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

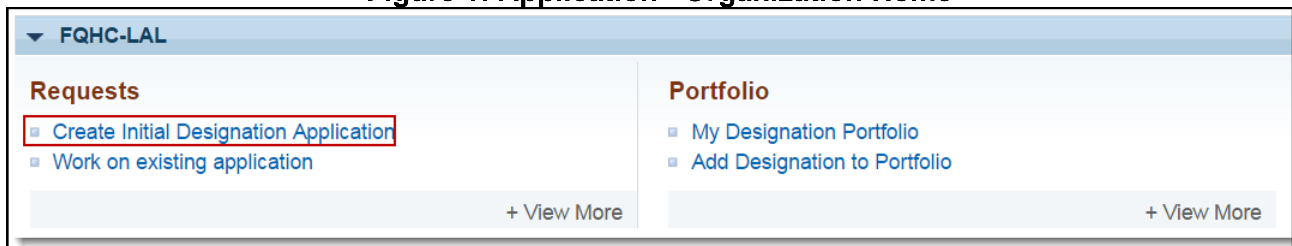
You must have an EHBs user account to create a Look-Alike Initial Designation (ID) application. For additional instruction on how to create an EHBs account, use the New User Registration page at https://grants.hrsa.gov/2010/WebEPSExternal/Interface/UserRegistration/RegistrationHome.aspx.

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



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.

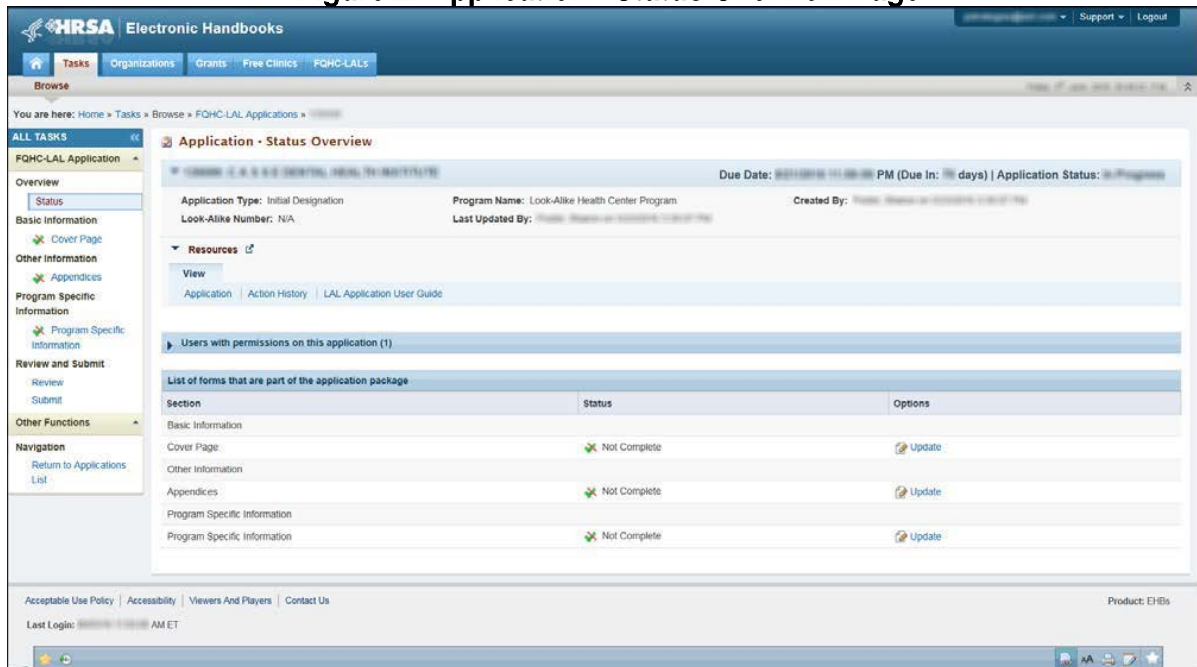
Click Continue with Application to open the **Application - Status Overview** page that has links to the application components (Cover Page, Appendices, and Program Specific Information) on the left menu.

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)**

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.

