**HRSA Electronic Handbooks (EHBs)** 

# Look-Alike Initial Designation Application User Guide

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This user guide describes the steps you need to follow to submit a Look-Alike Initial Designation application to the Health Resources and Services Administration (HRSA).

# **1.** Starting the Look-Alike Initial Designation Application

You must have an EHBs user account to create a Look-Alike Initial Designation (ID) application. For additional instruction on how to create an EHBs account, use the New User Registration page at <a href="https://grants.hrsa.gov/2010/WebEPSExternal/Interface/UserRegistration/RegistrationHome.aspx">https://grants.hrsa.gov/2010/WebEPSExternal/Interface/UserRegistration/RegistrationHome.aspx</a>.

**IMPORTANT NOTE**: If you do not have a username, you must register in EHBs. Do not create duplicate accounts. If you experience login issues or forget your password, contact the HRSA Contact Center (http://www.hrsa.gov/about/contact/ehbhelp.aspx) at (877) 464-4772.

After logging into EHBs, click on the 'Organizations' tab and then select the **Organization Folder** link under the 'Options' column of the list page to open the **Organization Home** page.

On the **Organization Home** page, click **Create Initial Designation Application (Figure 1**)link under the 'FQHC-LAL' section to open the **Look-Alike Create Application** page.

## Figure 1: Application - Organization Home

✓ FQHC-LAL				
Requests	Portfolio			
<ul><li>Create Initial Designation Application</li><li>Work on existing application</li></ul>	<ul><li>My Designation Portfolio</li><li>Add Designation to Portfolio</li></ul>			
+ Vie	v More + View More			

Select the target population(s) for your application and click the Continue button to access the confirmation page. The target population types to choose form are

- Community Health Center
- Health Care for Homeless
- Migrant Health Centers
- Public Housing

Click the Confirm button to confirm the creation of an Initial Designation (ID) application.

#### **IMPORTANT NOTE:**

- The selections made for target population(s) can be changed by going to the Cover Page and updating the existing selection
- Also, the system will create your ID application and display the tracking number. Make a note of your ID application tracking number. The tracking number will also be emailed to you.

Click Continue with Application to open the **Application - Status Overview** page that has links to the application components (Cover Page, Appendices, and Program Specific Information) on the left menu.

After you have created the Initial Designation application, you can return to work on it by finding it in your

Pending Tasks page, which can be accessed by clicking the 'Tasks' tab.

Locate the Look-Alike ID application using the ID application tracking number and click the **Start** link to begin working on the application in EHBs (if you have previously accessed the application, the **Start** link will be replaced with **Edit**). The system opens the **Application - Status Overview** page of the application (**Figure 2**)

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Status	Application Type: Initial Designation	Program Name: Look-Alike Health Center Program	Created By:
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## Figure 2: Application - Status Overview Page

The application consists of the **Cover Page**, **Appendices**, and **Program Specific Information** sections. You must complete all these sections to submit your application to HRSA. The green checkmarks in the left menu and the Status column indicate whether each section is complete or not.

For details about eligibility requirements and what must be included in your application, see the Look-Alike Initial Designation Application Instructions at

https://bphc.hrsa.gov/sites/default/files/bphc/programopportunities/lookalike/pdfs/LALidinstructions.pdf

# 2. Completing the Look-Alike Cover Page

The **Cover Page (Figure 3)** requires the following information, as indicated by the red asterisks to the left of these fields:

Select Target Population(s) (Figure 3, 1) – select the target population type(s) served by the applicant health center: Community Health Centers (CHC); Health Care for the Homeless (HCH); Migrant Health Centers (MHC); Public Housing Primary Care (PHPC).

Person to be contacted on matters involving this application (Figure 3, 2) – enter the point of contact for the look-alike initial designation application.

Authorized Representative (Figure 3, 3) – enter the person who is authorized by the board of directors to submit the look-alike initial designation application. Once completed, click the Save and Continue button to proceed to the **Appendices** form. Once completed, click the Save and Continue button to proceed to the **Appendices** form.

**IMPORTANT NOTE**: If you select any special populations on the cover page, you will be required to enter the current number of patients for that special population on Form 1A

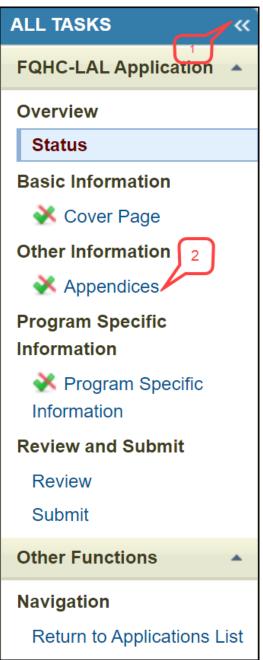
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Authorized Representative     3		© Add
	No Authorized Representative added.	
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# Figure 3: Cover Page of FQHC-LAL Application

# 3. Completing the Appendices Form

Expand the left navigation menu if not already expanded by clicking the double arrows displayed near the form name at the top of the page (Figure 4, 1). Click on the **Appendices** link (Figure 4, 2) to navigate to the **Appendices** form.

# Figure 4: Left Navigation Menu



Upload the following attachments by clicking the associated Attach File buttons (Figure 5). After completing the **Appendices** form, click the Save and Continue button to proceed to the **Program Specific Information – Status Overview** page.

- Project Abstract (Required) (Minimum 1, Maximum 1)
- Project Narrative (Required) (Minimum 1, Maximum 1)
- Attachment 1 Patient Origin and Utilization Information (Required) (Minimum 1, Maximum 1)

- Attachment 2 Service Area Map and Table (Required) (Minimum 1, Maximum 1)
- Attachment 3 Medicare and Medicaid Documentation (Required) (Minimum 1, Maximum 1)
- Attachment 4 Bylaws (Required) (Minimum 1, Maximum 1)
- Attachment 5 Governing Board Meeting Minutes (Required) (Minimum 1, Maximum 1)
- Attachment 6 Co-Applicant Agreement for Public Agencies (As applicable) (Minimum 0, Maximum 1)
- Attachment 7 Contracts and Referral Arrangements (As applicable) (Minimum 0, Maximum 1)
- Attachment 8 Articles of Incorporation (Required) (Minimum 1, Maximum 1)
- Attachment 9 Evidence of Non-Profit or Public Agency Status (Required) (Minimum 1, Maximum 1)
- Attachment 10 Financial Statements (Required) (Minimum 1, Maximum 1)
- Attachment 11 Organizational Chart (Required) (Minimum 1, Maximum 1)
- Attachment 12 Position Descriptions for Key Personnel (Required) (Minimum 1, Maximum 1)
- Attachment 13 Biographical Sketches for Key Personnel (Required) (Minimum 1, Maximum 1)
- Attachment 14 Sliding Fee Discount Schedule (Required) (Minimum 1, Maximum 1)
- Attachment 15 Collaboration Documentation (Required) (Minimum 1, Maximum 1)
- Attachment 16 Floor Plans (Required) (Minimum 1, Maximum 1)
- Attachment 17 Budget Narrative (Required) (Minimum 1, Maximum 1)
- Attachment 18 Health Center Program Requirements Compliance (Required) (Minimum 1, Maximum 1)
- Attachment 19 Other Relevant Documents (As applicable) (Minimum 0, Maximum 5)

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Figure 5: Appendices

# 4. Completing the Program Specific Forms

Click the **Update** link to edit each form. Once completed, click on the Save and Continue button to proceed to the next listed form.

Figure 6: Status Overview Page for Program Specific Forms
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# 4.1 Form 1A – General Information Worksheet

**Form 1A - General Information Worksheet** provides information related to the applicant, service area, and the number of patients and visits. This form has the following sections:

Applicant Information (Figure 7, 1) Proposed Service Area (Figure 7, 2)

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elect MUAINUP II Dimust be 5 to 12 dgts. Use commas to separa an MUAMUP of Service Area Type Choose Service Area Type Patients and Visits duplicated Patients and Visits by Populat way and patients and Visits by Populat out at the service of the service of the service service Area Type Patients and Visits by Populat duplicated Patients and Visits by Populat way and patients way and the service service Area Type cost at the service of the service service Area Type cost at the service of the service of the service service Type cost at Medical Services and Dental Services	Uthan     Rural     Sparsely Populated - 3 son Type roject to serve in the last year of     Patients	The three-year designation period	ding the number of people per so	Ind Population (MUP) ID # Ind Area Application Pending ID # ed Population Application Pending ID # uare mile: (Provide a value range Projected by End o Projected by End o	Designation Period     Visits
elect MUANUP RID must be 51b 12 dgtb. Use commus to separate best by 12 dgtb. Use commus to separate by 12 dgtb. Use community by 12 dgtb. Use community by 12 dgtb. Type Choose Service Area Type Choose Service Area Type Patients and Visits by Populat Dement Underserved Community by 12 dgtb. Type Choose Service Area Type Choose Service Service Type Total Medical Services Total Service Lise Disorder	Uthan     Rural     Sparsely Populated - 3 son Type roject to serve in the last year of     Patients	The three-year designation period	ding the number of people per so	Ind Population (MUP) ID # Ind Area Application Pending ID # ed Population Application Pending ID # uare mile: (Provide a value range Projected by End o Projected by End o	Designation Period     Visits
elect MUAINUP II Dimust be 5 to 12 dgts. Use commas to separa an MUAMUP of Service Area Type Choose Service Area Type Patients and Visits duplicated Patients and Visits by Populat way and patients and Visits by Populat out at the service of the service of the service service Area Type Patients and Visits by Populat duplicated Patients and Visits by Populat way and patients way and the service service Area Type cost at the service of the service service Area Type cost at the service of the service of the service service Type cost at Medical Services and Dental Services	Uthan     Rural     Sparsely Populated - 3 son Type roject to serve in the last year of     Patients	The three-year designation period	ding the number of people per so	Ind Population (MUP) ID # Ind Area Application Pending ID # ed Population Application Pending ID # uare mile: (Provide a value range Projected by End o Projected by End o	Designation Period     Visits

# Figure 7: Form 1A – General Information Worksheet

# 4.1.1 Completing the Applicant Information section

The **Applicant Information** section is prepopulated with your applicant name and application type. Complete this section by providing information in the required fields (Figure 8).

Select your organization's **Fiscal Year End Date** (e.g., June 30) from the drop-down menu.

Select one option in the '**Business Entity**' section. An applicant that is a Tribal or Urban Indian entity and meets the definition for a public or private entity should select the Tribal or Urban Indian category.

Select your **Organization Type**. Applicants may select one or more categories for the Organization Type section. You must specify the organization type if you select 'Other' (Figure 8,1).

Fields with * are required	
▼ 1. Applicant Information	
Applicant Name	AND TO REPORT AND TO REPORT AND
* Fiscal Year End Date	Select Option
Application Type	Initial Designation
* Business Entity	Select Option •
• Organization Type (Select all that apply)	Community based organization Faith based Hospital State government City/County/Local Government or Municipality University Conserved IT/Other' please specify: (maximum 100 characters)

## Figure 8: Applicant Information section

## 4.1.2 Completing the Proposed Service Area section

The 'Proposed Service Area' section is divided into the following sub-sections:

- 2a. Service Area Designation
- 2b. Service Area Type
- 2c. Patients and Visits

And Patients and Visits are further divided into the following sub-sections:

Unduplicated Patients and Visits by Population Type

Patients and Visits by Service Type

#### 4.1.2.1 Completing 2a. Service Area Designation

In the Select MUA/MUP field (Figure 9, 1), select the option(s) that best describe the designated service area you propose to serve. Enter ID number(s) for the MUA and/or MUP in the proposed service area.

#### **IMPORTANT NOTES:**

- Applicants applying for CHC funding MUST serve at least one Medically Underserved Area (MUA) or Medically Underserved Population (MUP).
- To search for MUAs or MUPs, visit the HRSA Data Warehouse at <u>https://datawarehouse.hrsa.gov/tools/analyzers/muafind.aspx</u> or contact the Shortage Designation Branch at sdb@hrsa.gov or 1-888-275-4772 (Option 1 then Option 2)

Figure 9: Proposed Service Area section

▼ 2. Proposed Service Area	
Note(s):     Applicants applying for Commutify Health Center Designation must provide at least one design	ated service area ID under an MUA or MUP. Provide the IDs for all MUAs and/or MUPs within the service area proposed in this application.
2a. Service Area Designation	Medically Underserved Area (MUA) ID #
<ul> <li>Select MUA/MUP (Each ID must be 5 to 12 digits. Use commas to separate multiple IDs, without spaces)</li> </ul>	Medically Underserved Population (MUP) ID #
1990 A. S. A. Andel M. S. S. Markellin, "A Statistical Control of Statistical Statistical Statistical Statistics of P A statistical Statistical Statistics of the Statistical Control of Statistical Statistics of Statistics	Medically Underserved Area Application Pending ID #
Find an MUA/MUP of	Medically Underserved Population Application Pending ID #

## 4.1.2.2 Completing 2b. Service Area Type section

In the **Service Area Type** field (**Figure 10**), indicate whether the service area is urban, rural, or sparsely populated. If sparsely populated is selected, specify the population density of the service area by providing the number of people per square mile (values must range from .01 to 7). For information about rural populations, visit the Office of Rural Health Policy's website at <u>https://www.hrsa.gov/rural-health/about-us/definition/index.html</u>

# Figure 10: Service Area Type Section

2b. Service Area Type	
* Choose Service Area Type	Urban     Orural     Sparsely Populated - Specify population density by providing the number of people per square mile:     (Provide a value ranging from 0.01 to 7)

#### **IMPORTANT NOTES:**

- If 'Sparsely Populated' is selected, provide the number of people per square mile (values must range from .01 to 7).
- 'Sparsely Populated' cannot be selected if Rural is not selected.
- For information about rural populations, visit the Office of Rural Health Policy's website at <a href="http://www.hrsa.gov/ruralhealth/policy/definition\_of\_rural.html">http://www.hrsa.gov/ruralhealth/policy/definition\_of\_rural.html</a>.

