

**HRSA Electronic Handbook**

# Look-Alike Initial Designation Application User Guide

Last updated on: August 17, 2016



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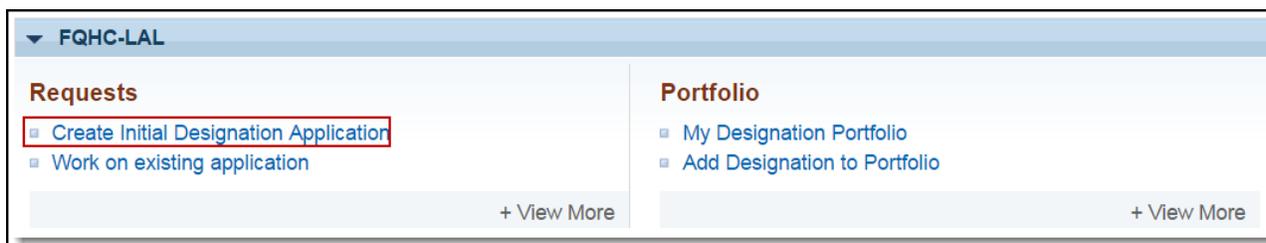
This user guide describes the steps you need to follow to submit a Look-Alike Initial Designation application to the Health Resources and Services Administration (HRSA).

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

You must have an EHB user account to create a Look-Alike application (also known as an Initial Designation). After logging into EHB, click on the 'Organizations' tab and then select the 'Organization Folder' link under the 'Options' column of the list page to open 'Organization Home' page.

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

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

Note: 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.

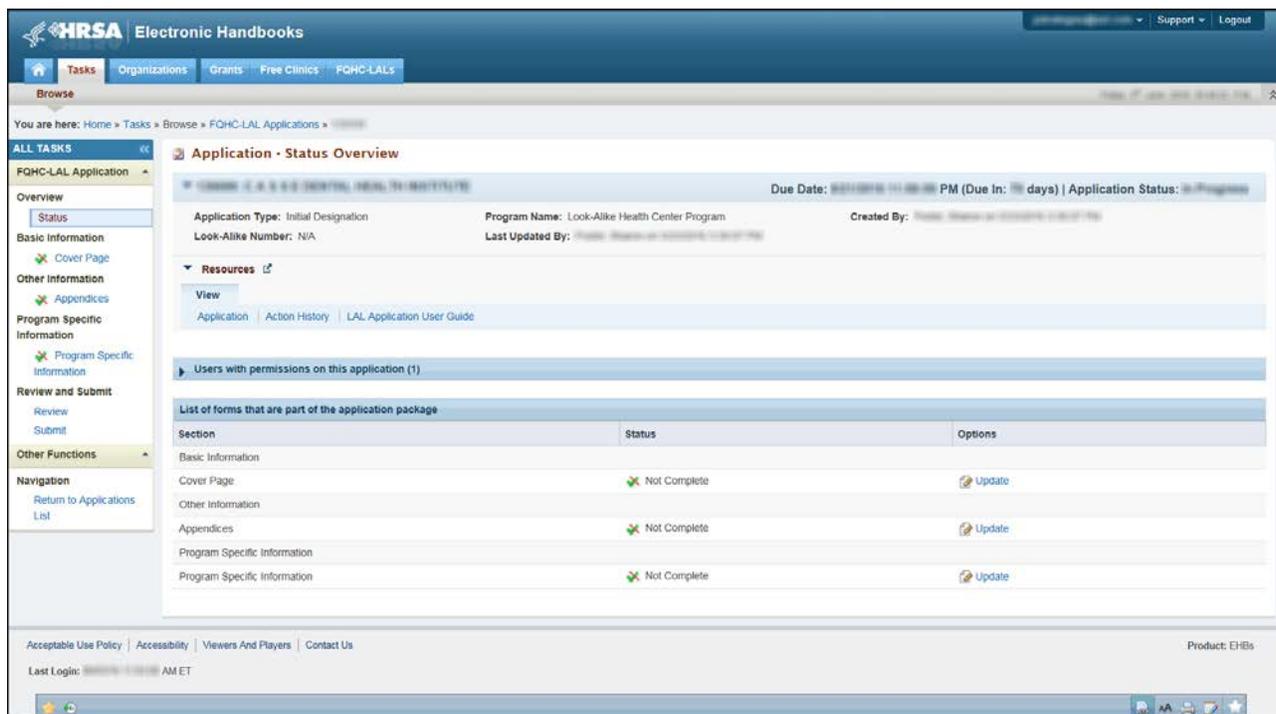
Click 'Continue with Application' to open the 'Application - Status Overview' page that has links to the Cover Page, Appendices, and Program Specific Information on the left menu.

**IMPORTANT NOTE:** If you do not have a username, you must register in EHB. Do not create duplicate accounts. If you experience log in issues or forget your password, contact the [HRSA Contact Center](#) at (877) 464-4772.

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

1. Locate the Look-Alike ID application using the EHB Application tracking number and click the **Start** link to begin working on the application in EHB (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 of these sections in order to submit your application to HRSA.

## 2. Completing the Look-Alike Cover Page section of the application

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), and/or 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.

Figure 3: Cover Page of FQHC-LAL Application

**Cover Page**

Resources of

View  
Application | Action History | LAL Application User Guide

Fields with \* are required

**Applicant Information**

Legal Name: [text field]  
Employer Identification Number (e.g. 53-2079819): [text field]  
Organizational DUNS: [text field]  
Mailing Address: [text field]

**Select Target Population(s)** 1

Select	Target Population Type
<input type="checkbox"/>	Community Health Centers
<input type="checkbox"/>	Health Care for the Homeless
<input checked="" type="checkbox"/>	Migrant Health Centers
<input type="checkbox"/>	Public Housing

**Person to be contacted on matters involving this application** 2

Person to be contacted on matters involving this application has not been added. [Add]

**Authorized Representative** 3

No Authorized Representative added. [Add]

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

Once completed, click the Save and Continue button to proceed to the **Appendices** form.

### 3. Completing the Appendices Form

1. 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



2. Upload the following attachments by clicking the associated Attach File buttons:
  - Project Abstract
  - Project Narrative
  - Attachment 1: Patient Origin Study (required)
  - Attachment 2: Service Area Map and Table (required)
  - Attachment 3: MUA/MUP Designation (required)
  - Attachment 4: Corporate Bylaws (required)
  - Attachment 5: Governing Board Meeting Minutes (required)
  - Attachment 6: Co-Applicant Agreement for Public Centers (required for public center applicants that have a co-applicant board) (as applicable)
  - Attachment 7: Summary of Contracts and Agreements (as applicable)
  - Attachment 8: Articles of Incorporation (required)
  - Attachment 9: Evidence of Nonprofit or Public Center Status (required)
  - Attachment 10: Medicare and Medicaid Documentation (required)
  - Attachment 11: Organizational Chart (required)
  - Attachment 12: Position Descriptions for Key Personnel (required)
  - Attachment 13: Biographical Sketches for Key Personnel (required)
  - Attachment 14: Sliding Fee Discount Schedule and Schedule of Charges (required)
  - Attachment 15: Financial Statements and Independent Financial Audit (required)
  - Attachment 16: Letters of Support (required)
  - Attachment 17: Floor Plans (required)
  - Attachment 18: Budget Narrative (required)
  - Attachment 19: Health Center Program Requirements Complianace (required)
  - Attachment 20: Other Relevant Documents (as applicable – maximum 5)
  
3. After completing the **Appendices** form, click the Save and Continue button to proceed to the **Program Specific Information – Status Overview** page.

