

HRSA Electronic Handbooks

FY 2015 New Access Points (NAP)

User Guide for Grant Applicants

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5. Submitting the FY 2015 NAP Application to HRSA 59

This user guide describes the steps you need to follow to submit a FY 2015 NAP application to HRSA.

1. Starting the FY 2015 NAP Application

You can complete and submit the FY 2015 NAP application by following a 2 step process:

1. In the first step, you must find the funding opportunity in Grants.gov, download the application package and submit the completed application in Grants.gov.
2. In the second step, you must validate, complete and submit this application in the HRSA Electronic Handbooks (EHB).

Note: Refer to the HRSA Electronic Submission Guide available at <http://www.hrsa.gov/grants/apply/userguide.pdf> for more details related to submitting the application in Grants.gov and validating it in EHB.

Once the application is validated in EHB, you can access it in your pending tasks. To access the application in EHB, follow the steps below:

1. After logging into EHB, click the Tasks tab on the EHB **Home** page to navigate to the **Pending Tasks – List** page.
2. Locate the FY 2015 NAP application using the EHB tracking number (e-mailed after successful Grants.gov submission) and click the **Edit** link to start working on the application in EHB.
 - The system opens the overall **Status Overview** page of the FY 2015 NAP application (**Figure 1**).

Figure 1: Accessing the Application - Status Overview Page

List of forms that are part of the application package		
Section	Status	Options
Basic Information 1		
SF-424	✘ Not Complete	
Part 1	✘ Not Complete	Update
Part 2	✘ Not Complete	Update
Project/Performance Site Location(s)	✘ Not Complete	Update
Project Narrative	✘ Not Complete	Update
Budget Information 2		
Section A-C	✔ Complete	Update
Section D-F	✘ Not Complete	Update
Budget Narrative	✘ Not Complete	Update
Other Information 3		
Assurances	✘ Not Complete	Update
Disclosure of Lobbying Activities	✘ Not Complete	Update
Appendices	✘ Not Started	Update
Program Specific Information		
Program Specific Information	✘ Not Complete	Update

The FY 2015 NAP application consists of a standard and a program specific section. You must complete the forms displayed in both of these sections in order to submit your application to HRSA.

2. Completing the standard SF-424 section of the application

The standard section of the application consists of the following main sections:

- Basic Information
- Budget Information
- Other Information

The Basic Information has been imported from Grants.gov and has undergone a data validation check. You may edit this information if necessary. This section consists of the following forms:

- The **SF-424 Part 1** form displays the basic application and applicant organization information.
- The **SF-424 Part 2** form displays project information including the project title, project periods, cities, counties, and Congressional districts affected by the project. The project abstract is attached in this form, under Project Description (**Figure 2, 1**).

Figure 2: Attach Project Description on SF-424 Part 2

The screenshot shows the SF-424 - Part 2 form. At the top, there are tabs for 'SF-424 - Part 1' and 'SF-424 - Part 2'. Below the tabs, it says 'Fields with * are required'. There are two main sections: 'Areas Affected by Project (Cities, Counties, States, etc.) (Minimum 0) (Maximum 1)' and 'Project Description (Minimum 0) (Maximum 1)'. Both sections have an 'Attach File' button. The 'Project Description' section is highlighted with a red box and a callout '1' pointing to the 'Attach File' button. The text 'No documents attached' is visible under both sections. The 'Descriptive Title of Applicant's Project' field contains 'Health Center Cluster'.

- The **Project/Performance Site Location(s)** form displays the locations where you provide services as provided in Grants.gov. You may also add Site Location(s) in this form.
- In the **Project Narrative** form, attach the project narrative by clicking on the **Attach File** button (**Figure 3, 1**).

Figure 3: Attach Project Narrative

The screenshot shows the Project Narrative form. At the top, it says 'Project Narrative'. Below that, there is a header with 'TRIPLES HEALTH WEST INC' and 'Due Date: 8/27/2014 5:00:00 PM (Due in: 0 days) | Section Status: Not Complete'. There is a 'Resources' section with a 'View' button and links for 'Application', 'Action History', 'Funding Opportunity Announcement', and 'FOA Guidance'. Below that, it says 'Fields with * are required'. There is a 'Project Narrative (Minimum 1) (Maximum 2)' section with an 'Attach File' button highlighted by a red box and a callout '1'. At the bottom, there are buttons for 'Go to Previous Page', 'Save', and 'Save and Continue'.

In the Budget Information section, provide HRSA with information about funding needs for the proposed project. Refer to the [Completing the Budget Information](#) section of this document for details regarding updating this section.

In the Other Information section, verify that you are aware of and agree to comply with all of the requirements when funds are awarded. These include non-discrimination, the right for the awarding agency to examine records associated with the award and compliance with statutes, such as the Hatch Act. Applicants that certify that they do NOT currently receive more than \$100,000 in Federal funds and engage in lobbying activities may skip the Disclosure of Lobbying Activities form. The Other Information section also includes the Appendices, where you upload attachments. Refer to the [Completing the Appendices](#) section of this document for details regarding updating this section.

2.1. Completing the Budget Information (SF-424A)

To complete this section, you must complete the **Budget Information** forms and provide a **Budget Narrative**.

