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

Bureau of Primary Health Care

Health Center Program

NEW ACCESS POINTS (NAP)

Announcement Type: NEW COMPETITION
Announcement Number: *HRSA-11-017*

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FUNDING OPPORTUNITY ANNOUNCEMENT
Fiscal Year 2011

Application Due Date in Grants.gov: November 17, 2010

Supplemental Information Due Date in EHBs: December 15, 2010

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Legislative Authority: Public Health Service Act as amended, Title III, section 330, (42 U.S.C. 254b)

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EXECUTIVE SUMMARY:

This funding opportunity announcement details the eligibility requirements, review criteria and awarding factors for organizations seeking a grant for operational support of New Access Points (NAPs) in fiscal year (FY) 2011. This announcement supersedes announcement number HRSA-08-077.

An important element of the Health Resources and Services Administration's (HRSA) commitment to improving and expanding access to needed primary health care services is the support of NAPs for the delivery of primary health care services for underserved and vulnerable populations under the Health Center Program. Authorized under section 330 of the Public Health Service (PHS) Act, as amended (i.e., Community Health Centers (CHC), Migrant Health Centers (MHC), Health Care for the Homeless (HCH) centers, and Public Housing Primary Care (PHPC) centers), health centers provide care to more than 19 million people nationwide. HRSA anticipates that up to $250 million may be available to support approximately 350 NAP grant awards in FY 2011.

Competitive NAP applications will demonstrate a high level of need in their community/population, present a sound proposal to meet this need, show that the organization is ready to rapidly initiate the proposal, display responsiveness to the health care environment of the service area, and demonstrate collaborative and coordinated delivery systems for the provision of health care to the underserved. Further, applicants are expected to demonstrate that the new access point(s) will increase access to comprehensive, culturally competent, quality primary health care services, including oral health, mental health and substance abuse services, and improve the health status of underserved and vulnerable populations in the area to be served.

All applicants are expected to demonstrate compliance with the requirements of section 330 of the PHS Act, as amended and applicable regulations. Applicants are encouraged to refer to www.bphc.hrsa.gov/about/requirements.htm for additional information on key health center program requirements.

HRSA has revised the NAP application in order to streamline and clarify the application instructions. For FY 2011, the following significant application changes/program updates should be noted:

- The application submission process has changed. Submission of the FY 2011 NAP application now involves a two-step submission process via Grants.gov and the HRSA Electronic Handbooks (EHB). Please carefully review details on the new application submission process.
- New forms have been added including:
    - An Environmental Information and Documentation Checklist in accordance with the National Environmental Policy Act (NEPA) of 1969.
    - Other Requirements for Sites Form (to address requirements for leased property and the National Historic Preservation Act (NHPA).
    - Equipment List Form.
    - Two forms for documenting Electronic Health Records.

- 424C Budget Information-Construction Programs (for proposed alteration and renovation).

- The majority of Program Specific Forms and Program Specific Information are now completed electronically within the EHBs (with the exception of Form 3 and Environmental Information and Documentation (EID) which are uploaded into the EHB).

- The following sections have been revised: Application and Submission Information, Review Criteria, Terms and Definitions, instructions for the Program Specific Forms, instructions for the Program Specific information, and Budget Presentation.

- The Project Period for new grantees will be two years.

- The scoring for the Need Section has been changed to include the weighted score of a revised Need for Assistance (NFA) Worksheet. The outcome of the NFA Worksheet calculation has been integrated into the overall application score and may result in up to 20 points of the overall 30 points allocated for the Need Section of the Review Criterion.

- A Funding Priority for applicants serving a high poverty area has been added.

- A Funding Priority for applicants requesting funding to serve special populations has been added, specifically migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330(h)) and/or residents of public housing (section 330(i)).

- A Funding Priority for applicants serving a sparsely populated rural area has been added in lieu of a Funding Preference.

- Requirements for the Health Care Plan and Business Plan have been revised to include Clinical and Financial Performance Measures.

- A Project Implementation Plan specific to proposed alteration and renovation projects has been added.

Eligible Applicants (please refer to Section III for additional information on eligibility requirements):

Organizations eligible to compete include public or nonprofit private entities, including tribal, faith-based and community-based organizations. Applications may be submitted from new organizations or organizations currently receiving funding under section 330.

Application Submission:

For FY 2011, HRSA will use a two-tier submission process for NAP applications via Grants.gov and the HRSA's EHBs. Please see the following chart for detailed information on the application process.

Phase 1 - Grants.gov: must be completed and successfully submitted via Grants.gov by 8:00 PM ET on November 17, 2010.

Phase 2 - HRSA's EHBs: must be completed and successfully submitted by 5:00 PM ET on December 15, 2010.

Please Note: Applicants can only begin Phase 2 in HRSA's EHBs after Phase 1 in Grants.gov has been completed by the assigned due date and HRSA has assigned the application a tracking number. Applicants will be notified by email when the application is ready within HRSA's EHBs for the completion of Phase 2. This email notification will be sent within 7 business days of the Phase 1 submission. Refer http://www.hrsa.gov/grants/userguide.htm (HRSA Electronic Submission Guide) for more details.

To ensure adequate time to follow procedures and successfully submit the application, HRSA recommends that applicants register immediately in Grants.gov and HRSA's EHBs if not done so already. The registration process can take up to one month. For Grants.gov technical assistance, please refer to http://www.grants.gov or call the Grants.gov Contact Center 24 hours a day, 7 days a week (excluding Federal holidays) at 1-800-518-4726 for information on registering. **Applicants are strongly encouraged to register multiple authorizing organization representatives.**

For information on registering in HRSA's EHBs, please refer to http://www.hrsa.gov/grants/userguide.htm or call the HRSA Call Center at 1-877-464-4772. If this registration process is not complete, you will be unable to submit an application. **HRSA recommends that applications be submitted in Grants.gov as soon as possible to ensure that maximum time is available for providing the supplemental information in HRSA's EHBs.**

TWO-TIERED APPLICATION SUBMISSION PROCESS

Phase	Due Dates	Helpful Hints
Phase 1 (Grants.gov): **Please complete and submit the following by the Grants.gov deadline** (all forms are available in the Grants.gov application package)**:** • SF 424 Face Page; • Project Summary/Abstract (uploaded on line 15 of the SF 424 Face Page); and • PHS-5161 HHS checklist.	Submit by 8:00 PM ET on November 17, 2010	Refer to www.hrsa.gov/grants/userguide.htm for detailed application and submission instructions. Registration in Grants.gov is required. As registration may take up to a month, start the process as soon as possible. The Central Contractor Registry (CCR) registration is an annual process. Verify your organization's CCR registration prior to Grants.gov submission well in advance of the application deadline. The Grants.gov registration process involves three basic steps: A. Register your organization B. Register yourself as an Authorized Organization Representative (AOR) C. Get authorized as an AOR by your organization Please visit the Grants.gov website at http://www.grants.gov/applicants/get_registered.jsp or call the Grants.gov Contact Center at 1.800.518.4726 24 hours a day, 7 days a week (excluding Federal holidays) for additional technical assistance on the registration process. ***Complete Phase 1 as soon as possible. Phase 2 may not begin until the successful completion of Phase 1.***

TWO-TIEREDAPPLICATION SUBMISSION PROCESS

Phase	Due Dates	Helpful Hints
Phase 2 (HRSA's EHBs): • **Complete and submit the following by the HRSA EHBs deadline. Instructions for all** referenced forms are available in Appendices A and B; forms may be found online at http://www.hrsa.gov/grants/apply/assistance/nap • 424A - Budget Information (Non-Construction Programs); • Program Narrative; • Budget Justification; • SF-424B Assurances – Non-Construction Programs; • SF-424 LLL Disclosure of Lobbying Activities (as applicable); • Program Specific Forms—(Note that all forms, with the exception of Form 3, will be completed electronically online). In some cases, these forms may be pre-populated for satellite applicants. • Program Specific Information (Note that all forms, with the exception of the Environmental Information and Documentation form (EID) and the Electronic Health Record (EHR) Readiness Checklist), will be completed electronically online). In some cases, these forms may be pre-populated for satellite applicants. • All required Attachments	Submit by 5:00 PM ET on December 15, 2010	Registration in HRSA's EHB is required. - Phase 1 must be completed to start phase 2. - Applicants will be able to access the EHBs (Phase 2) within 7 business days of completing Grants.gov (Phase 1) and receipt of the Grants.gov tracking number. - Refer to http://www.hrsa.gov/grants/userguide.htm for process instructions, and frequently-asked questions. - The Authorizing Official (AO) must complete submission of the application in Phase 2. Please refer to http://www.hrsa.gov/grants/userguide.htm for information on registering in EHBs or call the HRSA Call Center at 1-877-464-4772. For more information and technical assistance with the new electronic version of the Program Forms refer to: http://www.hrsa.gov/grants/apply/assistance/nap

Per section 330(k)(3)(H) of the PHS Act as amended, (42 U.S.C. 254b), the health center governing board must approve the health center's annual budget and approve applications for subsequent grants for the health center. In addition, the SF-424 face page included in the required application package must be electronically submitted by the applicant's authorized representative (most often the Executive Director, Program Director, or Board Chair). This form certifies that all data/content in the application (including the program specific forms) are true and correct and that the document has been duly reviewed and authorized by the governing board of the applicant. It also certifies that the applicant will comply with the attached assurances if the assistance is awarded.

The "electronic signature" in Grants.gov is the official signature when applying for a grant or cooperative agreement and is considered "binding." Selection of the responsible person should be consistent with responsibilities authorized by the organization's bylaws. **Authorized representatives who submit the SF-424 face page electronically are reminded that HRSA requires that a copy of the governing body's authorization permitting them to submit the application as an official representative must be on file in the applicant's office.**

Application Contact:

If you have questions regarding the FY 2011 New Access Point application and/or the review process described in this application guidance, please call Tiffani Redding in the Bureau of Primary Health Care's (BPHC) Office of Policy and Program Development at 301-594-4300 or BPHCNAP@hrsa.gov.

The BPHC will announce a pre-applicant teleconference conference calls shortly after the funding opportunity announcement release date. Please visit http://www.hrsa.gov/grants/apply/assistance/nap for the call dates and additional resources.

I. Funding Opportunity Description

PURPOSE

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

Individually, each health center plays an important role in the goal of ensuring access to services and combined, they have had a critical impact on the health care status of medically underserved and vulnerable populations throughout the United States. The Health Center Program targets the nation's neediest populations and geographic areas and currently funds over 1,100 health center grantees that operate 7,900 service delivery sites in every state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. In 2009, more than 19 million medically underserved and uninsured patients received comprehensive, culturally competent, quality primary health care services through the Health Center Program.

This funding opportunity announcement guidance details the New Access Point (NAP) eligibility requirements, review criteria and awarding factors for organizations seeking a grant for operational support under the Health Center Program, including: Community Health Center (CHC) (section 330(e)), Migrant Health Center (MHC) (section 330(g)), Health Care for the Homeless (HCH) (section 330(h)), and Public Housing Primary Care (PHPC) (section 330(i)) authorized under the PHS Act, as amended. For the purposes of this document, the term "health center" refers to the diverse types of health centers (i.e., CHC, MHC, HCH, and PHPC) that are supported under section 330 of the PHS Act.

GENERAL NEW ACCESS POINT APPLICATION BACKGROUND/INFORMATION

A new access point is a new full-time[1] service delivery site(s) for the provision of comprehensive primary and preventive health care services that will improve the health status and decrease health disparities of the medically underserved and vulnerable populations to be served. New access points will address the unique and significant barriers to affordable and accessible primary health care services for the specific population and/or community targeted by the application. Every NAP application is expected to demonstrate compliance (or have a plan for compliance within 120 days of a grant award) with the requirements of section 330 of the PHS Act, as amended and applicable regulations.

[1] While section 330 (b)(1)(B) allows MHC organizations to provide certain required primary health services on a seasonal basis, all applicants are expected under sections 330(k)(2)(C) and 330(k)(3)(A) to demonstrate that the project will maximize availability, access, and continuity of the required services to populations within the service area. Therefore, applicants proposing a part-time delivery site must demonstrate that the project will maximize access to services for the target population given the community's needs and barriers as presented in the application.

Applicants may submit a request for Federal support to establish a single new access point or multiple access points in a single NAP application. In addition, an applicant may request funding to support one or multiple types of health centers (i.e., CHC, MHC, HCH, PHPC) within a single application based on the population(s) to be served (e.g., an applicant proposing to serve both the general community and migrant and seasonal farmworkers can submit a NAP application requesting both the CHC and MHC funding). **Applicants must indicate on Form 1-B (see APPENDIX A) their request for section 330 funding.**

Applications may be submitted for consideration from new organizations (new start applicants) or existing grantees (satellite applicants):

- A **NEW START** applicant is an organization that is not currently a direct recipient of any grant support under the Health Center Program authorized under section 330 of the PHS Act. A new start application should address the entire scope of the project (see Terms and Definitions available at http://www.hrsa.gov/grants/apply/assistance/nap) being proposed for NAP grant support. New start applicants may submit an application for a single site or a multi-site operation. New start applicants may also request funding for one or multiple types of health centers authorized under section 330 based on the populations to be served.

- A **SATELLITE** applicant is an organization that is currently receiving grant support under the Health Center Program authorized under section 330 of the PHS Act. All satellite applicants must propose to establish a *new* service site that is outside the applicant's approved scope of project (i.e., not listed in the applicant's current approved scope of project). Satellite applicants **may not** request funding to support the expansion/addition of services/programs/staff at a site(s) that is currently listed as being a part of their approved scope of project under the Health Center Program. A satellite NAP application should address **ONLY** the service area and target population of the proposed new access point(s) (i.e., only the new site(s) and service area proposed in the satellite application, not all of the sites or the entire service area of the applicant) in terms of need, population to be served and the new delivery system being proposed. Satellite applicants may submit an application for Federal support to establish a single new access point or multiple access points (all proposed sites must be outside of their approved scope of project). Satellite applicants may also request funding for one or multiple types of health centers authorized under section 330 based on the populations to be served.

School Based Health Centers

Applicants may propose to establish a **school based health center** site for the delivery of primary care services as a new access point. To be eligible as a new access point, an applicant must demonstrate that the school based site will provide, independently or in conjunction with another site(s), all required primary and preventive health care services to the students of the school as well as the general underserved population in the service area without regard for ability to pay.

Mobile Medical Vans

Applicants proposing to use **mobile medical vans** for the delivery of primary care services may do so as a new access point only if it is a new mobile medical van added to an existing fleet or is a new addition for a heath center that previously did not have a mobile medical van in its approved scope of project. To be eligible as a new access point, the proposed mobile medical van must be fully equipped and staffed by health center clinicians providing direct primary care services (e.g., primary medical or oral health services) at various locations. Mobile vans do not need to provide services on a regularly scheduled basis, although this is encouraged to provide continuity and access to care for the target population. Proposals to expand the operation of an existing mobile van within the current scope of project (e.g., add new providers or services, expand hours of operation at current locations) are NOT eligible for consideration for NAP funding. Similarly, vans that are not equipped or utilized for direct patient care are not considered service sites and are therefore not eligible for NAP funding.

EXPECTED RESULTS

Applicants must demonstrate a high level of need in their community/population, a sound proposal to meet this need, responsiveness to the health care environment and readiness to rapidly implement the proposal. In addition, applicants must demonstrate that the new access point(s) will increase access to comprehensive, culturally competent, quality primary health care services and improve the health status of underserved and vulnerable populations in the area to be served. Applicants are also expected to demonstrate that the proposal will ensure the availability and accessibility of essential primary and preventive health services, including oral health, mental health and substance abuse services, to all individuals in the service area and that the new access point(s) maximizes established collaborative and coordinated delivery systems for the provision of health care to the underserved in their communities.

All competitive organizations will demonstrate:

- **Compliance** at the time of application (or a plan for compliance within 120 days of a grant award) 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.htm.

- Evidence that the proposed new access point(s) will serve populations in **high need areas**. All applicants must submit a completed Need for Assistance (NFA) Worksheet (see instructions in APPENDIX A) as part of the application to demonstrate the relative need for additional primary health care services.

- Evidence of how the proposed project will **increase access to primary health care services, improve health outcomes and reduce health disparities** in the community/population to be served. In particular, the applicant must demonstrate how section 330 funds will expand services and increase the number of people served through the establishment of a new service delivery site(s) and/or at an existing site(s) not currently within a section 330, HRSA funded scope of project.

- Evidence that **all persons in the target population will have ready access to the full range of required primary, preventive, enabling and supplemental health care services, including oral health care, mental health care and substance abuse services**, either directly on-site or through established arrangements without regard to ability to pay (see Terms and Definitions available at http://www.hrsa.gov/grants/apply/assistance/nap).

- Responsiveness to its health care environment by documenting that it has developed **collaborative and coordinated delivery systems** for the provision of health care to the underserved in their communities. Successful applicants will demonstrate actual or proposed partnerships and collaborative activities with other Federally Qualified Health Center (FQHC) Look-Alikes and section 330 grantees, rural health clinics, critical access hospitals, State and local health services delivery projects, and other programs serving the same population(s).

- **A sound and complete plan** that demonstrates responsiveness to the identified health care needs of the target population(s), appropriate short- and long-term strategic planning, coordination with other providers of care, organizational capability to manage the proposed project, and cost-effectiveness in addressing the health care needs of the target population.

- **A reasonable and accurate budget (2 year project period)** based on the activities proposed in the application. Competitive applicants will present a budget for the new access point(s) and request Federal funds that are reasonable and appropriate based on the scope of the services to be provided and the number of new individuals to be served. The budget should demonstrate how section 330 funds will augment already available funds and in-kind resources to expand existing primary health care service capacity to currently underserved populations. (See Section IV and APPENDIX C for further clarification and instructions on the presentation of the budget.).

- **Readiness to initiate the proposed project plan.** Applicants are expected to demonstrate that the new access point(s) will be operational and providing services in the community/population within 120-days of a grant award. Competitive applicants will demonstrate at a minimum, that within 120-days of a grant award, (1) a facility will be operational and ready to begin providing services for the proposed population/community, and (2) providers will be available to serve at the proposed new access point. It is expected that full operational capacity will be achieved within 2 years of receiving Federal section 330 grant support.

Throughout the application development and preparation process, applicants are highly encouraged to collaborate with the appropriate Primary Care Associations (PCAs), Primary Care Offices (PCOs) and/or National Cooperative Agreements (NCAs) in determining their readiness to develop a NAP application. Refer to http://www.bphc.hrsa.gov/technicalassistance/ for a complete listing of PCAs, PCOs, and NCAs.

Specific Program Requirements/Expectations

All applicants are expected to demonstrate compliance with the applicable requirements of section 330 of the PHS Act, as amended, and corresponding program regulations. There are specific requirements and expectations for applicants requesting funding under each type[2] of health center authorized under section 330. Applicants requesting funding to support one or more health center type are expected to demonstrate compliance in the application with the specific requirements of each type. Failure to document and demonstrate compliance in the application will significantly reduce the likelihood of funding.

COMMUNITY HEALTH CENTER APPLICANTS:

- Compliance with section 330(e) and program regulations; and
- A plan that ensures the availability and accessibility of required primary and preventive health services, including oral health, mental health and substance abuse services, to all individuals in the service area.

MIGRANT HEALTH CENTER APPLICANTS:

- Compliance with section 330(g) and, as applicable, section 330(e) and program regulations; and
- A plan that ensures (1) the availability and accessibility of required primary and preventive health services, including oral health, mental health and substance abuse services, to migratory and seasonal farmworkers and their families in the area to be served; (2) how adjustments will be made for service delivery during peak and off-season cycles; and (3) how the special environmental and occupational health concerns will be addressed.

HEALTH CARE FOR THE HOMELESS APPLICANTS:

- Compliance with section 330(h) and, as applicable, section 330(e) and program regulations;
- A plan that ensures the availability and accessibility of required primary and preventive health services, including oral health, mental health and substance abuse services, to homeless individuals and families in the area to be served; and
- A mechanism for delivering comprehensive substance abuse services to homeless patients (i.e., detoxification, risk reduction, outpatient treatment, residential treatment, and rehabilitation for substance abuse provided in settings other than hospitals).

PUBLIC HOUSING PRIMARY CARE APPLICANTS:

- Compliance with section 330(i) and, as applicable, section 330(e) and program regulations;
- A plan that ensures the availability and accessibility of required primary and preventive health services, including oral health, mental health and substance abuse services, to residents of public housing primary care in the area to be served; and
- A mechanism for involving residents in the preparation of the application and in the ongoing planning and administration of the program.

[2] The types of health centers authorized under section 330 of the PHS Act as amended are: Community Health Center (CHC) (section 330(e)), Migrant Health Center (MHC) (section 330(g)), Health Care for the Homeless (HCH) (section 330(h)), and Public Housing Primary Care (PHPC) (section 330(i)).

II. Award Information

1. Type of Award

Funding will be provided in the form of a grant.

2. Summary of funding

A NAP grant will provide funding for Federal fiscal years 2011-2012. Up to $250 million is expected to be available to fund approximately 350 grants. The period of support is two years. Awards to support projects beyond the first year will be contingent upon Congressional appropriation, compliance with applicable statutory and regulatory requirements, demonstrated organizational capacity to accomplish the project's goals, and a determination that continued funding would be in the best interest of the Federal government.

Maximum Grant Support

The HRSA has established an annual **cap of $650,000 for section 330 support** of new access points. The cap is the **maximum amount of section 330 funding** that can be requested annually in a new access point grant application in FY 2011 regardless of the number and/or type of new access points to be supported and/or populations to be served through the application.

Applicants may request Federal section 330 grant support up to $150,000 in Year 1 only for one-time minor capital costs for equipment and/or alterations/renovations (see Terms and Definitions available at http://www.hrsa.gov/grants/apply/assistance/nap); however, the total request for section 330 support MUST NOT exceed the established annual cap of $650,000 in Year 1 or Year 2. Applications that present a request for support in excess of the established annual cap in either Year 1 or Year 2 are considered ineligible for review.

Not all applicants approved and funded will receive the maximum grant support. Federal funding levels will be reviewed prior to a final funding decision and may be adjusted based on the organization's past performance and an analysis of experience related to operating costs, utilization, provider staffing and revenue generation. Federal funding levels for new start applicants may also be adjusted based on analysis of the budget and cost factors. See Section IV and APPENDIX C of this application guidance for further information and instruction on the development of the application budget.

III. Eligibility Information

1. Eligible Applicants

An application submitted under announcement number HRSA-11-017: New Access Points will be considered eligible if it meets all of the applicable eligibility requirements listed below. **Applications that do not meet the eligibility requirements will be considered non-responsive and will not be considered for funding under this announcement.**

1) *All Applicants:* Applicant is a public or private, nonprofit entity, including tribal, faith-based, and community-based organizations.

2) *All Applicants:* Only one application is submitted for consideration from the same applicant organization under HRSA-11-017 'New Access Points' in FY 2011. If more than one NAP application is submitted for consideration under HRSA-11-017, HRSA will only accept the last application received in grants.gov.

3) *All Applicants:* Application requests section 330 funds to establish a new access point(s) for the provision of required comprehensive primary, preventive, enabling and additional health care services (see Terms and Definitions available at http://www.hrsa.gov/grants/apply/assistance/nap) including oral health care, mental health care and substance abuse services, either directly on-site or through established arrangements without regard to ability to pay. An applicant may **not** propose a new access point application to provide only a single service, such as dental, mental health or prenatal services.

4) *All Applicants:* Application proposes access to services for all individuals in the targeted service area or population. In other words, applicant does not propose a new access point(s) to exclusively serve a single age group (e.g., children), lifecycle (e.g., geriatric), or health issue/disease category (e.g., HIV/AIDS). In instances where a sub-population is being targeted within the service area or population (e.g., homeless children and adolescents/children in schools), the applicant must demonstrate how health care services will be made available to other persons in need of care who may seek services at the proposed site(s).

5) *All Applicants:* Application request for annual Federal section 330 funding DOES NOT exceed the established annual cap of $650,000 in Years 1 or 2 available to support NAP grants as presented on the Application Form 424A.

6) *All Applicants:* Application adheres to the 200-page limit on the length of the application when printed by HRSA. See the tables in the Application and Submission Information section for specific information regarding the documents included in the 200 page limit.

7) *New Start Applicants Only:* Application proposes to serve a defined geographic area that is federally-designated, in whole or in part, as a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP). [If the area is not currently federally-designated, in whole or in part as a MUA or MUP, the applicant must provide documentation that the request has been submitted in order for timely processing prior to a final HRSA funding decision on the FY 2011 NAP application]. *NOTE: If the applicant is requesting funding only for MHC, HCH and/or PHPC, the applicant is not required to have a MUA/MUP designation for the proposed service area and/or target population.*

8) *Satellite Applicants Only:* Application proposes to establish a new delivery site, which is not currently in the applicant organization's approved scope of project. In other words, the

application *does not* (a) propose funding to support the relocation of a current site(s), and/or (b) propose the expansion of capacity (additional providers, new services, new populations, etc.) at any site(s) already in the applicant organization's approved scope of project.

2. Cost Sharing

Cost sharing or matching is not a requirement for this funding opportunity. As required by 42 CFR 51c.305, HRSA will take into consideration whether and to what extent an applicant plans to maximize all sources of revenue through an appropriate and reasonable budget which includes non-grant resources to support the proposed project. Please see the budget and budget justification section of this document (see Section IV and APPENDIX C) for clarification and guidelines pertaining to the presentation of the budget.

