

HRSA Electronic Handbook

Look-Alike Renewal of Designation Application User Guide

Last updated on May 21, 2024



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

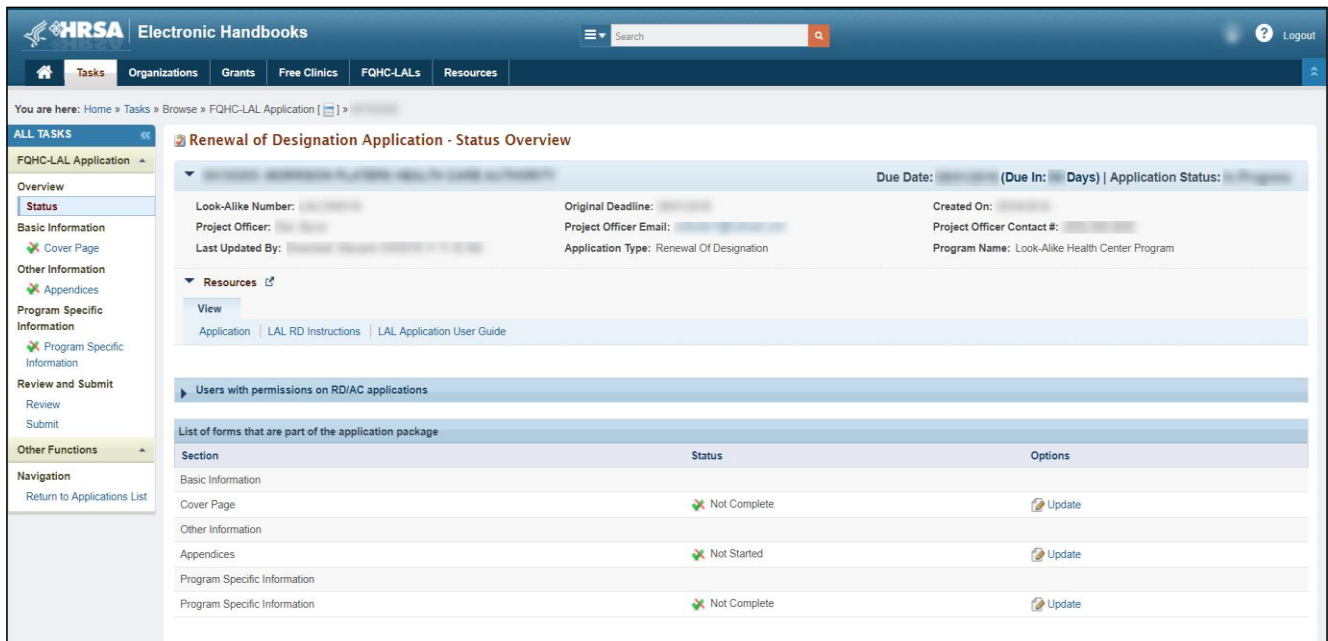
1. Starting the Look-Alike Renewal of Designation Application

You must have an Electronic Handbooks (EHBs) user account to create a Look-Alike application (also known as a Renewal of Designation or RD). After logging into EHBs, click the Tasks tab on the EHBs Home page to navigate to the **Pending Tasks – List** page.

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

Locate the Look-Alike RD application using the EHBs Application tracking number received in an email and click the **Start** link to begin working on the application in EHBs (if you have previously accessed the application, the **Start** link will be replaced with **Edit**). The system opens the **Renewal of Designation Application - Status Overview** page of the application (**Figure 1**). The application consists of the Cover Page, Appendices, and Program Specific Information sections. You must complete these sections to submit your application to HRSA.

Figure 1: Renewal of Designation Application - Status Overview Page



2. Completing the Look-Alike Cover Page Section of the Application

The Cover Page (Figure 2) requires the following information, as indicated by the red asterisks to the left of these fields:

1. Select Target Population(s) (Figure 2, 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 (PHPC).
2. Person to be contacted on matters involving this application (Figure 2, 2) – enter the point of contact for the Look-Alike Renewal of Designation application.
3. Authorized Official (Figure 2, 3) – enter the person who is authorized by the board of directors to submit the Look-Alike Renewal of Designation application. Once completed, click the Save and Continue button to proceed to the **Appendices** form.

Figure 2: Cover Page of FQHC-LAL Application

Cover Page

Due Date: 10/15/2018 (Due In: 88 Days) | Section Status: Not Complete

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Fields with * are required

Applicant Information

Legal Name: UNIVERSITY HEALTH FOUNDATION
Employer Identification Number (e.g. 53-2079819): 84-2147658
Organizational DUNS: 148214417
Mailing Address: 2020 BAYVIEW STREET, LOS ANGELES, CA 90012-1014

*** Select Target Population(s)**

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

Fields with * are required

*** Point of Contact (POC) Information** Add
No Point of Contact added.

Fields with * are required

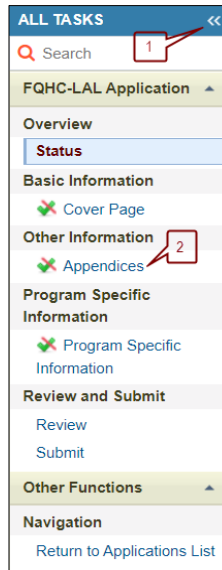
*** Authorizing Official (AO) Information** Add
No Authorizing Official added.

Go to Previous Page Save Save and Continue

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 3, 1). Click on the **Appendices** link (Figure 3, 2) to navigate to the **Appendices** form.

Figure 3: Left Navigation Menu



2. Upload the following attachments by clicking the associated Attach File buttons:
 - Project Abstract (Minimum 1 and Maximum 1) (Required)
 - Project Narrative (Minimum 1 and Maximum 1) (Required)
 - Attachment 1—Service Area Map and Table (Minimum 1 and Maximum 1) (Required)
 - Attachment 2—Bylaws (Minimum 1 and Maximum 1) (Required)
 - Attachment 3— Project Organizational Chart (Minimum 1 and Maximum 1) (Required)
 - Attachment 4—Position Descriptions for Key Management Staff (Minimum 1 and Maximum 1) (Required)
 - Attachment 5—Biographical Sketches for Key Management Staff (Minimum 1 and Maximum 1) (Required)
 - Attachment 6—Co-Applicant Agreement (Maximum 1) (as applicable)
 - Attachment 7—Summary of Contracts and Agreements (Maximum 1) (as applicable)
 - Attachment 8— Collaboration Documentation (Minimum 1 and Maximum 1) (Required)
 - Attachment 9— Sliding Fee Discount Schedule(s) (Minimum 1 and Maximum 1) (Required)
 - Attachment 10— Budget Justification Narrative (Minimum 1 and Maximum 1) (Required)
 - Attachment 11—Other Relevant Documents (Maximum 5) (as applicable)
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