## 4.1.2.3 Completing 2c. Patients and Visits

#### 4.1.2.3.1 Unduplicated Patients and Visits by Population Type

To complete this section. answer the question, 'How many unduplicated patients do you project to serve in the last year of the three-year designation period?' (Figure 11, 1). The system will auto-populate the number in the Total row of the

Patients column under the Projected by End of Designation Period heading (Figure 11, 2) when you click on the Save or Save and Continue button.

Under the Current Number heading, provide the current number of Patients being seen at the health center and corresponding Visits in the Total row and the current number of Patients and Visits for each Population Type (Figure 11, 3). The patients and visits for each Population Type must add up to the numbers in the Total row.

The Total row for the current number of Patients must be greater than 0. Under the Projected by End of Designation Period heading, provide the number of projected Visits in the Total row and provide the number of Patients and Visits that you project to serve annually for each Population Type (Figure 11, 4).

The patients and visits for each Population Type must add up to the numbers in the Total row.

2c. Patients and Visits				
Unduplicated Patients and Visits by Population Typ	e .		G	
<ul> <li>How many unduplicated patients do you project to</li> </ul>	o serve in the last year of the three-year	designation period?		<b>4</b>
Population Type	Current	Number	Projected by End of D	esignation Period
	Patients	Visits	Patients 2	Visits
Total				
<ul> <li>General Underserved Community (Include all patients/visits not reported in the rows below)</li> </ul>				
<ul> <li>Migratory and Seasonal Agricultural Workers and Families.</li> </ul>				
* Public Housing Residents				
<ul> <li>People Experiencing Homelessness</li> </ul>				

## Figure 11: Unduplicated Patients and Visits by Population Type

#### **IMPORTANT NOTES:**

- The General Underserved Community row should include all patients/visits not captured in other Population Types
- Across all Population Type categories, an individual can only be counted once as a patient.
- Migratory and Seasonal Agricultural Workers: The current number of patients in the Migratory and Seasonal Agricultural Workers row should be greater than 0, if you have selected Migrant Health Center in the Cover Page of this application.
- Public Housing Residents: The current number of patients in the Public Housing Residents row should be greater than 0, if you have selected Public Housing in the Cover Page of this application.
- People Experiencing Homelessness: The current number of patients in the People Experiencing Homelessness row should be greater than 0, if you have selected Health Care for the Homeless in the Cover Page of this application

#### 4.1.2.3.2 Patients and Visits by Service Type

To complete this section Provide the Current Number of patients and visits for each listed Service Type(Figure 12, 1).

The Current Number of patients and visits must be greater than zero for 'Total Medical Services' (Figure 12, 2). The Current Number of patients for 'Total Medical Services' must be greater than any other service type. (Figure 12,

**2**).Provide the annual number of patients and visits that you project to serve within each Service Type category by the End of the Designation Period (Figure 12, 3).

Patients and Visits by Service Type		ſ	1		3
Service Type		Current Number		Projected by End of De	asignation Period
	Patients	2	Visits	Patients 4	Visits
<ul> <li>Total Medical Services</li> </ul>		P			
<ul> <li>Total Dental Services</li> </ul>					
Behavioral Health Services					
<ul> <li>Total Mental Health Services</li> </ul>					
<ul> <li>Total Substance Use Disorder</li> <li>Services</li> </ul>					
<ul> <li>Total Vision Services</li> </ul>					
<ul> <li>Total Enabling Services</li> </ul>					

Figure 12: Patients and Visits by Service Type

#### **IMPORTANT NOTES:**

- The 'Patients and Visits by Service Type' section does not display total values since an individual patient may be included in multiple Service Type categories.
- Providing numbers for all the Service Types is required. Zeros are acceptable, except 'Total Medical Services'.
- For 'Total Medical Services', the number of current and projected patients (Figure 12, 2 and 4) must be greater than the number of patients you enter for each of the 'Total Dental', 'Total Mental Health', 'Total Substance Use Disorder', 'Total Vision Services' and 'Total Enabling Services' service type.

After completing all sections of **Form 1A: General Information Worksheet**, click the Save and Continue button to save your work and proceed to the next form.

# 4.2 Form 1C: Documents on File

Form 1C - Documents on File displays a list of documents to be maintained by an organization.

To complete Form 1C, provide the date of the last review/revision for each item listed:

Management and Finance (Figure 13, 1).

Services (Figure 13, 2).

Governance (Figure 13, 3).

Select N/A if an item is not applicable, where available. Click the Save and Continue button to proceed to the next form.

Form 1C - Documents On File		
Note(s):     Date of Last Review/Revision must use the date format of MM/DD/YYYY. This listing does not include all policy/pro procedures must also be available for review. <sup>1</sup> Pub L: 115 - 141, Consolidated Appropriations Act, 2018, Division H, Title V, Section 520 <sup>2</sup> Pub L: 115 - 141, Consolidated Appropriations Act, 2018, Division H, Title V, Sections 506 and 607	cedure documents required to be maintained on file. Records demonstratin	ig implementation of required policies and
Invention address cards made and in Proceedings	Due Date: (Due In:	Days)   Section Status:
▼ Resources ⊔		
View		
LAL ID User Guide   LAL ID Instructions   LAL ID TA		
Fields with • are required		
Management and Finance	Date of Last Review/Revision (MM/DD/YYYY)	Not Applicable (N/A)
<ul> <li>Personnel policies, including selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices.</li> </ul>		
Procurement procedures.	175	
Standards of Conduct/Conflict of Interest policies/procedures.		
<ul> <li>Financial Management/Accounting and Internal Control policies and/or procedures to ensure that any federal funds are not expended for restricted activities.</li> </ul>		
<ul> <li>Financial Management/Accounting and Internal Control policies/procedures related to restrictions on the use of federal funds for the purchase of sterile needles or syringes for the hypodermic injection of any illegal drug.<sup>1</sup> (Only applicable if your organization provides syringe exchange services or is otherwise engaged in syringe service programs; otherwise, indicate as N/A).</li> </ul>		D
<ul> <li>Financial Management/Accounting and Internal Control policies/procedures related to restrictions on the use of federal funds to provide abortion services, except in cases of rape or incest or where there is a threat to</li> </ul>		0
the life of the mother. <sup>2</sup> (Only applicable if your organization provides abortion services; otherwise, indicate as N/A).	100	
Billing and Collections policies/procedures, including those regarding waivers or fee reductions and refusal to pay.     2		
Services	Date of Last Review/Revision (MM/DD/YYYY)	Not Applicable (N/A)
Credentialing/Privileging operating procedures.		
Coverage for Medical Emergencies During and After Hours operating procedures.		
Continuity of Care/Hospital Admitting operating procedures.		
<ul> <li>Sliding Fee Discount Program policies, operating procedures, and sliding fee schedule.</li> </ul>		
Quality Improvement/Assurance Program policies and operating procedures that address clinical services and management patient safety, and confidentiality of patient records.		
Governance	Date of Last Review/Revision (MM/DD/YYYY)	Not Applicable (N/A)
<ul> <li>Governing Board Bylaws.</li> </ul>		
Co-Applicant Agreement (Only applicable to public entity health centers; otherwise, indicate as N/A.)		0
Go to Previous Page		Save Save and Continue

# 4.3 Form 4 - Community Characteristics

**Form 4 – Community Characteristics** reports the service area population and target population data for the entire scope of the project (i.e. all sites). This form has the following sections:

Race and Ethnicity (Figure 14, 1)

Hispanic or Latino Ethnicity (Figure 14, 2)

Income as a Percent of Poverty Level (Figure 14, 3)

Primary Third-Party Payment Source (Figure 14, 4)

Special Populations and Select Population Characteristics (Figure 14, 5)

Form 4 - Community Characteristics				
Note(s):     Data on race and/or ethnicity collected on this form will not be used as a designatio	n factor.			
· STATUTE Located, Adv. Agency Witnessman Facility Inc.		Due Date:	(Due In: Days)	Section Status:
Resources 13			(	
View				
LAL ID User Guide   LAL ID Instructions   LAL ID TA				
		6	ſ	7
Fields with * are required	Service Area Population	Service Area Population Percent	Target Population	Target Population Percent
* Asian	service Area Population	0.00 %	anger ropulation	0.00 %
Native Hawaiian		0.00 %		0.00 %
* Other Pacific Islanders		0.00 %		0.00 %
* Black/African American		0.00 %		0.00 %
American Indian/Alaska Native		0.00 %		0.00 %
* White		0.00 %		0.00 %
More than One Race		0.00 %		E 0.00 %
* Unreported/Refused to Report		A 0.00 %		0.00 %
	0	0.00%	0	8
Total	v		v	
Click the 'Save and Calculate Total' button to calculate and save the total Service Area no	umbers and Target Population numbers for	all sections displayed on this form.		Save and Calculate Total
Hispanic or Latino Ethnicity	Service Area Population	Service Area Population Percent	Target Population	Target Population Percent
* Hispanic or Latino		0.00.%		0.00 %
Non-Hispanic or Latino		0.00 %		0.00 %
Unreported/Refused to Report		B 0.00 %		F 0.00 %
Total	0		0	P
Click the 'Save and Calculate Total' button to calculate and save the total Service Area ni	umbers and Target Population numbers for	all sections displayed on this form		Save and Calculate Total
Income as a Percent of Poverty Level	Service Area Population	Service Area Population Percent	Target Population	Target Population Percent
* 100% and below 3		0.00 %		0.00 %
• 101-200%		C 0.00 %		0.00 %
• Over 200%		0.00 %		G 0.00 %
Total	0	<u>/</u>	0	1
Click the 'Save and Calculate Total' button to calculate and save the total Service Area no	umbers and Target Population numbers for	all sections displayed on this form.		Save and Calculate Total
Principal Third Party Medical Insurance	Service Area Population	Service Area Population Percent	Target Population	Target Population Percent
* Medicald	555 A 515 A 215 / ASIA / ASIA / ASIA	0.00 %		0.00 %
Medicare		0.00 %		0.00 %
Other Public Insurance		0.00 %		0.00 %
Private Insurance		0.00 %		0.00 %
* None/Uninsured		D 0.00 %		H 0.00 %
Total	0	P	0	$\sim$
	and a set Transf Day dation which as free			
Click the 'Save and Calculate Total' button to calculate and save the total Service Area no	umbers and Target Population numbers for	all sections displayed on this form.		Save and Calculate Total
Special Populations and Select Population Characteristics	Service Area Population	Service Area Population Percent	Target Population	Target Population Percent
Migratory/Seasonal Agricultural Workers and Families     5		0.00 %		0.00 %
People Experiencing Homelessness		0.00 %		0.00 %
<ul> <li>Residents of Public Housing</li> </ul>		0.00 %		0.00 %
School Age Children		0.00 %		0.00 %
* Veterans		0.00 %		0.00 %
* Lesbian, Gay, Bisexual and Transgender		0.00 %		0.00 %
<ul> <li>HIV/AIDS-Infected Persons</li> </ul>		0.00 %		0.00 %
<ul> <li>Individuals Best Served in a Language Other Than English</li> </ul>		0.00 %		0.00 %
* Other If Other Please Specify:		0.00 %		0.00 %
Go to Previous Page				Save Save and Continue

# Figure 14: Form 4 – Community Characteristics

## 4.3.1 Completing the Form 4 sections

To complete the **Race and Ethnicity**, **Hispanic or Latino Ethnicity**, **Income as a Percent of Poverty Level**, and **Primary Third-Party Payment Source** sections (Figure 14, 1, 2, 3, 4), enter the **Service Area** (Figure 14, 6) and **Target Population** for each of the respective categories (Figure 14, 7).