3. Other Eligibility Information

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

IV. Application and Submission Information

1. Address to Request Application Package

Application Materials

HRSA ***requires*** applicants for this funding opportunity to apply electronically through Grants.gov, http://www.grants.gov and the HRSA EHBs. All applicants ***must*** submit in this manner unless the applicant is granted a written exemption from this requirement in advance by the Director of HRSA's Division of Grants Policy or designee. Applicants must request an exemption in writing from DGPWaivers@hrsa.gov, and provide details as to why they are technologically unable to submit electronically though the Grants.gov portal. If requesting a waiver, make sure you specify announcement number HRSA-11-017, the name, address, and telephone number of the organization and the name and telephone number of the Project Director as well as the Grants.gov Tracking Number (GRANTXXXX) assigned to your submission along with a copy of the "Rejected with Errors" notification you received from Grants.gov. **HRSA and its Grants Application Center (GAC) will only accept paper applications from applicants that received prior written approval**. However, the application must still be submitted under the deadline. For those applicants that have been approved to submit paper applications, blank Program Specific Forms and blank Program Specific Information forms are available online at http://www.hrsa.gov/grants/apply/assistance/nap. Complete instructions for the forms may be found in Appendices A and B (APPENDIX A and APPENDIX B).

Refer to HRSA's *Electronic Submission User Guide*, available online at http://www.hrsa.gov/grants/userguide.htm, for detailed application and submission instructions. Pay particular attention to Sections 2 and 5 that provide detailed information on the competitive application and submission process.

Applicants must submit proposals according to the instructions in www.hrsa.gov/grants, using this guidance in conjunction with Application Form SF-424. The Application Package SF-424 contains additional general information and instructions for grant applications, proposal narratives and budgets. The SF-424 forms and instructions may be obtained from the following site by:

(1) Downloading from http://www.hrsa.gov/grants/apply/assistance/nap, or
(2) Contacting the HRSA Grants Application Center at:
910 Clopper Road
Suite 155 South
Gaithersburg, MD 20878
Telephone: 877-477-2123
HRSAGAC@hrsa.gov

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

2. Content and Form of Application Submission

Application Format Requirements

The total size of all uploaded files may not exceed the equivalent of 200 pages (approximately 25 MB) when printed by HRSA. Applications that exceed the specified limits (or a total file size of 25 MB, or that exceed 200 pages when printed by HRSA) will be deemed ineligible and will not be considered for funding under this announcement. **It is highly recommended that applicants print out the application before submitting it electronically to ensure that it is within the 200-page limit.**

Please note that the page limit DOES include the project abstract, program narrative, budget justification, Equipment List and attachments (excluding the audit in attachment 8; see chart below for detailed information).

The following chart details the forms and documents (see column labeled, Form Type) that are required submissions for this funding opportunity and the order in which they must be submitted. "Forms" refer to those documents that are completed online in the system and that do not require any downloading or uploading. "Documents" are those requirements that must be downloaded in the template provided, completed, and then uploaded into the system.

Step 1: Submission through Grants.Gov

- **It is mandatory to follow the instructions provided in this section to ensure that your application can be printed efficiently and consistently for review.**
- **Failure to follow these instructions may make your application non-compliant. Non-compliant applications will not receive further consideration in the application review process and those particular applicants will be notified.**
- **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.**
- **When providing any electronic attachment with several pages, add a table of content page specific to the attachment. Such page will not be counted towards the page limit.**

Application Section	Form Type	Instruction	HRSA/Program Guidelines
Application for Federal Assistance (SF-424)	Form	Complete pages 1, 2 & 3 of the SF 424 face page. See detailed instructions in the Application Format section of this guidance.	Not counted in the page limit
Project Summary/Abstract (SF-424)	Document	Type the title of the funding opportunity and upload the project abstract on page 2 of SF 424 - Box 15	Counted in the page limit.
Additional Congressional District (SF-424)	Document	If applicable, grantees serving multiple districts can upload a list of all districts served on page 2 of SF 424 - Box 16	As applicable to HRSA; not counted in the page limit
HHS Checklist Form PHS-5161	Form	Complete pages 1 & 2 of the HHS checklist.	Not counted in the page limit

After successful submission of the above forms in Grants.gov, and subsequent processing by HRSA, you will be notified within 7 business days by HRSA confirming the successful receipt of your application and requiring the Project Director and Authorizing Official to review and submit additional information in HRSA EHBs. Your application will not be considered submitted unless you review the information submitted through Grants.gov and submit the additional portions of the application required through HRSA EHBs. Refer to the HRSA Electronic Submission Guide provided in www.hrsa.gov/grants/userguide.htm for the complete process and instructions.

Step 2: Submission through HRSA's Electronic Handbooks (EHBs)

- **It is mandatory to follow the instructions provided in this section to ensure that your application can be efficiently and consistently reviewed.**
- **Failure to follow the instructions may make your application non-compliant. Non-compliant applications will not receive further consideration in the application review process and those particular applicants will be notified.**
- **For electronic submissions, applicants only have to number the electronic attachment pages sequentially, resetting the numbering for each attachment (i.e., start at page 1 for each attachment). Do not attempt to number standard OMB approved form pages.**
- **For electronic submissions, no table of contents is required for the entire application. HRSA will construct an electronic table of contents in the order specified.**
- **When providing any electronic attachment with several pages, add a table of content page specific to the attachment. Such page will not be counted towards the page limit.**
- **Merge similar documents into a single document. Where several pages are expected in the attachment, ensure that you place a table of content cover page specific to the attachment. Table of content page will not be counted in the page limit.**

Application Section	Form Type	Instruction	HRSA/ Program Guidelines
Program Narrative	Document	Upload the Program Narrative; see instructions for the Narrative in Section IV: Content and Form of Application Submission.	Required. Counted in the page limit.
424A Budget Information for Non-Construction Programs	Form	Complete Sections A, B, E and F (if applicable) online. See APPENDIX C for further information on completing the 424A Budget.	Not counted in the page limit
Budget Justification	Document	Upload the Budget Justification in the "Budget Narrative Attachment Form." See APPENDIX C for further information on developing the Budget Justification.	Counted in the page limit
Equipment List	Form	This form is required for applicants requesting Federal funding for moveable equipment that is equal to or exceeds $5,000/unit. Complete the spreadsheet online as presented. See APPENDIX C for further information on completing this form.	Not counted in the page limit
SF-424B Assurances for Non-Construction Programs	Form	Complete all portions of the Assurances form online.	Not counted in the page limit
SF-424 LLL Disclosure of Lobbying Activities	Form	Complete this form online.	Not counted in the page limit
Attachments 1-15	Documents	Complete and upload all attachments, as required.	Counted in the page limit
Program Specific Forms *Refer to the table of Program*	Varies (Forms/	Refer to APPENDIX A of this guidance for further details on Program Specific Forms instructions. Note that all forms, with the exception of	Not counted in the page limit

Application Section	Form Type	Instruction	HRSA/ Program Guidelines
Specific Forms following this information.	Documents)	Form 3, will be completed electronically online. Complete all forms as presented within HRSA EHBs.	
Program Specific Information: *Refer to the table of Program Specific Information forms following this information.*	Varies (Forms/ Documents)	Refer to APPENDIX B of this guidance for further details on Program Specific Information Forms and instructions. Note, Clinical and Financial Performance Measures and the EHR forms will be completed electronically online. Complete these forms as presented within HRSA EHBs. The EID and Other Requirements for Sites forms, if applicable, must be uploaded.	Not counted in the page limit

Step 2 (continued): Submission through HRSA's Electronic Handbooks (EHBs)
Attachments

- **To ensure that attachments are organized and printed in a consistent manner, follow the order provided below.**
- **Additional supporting documents, if applicable, can be provided in Attachment 14.**
- **Merge similar documents a single document. Where several pages are expected in the attachment, ensure that you place a table of content cover page specific to the attachment. Table of content page will not be counted in the page limit**

Attachments	Form Type	Instruction	HRSA/ Program Guidelines
Attachment 1: Service Area Map (Required)	Document	Applicants must upload a map of the service area for the proposed project, including the organization's current sites (as applicable) and proposed new access point(s) at a census tract and/or zip code level. The map must indicate any medically underserved areas (MUAs) and/or medically underserved populations (MUPs). The map must also include other section 330 grantees, FQHC Look-Alikes, and/or other health care providers serving the same population(s). For inquiries regarding MUAs or MUPs, call 1-888-275-4772. Press option 1, then option 2 or contact the Shortage Designation Branch via email sdb@hrsa.gov or 301-594-0816.	Included in page limit
Attachment 2: Corporate Bylaws (Required)	Document	Upload (in entirety) the applicant organization's most recent signed and dated bylaws. Bylaws should be signed and dated by the appropriate individual indicating review and approval by the Governing Board.	Included in page limit

Attachments	Form Type	Instruction	HRSA/ Program Guidelines
Attachment 3: Applicant Organizational Chart (Required)	Document	Upload a one-page figure that depicts the applicant's organizational structure including the governing board, key personnel, staffing, and any subrecipients and/or affiliating organizations.	Included in page limit
Attachment 4: Position Descriptions for Key Management Staff (Required)	Document	Upload position descriptions for key management staff: Chief Executive Officer (CEO), Chief Clinical Officer (CCO), Chief Financial Officer (CFO), Chief Information Officer (CIO), and Chief Operating Officers (COO) as applicable. Applicants should indicate on the position descriptions if key management positions are combined and/or part time (e.g., CFO and COO roles are shared). Each position description should be limited to **one page** or less and must include at a minimum, the position title, description of duties and responsibilities, position qualifications, supervisory relationships, skills, knowledge and experience requirements, travel requirements, salary range, and work hours.	Included in page limit
Attachment 5: Biographical Sketches for Key Management Staff (Required)	Document	Upload biographical sketches for key management staff: Chief Executive Officer (CEO), Chief Clinical Officer (CCO), Chief Financial Officer (CFO), Chief Information Officer (CIO), and Chief Operating Officers (COO) as applicable. A biographical sketch should not to exceed **two** pages in length. In the event that the identified individual is not yet hired, include a letter of commitment from that person along with the biographical sketch.	Included in page limit
Attachment 6: Co-Applicant Agreement (Required for Public Center[3] Applicants that have a co-applicant board).	Document	Public agency applicants that have a co-applicant board must submit in its entirety, the formal co-applicant agreement signed by both the co-applicant governing board and the public center. Note: Public agencies that receive section 330 funding must comply with all the applicable governance requirements and regulations. In cases where the public center's board cannot directly meet all applicable health center governance requirements, a separate co-applicant health center governing board must be established that meets all the section 330 governance requirements. The co-applicant agreement should stipulate roles, responsibilities and the delegation of authorities and any shared roles and responsibilities of each party in carrying out the governance functions.	Included in page limit
Attachment 7: Summary of Contracts, Agreements and Sub-recipient	Document	All applicants with any of the current or proposed agreements listed below (a through i) must upload a BRIEF SUMMARY describing these agreements. Applicants DO NOT need to discuss contracts for such areas as janitorial services. It is suggested that each	Included in page limit

[3] Public centers have also been referred to as "public entities" in the past.

Attachments	Form Type	Instruction	HRSA/ Program Guidelines
Arrangements (as applicable).		summary not exceed 3 pages in total. The summary should address the following items for each agreement: • Name and contact information for affiliated agency(ies); • Type of agreement (e.g., contract, subrecipient arrangement, affiliation agreement); • Brief description of the purpose and scope of the agreement (i.e., type of services provided, how/where these are provided). If the agreement is for a subrecipient arrangement, the applicant must demonstrate that the relationship between the applicant and subrecipient is in compliance with section 330 requirements; and • Timeframe for the agreement/contract/affiliation. **Types of current or proposed agreements to be discussed:** a. Contract or sub-award for a substantial portion of the proposed project b. Memorandum of Understanding (MOU)/Agreement (MOA) for a substantial portion of the proposed project c. Contract with another organization or individual contract for core primary care providers d. Contract with another organization for staffing health center e. Contract with another organization for the Chief Clinical Officer (CCO) or Chief Financial Officer (CFO) f. Merger with another organization g. Parent Subsidiary Model arrangement h. Acquisition by another organization i. Establishment of a New Entity (e.g., Network Corporation) *As a reminder, applicants must exercises appropriate oversight and authority over all contracted services, and procurement contracts must comply with 45 CFR Part 74.*	
Attachment 8: Most recent independent financial audit (Required).	Document	Upload the most recent audit. Audit information will be considered complete when it includes all balance sheets, profit and loss statements, audit findings, management letters and any noted exceptions. Applicants must submit their audit findings (management letter from their audit) or provide a signed statement that no letter was issued with the audit. Applicants that have been operational less than one year and do not have an audit may submit monthly financial statements for the most recent six-month period if available. Applicants with no audit/financial information available should provide a detailed	Not included in page limit

Attachments	Form Type	Instruction	HRSA/ Program Guidelines
		explanation of the situation including supporting documentation, as relevant (e.g., organization has been formed for the purposes of this grant application).	
Attachment 9: Articles of Incorporation – Signed Seal Page (Required).	Document	Applicants should upload the official signatory page (seal page) of the organization's Articles of Incorporation. Organizations that do not have signed Articles of Incorporation, must submit proof that an application has been submitted to the State for review.	Included in page limit
Attachment 10: Letters of Support (Required).	Document	Upload any *dated* letters of support as appropriate to demonstrate support of and commitment to the proposed New Access Point(s). **In particular, the applicant must secure a letter of support from any existing FQHC (section 330 grantee and/or FQHC Look-Alike) , rural health clinic and critical access hospital in the service area, or provide an explanation for why such a letter(s) cannot be obtained.** Support from local community stakeholders, patients, and collaborating organizations are as important as letters of support from elected officials. As necessary, applicants should also include a one-page list of all additional support letters that are not included in the application, but are available onsite. Merge various letters into a single document and upload it here.	Included in page limit
Attachment 11: Schedule of Discounts/Sliding Fee Scale (Required).	Document	Applicants must upload their current or proposed schedule of discounts/sliding fee scale. This schedule must correspond to a schedule of charges for which discounts are adjusted on the basis of the patient's ability to pay. The schedule of discounts must apply to persons with incomes below 200 percent of the Federal poverty level (see the Federal poverty guidelines at http://aspe.hhs.gov/poverty/).	Included in page limit
Attachment 12: Evidence of Non-Profit or Public Agency Status (Required for NEW START APPLICANTS).	Document	Private Non-Profit: Consistent with the instructions provided in Part D of the HHS Checklist Form PHS-5161, a private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence: • A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code. • A copy of a currently valid Internal Revenue Service Tax exemption certificate. • A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals. • A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.	Included in page limit

Attachments	Form Type	Instruction	HRSA/ Program Guidelines
		• Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate. Public Agency: Consistent with Policy Information Notice 2010-10, "Confirming Public Agency Status under the Health Center Program and FQHC Look-Alike Program, "applicants must provide documentation demonstrating the organization will qualify as a "public agency" for purposes of section 330 of the PHS Act, as amended. Any of the following is acceptable evidence: 1. "Affirm Instrumentality Letter" (4076C) from the IRS or a letter of authority from the Federal, State, or local government granting the entity one or more sovereign powers; or 2. A determination letter issued by the IRS, providing evidence of a past positive letter ruling by the IRS, or other documentation demonstrating that the organization is an instrumentality of government, such as documentation of the law that created the organization or documentation showing that the State or a political subdivision of the State controls the organization; or 3. Formal documentation from a sovereign State's taxing authority equivalent to the IRS or authority granting the entity one or more governmental powers. *Please provide a detailed explanation if none of the above evidence is available, with supporting documentation, as relevant.* For additional information, refer to Confirming Public Agency Status PIN at http://bphc.hrsa.gov/policy/pin1001/pin1001.pdf	
Attachment 13: Floor Plans/Schematic Drawings (Required).	Document	Applicant must provide a floor plan of the proposed new access point(s), including proposed exam rooms, waiting area, etc.	Included in page limit
Attachment 14: Other Relevant Documents (as applicable).	Document	Applicants may include other relevant documents to support the proposed project plan such as charts, organizational brochures, and Environmental Assessment. *Applicants should include any building lease, or intent to lease documents here as well.* Merge all additional documents into a single document and upload it here.	Included in page limit

Attachments	Form Type	Instruction	HRSA/ Program Guidelines
Attachment 15: Summary of Proposed Alteration and Renovation Project.	Document	Applicants requesting one-time funding for alteration and renovation, including the installation of equipment must upload a detailed summary of the proposed project(s). *See Section xi: Project Implementation for Alteration and Renovation Projects in Program Narrative.*	Included in page limit

Step 2 (continued): Submission through HRSA's Electronic Handbooks (EHBs)

Program Specific Forms

The following forms must be completed in HRSA EHBs. Note that the Program Specific Forms DO NOT count against the page limit.

Program Specific Form	Form Type	HRSA/Program Guidelines
Form 1A: General Information Worksheet	Form	Complete all portions of the form electronically online as presented.
Form 1B: BPHC Funding Request Summary	Form	Complete all portions of the form electronically online as presented
Form 1C: Documents on File	Form	Complete all portions of the form electronically online as presented.
Form 2: Staffing Profile	Form	Complete all portions of the form electronically online as presented. Complete one for each year of the project period.
Form 3: Income Analysis Form	Document	Please complete the form using the template provided in the EHB system and upload as an attachment. Complete one for each year of the project period.
Form 4: Community Characteristics	Form	Complete all portions of the form electronically online as presented.
Form 5A: Services Provided	Form	Complete all portions of the form electronically online as presented. Applicants must identify what services will be made available by the proposed new access point(s) and how these services will be provided. Only one form is required for the all of the required and additional services to be provided by the entire NAP application. *Information presented on Form 5A in the NAP application will be used by HRSA to determine the services included in the Scope of Project for the NAP grant. Only those services that are included on Form 5A will be considered to be in the approved Scope of Project. Any services that are described or detailed in other portions of the application (e.g., narratives, attachments) are not considered to be included in your approved Scope*

Program Specific Form	Form Type	HRSA/Program Guidelines
		of Project, even if the application is funded.
Form 5B: Service Sites	Form	Complete all portions of the form electronically online as presented. Applicants must complete Form 5B for each site proposed as a new access point. *Information presented on Form 5B in the NAP application will be used by HRSA to determine the sites included in the Scope of Project for the NAP grant. Only those sites that are included on Form 5B will be considered to be in the approved Scope of Project. Any sites that are 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, even if the application is funded.*
Form 5C: Other Activities/Locations (if applicable)	Form	Complete all portions of the form electronically online as presented. Provide the list of other activities related to the new access point(s) that: (1) do not meet the definition of a service site, (2) are conducted on an irregular timeframe/schedule, and/or (3) offer a limited activity from within the full complement of health center activities included within the scope of project.
Form 6A: Current Board Member Characteristics	Form	Complete all portions of the form electronically online as presented.
Form 6B: Request for Waiver of Governance Requirements (if applicable)	Form	Complete all portions of the form electronically online as presented. Note that 6B may only be submitted by NAP applicants requesting targeted funding **solely** to serve special populations (i.e., section 330(g), section 330(h), and/or section 330(i)).
Form 8: Health Center Affiliation Certification and Health Center Affiliation Checklist (if applicable)	Form	***Responses beyond Question 1 are required only for CHC and/or MHC applicants.*** Complete all portions of the form electronically online as presented *for each affiliation.*
Form 9: Need For Assistance (NFA) Worksheet	Form	Complete all portions of the form electronically online as presented. The converted score of the NFA Worksheet will account for up to 20 points in the overall score for the application.
Form 10: Annual Emergency Preparedness and Management report	Form	Complete all portions of the form electronically online as presented.
Form 12: Organization Contacts	Form	Complete all portions of the form electronically online as presented.
424C Budget Information-Construction	Form	Applicants requesting any one-time Federal funding for alteration and renovation, which

Program Specific Form	Form Type	HRSA/Program Guidelines
Programs		may include the installation of equipment, must complete this form electronically online as presented. Refer to APPENDIX C for further information on completing this form.

Step 2 (continued): Submission through HRSA's Electronic Handbooks (EHBs)
Program Specific Information

The following information must be completed in HRSA EHBs. Note that the Program Specific Information DOES NOT count against the page limit.

Program Specific Information	Form Type	HRSA/Program Guidelines
Clinical Performance Measures	Form	Complete all portions of the Clinical Performance Measures form electronically online as presented. Guidelines for the Clinical Performance Measures are provided in APPENDIX B.
Financial Performance Measures	Form	Complete all portions of the Financial Performance Measures Plan form electronically online as presented. Guidelines for the Financial Performance Measures Plan are provided in APPENDIX B.
Electronic Health Record (EHR)	Form	Complete all portions of the Electronic Health Record form electronically online as presented. Instructions are provided in APPENDIX B.
EHR Readiness Checklist (if applicable)	Document	Applicants are required to complete the EHR Readiness Checklist if Federal funding is being requested for the purchase or enhancement of an EHR system. Complete all portions of the Electronic Health Record form and upload as an attachment. Instructions are provided in APPENDIX B.
Environmental Information and Documentation (EID)	Document	Applicants are required to complete a separate form for each proposed new access point site. Upload the document as an attachment. Instructions are provided in APPENDIX B.
Other Requirements for Sites	Form	Applicants are required to complete this form for each site for which any Federal funding for alteration and renovation, which may include the installation of equipment, is being requested. Complete all portions of the form electronically online as presented. Instructions are provided in APPENDIX B.

Applicants are reminded that failure to include all required documents as part of the NAP application may result in an application being considered as incomplete or non-responsive. All incomplete applications will be considered non-responsive and will not be reviewed.

Application Preparation

In developing applications, applicants are highly encouraged to work with the appropriate PCA, PCO and/or NTAs (refer to lists of PCAs, PCOs and NTAs at: http://www.bphc.hrsa.gov/technicalassistance/) to prepare quality, competitive applications.

Applicants must provide all required information in the sequence and format described in the instructions. Information and data should be accurate and consistent. Application directions and written instructions should be followed carefully and completely. **Applications not meeting application requirements may not be accepted for review or may result in a low rating by the Objective Review Committee (ORC).**

Only those materials/documents included with the application submitted by the announced deadlines will be considered. Supplemental materials/documents submitted after the application deadlines will not be included for consideration. Documents such as letters of support must be submitted as part of the application. Letters of support sent directly to HHS, HRSA, or BPHC or sent after the application deadline will not be added to an application.

Organizations may find the following websites and resources helpful when preparing the application:

- Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended - Section 330 of the Public Health Service (PHS) Act
- Section 330 Program Requirements, http://bphc.hrsa.gov/about/requirements.htm
- Code of Federal Regulations, Title 42, Part 51c, Grants for Community Health Services Code of Federal Regulations, Grants for Community Health Services
- Code of Federal Regulations, Title 42, Part 56, Grants for Migrant Health Services and Centers -Code of Federal Regulations, Title 42, Part 56, Grants for Migrant Health Services and Centers
- Code of Federal Regulations, Title 45, Part 75, Grant Award Requirements, Code of Federal Regulations, Title 45, Part 75, Grant Award Requirements
- Office of Management and Budget Circular A-133 Office of Management and Budget Circular A-133
- PIN 1997-27, "Affiliation Agreements of Community and Migrant Health Centers" (signed July 22, 1997) http://bphc.hrsa.gov/policy/pin9727.htm
- PIN 1998-24, "Amendment to PIN 1997-27 Regarding Affiliation Agreements of Community and Migrant Health Centers" (signed August 17, 1998) http://bphc.hrsa.gov/policy/pin9824.htm
- PIN 2007-09, "Service Area Overlap: Policy and Process" (signed March 12, 2007) http://bphc.hrsa.gov/policy/pin0709.htm
- PIN 2007-15, "Health Center Emergency Management Program Expectations" (signed August 22, 2007) http://bphc.hrsa.gov/policy/pin0715/

- PIN 2008-01, "Defining Scope of Project and Policy for Requesting Changes" (signed December 31, 2007) http://bphc.hrsa.gov/policy/pin0801/
- PIN 2009-02, "Specialty Services and Health Centers' Scope of Project"(signed December 18, 2008) http://bphc.hrsa.gov/policy/pin0902/default.htm
- PIN 2009-03, "Technical Revision to PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes" (signed January 13, 2009) http://bphc.hrsa.gov/policy/pin0903.htm
- PIN 2009-05, "Policy for Special Populations-Only Grantees Requesting a Change in Scope to Add a New Target Population" (signed March 23, 2009) http://bphc.hrsa.gov/policy/pin0905/
- PIN 2010-01, "Confirming Public Agency Status under the Health Center Program and FQHC Look-Alike Program" (signed February 5, 2010) http://bphc.hrsa.gov/policy/pin1001/pin1001.pdf

Related Federal Agencies and Offices

- *HRSA, Bureau of Primary Health Care* – Information on the Health Center Program. http://bphc.hrsa.gov/about/apply.htm
- *HRSA, Bureau of Health Professions* – Information on HPSA, MUA, MUP. http://bhpr.hrsa.gov/shortage/
- *HRSA, Bureau of Clinician Recruitment and Service*– Information on National Health Service Corps. http://nhsc.hrsa.gov/
- *HRSA, Grants: Find, Apply, Manage, Review, and Report* – List of available HRSA funding opportunities. http://www.hrsa.gov/grants/default.htm
- *HRSA, Office of Pharmacy Affairs & 340B Drug Pricing Program.* http://www.hrsa.gov/opa/
- *Federal Audit Clearinghouse Homepage* – Guidelines for preparing an A-133 Audit. http://harvester.census.gov/sac/

Other Reference Materials/Resources

- *Governing Board Handbook* – Tool to assist new board members to understand the structure and responsibilities of a governing board. http://ask.hrsa.gov/detail_materials.cfm?ProdID=720
- *National Cooperative Agreements Directory* – Various national organizations that provide specialized assistance in: capital development and financing; oral health care; organizations serving special populations; clinical quality improvement; and State and local government. http://bphc.hrsa.gov/technicalassistance/ncadirectory.htm
- *State and Regional Primary Care Associations Directory* – Provides assistance to organizations in developing, strengthening and expanding health centers on a State or regional level. http://bphc.hrsa.gov/technicalassistance/pcadirectory.htm

- *State Primary Care Offices Directory* – Provides assistance to health centers around Medicaid issues, State health policy, MUA/MUP/HPSA, etc. http://bhpr.hrsa.gov/shortage/pcos.htm

Pre-Application Conference Call

HRSA will hold three pre-application conference calls for potential NAP applicants. The General Technical Assistance conference call will provide an overview of this program guidance and will include an opportunity for organizations to ask questions regarding the FY 2011 NAP funding opportunity, the expectations for NAP applications and the requirements of section 330-funded programs. A second Technical Assistance conference call will address the above and include issues specific to serving special populations. The third Technical Assistance call will focus on the clinical and financial performance measures. For the dates, times, dial-in numbers and other information for these calls, please visit the BPHC website at http://www.hrsa.gov/grants/apply/assistance/nap.