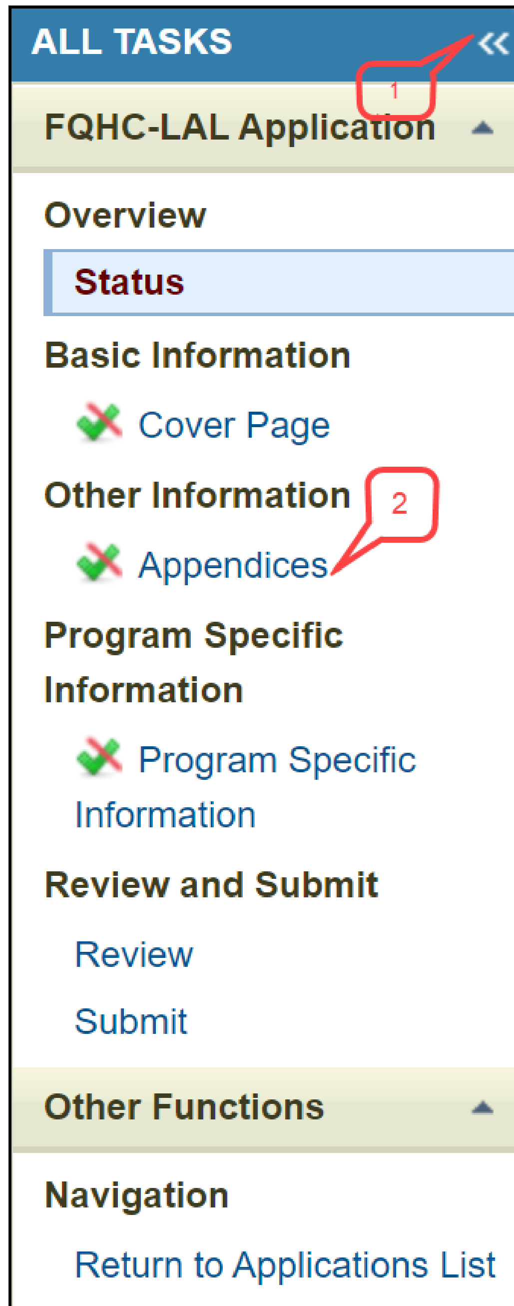
IMPORTANT NOTE: If you select any special populations on the cover page, you will be required to enter the current number of patients for that special population on Form 1A

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)

Figure 5: Appendices

Appendices

Section Not Complete

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* Project Abstract (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Project Narrative (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 1: Patient Origin and Utilization Information (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 2: Service Area Map and Table (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 3: Medicare and Medicaid Documentation (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 4: Bylaws (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 5: Governing Board Meeting Minutes (Minimum 1) (Maximum 1) — Attach File
No documents attached
Attachment 6: Co-Applicant Agreement (if applicable) (Maximum 1) — Attach File
No documents attached
Attachment 7: Contracts and Referral Arrangements (if applicable) (Maximum 1) — Attach File
No documents attached
* Attachment 8: Articles of Incorporation (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 9: Evidence of Non-Profit or Public Agency Status (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 10: Financial Statements (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 11: Organizational Chart (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 12: Position Descriptions for Key Personnel (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 13: Biographical Sketches for Key Personnel (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 14: Sliding Fee Discount Schedule (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 15: Collaboration Documentation (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 16: Floor Plans (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 17: Budget Narrative (Minimum 1) (Maximum 1) — Attach File
No documents attached
* Attachment 18: Health Center Program Requirements Compliance (Minimum 1) (Maximum 1) — Attach File
No documents attached
Attachment 19: Other Relevant Documents (Maximum 5) — Attach File
No documents attached

Go to Previous Page | Save | Save and Continue

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

Status Overview

Due Date: | Program Specific Status: Not Complete

Look-Alike Number: Not Available   Target Population: Application Type: Initial Designation

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Program Specific Information Status

Section	Status	Options
General Information		
Form 1A - General Information Worksheet	Not Started	Update
Form 1C - Documents On File	Not Started	Update
Form 4 - Community Characteristics	Not Started	Update
Budget Information		
Form 2 - Staffing Profile	Not Started	Update
Form 3 - Income Analysis	Not Started	Update
Form 3A - Budget Information	Not Started	Update
Sites and Services		
Form 5A - Services Provided	Not Started	
Required Services	Not Started	Update
Additional Services	Not Started	Update
Specialty Services	Not Started	Update
Form 5B - Service Sites	Not Started	Update
Form 5C - Other Activities/Locations	Not Started	Update
Other Forms		
Form 6A - Current Board Member Characteristics	Not Started	Update
Form 6B - Request for Waiver of Board Member Requirements	Not Started	Update
Form 8 - Health Center Agreements	Not Started	Update
Form 12 - Organization Contacts	Not Started	Update
Performance Measures		
Clinical Performance Measures	Not Started	Update
Financial Performance Measures	Not Started	Update

Return to Complete Status

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**)

Figure 7: Form 1A – General Information Worksheet

Form 1A - General Information Worksheet

Due Date: | Section Status:

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Fields with * are required

1

1. Applicant Information

Applicant Name

* 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
- Other

If 'Other' please specify:

(maximum 100 characters)

2

2. Proposed Service Area

Note(s):
Applicants applying for Community Health Center Designation must provide at least one designated 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

* Select MUA/MUP
(Each ID must be 5 to 12 digits. Use commas to separate multiple IDs, without spaces)

Find an MUA/MUP

- Medically Underserved Area (MUA) ID #
- Medically Underserved Population (MUP) ID #
- Medically Underserved Area Application Pending ID #
- Medically Underserved Population Application Pending ID #

2b. Service Area Type

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

2c. Patients and Visits

Unduplicated Patients and Visits by Population Type

* How many unduplicated patients do you project to serve in the last year of the three-year designation period?

Population Type	Current Number		Projected by End of Designation Period	
	Patients	Visits	Patients	Visits
* Total				
* General Underserved Community (Include all patients/visits not reported in the rows below)				
* Migratory and Seasonal Agricultural Workers and Families				
* Public Housing Residents				
* People Experiencing Homelessness				

Patients and Visits by Service Type

Service Type	Current Number		Projected by End of Designation Period	
	Patients	Visits	Patients	Visits
* Total Medical Services				
* Total Dental Services				
Behavioral Health Services				
* Total Mental Health Services				
* Total Substance Use Disorder Services				
* Total Vision Services				
* Total Enabling Services				

Go to Previous Page | Save | Save and Continue

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**).