#### **IMPORTANT NOTES:**

- Information provided regarding race and/or ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements.
- When entering data, the total Service Area values for the 'Race and Ethnicity', 'Hispanic or Latino Ethnicity', 'Income as a Percent of Poverty Level', and 'Primary Third Party Payment Source' sections should be equal (Figure 14, A, B, C, D). Likewise, the total Target Population values for each of these categories should be equal (Figure 14, E, F, G, H).
- Target Population data is a subset of Service Area data, and in most cases, is greater than the total number of patients projected on Form 1A. Patient data should not be used to report target population data since patients are typically a subset of all individuals targeted for service.
- If the target population includes a large number of transient individuals that are not included in the data set used for service area data (e.g., census data), adjust the service area numbers accordingly to ensure that the target population numbers are always less than or equal to the service area numbers.
- When entering data, the total Service Area Numbers and the total Target Population Numbers of the Race, Hispanic or Latino Ethnicity, Income as a Percent of Poverty Guideline, and Principal Third-Party Medical Insurance sections should be equal

To automatically calculate the Total Service Area and Total Target Population for all four sections, click on the Save and Calculate Total button (Figure 14, 8) under any of the sections.

## 4.3.2 Completing the Special Populations and Select Population Characteristics section

Under the 'Special Populations and Select Population Characteristics' section (Figure 15) enter the Service Area and Target Population for each population group listed.

If you select the target population related to special populations (i.e., MHC, HCH and/or PHPC) in the **Cover Page** form of this application, you must provide a **Service Area** and **Target Population** that is greater than 0 for the following line items under the 'Special Populations' section on **Form 4** as applicable: Migratory/Seasonal Agricultural Workers and Families, People Experiencing Homelessness, and Residents of Public Housing.

In the 'Other' row (Figure 15, 1), specify a population group that is not listed (if desired), and enter the Service Area and the Target Population for the specified population group. Individuals may be counted in multiple special population groups, so the numbers in this section do not have to match those in the other sections of this form.

After completing all sections of **Form 4**, click the Save and Continue button to save your work and proceed to the next form.

Figure 15: Special Populations section
--

Special Populations and Select Population Characteristics	Service Area Number	Service Area Percent	Target Population Number	Target Population Percent
<ul> <li>Migratory/Seasonal Agricultural Workers and Families</li> </ul>		0.00 %		0.00 %
People Experiencing Homelessness		0.00 %		0.00 %
<ul> <li>Residents of Public Housing</li> </ul>		0.00 %		0.00 %
School Age Children		0.00 %		0.00 %
Veterans		0.00 %		0.00 %
Lesbian, Gay, Bisexual and Transgender		0.00 %		0.00 %
People Living with HIV		0.00 %		0.00 %
<ul> <li>Individuals Best Served in a Language Other Than English</li> </ul>		0.00 %		0.00 %
Other Please specify: 1 Approximately 1/8 page (Max 200 Characters with spaces)		0.00 %		0.00 %

# 4.4 Form 2 – Staffing Profile

**Form 2 – Staffing Profile** reports current staffing for the look-alike. Complete this form by indicating all staff currently employed or under contract. Include only staff included in the look-alike scope of the project for sites included on Form 5B: Service Sites. This form should be consistent with your description of staffing in the Project Narrative.

The project director (PD)/chief executive officer (CEO) must be a direct employee of the health center. Allocate staff time in the Direct Hire FTE column by function among the staff positions listed. An individual's full-time equivalent (FTE) should not be duplicated across positions. For example, a provider serving as a part-time family physician and a part-time Clinical Director should be listed in each respective category with the FTE percentage allocated to each position (e.g., Clinical Director 0.3 (30%) FTE and family physician 0.7 (70%) FTE). Do not exceed 1.0 (100 %) FTE for any individual. For position descriptions, refer to the UDS Manual.

Record volunteers in the Direct Hire FTEs column. If you provide services through formal written contracts/agreements (Form 5A, Column II), Select Yes for contracted staff. Include contracted staff in Attachment 7: Contracts and Referral Agreements and/or include in contracts uploaded to Form 8: Health Center Agreements, as needed.

Contracted staff is indicated by answering Yes or No only. Do not quantify contracted staff in the Direct Hire column. Following are the major sub-sections in this form: Key Management Staff/Administration (Figure 16, 1); Facility and Non-Clinical Support Staff (Figure 16, 2); Physicians (Figure 16, 3); Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives (Figure 16, 4); Medical (Figure 16, 5); Dental Services (Figure 16, 6); Behavioral Health (Mental Health and Substance Abuse) (Figure 17, 7); Professional Services (Figure 17, 8); Vision Services (Figure 17, 9); Pharmacy Personnel (Figure 17, 10); Enabling Services (Figure 17, 11); Other Programs and Services (Figure 17, 12) and Total FTEs (Figure 17, 13)

Form 2 - Staffing Profile		
O Note(s): The health center must directly employ its Project Director/CEO. Allocate staff time by function among the positions lists serving as a part-time family physician and a part-time Clinical Director should be listed in each respective category, with FTE). Refer to the most resent UDS manual for position descriptions.	d. An individual's full-time equivalent (FTE) should not be d h the FTE portion allocated to each position (e.g., Clinical D	uplicated across positions. For example, a provider irector 0.3 (30%) FTE and family physician 0.7 (70%)
and the second sec	Due Date: (	Due In: Days)   Section Status: Not Started
▼ Resources C		
View LAL ID User Guide   LAL ID Instructions   LAL ID TA		
Fields with * are required		
Key Management Staff/Administration		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Project Director/Chief Executive Officer (CEO)		⊖ Yes ● No
Finance DirectoriChief Financial Officer (CFO)		⊖ Yes ● No
Chief Operating Officer (COO)		⊖ Yes ● No
Chief Information Officer (CIO)		⊖ Yes ● No
Clinical Director/Chief Medical Officer (CMO)		⊖ Yes ● No
Administrative Support Staff     2		⊖ Yes ● No
▼ Facility and Non-Clinical Support Staff		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Management and Support Staff		○ Yes ● No
* Fiscal and Billing Staff		⊖ Yes ● No
▲ IT Staff		⊖ Yes ● No
* Facility Staff		⊖ Yes ● No
Patient Support Staff     3		⊖ Yes ● No
▼ Physicians		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Family Physicians		⊖ Yes ● No
General Practitioners		⊖ Yes ● No
▲ Internists		○ Yes ● No
Obstetricians/Gynecologists		⊖ Yes ● No
Pediatricians     Other Specially Physicians		○ Yes ● No
Please Specify:		⊖ Yes ● No
(Maximum 40 characters)		
Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Starting Positions by Major Service Category     Nurse Practitioners	Direct Hire Files	Yes  No
Physician Assistants		⊖ Yes ● No
Certified Nurse Midwives     5		⊖ Yes ● No
▼ Medical		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Nurses		⊖ Yes ● No
Other Medical Personnel (e.g. Medical Assistants, Nurse Aides)		⊖ Yes ● No
Laboratory Personnel		⊖ Yes ● No
• X-Ray Personnel 6		⊖ Yes ● No
▼ Dental	Discust the men	
Staffing Positions by Major Service Category  Dentists	Direct Hire FTEs	Contract/Agreement FTEs
		○ Yes ● No
Dental Hygienists     Operated Theoremists		○ Yes ● No
Orther Dental Personnel     Other Dental Personnel		⊖ Yes ●No
Please Specify:		⊖ Yes ● No
(Maximum 40 characters)		

# Figure 16: Form 2 – Staffing Profile (Part 1)

Behavioral Health (Mental Health and Substance Use Disorder Services)		,,
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Psychiatrists 7		🔿 Yes 🔍 No
* Licensed Clinical Psychologists		O Yes  No
Licensed Clinical Social Workers		
Ucensed Linucal Social Workers     Other Licensed Mental Health Providers		○ Yes ● No
Unier Licensed Mental Health Providers Please Specify		O Yes  No
(Maximum 40 characters)		
Other Mental Health Staff Please Specify.		
(Maximum 40 characters)		O Yes 🔍 No
Substance Use Disorder Providers 8		O Yes  No
		U TES I E NO
Professional Services		
Staffing Positions by Major Service Category  Other Professional Health Services	Direct Hire FTEs	Contract/Agreement FTEs
Please Specify:		🔿 Yes 💿 No
(Maximum 40 characters) 9		
Vision Services		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Ophthalmologists		🔿 Yes 💿 No
* Optometrists		🔿 Yes 💿 No
Other Vision Care Staff		
Please Specify		🔿 Yes 🛛 💿 No
(Maximum 40 characters) 10		
Pharmacy Personnel		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Pharmacy Personnel		O Yes 🖲 No
Enabling Services		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Case Managers		🔾 Yes 🔍 No
Patient/Community Education Specialists		🔿 Yes 💿 No
Outreach Workers		O Yes 🔍 No
Transportation Staff		○ Yes
Eligibility Assistance Workers		O Yes 💿 Na
Interpretation Staff		🔾 Yes 🖲 No
Community Health Workers		🔾 Yes 🔍 No
Other Enabling Services     Please Specify:		7/2 AV / 10 AV / 1
(Maximum 40 characters) 12		O Yes 🔍 No
← Other Programs and Services	Direct Hire FTEs	Contract/Agreement FTEs
Quality Improvement Staff	51100 THE 7 TE 2	⊖Yes ●No
Other Programs and Services		- 152 - THV
Please Specify		O Yes 💿 No
(Maximum 40 characters) 13		
▼ Total FTEs		
Totals	Direct Hire FTEs	Contract/Agreement FTEs
Totals Calculate	0	N/A
So to Previous Page		Save Save and Contin

# Figure 17: Form 2- Staffing Profile Part 2 (Continued...)

# 4.4.1 Completing the Staffing Positions by Major Service Category sections

In the 'Direct Hire FTEs' column, provide only the number of Full-Time Employees (FTEs) directly hired by the health center for each staffing position. Enter 0 if not applicable (Figure 18, 1)

In the 'Contract/Agreement FTEs' column, indicate whether contracts are used for each staffing position (Figure 18, 2). Contracted staff should be summarized in Attachment 7: Summary of Contracts and Agreements and/or included in contracts uploaded to Form 8: Health Center Agreements (e.g., CEO contract), as applicable.

## **IMPORTANT NOTES**:

• Allocate staff time in the 'Direct Hire FTE' column by function among the staff positions listed. An individual's FTE should not be duplicated across positions. For example, a provider serving as a part- time family physician and a part-time Clinical Director should be listed in each respective category with the FTE portion allocated to each position (e.g., CMO 0.3 FTE and family physician 0.7 FTE). Do not exceed 1.0 FTE for any individual. For position descriptions, refer to the UDS Reporting Manual (<u>https://bphc.hrsa.gov/datareporting/reporting</u>)

- If a staffing position is not listed, you may specify in the Other section up to 40 characters.
- Volunteers should be recorded in the 'Direct Hire FTEs' column..

## Figure 18: Direct Hire and Contract/Agreement FTEs columns

Note(s): The health center must directly employ its Project Director/CEO. Allocate staff time by function amony serving as a part-time family physician and a part-time Clinical Director should be listed in each respe FTE). Refer to the mest recent UDS manual for position descriptions.		
STREET CONTRACTOR STREET	Due Date (I	Due In: Days)   Section Status:
▼ Resources of		
View		
LAL ID User Guide   LAL ID Instructions   LAL ID TA		
elds with * are required		
← Key Management Staff/Administration	1	2
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Project Director/Chief Executive Officer (CEO)		🔿 Yes 🛛 🔘 No
Finance Director/Chief Financial Officer (CFO)		🔿 Yes 🛛 No
Finance Director/Chief Financial Officer (CFO) Chief Operating Officer (COO)		○Yes ●No ○Yes ●No
Chief Operating Officer (COO)		⊖ Yes (● No

# 4.4.2 Completing the Total FTEs section

This row displays the sum of Direct Hire FTEs for the Staffing Positions by Major Service Categories. To calculate the totals, click the Calculate button (Figure 19). Click the Save and Continue button to save your work and proceed to the next form.