Application Format

The following provides additional instructions on completing the FY 2011 NAP application.

i. Application Face Page (Grants.gov)
Complete Application Form SF-424 provided with the application package. Prepare according to the instructions provided in the form itself. The Catalog of Federal Domestic Assistance Number is 93.527.

Please be sure to complete the SF-424 Face Page as follows:

- *Box 4: Applicant Identifier:* Not applicable-leave blank.
- *Box 5a: Federal Entity Identifier:* No action needed.
- *Box 5b: Federal Award Identifier:* 10-digit grant number (H80…) found in box 4b from the most recent Notice of Grant Award for applicants currently receiving section 330 funds. All other applicants may leave this blank.
- *Box 8c:* Applicant organization's DUNS number
- *Box 12: Funding Opportunity Number and Title:* HRSA-11-017 and New Access Point Application, respectively.
- *Box 15: Descriptive Title of Applicant's Project:* Type the title of the funding opportunity and upload the Project Abstract here.
- *Box 16: Congressional Districts:* Upload any additional congressional districts as applicable for the HRSA grant. Not counted in the page limit.
- *Box 17: Proposed Project Start and End Date:* Provide the start and end dates for the proposed project period (2 years project period).
- *Box 18: Estimated Funding:* Complete the required information based on the funding request for the first year of the project period. This information should be consistent with the total provided in the applicant's 424A Budget for Non-Construction Programs plus the total provided in the 424C Budget Information-Construction Programs form (if applicable).

For more information on completing each section of the SF-424 Face Page, activate the "Help Mode" function available at top of the electronic form.

DUNS Number
All applicant organizations are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant from the Federal Government. The DUNS number is a unique nine-character identification number provided by the commercial company, Dun and Bradstreet. There is no charge to obtain a DUNS number. Information about obtaining a DUNS number can be found at http://www.hrsa.gov/grants/dunsccr.htm or call 1-866-705-5711. Please include the DUNS number in item 8c on the application face page. Applications ***will not*** be reviewed without a DUNS number. Note: a missing or incorrect DUNS number is the primary reason for an application to be "Rejected for Errors" by Grants.gov.

Additionally, the applicant organization is required to register annually with the Federal Government's Central Contractor Registry (CCR) in order to do electronic business with the Federal Government. It is extremely important to verify that your CCR registration is active. Information about registering with the CCR can be found at http://www.ccr.gov.

ii. Table of Contents
The application should be presented in the order of the Table of Contents provided in Section IV: Application and Submission Information. For electronic applications, no table of contents is necessary as it will be generated by the system. (Note: the Table of Contents will not be counted in the page limit.)

iii. Application Checklist (Grants.gov)
Complete the HHS Checklist Form PHS 5161 provided with the application package.

Use the following instructions to assist you:

- Type of Application: Select "New."
- *Part B, #1:* Applicants may contact their State Primary Care Association (PCA) for instructions on how and where to submit a Public Health Impact statement as applicable. To review the list Intergovernmental Review Single Point of Contacts (SPOCs**),** go to www.whitehouse.gov/omb/grants/spoc.html.
- *Part B, #4-6:* Biographical sketches/job descriptions and budget information will be submitted in EHB, not Grants.gov. Check "Yes" to indicate that these documents will subsequently be submitted in EHBs.
- *Part B, #8 & 9:* Check "Not Applicable."
- Note: The Inventions section is not relevant to this funding opportunity.

iv. Budget (EHBs)
A complete budget presentation will include the following items:

- **Standard Form 424A-Budget Information for Non-Construction Programs**: Complete sections A and B for Year 1 and Year 2 of the NAP and complete section E for Year 2 of the proposed project period. See instructions in APPENDIX C for further details on completing the 424A.

- **Standard Form 424C**-Budget Information for Construction Programs: Applicants requesting Federal funding for alteration and renovation (A&R), which may include the installation of equipment, must complete the 424C as presented. This form should include only the total project cost for activities associated with the proposed A&R project. See instructions in APPENDIX A for further details on completing the 424C: Budget Information for Construction Programs.

- **Form 1B – BPHC Funding Request Summary:**
  Year 2 on Form 1B of the Program Specific Forms will be pre-populated from the data provided in Section E of the 424A. Applicants are required to enter budget information for Year 1, including any one-time funds for minor capital costs for equipment and/or alterations/renovations (see Terms and Definitions available at http://www.hrsa.gov/grants/apply/assistance/nap) that are being requested. NAP applicants may request funding for one or more types of health centers authorized under section 330 (i.e.,CHC, MHC, HCH, and/or PHPC). *Applicants will not be allowed to modify the pre-populated data on this form, however applicants may modify the 424A to correct any errors identified in a review of Form 1B.* Form 1B should indicate what portion of the total Federal funding requested in each of the two years under any or all of the program types. The specified types of health centers on this form will constitute a request for funding under that section 330 program.

  NOTE: The request for Federal section 330 grant funding MAY NOT exceed the established annual cap of $650,000 in Year 1 or Year 2

- **Form 2 – Staffing Profile:** Applicants must present a staffing plan justification for each year of the NAP project which identifies the total personnel and number of FTE staff to staff the proposed project. Salaries in categories representing multiple positions (e.g., LPN, RN) should be averaged. The amount for total salaries in the last column of the Staffing Profile should equal the amount allocated under the "Personnel" category of the 424A, Section B and should be consistent with the amounts included in the detailed budget justification as well. Please see APPENDIX A for instructions on completing the Income Analysis Form.

- **Form 3 - Income Analysis Form**: This form must be completed for Years 1 and 2. Please see APPENDIX C for instructions on completing the Income Analysis Form.

- **Equipment List:** This form is required for applicants requesting Federal funding for moveable equipment that is equal to or exceeding $5,000/unit of equipment. Please see APPENDIX C for instructions on completing the Equipment List.

Applicants should 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), the amount of grant funds made in any fiscal year may not exceed the amount by which the costs of operation of the center in such fiscal year exceed 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.

Each NEW START applicant is expected to budget for and set-aside a minimum of 2 percent of the expected award for technical assistance and performance improvement activities. See Required Technical Assistance Set-Aside for additional information.

v. Budget Justification (EHBs)

This announcement is inviting applications for project periods up to two years. Awards, on a competitive basis, will be for a one-year budget period, although project periods may be for two years. Applications for continuation grants funded under these awards beyond the initial one-year budget period, but within the two year project period, will be entertained in subsequent years on a noncompetitive basis, subject to availability of funds, satisfactory progress of the grantee and a determination that continued funding would be in the best interest of the Federal government.

Applicants are required to provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. Each budget period is for one year and NAP applicants must submit a one-year budget for Year 1 and Year 2 of the project. In Year 1, line item information must be provided to explain the costs entered in Standard Form 424A - Budget Information: Non-Construction Programs as well as any one-time Federal funding requested to support alteration and renovation from the 424C - Budget Information: Construction Programs (only applicable for applicants requesting one-time funding for alteration and renovation, which may include the installation of equipment). In Year 2, line item information must be provided to explain the costs entered in the 424A - Budget Information: Non-Construction Programs. **The budget justification must clearly describe each cost element and explain how each cost contributes to meeting the project's objectives/goals**. For subsequent budget years, the justification narrative should highlight the changes from year one or clearly indicate that there are no substantive budget changes during the project period. Be careful about showing how each item in the "other" category is justified. Do NOT use the justification to expand the program narrative. See budget justification samples http://www.hrsa.gov/grants/apply/assistance/nap.

Please be aware that Excel or other spreadsheet format documents with multiple pages (Sheets) may not print out in their entirety.

Include the following in the Budget Justification narrative:

- ***Personnel Costs:*** *Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percent full time equivalency, and annual salary. Please reference "Form 2: Staffing Profile" as justification for dollar figures.*

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

- ***Travel:*** *List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops.*

- ***Equipment:*** List equipment costs and provide justification under the program's goals. *NOTE: Applicants may only request Federal funding for movable equipment. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items. Equipment is defined as those items with a unit cost of $5000 (unless the applicant has a lower capitalization threshold) and a useful life of one or more years).* Applicants requesting Federal funding for moveable equipment that is equal to or exceeding $5,000 per unit (or above the applicant's capitalization threshold) must also complete the Equipment List. Please see APPENDIX C for instructions on completing the Equipment List.

- ***Minor Alteration and Renovation (i.e., one-time Federal funding in Year 1 ONLY):*** *Work that changes the interior arrangements or other physical characteristics of an existing facility or installed equipment so that it can be used more effectively for its currently designated purpose or adapted to an alternative use to meet a programmatic requirement. Alteration and renovation may include work referred to as improvements, conversion, rehabilitation, or remodeling, but is distinguished from new facility construction, facility expansion, or major alteration and renovation where the total Federal and non-Federal costs, excluding moveable equipment, exceeds $500,000.* ***Section 330 grant funds may not be used to support the construction, expansion or major alternation and renovation of facilities.*** If the proposed project is part of a larger overall project that exceeds $500,000, it may not be artificially segmented to achieve the cost threshold.

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

  Contracts*: Applicants and or grantees are responsible for ensuring that their organization and or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants and or grantees must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables.*

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

- ***Indirect Costs:*** *Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For institutions subject to OMB Circular A-21, the term "facilities and administration" is used to denote indirect costs. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may wish to obtain one through HHS's Division of Cost Allocation (DCA). Visit DCA's website at: http://rates.psc.gov/ to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.*

vi. Staffing Plan and Personnel Requirements (EHBs)

Applicants must present a staffing plan and provide a justification for the plan that includes the education and experience qualifications and rationale for the amount of time being requested for each staff position. Position descriptions of proposed project staff must be included in Attachment 4 of the application. Copies of biographical sketches for any key employed personnel that will be assigned to work on the proposed project must be included in Attachment 5 of the application. In addition, applicants must also complete Form 2: Staffing Profile.

Position descriptions for key management staff should include the roles, responsibilities, and qualifications. Applicants must indicate on the position descriptions if key management positions are combined and/or part time (e.g., CFO and COO roles are shared). Education and experience qualifications should be included in the biographical sketches for any key management staff. The one-page organizational chart must depict the governing board, key personnel, staffing, and any sub-recipients and/or affiliating organizations relevant to the proposed project.

Note: *New start applicants should include staff for the entire scope of the project (i.e., total for all proposed new access points). Satellite applicants should include a staffing profile for ONLY the new access point(s) being proposed.*

vii. Assurances (EHBs)

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

viii. Certifications (EHBs)

Complete the Certifications and Disclosure of Lobbying Activities Application Form provided with the application package.

ix. Project Abstract (Grants.gov)

Upload a single-spaced, one-page summary of the application under Box 15 of the SF-424 Face Page. Because the abstract is often distributed to the public and Congress, please prepare this information so that it is clear, accurate, concise, and *without reference to other parts of the application*. The project abstract must include a brief description of the proposed grant project including the needs to be addressed, the proposed services, the population group(s) to be served,

and a summary of the applicant organization. All information provided in the abstract should be consistent with data included in the application.

Place the following at the top of the abstract:

- Project Title
- Applicant Name
- Address
- Contact Name, Credentials, and Title
- Contact Phone Numbers (Voice, Fax)
- E-Mail Address
- Web Site Address, if applicable
- Congressional district(s) for the applicant organization and the proposed project (if different)
- Types of current HRSA funding requested in this application (i.e., CHC, MHC, HCH, and/or PHPC)
- Types of HRSA funding currently being received, if applicable (i.e., CHC, MHC, HCH, and/or PHPC)
- Other existing Federal funding received, if applicable

The project abstract should include:

- A brief history of the organization, the community to be served and the target population(s).
- A summary of the major health care needs and barriers to care to be addressed by the proposed project, including the needs for special population(s) if applicable.
- A summary of the proposed project including numbers of providers, FTEs, delivery locations, services (including oral health, mental health, and substance abuse), and total number of patients and visits expected at full operational capacity).
- A brief description of any other relevant information.

x. Program Narrative (EHBs)

This section provides a comprehensive description of the proposed NAP project. It should be succinct, self-explanatory and well organized providing **a detailed picture of the community/target population(s) to be served, the applicant organization, the organization's plan for addressing the identified health care needs/issues of the community/target population(s), projected outcomes and support required**. The program narrative is expected to describe the new access point(s) at full operational capacity and to demonstrate how this will be achieved over the two years project period.

The program narrative for **NEW START APPLICANTS** should address the entire scope of the NAP project being proposed for Federal support. The program narrative for SATELLITE APPLICANTS should address **ONLY** the service area and target population of the proposed new access point(s).

All applicants are encouraged to review http://bphc.hrsa.gov/about/requirements.htm for additional information on Health Center Program requirements. The Program Narrative should be consistent with the Clinical and Financial Performance Measures as well as all other Program Specific Forms, Program Specific Information, and Attachments.

- Throughout the Program Narrative, reference may be made to exhibits and charts, as needed, in order to reflect information about multiple sites and/or geographic or demographic data. These exhibits and charts should be included as part of the attachments that applicants must upload with the electronic submission.
- The attachments should not contain any required Program Narrative (see below).

The following provides a framework for the Program Narrative. The Program Narrative should be organized using the following section headers. All applicants should ensure that all of the specific elements in the Program Narrative are completely addressed (see Section V of this document for the corresponding Review Criteria).

NEED

- Describe the unique characteristics of the target population, including those characteristics that impact access to primary health care, health care utilization, and/or health status.

- Describe existing primary health care services (including mental health/substance abuse and oral health) currently available in the applicant's service area, including any gaps in services.

- Describe the health care environment and any significant changes that have affected the community's ability to provide services and/or have affected the applicant's fiscal stability, if applicable.

- Applicants requesting funding to serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330 (h)) and/or residents of public housing (section 330(i)) should describe the specific health care needs and access issues of the proposed special population.

Information provided on need should serve as the basis for, and align with, the proposed activities and goals described in the clinical and performance measures and throughout the application.

RESPONSE

- Describe the proposed service delivery model(s) to serve the community/population health care needs identified in Need section, including service delivery models to meet the specific needs of special populations if seeking targeted funding under section 330(g), section 330(h) and/or section 330(i). All sites and activities described should be consistent with those listed in Form 5B and 5C, including locations (*reference Attachment 1: Service Area Map, if applicable),* hours, and after-hours care. *Note:* Public Housing Primary Care applicants ONLY (section 330(i)) should demonstrate that the service site(s) is (are) immediately accessible to the public housing community being targeted.

- Describe how the proposed primary health care services are appropriate for the needs of the target population and are available and accessible to all life cycles without regard to

ability to pay (services discussed should be consistent with those listed in Form 5A). Note: Health Care for the Homeless applicants ONLY (section 330(h)) should demonstrate that substance abuse services will be made available as part of the required services.

- Describe how the service delivery model(s) assures the integration of enabling services (e.g., outreach, transportation), continuity of care (e.g., admitting privileges), access to a continuum of care, and access to special care services (e.g., referral relationships).

- Summarize all current or proposed subrecipient arrangements, contracts for a substantial portion of the operation of the health center and/or other agreements (as applicable) as detailed in Attachment 7: Summary of Contracts, Agreements, and Sub-recipient Agreements. Note: CHC and/or MHC applicants must complete Form 8 and reference it throughout the Response section as applicable. In addition, CHC and/or MHC applicants that respond "no" to any question in the Staffing or Governance section of Form 8 must clearly discuss the specific situation(s).

- Describe proposed clinical team staffing plan, the projected number of patients; and the plan for providing the required, preventive, enabling and additional health services as appropriate and necessary either directly or through established arrangements and referrals. Note: the applicant should reference Form 2 and Form 5A in their response as appropriate. If the clinical team staffing plan includes contracted providers, the applicant should include a summary of all such current or proposed contracts in Attachment 7.

- Describe the system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay and demonstrate how the schedule of charges is consistent with locally prevailing rates or charges. In addition, describe how the corresponding schedule of discounts (often referred to as a sliding fee scale) ensures that no patient will be denied services due to their inability to pay. [***Note:*** Ability to pay is determined by a patient's annual income and family size according to the most recent Federal Poverty Guidelines for the contiguous 48 states, Alaska and Hawaii (Information available at: http://aspe.hhs.gov/poverty/).] Reference the schedule of discounts in Attachment 11.

- Detail how the organization ensures that signs announcing the availability of discounts are in visible and accessible locations and how patients are made aware of the discount option through other publicly distributed materials, such as registration materials.

- Describe the implementation plan with appropriate and reasonable time-framed tasks (i.e., infrastructure planning, provider/staff recruitment and retention, facility development/operational planning, information system acquisition/integration, risk management/quality assurance procedures, and governance) to assure that within 120 days of NAP grant award, the new access point(s) will be operation and have the appropriate staff and providers in place. Provide applicable documentation (e.g., provider contracts, and commitment letters, as appropriate) in Attachment 14.

- Describe the organization's ongoing quality improvement/quality assurance (QI/QA) and risk management plan(s) that includes clinical services and management as well as maintains the confidentiality of patient records. Information provided should be consistent with the Clinical and Financial Performance Measures.

- Describe the organization's appropriate and board-approved policies and procedures related to: current clinical standards of care; provider credentials and privileges; risk management procedures; patient grievance procedures; incident management; and confidentiality of patient records.

COLLABORATION

- Describe both formal and informal collaboration and coordination of services with other health care providers. Provide evidence of proposed collaborations by providing letters of support, commitment and/or investment that reference the specific collaboration and/or coordinated activities in support of the project's operation and provision of primary health care services

- Provide a letter(s) of support from any FQHCs (current section 330 grantees and FQHC Look-Alikes), rural health clinics, and critical access hospitals in the proposed service area. If letters are not included, applicants must provide an explanation for why such letter(s) cannot be obtained, including documentation of efforts made to obtain the letter(s). All letters of support should be merged and included in Attachment 10: Letters of support, and referenced in the application as appropriate.

- If applicable, describe efforts to coordinate its activities with neighborhood revitalization initiatives supported through the Department of Housing and Urban Development's Choice Neighborhoods and/or Department of Education's Promise Neighborhoods.

- Applicants requesting funding for Migrant Health Center (section 330(g)), Health Care for the Homeless (section 330(h)) and/or Public Housing Primary Care (section 330(i)) should discuss any formal arrangements with other organizations that provide services or support to the special population such as Migrant Head Start, Public Housing Authority, homeless shelters, etc.

EVALUATIVE MEASURES

- Provide organization-wide health care and business plans, which include strategic objectives, outcome measures, program evaluation, and a process for continuous improvement, that will assess progress on the overarching goals of the proposed new access point(s) (e.g., operational status, number of patients served; patient satisfaction; quality and process improvements).
- Provide description of the organization's strategic planning process (e.g., how priorities are identified, what key outcomes are to be accomplished, and how success is measured and evaluated).

- Within their Clinical Performance Measures, outline time-framed and realistic goals with baselines *(if baselines are not yet available, applicant states when data will be available)* that are responsive to the health needs identified in the application. Provide data collection methodology to report on such clinical performance measures.

- Applicants may (but are not required to) include goals that address other key health needs within their community, target population(s) and/or for key life cycle groups (e.g., adolescents, elderly). Goals demonstrate a thorough understanding of the unique needs of the target population. Applicants applying to serve migrant populations, people experiencing homelessness and/or residents of public housing under section 330(g), section 330(h) and/or section 330(i) should discuss appropriate goals relevant to the needs of these populations.

- Provide a summary of the key factors that the applicant anticipates contributing to or restricting progress on the stated Clinical Performance Measures goals and any major planned responses to these factors. Note: In discussing responses to anticipated contributing or restricting factors, applicants should discuss this area broadly and do not need to provide detail at an "action step" level.

- Within their Financial Performance Measures, outline time-framed and realistic goals with baselines (if baselines are not yet available, applicant states when data will be available) that are responsive to the organizational and strategic planning needs identified in the application, including goals that work towards improving the organization's status in terms of Costs and Financial Viability, appropriate performance measures, and related data collection methodology to report on such measures.

- Provide a summary of the key factors that the applicant anticipates contributing to or restricting progress on the stated Financial Performance Measures goals and any major planned responses to these factors. Note: In discussing responses to anticipated contributing or restricting factors, applicants should discuss this area broadly and do not need to provide detail at an "action step" level.

- Provide a description of the experience, skills, and knowledge of evaluation staff, including previous work of a similar nature, in addition to the amount of time and effort proposed for staff to perform the project evaluation activities.

IMPACT

- Describe experience and expertise in a working with the target population(s); addressing the target population's identified health care needs; and developing and implementing appropriate systems and services. In cases where the proposed new access point(s) are already operational, specifically address how section 330 funds will augment existing services, resources and providers to expand accessibility and availability of primary health care services to underserved populations.

- Applicants seeking targeted funding for residents of public housing specifically (section 330(i)) should describe how residents will be involved in the development of the application and administration of the program.

- Discuss how the proposed new access point(s) will help to meet the identified performance measures indicated in the Clinical and Financial Performance Measures.

- Describe how the community/population's health care needs (as described in Narrative Section 1 – Need) and related performance goals and objectives (e.g., Clinical and Financial Performance Measures, patient satisfaction findings) are/or will be incorporated into its ongoing strategic planning process.

RESOURCES/CAPABILITIES

- Describe how the organizational structure is appropriate for the operational and oversight needs of the project including how lines of authority from the governing board to the Chief Executive Officer/Executive Director down to the management structure are maintained and are in accordance with Health Center Program requirements (http://bphc.hrsa.gov/about/requirements.htm). Reference Attachment 2: Corporate Bylaws, Attachment 3: Project Organizational Chart, and, as applicable, Attachment 6: Co-Applicant Agreement (for Public Centers that have a co-applicant board),[4] and Attachment 7: Summary of Contracts, Agreements and Subrecipient Arrangements.

- Describe appropriate oversight and authority over all contracted services, including any subrecipient(s) or affiliation arrangement(s) (as referenced in Program Specific Form 8: Health Center Affiliation Certification/Checklist), in accordance with Health Center Program requirements.[5]

- Describe how the organization maintains a fully staffed management team (Chief Executive Officer (CEO), Chief Clinical Officer (CCO), Chief Financial Officer (CFO), Chief Information Officer (CIO), and Chief Operating Officers (COO) as applicable) that is appropriate and adequate for the size, operation and oversight needs and scope of the proposed NAP project and are in accordance with Health Center Program requirements (http://bphc.hrsa.gov/about/requirements.htm).[6] Discuss if management positions are combined and/or part time (e.g., CFO and COO roles are shared). Position descriptions that include the roles, responsibilities, and qualifications as well as bio-sketches for the CEO, CCO, CFO, CIO, and COO as applicable should be included in Attachment 4: Position Descriptions for Key Management Staff and Attachment 5: Biographical Sketches of Key Management Staff.

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[4] In cases where a public center has a co-applicant board, the public center and co-applicant board must have a formal co-applicant agreement that stipulates: roles, responsibilities and the delegation of authorities; and any shared roles and responsibilities of each party in carrying out the governance functions.

[5] As stated in PIN 97-27: Affiliation Agreements of Community and Migrant Health Centers, and/or PIN 98-24: Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers. Applicants are encouraged to review http://bphc.hrsa.gov/about/requirements.htm for additional information on program requirements and expectations.

[6] See footnote 7 above.

- Describe the plan for recruiting and retaining key management staff and health care providers as appropriate for achieving the proposed staffing plan, and discuss any key management staff changes in the last year, as applicable.

- Describe readiness to initiate the proposed project plan within 120-days of a grant award, which includes:
  a) A facility that is operational (i.e., ready to provide services to the proposed population/community), and
  b) Providers are available to serve at the proposed new access point.