2.1.1 Budget Information - Section A-C

The **Budget Information – Section A-C** form consists of the following three sections:

- Section A – Budget Summary
- Section B – Budget Categories
- Section C – Non-Federal Resources

To complete this form, follow the steps below:

1. Click the [Update](#) link for Section A-C on the **Application - Status Overview** page ([Figure 4](#)).

Figure 4: Section A-C Update Link

Application - Status Overview

YINHO: LAPINE COMMUNITY HEALTH CENTER Due Date: 4/30/2016 11:59:00 PM (Due in: 30 days) | Application Status: In Progress

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance

Users with permissions on this application (1)

List of forms that are part of the application package

Section	Status	Options
Basic Information		
SF-424	Not Started	
Part 1	Not Started	Update
Part 2	Not Started	Update
Project/Performance Site Location(s)	Not Started	Update
Project Narrative	Not Started	Update
Budget Information		
Section A-C	Not Started	Update
Section D-F	Not Started	Update
Budget Narrative	Not Started	Update
Other Information		
Assurances	Not Complete	Update
Disclosure of Funding Activities	Not Complete	Update

- The system navigates to the **Budget Information – Section A-C** form (Figure 5).

Figure 5: Section A – Budget Summary on the Budget Information – Section A-C Page

Budget Information - Section A-C

YINHO: LAPINE COMMUNITY HEALTH CENTER Due Date: 4/30/2016 11:59:00 PM (Due in: 30 days) | Section Status: Not Complete

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance

Fields with * are required

*** Section A - Budget Summary** [Update](#)

Grant Program Function or Activity	CFDA Number	Estimated Unobligated Funds		New or Revised Budget		
		Federal	Non-Federal	Federal	Non-Federal	Total
Health Care for the Homeless	93.224	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Update Sub Program	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

*** Section B - Budget Categories** [Update](#)

Grant Program Function or Activity

2. Under Section A – Budget Summary, click on the **Update Sub Program** button.

- The **Sub Programs – Update** page opens.

Figure 6: Sub Programs – Update Page

Sub Programs - Update

TRINIDAD LAPINE COMMUNITY HEALTH CENTER Due Date: 8/10/2014 11:58:00 PM (Due in: 0 days) | Section Status: Not Complete

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance

Sub Programs

<input type="checkbox"/>	Sub-Program	CFDA
<input type="checkbox"/>	Community Health Centers	93.224
<input checked="" type="checkbox"/>	Health Care for the Homeless	93.224
<input type="checkbox"/>	Migrant Health Centers	93.224
<input type="checkbox"/>	Public Housing	93.224

Cancel Save and Continue

3. Select or de-select the sub programs. Only select the programs for which you are requesting funding.
4. Click the **Save and Continue** button.
 - The **Budget Information – Section A-C** page re-opens showing the selected sub-program(s) under the Section A – Budget Summary (**Figure 7, 1**).

Figure 7: Section A – Budget Summary Showing Addition of Sub Program

Section A - Budget Summary 2 **Update**

Grant Program Function or Activity	CFDA Number	Estimated Unobligated Funds		New or Revised Budget		
		Federal	Non-Federal	Federal	Non-Federal	Total
Health Care for the Homeless	93.224	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Migrant Health Centers	93.224	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Update Sub Program		Total	\$0.00	\$0.00	\$0.00	\$0.00

5. To enter or update the budget information for each sub-program, click the **Update** button displayed in right corner of the Section A – Budget Summary header (**Figure 7, 2**).
 - The **Section A – Update** page opens.

Figure 8: Section A – Update Page

Section A - Update

TRINIDAD LAPINE COMMUNITY HEALTH CENTER Due Date: 8/10/2014 11:58:00 PM (Due in: 0 days) | Section Status: Not Complete

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance

Fields with * are required

Section A - Budget Summary

Grant Program Function or Activity	CFDA Number	Estimated Unobligated Funds		New or Revised Budget		
		Federal	Non-Federal	Federal	Non-Federal	Total
Health Care for the Homeless	93.224	\$0.00	\$0.00	\$ 0.00	\$ 0.00	\$0.00
Migrant Health Centers	93.224	\$0.00	\$0.00	\$ 0.00	\$ 0.00	\$0.00
Total		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Cancel Save and Continue

- Under the New or Revised Budget section, enter the amount of Federal funds requested for the first 12-month budget period for each requested sub-program (CHC, MHC, HCH, and/or PHPC) (Figure 8, 1). In the Non-Federal Resources column, enter the Non-Federal funds in the budget for the first 12-month budget period for each requested sub-program (Figure 8, 2).

Note: The Federal amount refers to only the Federal section 330 grant funding requested, not all Federal grant funding that an applicant receives.

- Click the **Save and Continue** button.
 - The **Budget Information – Section A-C** page re-opens displaying the updated New or Revised Budget under Section A – Budget Summary.

Figure 9: Section A – Budget Summary Page after Update

* Section A - Budget Summary Update						
Grant Program Function or Activity	CFDA Number	Estimated Unobligated Funds		New or Revised Budget		
		Federal	Non-Federal	Federal	Non-Federal	Total
Health Care for the Homeless	93.224	\$0.00	\$0.00	\$30,000.00	\$0.00	\$30,000.00
Migrant Health Centers	93.224	\$0.00	\$0.00	\$20,000.00	\$0.00	\$20,000.00
Update Sub Program		Total	\$0.00	\$0.00	\$50,000.00	\$50,000.00

- In Section B – Budget Categories, you must provide the Federal and Non-Federal funding distribution across budget categories for the first 12-month budget period. Click the **Update** button provided at the right corner of the Section B header.