## 4. Completing the Program Specific Forms

1. 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 5: Status Overview Page for Program Specific Forms

**Status Overview**

BRIDGES CHRYSLER COUNTY GOVERNMENT Due Date: 11/22/2018 (Due In: 31 Days) | Program Specific Status: Not Complete

Look-Alike Number: Not Available Target Population: Migrant Health Centers, Public Housing, Health Care for the Homeless Application Type: Initial Designation

**Resources** [View](#)

[LAL ID User Guide](#) | [LAL ID Instructions](#) | [LAL ID TA](#)

Program Specific Information Status		
Section	Status	Options
<b>General Information</b>		
Form 1A - General Information Worksheet	Not Started	<a href="#">Update</a>
Form 1C - Documents On File	Not Started	<a href="#">Update</a>
Form 4 - Community Characteristics	Not Started	<a href="#">Update</a>
<b>Budget Information</b>		
Form 2 - Staffing Profile	Not Started	
Form 2 - Staffing Profile: Current Staff	Not Started	<a href="#">Update</a>
Form 2 - Staffing Profile: Prospective Staff	Not Started	<a href="#">Update</a>
Form 3 - Income Analysis	Not Started	<a href="#">Update</a>
Form 3A - Budget Information	Not Started	<a href="#">Update</a>
<b>Sites and Services</b>		
Form 5A - Services Provided	Not Started	
Required Services	Not Started	<a href="#">Update</a>
Additional Services	Not Started	<a href="#">Update</a>
Specialty Services	Not Started	<a href="#">Update</a>
Form 5B - Service Sites	Not Started	<a href="#">Update</a>
Form 5C - Other Activities/Locations	Not Started	<a href="#">Update</a>
Scope Certification	Not Started	<a href="#">Update</a>
<b>Other Forms</b>		
Form 6A - Current Board Member Characteristics	Not Started	<a href="#">Update</a>
Form 6B - Request for Waiver of Board Member Requirements	Not Started	<a href="#">Update</a>
Form 8 - Health Center Agreements	Not Started	<a href="#">Update</a>
Form 10 - Emergency Preparedness Report	Not Started	<a href="#">Update</a>
Form 12 - Organization Contacts	Not Started	<a href="#">Update</a>
<b>Performance Measures</b>		
Clinical Performance Measures	Not Started	<a href="#">Update</a>
Financial Performance Measures	Not Started	<a href="#">Update</a>

[Return to Complete Status](#)

## 4.1 Form 1A – General Information Worksheet

**Form 1A - General Information Worksheet** provides information related to the applicant, proposed service area, and patient and visit projections. This form has the following sections:

1. Applicant Information ([Figure 6, 1](#))
2. Proposed Service Area ([Figure 6, 2](#))



1. Select the applicant organization’s fiscal year end date (e.g., June 30) from the drop-down menu.
2. Select one option in the Business Entity section. An applicant that is a Tribal or Urban Indian entity and also meets the definition for a public or private entity should select the Tribal or Urban Indian category.
3. Select one or more categories for the Organization Type section. You must specify the organization type if you select ‘Other’ (Figure 7, 1).

**Figure 7: Applicant Information section**

The screenshot shows a web form titled "1. Applicant Information". The form contains the following fields and options:

- Applicant Name:** Look-Alike Initial Designation Health Institute
- \* Fiscal Year End Date:** Select Option (dropdown menu)
- Application Type:** Initial Designation
- \* Business Entity:** Select Option (dropdown menu)
- \* Organization Type (Select all that apply):**
  - All
  - Faith based
  - Hospital
  - State government
  - City/County/Local Government or Municipality
  - University
  - Community based organization
  - Other **1**
- If 'Other' please specify:** (text input field)
- (maximum 100 characters)

### 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
  - 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 8, 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).
- For inquiries regarding MUAs or MUPs, visit the [Shortage Designation web site](#) or call 1-888-275-4772 (option 1 then option 2), or contact the Shortage Designation Branch at [sdb@hrsa.gov](mailto:sdb@hrsa.gov) or 301-594-0816.

Figure 8: 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.

2a. Service Area Designation

\* Select MUA/MUP  
(Each ID must be a 5 digit integer. 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 9), indicate whether the service area is urban, rural, or sparsely populated. If sparsely populated is selected, specify the population density by providing the number of people per square mile (values must range from .01 to 7).

**IMPORTANT NOTE:** For information about rural populations, visit the [Office of Rural Health Policy's web site](#).

Figure 9: 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)

#### 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, follow these steps:

1. Answer the question, 'How many unduplicated patients are projected to be served by End of Designation Period' (Figure 10, 1).
2. 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 10, 2) when the user clicks on the Save or Save and Continue button.
3. Under the Current Number heading, provide the current number of Patients and Visits in the Total row and the current number of Patients and Visits for each Population Type listed (Figure 10, 3). The patients and visits for each Population Type must add up to the numbers in the Total row.
4. 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 listed (Figure 10, 4). The patients and visits for each Population Type must add up to the numbers in the Total row.

**Figure 10: Unduplicated Patients and Visits by Population Type**

2c. Patients and Visits					
Unduplicated Patients and Visits by Population Type					
<ul style="list-style-type: none"> <li>How many unduplicated patients are projected to be served by end of the Designation Period?</li> </ul>					
Population Type	Current Number		Projected by End of Designation Period		
	Patients	Visits	Patients	Visits	
Total					
<ul style="list-style-type: none"> <li>General Underserved Community (Include all patients/visits not reported in the rows below)</li> </ul>					
<ul style="list-style-type: none"> <li>Migratory and Seasonal Agricultural Workers and Families</li> </ul>					
<ul style="list-style-type: none"> <li>Public Housing Residents</li> </ul>					
<ul style="list-style-type: none"> <li>People Experiencing Homelessness</li> </ul>					

**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.

**4.1.2.3.2 Patients and Visits by Service Type**

To complete this section, follow these steps:

- Provide the Current Number of patients and visits for each listed Service Type (Figure 11, 1).
- The Current Number of patients and visits must be greater than zero for 'Total Medical Services' (Figure 11, 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 11, 3).

**Figure 11: Patients and Visits by Service Type**

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 Abuse 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 projected patients (Figure 11, 4) must be greater than the number of projected patients you enter for each of the 'Total Dental', 'Total Mental Health', 'Total Substance Abuse Services', and 'Total Enabling Services' service types.

4. 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 your organization.

Figure 12: Form 1C - Documents on File

**Form 1C - Documents on File**

**Note(s):**  
Example date formats for use on this form are: 01/15/2016, First Monday of every April, and bi-monthly (last rev 01/16).

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

**Resources**

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LAL ID User Guide | LAL ID Instructions | LAL ID TA

Fields with \* are required

Management and Finance	Date of Latest Review/Revision (Maximum 100 characters)
Personnel Policies and/or Procedures, including related Conflict of Interest Provisions (Program Requirements 3, 9, 17, and 19)	<input type="text"/>
Data Collection and Management Information Systems (Clinical and Financial) Policies and Procedures (Program Requirements 9 and 15)	<input type="text"/>
Billing, Credit and Collection Policies and Procedures (Program Requirement 13)	<input type="text"/>
Procurement Policies and/or Procedures, including related Conflict of Interest Provisions (Program Requirements 10, 12, and 19 and Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75)	<input type="text"/>
Emergency Preparedness and Management Plan (Policy Information Notice 2007-15)	<input type="text"/>
Fee Schedule/Schedule of Charges (Program Requirements 7 and 13)	<input type="text"/>
Sliding Fee Discount Program Policies and Procedures (Program Requirement 7)	<input type="text"/>
Financial Management/Accounting and Internal Control Policies and Procedures (Program Requirements 10 and 12)	<input type="text"/>

Services	Date of Latest Review/Revision (Maximum 100 characters)
HIPAA-Compliant Patient Confidentiality Policies and Procedures (Program Requirement 8)	<input type="text"/>
Clinical Protocols/Clinical Care Policies and Procedures (Program Requirements 2 and 8)	<input type="text"/>
Patient Grievance Policies and Procedures (Program Requirements 8 and 17)	<input type="text"/>
Quality Improvement and Quality Assurance Plan, including Incident Reporting System and Risk Management Policies (Program Requirement 8)	<input type="text"/>
Malpractice Coverage Plan (Program Requirement 8)	<input type="text"/>
Credentialing and Privileging Policies and Procedures (Program Requirement 3 and Policy Information Notices 2001-16 and 2002-22)	<input type="text"/>
After-Hours Coverage Policies and Procedures (Program Requirements 4 and 5)	<input type="text"/>
Hospital Admitting Privileges Documentation (Program Requirement 6)	<input type="text"/>

Governance	Date of Latest Review/Revision (Maximum 100 characters)
Organizational/Board Bylaws, including Board Authority, Composition, and Conflict of Interest Policies and Procedures (Program Requirements 17, 18, and 19)	<input type="text"/>
Co-Applicant Agreement, if a public organization (Program Requirement 17)	<input type="text"/>

Go to Previous Page:

1. To complete Form 1C, enter the date that each document was last reviewed or revised (Figure 12).

**IMPORTANT NOTE:** Examples date formats for use on this form are 01/15/2016, First Monday of every April, and bi-monthly (last rev 01/16).