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 4: Status Overview Page for Program Specific Forms

Status Overview

Due Date: (Due In: Days) | Program Specific Status:

Look-Alike Number: Target Population: Application Type: Renewal of Designation

Current Certification Period: Current Designation Period:

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

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, population, and patient and visit projections. This form has the following sections:

1. Applicant Information ([Figure 5, 1](#))
2. Proposed Service Area ([Figure 5, 2](#))

Figure 5: Form 1A – General Information Worksheet

Form 1A - General Information Worksheet

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

Resources

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Fields with * are required

1. Applicant Information

Applicant Name:

* Fiscal Year End Date:

Application Type:

LAL Number:

* Business Entity:

* Organization Type (Select all that apply)

- All
- Faith based
- Hospital
- State government
- City/County/Local Government or Municipality
- University
- Community based organization
- Other

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

2. Proposed Service Area

Note(s):
 Applicants applying for Community Health Center (CHC) designation must serve at least one MUA or MUP. Provide the IDs for all MUAs and/or MUPs within the service area proposed in this application.

2a. Service Area Designation

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

Find an MUA/MUP

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

2b. Service Area Type

Note(s):
 You must select Urban or Rural. If you select Rural, Sparsely Populated may also be selected, if applicable.

* Choose Service Area Type

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

2c. Patients and Visits

Unduplicated Patients and Visits by Population Type

* How many unduplicated patients are projected to be served by end of the Designation Period? (This projection is for calendar year 2026.)

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

Patients and Visits by Service Type

Service Type	Current Number		Projected by End of Designation Period	
	Patients	Visits	Patients	Visits
* Total Medical Services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
* Total Dental Services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Behavioral Health Services				
* Total Mental Health Services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
* Total Substance Use Disorder Services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
* Total Vision Services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
* Total Enabling Services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

4.1.1 Completing the Applicant Information Section

The **Applicant Information** section is pre-populated with the applicant’s name and application type. Complete this section by providing information in the required fields (**Figure 6**).

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 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 6, 1**).

Figure 6: Applicant Information Section

The screenshot shows a web form titled "1. Applicant Information". The fields are as follows:

- Applicant Name: KEVIN BAREFOOT VOLUNTEER EMERGENCY SOUND
- Fiscal Year End Date: Select Option
- Application Type: Renewal of Designation
- LAL Number: LALCSMB17
- Business Entity: Select Option
- Organization Type (Select all that apply): A dropdown menu is open, showing the following options:
 - All
 - Faith based
 - Hospital
 - State government
 - City/County/Local Government or Municipality
 - University
 - Community based organization
 - Other (marked with a red box and the number 1)

Below the Organization Type dropdown is a text field labeled "If 'Other' please specify:" with a character count "(maximum 100 characters)".

4.1.2 Completing the Proposed Service Area Section

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

1. 2a. Service Area Designation
 - Urban
 - Rural
 - Sparsely Populated
2. 2c. Patients and Visits
 - Unduplicated Patients and Visits by Population Type
 - Patients and Visits by Service Type

Completing 2a. Service Area Designation

In the Select MUA/MUP field (**Figure 7, 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 NOTE: For inquiries regarding MUAs or MUPs, visit the [What Is Shortage Designation? | Bureau of Health Workforce \(hrsa.gov\)](#) or call 1-888-275-4772 (option 1 then option 2), or contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816.

Figure 7: Proposed Service Area Section

2. Proposed Service Area

Note(s):
Applicants applying for Community Health Center (CHC) designation must serve at least one MUA or MUP. Provide the IDs for all MUAs and/or MUPs within the service area proposed in this application.

2a. Service Area Designation

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

Find an MUA/MUP

1

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

2b. Service Area Type

Note(s):
You must select Urban or Rural. If you select Rural, Sparsely Populated may also be selected, if applicable.

2

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)

Completing 2b. Service Area Type Section

The **Service Area Type** field (**Figure 7, 2**), indicates whether the service area is urban or rural. If the service is rural indicates if it is sparsely populated. If sparsely populated is selected, rural must be selected. Also, for sparsely populated 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 website](#).

Completing 2c. Patients and Visits

There are two required sections:

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 8, 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 8, 2**) when the user clicks on the Save or Save and Continue button.
3. Patient data under the Current Number heading (**Figure 8, 3**) is pre-populated from the Uniform Data System (UDS) for the Total and the

Population Types corresponding to the subprograms selected on the [Cover page - Select Target Population\(s\)](#) section of this application.

4. The Total Visits under the Current Number heading (**Figure 8, 4**) is pre-populated from the Uniform Data System (UDS).
5. You must enter the number of visits for Population Types corresponding to the subprograms selected in the [Cover page – Select Target Population\(s\)](#) section of this application, should be greater than zero (**Figure 8, 5**). For the remaining Population Types, you may provide zeros if there are no projections. You may also provide data for the Population Types beyond those selected on the Cover page.

Figure 8: Unduplicated Patients and Visits by Population Type

Population Type	Current Number		Projected by End of Designation Period	
	Patients	Visits	Patients	Visits
★ Total	0	0		
★ General Underserved Community (Include all patients/visits not reported in the rows below)	0	0		
★ Migratory and Seasonal Agricultural Workers and Families	0	0		
★ Public Housing Residents	0	0		
★ People Experiencing Homelessness	0	0		

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.

2. Patients and Visits by Service Type

To complete this section, follow these steps:

1. Patients and Visits under the Current Number heading (**Figure 9, 1**) are pre-populated from the Uniform Data System (UDS) for each Service type. If the UDS data is not available there will be a note displayed on top of the page stating “The 2021 UDS data is not yet available for prepopulating in this application. Please check back later.”
2. Provide the number of patients and visits under the Projected by End of Designation Period heading for each Service Type (**Figure 9, 2**). 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.

Figure 9: Patients and Visits by Service Type

Service Type	Current Number		Projected by End of Designation Period	
	Patients	Visits	Patients	Visits
Total Medical Services	0	0		
Total Dental Services	0	0		
Behavioral Health Services				
Total Mental Health Services	0	0		
Total Substance Use Disorder Services	0	0		
Total Vision Services	0	0		
Total Enabling Services	0	0		

IMPORTANT NOTES:

‘UDS/Baseline Value’ refers to the number of patients and visits for the proposed service area at the time of application.

Projected Patients and Visits for Medical Services must be greater than 0.

In the Patients and Visits by Service Type section, Projected Medical Patients (by end of designation period) must be greater than the projected number of patients for each of the other service types.

Project the number of patients and visits anticipated within each Service Type category by the end of the designation period.

To maintain consistency with the patients and visits reported in UDS, do not report patients and visits for vision or pharmacy services, or services outside the proposed scope of project. Refer to the Scope of Project (<http://bphc.hrsa.gov/about/requirements/scope>) policy documents.