Figure 10: Section B – Budget Categories

* Section B - Budget Categories Update				
Object Class Categories	Grant Program Function or Activity			Total
	Federal		Non-Federal	
Personnel	\$0.00		\$0.00	\$0.00
Fringe Benefits	\$0.00		\$0.00	\$0.00
Travel	\$0.00		\$0.00	\$0.00
Equipment	\$0.00		\$0.00	\$0.00
Supplies	\$0.00		\$0.00	\$0.00
Contractual	\$0.00		\$0.00	\$0.00
Construction	\$0.00		\$0.00	\$0.00
Other	\$0.00		\$0.00	\$0.00
Total Direct Charges	\$0.00		\$0.00	\$0.00
Indirect Charges	\$0.00		\$0.00	\$0.00
Total	\$0.00		\$0.00	\$0.00

- The system navigates to the **Section B – Update** page.
- Enter the federal dollar amount for each applicable object class category under the Federal column (Figure 11, 1).
 - Similarly, enter the non-federal dollar amount for each applicable object class category under the Non-Federal column (Figure 11, 2).

Figure 11: Section B – Update Page

Section B - Update

Note(s):
 Total federal amount in Section B must be equal to the total new or revised budget, federal amount specified in budget summary (section A) \$50,000.00.
 Total non-federal amount in Section B must be equal to the total new or revised budget, non-federal amount specified in budget summary (section A) \$0.00.

TRIMB: LAYFNE COMMUNITY HEALTH CENTER Due Date: 8/30/2014 11:59:59 PM (Due in: 0 days) | Section Status: Not Complete

Resources [View](#)
[Application](#) | [Action History](#) | [Funding Opportunity Announcement](#) | [FOA Guidance](#)

Fields with * are required

*** Section B - Budget Categories**

Object Class Categories	Grant Program Function or Activity		Total
	Federal	Non-Federal	
Personnel	\$ 0.00	\$ 0.00	\$0.00
Fringe Benefits	\$ 0.00	\$ 0.00	\$0.00
Travel	\$ 0.00	\$ 0.00	\$0.00
Equipment	\$ 0.00	\$ 0.00	\$0.00
Supplies	\$ 0.00	\$ 0.00	\$0.00
Contractual	\$ 0.00	\$ 0.00	\$0.00
Construction	\$ 0.00	\$ 0.00	\$0.00
Other	\$ 0.00	\$ 0.00	\$0.00
Indirect Charges	\$ 0.00	\$ 0.00	\$0.00
Total	\$0.00	\$0.00	\$0.00
Total Budget specified in Budget Summary (Section A)	\$50,000.00	\$0.00	\$50,000.00

Notes:

- The total federal amount in Section B – Budget Categories must be equal to the total new or revised federal budget amount specified in Section A – Budget Summary of the Budget Information – Section A-C form.
- The total non-federal amount in Section B – Budget Categories must be equal to the total new or revised non-federal budget amount specified in Section A – Budget Summary of the Budget Information – Section A-C form.

11. Click the **Save and Continue** button to navigate to the **Budget Information – Section A-C** form (Figure 11, 3).

12. In Section C – Non Federal Resources, distribute the non-federal budget amount specified in Section A – Budget Summary across the applicable non-federal resources. Click the **Update** button provided in the right corner of Section C header to do so (Figure 12, 1).

Figure 12: Section C - Non Federal Resources

*** Section C - Non Federal Resources**

Grant Program Function or Activity	Applicant	State	Local	Other	Program Income	Total
Health Care for the Homeless	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Migrant Health Centers	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Note: The total non-federal amount in Section C – Non Federal Resources must be equal to the total new or revised non-federal budget amount specified in Section A – Budget Summary of the Budget Information – Section A-C form.

13. Click the **Save and Continue** button to proceed to the next form (**Figure 12, 2**).

2.1.2 Budget Information – Section D-F

The Budget Information – Section D-F form consists of the following three sections:

- Section D – Forecasted Cash Needs
- Section E – Federal Funds Needed for Balance of the Project
- Section F – Other Budget Information

To complete this form, follow the steps below:

1. Section D – Forecasted Cash Needs is optional and may be left blank. However, you may enter the amount of cash needed by quarter during the first year for both the Federal and Non-Federal request. Click the **Update** button provided in the right corner of Section D to do so (**Figure 13, 1**).
2. In Section E - Federal Funds Needed for Balance of the Project, enter the Federal funds requested for Year 2 in the “First” column under Future Funding Periods (Years) for each proposed sub-program (**Figure 13, 5**). Click the **Update** button provided in the right corner of Section E to do so (**Figure 13, 2**).

Note: You can request a maximum of **\$650,000** for Year 2 in this NAP application. You must not request any funds for the remaining future funding years (i.e., Second, Third, and Fourth columns must be \$0).

3. In Section F – Other Information, you may provide information regarding direct and indirect charges. You can also document any relevant comments or remarks in this section. Click the **Update** button provided in the right corner of Section F to do so (**Figure 13, 3**).
4. Finally, click the **Save and Continue** button on the Budget Information – Section D-F to proceed (**Figure 13, 4**).

Figure 13: Budget Information – Section D-F

Section D - Forecasted Cash Needs

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Federal	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Non-Federal	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Section E - Federal Funds Needed for Balance of the Project

Grant Program	Future Funding Periods (Years)			
	First	Second	Third	Fourth
Health Care for the Homeless	\$0.00	\$0.00	\$0.00	\$0.00
Migrant Health Centers	\$0.00	\$0.00	\$0.00	\$0.00
Total	\$0.00	\$0.00	\$0.00	\$0.00

Section F - Other Budget Information

Direct Charges: No information added.