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 https://datawarehouse.hrsa.gov/tools/analyzers/muafind.aspx 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 Community Health Center Designation must provide at least one designated 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

1

* Select MUA/MUP
(Each ID must be 5 to 12 digits. Use commas to separate multiple IDs, without spaces)
Find an MUA/MUP

☐ Medically Underserved Area (MUA) ID #
☐ Medically Underserved Population (MUP) ID #
☐ Medically Underserved Area Application Pending ID #
☐ 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 https://www.hrsa.gov/rural-health/about-us/definition/index.html

Figure 10: Service Area Type Section

2b. Service Area Type

* Choose Service Area Type

○ Urban
○ Rural
☐ 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 http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html.

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.

Figure 11: Unduplicated Patients and Visits by Population Type

2c. Patients and Visits

Unduplicated Patients and Visits by Population Type

* How many unduplicated patients do you project to serve in the last year of the three-year designation period? (1)

Population Type	Current Number (3)		Projected by End of Designation Period (4)	
	Patients	Visits	Patients (2)	Visits
* Total				
* General Underserved Community (Include all patients/visits not reported in the rows below)				
* Migratory and Seasonal Agricultural Workers and Families				
* Public Housing Residents				
* People Experiencing Homelessness				

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**).

Figure 12: Patients and Visits by Service Type

Patients and Visits by Service Type

Service Type	Current Number (1)		Projected by End of Designation Period (3)	
	Patients (2)	Visits	Patients (4)	Visits
* Total Medical Services				
* Total Dental Services				
Behavioral Health Services				
* Total Mental Health Services				
* Total Substance Use Disorder Services				
* Total Vision Services				
* Total Enabling Services				

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.

Figure 13: Form 1C: Documents on File

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/procedure documents required to be maintained on file. Records demonstrating implementation of required policies and procedures must also be available for review.
[1] Pub.L. 115 - 141, Consolidated Appropriations Act, 2018, Division H, Title V, Section 520
[2] Pub.L. 115 - 141, Consolidated Appropriations Act, 2018, Division H, Title V, Sections 506 and 507

Due Date: (Due In: Days) | Section Status:

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Management and Finance	Date of Last Review/Revision (MM/DD/YYYY)	Not Applicable (N/A)
* Personnel policies, including selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices.		
* Procurement procedures.		
* Standards of Conduct/Conflict of Interest policies/procedures.		
* Financial Management/Accounting and Internal Control policies and/or procedures to ensure that any federal funds are not expended for restricted activities.		
* 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. [1] (Only applicable if your organization provides syringe exchange services or is otherwise engaged in syringe service programs; otherwise, indicate as N/A).		☐
* 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 the life of the mother.[2] (Only applicable if your organization provides abortion services; otherwise, indicate as N/A).		☐
* 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.		
* Sliding Fee Discount Program policies, operating procedures, and sliding fee schedule.		
* Quality Improvement/Assurance Program policies and operating procedures that address clinical services and management, patient safety, and confidentiality of patient records.		

3

Governance	Date of Last Review/Revision (MM/DD/YYYY)	Not Applicable (N/A)
* Governing Board Bylaws.		
* Co-Applicant Agreement (Only applicable to public entity health centers; otherwise, indicate as N/A.)		☐

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)

Figure 14: Form 4 – Community Characteristics

Form 4 - Community Characteristics

Note(s):
Data on race and/or ethnicity collected on this form will not be used as a designation factor.

Due Date: (Due In: Days) | Section Status:

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Fields with * are required

Race and Ethnicity	Service Area Population	Service Area Population Percent	Target Population	Target Population Percent
* Asian		0.00 %		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 %		0.00 %
* Unreported/Refused to Report		0.00 %		0.00 %
Total	0		0	

Click the '**Save and Calculate Total**' button to calculate and save the total Service Area numbers 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		0.00 %		0.00 %
Total	0		0	

Click the '**Save and Calculate Total**' button to calculate and save the total Service Area numbers 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		0.00 %		0.00 %
* 101-200%		0.00 %		0.00 %
* Over 200%		0.00 %		0.00 %
Total	0		0	

Click the '**Save and Calculate Total**' button to calculate and save the total Service Area numbers 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
* Medicaid		0.00 %		0.00 %
* Medicare		0.00 %		0.00 %
* Other Public Insurance		0.00 %		0.00 %
* Private Insurance		0.00 %		0.00 %
* None/Uninsured		0.00 %		0.00 %
Total	0		0	

Click the '**Save and Calculate Total**' button to calculate and save the total Service Area numbers 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		0.00 %		0.00 %
* People Experiencing Homelessness		0.00 %		0.00 %
* Residents of Public Housing		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 %
* HIV/AIDS-Infected Persons		0.00 %		0.00 %
* Individuals Best Served in a Language Other Than English		0.00 %		0.00 %
* Other If Other Please Specify:		0.00 %		0.00 %

Go to Previous Page | Save | Save and Continue

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
* Migratory/Seasonal Agricultural Workers and Families		0.00 %		0.00 %
* People Experiencing Homelessness		0.00 %		0.00 %
* Residents of Public Housing		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 %
* Individuals Best Served in a Language Other Than English		0.00 %		0.00 %
* Other 1 Please specify: 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**)

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

Form 2 - Staffing Profile

Note(s):
The health center must directly employ its Project Director/CEO. Allocate staff time by function among the 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 portion allocated to each position (e.g., Clinical Director 0.3 (30%) FTE and family physician 0.7 (70%) FTE). Refer to the most recent UDS manual for position descriptions.