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.

4.2 Form 1C – Documents on File

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

To complete the **Form 1C**, follow the steps below:

1. In the Management and Finance section, provide the date of the last review/revision. Click N/A if not applicable (**Figure 10, 1**).
2. In the Services section, provide the date of the last review/revision (**Figure 10, 2**).
3. In the Governance section, provide the date of the last review/revision. Click N/A if not applicable (**Figure 10, 3**).
4. Click Save and Continue to proceed to the next form.

Figure 10: Form 1C - Documents on File

Form 1C - Documents on File

Note(s):
Date of Last Review/Revision must use the date format of MM/DD/YYYY. This listing does not include all policy/procedure documents required to be maintained on file. Records demonstrating implementation of required policies and procedures must also be available for review.

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

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Fields with * are required

Management and Finance	Date of Last Review/Revision (MM/DD/YYYY)	Not Applicable (N/A)
* Personnel policies, including selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices.	[] [] []	<input type="checkbox"/>
* Procurement procedures.	[] [] []	<input type="checkbox"/>
* Standards of Conduct/Conflict of Interest policies/procedures.	[] [] []	<input type="checkbox"/>
* Financial Management/Accounting and Internal Control policies and/or procedures to ensure awarded Health Center Program federal funds are not expended for restricted activities.	[] [] []	<input type="checkbox"/>
* Financial Management/Accounting and Internal Control policies/procedures related to restrictions on the use of federal funds for the purchase of sterile needles or syringes for the hypodermic injection of any illegal drug. ¹ (Only applicable if your organization provides syringe exchange services or is otherwise engaged in syringe service program; otherwise, indicate as N/A.)	[] [] []	<input type="checkbox"/>
* Financial Management/Accounting and Internal Control policies/procedures related to restrictions on the use of federal funds to provide abortion services, except in cases of rape or incest or where there is a threat to the life of the mother. ² (Only applicable if your organization provides abortion services; otherwise, indicate as N/A.)	[] [] []	<input type="checkbox"/>
* Billing and Collections policies/procedures, including those regarding waivers or fee reductions and refusal to pay.	[] [] []	<input type="checkbox"/>

Services	Date of Last Review/Revision (MM/DD/YYYY)	Not Applicable (N/A)
* Credentialing/Privileging operating procedures.	[] [] []	<input type="checkbox"/>
* Coverage for Medical Emergencies During and After Hours operating procedures.	[] [] []	<input type="checkbox"/>
* Continuity of Care/Hospital Admitting operating procedures.	[] [] []	<input type="checkbox"/>
* Sliding Fee Discount Program policies, operating procedures, and sliding fee schedule.	[] [] []	<input type="checkbox"/>
* Quality Improvement/Assurance Program policies and operating procedures that address clinical services and management, patient safety, and confidentiality of patient records.	[] [] []	<input type="checkbox"/>

Governance	Date of Last Review/Revision (MM/DD/YYYY)	Not Applicable (N/A)
* Governing Board Bylaws.	[] [] []	<input type="checkbox"/>
* Co-Applicant Agreement (Only applicable to public entity health centers; otherwise, indicate as N/A.)	[] [] []	<input type="checkbox"/>
* Evidence of Nonprofit or Public Center Status	[] [] []	<input type="checkbox"/>

Go to Previous Page | Save | Save and Continue

4.3 Form 4 - Community Characteristics

Form 4 – Community Characteristics reports the 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 11, 1**)
2. Hispanic or Latino/a Ethnicity (**Figure 11, 2**)
3. Income as a Percent of Poverty Level (**Figure 11, 3**)
4. Principal Third-Party Medical Insurance (**Figure 11, 4**)
5. Special Populations and Select Population Characteristics (**Figure 11, 5**)

Figure 11: Form 4 – Community Characteristics

Form 4 - Community Characteristics

Note(s):
Data on race and/or ethnicity collected on this form will not be used as a designating factor, but will be used to assess compliance with Health Center Program requirements for new applicants.

REGISTERED ADAPTIVE SKIN HOSPITAL Due Date: 12/31/2024 (Due In: 72 Days) | Section Status: Not Started

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Fields with * are required

Race	Service Area Number	Service Area Percent	Target Population Number	Target Population Percent
* Asian		0.00%		0.00%
* Native Hawaiian		0.00%		0.00%
* Other Pacific Islander		0.00%		0.00%
* Black/African American		0.00%		0.00%
* American Indian/Alaska Native		0.00%		0.00%
* White		0.00%		0.00%
* More than One Race		0.00%		0.00%
* Unreported/ Chose Not to Disclose Race		0.00%		0.00%
Total	0		0	

Click the **'Save and Calculate Total'** button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form.

Hispanic or Latino/a Ethnicity	Service Area Number	Service Area Percent	Target Population Number	Target Population Percent
* Hispanic or Latino/a		0.00%		0.00%
* Non-Hispanic or Latino/a		0.00%		0.00%
* Unreported/ Chose Not to Disclose Ethnicity		0.00%		0.00%
Total	0		0	

Click the **'Save and Calculate Total'** button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form.

Income as a Percent of Poverty Guideline	Service Area Number	Service Area Percent	Target Population Number	Target Population Percent
* 100% and below		0.00%		0.00%
* 101-200%		0.00%		0.00%
* Over 200%		0.00%		0.00%
Total	0		0	

Click the **'Save and Calculate Total'** button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form.

Principal Third Party Medical Insurance	Service Area Number	Service Area Percent	Target Population Number	Target Population Percent
* Medicaid		0.00%		0.00%
* Medicare		0.00%		0.00%
* Other Public Insurance		0.00%		0.00%
* Private Insurance		0.00%		0.00%
* None/Uninsured		0.00%		0.00%
Total	0		0	

Click the **'Save and Calculate Total'** button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form.

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

Go to Previous Page Save Save and Continue

4.3.1 Completing the Form 4 Sections

To complete the **Race and Ethnicity, Hispanic or Latino/a Ethnicity, Income as a Percent of Poverty Level**, and **Primary Third-Party Medical Insurance** sections (**Figure 11, 1, 2, 3, 4**), enter the **Service Area Number** (**Figure 11, 6**) and **Target Population Number** for each of the respective categories (**Figure 11, 7**).

IMPORTANT NOTES:

Target Population data is a subset of Service Area data, and in most cases, is a greater than the number of patients projected on Form 1A. Patient data should not be used to report target population data since patients are typically a subset of all individuals targeted for service.

The 'Service Area Percentage' and 'Target Population Percentage' are auto populated.

If information for the service area is not available, extrapolate data from the U.S. Census Bureau, local planning agencies, health departments, and other local, state, and national data sources. Estimates are acceptable.

Data on race and/or ethnicity collected on this form will not be used as a designating factor.