2. After completing all sections of Form 1C, click the Save and Continue button to save your work and proceed to the next form.

### **4.3 Form 4 - Community Characteristics**

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

1. Race and Ethnicity (**Figure 13, 1**)
2. Hispanic or Latino Ethnicity (**Figure 13, 2**)
3. Income as a Percent of Poverty Level (**Figure 13, 3**)
4. Primary Third Party Payment Source (**Figure 13, 4**)
5. Special Populations and Select Population Characteristics (**Figure 13, 5**)

Figure 13: Form 4 – Community Characteristics

Fields with \* are required 1

Race and Ethnicity <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">1</span>	Service Area Number <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">8</span>	Target Population Number <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">7</span>
* Asian	<input type="text"/>	<input type="text"/>
* Native Hawaiian	<input type="text"/>	<input type="text"/>
* Other Pacific Islanders	<input type="text"/>	<input type="text"/>
* Black/African American	<input type="text"/>	<input type="text"/>
* American Indian/Alaska Native	<input type="text"/>	<input type="text"/>
* White	<input type="text"/>	<input type="text"/>
* More than One Race	<input type="text"/>	<input type="text"/>
* Unreported/Declined to Report (if applicable)	<input type="text"/>	<input type="text"/>
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. 8 8 Save and Calculate Total

Hispanic or Latino Ethnicity <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">2</span>	Service Area Number	Target Population Number
* Hispanic or Latino	<input type="text"/>	<input type="text"/>
* Non-Hispanic or Latino	<input type="text"/>	<input type="text"/>
* Unreported/Declined to Report (if applicable)	<input type="text"/>	<input type="text"/>
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. 3 Save and Calculate Total

Income as a Percent of Poverty Level <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">3</span>	Service Area Number	Target Population Number
* Below 100%	<input type="text"/>	<input type="text"/>
* 100-199%	<input type="text"/>	<input type="text"/>
* 200% and Above	<input type="text"/>	<input type="text"/>
* Unknown	<input type="text"/>	<input type="text"/>
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. 4 Save and Calculate Total

Primary Third Party Payment Source <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">4</span>	Service Area Number	Target Population Number
* Medicaid	<input type="text"/>	<input type="text"/>
* Medicare	<input type="text"/>	<input type="text"/>
* Other Public Insurance	<input type="text"/>	<input type="text"/>
* Private Insurance	<input type="text"/>	<input type="text"/>
* None/Uninsured	<input type="text"/>	<input type="text"/>
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. 5 Save and Calculate Total

Special Populations and Select Population Characteristics <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">5</span>	Service Area Number	Target Population Number
* Migratory/Seasonal Agricultural Workers and Families	<input type="text"/>	<input type="text"/>
* People Experiencing Homelessness	<input type="text"/>	<input type="text"/>
* Residents of Public Housing	<input type="text"/>	<input type="text"/>
* School Age Children	<input type="text"/>	<input type="text"/>
* Veterans	<input type="text"/>	<input type="text"/>
* Lesbian, Gay, Bisexual and Transgender	<input type="text"/>	<input type="text"/>
* HIV/AIDS-Infected Persons	<input type="text"/>	<input type="text"/>
* Individuals Best Served in a Language Other Than English	<input type="text"/>	<input type="text"/>
* Other	<input type="text"/>	<input type="text"/>

Please specify:  
Approximately 1/8 page (Max 200 Characters): 200 Characters left.

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 13, 1, 2, 3, 4**), enter the **Service Area Number** (**Figure 13, 6**) and **Target Population Number** for each of the respective categories (**Figure 13, 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 Numbers 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. Likewise, the total Target Population Numbers for each of these categories should be equal.

In order to automatically calculate the Total Service Area Numbers and Total Target Population Numbers for all four sections, click on the Save and Calculate Total button (**Figure 13, 8**) under any of the sections.

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

1. Under the Special Populations and Select Population Characteristics section (**Figure 14**), enter the **Service Area Number** and **Target Population Number** for each population group listed.
2. 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 Number and Target Population Number 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.
3. In the 'Other' row (**Figure 14, 1**), specify a population group that is not listed (if desired), and enter the Service Area Number and the Target Population Number for the specified population group.
4. 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.

**Figure 14: Special Populations section**

Special Populations and Select Population Characteristics	Service Area Number	Target Population Number
★ Migratory/Seasonal Agricultural Workers and Families	<input type="text"/>	<input type="text"/>
★ People Experiencing Homelessness	<input type="text"/>	<input type="text"/>
★ Residents of Public Housing	<input type="text"/>	<input type="text"/>
★ School Age Children	<input type="text"/>	<input type="text"/>
★ Veterans	<input type="text"/>	<input type="text"/>
★ Lesbian, Gay, Bisexual and Transgender	<input type="text"/>	<input type="text"/>
★ HIV/AIDS-Infected Persons	<input type="text"/>	<input type="text"/>
★ Individuals Best Served in a Language Other Than English	<input type="text"/>	<input type="text"/>
★ Other <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">1</span> Please specify: Approximately 1/8 page ⓘ (Max 200 Characters): 200 Characters left.	<input type="text"/>	<input type="text"/>

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

## 4.4 Form 2 – Staffing Profile

**Form 2 – Staffing Profile** reports current and prospective staffing for the look-alike. This form is completed twice; once for current staffing at the time of application, and once for prospective staffing at the end of the designation period. It has the following sections:

1. [Staffing Positions by Major Service Category](#) sections
  - Key Management Staff/Administration ([Figure 15, 1](#))
  - Facility and Non-Clinical Support Staff ([Figure 15, 2](#))
  - Physicians ([Figure 15, 3](#))
  - Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives ([Figure 15, 4](#))
  - Medical ([Figure 15, 5](#))
  - Dental Services ([Figure 15, 6](#))
  - Behavioral Health (Mental Health and Substance Abuse) ([Figure 16, 7](#))
  - Professional Services ([Figure 16, 8](#))
  - Vision Services ([Figure 16, 9](#))
  - Pharmacy Personnel ([Figure 16, 10](#))
  - Enabling Services ([Figure 16, 11](#))
  - Other Programs and Services ([Figure 16, 12](#))
2. [Total FTEs](#) ([Figure 16, 13](#))

Figure 15: Form 2 – Staffing Profile

**Form 2 - Staffing Profile**

**Note(s):**  
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 allocated to each position (e.g., Clinical Director 0.3 (30%) FTE and family physician 0.7 (70%) FTE). Do not exceed 1.0 FTE for any individual. Refer to the [2018 UDS manual](#) for position descriptions.