Due Date: (Due In: Days) | Section Status: Not Started

Resources

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Fields with * are required

1

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 Director/Chief 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		○ Yes ● No

2

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		○ Yes ● No

3

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		○ Yes ● No
* Other Specialty Physicians Please Specify: (Maximum 40 characters)		○ Yes ● No

4

Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Nurse Practitioners		○ Yes ● No
* Physician Assistants		○ Yes ● No
* Certified Nurse Midwives		○ Yes ● No

5

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		○ Yes ● No

6

Dental

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Dentists		○ Yes ● No
* Dental Hygienists		○ Yes ● No
* Dental Therapists		○ Yes ● No
* Other Dental Personnel Please Specify: (Maximum 40 characters)		○ Yes ● No

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

▼ Behavioral Health (Mental Health and Substance Use Disorder Services) (7)

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Psychiatrists		○ Yes ◉ No
* Licensed Clinical Psychologists		○ Yes ◉ No
* Licensed Clinical Social Workers		○ Yes ◉ No
* Other Licensed Mental Health Providers Please Specify: (Maximum 40 characters)		○ Yes ◉ No
* Other Mental Health Staff Please Specify: (Maximum 40 characters)		○ Yes ◉ No
* Substance Use Disorder Providers		○ Yes ◉ No

▼ Professional Services (8)

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Other Professional Health Services Please Specify: (Maximum 40 characters)		○ Yes ◉ No

▼ Vision Services (9)

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Ophthalmologists		○ Yes ◉ No
* Optometrists		○ Yes ◉ No
* Other Vision Care Staff Please Specify: (Maximum 40 characters)		○ Yes ◉ No

▼ Pharmacy Personnel (10)

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Pharmacy Personnel		○ Yes ◉ No

▼ Enabling Services (11)

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Case Managers		○ Yes ◉ No
* Patient/Community Education Specialists		○ Yes ◉ No
* Outreach Workers		○ Yes ◉ No
* Transportation Staff		○ Yes ◉ No
* Eligibility Assistance Workers		○ Yes ◉ No
* Interpretation Staff		○ Yes ◉ No
* Community Health Workers		○ Yes ◉ No
* Other Enabling Services Please Specify: (Maximum 40 characters)		○ Yes ◉ No

▼ Other Programs and Services (12)

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Quality Improvement Staff		○ Yes ◉ No
* Other Programs and Services Please Specify: (Maximum 40 characters)		○ Yes ◉ No

▼ Total FTEs (13)

Totals	Direct Hire FTEs	Contract/Agreement FTEs
Totals [Calculate]	0	N/A

[Go to Previous Page] [Save] [Save and Continue]

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 (https://bphc.hrsa.gov/datareporting/reporting)

• 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

Form 2 - Staffing Profile

Note(s):
The health center must directly employ its Project Director/CEO. Allocate staff time by function among the 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 portion allocated to each position (e.g., Clinical Director 0.3 (30%) FTE and family physician 0.7 (70%) FTE). Refer to the most recent UDS manual for position descriptions.

Due Date (Due In: Days) | Section Status:

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Fields with * are required

Key Management Staff/Administration

Staffing Positions by Major Service Category	Direct Hire FTEs (1)	Contract/Agreement FTEs (2)
* Project Director/Chief Executive Officer (CEO)		○ Yes ◉ No
* Finance Director/Chief 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		○ 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

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**)

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**).

Figure 21: Form 3A – Budget Information

Form 3A - Budget Information

Note(s):
The program income total on this form must match the program income total on Form 3.

Due Date: (Due In: Days) | Section Status:

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Fields with * are required

Budget Category	Community Health Centers (CHC - 330(e))	Migrant Health Centers (MHC - 330(g))	Health Care for Homeless (HCH - 330(h))	Public Housing Primary Care (PHPC - 330(i))	Total
1. Expenses (1)					
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 (3)	$0.00	$0.00	$0.00	$0.00	$0.00
j. Indirect Charges					$0.00
k. Total Expenses (sum of i and j) Calculate Total and Save (4)	$0.00	$0.00	$0.00	$0.00	$0.00
2. Revenue (2)					
a. Applicant					$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 (5)	$0.00	$0.00	$0.00	$0.00	$0.00

Go to Previous Page | Save | Save and Continue

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 Provided (Required Services)

Form 5A - Services Provided (Required Services)

Note(s):
Select service delivery methods for services as applicable to the proposed health center project. For more information, refer to the Service Descriptors for Form 5A: Services Provided and the Column Descriptors for Form 5A: Services Provided

Due Date: (Due In: Days) | Section Status:

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Fields with * are required

1 2 3

Required Services | Additional Services | Specialty Services

Service Type	Column I - Direct (Health Center Pays)	Column II - Formal Written Contract/Agreement (Health Center Pays)	Column III - Formal Written Referral Arrangement (Health Center DOES NOT Pay)
General Primary Medical Care	☐	☐	☐
Diagnostic Laboratory	☐	☐	☐
Diagnostic Radiology	☐	☐	☐
Screenings	☐	☐	☐
Coverage for Emergencies During and After Hours	☐	☐	☐
Voluntary Family Planning	☐	☐	☐
Immunizations	☐	☐	☐
Well Child Services	☐	☐	☐
Gynecological Care	☐	☐	☐
Obstetrical Care			
Prenatal Care	☐	☐	☐
Intrapartum Care (Labor & Delivery)	☐	☐	☐
Postpartum Care	☐	☐	☐
Preventive Dental	☐	☐	☐
Pharmaceutical Services	☐	☐	☐
HCH Required Substance Use Disorder Services	☐	☐	☐
Case Management	☐	☐	☐
Eligibility Assistance	☐	☐	☐
Health Education	☐	☐	☐
Outreach	☐	☐	☐
Transportation	☐	☐	☐
Translation	☐	☐	☐

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

Table 1: Modes of Service Provision

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

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.

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

Fields with * are required

Required Services | Additional Services | Specialty Services

Service Type	Column I - Direct (Health Center Pays)	Column II - Formal Written Contract/Agreement (Health Center Pays)	Column III - Formal Written Referral Arrangement (Health Center DOES NOT Pay)
Additional Dental Services	☐	☐	☐
Behavioral Health Services			
Mental Health Services	☐	☐	☐
Substance Use Disorder Services	☐	☐	☐
Optometry	☐	☐	☐
Recuperative Care Program Services	☐	☐	☐
Environmental Health Services	☐	☐	☐
Occupational Therapy	☐	☐	☐
Physical Therapy	☐	☐	☐
Speech-Language Pathology/Therapy	☐	☐	☐
Nutrition	☐	☐	☐
Complementary and Alternative Medicine	☐	☐	☐
Additional Enabling/Supportive Services	☐	☐	☐

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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)

Required Services | Additional Services | Specialty Services

Warning:
You cannot propose Specialty Services in an Initial Designation application. Click on Continue button to proceed.

Go to Previous Page | Continue

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

(**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.

Figure 25: Completed Form 5A

4.8 Form 5B – Service Sites

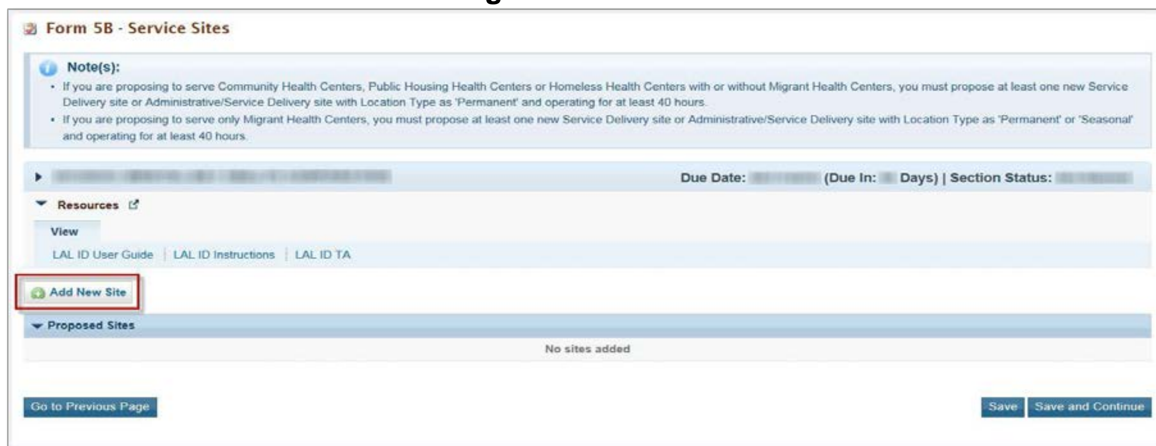
Form 5B – Service Sites identifies the sites in your scope of the project. You will be able to propose a Service Delivery Site; Administrative/Service Delivery Site and Administrative-only Site

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



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

* 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.	Yes 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 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 No 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**)

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

Register Performance Site 1

List of Pre-registered Performance Sites

Site Name	Performance Site Type	Performance Site Address	Perfomance Site Address Category	Options
[illegible]	Fixed	[illegible]	Approximate	Select Site Location
[illegible]	Fixed	[illegible]	Accurate	2 Select Site Location
[illegible]	Fixed	[illegible]	Accurate	Select Site Location
[illegible]	Fixed	[illegible]	Accurate	Select Site Location
[illegible]	Fixed	[illegible]	Approximate	Select Site Location
[illegible]	Fixed	[illegible]	Accurate	Select Site Location

Cancel

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.