When entering data, the total Service Area Numbers for the Race and Ethnicity, Hispanic or Latino/a 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.

Completing the Special Populations and Select Population Characteristics Section

1. Under the Special Populations and Select Population Characteristics section (**Figure 12**), enter the **Service Area Number** and **Target Population Number** for each special 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 12, 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.
5. After completing all sections of Form 4, click the Save and Continue button to save your work and proceed to the next form.

Figure 12: Special Populations Section

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

4.4 Form 2 – Staffing Profile

Form 2 – Staffing Profile reports current and prospective staffing for the look-alike. Report personnel for the **first certification year** of the proposed project. Include only staff for sites included on Form 5B: Service Sites. This form has the following sections:

1. Staffing Positions by Major Service Category sections
 - Management and Support Personnel (**Figure 13, 1**)
 - Facility and Non-Clinical Support Personnel (**Figure 13, 2**)
 - Physicians (**Figure 13, 3**)
 - Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives (**Figure 13, 4**)
 - Medical Care Services (**Figure 13, 5**)
 - Dental (**Figure 13, 6**)
 - Behavioral Health (Mental Health and Substance Use Disorder Services) (**Figure 14, 7**)
 - Professional Services (**Figure 14, 8**)
 - Vision Services (**Figure 14, 9**)
 - Pharmacy Personnel (**Figure 14, 10**)
 - Enabling Services (**Figure 14, 11**)
 - Other Programs and Services (**Figure 14, 12**)
2. Total FTEs (**Figure 14, 13**)

Figure 13: Form 2 – Staffing Profile

Form 2 - Staffing Profile

Note(s):
The health center must directly employ its Project Director/CEO. Allocate staff time by function among the positions listed. An individual's full-time equivalent (FTE) should not be duplicated across positions. For example, a provider serving as a part-time family physician and a part-time Clinical Director should be listed in each respective category, with the FTE portion allocated to each position (e.g., Clinical Director 0.3 (30%) FTE and family physician 0.7 (70%) FTE). Do not exceed 1.0 FTE for any individual. Refer to the [most recent UDS manual](#) for position descriptions.

INDICATED ADAPTIVE SKIN HOSPITAL **Due Date: 10/10/2024 (Due In: 72 Days)** | **Section Status: Not Started**

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

Fields with * are required

Management and Support Personnel

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Project Director/Chief Executive Officer (CEO)	<input type="text"/>	N/A
* Finance Director/Chief Financial Officer (CFO)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Chief Operations 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
* Other Management and Support Personnel	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

Facility and Non-Clinical Support Personnel

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

Physicians

Staffing Positions by 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
* Obstetrician/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	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives

Staffing Positions by 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

Medical Care Services

Staffing Positions by 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) Please Specify: <input type="text"/> (Maximum 40 characters)	<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

Dental

Staffing Positions by 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 14: Form 2 - Staffing Profile (continued)

Behavioral Health (Mental Health and Substance Use Disorder Services) ⁷		
Staffing Positions by 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 Personnel Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Substance Use Disorder Providers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Professional Services ⁸		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Other Professional Health Services Personnel Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Vision Services ⁹		
Staffing Positions by 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 Personnel Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Pharmacy Personnel ¹⁰		
Staffing Positions by 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 ¹¹		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Case Managers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Patient and 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 Workers	<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 Personnel	<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 Personnel Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Programs and Services ¹²		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Quality Improvement Personnel	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Programs and Services Personnel Please Specify: <input type="text"/> (Maximum 40 characters)	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Total FTEs ¹³		
Totals	Direct Hire FTEs	Contract/Agreement FTEs
Totals <input type="button" value="Calculate"/>	<input type="text" value="0.00"/>	<input type="text" value="N/A"/>

4.4.1 Completing the Staffing Positions by Major Service Category Sections

4. 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 15, 1).
5. In the Contract/Agreement FTEs column, indicate whether contracts are used for each staffing position (Figure 15, 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 Chief Medical Officer 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 15: Direct Hire and Contract/Agreement FTEs Columns

Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Management and Support Personnel		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Project Director/Chief Executive Officer (CEO)		N/A
Finance Director/Chief Financial Officer (CFO)		<input type="radio"/> Yes <input checked="" type="radio"/> No
Chief Operations Officer (COO)		<input type="radio"/> Yes <input checked="" type="radio"/> No
Chief Information Officer (CIO)		<input type="radio"/> Yes <input checked="" type="radio"/> No
Clinical Director/Chief Medical Officer (CMO)		<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Management and Support Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No
Facility and Non-Clinical Support Personnel		
Staffing Positions by Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
Fiscal and Billing Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No
IT Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No
Facility Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No
Patient Support Personnel		<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.

1. To calculate the totals, click the Calculate button (Figure 16).
2. Click the Save and Continue button to save your work and proceed to the next form.

Figure 16: 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"/>

4.5 Form 3 - Income Analysis

Form 3 – Income Analysis projects program income, by source, for upcoming certification period. This form has the following sections:

1. Payer Categories (**Figure 17, 1**)
2. Comments/Explanatory Notes (**Figure 17, 2**)

Figure 17: Form 3 – Income Analysis

Form 3 - Income Analysis

Note(s): The value in the Projected Income (d) column should equal the value in the Billable Visits (b) column multiplied by the value in the Income per Visit (c) column. If not, explain in the Comments/Explanatory Notes section. In the Prior FY Income (e) column, enter the income data from the health center's most recent fiscal year audit or interim financial statement.

00226495: KEENAN BAREFOOT VOLUNTEER EMERGENCY SQUAD Due Date: 07/10/2024 (Due In: 72 Days) | Section Status: Not Started

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

Comments/Explanatory Notes (if applicable)

Approximately 2 pages (Max 2500 Characters with spaces)

4.5.1 Completing the Payer Categories Section

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

1. Part 1: Patient Service Revenue - Program Income
2. Part 2: Other Income - Other Federal, State, Local, and Other Income
3. 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 17, 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 17, 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 17, 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 17, 6**). Enter 0 if not applicable.
5. In the 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 17, 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 17, 8**).

IMPORTANT NOTES:

The number of Billable Visits in column (b) should be Zero if the number of Patients by Primary Medical Insurance in column (a) for a Payer Categories is Zero.

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 17, 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, explain 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 – Look-Alike Budget Information

Form 3A: Budget Information shows the program budget, by category, for the upcoming certification period. This form has the following sections:

1. Expenses (**Figure 18, 1**)
2. Revenue (**Figure 18, 2**)

4.6.1 Completing the Expenses Section

In the Expenses section, enter the projected expenses for the upcoming certification period for each of the applicable categories. If the categories in the form do not describe all expenses, enter

expenses in the other category. Click the Calculate Total and Save button to calculate and save the values for each of the Budget Categories in Part 1. (Figure 18, 3, 4).