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

**Resources**

View  
LAL ID User Guide | LAL ID Instructions | LAL ID TA

Form 2 - Staffing Profile: Current Staff | Form 2 - Staffing Profile: Prospective Staff

Fields with \* are required

**1** **Key Management Staff/Administration**

Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Project Director/Chief Executive Officer (CEO)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Finance Director/Chief Fiscal Officer/CFO	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Chief Operating Officer/COO	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Chief Information Officer/CIO	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Clinical Director/Chief Medical Officer/CMO	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Administrative Support Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

**2** **Facility and Non-Clinical Support Staff**

Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Fiscal and Billing Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* IT Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Facility Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Patient Support Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

**3** **Physicians**

Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Family Physicians	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* General Practitioners	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Internists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Obstetricians/Gynecologists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Pediatricians	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Specialty Physicians Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

**4** **Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives**

Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Nurse Practitioners	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Physician Assistants	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Certified Nurse Midwives	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

**5** **Medical**

Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Nurses	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Medical Personnel (e.g. Medical Assistants, Nurse Aides)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Laboratory Personnel	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* X-Ray Personnel	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

**6** **Dental Services**

Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Dentists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Dental Hygienists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Dental Therapists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Dental Personnel Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

Figure 16: Form 2- Staffing Profile continued...

Behavioral Health (Mental Health and Substance Abuse) <sup>7</sup>		
Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Psychiatrists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Licensed Clinical Psychologists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Licensed Clinical Social Workers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Licensed Mental Health Providers Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Mental Health Staff Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Substance Abuse Providers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Professional Services <sup>8</sup>		
Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Other Professional Health Services Staff Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Vision Services <sup>9</sup>		
Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Ophthalmologists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Optometrists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Vision Care Staff Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Pharmacy Personnel <sup>10</sup>		
Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Pharmacy Personnel	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Enabling Services <sup>11</sup>		
Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Case Managers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Patient/Community Education Specialists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Outreach Workers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Transportation Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Eligibility Assistance Workers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Interpretation Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Community Health Workers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Enabling Services Staff Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Programs and Services <sup>12</sup>		
Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Quality Improvement Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Programs and Services Staff Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Total FTEs <sup>13</sup>		
Totals	Direct Hire FTEs	Contract/Agreement FTEs
Totals <input type="button" value="Calculate"/>	0	N/A

#### 4.4.1 Completing the Staffing Positions by Major Service Category sections

1. 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 17, 1).

- In Contract/Agreement FTEs column, indicate whether contracts are used for each staffing position (Figure 17, 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, 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 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 (<http://bphc.hrsa.gov/datareporting/reporting/index.html>).
- 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 17: Direct Hire and Contract/Agreement FTEs columns**

Fields with \* are required

Form 2 - Staffing Profile: Current Staff    Form 2 - Staffing Profile: Prospective Staff

**Key Management Staff/Administration**

Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Project Director/Chief Executive Officer (CEO)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Finance Director/Chief Fiscal Officer/CFO	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Chief Operating Officer/COO	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Chief Information Officer/CIO	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Clinical Director/Chief Medical Officer/CMO	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Administrative Support Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

**Facility and Non-Clinical Support Staff**

Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Fiscal and Billing Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* IT Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Facility Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Patient Support Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> 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 18).

Figure 18: Total FTEs

Total FTEs		
Totals	Direct Hire FTEs	Contract/Agreement FTEs
Totals <input type="button" value="Calculate"/>	0	N/A
<input type="button" value="Go to Previous Page"/>	<input type="button" value="Save"/>	<input type="button" value="Save and Continue"/>

2. Click the Save and Continue button to save your work and proceed to the next form.

## 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 the following sections:

1. [Payer Categories](#) (Figure 19, 1)
2. [Comments/Explanatory Notes](#) (Figure 19, 2)

Figure 19: Form 3 – Income Analysis

**Form 3 - Income Analysis**

**Note(s):**

- The value in column (d) - Projected Income should equal column (b) - Billable visits multiplied by column (c) - Income per Visit. If not, explain in the Comments/Explanatory Notes box.
- The program income total on this form must match the program income total on Form 3A.

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

**Resources**

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Fields with \* are required

Payer Category <sup>1</sup>	Patients By Primary Medical Insurance (a) <sup>3</sup>	Billable Visits (b) <sup>4</sup>	Income Per Visit (c) <sup>5</sup>	Projected Income (d) <sup>6</sup>	Prior FY Income (e) <sup>7</sup>
<b>Part 1: Patient Service Revenue - Program Income</b>					
* 1. Medicaid					
* 2. Medicare					
* 3. Other Public					
* 4. Private					
* 5. Self Pay					
6. Total (Lines 1 - 5) <input type="button" value="Calculate Total and Save"/> <sup>8</sup>	0	0	N/A	\$0	\$0
<b>Part 2: Other Income - Federal, State, Local and Other Income</b>					
* 7. Federal	N/A	N/A	N/A		
* 8. State Government	N/A	N/A	N/A		
* 9. Local Government	N/A	N/A	N/A		
* 10. Private Grants/Contracts	N/A	N/A	N/A		
* 11. Contributions	N/A	N/A	N/A		
* 12. Other	N/A	N/A	N/A		
* 13. Applicant (Retained Earnings)	N/A	N/A	N/A		
14. Total Other (Lines 7 - 13) <input type="button" value="Calculate Total and Save"/> <sup>8</sup>	N/A	N/A	N/A	\$0	\$0
<b>Total Income (Program Income Plus Other)</b>					
15. Total Income (Lines 6 + 14) <input type="button" value="Calculate Total and Save"/> <sup>9</sup>	N/A	N/A	N/A	\$0	\$0

**Comments/Explanatory Notes (if applicable)** <sup>2</sup>

Approximately 2 pages (1) (Max 2500 Characters): 2500 Characters left.

### 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 - Other Federal, State, Local and Other Income
- Total Income (Program Income Plus Other)

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

1. In column (a), provide the number of Patients by Primary Medical Insurance for each of the Payer Categories in Part 1 (**Figure 19, 3**). Enter 0 if not applicable.
2. In column (b), provide the number of Billable Visits for each of the Payer Categories in Part 1 (**Figure 19, 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.
3. In column (c), provide the amount of Income per Visit for each of the Payer Categories in Part 1 (**Figure 19, 5**). Enter 0 if not applicable.
4. In column (d), provide the amount of Projected Income for each of the Payer Categories in Parts 1 and 2. (**Figure 19, 6**). Enter 0 if not applicable.
5. 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 19, 7**). Enter 0 if not applicable.
6. Click the Calculate Total and Save button to calculate and save the values for each of the Payer Categories in Part 1. (**Figure 19, 8**).

**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.

7. 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 19, 9**).

#### 4.5.2 Completing the Comments/Explanatory Notes section

In this section, enter any comments/explanations related to this form.

1. 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, provide an explanation in this section. If these numbers are equal for all the Payer Categories, providing comments in this section is optional.
2. 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 the following sections:

- [Expenses](#) (**Figure 20, 1**)
- [Revenue](#) (**Figure 20, 2**)

## 4.6.1 Completing the Expenses section

In the Expenses section, enter the projected first year of expenses for each Health Center Program 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 20, 3 & 4).

Figure 20 – 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: Not Started

Resources

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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 (PHPG - 330(i))	Total
<b>1. Expenses</b>					
a. Personnel					\$0.00
b. Fringe Benefits					\$0.00
c. Travel					\$0.00
d. Equipment					\$0.00
e. Supplies					\$0.00
f. Contractual					\$0.00
g. Construction					\$0.00
h. Other					\$0.00
i. Total Direct Charges (sum of a through h) Calculate Total and Save	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
j. Indirect Charges					\$0.00
k. Total Expenses (sum of i and j) Calculate Total and Save	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>2. Revenue</b>					
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	\$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 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 20, 5).

### IMPORTANT NOTE:

- 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).

Click the Save and Continue button to save your work and proceed to the next form.

## 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 the following sections:

- [Required Services](#) (Figure 21, 1)
- [Additional Services](#) (Figure 21, 2)

Figure 21: Form 5A – Services Provided (Required Services)

**Form 5A - Services Provided (Required Services)**

**Notes:**

- Select service delivery methods for required services, as applicable to the proposed project.
- For more information on Form 5A, refer to [Form 5A Column Descriptors](#).