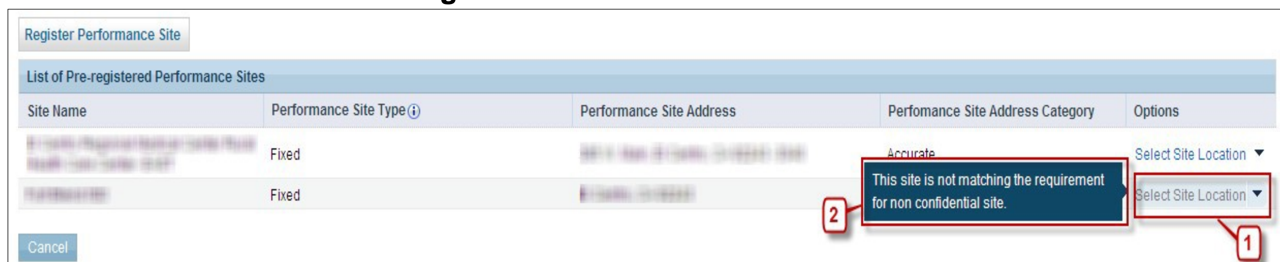
On the Register – Confirm page, the system displays the physical address you entered on the Address – Enter page along with the standardized format of the address. Select an option and click the Confirm button.

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**).

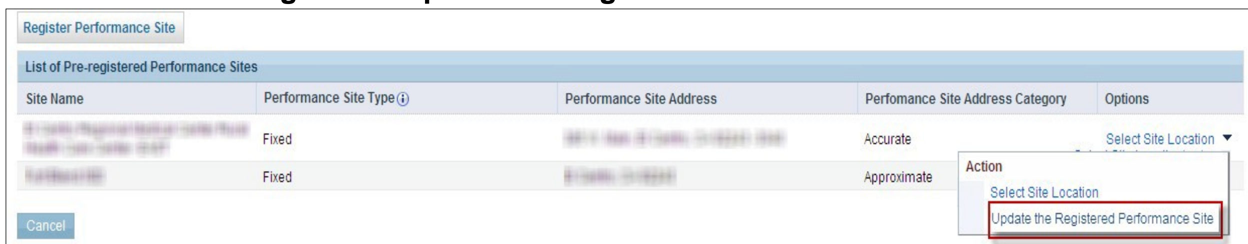
> **IMPORTANT NOTES:**
>
> - The Select Site Location link will be disabled (Figure 29, 1) if the site falls under any of these categories, and you will not be able to select the site. In these cases, hovering over the disabled Select Site Location link (Figure 29, 2) will provide the reason why the 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.

Figure 29: Disabled Site Locations



> **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



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**).

Figure 31: Form 5B – Edit page

Form-5B : Edit

Note(s):
It is recommended that you save your work often (e.g., every 5 minutes) to avoid a loss of data due to unforeseeable technical issues.

Fields with * are required for all site types.

Site Information | Status:

* Site Name — Change Site Name
* Physical Site Address
* Site Type — Service Delivery Site
* Site Phone Number — ( ) - Ext.
* Web URL

The following fields are required for "Service Delivery" and "Administrative/Service Delivery" site types, other than where exceptions are noted:

* Location Type — Select Location Type
* Site Setting — Select Site Setting
Date Site was Added to Scope — N/A
* Site Operational Date — N/A
* FQHC Site Medicare Billing Number Status — Select Medicare Billing Number Status
FQHC Site Medicare Billing Number (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing 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

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By'... (+ View More)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN	Options
No Subrecipient or Contractor information to be displayed			

Service Area Zip Code (Include only those from which the majority of the patient 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

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

Add New Site

Proposed Sites

Site Name	Physical Address	Service Site Type	Location Type	Site Status	Options
		All	All	All	
[illegible]	[illegible]	Service Delivery Site	Permanent	In Progress	Update

Go to Previous Page | Save | Save and Continue

IMPORTANT NOTES:

- 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**).

Figure 33: Form 5C – Other Activities/Locations

Form 5C - Other Activities/Locations

Due Date: (Due In: Days) | Section Status:

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Add New Activity/Location 1

Activity/Location Information

Type of Activity	Frequency of Activity	Description of Activity	Type of Location(s) where Activity is Conducted	Status	Options
No other activities/locations added.					

Go to Previous Page | Save and Continue

Figure 34: Activity/Location Information

Fields with * are required

Activity/Location Information

* Type of Activity	Select Option If 'Other', please specify: (maximum 100 characters)
* Frequency of Activity	Approximately 1/2 page (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 (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.

Figure 36: Form 6A – Current Board Member Characteristics

Form 6A - Current Board Member Characteristics

Note(s):
The List of Board Members displayed below is pre-populated from the latest awarded Health Center Program application/progress report.

Due Date: (Due In: Days) | Section Status:

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Fields with * are required

Add New Board Member 1

List of All Board 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
							Update
							Update

Gender	Number of Patient Board Members 3
* Male	
* Female	
* Unreported/Declined to Report	

Ethnicity	Number of Patient Board Members
* Hispanic or Latino	
* Non-Hispanic or Latino	
* Unreported/Declined to Report	

Race	Number of Patient Board Members
* Native Hawaiian	
* Other Pacific Islanders	
* Asian	
* Black/African American	
* American Indian/Alaska Native	
* White	
* More Than One Race	
* Unreported/Declined to Report	

Note(s):
This question is ONLY required if you selected Public (non-Tribal or Urban Indian) as the Business Entity on Form 1A of this application. In all other cases, select N/A.

If you are a public organization/center, do the board members listed above represent a co-applicant board?

Yes No N/A

If yes, ensure that the co-applicant agreement is included as Attachment 6 in the Appendices form of this application.

Go to Previous Page | Save | Save and Continue

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.