- Describe the proposed NAP facility(ies) and demonstrate that it is appropriate for the service delivery plan and reasonable in terms of the projected number of patients at full operational capacity. If facilities are not currently owned or under a lease agreement, provide a summary of relevant contracts and/or MOUs (e.g., with homeless shelter, public housing authority, other partner organizations) describing how access to facilities and on-site space is assured, in Attachment 13. Attach floor plans and lease/intent to lease documents for any facilities in Attachment 13.

- Describe financial management capability, accounting and control systems, and policies and procedures appropriate for the size and complexity of the organization, reflecting Generally Accepted Accounting Principles (GAAP) and separating functions appropriate to the organization's size to safeguard assets and maintain financial stability.

- Describe systems that are in place to maximize collections and reimbursement for its costs in providing health services, including written procedures for eligibility determination, as well as billing, credit and collection policies and procedures.

- Provide the most recent financial audit (performed in accordance with Federal audit requirements), and the management letter in Attachment 8. Organizations that have been operational for less than one year and do not have an audit may submit monthly financial statements for the most recent six-month period, if available. Organizations with no audit/financial information must provide a detailed explanation of the situation including supporting documentation as relevant (e.g., organization has been formed for the purposes of this grant application).

- Describe financial information systems that are/will be in place for collecting, organizing, and tracking key performance data for program reporting on the organization's financial status and that will support management decision making.

- Describe the status of emergency preparedness planning and development of emergency management plans, including participation or efforts to participate with State and local emergency planners. Address any "No" response(s) provided in Form 10: Annual Emergency Preparedness and Management Report.

- Describe the experience, skills, and knowledge of evaluation staff, including previous work of a similar nature, in addition to the amount of time and effort proposed for staff to perform the project evaluation activities.

SUPPORT REQUESTED

- Discuss the reasonableness of the proposed budget in relation to the objectives of the project.

- Complete a detailed budget presentation (424A, 424C (if applicable for applicants requesting funding for alteration and renovation), budget justification, Form 1B: BPHC Funding Request Summary, Form 2: Staffing Profile, and Form 3: Income Analysis, Equipment Plan) for Year 1 and Year 2.

GOVERNANCE

- Describe where and how the bylaws, and if applicable, Articles of Incorporation (required, Attachment 9) or Co-Applicant Agreement[7] (if applicable, Attachment 6) demonstrate that the organization has an independent governing board that is compliant with section 330 of the Public Health statute. Provide a copy of the signed bylaws in Attachment 2 and/or other relevant attachments are compliant with the requirements of section 330(k)(3)(H) of the PHS Act as amended (42 U.S.C. 254b). Note the governing board of a public center[8] is not required to establish general policies for the organization, and Governance requirements do not apply to an Indian tribe, tribal or Indian organization [9]

- Demonstrate that the structure of the Board (reference Form 6 in the response) is appropriate for the needs of the organization in terms of size (i.e., number of board members) and expertise (e.g., board members have a broad range of skills and perspectives in such areas as finance, legal affairs, business, health, social services), and that the board is comprised of:
    - A majority (at least 51%) of individuals ("consumers" or "patients") whom are or will receive their primary health care from the organization and who as a group, represent the individuals being served by the organization in terms of race,

[7] Applicants that are public centers whose board cannot directly meet health center governance requirements are permitted to establish a separate "co-applicant" health center governing board that meets all the section 330 governance requirements.

- In the co-applicant arrangement, the public center receives the section 330 grant and the co-applicant board serves as the "health center board."
- Together, the two collectively are referred to as the "health center."
- The co-applicant board members should be identified and documented in the center's application (using FORM 6-Part A: Board Member Characteristics).

The public center and health center board must have a formal co-applicant agreement that stipulates: roles, responsibilities and the delegation of authorities; and any shared roles and responsibilities of each party in carrying out the governance functions.

[8] The co-applicant health center board must meet all the size and composition requirements, perform all the duties of and retain all the authorities expected of governing boards except that the public center is permitted to retain responsibility for establishing general policies (fiscal and personnel policies) for the health center.

[9] Governance requirements do not apply to Indian tribe or tribal or Indian organization under the Indian Self-Determination Act or an urban Indian organization under the Indian Health Care Improvement Act.

ethnicity, and gender. Reference Form 6A[10] as well as Form 4: Community Characteristics in discussing the representativeness of the service area and target population. Note: An applicant who is requesting funding to serve general community (CHC) and special populations (HCH, PHPC and/or MHC) should have consumer/patient representation that is reasonably reflective of the populations targeted and served. At minimum, there must be at least one consumer/patient from each of the special population groups for which the organization is requesting/receiving section 330 funding. (This requirement may be waived for eligible applicants as noted in Form 6B, refer to APPENDIX A for specific instructions.);

  - Non-patient members that are representative of the community in which the center's service area is located and are selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions and other commercial and industrial concern, or social service agencies within the community;
  - A minimum of 9 but no more than 25 members, as appropriate for the complexity of the organization; and
  - No more than half (50%) non-patient members who derive more than 10% or their annual income from the health care industry.

- Demonstrate the effectiveness of the governing board by describing the Board's
  - Operations;
  - Organization and responsibilities of Board committees;
  - Process for monitoring and evaluation of its own (the board's) performance (e.g., identifies and develops processes for addressing board weaknesses and challenges, training needs, communication issues, meeting documentation); and
  - Training and development.

- If applicable, a waiver request (as noted in Form 6B), clearly demonstrates why the project cannot meet the statutory requirement(s) requested to be waived and describes appropriate alternative strategies detailing how the program intends to ensure consumer/patient participation (if board is not 51 percent consumers/patients) and/or regular oversight (if no monthly meetings) in the direction and ongoing governance of the organization. Note: Only applicants requesting targeted funding solely to serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330 (h)) and/or residents of public housing (section 330(i)) that do not receive or are not requesting to receive general (Community Health Center - section 330(e)) funds may request a waiver of one or both of these governance requirements. An approved waiver does not relieve the organization's governing board from fulfilling all other statutory and regulatory board responsibilities and requirements. All responses should be reported using Form 6B; no additional narrative is necessary.

[10] Eligible applicants that are requesting a waiver of the 51% consumer majority composition requirements must list the applicant's board members on Form 6-A: Board Member Characteristics and NOT the members of their advisory council(s) if they have one. Public centers with co-applicant agreements should list the co-applicant board members in Form 6A.

- If the consumer/patient majority is requested to be waived, briefly discuss in Form 6B, why the applicant cannot meet this requirement and describe the alternative mechanism(s) for gathering consumer/patient input (e.g., separate advisory boards, patient surveys, focus groups).
- If monthly meetings are requested to be waived, briefly discuss in Form 6B, why the applicant cannot meet this requirement and describe and outline the proposed alternative schedule of meeting and how the alternative schedule will assure that the board can still maintain appropriate oversight of the project.

xi. Project Implementation for Alteration and Renovation Projects:

Applicants requesting one-time funding available in YEAR 1 ONLY for alteration and renovation, including the installation of equipment, must upload (in Attachment 15) a summary of proposed project to include the following:

I. The full address for the relevant site(s) listed on Form 5B
II. A full description of the minor alteration/renovation project(s) being undertaken to include:
    1) **Amount of square footage being improved**
    2) **Total Project Scope of Work** (e.g., renovation of five 12x15 square-foot exam rooms within existing interior space; installation of 300 feet of interior ductwork and two condenser units on the exterior roof; installation of 40 energy efficient windows, and replacement of front entry door with automated glass doors; repair of a 1,500 square feet of asphalt roof; installation of 10x20 square-foot fabric canopy over entryway; resurfacing 500 square feet of parking lot).
    3) **Budget Justification** to describe each cost element and explain how each cost contributes to meeting the project's objectives/goals. This justification must support the costs detailed in the 424C: Budget Information-Construction Programs (424C is completed online as a Program Specific Form).
    4) **Other funding sources** needed to support overall project. Indicate whether funds are secured or not.
    5) **Project Timeline** – provide estimated start and completion dates for the project.
    6) **Schematic Drawings** – submit line drawings that indicate the location of the proposed renovation area in the existing building and the total net and gross square footage of space to be renovated. The schematic drawing should be legible on an 8.5" x 11" sheet of paper with the scale clearly indicating the size dimensions, function, as well as the net and gross square feet for each room. These drawings should not be blueprints and do not need to be completed by an architect. Changes or additions to existing mechanical and electrical systems should be clearly described in notes made directly on the drawings.

xii. Program Specific Forms and Program Specific Information

Please see APPENDIX A for Program Specific Form instructions and links, and APPENDIX B for Program Specific Information instructions and links. Please note that the electronic submission module in HRSA's EHB does not categorically differentiate between Program Specific Forms and Program Specific Information.

xiii. Attachments

Attachments are supplementary in nature and are not intended to be a continuation of the program narrative. Attachment should be clearly labeled and attached in the appropriate section. Refer to the Required Attachments Table for a complete listing of all required attachments (Content and Form of Application Submission).

3. SUBMISSION DATES AND TIMES

Application Due Date

The submission time in Grants.gov for applications under HRSA-11-017 is at **8:00 p.m. ET** on **November 17, 2010** and the submission time to complete all other required information in HRSA's EHBs is at **5:00 p.m. ET on December 15, 2010.** Applications will be considered as having been formally submitted and having met the deadline if: (1) the application has been successfully transmitted electronically by your organization's Authorized Organization Representative (AOR) through Grants.gov and it has been successfully validated by Grants.gov on or before the deadline date and time; and (2) the AOR has submitted the additional information in the HRSA EHBs on or before the deadline date and time. Applications which do not meet the criteria above are considered late applications and will not be considered in the current competition.

To ensure adequate time to follow procedures and successfully submit the application, HRSA recommends applicants register immediately in Grants.gov and complete the forms as soon as possible. Refer to http://www.hrsa.gov/grants/electronicsubmission.htm for important specific information on registering and applying through Grants.gov.

The Chief Grants Management Officer (CGMO) or designee may authorize an extension of published deadlines when justified by circumstances such as natural disasters (e.g., floods, hurricanes) or other disruptions of services, such as a prolonged blackout. The CGMO or designee will determine the affected geographical area(s).

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

4. INTERGOVERNMENTAL REVIEW

The Health Center Program is subject to the provisions of Executive Order 12372, as implemented by 45 CFR Part 100. Executive Order 12372 allows States the option of setting up a system for reviewing applications from within their States for assistance under certain Federal programs. Application packages made available under this guidance will contain a listing of States that have chosen to set up such a review system, and will provide a State Single Point of Contact (SPOC) for the review. Information on states affected by this program and State Points of Contact may also be obtained from the Grants Management Officer listed in the Agency Contact(s) section, as well as from the following Web site: http://www.whitehouse.gov/omb/grants/spoc.html.

All applicants (with the exception of federally recognized Native American Tribal Groups) should contact their SPOC as early as possible to alert them to the prospective applications and receive any necessary instructions on the State 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 State Single Point of Contact (SPOC) in response to Executive Order 12372 are due sixty days after the application due date.

Public Health System Reporting Requirements: Under these requirements (approved by the Office of Management and Budget, 0937-0195), the community-based non-governmental applicant must prepare and submit a Public Health System Impact Statement (PHSIS) to the head of the appropriate State and local health agencies in the area(s) to be impacted no later than the Federal application due date. The PHSIS should include:

a. A copy of the face page of the application (SF 424).
b. A summary of the project, not to exceed one page, which provides:
    - A description of the population to be served, whose needs would be met under the proposal.
    - A summary of the services to be provided, and
    - A description of the coordination planned with the appropriate State or local health agencies.

Applicants should contact their state Primary Care Association (see http://bphc.hrsa.gov/technicalassistance/pcadirectory.htm for a list of PCAs) for instructions on how and where to submit the Public Health Impact statement.

5. Funding Restrictions

Funds under this announcement may not be used for fundraising or for construction of facilities. Funds may, however, be used for minor capital costs including equipment and/or minor alterations and renovations of facilities for use as new access points. Applicants may request to use up to $150,000 of Federal funds in Year 1 ONLY for such minor capital costs. Applicants may not request Federal section 330 funding in Year 2 for minor capital costs including equipment and/or minor alterations and renovations of facilities. 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 is available at: ftp://ftp.hrsa.gov/grants/hhsgrantspolicystatement.pdf

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.

6. Other Submission Requirements

Except in rare cases, HRSA will no longer accept applications for grant opportunities in paper form. Applicants submitting for this funding opportunity are required to submit electronically through Grants.gov and HRSA's EHB.

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

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

- Obtain an organizational Data Universal Number System (DUNS) number
- Register the organization with Central Contractor Registry (CCR)
- Identify the organization's E-Business Point of Contact (E-Biz POC)
- Confirm the organization's CCR "Marketing Partner ID Number (M-PIN)" password
- Register an Authorized Organization Representative (AOR). HRSA recommends registering multiple AORs.
- Obtain a username and password from the Grants.gov Credential Provider

Step-by-step instructions on registering and applying, tutorials and FAQs are available on the Grants.gov web site at www.grants.gov. Assistance is also available from the Grants.gov help desk 24 hours a day, seven days a week (excluding Federal holidays) at support@grants.gov or by phone at 1-800-518-4726.

In order to submit the NAP application in HRSA EHBs, the Authorized Organization Representative (and other application preparers) must register in HRSA EHBs. The purpose of the registration process is to collect consistent information from all users, avoid collection of redundant information and allow for the unique identification of each system user. Note that registration within HRSA EHBs is required only once for each user. **Note that HRSA EHBs now allow the user to use his/her single username and associate it with more than one organization.**

User registration within HRSA EHBs is a two-step process. In the first step, individual users from an organization who participate in the grants process must create individual system accounts. In the second step, the users must associate themselves with the appropriate grantee organization. Once the individual is registered, they are given two options. One, they can search for an existing organization using the **10-digit grant number** from the **Notice of Award (NOA)** or two, if the grant number is not known or if the organization has never received a grant from HRSA, they can search using the **HRSA EHBs Tracking Number**. Your organization's record is created in HRSA EHBs based on information entered in Grants.gov.

To complete the registration quickly and efficiently HRSA recommends that applicants identify role for all users in the grants management process. HRSA EHBs offer the following three functional roles for individuals from applicant/grantee organizations:

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

For more information on functional responsibilities refer to the HRSA EHBs online help. Note that registration with HRSA EHBs is independent of Grants.gov registration. Once the registration is completed, all users from the organization must to go through an additional step to get access to the application in HRSA EHBs. This is required to ensure that appropriate individuals have access to the competing application.

IMPORTANT: The HRSA EHBs Tracking Number must be used to identify the applicant organization.

For assistance in registering with HRSA EHBs, please refer to the following:

- http://www.hrsa.gov/grants/userguide.htm
- 877-GO4-HRSA or 877-464-4772 (9:00 am to 5:30 pm ET)
- TTY for hearing impaired 1-877-897-9910 (9:00 am to 5:30 pm ET)
- E-mail callcenter@hrsa.gov.

Formal submission of the electronic application: Applications will be considered as having met the deadline if: (1) the application has been successfully transmitted electronically by your organization's Authorized Organization Representative (AOR) through Grants.gov and it has been successfully validated by Grants.gov on or before the deadline date and time; and (2) the Project Director has entered the HRSA EHBs to review the application and the AOR has submitted the additional information on or before the deadline date and time.

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

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

Tracking your application: It is incumbent on the applicant to track application status by using the Grants.gov tracking number (GRANTXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking your application can be found at http://www07.grants.gov/applicants/resources.jsp.

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of grant applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

Review Criteria are used to review and rank applications. The NAP application has eight (8) review criteria. All applicants should ensure that the review criteria are fully addressed within the Program Narrative *and* supported by other supplementary information in the other sections of the application as appropriate.

As a reminder, the application must be limited to the scope of the proposed NAP project and not necessarily the scope of the entire organization. Specifically**:**

- **New start applicants** should include information on the entire scope of the proposed NAP project.
- **Satellite applicants** should **address only the service area of the new access point(s)** (i.e., only the new area proposed under the satellite, not the scope of the entire organization of the applicant).

The eight (8) Review Criteria for the HRSA-11-017: New Access Points funding opportunity and maximum points to be awarded are as follows:

Criterion 1: NEED (30 Points)

Part A: Converted Need for Assistance (NFA) Worksheet Score (Maximum 20 points to be counted toward the 30 Points for Need)

The NFA Worksheet will be scored based on responses presented in the completed Form 9 using the NFA Worksheet scoring criteria (see APPENDIX A). The NFA Worksheet score of up to 100 points will be converted to the Need: Part A score with a maximum of 20 points to be counted toward the 30 Points allocated for the Need section using the Conversion Table in APPENDIX A. Applicants will have the NFA Worksheet score validated by the ORC as part of the complete assessment of the application.

Part B: Need Narrative (Maximum 10 points to be counted toward the 30 Points for Need)

1. The extent to which the applicant describes the unique characteristics of the target population within the proposed service area that affect access to primary health care, health care utilization and/or health status, including:
    a. Cultural/ethnic factors including language, attitudes, knowledge and/or beliefs;
    b. Geographic/transportation barriers;

c. Unemployment or educational factors; and
d. Unique health care needs of the target population(s).

2. The extent to which the applicant demonstrates knowledge/documentation of existing primary health care services (including mental health/substance abuse and oral health) currently available in the applicant's service area, including any gaps in services (e.g., provider shortages) and the role and location of any other providers who currently serve the target population.

3. The extent to which the applicant demonstrates a thorough understanding of the health care environment and describes any significant changes that have affected the community's ability to provide services and/or have affected the applicant's fiscal stability, if applicable. The topics may include:
    a. Changes in insurance coverage, including Medicaid, Medicare and CHIP; changes in State/local/private uncompensated care programs;
    b. Major events including changes in the economic or demographic environment of the service area (e.g., influx of refugee population; closing of local hospitals; community health care providers or major local employers; major emergencies such as hurricanes, flooding, terrorism); and
    c. Significant changes affecting the special populations served (if applicable).

4. If applicable, the extent to which an applicant requesting targeted funds to serve migrant and seasonal farmworkers (section 330(g)) demonstrates a thorough understanding of the specific health care needs and access issues impacting migrant and seasonal farmworkers, including:
    a. Agricultural environment (e.g., crops and growing seasons, need for hand labor, number of temporary workers);
    b. Approximate period or periods of residence of all groups of migratory workers and their families and the availability of local providers to provide care during these times;
    c. Migrant occupation-related factors (e.g., working hours, housing, sanitation, hazards including pesticides, and other chemical exposures); and
    d. Any significant increases or decreases in migrant and seasonal farmworkers.

5. If applicable, the extent to which an applicant requesting targeted funds to serve people experiencing homelessness (section 330 (h)) demonstrates a thorough understanding of the specific health care needs and access issues impacting people experiencing homelessness, including:
    a. Number of providers treating homeless individuals, availability of homeless shelters and/or affordable housing); and
    b. Any significant increases or decreases in people experiencing homelessness.

6. If applicable, the extent to which an applicant requesting targeted funds to serve people in public housing (section 330 (h)) demonstrates a thorough understanding of the specific health care needs and access issues impacting residents of public housing, including:

a. Availability of public housing, impact on the residents in the targeted public housing, communities served; and
b. Any significant increases or decreases in residents of public housing.

7. The extent to which the identified need serves as the basis for, and aligns with, the proposed activities and goals described in the Clinical and Financial Performance Measures and throughout the application.

Criterion 2: RESPONSE (20 Points)

1. The extent to which the applicant demonstrates that its service delivery model(s) is appropriate and responsive to the identified community/population health care needs, including the specific needs of special populations (if seeking funding under section 330(g), section 330(h) and/or section 330(i)), including:
    a. Locations where services will be provided and the proposed arrangements for how services will be provided (e.g., on-site, mobile vans, by referrals, via contract) at each proposed site;
    b. How the organization's hours of operation assure that services are available and accessible at times that meet the needs of the population;
    c. How the organization provides professional coverage during hours when the organization is closed; and
    d. If applicable, the extent to which an applicant requesting targeted funding to serve residents of public housing (section 33(i)) demonstrates that the service site(s) is (are) immediately accessible to the public housing community being targeted.

2. The extent to which the applicant demonstrates that the proposed primary health care services are appropriate for the needs of the target population and are available and accessible to all life cycles without regard to ability to pay, including:
    a. The provision of required primary, preventive, enabling health services and additional health services[11] as appropriate and necessary, including whether these are provided either directly, or through established arrangements and referrals;
    b. Any arrangements, including whether these are provided directly or by referral, for mental health/substance abuse services;
    c. Any arrangements for oral health care services, including whether these are provided directly or by referral;
    d. How services will be culturally and linguistically appropriate (e.g., availability of interpreter/translator services, bilingual/multicultural staff, training opportunities); and
    e. If applicable, the extent to which an applicant requesting targeted funding to serve people experiencing homelessness (section 330(h)) provides evidence that substance abuse services will be made available as part of the required services.

[11] As defined in Terms and Definitions, see www.hrsa.gov/grants/technicalassistance/NAP.htm.

3. The extent to which the applicant demonstrates that its service delivery model(s) assures:
    a. Enabling services, including outreach and transportation, have been integrated into the primary health care delivery system, including specific models addressing increasing access for special populations (if applicable);
    b. Arrangements for admitting privileges for health center physicians at one or more hospitals, or other such arrangements to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, the organization demonstrates established arrangements for hospitalization, discharge planning and patient tracking;
    c. How a seamless continuum of care is assured (e.g., appropriate arrangements for discharge planning and patient tracking among providers) that best meets the broader community need; and
    d. Referral relationships for additional health services and specialty care and with other health care providers, including one or more hospitals with an emphasis on working collaboratively to meet the community need.

4. The extent to which the applicant documents and demonstrates the appropriateness of all current or proposed subrecipient arrangements, contracts for a substantial portion of the operation of the health center and/or other agreements (as applicable).

5. The strength of the proposed clinical team staffing plan including the number and mix of primary care physicians, nurse practitioners, physician assistants, certified nurse midwives, oral health and/or behavioral professionals, and other providers as well as clinical support staff, assuring appropriate language and cultural competence, that it is necessary for:
    a. The projected number of patients; and
    b. To carry out required, preventive, enabling and additional health services as appropriate and necessary either directly or through established arrangements and referrals.

6. The extent to which the applicant documents and demonstrates a system in place to determine the following:
    a. Eligibility for patient discounts adjusted on the basis of the patient's ability to pay;
    b. Demonstration of how the schedule of charges is consistent with locally prevailing rates or charges and is designed to cover the reasonable costs of operation for services;
    c. Demonstration of how the corresponding schedule of discounts (often referred to as a sliding fee scale) ensures that no patient will be denied services due to their inability to pay.

7. The extent to which the applicant documents and demonstrates:
    a. How often the governing board reviews and updates the organization's fee and discount schedule;
    b. How the organization ensures that signs announcing the availability of discounts are in visible and accessible locations;

c. How patients are made aware of the discount option through other publicly distributed materials, such as registration materials; and
d. How the organization assures that no patient will be denied health care services due to a person's inability to pay including evidence that the schedule of discounts is:[12]
   - utilized only for all individuals and families with an annual income below 200 percent of the poverty guidelines; and
   - provides for a full (100 percent) discount for all individuals and families with an annual income at or below 100 percent of the poverty guidelines (nominal fees may be collected from individual or families with an annual income at or below 100 percent of the poverty guidelines when imposition of such a fee is consistent with project goals and **does not** pose a barrier to receiving care).

8. The extent to which the applicant documents and demonstrates an implementation plan with appropriate and reasonable time-framed tasks to assure that within 120 days of NAP grant award, the new access point(s) will be operational in terms of service delivery and have appropriate staff and providers in place., including:
   a. Infrastructure planning (e.g., developing operational policies/procedures, applying for billing numbers, formalizing referral agreements);
   b. Provider/staff recruitment and retention;
   c. Facility development/operational planning;
   d. Information system acquisition/integration;
   e. Risk management/quality assurance procedures; and
   f. Governance

9. Strength of the organization's ongoing quality improvement/quality assurance (QI/QA) and risk management plan(s) regarding:
   a. Clinical services and management;
   b. Confidentiality of patient records; and
   c. Consistency with the Clinical and Financial Performance Measures.

10. The extent to which the QI/QA and risk management plan(s) includes evidence of:
   a. A clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care; and
   b. Periodic assessment of the appropriateness of service utilization, quality of services delivered, and/or the health status/outcomes of health center patients including that the assessment:
      - Is conducted by physicians or by other licensed health professionals under the supervision of physicians;
      - Is based on the systematic collection and evaluation of patient records;

[12] 42 CFR Part 51c, Grants for Community Health Services and 42 CFR Part 56, Grants for Migrant Health Services and Centers.

- Identifies and documents the necessity for change in the provision of services by the organization and results in the institution of such change, where indicated;
- Is appropriate clinical information systems are/will be in place for tracking/analyzing/reporting key performance data related to the organization's plan (e.g., electronic health records); and
- Includes how the findings of the QI/QA process are/will be used to improve organizational performance.

11. The extent to which the applicant demonstrates the appropriateness of board-approved policies and procedures related to:
    a. Current clinical standards of care;
    b. Provider credentials and privileges;
    c. Risk management procedures;
    d. Patient grievance procedures;
    e. Incident management; and
    f. Confidentiality of patient records.