Figure 18: Form 3A – Budget Information

4.6.2 Completing the Revenue Section

In the Revenue section, enter the projected revenue for the upcoming certification period from each category. If you are a state agency, leave the State row blank and include state funding in the Applicant row. If revenue is collected from sources other than those listed, indicate the additional sources in the other category. Click the Calculate Total and Save button to calculate and save the values for each of the Budget Categories in Part 2. (Figure 18, 5). Click the Save and Continue button to save your work and proceed to the next form.

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).

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 Renewal of Designation applications, **Form 5A – Services Provided** has the following sections:

1. Required Services (Figure 19, 1)
2. Additional Services (Figure 19, 2)
3. Specialty Services (Figure 19, 3)

Figure 19: Form 5A – Services Provided (Required Services)

Form 5A - Services Provided (Required Services)

Note(s):
Review the list of services retrieved from your scope on file as of '04/29/2024 01:45:14 PM'. If there was a recent change approved for your scope (e.g. through a Change In Scope application), click the 'Refresh From Scope' button below to get your most recent scope on file.

00226495: KEENAN BAREFOOT VOLUNTEER EMERGENCY SQUAD Due Date: 07/10/2024 (Due In: 72 Days) | Section Status: Not Complete

Resources

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[LAL RD User Guide](#) | [LAL RD Instructions](#) | [LAL RD TA Webpage](#) | [Services in LAL Scope](#)

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 (.)	[X]	[.]	[.]
Diagnostic Laboratory (.)	[X]	[X]	[X]
Diagnostic Radiology (.)	[.]	[X]	[X]
Screenings (.)	[X]	[.]	[X]
Coverage for Emergencies During and After Hours (.)	[X]	[.]	[X]
Voluntary Family Planning (.)	[X]	[.]	[X]
Immunizations (.)	[X]	[.]	[.]
Well Child Services (.)	[X]	[.]	[.]
Gynecological Care (.)	[X]	[.]	[X]
Ophthalmological Care (.)	[.]	[.]	[.]
Prenatal Care (.)	[X]	[.]	[X]
Intrapartum Care (Labor & Delivery) (.)	[.]	[.]	[X]
Postpartum Care (.)	[X]	[.]	[X]
Preventive Dental (.)	[X]	[.]	[X]
Pharmaceutical Services (.)	[X]	[X]	[X]
HCH Required Substance Use Disorder Services (.)	[.]	[.]	[.]
Case Management (.)	[X]	[.]	[.]
Eligibility Assistance (.)	[X]	[.]	[X]
Health Education (.)	[X]	[.]	[.]
Outreach (.)	[X]	[.]	[.]
Transportation (.)	[X]	[.]	[.]
Translation (.)	[X]	[X]	[.]

The **Form 5A: Services Provided** is pre-populated with the services in your current Health Center Program scope that HRSA has on file for your organization and is non-editable.

If the pre-populated data on Form 5A does not reflect any recently approved scope changes, click the Refresh from Scope button to refresh the data and display the approved changes. (Figure 19, 4)

4.7.1 Completing the Required, Additional & Specialty Services Section

The **Form 5A: Service Provided** is pre-populated with the services in the current Health Center Program scope that HRSA has on file for your organization and is not editable. If the pre-populated data on **Form 5A** does not reflect any recently approved scope changes, click the Refresh from Scope button (Figure 19, 4) to refresh the data and display the approved changes. You will be required to visit the Required Services, Additional Services, and Specialty Services sections (Figure 19, 1, 2, 3) at least once by clicking the Continue button on each section to change the status of the form 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 20).

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

Figure 20: Completed Form 5A

View

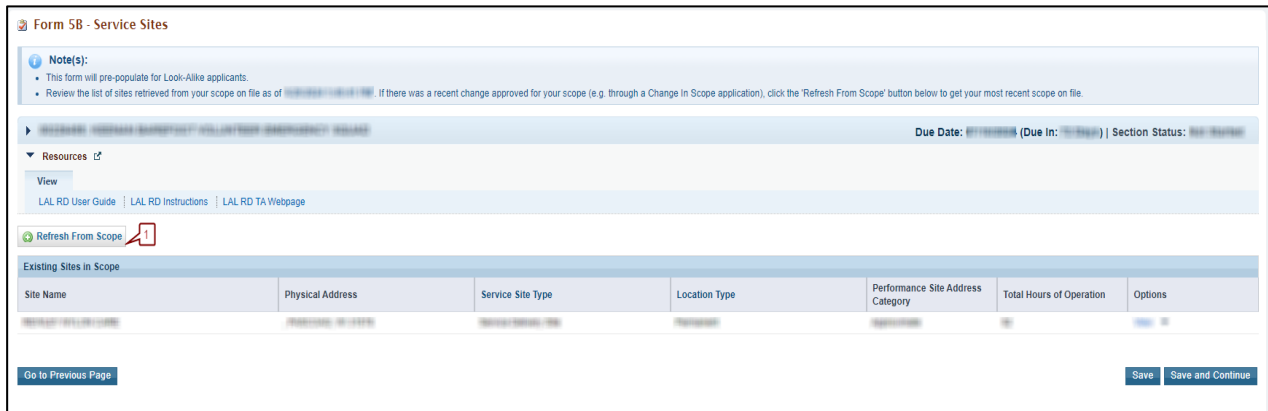
[LAL RD User Guide](#) | [LAL RD Instructions](#) | [LAL RD TA Webpage](#) | [Services in LAL Scope](#)

Required Services Additional Services Specialty Services

4.8 Form 5B – Service Sites

Form 5B – Service Sites identifies the sites in your scope of the project. Form 5B is pre-populated with the sites in the current Health Center Program scope that HRSA has on file for your organization. Form 5B is not editable. You will be required to visit the form at least once to change the status of the form to Complete.

Figure 21: Form 5B Service Sites



The screenshot displays the 'Form 5B - Service Sites' interface. At the top, there is a 'Note(s)' section with instructions. Below this is a 'Resources' section with links to 'LAL RD User Guide', 'LAL RD Instructions', and 'LAL RD TA Webpage'. A 'Refresh From Scope' button is visible. The main content is a table titled 'Existing Sites in Scope' with the following columns: Site Name, Physical Address, Service Site Type, Location Type, Performance Site Address Category, Total Hours of Operation, and Options. The table contains one row of data. At the bottom, there are buttons for 'Go to Previous Page', 'Save', and 'Save and Continue'.

Site Name	Physical Address	Service Site Type	Location Type	Performance Site Address Category	Total Hours of Operation	Options

If the pre-populated data on **Form 5B** does not reflect any recently approved scope changes, click the Refresh from Scope button to refresh the data and display the approved changes (**Figure 21, 1**).

After providing complete information on **Form 5B – Edit** page, click the Save and Continue button.