Indirect Charges: No information added.

Remarks: No information added.

2.1.3 Budget Narrative

1. Attach a budget justification by clicking on the **Attach File** button shown in Figure 14.

Figure 14: Budget Narrative

Budget Narrative

YTHHS: LAPINE COMMUNITY HEALTH CENTER Due Date: 8/30/2014 11:59:59 PM (Due in: 0 days) | Section Status: Not Complete

Resources View

Application | Action History | Funding Opportunity Announcement | FOA Guidance

Fields with * are required

* Budget Narrative (Minimum 1) (Maximum 2) **Attach File**

No documents attached

Go to Previous Page Save Save and Continue

3. Completing the Appendices Form

1. Click on the **Appendices** link on the left navigation menu to navigate to the **Appendices** form.
2. Upload the following standard attachments by clicking the associated **Attach File** buttons:
 - Attachment 1: Service Area Map and Table (Required)
 - Attachment 2: Implementation Plan (Required)
 - Attachment 3: Applicant Organizational Chart (Required)

- Attachment 4: Position Descriptions for Key Management Staff (Required)
 - Attachment 5: Biographical Sketches for Key Management Staff (Required)
 - Attachment 6: Co-Applicant Agreement (Required for public center applicants that have a co-applicant board)
 - Attachment 7: Summary of Contracts and Agreements (as applicable)
 - Attachment 8: Independent Financial Audit (Required)
 - Attachment 9: Articles of Incorporation (Required for nonprofit organizations)
 - Attachment 10: Letters of Support (Required)
 - Attachment 11: Sliding Fee Discount Schedule(s) (Required)
 - Attachment 12: Evidence of Nonprofit or Public Center Status (Required for NEW START Applicants)
 - Attachment 13: Floor Plans (Required)
 - Attachment 14: Corporate Bylaws (Required)
 - Attachment 15: Other Relevant Documents (as applicable)
3. After completing the **Appendices** form, click the **Save and Continue** button to proceed.

4. Completing the Program Specific Forms

1. Click the **Program Specific Information** link (**Figure 15**) under the Program Specific Information section in the left menu to open the **Status Overview** page for the Program Specific Information forms (**Figure 16**). Click the **Update** link to edit a form.

Figure 15: Program Specific Information Link



Figure 16: Status Overview Page for Program Specific Forms

Program Specific Information Status		
Section	Status	Options
General Information		
Form 1A - General Information Worksheet	Not Started	Update ▼
Form 1C - Documents On File	Not Started	Update ▼
Form 4 - Community Characteristics	Not Started	Update ▼
Budget Information		
Form 1B - Funding Request Summary	Not Started	Update ▼
Form 2 - Staffing Profile	Not Started	
Year 1	Not Started	Update ▼
Year 2	Not Started	Update ▼
Form 3 - Income Analysis	Not Started	Update ▼
Sites and Services		
Form 5A - Services Provided	Not Started	
Required Services	Not Started	Update ▼
Additional Services	Not Started	Update ▼
Form 5B - Service Sites	Not Started	Update ▼
Form 5C - Other Activities/Locations	Not Started	Update ▼
Alteration/Renovation (A/R) Information	Not Started	Update ▼
Other Forms		
Form 6A - Current Board Member Characteristics	Not Started	Update ▼
Form 8 - Health Center Agreements	Not Started	Update ▼
Form 9 - Need for Assistance Worksheet	Not Started	
Section I - Core Barriers	Not Started	Update ▼
Section II - Core Health Indicators	Not Started	Update ▼
Section III - Other Health and Access Indicators	Not Started	Update ▼
Form 10 - Annual Emergency Preparedness Report	Not Started	Update ▼
Form 12 - Organization Contacts	Not Started	Update ▼
Performance Measures		
Clinical Performance Measures	Not Started	Update ▼
Financial Performance Measures	Not Started	Update ▼
Other Information		
Equipment List	Not Started	Update ▼
Summary Page	Not Started	Update ▼

[Return to Standard Status](#)

Note: Your session remains active for 30 minutes after your last activity. Save your work every five minutes to avoid losing data.

4.1. Form 1A: General Information Worksheet

Form 1A - General Information Worksheet provides a summary of information related to the applicant, proposed service area, population, and patient and visit projections.

4.1.1 Applicant Information section

The **Applicant Information** section is pre-populated with application and grant-related information as applicable. Complete this section by providing information in the required fields ([Figure 17](#)).

Note: If you choose to select 'Other' as one of the Organization Type values (Figure 17, 1), you must provide the organization type definition.

Figure 17: Applicant Information section

1. Applicant Information

Applicant Name: The Wright Center for Graduate Medical Education

* Fiscal Year End Date: Select Option

Application Type: New

Existing Grantee: No

Grant Number: N/A

* Business Entity: Select Option

* Organization Type:

- All
- Faith based
- Hospital
- State government
- City/County/Local Government or Municipality
- University
- Community based organization
- Other **1**

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

4.1.2 Proposed Service Area section

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

- 2a. Target Population and Service Area Designation
- 2b. Service Area Type
- 2c. Target Population and Provider Information

4.1.2.1 Completing 2a. Target Population and Service Area Designation section

The system pre-populates the **Population Types** field (Figure 18, 1) with the sub-programs selected in the **Section A – Budget Summary** form in the standard section of the application. In order to update the population types indicated, follow the steps explained in [Changing Population Types](#) section below.