Figure 37: Current Board Member – Add Page

Current Board Member - Add

Due Date: (Due In: Days)

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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 ? Live 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

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.

Figure 38: Form 6B when Not Applicable

Form 6B - Request for Waiver of Board Member Requirements

Due Date: (Due In: Days) | Section Status:

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Alert:

This form is not applicable to you as you are currently receiving or applying to receive **Community Health Centers (CHC)** designation and/or you have selected **'Tribal'** or **'Urban Indian'** as the Business Entity in Form 1A.

Go to Previous Page | Continue

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.

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**).

Figure 40: Form 8 – Health Center Agreements

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.

Figure 41: Organization Agreement – Add page

<u>IMPORTANT NOTES</u>: 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**).

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.

Figure 43: Chief Executive Officer – Add page

Chief Executive Officer - Add

Due Date: (Due In: Days)

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Fields with * are required

Add New Contact Information

Field	Value
Position Title	Chief Executive Officer
* Prefix	Select Option
* First Name	
* Last Name	
Middle Initial	
Suffix	Select Option If 'Other', please specify: (maximum 100 characters)
Highest Degree	Select Option If 'Other', please specify: (maximum 100 characters)
* Email Address	
* Phone Number	- Ext.

Cancel Save Save and Continue

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.

IMPORTANT NOTES:

- 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**).

Figure 44: Clinical Performance Measures page

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

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**).

IMPORTANT NOTES:

- If the performance measure goal for Dental Sealants for Children between 6-9 Years is set to 0, at least one self-defined 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.

Figure 47: Add Clinical Performance Measure

Fields with * are required

Add Clinical Performance Measure Information

* Focus Area: Oral Health [1] | Load Performance Measure Category [2]

If 'Other', please specify: (maximum 100 characters)

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

If 'Other', please specify: (maximum 100 characters)

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**).

Figure 48: Financial Performance Measures – List page

IMPORTANT NOTES:

- 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.

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.

Figure 50: Financial Performance Measures- Add

Financial Performance Measures - Add

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Fields with * are required

Add Financial Performance Measure Information

* Focus Area	Select Option (1) If 'Other', please specify: (maximum 100 characters) (2)
* Performance Measure	Approximately 1/4 page (Max 500 characters with spaces)
* Target Goal Description (Sample Goals)	Approximately 1/4 page (Max 500 characters with spaces)
* Numerator Description (Examples)	Approximately 1/4 page (Max 500 characters with spaces)
* Denominator Description (Examples)	Approximately 1/4 page (Max 500 characters with spaces)
* Baseline Data	Baseline Year (yyyy) Measure Type: Select Option Numerator Denominator Calculate Baseline
* Projected Data (by End of Designation Period) (Sample Calculation)	Projected Goal Measure Type: Select Option
* Data Sources & Methodology	Approximately 1/4 page (Max 500 characters with spaces)

Add New Key Factor and Major Planned Action

* List of Key Factors and Major Planned Actions (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 not applicable)

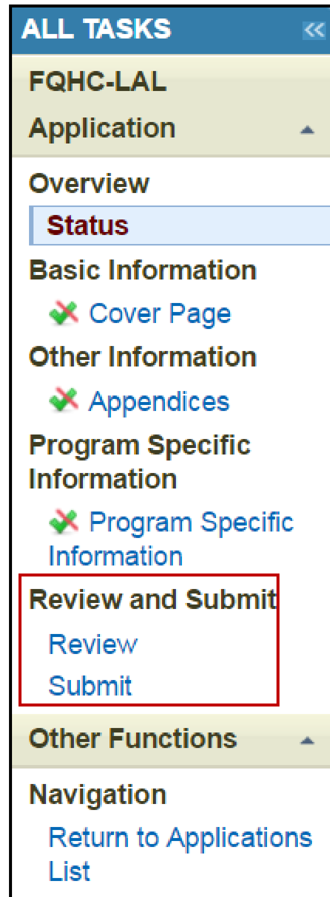
Approximately 3/4 page (Max 1500 Characters with spaces)