## Figure 19: Total FTEs

▼ Total FTEs		
Totals	Direct Hire FTEs	Contract/Agreement FTEs
Totals Calculate	0	N/A
Go to Previous Page		Save Save and Continue

# 4.5 Form 3 - Income Analysis

**Form 3 – Income Analysis** projects program income, by source, for Year 1 of the proposed designation period. This form has Payer Categories (Figure 20, 1) and Comments/Explanatory Notes (Figure 20, 2)

3 Form 3 - Income Analysis					
Note(s):     The value in column (d) - Projected income should equal column (b) - Billable v     The program income total on this form must match the program income total on		If not, explain in the Comments/Ex	xplanatory Notes box.		
· services < + + + + + + + + + + + + + + + + + +			Due Date:	(Due In: Days)   Se	ection Status: Her Hereine
▼ Resources d					
View					
LAL ID User Guide   LAL ID Instructions   LAL ID TA					
Fields with * are required	[3]	-	(7)	-	-
	Patients By Primary Medical	1	5	6	1
Payer Category	Insurance (a)	Billable Visits (b)	Income Per Visit (c)	Projected Income (d)	Prior FY Income (e) (i)
Part 1: Patient Service Revenue - Program Income					
<ul> <li>1. Medicaid</li> </ul>					
* 2. Medicare					
* 3. Other Public					
4. Private					
• 5. Self Pay					
6. Total (Lines 1 - 5) Calculate Total and Save	0	0	NIA	\$0	\$0
Part 2: Other Income - Federal, State, Local and Other Income					
7. Federal	N/A	N/A	N/A		
* 8. State Government	N/A	N/A	N/A		
9. Local Government	N/A	N/A	N/A		
10. Private Grants/Contracts	N/A	N/A	N/A	1	1
11. Contributions	N/A	NA	NA		
* 12. Other	N/A	N/A	N/A		
13. Applicant (Retained Earnings)	N/A	N/A	NIA	-	
14. Total Other (Lines 7 - 13) Calculate Total and Save	NIA	N/A	N/A	50	\$0
Total Income (Program Income Plus Other)					
15 Total Income (Lines 6 + 14) Calculate Total and Save	NIA	N/A	N/A	\$0	\$0
Comments/Explanatory Notes (if applicable)					
Approximately 2 pages (1) (Max 2500 Characters): 2600 Characters left.					
					~
					~
Go to Previous Page					Save Save and Continue

Figure 20: Form 3 – Income Analysis

# 4.5.1 Completing the Payer Categories section

The Payer Categories section is divided into the following sub-sections:

#### Part 1: Patient Service Revenue - Program Income

Part 2: Other Income - Federal, State, Local and Other Income

## Total Income (Program Income Plus Other)

To complete the 'Payer Categories' section, follow these steps:

In column (a), provide the number of Patients by Primary Medical Insurance for each of the Payer Categories in Part 1 (Figure 20, 3). Enter 0 if not applicable.

In column (b), provide the number of Billable Visits for each of the Payer Categories in Part 1 (Figure 20, 4). Visits must be greater than or equal to the number of Patients by Primary Medical Insurance (i.e., column (a)). Enter 0 if not applicable.

In column (c), provide the amount of Income per Visit for each of the Payer Categories in Part 1 (Figure 20, 5). Enter 0 if not applicable.

In column (d), provide the amount of Projected Income for each of the Payer Categories in Parts 1 and 2. (Figure 20, 6). Enter 0 if not applicable.

In Prior FY Income column (e), provide the amount of income from the prior fiscal year for each of the Payer Categories in Parts 1 and 2 (Figure 20, 7). Enter 0 if not applicable.

Click the Calculate Total and Save button to calculate and save the values for each of the Payer Categories in Part 1. (Figure 20, 8).

Click the Calculate Total and Save button in the 'Total Income (Program Income Plus Other)' section to calculate and save the values for each of the Payer Categories in Parts 1 and 2. (Figure 20, 9).

## **IMPORTANT NOTES:**

- The value for the Total Program Income (line 6, column (d)) should equal the value for the Total Program Income on Form 3A, line (f) under section 2. Revenue.
- The Patients by Primary Medical Insurance (a), Billable Visits (b) and Income Per Visit (c) columns in Part 2 are disabled and set to N/A.
- The number of Billable Visits in column b should be zero if the number of Patients by Primary Medical Insurance in column a for a Payer Category is zero.
- The value in the Projected Income (d) column should equal the value in the Billable Visits (b) column multiplied by the value in the Income per Visit (c) column. If these values are not equal, explain in the Comments/Explanatory Notes box.

# 4.5.2 Completing the Comments/Explanatory Notes section

In this section, enter any comments/explanations related to this form. For each of the Payer Categories in Part 1, the value in the 'Projected Income (d)' column should equal the value obtained by multiplying Billable Visits (b) and Income per Visit (c). If these values are not equal, explain in this section. If these numbers are equal for all the Payer Categories, providing comments in this section is optional. Click the Save and Continue button to save your work and proceed to the next form.

# 4.6 Form 3A – Budget Information

**Form 3A: Budget Information** shows the program budget, by category, for Year 1 of the proposed designation period. This form has Expenses (Figure 21, 1) and Revenue (Figure 21, 2)

# 4.6.1 Completing the Expenses section

In the 'Expenses' section, enter the projected first year of expenses for each Health Center Program population type for which designation is requested (i.e., CHC, MHC, HCH, PCPH). Click the Calculate Total and Save button to calculate and save the values for each of the Budget Categories in Part 1. (Figure 21,3 & 4).

The program income total on this form must match the program income total on For	m a.				
<ul> <li>METORENIE - E. M. S. S. E. DESETTIN, AND AN AND TYPE TO</li> </ul>			Due Date:	(Due in: Days)   Sect	on Status: the design
▼ Resources 🕑					
View					
LAL ID User Guide   LAL ID Instructions   LAL ID TA					
Fields with * are required					
Budget Category	Community Health Centers	Migrant Health Centers	Health Care for Homeless	Public Housing Primary Care	Tot
	(CHC - 330(e))	(MHC - 330(g))	(HCH - 330(h))	(PHPC - 330(I))	
. Expenses					(892) - F
a. Personnel					\$0.00
b. Fringe Benefits					\$0.00
c. Travel					\$0.00
d Equipment					\$0.00
e. Supplies					\$0.00
f. Contractual					\$0.00
g. Construction					\$0.00
h. Other					\$0,00
I. Total Direct Charges (sum of a through h) Calculate Total and Save	\$0.00	\$0.00	\$0.00	\$0,00	\$0.00
Indirect Charges					\$0.00
	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
2. Revenue					
a. Applicant		1			\$0.00
b. Federal					\$0.00
c. State					\$0.00
d. Local					\$0.00
e. Other					\$0.00
f. Program Income					\$0.00
g. Total Revenue (sum of a through f) Calculate Total and Save	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

## Figure 21: Form 3A – Budget Information

# 4.6.2 Completing the Revenue section

In the 'Revenue' section, enter the projected first year of revenue by funding source for each Health Center Program population type for which designation is requested (i.e., CHC, MHC, HCH, PCPH). Click the Calculate Total and Save button to calculate and save the values for each of the Budget Categories in Part 2. (Figure 21, 5). Click the Save and Continue button to save your work and proceed to the next form.

#### **IMPORTANT NOTES:**

- The value for the Total Program Income in the 'Revenue' section (line (f)) should equal the value for the Total Program Income on Form 3, line 6, column (d).
- To change the Health Center Program population type (i.e., CHC, MHC, HCH, PCPH), return to the
- Cover Page to select or de-select the Target Population type for which designation is requested.

# 4.7 Form 5A – Services Provided

Form 5A – Services Provided identifies the services to be provided, and how they will be provided by the applicant organization. For Initial Designation applications, Form 5A – Services Provided has Required Services (Figure 22, 1) and Additional Services (Figure 22, 2)

Figure 22: Form 5A – Services Provide	d (Required Services)

Note(s): Select service delivery methods for services as applicable to the proposed Services Provided	health center project. For more information, refer to the	Service Descriptors for Form 5A: Services Pro	ided and the Column Descriptors for Form 5A:
ACCESS ARROND AND MAKE MAKE MAKENING		Due Date: (D	ue In: Days)   Section Status:
Resources Id			
View			
LAL ID User Guide   LAL ID Instructions   LAL ID TA			
1 2			
ids with * are required			
K Required Services Addsonal Services Specialty Services			
	Column I - Direct	Column II - Formal Written	Column II - Formal Written Referral
Service Type	(Health Center Pays) ()	Contract/Agreement (Health Center Pays) (i)	Arrangement (Health Center DOES NOT Pay) (i)
General Primary Medical Care	Ö		
Diagnostic Laboratory (i)	0	0	0
Diagnostic Radiology (i)	0	0	
Screenings (i)	0	0	0
Coverage for Emergencies During and After Hours (i)	0	0	0
Voluntary Family Planning (i)		0	0
Immunizations (i)	0	0	0
Well Child Services (i)	0	0	0
Gynecological Care (i)	0	0	0
Obstetrical Care (1)			
Prenatal Care (i)		0	
<ul> <li>Intrapartum Care (Labor &amp; Delivery) (i)</li> </ul>		0	0
Postpartum Care ()	0	0	0
Preventive Dental (i)		0	
Pharmaceutical Services (i)	0	0	
HCH Required Substance Use Disorder Services (i)	0	0	0
Case Management (i)		0	0
Eligibility Assistance ()	0	0	0
Health Education ()	0	0	0
Outreach ()		0	
Transportation (i)	0	0	0
Translation (i)		0	0

Look-alikes may provide required services directly, by contracting with another provider, or by referral to another provider. These modes of service provision differ according to the service provider and the payment source (Table 1). See the Form 5A Column Descriptors at

<u>http://bphc.hrsa.gov/programrequirements/scope.html</u> for descriptions and requirements for each of the three service delivery modes.

Service Delivery Methods	Your Organization Provides the Service	Your Organization Pays for the Service
Service provided directly by health center	Yes	Yes
Service provided by formal written contract/agreement	No	Yes
Service provided by formal written referral arrangement	No	No

# Table 1: Modes of Service Provision

# 4.6.3 Completing the Requires Services Section

To complete this section of **Form 5A**, check one or more boxes to indicate the service delivery method(s) for each of the required services as applicable to the look-alike project. To view details about service, hover over the information icon provided for that service (**Figure 22, 3**). Click the Save and Continue button to navigate to the 'Additional Services' section OR click the Save button on the 'Required Services' section and select the **Additional Services** tab (**Figure 22, 2**).

#### **IMPORTANT NOTES:**

- You must select Column I and /or Column II for the 'General Primary Medical Care' service row (Figure 22, 3) for your application to be eligible.
- You cannot select a service delivery method for 'HCH Required Substance Use Disorder Services' if you have not selected HCH as a Target Population type in the Cover Page form of this application. If you selected HCH as a Target Population, you are required to select at least one service delivery method for 'HCH Required Substance Use Disorder Services'.
- When selecting Col. III only for General Primary Medical Care. Applicants will not be able to select this option only since this service has to be provided either directly (Col. 1) and/or via contract (Col. 2).
- Only one form is required regardless of the number of proposed sites.
- All referral arrangements/agreements for services noted on Form 5A as provided via Column II and/or III must be formal written contracts or agreements.

## 4.7.1 Completing the Additional Services Section

The Additional Services section of **Form 5A** is optional. You are not required to identify service delivery methods for any additional services listed in this section. However, if your organization provides any of the additional services, complete this section of the form. Indicate the service delivery method(s) for the desired additional service (**Figure 23**). Click the Save and Continue button to navigate to the 'Specialty Services' section OR click the Save button on the 'Additional Services' section and select the Specialty Services tab.

arvice Type	Column I - Direct (Health Center Pays) (i)	Column II - Formal Written Contract/Agreement (Health Center Pays) ①	Column III - Formal Written Referral Arrangement (Health Center DOES NOT Pay) ()
dditional Dental Services 🚯	0	0	0
Behavioral Health Services 🕕			
Mental Health Services ④	D	0	D
Substance Use Disorder Services ④	0	0	0
Optometry 🚯		0	0
ecuperative Care Program Services (i)		0	0
invironmental Health Services 🚯	0	0	0
Coupational Therapy ()		0	0
hysical Therapy ()	0	0	0
peech-Language Pathology/Therapy 🚯	0	0	0
lutrition (j)	0	0	0
complementary and Alternative Medicine 🕢		0	0
dditional Enabling/Supportive Services (i)	0	0	0

## Figure 23: Form 5A – Services Provided (Additional Services)

#### **IMPORTANT NOTES:**

- If you have not selected HCH as a Target Population type in the Cover Page form of this application, you will not be able to select 'HCH Required Substance Use Disorder Services' in the 'Required Services' section. However, you may select 'Substance Use Disorder Services' in the 'Additional Services' section(Figure 23, 1).
- All required AND additional services proposed on Form 5A in this application must be accessible to patients at any sites proposed in this application, though the mode of service delivery (Column I, II, or
- III) may be different across sites.

## 4.7.2 Completing the Specialty Services Section

You cannot propose specialty services in the Initial Designation application. You will see the message below (Figure 24) when you access the 'Specialty Services' section of Form 5A. Click the Continue button to proceed.

## Figure 24: Form 5A – Services Provided (Specialty Services)

X Required Services	💸 Additional Services	✓ Specialty Services
Warning:		
	oose Specialty Services in a	an Initial Designation application. Click on Continue button to proceed.

Go to Previous Page

**IMPORTANT NOTE:** You will be required to visit the Specialty Services section to update the page status to complete.

Form 5A: Services Provided will be complete when each of the 'Required Services', 'Additional Services',

and 'Specialty Services' sections are complete, indicated with a green checkmark in the section tabs

Continue

(Figure 25). After completing all the sections on Form 5A, click the Save and Continue button to save your work and proceed to Form 5B.

View		
LAL ID User Guide LAL ID Ins	structions   LAL ID TA	
Required Services Additional S	Services Specialty Services	

# 4.8 Form 5B – Service Sites

**Form 5B – Service Sites** identifies the sites in your scope of the project. You will be able to propose a Service Delivery Site; Administrative/Service Delivery Site and Administrative-only Site

**IMPORTANT NOTE**: You will be required to propose at least one Service Delivery or Administrative/Service Delivery site.