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

**Resources**

View

LAL ID User Guide | LAL ID Instructions | LAL ID TA

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)
* General Primary Medical Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Diagnostic Laboratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Diagnostic Radiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Screenings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Coverage for Emergencies During and After Hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Voluntary Family Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Well Child Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Gynecological Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Obstetrical Care</b>			
* Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Intrapartum Care (Labor & Delivery)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Postpartum Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Preventive Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Pharmaceutical Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>HCH Required Substance Abuse Services</b>			
* Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Eligibility Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Health Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Outreach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Transition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Go to Previous Page | Save | Save and Continue

HRSA permits organizations to 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 using 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

### 4.7.1 Completing the Required Services Section

To complete this section of **Form 5A**, follow the instructions below:

1. 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 a service, hover over the information icon provided for that service (**Figure 21, 3**).
2. 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 21, 2**).

**IMPORTANT NOTES:**

- You must select Column I and /or Column II for the ‘General Primary Medical Care’ service row (**Figure 21, 3**) for your application to be eligible.
- You cannot select a service delivery method for ‘HCH Required Substance Abuse Services’ if you have not selected HCH as a Target Population 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 Abuse Services’.

### 4.7.2 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.

1. Indicate the service delivery method(s) for the desired additional service (**Figure 22**).

**Figure 22: Form 5A – Services Provided (Additional 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 ⓘ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Health Services ⓘ			
Mental Health Services ⓘ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Services ⓘ <b>1</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optometry ⓘ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recuperative Care Program Services ⓘ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environmental Health Services ⓘ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy ⓘ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy ⓘ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech-Language Pathology/Therapy ⓘ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition ⓘ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complementary and Alternative Medicine ⓘ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Enabling/Supportive Services ⓘ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Go to Previous Page Save Save and Continue

**IMPORTANT NOTES:**

- If you have not selected HCH as a Target Population in the Cover Page form of this application, you will not be able to select ‘HCH Required Substance Abuse Services’ in the Required Services section. However, you may select ‘Substance Abuse Services’ in the Additional Services section (**Figure 22, 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.

2. 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.

**4.7.3 Completing the Specialty Services Section**

You cannot propose specialty services in the Initial Designation application. You will see the message below (**Figure 23**) when you access the Specialty Services section of **Form 5A**. Click the Continue button to proceed.

**Figure 23: 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 in order 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 tick mark in the section tabs (**Figure 24**).

**Figure 24: Completed Form 5A**



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

## 4.8 Form 5B – Service Sites

**Form 5B – Service Sites** identifies the sites in your scope of project. You will be able to propose the following types of sites in this form:

- Service Delivery Site
- Administrative/Service Delivery Site
- Admin-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, follow the steps below:

3. Click the Add New Site button (**Figure 25**) provided above the **Proposed Sites** section.

**Figure 25: Form 5B**



➤ The system navigates to the **Service Site Checklist** page.

4. Answer the questions displayed on the **Service Site Checklist** page.

**Figure 26: 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 26, 1), i.e. if the site being added is not an 'Admin-only' site.
  - o Select 'Yes' for questions 'a' through 'd' so that the site is qualified to be added to the application, AND
  - o Indicate whether the site being added is a domestic violence site by answering 'Yes' or 'No' to question 2 (Figure 26, 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 26, 1), i.e. if the site being added is an 'Admin-only' site, select 'Not Applicable' to question 2

5. Click the Verify Qualification button (Figure 26, 3).

➤ The system navigates to the **List of Pre-registered Performance Sites at HRSA Level** page. All of the sites that are registered by your organization within EHB will be listed on this page.

**Figure 27: 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	Performance Site Address Category	Options
Madison County Dental Care	Fixed	76 Howard Avenue, Bristol, VT 05602	Approximate	Select Site Location
Stowe Park Dental	Fixed	6 Park St, BRISTOL, VT 05602-1028	Accurate	Select Site Location
Mountain Health Center	Fixed	100 West Avenue, Bristol, VT	Accurate	Select Site Location
Mountain Health Center	Fixed	76 Howard Avenue STE 100, Bristol, VT 05602	Accurate	Select Site Location
Mountain Health Center Home	Fixed	67 Pine Street, Building 6, Bristol, VT 05602	Approximate	Select Site Location
Mountain Health Center	Fixed	67 Pine St, Bristol, VT 05602-1040	Accurate	Select Site Location

Cancel

6. To use a new location for the site you are proposing in Form 5B, click the Register Performance Site button (Figure 27, 1) and register your site using the Enterprise Site Repository (ESR) system by following the steps below:

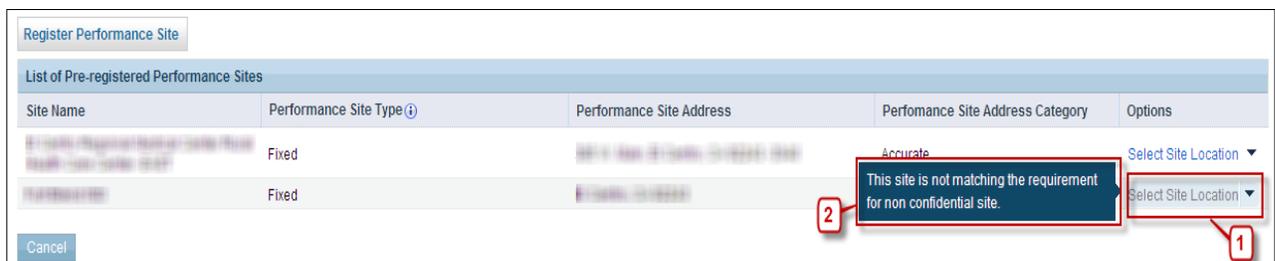
- On the Basic Information – Enter page, provide a site name and select a site type from the following options: Fixed, Mobile. Click the Next Step button.
  - On the Address – Enter page, enter the physical address of the site and click the Next Step button.
  - On the Register – Confirm page, the system 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.
7. Select a site from the List of Pre-registered Performance Sites and click its **Select Site Location** link (Figure 27, 2).

**IMPORTANT NOTES:** The Select Site Location link will be disabled (Figure 28, 1) if the site falls under any of these categories, and you will not be able to select the site

- 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.

In these cases, hovering over the disabled **Select Site Location** link (Figure 28, 2) will provide the reason why the site is disabled

**Figure 28: Disabled Site Locations**



**IMPORTANT NOTE:** If you wish to update the name of any site listed on this page, click on **Update the Registered Performance Site** link (Figure 29) and update the site name.



For each Service Delivery site, complete the form by following these steps:

1. The name, address, and service site type populate from the list of pre-registered performance sites.
2. Select a Location Setting (i.e., all other clinic types, hospital, or school) and Location Type (i.e., permanent, seasonal, or mobile van).
3. Enter the date that the site became operational.
4. Select the Medicare billing status and enter Medicare billing number, if applicable. Enter 'N/A' if you do not have a billing number.
5. Enter the total hours of operation per week for the site.
6. Select whether the site is operated by the health center/applicant or contractor.
7. If the site is operated by a contractor, you must enter information about the operating organization.
8. 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.
9. 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 31**). 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 31: Newly added site displayed under Proposed Sites section**

Site Name	Physical Address	Service Site Type	Location Type	Site Status	Options
Northwestern Health at St. Vincent de Paul Health Center	1000 ALPHEA AVE N, SEATTLE, WA 98108-7211	Service Delivery Site	Permanent	In Progress	Update

**IMPORTANT NOTES:**

- 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** identifies other activities or locations associated with your look-alike.

**IMPORTANT NOTE:** This is an optional form. If you do not want to propose any other activities or locations in your application, 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, follow these steps:

1. Click the Add New Activity/Location button provided at the top of the form (**Figure 32, 1**).

**Figure 32: Form 5C – Other Activities/Locations**

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

- The system navigates to the **Activity/Location Information** page (**Figure 33**).

**Figure 33: 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

2. 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 34**).

**Figure 34: 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 Indian” 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 Indian” or “Urban Indian,” you must enter all required information on **Form 6A**.