Criterion 3: COLLABORATION (10 Points)

1. The extent to which the applicant documents and demonstrates:
    a. Formal and informal collaboration and coordination of services with other health care providers, specifically other section 330 grantees, FQHC Look-Alikes, rural health clinics, critical access hospitals, other federally-supported grantees including Ryan White programs, State and local health services delivery projects, and other private providers and programs serving the same population(s) (e.g., social services, job training, Women, Infants and Children (WIC), coalitions, community groups);
    b. Efforts to coordinate its activities with neighborhood revitalization initiatives supported through the Department of Housing and Urban Development's Choice Neighborhoods and/or Department of Education's Promise Neighborhoods (if applicable); and
    c. Proposed collaborations as evidenced by letters of support, commitment and/or investment that reference the specific collaboration and/or coordinated activities in support of the project's operation and provision of primary health care services (e.g., from a neighboring health center or rural health clinic, local school board, hospital, critical access hospital, public health department, homeless shelters, advocacy groups, and other service providers).

2. The extent to which applicants requesting targeted funding for special populations (Migrant Health Center (section 330(g)), Health Care for the Homeless (section 330(h)) and/or Public Housing Primary Care (section 330(i)) documents and demonstrates formal arrangements with other organizations that provide services or support to the proposed special population (e.g., Migrant Head Start, Public Housing Authority, homeless shelters).

3. The extent to which the applicant provides evidence of letter(s) of support from any FQHC (current section 330 grantees and FQHC Look-Alikes), rural health clinics, and critical access hospitals in the proposed service area. If letter(s) are not included, the extent to which the applicant explains why such letter(s) cannot be obtained, including documentation of efforts made to obtain the letter.

Criterion 4: EVALUATIVE MEASURES (5 Points)

1. The extent to which the applicant documents and demonstrates organization-wide health care and business plans, including strategic objectives, outcome measures, program evaluation, and a process for continuous improvement that will assess progress on the overarching goals of the proposed new access point(s) (e.g., operational status, number of patients served; patient satisfaction; quality and process improvements).

2. The extent to which the applicant documents and demonstrates the organization's strategic planning process (e.g., how priorities are identified, what key outcomes are to be accomplished, how success is measured and evaluated).

3. The extent to which the applicant documents and demonstrates in the Clinical Performance Measures, time-framed and realistic goals with baselines *(if baselines are not yet available, applicant states when data will be available)* that are responsive to the health needs identified in the application including:
    a. Goals that work towards improving quality of care, health outcomes and eliminating health disparities in the areas of Diabetes, Cardiovascular Disease, Cancer, Prenatal and Perinatal Health, Child Health, and Behavioral and Oral Health;
    b. Goals that demonstrate a thorough understanding of the unique needs of the target population. Note: The extent to which applicants requesting targeted funding to serve special populations, (migrant populations, people experiencing homelessness and/or residents of public housing under section 330(g), section 330(h) and/or section 330 (i), respectively), demonstrate appropriate goals relevant to the needs of these populations;
    c. Appropriate performance measures for all goals and related data collection methodology to report on such measures; and
    d. An adequate summary of the key factors that the applicant anticipates contributing to or restricting progress on the stated Clinical Performance Measures goals and any major planned responses to these factors.

4. The extent to which the applicant documents and demonstrates in the Financial Performance Measures, time-framed and realistic goals with baselines *(if baselines are not yet available, applicant states when data will be available)* that are responsive to the organizational and strategic planning needs identified in the application including:
    a. Goals that work towards improving the organization's status in terms of Costs and Financial Viability. Applicants may (but are not required to) include goals that address any other key financial viability and/or cost issues with their organization;

b. Appropriate performance measures for all goals and related data collection methodology to report on such measures; and
c. An adequate summary of the key factors that the applicant anticipates contributing to or restricting progress on the stated Financial Performance Measures goals and any major planned responses to these factors.

5. The extent to which the applicant demonstrates the experience, skills, and knowledge of evaluation staff, including evidence of previous work of a similar nature, in addition to the amount of time and effort proposed for staff to perform the project evaluation activities.

Criterion 5: IMPACT (5 Points)

1. The extent to which the applicant demonstrates why it is the appropriate entity to receive funding by documenting its experience and expertise in:
    a. Working with the target population(s);
    b. Addressing the target population's identified health care needs; and
    c. Developing and implementing appropriate systems and services. In cases where the proposed new access point(s) are already operational, the extent to which the applicant specifically addresses how section 330 funds will augment existing services, resources and providers to expand accessibility and availability of primary health care services to underserved populations.

    Note: If applicable, the extent to which applicants seeking funding for Public Housing Primary Care applicants (section 330(i)) demonstrate how residents will be involved in the development of the application and administration of the program.

2. The strength of the applicant's discussion regarding how the proposed new access point(s) will help to meet the goals indicated in the Clinical and Financial Performance Measures.

3. The extent of the applicant's discussion and documentation of how the community/population's health care needs (as described in Criterion 1 – Need) and related performance goals and objectives (e.g., Clinical and Financial Performance Measures, patient satisfaction findings) are/or will be incorporated into its ongoing strategic planning process.

4. The extent to which the applicant demonstrates that the development of the new access point(s) is the result of a strategic planning process that examined the needs of the community and included community input and Board involvement.

Criterion 6: RESOURCES/CAPABILITIES (10 points)

1. The extent to which the applicant demonstrates how the organizational structure is appropriate for the operational and oversight needs of the project including how lines of authority from the governing board to the Chief Executive Officer/Executive Director down to the management structure are maintained and are in accordance with Health Center Program requirements (http://bphc.hrsa.gov/about/requirements.htm).

2. The extent to which the applicant documents and demonstrates appropriate oversight and authority over all contracted services, including any subrecipient(s) in accordance with Health Center Program requirements.[13]

3. The extent to which the applicant documents and demonstrates how the organization maintains a fully staffed management team (Chief Executive Officer (CEO), Chief Clinical Officer (CCO), Chief Financial Officer (CFO), Chief Information Officer (CIO), and Chief Operating Officers (COO) as applicable) that is appropriate and adequate for the size, operation and oversight needs and scope of the proposed NAP project and are in accordance with Health Center Program requirements.[14]

4. The strength of the applicant's plan for recruiting and retaining key management staff and health care providers as appropriate for achieving the proposed staffing plan, including a discussion of any key management staff changes in the last year, as applicable.

5. The extent to which the applicant documents and demonstrates readiness to initiate the proposed project plan within 120-days of a grant award, which includes:
   c) A facility that is operational (i.e., ready to provide services to the proposed population/community), and
   d) Providers are available to serve at the proposed new access point.

6. The extent to which the applicant documents and demonstrates that the proposed NAP facility(ies) is appropriate for the service delivery plan and is reasonable in terms of the projected number of patients at full operational capacity, or the extent to which the applicant summarizes the relevant contracts and/or MOUs (e.g., with homeless shelter, public housing authority, other partner organizations) documenting access to facilities and on-site space (for facilities not currently owned or leased).

7. The extent to which the applicant demonstrates that the financial management capability, accounting and control systems, and policies and procedures are appropriate for the size and complexity of the organization, reflecting Generally Accepted Accounting Principles (GAAP) and separating functions appropriate to the organization's size to safeguard assets and maintain financial stability.

8. The extent to which the applicant demonstrates systems are in place to maximize collections and reimbursement for its costs in providing health services, including written procedures for eligibility determination, as well as billing, credit and collection policies and procedures.

9. The extent to which the applicant documents and demonstrates that an annual independent financial audit is performed in accordance with Federal audit requirements (or for

[13] As stated in PIN 97-27: Affiliation Agreements of Community and Migrant Health Centers, and/or PIN 98-24: Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers. Applicants are encouraged to review http://bphc.hrsa.gov/about/requirements.htm for additional information on program requirements and expectations.
[14] See footnote 7 above.

organizations that have been operational for less than one year and do not have an audit, the inclusion of monthly financial statements for the most recent six-month period, if available). In instances where no audit/financial information is available, the extent to which the applicant provides a detailed explanation including supporting documentation as relevant (e.g., organization has been formed for the purposes of this grant application).

10. The extent to which the applicant documents and demonstrates financial information systems are in place for collecting, organizing, and tracking key performance data for program reporting on the organization's financial status (e.g., revenue generation by source, aged accounts receivable by income source, debt to equity ratio, net assets to expenses, working capital to expenses, visits by payor category) and that will support management decision making.

11. The extent to which the applicant demonstrates emergency preparedness planning and development of emergency management plans, including participation or efforts to participate with State and local emergency planners.

Criterion 7: SUPPORT REQUESTED (10 Points)

1. The extent to which the applicant demonstrates that the proposed budget is reasonable in relation to the objectives of the project.

2. The extent to which the applicant demonstrates a complete and detailed budget presentation (424A, Budget Justification, Form 1B: BPHC Funding Request Summary, Form 2: Staffing Profile, and Form 3: Income Analysis, 424C-Budget Information for Construction Programs, Equipment List) for Year 1 and Year 2 that reflects:
    a. The costs of operations, expenses and revenues (including the Federal grant) necessary to accomplish the service delivery plan including the number of patients to be served;
    b. How reimbursement is or will be maximized from third party-payors (e.g., Medicare, Medicaid, CHIP, private insurance) given the patient mix and number of projected patients and visits.
    c. How the proportion of requested Federal grant funds is appropriate given other sources of documented income.

Criterion 8: GOVERNANCE (10 Points)

1. The extent to which the applicant's signed bylaws (Attachment 2) and/or other relevant attachments demonstrate compliance with the requirements of section 330(k)(3)(H) of the PHS Act as amended (42 U.S.C. 254b). Specifically, the extent to which the applicant demonstrates where and how the bylaws, and if applicable, Articles of Incorporation (Attachment 9) or Co-Applicant Agreement[15] (Attachment 6) represent that the organization has an independent governing board that has the following authorities:

[15] Applicants that are public centers whose board cannot directly meet health center governance requirements are permitted to establish a separate "co-applicant" health center governing board that meets all the section 330 governance requirements.

a. Meets at least once a month;
b. Selects the services to be provided by the organization;
c. Determines the hours during which such services will be provided;
d. Measures and evaluates the organization's progress in meeting its annual and long-term programmatic and financial goals, and develops a plan for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational performance and assets;
e. Approves the health center's annual budget;
f. Approves the health center grant applications;
g. Approves the selection/dismissal and conducts the performance evaluation of the organization's Executive Director/CEO; and
h. Establishes general policies for the organization, except in the case of a governing board of a public center.[16]

Note: Governance requirements do not apply to an Indian tribe, tribal or Indian organization [17]

2. The extent to which the applicant demonstrates that the structure of the board is appropriate for the needs of the organization in terms of size (i.e., number of board members) and expertise (e.g., board members have a broad range of skills and perspectives in such areas as finance, legal affairs, business, health, social services).

3. The extent to which the applicant documents and demonstrates that the board is comprised of:
    a. A majority (at least 51%) of individuals ("consumers" or "patients") whom are or will receive their primary health care from the organization and who as a group, represent the individuals being served by the organization in terms of race, ethnicity, and gender.
    b. If applicable, applicants requesting targeted funding to serve to serve general community (CHC) **AND** special populations (HCH, PHPC and/or MHC) demonstrate a consumer/patient board representation that is reasonably reflective of the populations targeted and served (at minimum, there must be at least one consumer/patient from each of the special population groups for which the organization is requesting/receiving section 330 funding).

- In the co-applicant arrangement, the public center receives the section 330 grant and the co-applicant board serves as the "health center board."
- Together, the two collectively are referred to as the "health center."
- The co-applicant board members should be identified and documented in the center's application (using FORM 6-Part A: Board Member Characteristics).

The public center and health center board must have a formal co-applicant agreement that stipulates: roles, responsibilities and the delegation of authorities; and any shared roles and responsibilities of each party in carrying out the governance functions.

[16] The co-applicant health center board must meet all the size and composition requirements, perform all the duties of and retain all the authorities expected of governing boards except that the public center is permitted to retain responsibility for establishing general policies (fiscal and personnel policies) for the health center.

[17] Governance requirements do not apply to Indian tribe or tribal or Indian organization under the Indian Self-Determination Act or an urban Indian organization under the Indian Health Care Improvement Act.

c. Non-patient members who are representative of the community in which the center's service area is located and are selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions and other commercial and industrial concern, or social service agencies within the community;
d. A minimum of 9 but no more than 25 members, as appropriate for the complexity of the organization; and
e. No more than half (50%) of non-patient members who derive more than 10% or their annual income from the health care industry.

4. The extent to which the applicant discusses the effectiveness of the governing board by describing how the Board:
    a. Conducts business, including the organization and responsibilities of Board committees (committee examples may include Executive, Finance, Quality Improvement/ Assurance, Risk Management, Human Resources, and Planning, etc.);
    b. Monitors and evaluates its own (the board's) performance (e.g., identifies and develops processes for addressing board weaknesses and challenges, training needs, communication issues, meeting documentation); and
    c. Provides board training and development and orientation for new members to ensure that members have sufficient knowledge and information to make informed decisions regarding the strategic direction, general policies and financial position of the organization.

5. If applicable, the extent to which the applicant's board waiver request demonstrates why the applicant cannot meet the statutory requirement(s) requested to be waived, and describes appropriate alternative strategies detailing how the program intends to ensure consumer/patient participation (if board is not 51 percent consumers/patients) and/or regular oversight (if no monthly meetings) in the direction and ongoing governance of the organization including:
    a. If the consumer/patient majority is requested to be waived, the applicant describes the alternative mechanism(s) for gathering consumer/patient input (e.g., separate advisory boards, patient surveys, focus groups) including:
        - Specific type of consumer/patient input to be collected;
        - Methods for documenting such input in writing;
        - Process for formally communicating the input directly to the organization's governing board (e.g., quarterly presentations of the advisory group to the full board, quarterly summary reports from consumer/patient surveys); and
        - How the consumer/patient input will be used by the governing board in such areas as: 1) selecting services; 2) setting operating hours; 3) defining strategic priorities; and 4) evaluating the organization's progress in meeting monthly goals, including patient satisfaction, and 5) other relevant areas of governance that require and benefit from consumer/patient input.
    b. If monthly meetings are requested to be waived, the applicant demonstrates why the project cannot meet this requirement and describes/outlines the proposed

alternative schedule of meeting and how the alternative schedule will assure that the board can still maintain appropriate oversight of the project.

Note: Only applicants requesting targeted funding solely to serve special populations (i.e., migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330 (h)) and/or residents of public housing (section 330(i))) that do not receive or are not requesting to receive general (Community Health Center - section 330(e)) funds may request a waiver of one or both of the governance requirements (51 percent consumer/patient majority and/or monthly meetings).

2. Review and Selection Process

HRSA's Division of Independent Review (DIR) is responsible for managing objective reviews. Applicants competing for Federal funds receive an objective and 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 above. The committee provides expert advice on the merits of each application to program officials responsible for final selections for award.

All NAP applications will be reviewed initially for eligibility (see Section III for Eligibility requirements, Eligibility Information), completeness (see Section IV for Application Format, Content and Form of Application Submission) and responsiveness to the application. **Those applications that are determined to be ineligible, incomplete or non-responsive to the grant application guidance and/or section 330 program requirements will not be considered in the review process.**

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 relevant sections of this program announcement. The review criteria are designed to enable the review panel to assess the quality of a proposed project and determine the likelihood of its success. The criteria are closely related to each other and are considered as a whole in judging the overall quality of an application.

The NFA Worksheet will be scored based on responses presented in the completed Form 9 using the NFA Worksheet scoring criteria (see APPENDIX A of this document for scoring and instructions for completing the NFA Worksheet, Program Specific Forms). The NFA Worksheet score of up to 100 points will be converted to a scale of 20 points using the Conversion Table (APPENDIX A) to determine Part A (20 of the 30 total points) of the assessment of Need in the Review Criteria (see Section V, Review Criteria). The Objective Review Committee will also evaluate the technical merits of the proposal using the review criteria presented in this application guidance with points assigned up to a maximum of 80 points total (see Section V, Review Criteria).

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. The funding Priorities detailed below (i.e., sparsely populated, high poverty, special populations) will be assessed by the HRSA based on supporting documentation contained in the application.

HRSA reserves the right to review fundable applicants for compliance with HRSA program requirements through reviews of site visits, audit data, Uniform Data System (UDS) or similar reports, Medicare/Medicaid cost reports, external accreditation or other performance reports, as applicable. The results of this review may impact final funding decisions.

Funding Priorities
A funding priority is defined as the favorable adjustment of combined review scores of individually approved applications when applications meet specified criteria. An adjustment is made by a set, pre-determined number of points. The NAP funding opportunity, HRSA-11-017, has three funding priorities:

High Poverty Application (1- 5 points): In order to be considered for this Funding Priority, an applicant must demonstrate that the Percent of Population at or below 100 percent of poverty **exceeds 30 percent** in the entire service area to be served by the proposed New Access Point. A maximum of 5 priority points will be added to the total score based on the scale below. When determining whether the service area meets the Funding Priority for *High Poverty*, the entire, defined service area for the application must be considered in whole (e.g., all of the census tracts/zip codes for the entire service area, not just a specified few census tracks/zip codes within the proposed service area). **Applicants requesting consideration of a Funding Priority MUST indicate the request on FORM 1-A, and provide specific documentation (e.g., information from the Census Bureau) indicating that the Percent of Population for the entire service area at or below 100% of poverty exceeds 30 percent.** Data should be presented at the census tract and/or zip code level.

Percent of Population at or Below 100% of Poverty	Priority Points Received
>30% - 42%	1
>42% - 46.6%	2
>46.6% - 50.9%	3
>50.9% - 56%	4
>56%	5

Sparsely Populated Areas (5 points): In order to be considered for this Funding Priority, an applicant must (1) be requesting funding under section 330(e) of the PHS Act and (2) demonstrate that the entire service area to be served by the proposed New Access Point(s) has seven (7) or less people per square mile. Applicants requesting funding ONLY under section 330(g), section 330(h), and/or section (i) (i.e., not requesting any funding under

section 330(e)) are not eligible for this priority. When determining whether the service area meets the Funding Priority for sparsely populated, the entire, defined service area for the application must be considered in whole (e.g., all of the census tracts/zip codes for the entire service area, not just a specified few census tracks/zip codes within the proposed service area). **Applicants requesting consideration of a Funding Priority MUST indicate the request on FORM 1-A, and provide specific documentation (e.g., information from the Census Bureau) indicating that the entire area to be served has seven (7) or less people per square mile.** Data should be presented at the census tract and/or zip code level.

Special Population Application (5- 10 points): In order to be considered for this Funding Priority, an applicant must demonstrate a request for Federal section 330 funding to serve a special population(s) (i.e., migrant and seasonal farmworkers under section 330(g), people experiencing homelessness under section 330 (h) and/or residents of public housing (section 330(i)) that is at least 25 percent of the total Federal section 330 funds requested as documented on Form 1B. A maximum of 10 points will be added to the total score based on the scale below. **Applicants requesting consideration of a Funding Priority must indicate the request on FORM 1-A and demonstrate on Form 1B a request for special population(s) funding (section 330(i), section 330(h), and/or section 330(g)) that is at least 25 percent of the total requested section 330 funds.**

Percent of Targeted Funding to Serve Special Populations	Priority Points Received
≥25% - 35%	5
>35% - 45%	6
>45% - 55%	7
>55% - 65%	8
>65% - 75%	9
>75%	10

Funding Special Considerations

HRSA intends to achieve a wide distribution of NAP awards. HRSA will consider all of the following factors, in addition to the funding priorities indicated above, in making awards for NAPs in FY 2011.

RURAL/URBAN DISTRIBUTION OF AWARDS:

Aggregate awards in FY 2011 to serve rural and urban areas will be made to ensure that no more than 60 percent and no fewer than 40 percent of the people served come from either rural or urban areas.

PROPORTIONATE DISTRIBUTION

Aggregate awards in FY 2011 to support the various types of health centers (i.e., section 330(e) Community Health Centers, section 330(g) Migrant Health Centers, section 330(h)

Health Care for the Homeless Health Centers, and section 330(i) Public Housing Primary Care 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.

GEOGRAPHIC CONSIDERATION:
The goal of the HRSA in making this funding announcement is to expand the current safety net on a national basis by creating new access points in areas not currently served by federally funded health centers. Therefore, the HRSA will consider geographic distribution and the extent to which an area may currently be served by another section 330 health center when deciding which applications to fund.

3. Anticipated Announcement and Award Dates

One application cycle has been announced for NAP applications for FY 2011. It is the responsibility of the applicant to ensure that the complete application is submitted through Grants.gov and HRSA's EHBs by the published due dates. Applications under HRSA-11-017 received in Grants.gov by 8:00 pm on November 17, 2010 deadline and in the EHB by 5:00 pm on December 15, 2010 will be reviewed with funding decisions announced in 2011. Applications submitted electronically or E-marked in Grants.gov after November 17, 2010 or in HRSA's EHB after December 15 2010, will not be accepted for review.

VI. Award Administration Information

1. Award Notices

Each applicant will receive written notification of the outcome of the objective review process, including a summary of the expert committee's assessment of the application's merits and weaknesses, and whether the application was selected for funding. Applicants who are selected for funding may be required to respond in a satisfactory manner to Conditions placed on their application before funding can proceed. Letters of notification do not provide authorization to begin performance.

The Notice of Award sets forth the amount of funds granted, the terms and conditions of the grant, the effective date of the grant, the budget period for which initial support will be given, the non-Federal share to be provided (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant agency's Authorized Representative, and reflects the only authorizing document. It will be sent prior to the 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 awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable based on recipient type and purpose of award. This includes, as applicable, any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at http://www.hrsa.gov/grants/. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award).

Cultural and Linguistic Competence
HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, materials delivered by competent providers in a manner that factors in the language needs, cultural richness, and diversity of populations served. Quality also means that, where appropriate, data collection instruments used should adhere to culturally competent and linguistically appropriate norms. For additional information and guidance, refer to the National Standards for Culturally and Linguistically Appropriate Services in Health Care published by HHS. This document is available online at http://www.omhrc.gov/CLAS.

Trafficking in Persons
Awards issued under this guidance are subject to the requirements of Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to http://www.hrsa.gov/grants/trafficking.html. If you are unable to access this link, please contact the Grants Management Specialist identified in this guidance to obtain a copy of the Term.

HRSA Guidance on Preparations for the 2nd Phase of the Novel H1N1 Influenza
HRSA has been working with HHS, other Federal agency partners, grantees and grantee associations to get ready for the upcoming flu season. "H1N1 Guidance for HRSA Grantees," which can be found at www.hrsa.gov/h1n1/, is voluntary guidance intended primarily for HRSA-funded direct service grantees and their sub grantees and contractors, although other HRSA grantees may also find the information useful. This guidance may also be of interest to eligible 340B entities and HRSA's cooperative agreement partners.

HRSA is providing this to help HRSA–funded programs plan how to best protect their workforce and serve their communities. HRSA will continue to monitor evolving pandemic preparedness efforts and work to provide guidance and information to grantees and grantee associations as it becomes available. Products and updates in support of H1N1 pandemic response efforts will be posted to www.hrsa.gov/h1n1/ as soon as they are released.

PUBLIC POLICY ISSUANCE

HEALTHY PEOPLE 2010/2020
Healthy People 2010/2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The initiative has two major goals: (1) To increase the quality and years of a healthy life; and (2) Eliminate our country's health disparities. The program consists of 28 focus areas and 467 objectives. HRSA has actively participated in the work groups of all the focus areas, and is

committed to the achievement of the Healthy People 2010 goals and the updated Healthy People 2020.

Applicants must summarize the relationship of their projects and identify which of their programs objectives and/or sub-objectives relate to the goals of the Healthy People 2010 or the updated Healthy People 2020 initiatives.

Copies of the Healthy People 2010/2020 may be obtained from the Superintendent of Documents or downloaded at the Healthy People website: http://www.health.gov/healthypeople/document/.

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

3. REPORTING

The successful applicant under this guidance must comply with the following reporting and review activities:

a. **Audit Requirements**
Comply with audit requirements of the Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at http://www.whitehouse.gov/omb/circulars_default.

Health centers must maintain accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separate functions appropriate to organizational size to safeguard assets and maintain financial stability. Health centers must assure an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. (Section 330(k)(3)(D), section 330(q) of the PHS Act and 45 CFR Part 74.14(a)(4), 45 CFR Part 74.21 and 45 CFR Part 74.26)

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

c. **Status Reports**

1) Submit a **Financial Report**. A financial report is required within 90 days of the end of each grant year. It must be submitted online through the HRSA EHBs. The report is an accounting of expenditures under the project that year. More specific information will be included in the award notice;

2) Submit a **Uniform Data System (UDS) Report**. All grantees are required to submit a Universal Report and Grant Report (if applicable) annually for the UDS. This report provides data on services, staffing and financing across all section 330 health centers. The UDS is an integrated reporting system used to collect data annually on its programs to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments.