## 4.8.1 Proposing a New Site

To propose a new site, click the Add New Site button (Figure 26) provided above the 'Proposed Sites' section.

## Figure 26: Form 5B

O Note(s):		
<ul> <li>If you are proposing to serve Community Health Centers, Public Housing Health Centers Delivery site or Administrative/Service Delivery site with Location Type as 'Permanent' a</li> </ul>		t Health Centers, you must propose at least one new Service
<ul> <li>If you are proposing to serve only Migrant Health Centers, you must propose at least on</li> </ul>		Delivery site with Location Type as "Permanent' or "Seasons
and operating for at least 40 hours.	e nen dernee derrery alle of Planmaderrerdernee	benery sie morestaan Type as Tennanen of Stasons
<ul> <li>An other states and a state of a second state</li> </ul>	Due Date:	(Due In: Days)   Section Status:
* Resources 🖒		
View		
LAL ID User Guide LAL ID Instructions LAL ID TA		
() Add New Site		
Proposed Sites		
	No sites added	
So to Previous Page		Save Save and Conti

The system navigates to the **Service Site Checklist** page. Answer the questions displayed on the **Service Site Checklist** page. (Figure 27)

## Figure 27: Service Site Checklist page

Fields with * are required	
Site Qualification Criteria	
★ 1. Is the site an "admin-only" site? If Yes, the site is an 'Admin-only' site, select 'Not Applicable' for questions 'a' to 'd' below If No, the site is a Service Delivery site, answer questions 'a' to 'd' Yes or No.	Ves No
a. Are/will health center visits be generated by documenting in the patients records face-to-face contacts between patients and providers?	Yes No Not Applicable
b. Do/will providers exercise independent judgment in the provision of services to the patient?	😔 Yes 🛛 No 💿 Not Applicable
c. Are/will services be provided directly by or on behalf of the designee, whose governing board retains control and authority over the provision of the services at the location?	Yes O No Not Applicable
d. Are/will services be provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every month)?	Yes No Not Applicable
• 2. Is the site a Domestic Violence (Confidential) shelter? () - 2	Yes INO Not Applicable
Go to Previous Page	3 Verify Qualification

#### **IMPORTANT NOTES:**

- If the answer to question 1 is 'No' (Figure 27, 1), i.e. if the site being added is not an 'Admin-only' site: Select 'Yes' for questions 'a' through 'd' so that the site is qualified to be added to the application; AND Indicate whether the site being added is a domestic violence site by answering 'Yes' or 'No' to question 2 (Figure 27, 2). A Domestic Violence site is a confidential site serving victims of domestic violence and the site address cannot be published due to the necessity to protect the location of the domestic violence shelter.
- If the answer to question 1 is 'Yes' (Figure 27, 1), i.e. if the site being added is an 'Admin-only' site, select 'Not Applicable' to question 2.

Click the Verify Qualification button (Figure 27, 3). The system navigates to the List of Pre-Registered Performance Sites at the HRSA Level page. All the sites that are registered by your organization within EHBs will be listed on this page. (Figure 28)

List of Pre-registered Performance S	Sites			
Site Name	Performance Site Type 🕕	Performance Site Address	Perfomance Site Address Category	Options
Applicate County Device Care	Fixed	Tel Munsell Avenue, Brassel VIT Streets	Approximate 2	Select Site Location
Brass Park Dentel	Fixed	COMPANY OF BRIDER, OF BRIDE COM	Accurate	Select Site Location
Weighted (Mealth / Service)	Fixed	Munal Avenue, Branci 1177	Accurate	Select Site Location
Number Health Cartler	Fixed	Technical Avenue 275 100 Brass 177 (Blass)	Accurate	Select Site Location
Warning ready Dense wrown	Fixed	\$1 Fre Direct Building 4 Brazzi, VT (Bred)	Approximate	Select Site Location
Intrusteer / Intellity / Cashiner	Fixed	WT-Prog DI. Branni, 177 (Stands (SAD)	Accurate	Select Site Location

Figure 28: List of Pre-Registered Performance Sites at HRSA Level page

If you have no pre-registered sites, or to use a new location for the site you are proposing in Form 5B, click the Register Performance Site button (Figure 28, 1) and register your site using the Enterprise Site Repository (ESR) system by following the steps below:

**On the Basic Information** – Enter page, provide a site name, and select a site type from the following options: Fixed, Mobile. Click the Next Step button.

**On the Address** – Enter page, enter the physical address of the site, and click the Next Step button.

**On the Register** – Confirm page, the system displays the physical address you entered on the Address – Enter page along with the standardized format of the address. Select an option and click the Confirm button.

**On the Register** – Result page, click the Finish button to register the site to your organization.

Select a site from the List of Pre-Registered Performance Sites and click its **Select Site Location** link (Figure 28, 2).

#### **IMPORTANT NOTES:**

- The Select Site Location link will be disabled (Figure 29, 1) if the site falls under any of these categories, and you will not be able to select the site. In these cases, hovering over the disabled Select Site Location link (Figure 29, 2) will provide the reason why the site is disabled.
- If the site is already included in the current application.
- If the site is already in any Health Center Program award recipient's scope of project.
- If the site is a Mobile site and the applicant is trying to propose an "Admin-only" site.
- If the site is a confidential site and the applicant is trying to propose a non-confidential/non- domestic violence site.
- If the site is a non-confidential site and the applicant is trying to propose a confidential/ domestic violence site.



Register Performance Site				
List of Pre-registered Performance Site	S			
Site Name	Performance Site Type (i)	Performance Site Address	Perfomance Site Address Category	Options
A CONTRACTOR FRAME ACCORDANCES	Fixed	3611 Aut 2 Gall, 3 (224) 346		Select Site Location 🔻
11.01.0000.01.000	Fixed	Filianti increase	This site is not matching the requirement for non confidential site.	Select Site Location 🔻
Cancel		٤	4	

**IMPORTANT NOTES**: If you wish to update the name of any site listed on this page, click on **Update the Registered Performance Site** link (Figure 30) and update the site name.

## Figure 30: Update the Registered Performance Site link

Register Performance Site					
List of Pre-registered Performance Site	S				
Site Name	Performance Site Type (i)	Performance Site Address	Perfomance S	ite Address Category	Options
E CONTRACTORIS CONTRACTORIS CONTRACTORIS	Fixed	3411 Ann 3 Gans (1922) (192	Accurate		Select Site Location 🔻
Cancel	Fixed	E-Same Screene	Approximate	Action Select Site Locati Update the Regis	on stered Performance Site

When you click the **Select Site Location** link of a site, the system navigates to the **Form 5B – Edit** page where you must provide all the required information for the site (Figure 31).

∃ Form-5B : Edit					
Note(s):     It is recommended that you save your work off	ten (e.g., every 5 minutes) to av	old a loss of data due to unforeseeable techn	ical issues.		
Fields with * are required for all site types.					
Site Information					Status the decide
* Site Name	Change Site Name	- China Streye with Section day solve	Physical Site Address	107708-line(.164466-147700)	
• Site Type	Service Delivery Site	•	Site Phone Number	( ) Ext	
* Web URL					
The following fields are required for "Service De	elivery" and "Administrative/S	ervice Delivery" site types, other than whe	are exceptions are noted:		
Location Type	Select Location Type	•	Site Setting	Select Site Setting	
Date Site was Added to Scope	NA		* Site Operational Date	NA	
• FQHC Site Medicare Billing Number Status	Select Medicare Billing Num	ber Status 👻	FQHC Site Medicare Billing Number (Required if "This site has a Medicare biling number" is selected in FQHC Site Medicare Biling Number Status" field ) e.g. 12345 OR 123456		
FQHC Site National Provider Identification (NPI) Number (Optional field ) e.g. 1234567890			Total Hours of Operation     (when Patients will be Served per Week)		
Months of Operation		•			
Saved Months of Operation					
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)			Number of Intermittent Sites (Required only for Intermittent' Site Type)		
Site Operated by	Select Site Operated By	-)			
Add Subrecipient/Contractor					
<ul> <li>Subrecipient or Contractor Information (Reg</li> </ul>	uired only if 'Subrecipient or (	Contractor' is selected in 'Site Operated B	V (+ View More)		
Subrecipient/Contractor Organization Name		Subrecipient/Contractor Organization Ph		Subrecipient/Contractor EIN	Options
		No Subrecipient or Con	ntractor information to be displayed		
Service Area Zip Code (Include only those from	which the majority of the patie	ent population will come)			
* Service Area Zip Codes		-			
	Save Zip Code(s)				
Saved Service Area Zip Code(s)					
Go to Previous Page					Save Save and Continue

## Figure 31: Form 5B – Edit page

## 4.8.2 Completing Form 5B

For each Service Delivery site, complete the form by following these steps (Figure 31):

The name, address, and service site type populate from the list of pre-registered performance sites.

Select a Location Setting (i.e., all other clinic types, hospital, or school) and Location Type (i.e., permanent, seasonal, or mobile van).

Enter the date that the site became operational.

Select the Medicare billing status and enter Medicare billing number, if applicable.

Enter the total hours of operation per week for the site.

Select whether the site is operated by the health center/applicant or contractor.

If the site is operated by a contractor, you must enter information about the operating organization.

Enter the zip codes for the service area. After each five zip codes entered, click Save Zip Codes, to save and add more, if applicable. After providing complete information on **Form 5B – Edit** page, click the Save and Continue button.

**IMPORTANT NOTE**: Zip codes entered in the Service Area Zip Codes field should be those where at least 75 percent of the current patients within the service area reside.

Form 5B – Service Sites list page opens with the newly added site displayed in the 'Proposed Sites' section (Figure 32). To add additional sites, follow the steps above. Once you have completed Form 5B for all proposed sites, click the Save and Continue button to save your work and proceed to the next form.

Figure 32: Newly added site displayed under Proposed Sites section

Site Name	Physical Address	Service Site Type	Location Type	Site Status	Options
A	Y	All 🔹 🍸	All 🔹 🏹	All 🔹 🍸	
Nangalitasi sanisi Masalili shi Siri Sirikasi shi Panat - Matalan	TOTOL ALANCINAL MARCHLINE METRIC.	Service Delivery Site	Permanent	In Progress	🕜 Update 💌

## **IMPORTANT NOTES:**

A did blow Oli

- The 'Physical Site Address' must be a verifiable physical street address.
- If you are proposing to serve Community Health Center, Public Housing Primary Care, and/or Health Care for the Homeless (with or without Migrant Health Center) in the Cover Page form in this application, you must propose at least one Service Delivery site or Administrative/Service Delivery that has Location Type as 'Permanent', and that is operating for at least 40 hours a week.
- If you are proposing to serve only Migrant Health Centers in the Cover Page form in this application, you must propose at least one Service Delivery site or Administrative/Service Delivery site that has Location Type as 'Permanent' or 'Seasonal,' and that is operating for at least 40 hours a week.

# 4.9 Form 5C – Other Activities/Locations

Form 5C – Other Activities/Locations identify other activities or locations associated with your look-alike.

**IMPORTANT NOTE**: This is an optional form. If you do not have any other activities or locations, you can click on the Save and Continue button provided at the bottom of the form to complete it.

To add other activities or locations Click the Add New Activity/Location button provided at the top of the form (Figure 33, 1). The system navigates to the Activity/Location Information page (Figure 34).

Form 5C - C	Other Activities/Locations				
•			Due Date: (Due In: Days)	Section Statu	s: In Anna i
▼ Resources ☑ View					
LAL ID User Gu					
Type of Activity	Frequency of Activity	Description of Activity	Type of Location(s) where Activity is Conducted	Status	Options
		No other activities/locatio	ons added.		
Go to Previous Pa	ge			s	ave and Continue

# Figure 33: Form 5C – Other Activities/Locations



Fields with * are required	
Activity/Location Information	
* Type of Activity	Select Option If 'Other', please specify: (maximum 100 characters)
<ul> <li>Frequency of Activity</li> </ul>	Approximately 1/2 page (3) (Max 600 Characters) 600 Characters left.
Description of Activity	Approximately 1/2 page 🕃 (Max 600 Characters) 600 Characters left
Type of Location(s) where Activity is Conducted	Approximately 1/2 page ④ (Max 600 Characters): 600 Characters left.
Cancel	Save Save and Continue

Provide information in all the fields on this page and click the Save and Continue button. The system navigates to the **Form 5C** list page displaying the newly added activity (**Figure 35**).

# Figure 35: Activity/Location Information added



Once the activity is added, it can be updated or deleted as needed. After completing **Form 5C**, click the Save and Continue button to save your work and proceed to the next form.

# 4.10 Form 6A – Current Board Member Characteristics

**Form 6A: Current Board Member Characteristics** provides information about your organization's current board members.

## **IMPORTANT NOTES:**

- This form is optional if you selected "Tribal" or "Urban Indian" as the Business Entity in Form 1A General
  Information Worksheet. You can click the Save or the Save and Continue button at the bottom of the page to
  proceed to the next form. If Form 6A is optional for you, but you choose to enter information, then you must
  enter all required information.
- If you chose a Business Entity other than "Tribal" or "Urban Indian," you must enter all required information on Form 6A.
- The minimum number of board members to be entered on Form 6A is 9 and the maximum number is 25.
- Applicants are required to list all current board members and provide the relevant details.