**Figure 35: 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: 07/01/2018 (Due In: 0 Days) | Section Status: Not Started

**Resources**

View  
[LAL ID User Guide](#) | [LAL ID Instructions](#) | [LAL ID TA](#)

Fields with \* are required

**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
Bethany Toman	Treasurer	Finance	No	No	Yes	No	<input type="button" value="Update"/>
Nancy Martineau	Vice President	Social Work	Yes	Yes	Yes	No	<input type="button" value="Update"/>

**Gender** Number of Patient Board Members

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.

1. To add the board member information, click the Add Board Member button (Figure 35, 1). You must provide a minimum of 9 and maximum of 25 board members.
  - The system navigates to the **Current Board Member – Add** page (Figure 36).
2. 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 36, 1), or the Save and Add New button to save the information and add a new board member (Figure 36, 2).
3. 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 35, 2).
4. 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 35, 3).
5. If you selected Public (non-Tribal or Urban Indian) as the business entity in [Form 1A](#) 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](#), 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 36: Current Board Member – Add Page**

**IMPORTANT NOTES:**

- The totals of each Patient Board Member Classification sections should be equal.
- The total number of patient board members under each classification section should be less than or equal to the total number of board members added in the List of All Board Members section.

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

**4.11 Form 6B - Request for Waiver of Governance 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** will not be applicable in the following cases:

- You have selected Community Health Centers (CHC) as the Target Population in the Cover Page form of this application.
- You selected “Tribal” or “Urban Indian” as the Business Entity in [Form 1A](#).

Click on the Continue button provided at the bottom of the form to complete and proceed to the next form (Figure 37).

Figure 37: Form 6B when Not Applicable

**Form 6B - Request for Waiver of Board Member Requirements**

BENEDICTE JONES COMMUNITY HEALTH CENTER, LLC Due Date: 10/18/2018 (Due In: 85 Days) | Section Status: Complete

Resources

View

[LAL ID User Guide](#) | [LAL ID Instructions](#) | [LAL ID TA](#)

**Alert:**  
This form is not applicable to you as you are currently receiving or applying to receive 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, follow these steps:

1. Indicate whether you are requesting a new waiver of the 51% patient majority governance requirement under the New Waiver Request section (Figure 38, 1). If you answer “Yes”, you must then complete the Demonstration of Good Cause for Waiver section (Figure 38, 2) and the Alternative Mechanism for Addressing Patient Representation section (Figure 38, 3).

Figure 38: Form 6B when Applicable

The screenshot displays the 'Form 6B - Request for Waiver of Board Member Requirements' interface. On the left is a sidebar with 'ALL TASKS' and various form categories like 'Program Specific Information', 'Overview', 'General Information', 'Budget Information', 'Sites and Services', 'Other Forms', 'Performance Measures', 'Review', and 'All Forms'. The main content area is titled 'Form 6B - Request for Waiver of Board Member Requirements' and includes a 'Resources' section with links to 'LAL ID User Guide', 'LAL ID Instructions', and 'LAL ID TA'. Below this, a note states 'Fields with \* are required'. The form is divided into three sections, each with a red callout box containing a number: 1. 'New Waiver Request' (callout 1), 2. 'Demonstration of Good Cause for Waiver (demonstrate good cause for the waiver request by addressing the following areas)' (callout 2), and 3. 'Alternative Mechanism Plan for Addressing Patient Representation' (callout 3). Section 2 includes a question: '\* Are you requesting a new waiver of the 51% patient majority governance requirement?' with 'Yes' and 'No' radio buttons. Below this are two text input areas for 2a and 2b, each with a character limit of 1000. Section 3 includes a text input area for a plan, also with a 1000-character limit. At the bottom, there are 'Go to Previous Page', 'Save', and 'Save and Continue' buttons.

2. Answer the remaining questions on the form as applicable.

**IMPORTANT NOTE:** Questions 2a, 2b, and 3 are required if you answered 'Yes' to question 1.

After completing **Form 6B**, click the Save and Continue button to save your work and proceed to the next form.

## 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 project, including a proposed site operated by a contractor, as identified in Form 5B: Service Sites. This form has the following sections:

1. [Part I: Health Center Agreements](#) (Figure 39, 1)
2. [Part II: Attachments](#) (Figure 39, 2)

Figure 39: Form 8 – Health Center Agreements

#### 4.12.1 Completing Part I of Form 8

To complete Part I: Health Center Agreements, follow these steps:

3. In Part I, question 1 (Figure 39, 3), answer if your organization has a parent, affiliate, or subsidiary organization.
4. Select 'Yes' in question 2 (Figure 39, 4), if any current or proposed agreements exist with another organization to carry out a substantial portion of your organization's approved scope of project. If 'Yes' is selected, complete 2a (Figure 39, 5).

**IMPORTANT NOTE:** If any of the sites proposed in [Form 5B: Service 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 organization. To add agreements, follow these steps:

1. Click on Add Organization Agreement (Figure 39, 2) to open the Organization Agreement – Add page (Figure 40).

Figure 40: Organization Agreement – Add page

2. 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).

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

3. Click Save and Continue to return to **Form 8 – Health Center Agreements** page. Following the steps described above, enter additional organizations and corresponding agreements as referenced in Part I.
4. After completing **Form 8**, click the Save and Continue button to save your work and proceed to the next form.

### 4.13 Form 10 – Emergency Preparedness Report

The **Emergency Preparedness Report** assesses your organization's overall emergency readiness.

1. Complete the sections of this form by selecting a 'Yes' or 'No' response for the required questions ([Figure 41](#)).
2. After providing complete information on **Form 10**, click the Save and Continue to save the information and proceed to the next form.

Figure 41: Form 10 – Emergency Preparedness Report

**Form 10 - Emergency Preparedness Report**

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

**Resources**

**View**

[LAL ID User Guide](#) | [LAL ID Instructions](#) | [LAL ID TA](#)

Fields with \* are required

**Section I : Emergency Preparedness and Management (EPM) Plan**

\* 1. Has your organization conducted a thorough Hazards Vulnerability Assessment?  
If Yes, date completed:  (mm/dd/yyyy)  Yes  No

\* 2. Does your organization have an approved EPM plan?  
If Yes, date that the most recent EPM plan was approved by your Board:  (mm/dd/yyyy)  Yes  No  
If No, skip to Readiness section below.

3. Does the EPM plan specifically address the four disaster phases?  
This question is mandatory if you answered Yes to Question 2.

3a. Mitigation  Yes  No

3b. Preparedness  Yes  No

3c. Response  Yes  No

3d. Recovery  Yes  No

4. Is your EPM plan integrated into your local/regional emergency plan?  
This question is mandatory if you answered Yes to Question 2.  Yes  No

5. If no, has your organization attempted to participate with local/regional emergency planners?  
This question is mandatory if you answered Yes to Question 2 and No to Question 4.  Yes  No

6. Does the EPM plan address your capacity to render mass immunization/prophylaxis?  
This question is mandatory if you answered Yes to Question 2.  Yes  No

**Section II : Readiness**

\* 1. Does your organization include alternatives for providing primary care to the current patient population if you are unable to do so during emergency?  Yes  No

\* 2. Does your organization conduct annual planned drills?  Yes  No

\* 3. Does your organization's staff receive periodic training on disaster preparedness?  Yes  No

\* 4. Will your organization be required to deploy staff to Non-Health Center sites/locations according to the emergency preparedness plan for local community?  Yes  No

\* 5. Does your organization have arrangements with Federal, State and/or local agencies for the reporting of data?  Yes  No

\* 6. Does your organization have a back-up communication system?

6a. Internal  Yes  No

6b. External  Yes  No

\* 7. Does your organization coordinate with other systems of care to provide an integrated emergency response?  Yes  No

\* 8. Has your organization been designated to serve as a point of distribution for providing antibiotics, vaccines and medical supplies?  Yes  No

\* 9. Has your organization implemented measures to prevent financial/revenue and facilities loss due to an emergency?  
(e.g. Insurance coverage for short-term closure)  Yes  No

\* 10. Does your organization have an off-site back up of your information technology system?  Yes  No

\* 11. Does your organization have a designated EPM coordinator?  Yes  No

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

## 4.14 Form 12 – Organization Contacts

Use **Form 12 – Organization Contacts** to provide contact information for the proposed project.