In the **Select MUA/MUP** field (Figure 18, 2), select the options that best describe the designated service area you propose to serve. (Multiple selections are allowed.)

Note: If you are applying for Community Health Centers funding, you must provide Service Area IDs for at least one of the line items listed in this field. Otherwise, providing Service Area IDs is optional.

Figure 18: Proposed Service Area section

▼ 2. Proposed Service Area

2a. Target Population and Service Area Designation

★ Population Types ⓘ

- Serving Section 330(e) - Community Health Centers
- Serving Section 330(g) - Migrant Health Centers
- Serving Section 330(h) - Homeless Health Centers
- Serving Section 330(i) - Public Housing Health Centers

★ Select MUA/MUP ⓘ
(Each ID must be a 5 digit integer. Use commas to separate multiple IDs)

[Find an MUA/MUP](#) 🔍

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

Changing Population Types

1. To change the population types, navigate to the **Application – Status Overview** page by following one of these options:
 - A. Click the **Grant Application** link in the navigation links displayed at the top of the page above the page name (**Figure 19, 1**).
 - B. Expand the left menu if not already expanded by clicking the double arrows displayed near the form name at the top of the page (**Figure 19, 2**). Then click the **Complete Status** link provided under the All Forms menu (**Figure 19, 3**).
 - The system navigates to the **Status Overview** page for the entire application.
2. Click the **Update** link for the **Budget Information – Section A-C** form.
3. Repeat the steps described in [Section A – Budget Summary](#).

Figure 19: Links to Access the Standard Section from the Program Specific Section

The screenshot displays the HRSA Form 1A - General Information Worksheet. The breadcrumb trail at the top reads: "You are here: Home » Tasks » Browse » Grant Application (1) » Program Specific Information (1)". In the left-hand navigation menu, under "Program Specific Information", "Form 1A" is highlighted. At the bottom left, under "All Forms", the "Complete Status" link is highlighted. The main content area shows the "1. Applicant Information" section with fields for Applicant Name, Fiscal Year End Date, Application Type, Existing Grantee, Grant Number, and Business Entity. A dropdown menu for Business Entity is open, showing options like All, Faith based, Hospital, State government, etc. The "2. Proposed Service Area" section is partially visible at the bottom.

4.1.2.2 Completing 2b. Service Area Type section

In the **Service Area Type** field (**Figure 20**), indicate whether the service area is urban, rural, or sparsely populated. If you propose that the service area is sparsely populated, specify the population density by providing the number of people per square mile.

Note: A Sparsely Populated Area is defined as a geographical area with seven or fewer people per square mile for the entire service area.

Figure 20: 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. Target Population and Provider Information section

For **Target Population** information (**Figure 21, 1**), report the Current Numbers for Total Service Area Population and Total Target Population.

Notes:

- The Current Number provided for Total Service Area Population should be equal to the total Service Area Number provided for ‘Race / Hispanic or Latino Identity / Income as a Percent of Poverty Level / Primary Third Party Payment Source’ categories on **Form 4: Community Characteristics** of this application.
- The Current Number provided for Total Target Population should be equal to the total Target Population Number provided for ‘Race / Hispanic or Latino Identity / Income as a Percent of Poverty Level / Primary Third Party Payment Source’ categories on **Form 4: Community Characteristics** of this application.
- **Form 1A: General Information Worksheet** cannot be marked complete until **Form 4: Community Characteristics** is complete. After **Form 4: Community Characteristics** is complete, return to Form 1A to save and mark complete.
- The fields for provider information (Total FTE Medical Providers, etc.) will be disabled.

Figure 21: Target Population and Provider Information section

2c. Target Population and Provider Information		
Target Population	Current Number	Projected at End of Project Period
★ Total Service Area Population	<input type="text"/>	N/A
★ Total Target Population	<input type="text"/>	N/A
Provider Information	Current Number	Projected at End of Project Period
★ Total FTE Medical Providers	N/A	N/A
★ Total FTE Dental Providers	N/A	N/A
Total FTE Behavioral Health Providers		
★ Total FTE Mental Health Providers	N/A	N/A
★ Total FTE Substance Abuse Services Providers	N/A	N/A
★ Total FTE Enabling Services Providers	N/A	N/A

4.1.3 Patients and Visits by Service Type

To complete this section, follow the steps below:

1. Report the numbers of patients and visits you project by December 31, 2016 by the service types listed in this section. (**Figure 22**).

Notes:

- In Patients and Visits by Service Type, the Patients and Visits fields for ‘Current Number’ will be disabled.
- For Total Medical service type, you must provide a number greater than zero in Patients and Visits fields.
- For Total Medical service type, the number of Patients you provide should be greater than or equal to the number of Patients you provide for Total Dental, Total Mental Health, Total Substance Abuse Services, and Total Enabling Services service types.