O Note(s):							
The List of Board M	tembers displayed below is pre	-populated from the late	st awarded Health Center P	rogram application/progre	ss report.		
· DETURIOR PINE	NUMBER OF ALLING	8. MC.		Due Date	e: all an all of (Due	In: Days)   Section	Status: Not Biothy
▼ Resources 🖬							
View LAL ID User Gu	ide LAL ID Instruction	IS LALIDITA					
elds with * are required Add New Board Men							
. List of All Board I	Member(s)						
Name	Current Board Office Position Held	Area of Expertise	>10% of income from health industry	Health Center Patient	Live or Work in Service Area	Special Population Representative	Options 2
Bartiana Torian	Teasurer	Prend	100	146	UNK .	14	@Update •
tancy trianalise	Vite President	Social Houts	14	-	UNK	140	@Update +
Jender					Number of Patie	ent Board Members	
Male							
Female							
Unreported/Declined	d to Report						
Ethnicity					Number of Patie	ent Board Members	
Hispanic or Latino							
Non-Hispanic or Lat	tino						
Unreported/Decliner	d to Report						
Race					Number of Patie	ent Board Members	
Native Hawalian							
Other Pacific Island	ers						
Aslan							
Black/African Ameri	ican						
American Indian/Ala	iska Native						
• White							
More Than One Rac	*						
Unreported/Declines	d to Report						
Note(s): This question is ON	ILY required if you selected Pu	blic (non-Tribal or Urban	Indian) as the Business En	tty on Form 1A of this a	pplication. In all other o	ases, select N/A.	
f you are a public orga	nization/center, do the board	members listed above	represent a co-applicant	board?			
©Yes ⊙No ₩	N/A						
fyes, ensure that the o	co-applicant agreement is in	cluded as Attachment	5 in the Appendices form	of this application.			
Go to Previous Page						11-12-12	Save and Continu

# Figure 36: Form 6A – Current Board Member Characteristics

To add the board member information, click the Add Board Member button (Figure 36, 1).

You must provide a minimum of 9 and a maximum of 25 board members. The system navigates to the **Current Board Member – Add** page (Figure 37).

Provide the required board member information on this page. Click the Save and Continue button to save the information and navigate back to the **Form 6A** list page (Figure 37, 1), or the Save and Add New button to save the information and add a new board member (Figure 37, 2).

To update or to delete information for any board member, click on **Update** or **Delete** link under the options column in the 'List of All Board Members' section (Figure 36, 2).

Enter the gender, ethnicity, and race of board members who are patients of the health center in the 'Number of Patient Board Members' sections (Figure 36, 3).

The totals for each of these sections should be equal. If you selected Public (non-Tribal or Urban Indian) as the business entity in **Form 1A** (Figure 7), of this application, then select 'Yes' or 'No' for the public organization/center related question. If you selected a different business entity in **Form 1A** (Figure 7), then select 'N/A' for this question. If you answer 'Yes' to this question, ensure that the co-applicant agreement is included as Attachment 6 in the **Appendices** form of this application. (Figure 5).

After providing complete information on **Form 6A**, click the Save and Continue button to save the information and proceed to the next form.

a Current Board Member - Add	
· BENDRICH PINE TOWN HERLTH ALLIANCE, INC.	Due Date: to an international (Due In: in Days)
Resources of     View     LAL ID User Guide LAL ID Instructions LAL ID TA	
Fields with * are required	
Board Member Information	
First Name	
Last Name	
Middle Initial	
Current Board Office Position Held	
Area of Expertise	
Does member derive more than 10% of income from health industry ?	© Yes © No
Is member a health center patient ?	© Yes © No
Live or work in service area ?	ELive E Work
Is member a special population representative (MHC, HCH, PHPC) ?	Yes. © No If Yes, please specify Special Population: Migrant Health (MHC) Homeless Health (HCH) Public Housing (PHPC)
Cancel	Save and Continue Save and Add New

# Figure 37: Current Board Member – Add Page

#### **IMPORTANT NOTES:**

- The totals of each **Patient Board Member Characteristics** section should be equal.
- The total number of patient board members under each characteristic should be less than or equal to the total number of patient board members (Yes under the Health Center Patient column) listed in the List of All Board Members section.
- Do not include board members that are not patients of the health center in this section.

# 4.11 Form 6B - Request for Waiver of Board Member Requirements

If you are proposing to serve only Migrant Health Center, Health Care for the Homeless, and/or Public Housing Primary Care, **Form 6B** is used to request a waiver of the patient majority governance requirement. HRSA will not grant a waiver request if your organization is applying to serve the general underserved community (Community Health Center (CHC)).

# 4.11.1 Completing Form 6B when it is not applicable

**Form 6B** is not applicable and you will only see the message depicted (Figure 38) if you have selected Community Health Centers (CHC) as the Target Population in the **Cover Page** form of this application. (Figure 3) OR You selected "Tribal" or "Urban Indian" as the Business Entity in Form 1A. (Figure 7). You can proceed to the next form by clicking the **Continue** button at the bottom of the form to change the status to complete.



BEFORE JONES COMMINSTY REALTY CENTER, LLC	Due Date: (Due In: Days)   Section Status:
Resources &	
View	
LAL ID User Guide   LAL ID Instructions   LAL ID TA	
Alert:     This form is not applicable to you as you are currently receiving or applying to receive Commu Entity in Form 1A.	inity Health Centers (CHC) designation and/or you have selected "Tribal" or 'Urban Indian' as the Busine:

# 4.11.2 Completing Form 6B when it is applicable

To complete **Form 6B** when it is applicable and necessary for your organization, indicate whether you are requesting a new waiver of the 51% patient majority governance requirement under the 'New Waiver Request' section (Figure 39, 1). If you answer "Yes", you must then complete the 'Demonstration of Good Cause for Waiver' section (Figure 39, 2) and the 'Alternative Mechanism for Addressing Patient Representation' section (Figure 39, 3). Answer the remaining questions on the form as applicable. After completing **Form 6B**, click the Save and Continue button to save your work and proceed to the next form.

Note(s): This form is applicable if you are proposing to serve only special populations in e. HORANIC, and/or PHPC)	
acception of the local of the local of the second states	
	Due Date: (Due In: Days)   Section Status:
· Resources (2	
View	
LAL ID User Guide   LAL ID Instructions   LAL ID TA	
iddo with * are required	
Request for Wolver	
Name of the Organization 1	ABOVE AND ADD. STORE CONTRACTOR
1. New Walver Request	
Are you requesting a new waiver of the 51% patient majority governance requirement?	O Yes O No
2. For Applicants with Previous Walver	
2a. Do you currently have a waiver of the \$1% patient majority governance requirement?	Cives = No
2b. Are you requesting the patient majority waiver to be continued?	C Yes T No (Governing board is in full compliance)
3. Demonstration of Good Cause for Walver (Demonstrate good cause for the walver request by addressing the fo	Rowing areas)
	Approximately 1/2 page (ii) (Max 1000 Characters without spaces): 1000 Characters left
3a. Provide a description of the population to be served and the characteristics of the population/service area that would necessitate a warver. (This question is notined, if you answered this to question 1 and/or question 2b.)	
	Approximately 12 page (II) (Max 1000 Characters without spaces), 1000 Characters left.
3b. Provide a description of the health center's attempts to meet the requirement to date and explain why these attempts have not been successful. (This question is required from ansense "Vis" to question 1 and or question 2b.)	
4. Alternative Mechanism Plan for Addressing Patient Representation	
	Approximately 1/2 page (#) (Max 1000 Characters without spaces): 1999 Characters (eff.
Present a plan for complying with the Internet of the statuse via an attainable mechanism that ensures patient Input and participation in the organization, as well as direction and organization provided the test of the health center. (This gestion is registed Figure answered "Res" to gestion 1 writin gestion 26.)	

# Figure 39: Form 6B when Applicable

#### **IMPORTANT NOTES:**

- Question 2 a and b will be pre-populated with 'No' and will be locked for any edits.
- Question 3 is required if you answered 'Yes' to question 1.

# 4.12 Form 8 - Health Center Agreements

**Form 8** indicates whether you have 1) any agreements with a parent, affiliate, or subsidiary organization; and/or 2) any agreements that will constitute a substantial portion of the proposed scope of the project, including a proposed site operated by a contractor, as identified in **Form 5B – Service Sites**. This form has Part I: Health Center Agreements (Figure 40, 1) and Part II: Attachments (Figure 40, 2).



	Intrangement after designation that will either (1) result in another organization carrying out a substantial portion of th , a Prior Approval request must be submitted in EHB and approved by HRSA before the agreement/arrangement can br
analysis among any fast, which thereafter	Due Date: (Due In: Days)   Section Status:
Resources C	
View	
LAL ID User Guide   LAL ID Instructions   LAL ID TA	
Ids with * are required	
ART I: Health Center Agreements	<b>(</b> )
1. Does your organization have a parent, affiliate, or subsidiary organization?	Oyes ONO
2. Do you currently have, or plan to utilize any contract or agreement with another organization to perform ubstantive programmatic work within the proposed scope of project? Contracting for substantive rogrammatic work applies to contracting with a single entity for the majority of health care providers.	
Note(s): • Contracts or agreements with related organizations, such as a parent, affiliate, or subsidiary must be addressed in this form, including management agreements. • The acquisition of supplies, materials, equipment, or general support services (e.g., janitorial services, contracts with individual providers) is not considered programmatic work.	Oyes ON
Yes, indicate the number of each agreement in 2a and complete Part II. If No, Part II is Not Applicable.	5
a. Number of contracts/agreements with another organization to perform substantive programmatic work ithin the proposed scope of project.	(A number up to 4 digits)
Add Organization Agreement	
art II: Attachments II contracts or agreements, including those which involve a parent, affiliate, or subsidiary organization referenc	ed in Part I must be uploaded in full. Uploaded documents will NOT count against the page limit.
No organization agr	eement details added

# 4.12.1 Completing Part I of Form 8

To complete Part I: Health Center Agreements, in Part-I, question 1 (Figure 40, 3), answer if your organization has a parent, affiliate, or subsidiary organization. Select '**Yes'** in question 2 (Figure 40, 4), if any current or proposed agreements exist with another organization to carry out a substantial portion of your organization's approved scope of the project, including a contract for the CEO. If 'Yes' is selected, complete 2a (Figure 40, 5).

**IMPORTANT NOTES:** If any of the sites proposed in **Form 5B – Services Sites** are operated by a contractor; the system will auto select 'Yes' for question 2 and make it non-editable.

# 4.12.2 Completing Part II of Form 8

If you answered 'Yes' to questions 1 or 2, provide each agreement with external organizations as noted in Part I. The agreements will be organized by the organization. To add agreements, click on Add Organization Agreement (Figure 40, 2) to open the Organization Agreement – Add page (Figure 41). Provide the required information for the agreement in the 'Organization Agreement Detail' section on this page. Upload at least one document related to the agreement in the 'Attachments' section at the bottom of this page by clicking the Attach File button. Click Save and Continue to return to the Form 8 – Health Center Agreements page. Following the steps described above, enter additional organizations and corresponding agreements as referenced in Part I. After completing Form 8, click the Save and Continue button to save your work and proceed to the next form.

Organization Agreement - Add			
<ul> <li>INFERIOR</li> <li>E. B. S. S. E. SHORTING, INC., 10 (10) 1711-181</li> </ul>			Due Date: (Due In: Days)
▼ Resources ⊔*			
View			
LAL ID User Guide LAL ID Instructions LAL ID TA			
Fields with * are required			
Organization Agreement Detail			
Organization			
Affiliate/Contract Organization Name		(maximum 50 characters)	
Type of Agreement	O Affiliation Agreement		
<ul> <li>type or Agreement</li> </ul>	O Contract		
Wote(s):			
<ul> <li>You must upload at least one document for this affiliation.</li> <li>Before uploading a document for this affiliation, please rename the file to include the affiliated organizable</li> </ul>	on's name e.g. 'CincinnatiHospital _LocationDe	tails.doc'.	
<ul> <li>Attachments (Minimum 1) (Maximum 5)</li> </ul>			2 Attach File
	No documents attached		
Cancel			Save Save and Continue

## Figure 41: Organization Agreement – Add page

**IMPORTANT NOTES**: Before uploading a document for Form 8, rename the file to include the affiliated organization's name (e.g., 'CincinnatiHospital\_MOA.doc').

# Form 12 – Organization Contacts

Use **Form 12 – Organization Contacts** to provide contact information for the proposed project. Enter contact information for the Chief Executive Officer, Contact Person, Clinical Director, and Dental Director (optional) by clicking on the Add button (Figure 42).