VII. Agency and National Organization Contacts

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

Angela S. Wade
Grants Management Specialist
HRSA/OFAM/DGMO/HSB
5600 Fishers Lane, Room 11A-02
Rockville, MD 20857-0001
301-594-5296 (phone)
301-443-6686 (fax)
Email: awade@hrsa.gov

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

Tiffani Redding
Office of Policy and Program Development
Bureau of Primary Health Care, HRSA
5600 Fishers Lane, Room 17C-26
Rockville, MD 20857
Telephone: 301-594-4300
Fax: 301-594-4997
Email: BPHCNAP@hrsa.gov

Additional technical assistance regarding this funding announcement may be obtained by contacting the appropriate PCA, PCO or NCA. (See http://bphc.hrsa.gov/technicalassistance/ for a list of PCAs, PCOs and NCAs.)

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
Phone: 1-800-518-4726
E-mail: support@grants.gov

Assistance with using HRSA EHBs may be obtained by contacting:

HRSA Call Center
Telephone: 1-877-GO4-HRSA (877)-464-4772. Available between 9:00 am to 5:30 pm ET
TTY: (877) 897-9910
Email: CallCenter@hrsa.gov
Online: https://grants.hrsa.gov/webexternal/home.asp and click on 'Help'

VIII. Other Information

Required Technical Assistance Set-Aside

The changing health care environment demands that key health center management staff including the Chief Executive Officer, Chief Clinical Officer, Chief Financial Officer, and Chief Information Officer, work together as a team to develop a strong organizational structure that ensures the provision of high quality health care services and supports the overall success of their project. Experience has proven that organizations that start with these attributes have the highest probability of being successful.

Each NEW START applicant is expected to budget for and set-aside a minimum of 2 percent of the expected award for technical assistance and performance improvement activities. Each new start organization that is selected for funding will be scheduled for a site visit within 150 days of grant award to assist the grantee in identifying and prioritizing areas of technical assistance. Successful new applicants will be expected to submit a TA work plan and budget to their project officer following this visit. Both the HRSA project officer and the PCA contact are available to assist in identifying training and technical assistance opportunities. Examples of areas of technical assistance and training activities include administration; staffing/human resources; governance; managed care; financial management; Management Information Systems (MIS); clinical management; and quality/performance improvement.

Federal Tort Claims Act Coverage/Medical Malpractice Insurance

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

Organizations should be aware that participation in the FTCA program is not guaranteed. If an applicant is not absolutely certain it can meet the requirements of the Act, the costs associated with the purchase of malpractice insurance should be included in the proposed budget. The search for malpractice insurance, if necessary, should begin as soon as possible. All applicants interested in FTCA will need to submit a new application annually to be deemed. Applicants are

encouraged to review PIN 99-08: Health Centers and the Federal Tort Claims Act (Signed April 12, 1999), and contact the toll free hotline 866-FTCA-HELP (866-382-2435) if they have additional questions.

340B Drug Pricing Program

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

IX. Tips for Writing a Strong Application

A concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at http://www.HHS.gov/ASRT/OG/Grantinformation/Apptips.html.

X. Health Center Program: Terms and Definitions

A consolidated list of Terms and Definitions for the Health Center Program may be found online at http://www.hrsa.gov/grants/apply/assistance/nap. HRSA recommends the use of this resource in conjunction with the Glossary in the HHS Grants Policy Statement available at http://www.hrsa.gov/grants/default.htm.

APPENDIX A: Program Specific Form Instructions for NAP

The BPHC Program-Specific forms MUST BE completed electronically in the HRSA EHBs (see chart in Section IV of this guidance, Content and Form of Application Submission). "Forms" refer to those documents that are completed online in the system and DO NOT require any downloading or uploading. "Documents" are those requirements that must be downloaded in the template provided, completed, and then uploaded into the system. Only in cases with an approved paper waiver by the Division of Grants Policy may an Applicant print Program Specific Forms and Documents and complete offline. Please note that only these forms which are available via the online application, approved by the U.S. Office of Management and Budget, should be submitted with the application. See http://www.hrsa.gov/grants/apply/assistance/nap for copies of the forms to be completed in the EHB.

Please note the following:

- Forms 1, 2, 3, 4, 5, 6A, 6B, 8, 9, 10 and 12 are required for all applicants.
- Any portions of the Program Specific Forms that are "blocked/grayed-out" are not relevant to the NAP application and DO NOT need to be completed.

➢ FORM 1A – GENERAL INFORMATION WORKSHEET

Form 1A provides a summary of information related to the proposed NAP project, including specific applicant information, the proposed service area, target population, service type, current and projected patient and visits, and applicable funding factors. The following instructions are intended to clarify the information to be reported in each section of the form.

- Applicants with more than one proposed new access point should report aggregate data for all of the sites included in the proposed NAP application.
- New start applicants proposing one or more new access points should report combined data for all of the sites to be included under the scope of project.
- Satellite applicants should provide data for the proposed NEW ACCESS POINT(S) ONLY.
- "Current" refers to the number of patients and/or visits served by the organization at the time of application. "Projected at the End of the Project Period" refers to the number of patients and/or visits by the new access point(s) at the end of the two year project period.
- If a new access point(s) is already operational, report the current number of patients/visits, as well as the projected number of patients and visits after 2 years of operation. If the new access point (s) is not operational, report current number as "0".
- Applicants that were awarded section 330 funding for the first time under the Recovery Act are considered to be an existing section 330 grantee and may apply as a satellite applicant for HRSA-11-017.

1. APPLICANT INFORMATION

- Complete all relevant information that is not automatically pre-populated. Note that Grant and UDS Numbers are ONLY applicable for satellite applicants.
- 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 only.

- Applicants may select more than one category for the Organization Type section.

2. PROPOSED SERVICE AREA:

2a. Service Area Designation:

- Select the designation(s) which best describe the proposed service area. Multiple selections are allowed. For inquiries regarding Medically Underserved Areas or Medically Underserved Populations, please call 1-888-275-4772. Press option 1, then option 2 or contact the Shortage Designation Branch via email sdb@hrsa.gov or 301-594-0816. For additional information, visit the HRSA Bureau of Health Professions Shortage Designation website at http://bhpr.hrsa.gov/shortage/.
- Select the type of funding requested (i.e., section 330(e), section 330(g), section 330(h), and/or section 330(i)).

2b. Target Population Type: Classify the proposed target population type as Rural or Urban.

2c. Target Population and Provider Information: ***For all portions of this section, applicants with more than one proposed new access point should report aggregate data for all of the sites included in the proposed project.***

Target Population Information:

- Provide the estimated number of individuals currently composing the service area and target population.

Provider FTEs by Type:

- **Provide a count of Billable Provider FTEs ONLY** (e.g., physician, nurse practitioner, physician assistant, certified nurse midwife, psychiatrist, psychologist, dentist).
- "Projected at the End of the Project Period" refers to the number of FTEs as a result of the NAP application at the end of the two year project period.
- Do not report provider FTEs outside the organization's proposed scope of project.

Patients and Visits by Service Type:

- "Projected at End of the Project Period" refers to the number of patients and/or visits anticipated as a result of the NAP application at the end of the project period.
- Do not report patients and visits for services outside the organization's proposed scope of project.
- Data reported for patients and visits should not be duplicated WITHIN each of the four categories (i.e., Medical, Dental, Mental Health, and Substance Abuse). Within each category, an individual can only be counted once as a patient. However, an individual who receives multiple types of services should be counted as a patient for EACH service type for which services were rendered (i.e., data reported for patients and visits should be duplicated ACROSS each of the four categories). For example, if an individual is a patient receiving both mental health and dental services, then this individual would be recorded as a patient (and

encounter) in both the mental health and dental categories. *Note: Please use the following guidelines when providing data regarding patients and visits:*

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

Patients and Visits by Population Type:

- "Projected at End of the Project Period" refers to the number of patients and/or visits anticipated as a result of the NAP application at the end of the project period.
- Do not report patients and visits for services outside the organization's proposed scope of project.
- Data reported for patients and visits should not be duplicated WITHIN or ACROSS the four Target Population Categories (i.e., General Community, Migrant/Seasonal Farm Workers, Public Housing Residents, Homeless Persons). *Please use the guidelines a-c above when providing data regarding patients and visits.* 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)).

3. FUNDING PRIORITIES

Sparsely Populated Areas (5 points, see section V.2, Review and Selection Process). Applicants requesting consideration of a Funding Priority must indicate the request on FORM 1-A and provide documentation (e.g., information from the Census Bureau) indicating that the entire area to be served has seven (7) or less people per square mile. Data should be presented at the census tract and/or zip code level.

High Poverty Application (1 to 5 points; see section V.2, Review and Selection Process). Applicants requesting consideration of a Funding Priority must indicate the request on FORM 1-A and provide documentation (e.g., information from the Census Bureau) indicating that the Percent of Population at or below 100% of poverty exceeds 30 percent in the entire service area to be served by the proposed project. Data should be presented at the census tract and/or zip code level.

Special Population Application (5 to 10 points, see section V.2, Review and Selection Process). Applicants requesting consideration of a Funding Priority must indicate the request on FORM 1-A and demonstrate on Form 1B a request for special population(s) funding (section 330(i), section 330(h), and/or section 330(g)) that is at least 25 percent of the total requested section 330 funds.

- **FORM 1B – BPHC-FUNDING REQUEST SUMMARY**
  Year 2 on Form 1B will be pre-populated from the data provided by the applicant in Section E of the 424A. Applicants are required to enter budget information for year 1, including any one-time funds that are being requested for minor alteration and renovation, which may include the installation of equipment. *Applicants will not be allowed to modify the pre-populated data on this form, however applicants may modify the 424A to correct any errors identified in a review of Form 1B.* Applicants should indicate what portion of the total Federal funding requested in each of the years under any or all of the program types (i.e., CHC, MHC, HCH, and/or PHPC). The specified types of health centers on this form will constitute a request for funding under that section 330 program.

- **FORM 1C – DOCUMENTS ON FILE**
  Documents categorized under "Documents on File" must be kept at the applicant organization and should be made available to HRSA upon request within 3-5 business days. **DO NOT** include these items as part of the NAP application. Provide the date that each document was last revised.

- **FORM 2 – PROPOSED STAFF PROFILE**
  The Staffing Profile reports personnel salaries supported by the total budget for **each year** of the proposed NAP project. **New Start applicants should include staff for the entire scope of the project (i.e., total for all new access point(s)). Satellite applicants should include a staffing profile for ONLY the new access point(s) being proposed.**
  - Salaries in categories representing multiple positions (e.g., LPN, RN) should be averaged.
  - The amount for total salaries in the last column of the Staffing Profile should equal the amount allocated under the "Personnel" category of the 424A, Section B and should be consistent with the amounts included in the detailed budget justification.
  - See Application Format, Section IV for additional information.

- **FORM 3 – INCOME ANALYSIS FORM**
  The Income Analysis Form must be completed for **each year** of the proposed project.

  The Income Analysis Form displays the estimated non-Federal revenues **(all other sources of income ASIDE FROM the section 330 grant funds)** for the application budget. Any specific entries that require additional explanation (e.g., projections that include reimbursement for billable events that are not counted as visits) should be discussed in the "Comments/Explanatory Notes" box at the bottom of page 2 of the form and if necessary, detailed in the Budget Justification. Applicants should not use this form to provide additional narrative beyond that was included in the Program Narrative. The worksheet must be based on the proposed NAP project. *It may not include any grant funds from any pending supplemental grants or other unapproved changes in sites, services or capacity.*

  There are two major classifications of revenues, Program Income and Other Income.
  - **Part 1: Program Income** includes fees, premiums and third party reimbursements and payments generated from the projected delivery of services. Program income is divided into two types of income: Fee for Service and *capitated* Managed Care.

- **Part 2: Other Income** includes State, Local or other Federal grants (e.g., Ryan White, HUD, Head Start) or contracts and local or private support that is NOT generated from charges for services delivered.

If the categories in the worksheet do not describe all possible categories of Program or Other Income, such as "pharmacy", applicants may add lines for any additional income source <u>if necessary.</u> Clarifications for these additions may be noted in the "Comments/Explanatory Notes" box at the bottom of page 2 of the form.

<u>PART 1: PROGRAM INCOME</u>

NOTE: *This form reports only on those visits which are billable to first or third parties including individuals who, after the schedule of discounts/sliding fee scale, may pay little or none of the actual charge. Please see http://www.hrsa.gov/data-statistics/health-center-data/index.html for additional information.*

Projected Fee for Service Income
Lines 1a.-1e. and 2a. – 2b. (Medicaid and Medicare): Show income from Medicaid and Medicare *regardless of whether there is another intermediary involved.* For example, if the applicant has a Blue Cross fee-for-service managed Medicaid contract, the information would be included on lines 1a.-1e., not on lines 3a.-3c. If the SCHIP is paid through Medicaid, it should be included in the appropriate category on lines 1a-1e. In addition, if the applicant receives Medicaid reimbursement via a Primary Care Case Management (PCCM) model, this income should be included on line 1e. "Medicaid: Other Fee for Service."

Line 5 (Other Public): Include here any SCHIP program NOT paid through the Medicaid program as well as any other state or local programs that pay for visits including Title X family planning visits, CDC's Breast and Cervical Cancer Early Detection Program, Title I and II Ryan White visits, etc.

Column (a): Enter the number of billable visits that will be covered by each category and payment source: Medicaid, Medicare, other third-party payors and uninsured self-pay patients.

Column (b): Enter the average charge per visit by payor category. An analysis of charges will generally reveal different average charges; for example, Medicare charges may be higher than average Medicaid EPSDT charges. If this level of detail is not available, averages may be calculated on a more general level (i.e., at the payor or service type or agency level.)

Column (c): Enter Total Gross Charges before any discount or allowance for each payment category calculated as [columns (a)*(b)].

Column (d): Enter the average adjustment to the average charge per visit in column (b). A negative number reduces and a positive number increases the Net Charges calculated in column (e). (In actual operation, adjustments may be taken either before or after the bill is submitted to a first or third party.) Adjustments reported here do NOT include adjustments for bad debts. These are shown in columns (f) and (g). Adjustments in column (d) include those related to:

a) Projected contractual allowances or discounts to the average charge per visit.
b) Sliding discounts given to self-pay patients (with incomes 0 to 200% of the FPL as applicable).
c) Adjustments to bring the average charge up/down to the negotiated FQHC or Prospective Payment System established reimbursement rate or the cost based reimbursement expected after completion of a cost reimbursement report.
d) Any other applicable adjustments. These should be discussed in the "Comments/Explanatory Notes" box at the bottom of page 2 of the form.

Column (e): Enter the total Net Charges by payment source calculated as [columns c-(a*d)]. Net charges are gross charges less adjustments described in column (d).

Column (f): Enter the estimated collection rate (%) by payor category. The collection rate is the amount projected to be collected divided by the amount actually billed. As a rule, collection rates will not exceed 100%, and may be less than 100% due to factors such as bad debts (especially for self pay), billing errors, or denied claims not re-billable to another source. Explain any rate greater than 100% using the "Comments/Explanatory Notes" section of the form.

> **NOTE:** *Do not show sliding discount percentages here – they are included in column (d); do show the collection rate for actual direct patient billings.*

Column (g): Enter Projected income for each payor category calculated as:
column (e) * column (f)

Column (h): Enter the actual accrued income by payor category for the most recent 12-month period for which data are available. Any significant variance between projected income (column g) and actual accrued income (column h) should be explained in the SUPPORT REQUESTED review criterion in the Program Narrative portion of the application.

Projected Capitated Managed Care Income

This section applies only to capitated programs. Visits provided under a fee-for-service managed care contract are included in the fee-for-service section of this Form. Note also, that unlike the fee-for-service section of this Form, applicants will group together all types of services on a single line for the type of payor. Thus, capitated Medicaid dental visits and capitated Medicaid medical visits are added together and reported on line 7a.

Number of Member Months (Column a): "Member months" are the number of member months for which the applicant receives payment. One person enrolled for one month is one member month; a family of five enrolled for six months is 30 member months. A member month may cover just medical services or medical and dental or an even more unique mix of services. Unusual service mixes which provide for unusually high or low PMPM payments should be described in the notes section.

Rate per Member Month (Column b): Also referred to as PMPM rate. This is the average payment across all managed care contracts for one member. PMPM rates may

actually be based on multiple age/gender specific rates or on service specific plans, but all these should be averaged together for a "blended rate" for the provider type.

Risk Pool Adjustment (Column c): This is an *estimate* of the *total* amount that will be earned from risk or performance pools. It includes any payment made by the HMO to the applicant for effectively and efficiently managing the health care of the enrolled members. It is almost always for a prior period, but must be accounted for in the period it is received. Describe risk pools in the narrative. Risk pools may be estimated by using the average risk pool receipt PMPM over an appropriate prior period selected by the applicant.

FQHC and Other Adjustments (Column d): This is the *total* amount of payments made to the applicant to cover the difference between the PMPM amount paid for Medicaid or Medicare managed care visits and the applicant's PPS/FQHC rate.

Projected Gross Income (Column e): Column e is calculated for each line as: [column (a)* column (b)] + [column c + column d] = e.

PART 2: OTHER INCOME

This category includes **all non-section 330 income not entered elsewhere on this table.** It includes grants for services, construction, equipment or other activities that support the project, *where the revenue **is not** generated from services provided or visit charges. It also includes income generated from fundraising and contributions, foundations, etc.*

Line 9. "Applicant" refers to any income generated by the applicant through the expenditure of its OWN assets such as income from reserves or realized sale of property.

Please note that in-kind donations should NOT be included in the Income Analysis; however applicants may discuss in-kind contributions as applicable, in the Program Narrative.

- **FORM 4 – COMMUNITY CHARACTERISTICS**

The Community Characteristics form reports service area and target population data for the entire scope of the project (i.e., all proposed sites) for the most recent period for which data are available. New Start applicants should display characteristics for the entire scope of the project (i.e., total for all sites). Satellite applicants should include characteristics for ONLY the new access point(s) being proposed.

Service area and target population data should reflect all counties, cities, etc., in the applicant's proposed project. Service area data should include the total number of persons and the percent of the total population for each characteristic. Target population data is most often a subset of the service area data. Target population should include the number of persons and the percent of the total population the applicant **targets** for each characteristic. If information for your service area is not available, utilize data from U.S. Census Bureau, local planning agencies, health departments and other local, State and national data sources. **Estimates are acceptable.** *Do not utilize patient data to report target population data.*

RACE:
Report race and ethnicity for all individuals to be served. The total number of individuals in the "Hispanic or Latino Identity" ethnicity section must equal the total number of individuals in the "Race" section total:

- Report the number of individuals in each racial category.
- All individuals must be classified in one of the racial categories (including "Unreported / refused to report"). This includes individuals who *also* consider themselves to be "Latino" or "Hispanic". If your data system has not separately classified these individuals by race, then report them all as "race unreported."
- Individuals are further divided on the Race table into separate ethnic categories:
  - Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
  - Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, or other Pacific Islands.
  - Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
  - American Indian/Alaska Native should be considered to include persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

HISPANIC OR LATINO IDENTITY (Ethnicity)

- Report on the "Hispanic or Latino" line persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- If the individual is not a member of one of the cultures or origins listed in the bullet above then include them in the "Unreported" line.

Please note that all information provided regarding race and/or ethnicity will be used only to ensure compliance with statutory and regulatory Governing Board requirements. Data on race and/or ethnicity collected on this form will not be used as an awarding factor.

- **FORM 5A – SERVICES PROVIDED**

Form 5A identifies the required and additional services that will be available through the proposed new access point(s) and how these services will be provided (i.e., Applicant, Agreement, Referral). Only one form is required for the entire application.

Information presented on Form 5A in the application will be used by HRSA to determine the Scope of Project for the NAP grant. Only those services that are included on Form 5A will be considered to be in the approved Scope of Project. Any services that are 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 even if the application is funded.

- **FORM 5B – SERVICE SITES**

Form 5B identifies the new access point(s) service sites. Provide the required data for each proposed new access point that meets the definition of a service site (see Terms and Definitions at http://www.hrsa.gov/grants/apply/assistance/nap). Refer to PIN 2008-01

Defining Scope of Project and Policy for Requesting Changes available at www.bphc.hrsa.gov/policy/pin0801/ for more information on defining sites and for special instructions for recording mobile, intermittent or other site types.

Information presented on Form 5B in the application will be used by HRSA to determine the Scope of Project for the NAP grant. Only those sites that are included on Form 5B will be considered to be in the approved Scope of Project. Any sites that are 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 even if the application is funded.

- **FORM 5C – OTHER ACTIVITIES/LOCATIONS**

  Refer to PIN 2008-01 Defining Scope of Project and Policy for Requesting Changes available at www.bphc.hrsa.gov/policy/pin0801 (page 7) to determine those activities or locations that should be listed on this form. Only those other activities related to the new access point(s) that (1) do not meet the definition of a service site, (2) are conducted on an irregular timeframe/schedule, and/or (3) offer a limited activity from within the full complement of health center activities included within the scope of project, should be listed on Form 5C. New access point service site(s) should be listed on Form 5B.

  Information presented on Form 5C in the application will be used by HRSA to determine the Scope of Project for the NAP grant. However, regardless of what information is included in Form 5C, only those Services included in Form 5A and those Service Sites included on Form 5B will be considered part of the approved scope of project. Any additional activities that are 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 even if the application is funded.

- **FORM 6A – CURRENT BOARD MEMBER CHARACTERISTICS**
  - All applicants (with the exception of Tribal organizations) must complete the Board Member Characteristics form.
  - Applicants must list all current board members and provide information on all characteristics as requested.
  - Public entities with co-applicant health center governing boards should list the co-applicant board members on Form 6A.
  - Applicants requesting a waiver of the 51% consumer majority composition requirement must list the health center's board members on Form 6A, not the members of their advisory council(s) if they have one.

- **FORM 6B – REQUEST FOR WAIVER OF GOVERNANCE REQUIREMENTS**
  - All applicants must complete Question 1A on Form 6B (at a minimum).
  - Tribal entities are exempt from Governance Requirements and should indicate "non-applicable" on Question 1A for Form 6B.
  - An applicant that currently receives or is applying to receive section 330(e) Community Health Center funding should indicate "no" on Question 1A for Form 6B.
  - The remainder of Form 6B only needs to be completed by NAP applicants requesting a governance waiver for 51% consumer/patient majority and/or monthly meetings.

- Only applicants requesting targeted funding to ***solely*** serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330 (h)) and/or residents of public housing (section 330(i)) and that are NOT requesting Community Health Center (section 330(e)) funds are eligible for a waiver request.
- Applicants currently receiving section 330 funding with an existing waiver must reapply for governance waiver approval as part of their NAP application by completing and submitting Form 6B.

Note: *An approved waiver does not absolve the organization's governing board from fulfilling all other statutory board responsibilities and requirements.*

Applicants must clearly describe on Form 6B why the project cannot meet the statutory requirements requested to be waived and describe the appropriate alternative strategies detailing how the program intends to assure consumer/patient participation (if board is not 51 percent consumer/patients) and/or regular oversight (if no monthly meetings) in the direction and ongoing governance of the organization.

Waiver of Consumer/Patient Majority:
If the consumer/patient majority is requested to be waived, the applicant must briefly discuss why the project cannot meet this requirement and describe the alternative mechanism(s) for gathering consumer/patient input (e.g., separate advisory boards, patient surveys, focus groups). Areas of discussion should include:

- Specifics on the type of consumer/patient input to be collected.
- Methods for documenting such input in writing.
- Process for formally communicating the input directly to the organization's governing board (e.g., quarterly presentations of the advisory group to the full board, quarterly summary reports from consumer/patient surveys).
- Specifics on how the consumer input will be used by the governing board in such areas as: 1) selecting services; 2) setting operating hours; 3) defining strategic priorities; 4) evaluating the organization's progress in meeting goals, including patient satisfaction; and 5) other relevant areas of governance that require and benefit from consumer input.

Waiver of Monthly Meetings
If monthly meetings are requested to be waived, the applicant must briefly discuss why the project cannot meet this requirement and describe and outline the proposed alternative schedule of meeting and how the alternative schedule will assure that the board can still maintain appropriate oversight and operation of the project.

- **FORM 8 - HEALTH CENTER AFFILIATION CERTIFICATION AND HEALTH CENTER AFFILIATION CHECKLIST**

Responses beyond Question 1 are required for CHC and/or MHC applicants only. Applicants must indicate whether any of the identified affiliation arrangements are currently present or proposed. Applicants must also report on each organization with which they have identified any present or proposed affiliation arrangements and complete the checklist as applicable. This information will be used to assure that organizations receiving section 330 funds are compliant with the requirements and guidelines set forth in PINs 97-27: Affiliation

Agreements of Community and Migrant Health Centers and 98-24: Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers (available at http://www.bphc.hrsa.gov/policy/). Applicants that respond "no" to any question in the Staffing or Governance section of Form 8: Health Center Affiliation Checklist must clearly discuss the specific situation(s). In addition, applicants should provide evidence of 'reference documents' for each of the requirements and guidelines listed on Form 8. Evidence should include the name of the 'reference document' which contains evidence of the specific requirement/guideline, as well as the specific application page number(s) where the documentation may be found.

A summary of all subrecipient arrangements, contracts and affiliations agreements must be included in Attachment 7: Summary of Contracts, Agreements and Subrecipient Arrangements (if applicable).

➢ FORM 9 - NEED FOR ASSISTANCE (NFA) WORKSHEET

I. GENERAL INSTRUCTIONS FOR COMPLETING FORM 9

All applicants must submit a completed NFA Worksheet (Form 9) as part of the application. Applicants must present data on the NFA Worksheet based ***the target population to be served within the proposed service area***, as appropriate. (See Section III below, Population to be Served, for additional information.) Only one NFA Worksheet will be submitted regardless of the number of new access points proposed in the application.