4.9 Form 5C – Other Activities/Locations

Form 5C - Other Activities/Locations are pre-populated with the activities/locations Information in the current Health Center Program scope that HRSA has on file for your organization and is not editable. You will be required to visit this form at least once to change the status of the form to Complete. After completing Form 5C, click the Continue button to save your work and proceed to the next form.

Figure 22: Form 5C – Other Activities/Locations

Form 5C - Other Activities/Locations

Note(s):
Review the list of activities and locations retrieved from your scope on file as of [redacted]. If there was a recent change approved for your scope (e.g. through a Change In Scope application), click the 'Refresh From Scope' button below to get your most recent scope on file.

Resources
View
LAL RD User Guide | LAL RD Instructions | LAL RD TA

Refresh From Scope

Activity/Location Information

Type of Activity	Frequency of Activity	Description of Activity	Type of Location(s) where Activity is Conducted
[dropdown]	[dropdown]	[dropdown]	[dropdown]

Go to Previous Page **Continue**

4.10 Scope Certification

Scope Certification allows you to certify if the scope of your organization, displayed in Form 5A: Services Provided and Form 5B: Service Sites of this Renewal of Designation, is correct.

Figure 23: Scope Certification

Scope Certification

1. Scope of Project Certification - Services – Select only one below

By checking this option, I certify that I have reviewed my Form 5A: Services Provided and it accurately reflects all services and service delivery methods included in my current approved scope of project.

By checking this option, I certify that I have reviewed my Form 5A: Services Provided and it requires changes that I have submitted through the change in scope process.

2. Scope of Project Certification - Sites – Select only one below

By checking this option, I certify that I have reviewed my Form 5B: Service Sites and it accurately reflects all sites included in my current approved scope of project.

By checking this option, I certify that I have reviewed my Form 5B: Service Sites and it requires changes that I have submitted through the change in scope process.

3. Compliance Achievement Plan

By checking this box, I certify that if my organization is noncompliant with any Health Center Program requirements, in accordance with Section 330(e)(1)(B), I will submit for HRSA's approval within 120 days of receipt of the Notice of Look-Alike Designation (NLD) a Compliance Achievement Plan to come into compliance. I acknowledge that areas of noncompliance will be documented through the carryover of any unresolved, existing condition from the current designation period and/or the placement of new condition(s) on the designation based on the review of this application. I also acknowledge that all conditions on my designation must be addressed within the timeframes and due dates specified on my Health Center Program NLD(s) and that the Compliance Achievement Plan I submit must align with such timelines.

4. Uniform Data System (UDS) Report Certification

By checking this box, I certify that I have reviewed the UDS Resources, including the most recent UDS Manual, and understand that my organization will be required to report data on patients, services, staffing, and financing annually. I also acknowledge that failure to submit a complete report by the specified deadline may result in conditions or restrictions being placed on the Health Center Program designation.

Go to Previous Page **Save** **Save and Continue**

To complete this form, follow the steps below:

1. Select an option in section 1 - Scope of Project Certification - Services to certify that the Form 5A: Services Provided form of this Renewal of Designation accurately reflects all services and service delivery methods included in your current approved project scope or that it requires changes that you submitted through the change in scope process (**Figure 23, 1**).

2. Select an option in section 2 - Scope of Project Certification - Sites to certify that the Form 5B: Service Sites form of this Renewal of Designation accurately reflects all sites included in your current approved project scope or that it requires changes that you submitted through the change in scope process (**Figure 23, 2**).
3. Click the Save and Continue button to save the information and proceed to the next form.

4.11 Form 6A – Current Board Member Characteristics

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

IMPORTANT NOTE:

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 24: Form 6A – Current Board Member Characteristics

Form 6A - Current Board Member Characteristics

Note(s):
The list of the designee's Board Members will pre-populate for the Renewal of Designation.

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Fields with * are required

Add New Board Member

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
	Member	Attorney and Physician	No	Yes	Live/Work	No	Update
	Member	Business Owner	No	Yes	Live/Work	No	Update
	Member	City Council	No	No	Live/Work	No	Update
	Member	Community Service	No	No	Live/Work	No	Update
	Member	Pharmer	No	Yes	Live/Work	No	Update
	Member	Mayor Pro Tem	No	No	Live/Work	No	Update
	President	City Council	No	No	Live	No	Update
	Member	Community Service	No	Yes	Live/Work	No	Update
Felma Wingig	Vice President	Nurse	Yes	Yes	Live/Work	No	Update
	Treasurer	Community	No	Yes	Live	No	Update
	Secretary	Community Service	No	Yes	Live/Work	No	Update

PATIENT BOARD MEMBER CHARACTERISTICS

Note(s):
Only include board members that are patients of the health center in the Patient Board Member Characteristics section.

Gender Number of Patient Board Members

- Male
- Female
- Unreported/Declined to Report

Ethnicity Number of Patient Board Members

- Hispanic or Latino/a
- Non-Hispanic or Latino/a
- Unreported/Declined to Report

Race Number of Patient Board Members

- Native Hawaiian
- Other Pacific Islander
- 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 the applicant is a public organization/center, do the board members listed above represent a co-applicant board?
 Yes No N/A

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

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

To complete this form, follow the steps below:

1. To add the board member information, click the Add Board Member button (Figure 24, 1). You must provide a minimum of 9 and a maximum of 25 board members. The system navigates to the **Current Board Member – Add** page (Figure 25).
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 25, 1), or the Save and Add New button to save the information and add a new board member (Figure 25, 2).
3. To update or to delete information for any board member, click on the **Update** or **Delete** link under the options column in the **List of All Board Members** section (Figure 24, 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 24, 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.
6. After providing complete information on Form 6A, click the Save and Continue button to save the information and proceed to the next form.

Figure 25: Current Board Member – Add Page

IMPORTANT NOTE:

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.

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

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

4.12.1 Completing Form 6B When it is not Applicable

Form 6B will not be applicable in the following cases:

1. You have selected Community Health Centers (CHC) as the Target Population in the Cover Page form of this application.
2. 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 26](#)).

Figure 26: Form 6B When Not Applicable

Form 6B - Request for Waiver of Board Member Requirements

BENEDICT JONES COMMUNITY HEALTH CENTER, LLC Due Date: 10/18/2018 (Due In: 88 Days) | Section Status: Complete

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

Go to Previous Page Continue

4.12.2 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 27, 1](#)) or if you currently have a waiver in the For Applicants with Previous Waiver section ([Figure 27, 2](#))
2. Answer the remaining questions on the form as applicable. After completing Form 6B, click the Save and Continue button to save your work and proceed to the next form.

IMPORTANT NOTE:

1. Question 1 and Question 2a both cannot be marked 'Yes'.
2. Select 'Yes' or 'No' for question 2a if you answered 'No' to question 1.
3. Select 'Yes' or 'No' for question 2b if you answered 'Yes' to question 2a. Select 'N/A' for this question if you answered 'No' to question 2a.
4. Questions 3a, 3b, and 4 are required if you answered 'Yes' to question 1 and/or question 2b.