<ul> <li>Annual Annual Annual Annual</li> </ul>	CONTRACTOR OF THE OWNER OF THE OWNER			Due Date: (Due In	Days)   Section Status:
Resources				Due Date. (Due in	Days) [ section status.
View					
LAL ID User Guide   LAL ID Instru	actions   LAL ID TA				
Fields with * are required					
Contact Information					
Chief Executive Officer	Name	Highest Degree	Email	Phone Number	Option
					O Add Chief Executive Officer 👒
Contact Person	Name	Highest Degree	Email	Phone Number	Option
					🙆 Add Contact Person 👻
* Chief Medical Officer	Name	Highest Degree	Email	Phone Number	Option
					🚫 Add Chief Medical Officer 🖙
Dental Director	Name	Highest Degree	Email	Phone Number	Option
					Add Dental Director 💌
Behavioral Health Director	Name	Highest Degree	Email	Phone Number	Option
					Add Behavioral Health Director

Figure 42: Form 12 – Organization Contacts

The system directs you to the data entry page for the corresponding contact. Enter the required contact information. (Figure 43). Click Save to save the information and remain on the same page or click Save and Continue to save the information and proceed to the Form 12 – Organizations Contact page to add information for the next contact. To update the contact information provided, click on the Update link under the options column. To delete the contact information already provided, click on the Delete link under the options column. After providing complete information on Form 12, click the Save and Continue button to save the information and proceed to the next form.

Chief Executive Officer - Add						
101100000 E.A.S.S.E.BEATHL HENLTH	AND TTALTE	Due Date: (Due In: Days)				
▼ Resources 🖸						
View						
LAL ID User Guide   LAL ID Instructions   LA	L ID TA					
Fields with * are required						
Add New Contact Information						
Position Title	Chief Executive Officer					
* Prefix	Select Option					
* First Name						
* Last Name						
Middle Initial						
Suffix	Select Option					
Sullix	If 'Other', please specify:	(maximum 100 characters)				
Highest Degree	Select Option					
nigliest peglee	If 'Other', please specify:	(maximum 100 characters)				
* Email Address						
* Phone Number	- Ext.					
Cancel		Save Save and Continue				

# Figure 43: Chief Executive Officer – Add page

# **IMPORTANT NOTE:**

The Update and the Delete link will be displayed only after you have added the contact information. The 'Prefix' (e.g., Dr., Ms.) is a required field for the Chief Executive Officer.

# 4.13 Clinical Performance Measures

Use this form to provide information about Clinical Performance Measures. The Clinical Performance Measures form displays Required Measures and Additional Measures. The Required Measures are HRSA-defined measures; applicants are required to provide the requested information for all required measures. Additional Measures are self-defined and optional.

- Refer to the Look-Alike Initial Designation instructions for more information on completing the Clinical Performance Measures form.
- Two clinical performance measures were removed (Use of Appropriate Medications for Asthma and Coronary Artery Disease: Lipid Therapy), four were added (Statin Therapy for the Prevention and Treatment of Cardiovascular Disease, Depression Remission at 12 Months, Breast Cancer Screening, and HIV Screening) and one was revised (HIV Linkage to Care).
- The Dental Sealants measure is the only measure for which the goal can be zero if services are not provided directly or by a formal agreement in which your health center pays for the service. In this instance, a self-defined Oral Health measure must be proposed.
- You must provide all information for all required performance measures listed in this form.

# **4.14.1 Completing the Required Clinical Performance Measures**

To complete the required Clinical Performance Measures click on the **Update** link to start working on a performance measure (Figure 44, 1) and the system navigates to the **Clinical Performance Measure – Update** page (Figure 45).

CARLS INCOME IN CARLS	C BALTY TARBETTA		Due Dat	e: (Du	n: Days)   Sec	tion Status:	-
Resources 🕈							
ew							
AL ID User Guide   LAL ID Instructions	LALIDTA						
	2						
id Additional Performance Measure					Col	apsa Genep] 📰 Da	tailed
Focus Area	Performance Measure	Baseline Data	Baseline Year	Projected Data	Status	Options	
Y	x .		Al • ¥		AI •	1	(
quired Measures							
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Percentage of patients age 16-75 years with diabetes who had temographin A1c > 9.0% during the measurement period.				Not Complete	@Update	1
Screening for Depression and Follow-up Plan	Percentage of partients age 12 years and older screened for depression on the date of the visit using an age appropriate standardized depression screening tool AND. If the screening is positive, a follow-up plan is documented on the date of the positive screening.				Not Complete	@Update	•
Depression Remission at 12 Nonths	Percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+i-60 days) after an index event.				Not Complete	@ Update	•
Weight Assessment and Counseling for Nutrition and Physical Adivity for Children and Adolescents	Percentage of patients age 3-17 years who had a medical visit and evidence of height, weight, and BMI percentile documentation, and who had documentation of (1) counseling for nutrition, and (2) counseling for physical activity during the measurement period.				Not Complete	@ Update	•
Body Mass Index (BNI) Screening and Follow-up Plan	Percentage of patients age 15 years and older with a BMI documented during the most recent visit or within the previous 12 months to that visit. AVD when the BMI is outside of neural genarateers, a follow-up plan is documented during the visit of using the pervious 12 months of that visit. Normal Perameters: Age 18 years and older with a BMI greater than or equal to 18.5 and less than 25 kg/m2.				Not Complete	@ Update	•
Controlling High Blood Pressure	Percentage of patients age 18-85 years who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/96 mm Hg) during the measurement period.				Not Complete	(@ Update	•
Low Birth Weight	Percentage of babies of health center prenatal care patients born whose birth weight was below normal (less than 2,500 grams)				Not Complete	( Update	•
Early Entry Into Prenatal Care	Percentage of prenatal care patients who entered prenatal care during their first trimester.				Not Complete	Update	•
Childhood Immunization Status	Percentage of children 2 years of age who had four diphtneria, tetanos, and aceituire persusia (DTaPE) troes polo (IPV), one measies, munoya, and rubeia (MMR), thee M Hinduras type B) (Hills, three Hepatitis B) (Hep- B), one chicken pox (VZP), four presenceccard cotigate (PCV); one Hepatite A (Hep A); two or three rotariums (RV), and the influenze (Bio vaccines by their second birthday.				Not Complete	@ Update	•
Cervical Cancer Screening	Percentage of women age 21-54 years, who were screened for cervical cancer using either of the following criteria: 1). Women age 21-54 who had cervical cyblogy performed every three years, or 2). Women age 30- 64 who had cervical cyblogy/human pepilomative, (HPY) co being performed every three years.				Not Complete	@ Update	•
Tobacco Use: Screening and Cessation Intervention	Percentage of patients age 16 years and older who were screered for tobacco use one or more times within 24 months AND who received cessation intervention, if defined as a tobacco user.				Not Complete	@ Update	•
	Percentage of the following patients - all considered at high risk of cardiovasoilar events - who were prescribed or were on statin therapy during the measurement period.						
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	<ul> <li>Adhta sgs &gt;= 21 years into verie previously diagnosed with, or currently have, an active diagnosis of clinical administration resolution of the diagnosis of the diagnosis of Adhta sgs &gt;= 21 years had have even have fasting, or direct low-density lipsprotein cholesterol (USLC) with 21 bit 700 mgl, or user previously diagnosed with, or currently have an active diagnosis of familial or pure hypercholestoniaming. OB</li> <li>Adhta sgs 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-185 mg/dQ.</li> </ul>				Not Complete	@Update	•
Ischemic Vascular Disease (IVD) Use of Aspirin or Another Antiplatelet	Percentage of patients age 18 years and older who were diagnosed with acute myocardial inflaction (AMI), commary strety typass graft (CABG) or percentaneous coronary interventions (PCI) in the 12 months prior to the measurement proticed, and had active diagnosis of informic vascular disease (WO) during the measurement priori.				Not Complete	( Update	•
Colorectal Cancer Screening	Percentage of patients age 50-75 years who had appropriate screening for colorectal cancer.				Not Complete	@Update	•
Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast carcar in the 27 months prior to the end of the measurement period.				Not Complete	@ Update	•
HIV Screening	Percentage of patients age 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV.				Not Complete	( Update	•
HIV Linkage to Care	Percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 30 days of diagnosis.				Not Complete	Dpdate	•
Dental Sealants for Children between 6-9 Years	Percentage of children, age 6-9 years at moderate to high risk for caries who received a sealant on a permanent first molar during the measurement paelod.				Not Complete	(@Update	•

# Figure 44: Clinical Performance Measures page

Clinical Performance Measure	s - Update
a second among some hand.	No. 5 Party Tax
▼ Resources ピ	
View	
LAL ID User Guide   LAL ID Instructions	LALID TA
Fields with * are required	
Update Clinical Performance Measure Inform	ation
Focus Area	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
Performance Measure	Percentage of patients age 18-75 years with diabetes who had hemoglobin A1c > 9.0% during the measurement period.
	Approximately 1/4 page (Max 500 characters with spaces)
Target Goal Description     (Sample Goals@)	
Numerator Description	Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%.
Denominator Description	Patients age 18-75 years with diabetes with a visit during the measurement period. Exclude patients: whose hospice care overlaps the measurement period, 66 and older with advanced illness and fraitly, because it is unlikely that patients will benefit from the services being measured, OR who are living long term in an institution for more than 90 days during the measurement period.
• Baseline Data	Baseline Year (yyyy) Measure Type Percentage Numerator Denominator Calculate Baseline
<ul> <li>Projected Data (by End of Designation Pe (Sample Calculation<sup>2</sup>)</li> </ul>	Projected Goal Measure Type Percentage
<ul> <li>Data Sources &amp; Methodology</li> </ul>	EHR     Chart Audit     Other If 'Other', please specify:     (maximum 100 characters)  Approximately 1/4 page (Max 500 characters with spaces)
Add New Key Factor and Major Planned A	uction
List of Key Factors and Major Planned Ac	tions (Minimum 2) (Maximum 3)
Key Factor Type	Description Major Planned Action Options
	No key factors and major planned actions added
Comments (Required if performance measure is n	of applicable)
Approximately 3/4 page (Max 1500 Characters	with spaces)
Cancel	

#### Figure 45: Clinical Performance Measure - Update page

Provide a **Target Goal Description** for each performance measure (**Figure 45, 1**). For all required measures, the Numerator and Denominator descriptions are prepopulated (**Figure 45, 2**). For Baseline Data, enter the year of the data provided and the numerator and denominator values based on the descriptions given. Click the Calculate Baseline button to show the baseline percentage (**Figure 45, 4**). Enter the projected goal by the end of the designation period as a percentage (**Figure 45, 3**). Select an appropriate response in the Data Sources & Methodology field. If 'Other' is selected, specify a name and description. Click on the Add New Key Factor and Major Planned Action button to add Key Factors (**Figure 45, 5**). The system navigates to the **Key Factor and Major Planned Action – Add** page (**Figure 46**). Provide all the required information.

#### **IMPORTANT NOTES:** The Projected goal should not be greater than 100%

#### Figure 46: Key Factors and Major Planned Action - Add page

Key Factor and Major Planned Action - Add	
	Due Date: (Due In: J Days)
▼ Resources Ľ	
View	
LAL ID User Guide LAL ID Instructions LAL ID TA	
Fields with * are required	
Key Factor and Major Planned Action Information	
* Key Factor Type	O Contributing O Restricting
	Approximately 3/4 page ④ (Max 1500 Characters): 1500 Characters left.
* Key Factor Description	^
	✓
	Approximately 3/4 page (i) (Max 1500 Characters): 1500 Characters left.
<ul> <li>Major Planned Action Description</li> </ul>	
Cancel	Save and Continue Save and Add New

Click the Save and Continue button (Figure 46, 1) to save the information on this page and proceed to the **Clinical Performance Measures – Update** page, or click the Save and Add New button (Figure 46, 2) to save the key factor information you provided and proceed to add a new key factor. Provide information for at least one restricting and one contributing Key Factor type. This option will not be available if two key factors have already been added and they are completing a third. Provide comments in the Comment field if needed (Figure 45, 6). Click on the Save button to save the information on the **Update Measure** page (Figure 45, 7). To proceed to the **Clinical Performance Measures – List** page, click on the Save and Continue to List button (Figure 45, 8) or click on the Save and Update Next button to update the next performance measure (Figure 45, 9).

- If the performance measure goal for Dental Sealants for Children between 6-9 Years is set to 0, at least one selfdefined Oral Health performance measure must be entered in the Additional Clinical Performance Measures section.
- Provide information for at least one restricting and one contributing Key Factor type. You can add a minimum of 2 and a maximum of 3 Key Factors. (Figure 45, 5).
- The Numerator should be less than or equal to the denominator so that the Baseline Percentage is less than or equal to 100%. (Figure 45, 4).

# 4.15.1 Adding Additional Clinical Performance Measures

To add an Additional Clinical Performance Measure to your application click the Add Additional Performance Measure button on the **Clinical Performance Measures – List** page (Figure 44, 2). The **Add Clinical Performance Measure** page opens.