Cancel | Save | Save and Continue to List (3) | Save and Update Next

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

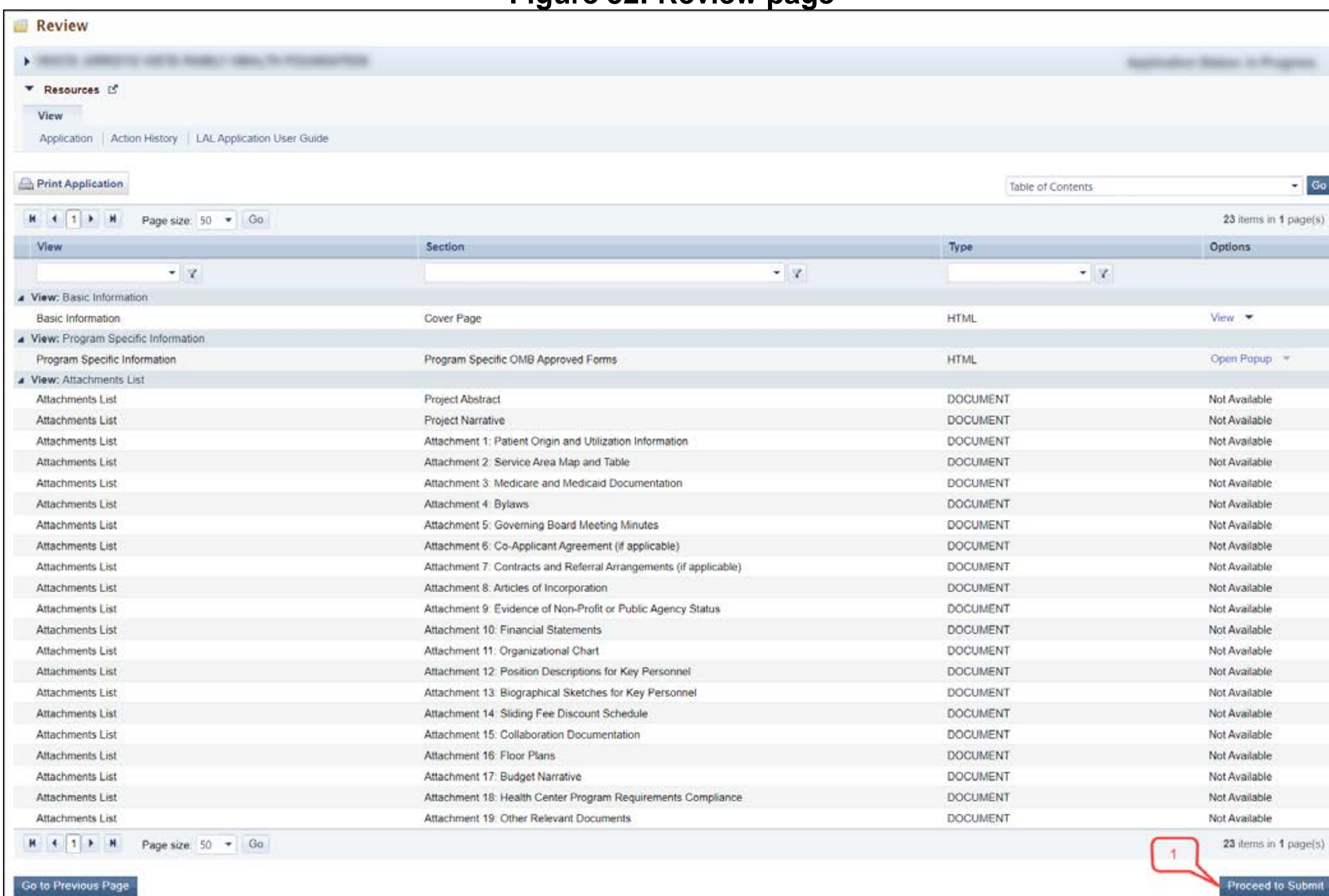
To review your application, click on the **Status** link on the left side menu. (**Figure 51**)

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: Review page



View	Section	Type	Options
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.

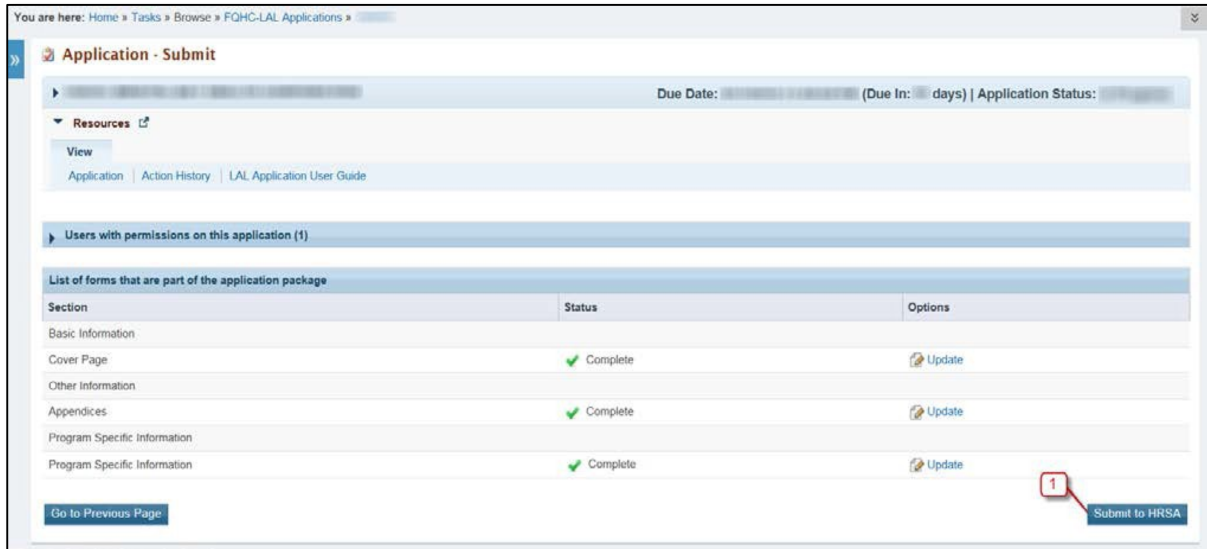
If you are ready to apply HRSA, click the Proceed to Submit button at the bottom of the **Review** page (**Figure 52, 1**). The system navigates to the **Submit** page (**Figure 52**).

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

IMPORTANT NOTES:

- 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



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** (http://www.hrsa.gov/about/contact/bphc.aspx).