Figure 27: Form 6B When Applicable

Form 6B - Request for Waiver of Board Member Requirements

Note(s):
This form is applicable if proposing to serve only special populations (i.e., HCH, MHC, and/or PHPC).

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

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Fields with * are required

Request for Waiver

Name of Organization 1

1. New Waiver Request

* Are you requesting a new waiver of the 51% patient majority governance requirement? Yes No

2. For Applicants With Previous Waiver

* 2a. Do you currently have a waiver of the 51% patient majority governance requirement? Yes No

2b. Are you requesting the patient majority waiver to be continued?
(This question is required if you answered Yes to question 2a.) Yes No Not Applicable

3. Demonstration of Good Cause for Waiver (Demonstrate good cause for the waiver request by addressing the following areas)

3a. Provide a description of the population to be served and the characteristics of the population/service area that would necessitate a waiver.
(This question is required if you answered Yes to question 1 and/or question 2b.)

Approximately 1/2 page (Max 3000 Characters with spaces)

3b. Provide a description of the health center's attempts to meet the requirement to date and explain why these attempts have not been successful.
(This question is required if you answered Yes to question 1 and/or question 2b.)

Approximately 1/2 page (Max 3000 Characters with spaces)

4. Alternative Mechanism Plan for Addressing Patient Representation

Present a plan for complying with the intent of the statute via an alternative mechanism that ensures patient input and participation in the organization, as well as direction and ongoing governance of the health center.
(This question is required if you answered Yes to question 1 and/or question 2b.)

Approximately 1/2 page (Max 3000 Characters with spaces)

Go to Previous Page Save Save and Continue

4.13 Form 8 - Health Center Agreements

Form 8 indicates whether you have 1) any agreements with a parent, affiliate, or subsidiary organization; and/or 2) any agreements that will constitute a substantial portion of the proposed scope of the project, including a proposed site operated by a contractor, as identified in Form 5B: Service Sites. This form has the following sections:

1. Part I: Health Center Agreements (**Figure 28, 1**)
2. Part II: Attachments (**Figure 28, 2**)

Figure 28: Form 8 – Health Center Agreements

Form 8 - Health Center Agreements

Note(s):
If Look-Alike designee wishes to enter into an additional agreement/arrangement post-designation that will either (1) result in another organization carrying out a substantial portion of the approved scope of project or (2) impact the governing board's composition, authorities, functions, or responsibilities, a Prior Approval request must be submitted in EHB and approved by HRSA before the agreement/arrangement can be formalized and implemented.

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Fields with * are required

PART I: Health Center Agreements

* 1. Does your organization have a parent, affiliate, or subsidiary organization?
If Yes, indicate the number of each agreement by type in 1a, 1b, or 1c below and complete Part II. If No, Part II is Not Applicable.

Yes No

1a. Number of Parent Organizations

1b. Number of Affiliate Organizations

1c. Number of Subsidiary Organizations

Total Number of Parent, Affiliate, or Subsidiary Organizations 0
Save and Calculate

* 2. Do you currently have, or plan to utilize:

a) Contract(s) with another organization to perform substantive programmatic work within the proposed scope of project? For the purposes of the Health Center Program, contracting for substantive programmatic work applies to contracting with a single entity for the majority of health care providers.

Or

b) Subawards to carry out a portion of the proposed scope of project. The purpose of a subaward is to carry out a portion of the Federal award and creates a Federal assistance relationship with the subrecipient.

Yes No

Note(s):

- Subawards or contracts made to related organizations such as a parent, affiliate, or subsidiary must be identified and addressed in this form. The acquisition of supplies, material, equipment, or general support services (e.g., janitorial services, contracts with individual providers) is not considered programmatic work.

If Yes, indicate the number of each agreement by type in 2a and/or 2b below and complete Part II. If No, Part II is Not Applicable.

2a. Number of contracts with another organization to perform substantive programmatic work within the proposed scope of project. (A number up to 4 digits)

2b. Number of subawards made to subrecipients to carry out a portion of the proposed scope of project. (A number up to 4 digits)

2c. Total number of contracts for substantive programmatic work and/or subawards.
Save and Calculate

Add Organization Agreement

Part II: Attachments

All parent, affiliate or subsidiary agreements, as well as contracts for substantive programmatic work and subawards, including contracts or subawards which involve a parent, affiliate, or subsidiary organization referenced in Part I must be uploaded in full. Uploaded documents will NOT count against the page limit.

No organization agreement details added

Go to Previous Page **Save** **Save and Continue**

4.13.1 Completing Part I of Form 8

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

1. In Part, I, question 1 (**Figure 28, 3**), answer if your organization has a parent, affiliate, or subsidiary organization and provide number of Parent, Affiliate and/or Subsidiary organizations.
2. Select 'Yes' in question 2 (**Figure 28, 4**), if any current or proposed agreements exist with another organization to conduct a substantial portion of your organization's approved scope of the project. If 'Yes' is selected, complete 2a (**Figure 28, 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.

4.13.2 Completing Part II of Form 8

If you answered 'Yes' to questions 1 or 2, provide each agreement with external organizations as noted in Part I. The agreements will be organized by the organization. To add agreements, follow these steps:

1. Click on Add Organization Agreement (**Figure 28, 6**) to open the Organization Agreement – Add page (**Figure 29**).
2. Provide the required information for the agreement in the Organization Agreement Detail (**Figure 29, 1**) 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 (**Figure 29, 2**) button.

Figure 29: Organization Agreement – Add page

IMPORTANT NOTE:

Before uploading a document for Form 8, rename the file to include the affiliated organization’s name (e.g., ‘CincinnatiHospital_MOA.doc’).

Part II will accept a maximum of five document uploads for 10 organizations. Additional documentation that exceeds this limit should be included in Attachment 12: Other Relevant Documents.

Attachments to Form 8 will not count toward the application page limit of 160 pages.

A warning will be displayed if the number of attachments attached in Part II does not match with the number of Parent, Affiliate or Subsidiary organizations. However, this will not stop you from completing the form.

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

4.14 Form 12 – Organization Contacts

The Contact information shall be pre-populated on this form if you wish to update or delete any of the contact information, follow the following steps:

1. To update the contact information provided, click on the **Update** link under the options column (Figure 30, 1).
2. To delete the contact information already provided, click on the **Delete** link under the options column (Figure 30, 2).
3. After providing complete information on **Form 12**, click the Save and Continue button to save the information and proceed to the Reviewing and Submitting the Look-Alike Renewal of Designation Application (Figure 30, 3).

Figure 30: Form 12 – Organization Contacts

Form 12 - Organization Contacts

Note(s):
The organization contacts displayed below are pre-populated from the latest designated Form12.