Fields with * are required          Add Clinical Performance Measure Information         • Focus Area         (ral Health         • Cal Bease specify:         (maximum 100 characters)         Performance Measure Category         Performance Measure Category         Performance Measure Category         Performance Measure Category         (ral Health         (ral Health         • Cal Bease specify:         (maximum 100 characters)         (ral Health         • Could Surgery         • Rehabilitative Services         • Oral Surgery         • If 'Other', please specify:         • (maximum 100 characters)         • (f'Other', please specify:         • (maximum 100 characters)	FI	gure 47: Add Clinical Performance Me	asure
Focus Area  Oral Health      f 'Other', please specify:      f 'Other', please specify:	Fields with * are required		
Focus Area  If 'Other', please specify:  (maximum 100 characters)  All  mergency Services Oral Exams Restorative Services Oral Surgery Rehabilitative Services Rehabilitative Servi	Add Clinical Performance Measure Information		
All         Emergency Services         Oral Exams         Restorative Services         Oral Surgery         Rehabilitative Services         Oral Surgery         Rehabilitative Services         Prophylaxis - Adult or Child         Sealants         Fluoride Treatment - Adult or Child         Other	* Focus Area		
	Performance Measure Category	All Emergency Services Oral Exams Restorative Services Oral Surgery Rehabilitative Services Prophylaxis - Adult or Child Sealants Fluoride Treatment - Adult or Child Other	

Select a focus area from the drop-down menu (Figure 47, 1).

If you select Oral Health as the focus area, click on the Load Performance Measure

Category button (Figure 47, 2) to load the performance measure categories and then select one or more, as applicable.

If you select Other as the focus area, you must specify the performance measure focus area. Provide the required information on this page.

Click on the Add New Key Factor and Major Planned Action button to add Key Factors. Provide information for at least one restricting and one contributing Key Factor type.

There is a maximum of 3 and a minimum of 2 Key Factors that can be added.

Click on the Save button to save the information on the **Update Measure** page.

To proceed to the **Clinical Performance Measures – List** page, click the Save and Continue button.

The newly added measure will be listed under the 'Additional Measures' section. Additional measures can be updated and/or deleted by using the **Update** and/or **Delete** links provided as options.

# **4.16** Financial Performance Measures

Use this form to provide information about financial performance measures.

#### **IMPORTANT NOTE:**

Refer to the Look-Alike Initial Designation instructions for more information on completing the Financial Performance Measures form.

The **Financial Performance Measures** form displays Required and Additional Measures. The **Required Measures** are pre-defined measures; applicants are required to provide the requested information for all the required measures. If desired, applicants may enter Additional Measures. These measures are optional.

#### 4.16.1 Completing the Required Financial Performance Measures

There are two required performance measures listed in this form. To complete this form click on the **Update** link to start working on a performance measure (Figure 48, 1). The system navigates to the Financial Performance Measure – **Update** page (Figure 49).

🗟 Fina	ancial Performance M	easures						
•	CARLES AND DESCRIPTION OF	NUMBER OF TRANSPORTED			Due Date:	(Due In:	Days)   Section	Status:
- R	esources 🖆							
Vie	w							
LA	LID User Guide   LAL ID Instru	ictions   LAL ID TA						
	d Additional Performance Meas Focus Area	Performance Measure	7	Baseline Data	Baseline Year	Projected Data	Collapse C Status	Options
# Req	uired Measures							
•	Total Cost Per Total Patient (Costs)	Ratio of total cost per patient served in the measurement calendar year.					Not Complete	Update 👻
	Medical Cost Per Medical Visit (Costs)	Ratio of total medical cost per medical visit in the measurement calendar ye	ar.				Not Complete	🚱 Update 🔻
Go to	Previous Page						Save	Save and Continue

# Figure 48: Financial Performance Measures – List page

- All required Financial Performance Measures will have a status of 'Not Complete'.
- The Financial Performance Measures form will become 'Complete' when the statuses of all required performance measures and additional performance measures are 'Complete'.
- You must provide all information for all required performance measures listed in this form.
- Provide information for at least one restricting and one contributing Key Factor type.

ACCOUNTS ADDRESS OF TAXABLE MADE	to Annual State	Du	e Date: (Due In: Days)   Section S	status:
Resources L				
View				
LAL ID User Guide   LAL ID Instructions   LAL ID	AT			
lds with * are required				
pdate Financial Performance Measure Information				
ocus Area	Total Cost Per Total Patient (Costs)			
erformance Measure	Ratio of total cost per patient served in th	e measurement calendar year.		
1	Approximately 1/4 page (Max 500 charac	ters with spaces)		
Target Goal Description				
lumerator Description	Total accrued cost before donations and	after allocation of overhead.		
enominator Description	Total number of patients			
Baseline Data	Baseline Year Measure Type Ratio Numerator Denominator Galculate Baseline & 2	(איניני)		
Projected Data (by End of Designation Period) Sample Calculation(2)	Projected Goal Measure Type Ratio			
* Data Sources & Methodology	Approximately 1/4 page (Max 500 charac	ters with spaces)		
Add New Key Factor and Major Planned Action				
List of Key Factors and Major Planned Actions (M	inimum 2) (Maximum 3)			
ey Factor Type	Description	Major Planned Action	Options	
	No key	factors and major planned actions added		
omments (Required if performance measure is not applica				
pproximately 3/4 page (Max 1500 Characters with spar	ces)			

## Figure 49: Financial Performance Measure – Update Page

Provide a **Target Goal Description** for each performance measure (Figure 49, 1). For Baseline Data, enter the year of the data provided and the numerator and denominator values based on the descriptions given.

Click the Calculate Baseline button to show the baseline ratio (Figure 49, 2). Enter the projected goal by the end of the designation period.

Enter the Data Sources & Methodology used for the measure. Click on the Add New Key Factor and Major Planned Action button to add Key Factors.

Provide information for at least one restricting and one contributing Key Factor type.

Click the Save and Continue button to save the information on the **Key Factor and Major Planned Action – Add the** page and proceed to the **Financial Performance Measures – Update** page, or click the Save and Add New button to save the key factor information and proceed to add a new key factor.

The Comments field is optional. Click on the Save button to save the information on this page.

To proceed to the **Financial Performance Measures – List** page, click on the Save and Continue to List button, or click on the Save and Update Next button to update the next performance measure.

# 4.16.2 Adding Additional Financial Performance Measures

To add an Additional Financial Performance Measure to your application, click the Add Additional Performance Measure button on the **Financial Performance Measures – List** page. The **Add Financial Performance Measures** page opens. (Figure 50). Select the Focus Area in the Financial Performance Measures. (Figure 50, 1). The options are

- Medical Costs Per Medical Visits (Costs)
- Total Cost Per Total Patients (Costs)
- Other

If you select Other as the focus area, you must specify the performance measure focus area. (Figure 50, 2). To add the key factors, click on the Add New Key Factor and Major Planned Action button. Provide information for at least one restricting and one contributing Key Factor type.

Click on the Save button to save the information on the **Update Measure** page. To proceed to the performance measure list page, click on the Save and Continue button. The newly added measure will be listed in the 'Additional Measures' section on the **Financial Performance Measures – List** page. (Figure 50, 3)

Additional measures can be updated and/or deleted by using the **Update** and/or **Delete** links provided as options.

**IMPORTANT NOTE**: Provide information for a minimum of 2 and a maximum of 3 New Key Factor and Major Planned Action.

Financial Performance Measures - A	dd		
<ul> <li>many second contract, spectral</li> </ul>	h Maadaa Mada	20.0	as WOUND for to 8 Maps, Solito Bate for Longen.
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Fields with * are required			
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* Focus Area	Select Option		2
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Performance Measure			
	/		
	Approximately 1/4 page (Max 500 characters with spa	ces)	
<ul> <li>Target Goal Description (Sample Goalse)</li> </ul>			
	Approximately 1/4 page (Max 500 characters with spa	ces)	
Numerator Description			
(Examples 2)			
	<i>A</i>		
	Approximately 1/4 page (Max 500 characters with spa	ces)	
Denominator Description     (Examples@)			
	Baseline Year	(уууу)	
	Measure Type Select Option	•	
* Baseline Data	Numerator		
Daterire Data	Denominator		
	Calculate Baseline		
	0		
Projected Data (by End of Designation Period)	Projected Goal		
(Sample Calculatione)	Measure Type Select Option *		
	Approximately 1/4 page (Max 500 characters with spa	ces)	
Data Sources & Methodology			
Add New Key Factor and Major Planned Action			
<ul> <li>List of Key Factors and Major Planned Actions (Mi</li> </ul>			
Key Factor Type	Description	Major Planned Action	Options
	No Key factors and	major planned actions added	
Comments (Required if performance measure is not applicate	bie)		
Approximately 3/4 page (Max 1500 Characters with space	ces)		
L			
Cancel			Save Save and Continue to List Save and Update Next

# Figure 50: Financial Performance Measures- Add

# 5. Reviewing and Submitting the Look-Alike Initial Designation Application to HRSA

To review your application, click on the Status link on the left side menu. (Figure 51)



# Figure 51: Left menu – Review and Submit

On the **Application – Status Overview** page, click the **Review** link in the 'Review and Submit' section of the left menu. The system navigates to the **Review** page (Figure 52).

Figure \$	52: Re	view p	bage
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<ul> <li>must reach a sup cost of the property of the second se second second sec</li></ul>			Approximation designs in frequency
▼ Resources ⊡*			
View			
Application Action History LAL Application User Guide			
Print Application		Table of Contents	
H ( ) H Page size 50 V Go			23 items in 1 page
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- x	- Y	• V	
View: Basic Information			
Basic Information	Cover Page	HTML	View 👻
View: Program Specific Information			
Program Specific Information	Program Specific OMB Approved Forms	HTML	Open Popup *
View: Attachments List			
Attachments List	Project Abstract	DOCUMENT	Not Available
Attachments List	Project Narrative	DOCUMENT	Not Available
Attachments List	Attachment 1: Patient Origin and Utilization Information	DOCUMENT	Not Available
Attachments List	Attachment 2: Service Area Map and Table	DOCUMENT	Not Available
Attachments List	Attachment 3: Medicare and Medicaid Documentation	DOCUMENT	Not Available
Attachments List	Attachment 4. Bylaws	DOCUMENT	Not Available
Attachments List	Attachment 5: Governing Board Meeting Minutes	DOCUMENT	Not Available
Attachments List	Attachment 6: Co-Applicant Agreement (if applicable)	DOCUMENT	Not Available
Attachments List	Attachment 7. Contracts and Referral Arrangements (if applicable)	DOCUMENT	Not Available
Attachments List	Attachment 8: Articles of Incorporation	DOCUMENT	Not Available
Attachments List	Attachment 9: Evidence of Non-Profit or Public Agency Status	DOCUMENT	Not Available
Attachments List	Attachment 10: Financial Statements	DOCUMENT	Not Available
Attachments List	Attachment 11: Organizational Chart	DOCUMENT	Not Available
Attachments List	Attachment 12: Position Descriptions for Key Personnel	DOCUMENT	Not Available
Attachments List	Attachment 13: Biographical Sketches for Key Personnel	DOCUMENT	Not Available
Attachments List	Attachment 14 Sliding Fee Discount Schedule	DOCUMENT	Not Available
Attachments List	Attachment 15: Collaboration Documentation	DOCUMENT	Not Available
Attachments List	Attachment 16: Floor Plans	DOCUMENT	Not Available
Attachments List	Attachment 17: Budget Narrative	DOCUMENT	Not Available
Attachments List	Attachment 18: Health Center Program Requirements Compliance	DOCUMENT	Not Available
Attachments List	Attachment 19: Other Relevant Documents	DOCUMENT	Not Available

Verify the information displayed on the **Review** page.

If you are ready to apply HRSA, click the Proceed to Submit button at the bottom of the Review page (Figure

52, 1). The system navigates to the Submit page (Figure 52).

Click the Submit to HRSA button at the bottom of the **Submit** page (Figure 52, 1). The system navigates to a confirmation page.

- The application must be submitted to HRSA by the Authorizing Official.
- To apply, you must have the 'Submit' privilege. This privilege must be given by the Project Director (PD) to the Authorizing Official (AO).
- If you are not the AO, a Submit to AO button will be displayed at the bottom of the Submit page. Click the button to notify the AO that the application can be submitted to HRSA.

Figure 53: Submit to HRSA

re here: Home » Tasks » Browse » FQHC-LAL Applications »		
Application - Submit		
	Due Date:	(Due In: days)   Application Status:
▼ Resources Ľ		
View		
Application Action History LAL Application User Guide		
Users with permissions on this application (1)		
List of forms that are part of the application package		
Section	Status	Options
Basic Information		
Cover Page	🖌 Complete	🕜 Update
Other Information		
Appendices	Complete	🕜 Update
Program Specific Information		
Program Specific Information	Complete	🕼 Update
Program Specific Information		
Program Specific Information		1

Check the Application Certification to electronically sign the application and click the Submit to HRSA button.

If you experience any technical issues (e.g. problems with submitting the application in EHBs), contact the **Health Center Program Support** at 1-877-464-4772 (Monday – Friday, 8:30 AM - 5:30 PM ET) or send an email through the **Web Request Form** (<u>http://www.hrsa.gov/about/contact/bphc.aspx</u>).