

Applicants may request up to $40,000 of Year 1 funding ONLY to support the purchase of relevant equipment. In addition to including details in the Budget Justification, an equipment list form must also be completed. See Appendix A for details. The Budget Justification must clearly indicate how funding used to support equipment in Year 1 will be used to support operations in Year 2 if the same amount of funding is requested in each year.

Supplies: List the items necessary for implementing the proposed project, separating items into three categories: office supplies (e.g., paper, pencils), medical supplies (e.g., syringes, blood tubes, gloves), and educational supplies (e.g., brochures, videos).

Contractual: Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. List both patient care (e.g., laboratory) and non-patient care (e.g., janitorial) contracts. Each applicant is responsible for ensuring that its organization/institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring contracts. Reminder: Recipients must notify potential sub-recipients that entities receiving subawards must be registered in SAM and provide the recipient with their DUNS number.

Construction: For the purposes of this funding opportunity announcement, the construction line item is not allowed.

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

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

If an organization does not have a Federally Negotiated Indirect Costs (IDC) Rate Agreement, all costs will be considered direct costs until a rate agreement is negotiated with a Federal cognizant agency and provided to HRSA as part of the budget request. If the application is funded, HRSA will reallocate any amount identified under the Indirect Charges cost category to the Other cost category. If the grantee can provide an approved IDC Rate Agreement within 90 days of award, the funds can be moved back to the Indirect Charges cost category.