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

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Fields with * are required

Contact Information	Name	Highest Degree	Email	Phone Number	Option
* Chief Executive Officer	Dr. Philip ...	D.D.S.	Update ¹ Delete ²
* Contact Person	Philip ...	D.D.S.	Update
* Chief Medical Officer	Dr. ...	D.D.S.	Update
Dental Director					Add Dental Director
Behavioral Health Director					Update

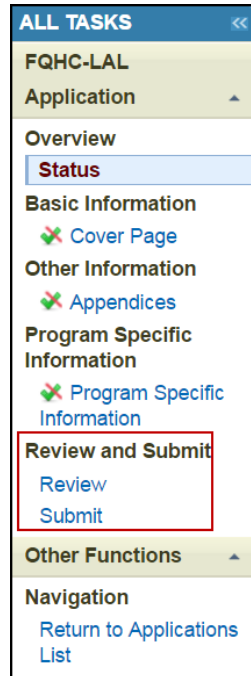
Go to Previous Page | Save | Save and Continue ³

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

To review your application, follow these steps:

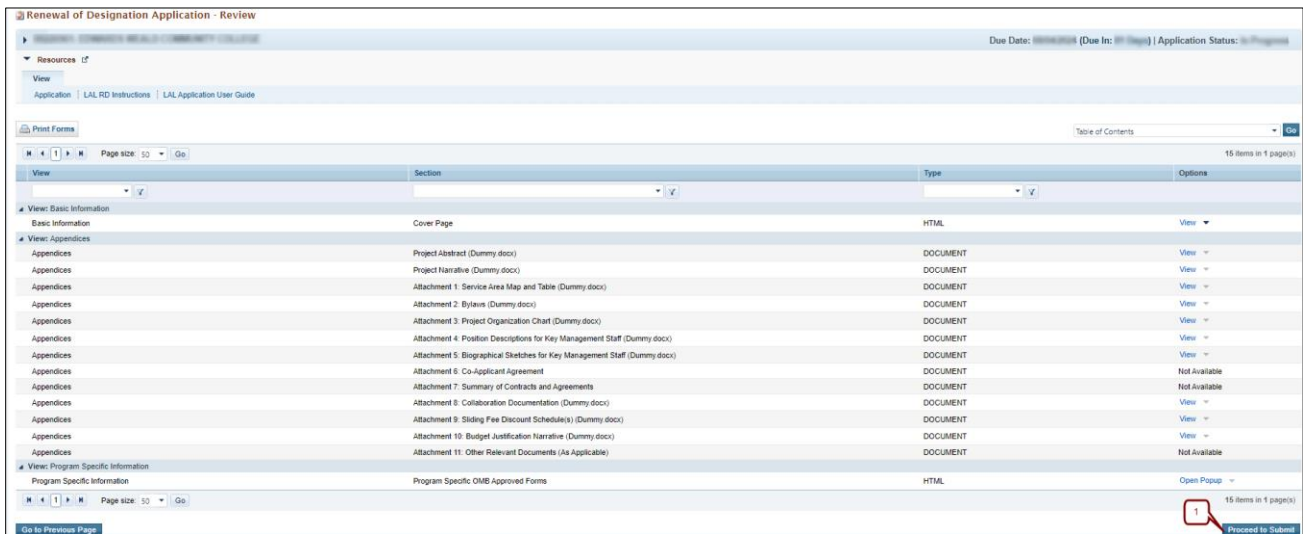
1. Click on the **Status** link on the left side menu.

Figure 31: Left menu – Review and Submit



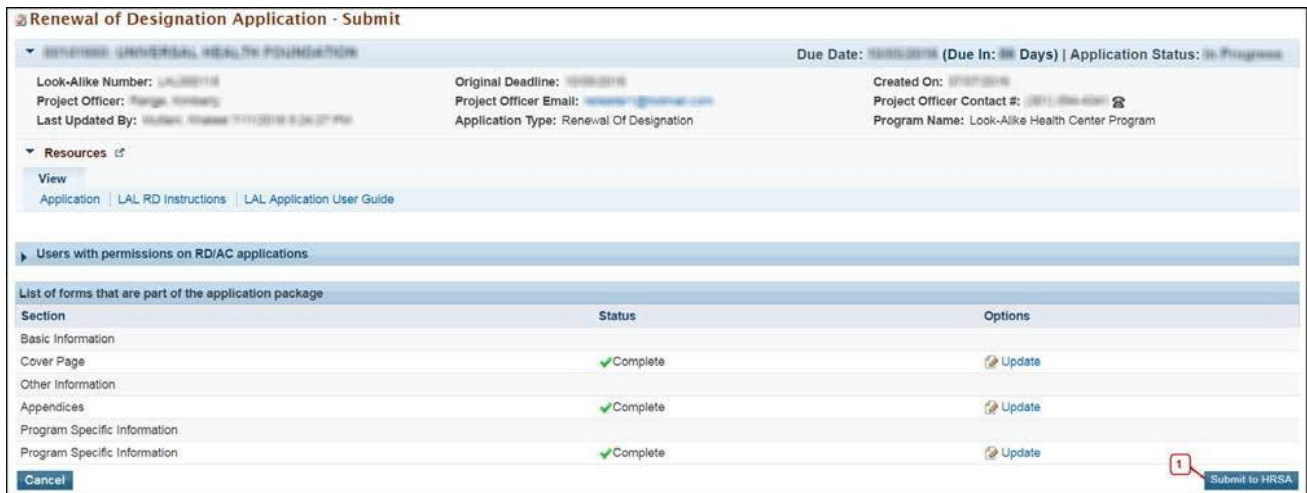
2. On the **Application – Status Overview** page, click the **Review** link in the Review and Submit section of the left menu. The system navigates to the **Review** page (**Figure 31**).
3. Verify the information displayed on the **Review** page.
4. If you are ready to submit the application to HRSA, click the Proceed to Submit button at the bottom of the **Review** page (**Figure 32, 1**). The system navigates to the **Submit** page (**Figure 33, 1**).
5. Click the Submit to HRSA button at the bottom of the **Submit** page (**Figure 33, 1**). The system navigates to a confirmation page.

Figure 32: Review Page



1. Verify the information displayed on the **Review** page.
2. If you are ready to submit the application to HRSA, click the Proceed to Submit button at the bottom of the **Review** page (Figure 32). The system navigates to the **Submit** page (Figure 32)
3. Click the Submit to HRSA button at the bottom of the **Submit** page (Figure 32, 1). The system navigates to a confirmation page.

Figure 33: Submit to HRSA



1. Check the Application Certification to electronically sign the application and click the Submit to HRSA button.
2. If you experience any problems with submitting the application in EHBs, contact the Health Center Program Support at 877-464-4772 or <http://www.hrsa.gov/about/contact/bphc.aspx>.