Figure 22: Patients and Visits by Service Type

Patients and Visits by Service Type				
Service Type	Current Number		Projected by December 31, 2016	
	Patients	Visits	Patients	Visits
* Total Medical	N/A	N/A	<input type="text"/>	<input type="text"/>
* Total Dental	N/A	N/A	<input type="text"/>	<input type="text"/>
Total Behavioral Health				
* Total Mental Health	N/A	N/A	<input type="text"/>	<input type="text"/>
* Total Substance Abuse Services	N/A	N/A	<input type="text"/>	<input type="text"/>
* Total Enabling Services	N/A	N/A	<input type="text"/>	<input type="text"/>

Notes:

- In NAP FY 2015 applications, the “Current Number” fields for patients and visits will be disabled (i.e., N/A).
- “Projected at End of Project” or “Projected by December 31, 2016” refers to the number of patients and visits anticipated by December 31, 2016.
- “Visits” are defined to include a documented, face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services rendered must be documented.
- Since patients must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.
- Providing numbers for all the service types is required. Zeroes are acceptable.

4.1.4 Unduplicated Patients and Visits by Population Type

To complete this section, follow the steps below:

1. Report the number of patients and visits you project by December 31, 2016 by the population types/sub-programs listed in this section. (Figure 23).

Notes:

- Under the Unduplicated Patients and Visits by Population Type section, the Patients and Visits fields for ‘Current Number’, ‘Number at End of Year 1’ and ‘Number at End of Year 2’ will be disabled (i.e., N/A).
- For the population types corresponding to the sub-programs selected in **Section A – Budget Summary** form of this application, the number of patients and visits in the Projected by December 31, 2016 column should be greater than zero. For the remaining population types, zeroes are acceptable if there are no projected numbers.

- After providing the number of patients and visits in this section, click on the **Calculate** button to automatically calculate the total number of patients and visits under the **Projected by December 31, 2016** columns.

Figure 23: Unduplicated Patients and Visits by Population Type

Unduplicated Patients and Visits by Population Type								
Population Type	Current Number		Number at End of Year 1		Number at End of Year 2		Projected by December 31, 2016	
	Patients	Visits	Patients	Visits	Patients	Visits	Patients	Visits
* General Underserved Community	N/A	N/A	N/A	N/A	N/A	N/A	<input type="text"/>	<input type="text"/>
* Migratory and Seasonal Agricultural Workers	N/A	N/A	N/A	N/A	N/A	N/A	<input type="text"/>	<input type="text"/>
* Public Housing Residents	N/A	N/A	N/A	N/A	N/A	N/A	<input type="text"/>	<input type="text"/>
* People Experiencing Homelessness	N/A	N/A	N/A	N/A	N/A	N/A	<input type="text"/>	<input type="text"/>
Total Calculate	N/A	N/A	N/A	N/A	N/A	N/A	<input type="text"/>	<input type="text"/>

- After completing all the sections on **Form 1A**, 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. You are required to provide the date on which each document was last reviewed or revised.

To complete **Form 1C**, enter the requested review/revision dates for each document listed on this form.

Note: Examples of formats that you can use to provide dates on this form are: 01/15/2013, First Monday of every April, bi-monthly (last rev 01/13), etc.

Figure 24: Form 1C - Documents on File

Management and Finance	Date of Latest Review/Revision
* Personnel Policies and Procedures, including related Conflict of Interest Policies and Procedures (Program Requirements 3, 9, 17, and 19)	<input type="text"/>
* Data Collection and Management Information Systems (Clinical and Financial) Policies and Procedures (Program Requirements 8 and 15)	<input type="text"/>
* Billing, Credit, and Collection Policies and Procedures (Program Requirement 13)	<input type="text"/>
* Procurement Policies and Procedures, including related Conflict of Interest Policies and Procedures (Program Requirements 10, 12, and 19)	<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	
* HIPAA-Compliant Patient Confidentiality Policies and Procedures (Program	<input type="text"/>

After completing all the sections on **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 and target population data for the entire scope of the project (i.e. all NAP sites).

To complete **Form 4**, follow the steps below:

1. Enter the Service Area Number and corresponding Target Population Number for each of the following categories.
 - A. Race ([Figure 25, 1](#))
 - B. Hispanic or Latino Ethnicity ([Figure 25, 2](#))
 - C. Income as a Percent of Poverty Level ([Figure 25, 3](#))
 - D. Primary Third Party Payment Source ([Figure 25, 4](#))

Notes:

- Information provided regarding race and/or ethnicity will be used only to ensure compliance with statutory and regulatory Governing Board requirements. Data on race and/or ethnicity collected on this form will not be used as an awarding factor.
- When entering data, the total Service Area Numbers and the total Target Population Numbers of the Race, Hispanic or Latino Ethnicity, Income as a Percent of Poverty Level, and Primary Third Party Payment Source sections should be equal.

2. In order to automatically calculate the Total Service Area Numbers and Total Target Population Numbers for all these four sections, click the **Save and Calculate Total** button ([Figure 25, 5](#)) under any of the sections.

Figure 25: Race, Hispanic or Latino Ethnicity, Income as a Percent of Poverty Level, and Primary Third Party Payment Source sections

Race	Service Area Number	Target Population Number
* Native Hawaiian	<input type="text"/>	<input type="text"/>
* Other Pacific Islanders	<input type="text"/>	<input type="text"/>
* Asian	<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	<input type="text"/>	<input type="text"/>

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

Hispanic or Latino Ethnicity	Service Area 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	<input type="text"/>	<input type="text"/>

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

Income as a Percent of Poverty Level	Service Area 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	<input type="text"/>	<input type="text"/>

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

Primary Third Party Payment Source	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	<input type="text"/>	<input type="text"/>

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

- Under the **Special Populations** section ([Figure 26](#)), enter the Service Area Number and the corresponding Target Population Number to each population group listed.