1. 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.

2. Enter the required contact information.

**Figure 43: Chief Executive Officer – Add page**

3. 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.

4. To update the contact information provided, click on the **Update** link under the options column.
5. To delete the contact information already provided, click on the **Delete** link under the options column.

**IMPORTANT NOTE:**

- The Update and the Delete link will be displayed only after you have added the contact information.

6. After providing complete information on **Form 12**, click the Save and Continue button to save the information and proceed to the next form.

## 4.15 Clinical Performance Measures

Use this form to provide information about Clinical Performance Measures.

**IMPORTANT NOTE:**

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

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

### 4.15.1 Completing the Required Clinical Performance Measures

There are 16 required performance measures listed in this form. To complete this form:

Figure 44: Clinical Performance Measures page

**Clinical Performance Measures**

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

Resources

View

LAL ID User Guide | LAL ID Instructions | LAL ID TA

Add Additional Performance Measure 2

Collapse Group | Detailed View

Focus Area	Performance Measure	Baseline Data	Baseline Year	Projected Data	Status	Options
<b>Required Measures</b>						
Diabetes: Hemoglobin A1c Poor Control	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.		All		Not Complete	<span style="border: 1px solid red; padding: 2px;">1</span> Update
Hypertension: Controlling high blood pressure	Percentage of patients 18-65 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90mmHg) during the measurement period.				Not Complete	Update
Cervical cancer screening	Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.				Not Complete	Update
Access to prenatal care	Percentage of prenatal care patients who entered treatment during their first trimester.				Not Complete	Update
Low birth weight	Percentage of patients born to health center patients whose birth weight was below normal (less than 2,500 grams).				Not Complete	Update
Childhood immunization status (CIS)	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP), three polio (IPV), one measles, mumps and rubella (MMR), three H influenza type B (HIB), three hepatitis B (Hep B), one chicken pox (VZV), four pneumococcal conjugate (PCV), one hepatitis A (Hep A), two or three rotavirus (RV), and two influenza (flu) vaccines by their second birthday.				Not Complete	Update
Dental sealants	Percentage of children, age 6 through 9 years, at moderate to high risk for caries who received a sealant on a permanent first molar during the measurement period.				Not Complete	Update
Weight Assessment and Counseling for Children and Adolescents	Percentage of patients aged 3 -17 years of age who had evidence of BMI percentile documentation and who had documentation of counseling for nutrition and who had documentation of counseling for physical activity during the measurement year.				Not Complete	Update
Adult Weight Screening and Follow-Up	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter. Normal parameters: Age 18 - 64 years BMI => 18.5 and < 25 kg/m <sup>2</sup> , and Age 65 years and older BMI => 23 and < 30 kg/m <sup>2</sup> .				Not Complete	Update
Tobacco use screening and cessation intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.				Not Complete	Update
Asthma: Use of appropriate medications	Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.				Not Complete	Update
Coronary Artery Disease (CAD): Lipid Therapy	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) who were prescribed a lipid-lowering therapy.				Not Complete	Update
Ischemic vascular disease (IVD): use of aspirin or another antithrombotic	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period.				Not Complete	Update
Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.				Not Complete	Update
HIV Linkage to Care	Percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis.				Not Complete	Update
Depression Screening and Follow Up	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.				Not Complete	Update

Go to Previous Page | Save | Save and Continue

1. Click on the **Update** link to start working on a performance measure (Figure 44, 1).
  - The system navigates to the **Clinical Performance Measure – Update** page (Figure 45).

Figure 45: Clinical Performance Measure - Update page

The screenshot shows the 'Clinical Performance Measures - Update' page. At the top, there's a breadcrumb trail and a 'Resources' section with links for 'LAL ID User Guide', 'LAL ID Instructions', and 'LAL ID TA'. Below this, a 'Fields with \* are required' note is present. The main form is titled 'Update Clinical Performance Measure Information' and contains several sections:

- Focus Area:** Diabetes: Hemoglobin A1c Poor Control
- Performance Measure:** Percentage of patients 19-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.
- Target Goal Description:** A text area with a character count of 500. A red callout box '1' points to this field.
- Numerator Description:** A text area with pre-populated text: 'Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%'. A red callout box '2' points to this field.
- Denominator Description:** A text area with pre-populated text: 'Patients 19-75 years of age with diabetes with a visit during the measurement period.' A red callout box '2' also points to this field.
- Baseline Data:** Includes fields for 'Baseline Year' (with a '(yyyy)' placeholder), 'Measure Type' (set to 'Percentage'), 'Numerator', and 'Denominator'. A 'Calculate Baseline' button is located below these fields. A red callout box '4' points to the 'Denominator' field.
- Projected Data (by End of Designation Period):** Includes a 'Projected Goal' field and a 'Measure Type' field (set to 'Percentage'). A red callout box '3' points to the 'Projected Goal' field.
- Data Sources & Methodology:** A text area with a character count of 500. A red callout box '5' points to the 'Add New Key Factor and Major Planned Action' button below this section.
- Key Factors and Major Planned Actions:** A table with columns 'Key Factor Type', 'Description', 'Major Planned Action', and 'Options'. It currently shows 'No key factors and major planned actions added'.
- Comments:** A text area with a character count of 1500. A red callout box '6' points to this field.

At the bottom of the page, there are three buttons: 'Cancel', 'Save', and 'Save and Update Next'. A red callout box '7' points to the 'Save' button, a red callout box '8' points to the 'Save and Continue to List' button, and a red callout box '9' points to the 'Save and Update Next' button.

2. Provide a **Target Goal Description** for each performance measure (Figure 45, 1). For all required measures, the Numerator and Denominator descriptions are pre-populated (Figure 45, 2).
3. 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).
4. Enter the projected goal by the end of the designation period as a percentage (Figure 45, 3).
5. Select an appropriate response in the Data Sources & Methodology field. If 'Other' is selected, specify a name and description.
6. 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).
7. Provide all the required information.

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

8. 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.
9. Provide comments in the Comment field if needed (Figure 45, 6).
10. 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 NOTE:** If the goal for Oral Health performance measure for sealants is set to 0, at least one self-defined Oral Health performance measure must be entered in the Additional Clinical Performance Measures section.

#### 4.15.2 Adding Additional Clinical Performance Measures

To add an Additional Clinical Performance Measure to your application, follow these steps:

1. 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**

2. Select a focus area from the drop-down menu (Figure 47, 1).
3. If you select Oral Health or Behavioral 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.
4. If you select Other as the focus area, you must specify the performance measure focus area.
5. Provide the required information on this page.
6. 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.
7. 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.
8. 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 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:

1. 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

**Financial Performance Measures**

Due Date: 08/31/2016 (Due In: 76 Days) | Section Status: Not Started

Resources: LAL ID User Guide | LAL ID Instructions | LAL ID TA

Add Additional Performance Measure

Focus Area	Performance Measure	Baseline Data	Baseline Year	Projected Data	Status	Options
			All		All	
<b>Required Measures</b>						
Costs	Ratio of total cost per patient served in the measurement calendar year.				Not Complete	Update
Costs	Ratio of total medical cost per medical visit in the measurement calendar year.				Not Complete	Update

Go to Previous Page | Save | Save and Continue

Figure 49: Financial Performance Measure – Update Page

**Financial Performance Measures - Update**

Due Date: 08/31/2016 (Due In: 76 Days) | Section Status: Not Completed

Resources: LAL ID User Guide | LAL ID Instructions | LAL ID TA

Fields with \* are required

**Update Financial Performance Measure Information**

Focus Area: Costs

Performance Measure: Ratio of total cost per patient served in the measurement calendar year.

Target Goal Description (Sample Goal):  (Max 500 Characters) 500 Characters left.

Numerator Description: Total accrued cost before donations and after allocation of overhead.