- **New start applicants** are expected to complete the NFA Worksheet based on the entire proposed scope of their project.
- **Satellite applicants** are expected to complete the NFA Worksheet based on their **proposed new service delivery site(s) ONLY.**
- If an applicant proposes to serve **multiple sites, populations and/or service areas**, the NFA Worksheet responses should represent the total targeted population within the proposed service area. Different values for different sites/populations/service areas may be combined using population weighting described below. **No more than one response should be submitted for any barrier or health indicator.**

Guidelines for Completing the NFA Worksheet:

- If no response or data source is provided for a particular barrier or health indicator, or if the data source and date for the response are not provided, **NO** points will be awarded for that barrier or health indicator.
- All responses must be expressed as a finite number (e.g., 212.5) and cannot be presented as a range (e.g., 31-35).
- Responses to all indicators must be expressed in the *same format/unit of analysis* identified in the specific barrier or health indicator (e.g., a mortality ratio cannot be used to provide a response to "age-adjusted death rate"). The following table provides examples of the unit and format of responses:

Format/Unit of Analysis	Example
Percent	25% (25 percent of target population is uninsured)
Prevalence (expressed as percent or rate)	8.5% (8.5 percent of population has asthma) **or** 85 per 1,000 (85 asthma cases per 1,000 population)
Proportion	0.25 (25 out of 100 people, or 25% of all persons, are obese)
Rate	50 per 100,000 (50 hospital admissions for hypertension per 100,000 population)
Ratio	3000:1 (3000 people per every 1 primary care physician)

II. CONVERSION OF NFA WORKSHEET SCORE TO APPLICATION SCORE:

The NFA Worksheet will be scored using the criteria below. The converted NFA Worksheet score will account for up to 20 points out of 100 total points in the overall score for the application. The NFA Worksheet score of up to 100 points will be converted to the Need: Part A using the following Conversion Table.

NFA WORKSHEET TO APPLICATION SCORE CONVERSION TABLE

NFA Worksheet Score (Maximum 100 Points)		Application Need: Part A Score (Maximum 20 Points)
100-96	=	20
95-91	=	19
90-86	=	18
85-81	=	17
80-76	=	16
75-71	=	15
70-66	=	14
65-61	=	13
60-56	=	12
55-51	=	11
50-46	=	10
45-41	=	9
40-36	=	8
35-31	=	7
30-26	=	6
25-21	=	5
20-16	=	4
15- 11	=	3
10- 6	=	2
5- 1	=	1

III. POPULATION TO BE SERVED:

All responses must be based on data for the total target population within the proposed service area, as appropriate, per the following criteria:

(a) Applicants requesting funding to serve the medically underserved population of a service area **(under section 330(e) ONLY)** must provide responses that reflect the health care needs of the target population for the application. When the service area

is a sub-county area (made up of groups of census tracts, other county divisions or zip codes), but data for a particular Barrier or Health indicator are not available at sub-county levels, applicants may use an extrapolation technique to appropriately modify the available county-level or other level (including if necessary, national) data to reflect the service area population.

(b) Applicants requesting funding to serve **ONLY a homeless population (under section 330 (h)), a migrant/seasonal farmworkers population (under section 330(g)) or residents of public housing (under section 330(i)), or any combination of these special populations**, may use an extrapolation technique to appropriately modify available data for these special populations to reflect their specific population(s) within the proposed service area.

(c) Applicants requesting funding to **serve a homeless population (under section 330 (h)), a migrant/seasonal farmworker population (under section 330(g)) or residents of public housing (under section 330(i)) IN COMBINATION WITH the medically underserved, general population of a service area (under section 330(e))**, must present responses that reflect the total population to be served. In calculating the response, applicants may use extrapolation techniques to appropriately modify available data to reflect the homeless, migrant/seasonal farmworker and/or public housing population within the service area (as in (b) above), then combine this with data the general population within the defined the service area. As above, where sub-county data are not available, applicants may use an extrapolation technique to modify available county-level or other level data to reflect the service area population.

IV. DATA SOURCES:

Please refer to the Data Resources for Demonstrating Need for Primary Care Services guide provided online at http://bphc.hrsa.gov/needforassistance/dataresourceguide.htm for a listing of data sources that may be helpful when completing this form. Please use the following guidelines when reporting data:

(a) All data must be from a reliable and independent source, such as a State or local government agency, professional body, foundation or other well-known organization using recognized, scientifically accepted data collection and/or analysis methods;

(b) Applicants must provide the following information for all data sources:

- Name of data source;
- The year to which the data apply;
- Description of the methodology utilized (e.g., extrapolation); and
- Any additional information of relevance

V. NFA WORKSHEET SCORING: (Maximum 100 points)

The NFA Worksheet (completed Form 9) will be scored out of a total possible 100 points. If no response or data source is provided for a Barrier or Health Indicator, no points will be awarded.

SECTION 1: CORE BARRIERS (Maximum 60 points)

A response is required for **three (3) out of the four (4) Core** Barriers listed. The points awarded for each Barrier response will be calculated using the point distributions provided below.

a. Population to One FTE Primary Care Physician

Population to One FTE Primary Physician	Points
<360	0
360 - <722	1
722 - <855	2
855 - <953	3
953 - <1045	4
1045 - <1126	5
1126 - <1211	6
1211 - <1292	7
1292 - <1392	8
1392 - <1481	9
1481 - <1575	10
1575 - <1685	11
1685 - <1836	12
1836 - <1991	13
1991 - <2175	14
2175 - <2467	15
2467 - <2840	16
2840 - <3117	17
3117 - <4110	18
4110 - <6412	19
≥6412	20

b. Percent of Population at or below 200 percent of poverty.

Percent of Population at or Below 200% of Poverty	Points
0 - <18	0
18 - <22	1
22 - <24.5	2
24.5 - <26.5	3
26.5 - <28	4
28 - <30	5
30 - <31	6
31 - <32	7
32 - <33	8
33 - <33.5	9
33.5 - <35	10
35 - <36.5	11
36.5 - <37.5	12
37.5 - <39	13
39 - <40	14
40 - <42	15
42 - <44	16
44 - <46	17
46 - <49	18
49 - <53	19
≥53	20

c. Percent of Population Uninsured

Percent of Population Uninsured	Points
0 - <5.5	0
5.5 - <6.8	1
6.8 - <7.8	2
7.8 - <8.7	3
8.7 - <9.5	4
9.5 - <10.3	5
10.3 - <11.1	6
11.1 - <11.9	7
11.9 - <12.7	8
12.7 - <13.5	9
13.5 - <14.3	10
14.3 - <15.2	11
15.2 - <16.2	12
16.2 - <17.3	13
17.3 - <18.5	14
18.5 - <19.9	15
19.9 - <21.8	16
21.8 - <24.0	17
24.0 - <27.7	18
27.7 - <31.1	19
≥31.1	20

d. Distance (miles) OR travel time (minutes) to nearest primary care provider accepting new Medicaid patients and/or uninsured patients

Average distance (miles)	Average Travel time minutes)	Points
<13.2	<22	0
13.2 - <14.4	22 - <24	1
14.4 - <15.6	24 - <26	2
15.6 - <16.8	26 - <28	3
16.8 - <18.0	28 - <30	4
18.0 - <19.2	30 - <32	5
19.2 - <20.4	32 - <34	6
20.4 - <21.6	34 - <36	7
21.6 - <22.8	36 - <38	8
22.8 - <24.0	38 - <40	9
24.0 - <25.2	40 - <42	10
25.2 - <26.4	42 -<44	11
26.4 - <27.6	44 - <46	12
27.6 - <28.8	46 - <48	13
28.8 - <30.0	48 - <50	14
30.0 - <31.2	50 - <52	15
31.2 - <32.4	52 - <54	16
32.4 - <33.6	54 -<56	17
33.6 - <34.8	56 - <58	18
34.8 - <36.0	58 - <60	19
≥36.0	≥60	20

SECTION 2: CORE HEALTH INDICATORS (Maximum 30 points)

Applicant should provide a response to **one (1)** core health indicator **from within each of the six (6) categories**: Diabetes, Cardiovascular Disease, Cancer, Prenatal and Perinatal Health, Child Health, and Behavioral and Oral Health. The table below provides national benchmark and severe benchmark data for each indicator within the six (6) categories.

Applicants will receive four (4) points for each category response if it exceeds the corresponding national benchmark and an additional one (1) point if the response also exceeds the corresponding severe benchmark provided below.

If an applicant believes that none of the specified indicators represent the applicant's service area or target population, the applicant may propose to use an "Other" alternative for that core health indicator category. In such a case, the applicant must specify the indicator's definition, data source used, proposed benchmark to be used, source of the benchmark, and rationale for using this alternative indicator. However, if an "Other" indicator is used, the applicant will NOT be eligible for any additional points for exceeding a "severe" benchmark

CORE HEALTH INDICATOR CATEGORIES	National Benchmark 4 Points Awarded	Severe Benchmark 1 Additional Point Awarded
1. Diabetes		
1(a) Diabetes Short-term Complication Hospital Admission Rate	46.7 per 100,000	82 per 100,000
1(b) Diabetes Long-term Complication Hospital Admission Rate	112.6 per 100,000	180.2 per 100,000
1(c) Uncontrolled Diabetes Hospital Admission Rate	27.2 per 100,000	61.1 per 100,000
1(d) Rate of Lower-extremity Amputation Among Patients with Diabetes	37.5 per 100,000	65.7 per 100,000
1(e) Age Adjusted Diabetes Prevalence	6.5%	7.8%
1(f) Adult Prevalence	23%	24.5%
1(g) Diabetes Mortality Rate[18]	26 per 100,000	35 per 100,000
1(h) Other	Provided by Applicant	
2. Cardiovascular Disease		
2(a) Hypertension Hospital Admission Rate	50.2 per 100,000	99.5 per 100,000
2(b) Congestive Heart Failure Hospital Admission Rate	502.8 per 100,000	753.6 per 100,000
2(c) Angina without Procedure Hospital Admission Rate	82.3 per 100,000	160.3 per 100,000
2(d) Mortality from Diseases of the Heart[19]	240.8 per 100,000	271 per 100,000
2(e) Proportion of Adults reporting diagnosis of high blood pressure	24.8%	27.7%
2(f) Other	Provided by Applicant	
3. Cancer		
3(a) Cancer Screening – Percent of women 18 and older with No Pap test in past 3 years	16.0%	13.8%
3(b) Cancer Screening – Percent of women 40 and older with No Mammogram in past 3 years	25.3%	27.8%
3(c) Cancer Screening – Percent of adult 50 and older with No Fecal Occult Blood Test within the past 2 years	75.9%	78.3%
3(d) Other	Provided by Applicant	
4. Prenatal and Perinatal Health		
4(a) Low Birth Weight Rate (5 year average)	6.0%	9.8%
4(b) Infant Mortality Rate (5 year average)	6.9/1000 births	9.1/1000 births
4(c) Births to Teenage Mothers (ages 15-19; Percent of all births)	6.3% of births	9.2% of births
4(d) Late entry into prenatal care (entry after first trimester; Percent of all births)	16%	20%
4(e) Cigarette use during pregnancy (Percent of all pregnancies)	10.7%	14.3%
4(f) Other	Provided by Applicant	
5. Child Health		
5(a) Pediatric Asthma Hospital Admission Rate	164.6 per 100,000	347.1 per 100,000
5(b) Percent of Children not tested for elevated blood lead levels by 36 months of age	<15%	<7%
5(c) Percent of children not receiving recommended immunizations: 4-3-1-3-3[20]	17.95%	21.4%
5(d) Other	Provided by Applicant	

[18] Number of deaths per 100,000 reported as due to diabetes as the underlying cause or as one of multiple causes of death (ICD-9 Code 250).

[19] Total number of deaths per 100,000 reported as due to heart disease (includes ICD-9 Codes I00-I09, I11, I13, and I20-I51).

[20] 4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B

CORE HEALTH INDICATOR CATEGORIES (Cont.)	National Benchmark 4 Points Awarded	Severe Benchmark 1 Additional Point Awarded
6. Behavioral and Oral Health		
6(a) Depression Prevalence	9.1%	12.8%
6(b) Suicide Rate	11/100,000	16/100,000
6(c) Youth Suicide attempts requiring medical attention	2.6%	3.6%
6(d) Percent of Adults with Mental disorders not receiving treatment	52%	63%
6(e) Any Illicit Drug Use in the Past Month (Percent of all Adults)	8.25%	9.3%
6(f) Heavy alcohol use (Percent among population 12 and over)	6.8%	7.5%
6(g) Homeless with severe mental illness (Percent of all homeless)	25%	30%
6(h) Oral Health (Percent without dental visit in last year)	56.69%	66%
6(i) Other	Provided by Applicant	

SECTION 3: OTHER HEALTH INDICATORS (Maximum 10 points)

Applicants must provide responses to **two (2) out of the twelve (12)** Other Health Indicators listed below. Applicants will receive five (5) points for each response that exceeds the corresponding national benchmark provided in the table below. Alternatively, applicants can propose up to two (2) of the identified indicators using an "Other" indicator. For each "Other" indicator (up to two (2)), applicants must specify the indicator's definition, data source used, proposed benchmark to be used, source of the benchmark, and rationale for using this indicator in place of one of those specified.

OTHER HEALTH INDICATORS	National Benchmark 5 Points Awarded
(a) Age-Adjusted Death Rate	870 per 100,000 population
(b) HIV Infection Prevalence	0.4%
(c) Percent Elderly (65 and older)	15.2%
(d) Adult Asthma Hospital Admission Rate	98.4 per 100,000
(e) Chronic Obstructive Pulmonary Disease Hospital Admission Rate	344.3per 100,000
(f) Bacterial Pneumonia Hospital Admission Rate	503.9per 100,000
(g) Three Year Average Pneumonia Death Rate[21]	1 per 10,000
(h) Adult Current Asthma Prevalence	7.6%
(i) Adult Ever Told Had Asthma (Percent of all adults)	13.2%
(j) Unintentional Injury Deaths	35/100,000
(k) Percent of population linguistically isolated (percent of people 5 years and over who speak a language other than English at home)	19.6%
(l) Waiting time for public housing where public housing exists	9 months
(m) Other	Provided by Applicant
(n) Other	Provided by Applicant

[21] Three year average number of deaths per 100,000 due to pneumonia (includes ICD-9 Codes 480-486).

- **FORM 10 – ANNUAL EMERGENCY PREPAREDNESS (EP) REPORT**
  The Annual Emergency Preparedness Report will be used to assess the status of emergency preparedness planning, progress towards developing and implementing an emergency management plan, and technical assistance, training and resource needs.

- **FORM 12 – ORGANIZATION CONTACTS**
  This form captures the accurate points of contacts within the application organization. Provide appropriate prefix, suffix, and highest degree earned (e.g., MSW, MPH, Ph.D., MD) for each contact.

APPENDIX B: Program Specific Information Instructions for NAP

The BPHC Program Specific Information must be completed in the HRSA EHBs (see chart in Section IV.2 of this guidance, Content and Form of Application Submission). "Forms" refer to those documents that are completed online in the system and DO NOT require any downloading or uploading. "Documents" are those requirements that must be downloaded in the template provided, completed, and then uploaded into the system. Only in cases with an approved paper waiver by the Division of Grants Policy may an Applicant print Program Specific Information Documents and complete offline. Please note that only these forms which are available via the online application, approved by the U.S. Office of Management and Budget, should be submitted with the application. See http://www.hrsa.gov/grants/apply/assistance/nap for copies of the Program Specific Information forms to be completed in the EHB.

Clinical and Financial Performance Measures

The Clinical and Financial Performance Measures serve as ongoing monitoring and evaluation tools for Health Center Program grantees and HRSA. The measures outline time-framed and realistic goals (as referenced below) to be accomplished during the two-year NAP project period. The goals and performance measures should be responsive to the proposed target population, identified community health and organizational needs, as well as to key service delivery activities discussed in the program narrative. Baseline data must be established for each performance measure that is responsive to the identified primary health care needs of the proposed service area as well as to the strategic needs of the overall organization.

The Clinical and Financial Performance Measures **should address ONLY the service area and target population of the proposed new access point(s) (i.e., only the new site(s) and service area proposed in the application).**

- **New start applicants** are expected to complete the Clinical and Financial Performance Measures based on the entire proposed scope of their project.
- **Satellite applicants** are expected to complete the Clinical and Financial Performance Measures based on their **proposed new service delivery site(s) ONLY.**
- If an applicant proposes to serve **multiple sites, populations and/or service areas**, **the Clinical and Financial Performance Measures** should represent the total targeted population within the proposed service area (with the exception of special populations, see below).
- Applicants requesting to serve special populations may identify additional population-specific (i.e., migrant/seasonal farmworkers, individuals who are experiencing homelessness, individuals in public housing) clinical performance measures in the 'Other' Section only of the Clinical Performance Measures. For example, "60% of pregnant women who are experiencing homelessness will begin prenatal care in the first trimester."

All applicants MUST respond to the **required clinical and financial performance measures**. In addition, all applicants MUST include a minimum of one Behavioral Health (i.e., Mental Health or Substance Abuse) and one Oral Health Clinical performance measure of their choice.

Further detail on the required Clinical and Financial Performance Measures can be found at http://www.hrsa.gov/grants/apply/assistance/nap and at www.bphc.hrsa.gov/about/performancemeasures.htm.

Additional Information about Completing the Clinical and Financial Performance Measures

- Please note that only applicants that provide or assume primary responsibility for some or all of a patient's prenatal care services, regardless of whether or not the applicant does the delivery, are required to include the two prenatal performance: **Percentage of pregnant women beginning prenatal care in the first trimester and Percentage of births less than 2,500 grams to health center patients**.
- Public entities, Tribal entities, or Urban Indian Entities are exempt from completing the three audit-related Financial Performance Measures (i.e., change in net assets to expenses ratio, working capital to monthly expense ratio, and long-term debt to equity ratio).
- If the applicant is applying for funds to target a special population (i.e., migrant/seasonal agricultural workers, residents of public housing, persons experiences homelessness) in addition to the general community, then additional goals and related performance measures that address the unique health care needs of these populations should be included in the Plan(s) in the 'Other' category of the Clinical Performance Measures, as appropriate.
- If the applicant has identified other unique populations, life-cycles, health issues, risk management efforts, etc. in the Need section of the program narrative, they are encouraged to include additional goals and related performance measures in the 'Other' category of the Clinical Performance Measures, as appropriate.
- **NOTE**: each performance measure includes a comment text box that can be used to provide information about individual performance measures. The comment boxes have a 1,000 character limit. Applicants should also include additional information regarding the Clinical and Financial Performance Measures in the Evaluative Measures section as appropriate.

Specific Elements of the Clinical and Financial Performance Measures

Focus Area

The Focus Area field contains the content area for each of the required clinical and financial performance measures. Applicants are expected to provide information for each focus area. The EHB system ***will not*** allow applicants to edit the Focus Area field for any of the HRSA clinical and/or financial performance measures.

Performance Measure

The Performance Measure field defines each of HRSA's required clinical and financial performance measures for each Focus Area. All applicants must provide information for each of the required Clinical and Financial Performance (with the exception of the prenatal and audit-related measures; see 'Performance Measures Applicability Section' below for exceptions). In

addition, applicants should note that they are required to include one Behavioral Health (e.g., Mental Health or Substance Abuse) and one Oral Health Performance Measure as part of their Clinical Performance Measures. Applicants may also include one or more additional Clinical Performance Measures that are specific to their target population or service area in the 'Other' section of the Clinical Performance Measures. Applicants must define the Performance Measure for the Behavioral, Oral, and ''Other' Performance Measures that are included as part of their Clinical and Financial Performance Measures. All performance measures should include a numerator and denominator that can be quantified **AND** tracked over time using a systematic process.

Performance Measure Applicability

The Performance Measure Applicability field requires applicants to indicate whether a particular performance measure is applicable to their application.

Clinical Performance Measures: The Prenatal Clinical Performance Measures (i.e., prenatal care and birth weight) are the ***only*** performance measure that may be indicated as being *"Not Applicable."* Applicants that provide or assume primary responsibility for some or all of a patient's prenatal care services as a part of their proposed scope of project must respond to the Prenatal Performance Measures. Applicants that indicate that the Prenatal Health Performances Measure as *"Not Applicable"* to their organization are required to provide a justification response in the comments field. The EHB system ***will not allow*** applicants to mark any other Clinical Performance Measures as being *"Not Applicable"* to their organization.

Financial Performance Measures: The EHB system ***will not*** allow an applicant to mark any Financial Performance Measure *as "Not Applicable"* with exception of the three audit-related performance measures. *ONLY* applicants that represent a Tribal, Urban Indian, or Public Business Entity are able to select *"Not Applicable"* for the three audit-related performance measures. Applicants that indicate that an audit-related measure is *"Not Applicable"* to their organization *must provide* a justification response in the comments section of the Financial Performance Measures form.

Target Goal Description

The Target Goal Description field provides detailed information regarding the target goals for the proposed new access point(s). Applicants are required to define the target goal for each of the clinical and financial performance measures.

Numerator - Denominator Description

The numerators and denominators for the required clinical and financial performance measures are specified on the HRSA web site at http://bphc.hrsa.gov/about/performancemeasures.htm. Applicants including additional clinical or financial performance measures in the 'Other' Section of are required to specify the numerator and denominator description for each measure. For Clinical Performance Measures, the numerator is the number of patients that meet the criteria identified by the performance measure for the measurement year. The denominator represents all of the patients to which the measure applies, as specified for each performance measure. The specification may include age range, diagnosis, or some other factor appropriate for that measure. Exclusions may be also be specified.

Baseline Data

The baseline data field contains four subfields that provide information regarding an applicant's initial threshold that is used to measure progress change over the course of the two year project period. The ***"Baseline Year"*** subfield identifies the initial reference time point from which an applicant will measure all subsequent performance measure progress. The ***"Measure Type"*** subfield provides information that reflects the unit of measurement utilized by the applicant (i.e., percentage or ratio) when measuring change over the two year project period. The ***"Numerator"*** and ***"Denominator"*** subfields identify the actual patient demographics and/or organizational characteristics that will be quantified and measured over time by the applicant. All applicants are required to provide information for each of the four baseline data subfields.

Projected Data (by end of Project Period)

This field defines the goals for each clinical and financial performance measure as projected at the end of the project period.

Data Source and Methodology

The Data Source and Methodology field provides information regarding the various data sources utilized by the applicant in developing each performance measure. All applicants are required to cite their data sources and to discuss the methodology utilized to collect data for their performance measures. Specifically, the data source and method of collection and analysis (e.g., electronic health records, disease registries, chart audits/sampling, extrapolation) should be noted by the applicant. Data used by applicants should be valid and reliable, and wherever possible, derived from currently established management information systems. Applicants may refer to HRSA's Data Resources for Demonstrating Need for Primary Care Services guide provided online at http://bphc.hrsa.gov/needforassistance/dataresourceguide.htm for a listing of data sources that may be helpful in developing goals for each performance measure.

Key Factor and Major Planned Action

The Key Factor and Major Planned Action fields contain three data subfields. The ***"Key Factor Type"*** subfield provides information regarding a particular circumstance or condition that may impact an applicant's ability to achieve a specified performance measure. The circumstances or conditions associated with a key factor type may be Positive *(Contributing)* or Negative *(Restrictive)*. The ***"Key Factor Description"*** subfield provides detailed information that describes the actual key factor type that has been identified by an applicant. The ***"Major Planned Action Description"*** subfield provides detailed information regarding important action steps and strategies that will be implemented to support the achievement of a performance measure. All applicants are required to identify at least one key factor type, along with an accompanying key factor description and major planned action, for each of the required performance measures. Applicants may include up to a total of three key factor types, key factor descriptions, and major planned actions for each of the required performance measures.

Comments

Applicants may provide additional information regarding key factor(s) for each performance measure. Since the comment section field has a 1,000 character limit, applicants are encouraged to use the Evaluative Measures section of the program narrative to include any information that exceeds the 1,000 character limit.

Other Performance Measures

In addition to the required clinical and financial performance, applicants may also identify additional performance measures in the 'Other' section of the Clinical and Financial Performance Measures form based on the applicant's proposed service area and/or target population needs, including but not limited to the following:

- If the applicant is applying for funds to target a special population (i.e., migrant/seasonal agricultural workers, residents of public housing, persons experiences homelessness) in addition to the general community, then additional goals and related performance measures that address the unique health care needs of these populations should be included in the Plan(s) in the 'Other' category of the Clinical Performance Measures, as appropriate.
- If the applicant has identified other unique populations, life-cycles, health issues, risk management efforts, etc. in the Need section of the program narrative, they are encouraged to include additional goals and related performance measures in the 'Other' category of the Clinical Performance Measures, as appropriate.
- Financial Performance Measures added by applicants in the 'Other' section should focus on the financial performance of their organization.

All *'Other' Performance Measures* should be defined by a numerator and a denominator and tracked over time by an applicant.

Resources for Performance Measures

Applicants are encouraged to review state and national performance reports when developing their individual clinical performance measures. Information regarding state and national performance reports can be found at: http://www.hrsa.gov/data-statistics/health-center-data/reporting/2009udsreportingmanual.pdf. Applicants may refer to HRSA's Data Resources for Demonstrating Need for Primary Care Services guide provided online at http://bphc.hrsa.gov/needforassistance/dataresourceguide.htm for a listing of data sources that may be helpful in developing goals for each performance measure.