Notes:

- In the 'Other' row ([Figure 26, 1](#)), specify a special population group that is not listed (if desired), and then enter the Service Area Number and the corresponding Target Population Number for the specified special population group.
- Individuals may be counted in multiple special population groups, so the numbers in this section do not have to match those in the other sections of this form.

Figure 26: Special Populations section

Special Populations	Service Area Number	Target Population Number
* Migratory/Seasonal Agricultural Workers and Families	<input type="text"/>	<input type="text"/>
* Homeless	<input type="text"/>	<input type="text"/>
* Residents of Public Housing	<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"/>
* Persons with Behavioral Health/Substance Abuse Needs	<input type="text"/>	<input type="text"/>
* School Age Children	<input type="text"/>	<input type="text"/>
* Infants Birth to 2 Years of Age	<input type="text"/>	<input type="text"/>
* Women Age 25-44	<input type="text"/>	<input type="text"/>
* Persons Age 65 and Older	<input type="text"/>	<input type="text"/>
* Other 1	<input type="text"/>	<input type="text"/>

Please Specify: Approximately 1/4 page(s) (Max 200 Characters): 200 Characters left

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

4.4. Form 1B: Funding Request Summary

In **Form 1B: Funding Request Summary**, you are required to distribute the **Total Federal Funds** that you requested for **Year 1** among the grant program functions/sub-programs.

Figure 27: Form 1B: Funding Request Summary

View Resources

- Refer to Section A – Budget Summary in Budget Information form to view the Total Federal Funds requested for Year 1.
- Refer to Section E – Budget Estimates Of Federal Funds Needed For Balance Of The Project in Budget Information form to view the Total Federal Funds requested for Year 2.

Federal Funds Requested: Based on a 12-month Budget for each Budget Period

Type of Health Center	Program	Year 1	Year 2		Year 3	Year 4	Year 5
		Operational	Operational	Funding Population Percentage	N/A	N/A	N/A
Community Health Centers	CHC-330(e)	\$0.00	\$0.00	0%	\$0.00	\$0.00	\$0.00
* Health Care for the Homeless	HCH-330(h)	<input type="text"/>	\$500,000.00	83.33%	\$0.00	\$0.00	\$0.00
* Migrant Health Centers	MHC-330(g)	<input type="text"/>	\$100,000.00	16.67%	\$0.00	\$0.00	\$0.00
Public Housing Primary Care	PHPC-330(i)	\$0.00	\$0.00	0%	\$0.00	\$0.00	\$0.00
Total Operational Costs	<input type="button" value="Calculate"/>	\$0.00	\$600,000.00		\$0.00	\$0.00	\$0.00
* One-Time Funding	<input type="text"/>		\$0.00		\$0.00	\$0.00	\$0.00
Total Federal Funding Request	<input type="button" value="Calculate"/>	\$0.00	\$600,000.00		\$0.00	\$0.00	\$0.00

One-time funds will be used for

Equipment only

Minor alteration/renovation with equipment

Minor alteration/renovation without equipment

N/A

1. For each sub-program you are proposing to serve, enter **Operational Funds** (Figure 27, 1) for **Year 1**.
2. Enter an amount for **One-Time Funding** for **Year 1** (Figure 27, 2), if appropriate.

Notes:

- You must request **Operational Funds** that are greater than \$0 for every sub-program you selected in the **Budget Summary** form in the standard section of this FY 2015 NAP application.
- Requesting **One-Time Funding** is optional. You may request One-Time funds of up to \$150,000.
- The combined total of the **Operational Funds** and the **One-Time Funds** for Year 1 should not exceed **\$650,000**.
- The combined total of the **Operational Funds** and the **One-Time Funds** for Year 1 must be equal to the **Total Federal** funds requested in the **Budget Summary** form in the standard section of this FY 2015 NAP application.

3. If you entered an amount for **One-Time Funding**, click the **One-time funds will be used for:** radio button that describes how you will use the funds (Equipment only, Minor alteration or renovation with equipment, Minor alteration or renovation without equipment). You should select the "N/A" radio button if you are not requesting **One-Time Funding**.

Notes:

- If you indicated that you will use the **One-Time Funding** for 'Equipment only' purpose, you must provide necessary information in **Equipment List** form of this FY 2015 NAP application.
- If you indicated that you will use the **One-Time Funding** for 'Minor alteration/renovation with equipment' purpose, you must provide the necessary information in the **Alteration/Renovation (A/R) Information** and **Equipment List** forms of this FY 2015 NAP application.
- If you indicated that you will use the **One-Time Funding** for 'Minor alteration/renovation without equipment' purpose, you must provide the necessary information in the **Alteration/Renovation (A/R) Information** form that includes the A/R Project Cover page and Other Requirements for Sites forms of this FY 2015 NAP application.
- If you did not request **One-Time Funding**, you must select the 'N/A' option in **One-time funds will be used for:** section. You will not be able to provide any information in the **Alteration/Renovation (A/R) Information** and **Equipment List** forms in this scenario.
- If you update the radio button selection in **One-time funds will be used for:** section at any time and save the new selection, the system will delete the information provided by you in all forms that no longer apply based on the new selection.