Denominator Description: Total number of patients.

Baseline Data: Baseline Year: (yyyy), Measure Type: Ratio, Numerator: , Denominator: . Calculate Baseline.

Projected Data (by End of Designation Period) (Sample Calculator): Projected Goal: , Measure Type: Ratio.

Data Sources & Methodology:  (Max 500 Characters) 500 Characters left.

**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):  (Max 1500 Characters) 1500 Characters left.

Cancel | Save | Save and Continue to List | Save and Update Next

2. Provide a **Target Goal Description** for each performance measure (Figure 49, 1).

3. 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](#)).
4. Enter the projected goal by the end of the designation period.
5. Enter the Data Sources & Methodology used for the measure.
6. 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.
7. Click the Save and Continue button to save the information on the **Key Factor and Major Planned Action – Add** 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.
8. The Comments field is optional.
9. 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, follow these steps:

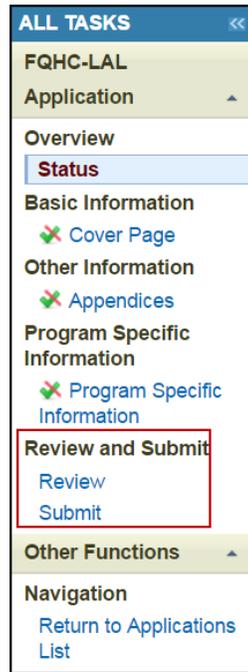
9. Click the Add Additional Performance Measure button on the **Financial Performance Measures – List** page.
  - The **Add Financial Performance Measures** page opens.
10. Provide the required information on this page.
11. If you select Other as the focus area, you must specify the performance measure focus area.
12. 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.
13. 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.
14. Additional measures can be updated and/or deleted by using the **Update** and/or **Delete** links provided as options.

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

To review your application, follow these steps:

1. Click on the **Status** link on the left side menu.

Figure 50: Left menu – Review and Submit



2. 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 51](#)).

Figure 51: Review page

You are here: Home > Tasks > Browse > FQHC-LAL Applications > Review

**Review**

Due Date: (Due In: days) | Application Status:

Resources

View

Application | Action History | LAL Application User Guide

Print Application

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View	Section	Type	Options
View: Basic Information			
Basic Information	Cover Page	HTML	View
View: Attachments List			
Attachments List	Project Abstract (Project Abstract.docx)	DOCUMENT	View
Attachments List	Project Narrative (Project Narrative.docx)	DOCUMENT	View
Attachments List	Attachment 1—Patient Origin Study (Attachment 1.docx)	DOCUMENT	View
Attachments List	Attachment 2—Service Area Map and Table (Attachment 2.docx)	DOCUMENT	View
Attachments List	Attachment 3—MUA/MUP Designation (Attachment 3.docx)	DOCUMENT	View
Attachments List	Attachment 4—Corporate Bylaws (Attachment 4.docx)	DOCUMENT	View
Attachments List	Attachment 5—Governing Board Meeting Minutes (Attachment 5.docx)	DOCUMENT	View
Attachments List	Attachment 6—Co-Applicant Agreement for Public Centers	DOCUMENT	Not Available
Attachments List	Attachment 7—Summary of Contracts and Agreements	DOCUMENT	Not Available
Attachments List	Attachment 8—Articles of Incorporation (Attachment 8.docx)	DOCUMENT	View
Attachments List	Attachment 9—Evidence of Nonprofit or Public Center Status (Attachment 9.docx)	DOCUMENT	View
Attachments List	Attachment 10—Medicare, Medicaid, and State CHIP Documentation (Attachment 10.docx)	DOCUMENT	View
Attachments List	Attachment 11—Organizational Chart (Attachment 11.docx)	DOCUMENT	View
Attachments List	Attachment 12—Position Descriptions for Key Personnel (Attachment 12.docx)	DOCUMENT	View
Attachments List	Attachment 13—Biographical Sketches for Key Personnel (Attachment 13.docx)	DOCUMENT	View
Attachments List	Attachment 14—Sliding Fee Discount Schedule and Schedule of Charges (Attachment 14.docx)	DOCUMENT	View
Attachments List	Attachment 15—Financial Statements and Independent Financial Audit (Attachment 15.docx)	DOCUMENT	View
Attachments List	Attachment 16—Letters of Support (Attachment 16.docx)	DOCUMENT	View
Attachments List	Attachment 17—Floor Plans (Attachment 17.docx)	DOCUMENT	View
Attachments List	Attachment 18—Budget Justification Narrative (Attachment 18.docx)	DOCUMENT	View
Attachments List	Attachment 19—Other Relevant Documents	DOCUMENT	Not Available
View: Program Specific Information			
Program Specific Information	Program Specific OMB Approved Forms	HTML	Open Popup

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23 items in 1 page(s)

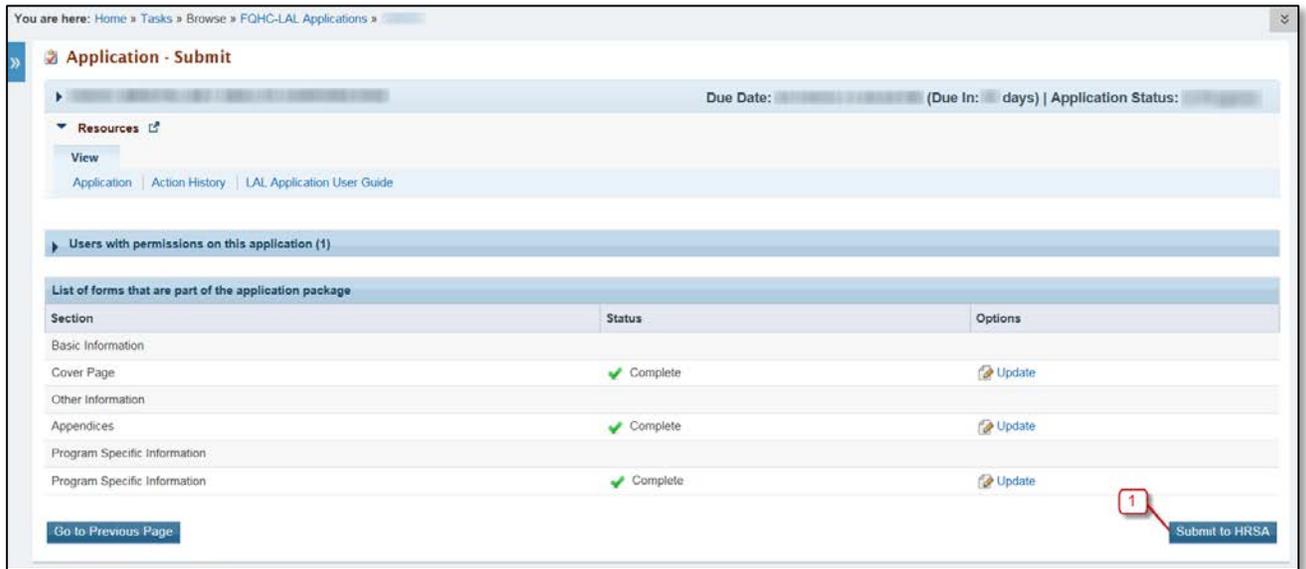
23 items in 4 page(s)

Go to Previous Page

Proceed to Submit

3. Verify the information displayed on the **Review** page.
4. If you are ready to submit the application to HRSA, click the Proceed to Submit button at the bottom of the **Review** page (Figure 51, 1).
  - The system navigates to the **Submit** page (Figure 52).
5. Click the Submit to HRSA button at the bottom of the **Submit** page (Figure 52, 1).
  - The system navigates to a confirmation page.

Figure 52: Submit to HRSA



6. Check the Application Certification to electronically sign the application and click the Submit to HRSA button.
7. If you experience any problems with submitting the application in EHB, contact the BPHC Helpline at 1-877-974-2742, ext. 3 or <http://www.hrsa.gov/about/contact/bphc.aspx>.