Uniform Data System (UDS)

Applicants with existing health centers who have a UDS trends report that reflects their previous performance on a particular measure may use these data to assist in establishing performance measures. Please note that all information for the Clinical and Financial Performance Measures reflect the proposed new access point site(s) only.

Healthy People 2010/2020

Healthy People 2010/2020 is a national program initiative led by DHHS that sets priorities for all HRSA programs. The program consists of 28 focus areas and 467 objectives. All applicants are encouraged to refer to Healthy People 2010, or the updated Healthy People 2020, goals and objectives when developing their Clinical and Financial Performance Measures. The Healthy People 2010/2020 goals and objectives represent health promotion goals for the country. Consequently, applicants should not cut and paste Healthy People 2010/2020 goals and objectives into their Clinical Performance Measures. Instead, applicants should use Healthy People 2010/2020 goals as a **guide** to help develop their organization's performance measure. Additional information on Healthy People 2010/2020 goals and objectives may be downloaded at http://www.healthypeople.gov/document/.

Fiscal Year 2011
Clinical and Financial Performance Measures
Consolidated List of Performance Measures

Clinical Performance Measures	
Performance Measure	**Measure Detail**
Percentage of diabetic patients whose HbA1c levels are less than or equal to 9 percent	**Numerator:** Number of adult patients age 18 to 75 years[22] with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator. **Denominator:** Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria
Percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90	**Numerator:** Patients 18 to 85 years with a diagnosis of hypertension with most recent systolic blood pressure measurement < 140 mm Hg and diastolic blood pressure < 90 mm Hg. **Denominator:** All patients 18 to 85 years of age as of December 31 of the measurement year with diagnosis of hypertension and have been seen at least twice during the reporting year, and have a diagnosis of hypertension.
Percentage of diabetic patients whose HbA1c levels are less than or equal to 9 percent.	**Numerator:** Number of adult patients age 18 to 75 years[23] with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator. **Denominator:** Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria
Percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90.	**Numerator:** Patients 18 to 85 years with a diagnosis of hypertension with most recent systolic blood pressure measurement < 140 mm Hg and diastolic blood pressure < 90 mm Hg. **Denominator:** All patients 18 to 85 years of age as of December 31 of the measurement year with diagnosis of hypertension and have been seen at least twice during the reporting year, and have a diagnosis of hypertension.

[22] For example, for measurement year 2009, adult patients age 18 to 75 years would include those individuals with a date of birth on or after January 1, 1934 and on or before December 31, 1991.
[23] For example, for measurement year 2009, adult patients age 18 to 75 years would include those individuals with a date of birth on or after January 1, 1934 and on or before December 31, 1991.

Clinical Performance Measures	
Performance Measure	**Measure Detail**
Percentage of women age 21-64 who received one or more Pap tests during the measurement year or during the two years prior to the measurement ye	**Numerator:** Number of female patients 24 – 64 years of age receiving one or more Pap tests during the measurement year or during the two years prior to the measurement year, among those women included in the denominator. **Denominator:** Number of female patients age 24-64 years of age during the measurement year who were seen for a medical encounter at least once during the measurement year and were first seen by the grantee before their 65th birthday.
Percentage of pregnant women beginning prenatal care in first trimester	**Numerator:** All female patients who received prenatal care during the measurement year (regardless of when they began care) who initiated care in the first trimester either at the grantee's service delivery location or with another provider. **Denominator:** Number of female patients who received prenatal care during the measurement year (regardless of when they began care), either at the grantee's service delivery location or with another provider. Initiation of care means the first visit with a clinical provider (MD, NP, CNM) where the initial physical exam was done and does not include a visit at which pregnancy was diagnosed or one where initial tests were done or vitamins were prescribed.
Percentage of births less than 2,500 grams to health center patients.	**Numerator:** Women in the "Universe" whose child weighed less than 2,500 grams during the measurement year, regardless of who did the delivery. **Denominator:** Total births for all women who were seen for prenatal care during the measurement year regardless of who did the delivery.
Percentage of children with 2nd birthday during the measurement year with appropriate immunizations.	**Numerator:** Number of children in the "universe" who received all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella) and 4 Pneumoccocal conjugate, prior to or on their 2nd birthday whose second birthday occurred during the measurement year (prior to 31 December), among those children included in the denominator. **Denominator:** Number of children with at least one medical encounter during the reporting period, who had their second birthday during the reporting period, who did not have a contraindication for a specific vaccine, who were seen for the first time in the clinic prior to their second birthday, regardless of whether or not they came to the clinic for vaccinations or well child care.
Behavioral Health	**Applicant determines the information/data provided**
Oral Health	**Applicant determines the information/data provided**

FINANCIAL PERFORMANCE MEASURES	
Performance Measure	**Measure Detail**
Total cost per patient	**Numerator:** Total accrued cost before donations and after allocation of overhead **Denominator:** Total number of patients
Medical Cost per Medical Visit	**Numerator:** Total accrued medical staff and medical other cost after allocation of overhead (excludes lab and x-ray cost) **Denominator:** Non-nursing medical visits (excludes nursing (RN) and psychiatrist visits)
Change in Net Assets to Expense Ratio	**Numerator:** Ending Net Assets - Beginning Net Assets **Denominator:** Total Expense
Working Capital to Monthly Expense Ratio	**Numerator:** Current Assets - Current Liabilities **Denominator:** Total Expense / Number of Months in Audit
Long Term Debt to Equity Ratio	**Numerator:** Long Term Liabilities **Denominator:** Net Assets

ELECTRONIC HEALTH RECORDS FORM

All applicants must complete the Electronic Health Records (EHR) form indicating whether or not an electronic system is maintained by the applicant and integrated within an EHR. When completing this form, please note that all information provided will be used only to collect data and will NOT be used as an awarding factor. All applicants **must** complete questions **1 AND 4.** Questions **2 AND 3** are required if the applicant uses an electronic system.

EHR Form: Question 1

All applicants **must** complete **question 1** based on the current system used at the time of application submission. If an applicant **DOES NOT** use an electronic health records system, then skip questions 2 and 3.

EHR Form: Question 2

EHR Certification: Commission for Healthcare Information Technology (CCHIT) certified. Please check "Yes" if your system is certified by a certification body recognized by the U.S. Department of Health and Human Services. For reference, please visit the CCHIT Web site at http://www.cchit.org/choose/index.asp. Any certification year is considered certified for the purposes of this survey. Please check "No" if it is not certified. Only check "N/A" if you do not have an electronic health records system.

EHR Form: Question 3

Question 3 is a two-part question. The applicant should select the appropriate check box selection for the following: 1) Clinical programs that use an electronic health records system, and 2) Clinical programs that are integrated within the health center's EHR.

EHR Form: Question 4

This question should be completed by all applicants:

EHR READINESS FORM

Applicants requesting any Federal funding for the purchase or enhancement of an Electronic Health Record system must respond to all questions on the EHR Readiness Form.

OTHER REQUIREMENTS FOR SITES FORM

HRSA requires applicants that are requesting **any Federal funds for projects involving alteration or renovation**, which may include the installation of equipment, to complete the Other Requirements for Sites Form in its entirety.

Leased Facilities

Applicants with an existing lease are required to certify the following:

- The existing lease will provide the health center reasonable control of the project site;
- The existing lease is consistent with the proposed scope of project; and
- Understand and accept the terms and conditions regarding Federal Interest in the property.

This information is collected to ensure that applicants can maintain reasonable control of leased property (e.g., tenant has reasonable control and access to the site, no unreasonable restrictions to hours of operation). Additionally, although applicants will not be required to file a Notice of Federal Interest, please be aware that HRSA still has Federal Interest in the improved facility. The facility improvements may be subject, for example, to the property disposition requirements in 45 CFR Part 74.32 should use of the facility be terminated prior to the end of the lease period.

National Historic Preservation Act (NHPA) Section 106 Review

Grant applications for NAP funds for A&R project(s) must be reviewed under the terms of Section 106 of the National Historic Preservation Act (NHPA). Under section 106, prior to the expenditure of funds to implement the A&R, an assessment must be made of the potential effects of undertakings on historic properties (which include any prehistoric or historic district, site, building, structure, or object), that are eligible for listing or are listed on the National Register of Historic Places (NRHP).

HRSA has determined that the following activities constitute an undertaking: 1) all new construction and expansion projects (including demolition of existing buildings); 2) alteration and renovation projects where exterior changes to the building façade or surroundings (such as grading, fencing, or additional parking) may be made (including roof, windows, parking lots, generators, and exterior HVAC), and 3) where interior renovations may be made to a building that is over fifty (50) years old, or is historically, architecturally, or culturally significant. If the facility where the proposed A&R project is located falls under one of the three listed activities, a Section 106 consultation must be initiated with the State Historic Preservation Officer.

Ensuring Timely Consultation

If HRSA determines that additional review by the SHPO is necessary, then HRSA will contact the applicant and require Section 106 consultation with the State Historic Preservation Officer. Consultation must be completed prior commencing work outside of pre-A&R architectural and engineering services, or acquiring necessary licenses, permits and other approvals for the project. The NHPA regulations provide for applicants or their authorized representatives to initiate the section 106 compliance consultations when authorized to do so by the Federal agency. **All NAP applicants undertaking A&R and their authorized representatives are hereby authorized to initiate the section 106 process directly with the State Historic Preservation Officer (SHPO).** Until the applicant/authorized representative discusses the project with the SHPO, it should be assumed that the proposed A&R may potentially impact cultural and historic properties.

The applicant will present its initial finding related to historic preservation status to the SHPO and the SHPO will concur or disagree in writing with the finding. NAP funds may be used to hire consultants to complete the applicant's section 106 and other related historic preservation responsibilities. An applicant should discuss with the SHPO whether to hire a consultant to assist with the section 106 review. In most cases, it would be advantageous to the applicant. The SHPO should have a list of qualified consultants in the area. When consulting with SHPOs, the applicant/authorized representative should

identify the organization they are representing, include an appropriate contact person within the organization, and describe the undertaking needing the section 106 review.

Pursuant to the regulations at 36 CFR Part 800, HRSA determines the project's potential effect on historic properties in consultation with the State Historic Preservation Officer (SHPO), Tribal Historic Preservation Officers (THPO), representatives of the local government, and other affected Indian tribes and other interested parties. Funds may not be drawn down and A&R work may not commence until HRSA receives documentation from the SHPO/THPO concurring whether the property:

- Is not historic; or
- Is historic, with the project causing no potential adverse effects; or
- Is historic and the project may cause adverse effects. In this case, applicants must provide a resolution to the adverse effects through a fully executed MOA finalized by all parties.

Working with Projects Located on Tribal Lands

In accordance with 36 CFR Section 800.2(c)(2), HRSA shall ensure that all consultations with THPOs/Indian Tribes are conducted in a manner respectful of Tribal sovereignty and the government-to-government relationship between the Federal government and Indian Tribes. This policy, therefore, is not intended to modify or limit such requirements. HRSA recognizes its Tribal consultation responsibility. Only if the THPO/Tribe decides to forgo its government-to-government relationship in this instance, and the THPO/Tribe agrees to work with the applicants directly, will the applicant/authorized representative contact the THPO/Tribe. (For information on THPOs, see www.nathpo.org).

ENVIRONMENTAL INFORMATION AND DOCUMENTATION (EID) FORM

The National Environmental Policy Act of 1969 (NEPA), 42 U.SC 4321 (P.L. 91-190, Sec. 2, Jan. 1, 1970, 83 Stat., 852), including Public Disclosure, Section 102 of NEPA, and EO 11514, requires, among other things, that HRSA consider the environmental impacts of any Federal action, including A&R projects supported in whole or in part through Federal grants.

In order to comply with the requirements of NEPA, applicants must submit a completed Environmental Information and Documentation checklist **for each proposed new access point site for which any Federal funds are being requested,** for HRSA to review and approve. Applicants are required to submit a brief explanation supporting each response of "yes." If funded, Grantees must receive HRSA approval prior to initiating any projects involving A&R.

Following the review of the EID and the project proposal, HRSA will make a determination if the potential exists for the project to have a significant impact on the environment. If HRSA determines a potential environment impact exists, then HRSA will contact the applicant and require preparation of a draft Environmental Assessment (EA) in compliance with NEPA. It is advised that if the applicant does not possess in-house expertise in environmental compliance, that the services of a consultant with the appropriate expertise be secured. Requirements on the

contents of an EA can be found in regulations promulgated by the Council on Environmental Quality (CEQ) at 40 CFR. Part 1508 (and may be found on the web at http://ceq.eh.doe.gov/nepa/regs/ceq/toc_ceq.htm). Note that 40 C. F. R. § 1508.9 indicates that the EA is a concise document. It is the HRSA's intention to adhere strongly to this instruction and to require only enough analysis to accomplish the objectives specified by the regulation. Grantees will be required to complete and submit a draft EA and receive HRSA approval prior to commencing grant funded work.

Until the environmental review is completed by HRSA, grantees are not authorized to acquire fixed equipment or initiate A&R work beyond the design and permitting stage of the project. The cost for hiring a qualified environmental consultant to prepare the draft EA is an eligible cost under this program.

Based on a review of the draft EA, HRSA will determine if there is a Finding of No Significant Impact (FONSI) or a significant impact on the environment. If the draft EA reveals no significant impact on the environment, the applicants will prepare a draft FONSI document briefly presenting the reasons why the project will not have a significant effect on the environment. The FONSI will be forwarded to the HRSA for review and approval.

If HRSA determines that there is a significant impact on the environment, the grantee will be required to submit a draft Environmental Impact Statement (EIS). In this situation, HRSA will do the following: provide advice and assistance to the grantee, as necessary, concerning review procedures; evaluate the results of the review; and make the final decision on environmental impact as required by NEPA. Upon receipt and review of the draft EIS, HRSA will issue a Record of Decision before action is taken on the proposal addressed by the EA.

An architectural and engineering (A&E) review will also need to be conducted before a health center may expend project funds related to the proposed alteration and renovation project.

APPENDIX C: GUIDELINES FOR COMPLETION OF THE BUDGET PRESENTATION for NAP

This section explains the requirements for developing and presenting the Budget Presentation as part of the application for Federal support under the Health Center Program.

Applicants should note that in the formulation of their budget presentation, per section 330(e)(5)(A) of the PHS Act (42 U.S.C. 254b), the amount of grant funds made in any fiscal year may not exceed the amount by which the costs of operation of the center in such fiscal year exceed 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.

GUIDELINES FOR COMPLETING STANDARD FORM 424A, SECTIONS A-F

Please complete Sections A, B, E, and F (if F is applicable) of the Standard Form (SF) 424A – Budget Information for Non-Constructions Programs (part of the PHS 5161 application package) completed as part of the EHB submission process. As necessary, utilize a separate column on the SF 424A section B and E to list funds by type of health center program (CHC, MHC, HCH, and/or PHPC). The budget should clearly indicate cost for each program. **All budgets should be prepared for a 12-month period for Year 1 and Year 2.** The request for annual Federal section 330 funding MAY NOT exceed the established annual cap of $650,000 in Year 1 (of which applicants may request $150,000 for one-time minor capital costs for equipment and/or alterations/renovations) or $650,000 in YEAR 2 (operational support only)**.**

- The Federal cost principles apply only to Federal grant funds, as stated in section 330 of PHS Act.
- Amounts in the budget(s) must be rounded to the nearest whole dollar.

The following guidelines should be used by the applicant in the completion of the 424A. In addition, please review the sample 424A located in this Appendix.

SECTION A - BUDGET SUMMARY

Section A (under "New or Revised Budget") should reflect the proposed budget for the first 12-month budget period broken down by each section 330 program for which the applicant is requesting funding (e.g., MHC on row 1, CHC on row 2, PHPC on row 3, etc. as applicable); complete columns (e), (f), and (g). Please note that for the purposes of this application, column (e) "Federal" refers to only the Federal section 330 grant funding and not other Federal grant funding that applicant may receive.

SECTION B - BUDGET CATEGORIES

This section is a summary of all budget calculations and information for the project for the first 12-month budget period. Each line represents a distinct object class category that should be addressed in the budget justification (see below). Each column should reflect the total budget by object class for each section 330 program for which the applicant is requesting funding (e.g.,

MHC in column 1, CHC in column 2, etc. as applicable). Note that row 7 "Program Income" should be consistent with the "Total Program Income" presented in Form 3 – Income Analysis.

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

Use the columns in Section E (titled: (b) First, (c) Second, etc.) to present the projected Federal section 330 funding requests for the 2nd year of the project period for each section 330 program for which funding is requested (e.g., MHC on row 1, CHC on row 2, etc., as applicable). **The requested annual amount for YEAR 2 of the project period MUST NOT exceed the annual funding cap of $650,000.**

SECTION F – OTHER BUDGET INFORMATION (<u>ONLY IF APPLICABLE</u>)

Line 21: Use this space to explain amounts for individual direct object-class cost categories that may appear to be out of the ordinary.

Line 22: Enter the type of indirect rate (provisional, predetermined, final or fixed) that will be in effect during the funding period, the estimated amount of the base to which the rate is applied, and the total indirect expense.

Line 23: Provide any other explanations or comments deemed necessary.

<u>GUIDELINES FOR COMPLETING 424C-BUDGET INFORMATION-CONSTRUCTION PROJECTS</u>

Applicants requesting one-time Federal funding for alteration and renovation (A&R), which may include the installation of equipment, must detail each cost element for the proposed A&R project in the 424C-Budget Information-Construction Programs. This form is only required for applicants requesting one-time funding in Year 1 and should include only the total project cost for activities associated with the proposed A&R project(s).

- The equipment budget category on the 424C should correspond with the 'equipment' budget category on the 424A.
- All remaining budget categories on the 424C should correspond with the 'other' budget category on the 424A
- Since one-time funding is only allowable for minor alteration and renovation, budget categories that pertain solely to construction have been disabled (refer to completed sample of 424C).

Applicants should use the following guidelines to help determine what activities are considered "allowable" for one-time funding specific to alteration and renovation (Federal funds up to $150,000 in Year 1 only). Costs associated with abandoned projects (A&E, permitting, environmental assessments, etc.) are unallowable.

	ALLOWABLE	UNALLOWABLE
Administrative and legal expenses	▪ Salary of applicant's staff and consultant fees that are directly related to the administration of the technical aspects of the proposed project. Generally, administrative and legal expenses should be less than 10% of total project costs; ▪ Costs of obtaining required data for the environmental analysis report; and ▪ Bonding and insurance costs (for more details, visit website at www.hrsa.gov/hcofconstruction/bonding-insurance_ltr.htm).	▪ Salary of applicant's staff and consultant fees that are not related to the administration of the technical aspects of the proposed project; ▪ Bonus payments to contractors; ▪ Costs of groundbreaking and dedication ceremonies and items such as plaques; ▪ Indirect expenses such as general department operations and maintenance; ▪ Expendable office, medical, and laboratory supplies; and ▪ Fund-raising expenses.
Architectural and engineering fees	▪ Fees associated with architectural and engineering professional services; ▪ Associated expenses for preparation of specifications and reproduction of design documents; and ▪ For A&R projects, costs incurred before an award for architect's fees and consultant's fees necessary to the planning and design of the project if the project is approved and funded.	▪ Architectural and engineering fees for work that is not within the scope of the approved project; ▪ Costs of abandoned designs (costs associated with a design that will not be used to construct the building); and ▪ Elaborate or extravagant designs, materials, or projects that are above the known local costs for comparable buildings.
Other architectural and engineering fees	▪ Other architectural and engineering services, such as surveys, tests, and borings. ▪ Preliminary expenses associated with the approved award.	
Project inspection fees	▪ Clerk-of-the-works, inspection fees, structural certification, etc., to be provided by architectural engineering firm or the applicant's staff.	▪ Fees not associated with the requested project.
Site work	See Alteration and Renovation	▪ Fees not associated with the requested project.

	ALLOWABLE	UNALLOWABLE
Demolition and removal	▪ Costs of demolition or removal of structures or improvements. Reduce the costs on this line by the amount of expected proceeds from the sale of salvage.	▪ Costs not associated with the requested award.
Alteration and Renovation	▪ Costs of fixed equipment necessary for the functioning of the facility. FIXED EQUIPMENT is equipment that requires modification of the facility for its satisfactory installation or removal and is included in the construction contract. Examples include: fume hoods, linear accelerator, laboratory casework, sinks, fixed shelving, built-in sterilizers, built-in refrigerators, and drinking fountains; ▪ Construction costs for remodeling and alteration of existing buildings, which will be used for the program; ▪ Sanitary sewer, storm sewer, and portable water connections, providing that such municipal utilities are located in streets, roads, and alleys contiguous to the site; ▪ Costs of connecting to existing central utility distribution systems contiguous to the site, such as steam and chilled water that service a campus from centrally located boiler and refrigeration plants. Prorated costs for new boilers and chillers to serve the proposed facility are acceptable; ▪ Repaving of parking areas which are located on the site and are essential for the use and operation of an approved project; ▪ Special features for earthquake resistance code requirements. Use nationally recognized codes adopted by authorities having jurisdiction; ▪ Costs of eliminating architectural barriers to the handicapped; and ▪ Costs of pollution-control equipment for the facility's boilers, incinerators, waste water treatment, etc., which may be required by local, State, or Federal regulations. The facility must meet requirements of both current and future pollution abatement regulations as described in currently approved pollution plans.	▪ Relocation of utilities that are off site and off-site improvements; ▪ Prorated cost of existing central utility plant and distribution systems, which serve the proposed facility; ▪ Works of art; and ▪ Fixed equipment if it is not part of the construction contract.

	ALLOWABLE	UNALLOWABLE
Equipment	▪ MOVABLE EQUIPMENT - defined as an article of non-expendable, tangible personal property having a useful life of more than 1 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. Items with a unit cost less than $5,000 are allowable only if the applicant's capitalization policy indicates that individual items or groups of items are capitalized at a level less than $5,000. Moveable equipment can be readily shifted from place to place without requiring a change in the utilities or structural characteristics of the space. This equipment is usually purchased outside of any construction contract. This category includes such items as video systems, moveable desks, chairs, operating and obstetrical tables, anesthesia apparatus, oxygen tents, wheeled equipment, computers with software and licenses, but does not include items that are expendable at the time of use (such as food, fuel, dressings, drugs). All radiographic equipment, including CAT scanners and MRIs, is considered moveable; ▪ The cost to train individuals how to operate the equipment, if included in the purchase contract; ▪ Fixed equipment if it is not part of the construction contract; ▪ Sales tax (unless the applicant is otherwise exempt) and shipping costs on the equipment; and ▪ Service contract costs if it is included in the purchase contract.	▪ Equipment that does not meet the moveable equipment definition; and ▪ Donated equipment, leased equipment, or equipment purchased through a conditional sales contract (lease purchasing).

GUIDELINES FOR THE BUDGET JUSTIFICATION

A detailed budget justification in line-item format must be completed for each 12-month period of the 2 year project period. **Only the first year of the budget justification should itemize revenues and expenses for each type of health center program for which funding is requested (CHC, MHC, HCH, and/or PHPC).** In addition, if there are budget items for which costs are shared with other programs (e.g., other HRSA programs or an independent home health program administered by the applicant organization), the basis for the allocation of costs between federally supported programs and other independent programs must be explained. See Content and Form of Application Submission for further information on the budget justification).

The budget justification must clearly describe each cost element and explain how each cost contributes to meeting the project's goals. Be very careful about showing how each item in the

"other" category is justified. The budget justification MUST be concise. Do NOT use the justification to expand the program narrative. See budget justification samples for further details.

As indicated in Section VIII (Other Information), each NEW START applicant must budget for and set-aside a minimum of 2 percent of the expected award for technical assistance and performance improvement activities.

Please be aware that Excel or other spreadsheet format documents with multiple pages (Sheets) may not print out in their entirety.

GUIDELINES FOR COMPLETING FORM 1B – BPHC FUNDING REQUEST SUMMARY – (see APPENDIX A for instructions for completing this form)

GUIDELINES FOR COMPLETING FORM 2 – STAFFING PROFILE (see APPENDIX A for instructions for completing this form)

GUIDELINES FOR COMPLETING FORM 3 - INCOME ANALYSIS FORM (see APPENDIX A for instructions for completing this form)

GUIDELINES FOR COMPLETING THE EQUIPMENT LIST:

Applicants requesting one-time funding for alteration and renovation (A&R) must provide a detailed equipment list to identify moveable equipment that is equal to or exceeds $5,000/unit that is to be purchased for the proposed NAP project. If applicable, complete the spreadsheet online as presented.

Any equipment purchased through the proposed A&R project should be pertinent to health center operations. Please note that equipment must be maintained, tracked, and disposed of in accordance with 45 CFR Parts 74.34 and 92.32.

The selection of all equipment to be purchased through the NAP is to 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 IT and other equipment. Following these standards will mitigate many of the negative effects on human health and the environment from the proliferation, rapid obsolescence, low recycling rate, high energy consumption, and potential to contain hazardous materials, and increased liability from improper disposal. Additional information for these standards can be found online at the following sites:

- For EPEAT at http://www.epeat.net
- For Energy Star at http://www.energystar.gov