4. Year 2 **Operational Funds** in **Form 1B** will be pre-populated with the federal funds requested for the first future funding year in the **Federal Resources** form (or **Section E - Budget Estimates of Federal Funds Needed for Balance of the Project**) in the standard section of this FY 2015 NAP application (Figure 27, 3).
5. Years 3, 4, and 5 will be populated in **Form 1B** with the federal funds requested for second, third and fourth future funding years respectively in **Federal Resources** form in the standard section of this FY 2015 NAP application.

Notes:

- In **Form 1B**, you will not be able to edit the information pre-populated from the standard section of this FY 2015 NAP application. If you need to edit this information, navigate to the overall **Status Overview** page by clicking the [Complete Status](#) link in the left menu or the [Grant Application](#) link in the navigation links provided at the top of the page, and then refer to the details provided in section [2.1.4 Federal Resources](#) of this user guide.
- **Operational Funds** requested for **Year 2** for every sub-program you selected in the standard section of the application must be greater than **\$0**.
- Total Operational Funds requested for Year 2 should not exceed **\$650,000**.
- You cannot request **One-Time Funding** for Year 2.
- You must not request any federal funds for Years 3, 4, and 5, as this FY 2015 NAP funding opportunity has a project length of 2 years. The federal funds requested for every sub-program you selected in the standard section of the application for Years 3, 4, and 5 must be equal to **\$0**.

6. Click the **Save and Continue** button, at the bottom of the screen, to save your work and proceed to the next form.

4.5. Form 2 – Staffing Profile

Form 2: Staffing Profile reports personnel salaries supported by the total budget for the proposed project. Provide staffing profile information for Year 1 and Year 2.

1. In column (a), provide the number of Full Time Employees (FTEs) for each staffing position for Year 1. Enter 0 if not applicable ([Figure 28, 1](#)).
2. In column (b), provide the Average Annual Salary for the staffing positions with Total FTEs greater than 0 ([Figure 28, 2](#)).
3. Provide the Total Federal Support Requested for the staffing positions with Total FTEs greater than 0 ([Figure 28, 3](#)).
4. Click the **Save and Calculate Total Salary** button to calculate and save the Total Salary for each position. ([Figure 28, 4](#)).

Notes:

- The Total Federal Support Requested amount should be less than or equal to the Total Salary for each position calculated by the system.
- If you enter 0 as the number of Total FTEs for a staffing position, you are not required to provide the Average Annual Salary of Position (b) and the Total Federal Support Requested values for that position.

5. Click the **Calculate** button to calculate the Total FTEs, Total Salary, and Total Federal Support Requested for all staffing positions for Year 1 ([Figure 28, 5](#)).
6. Click the **Save and Continue** button to save your work and proceed to **Form 2: Staffing Profile** for Year 2.
7. Provide Total FTE(s), Average Annual Salary of Position, and Total Federal Support Requested details for each staffing position listed for Year 2, and click the **Save and Continue** button to proceed to the next form.

Notes:

- Information provided for **Year 1** will not be carried over to **Year 2**. Consider printing information you provide for **Year 1** as reference to provide information for **Year 2**.
- **Form 2** will be complete when the status of Year 1 and Year 2 sections of the form is complete. The completed status of both these sections is indicated with a green tick mark (✓ icon) in the section tabs.

Figure 28: Form 2- Staffing Profile

4.6. Form 3 - Income Analysis

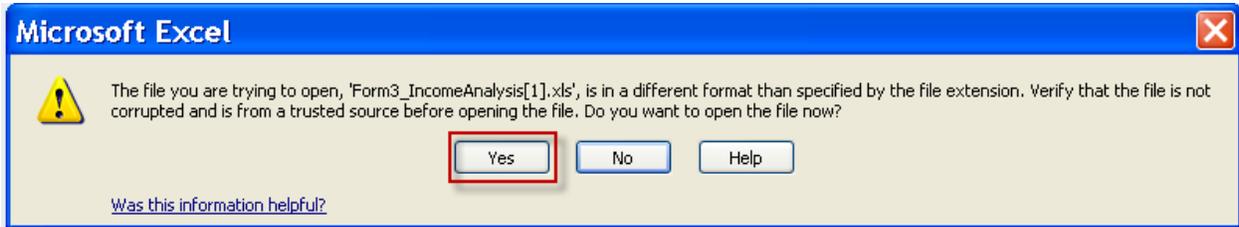
Form 3: Income Analysis projects program income, by source, for Year 1 and Year 2 of the proposed project.

1. Click the **Download** link (**Figure 29**) in the **Document Template** section to download the form.

Figure 29: Form 3 - Income Analysis Form

2. A **Template – Download** page will be displayed, with instructions on how to save the document on your computer. Click the **Continue** button at the bottom of this page to continue with the download.
3. When prompted, select the ‘Save’ option to save the template on your computer.
4. When you try to open the saved template, the system may display a warning indicating that the file that you are downloading is in a different format than specified by the file extension. If you receive this warning, select ‘Yes’ and continue with opening the template (**Figure 30**).

Figure 30: Warning displayed when Form 3 template is opened



5. The **Income Analysis** template opens in an **EXCEL** format (**Figure 31**). Provide complete information in this template and save it to your computer.

Figure 31: Form 3 Income Analysis EXCEL Template

Department of Health and Human Services Health Services and Resources Administration		For HRSA Use Only				
Form 3: Income Analysis		Applicant Name:	Community Health Care Association of New York State, Inc.			
Year 1 ___ Year 2 ___		Grant Number:	N/A			
		Application Tracking Number:	011880			
Part 1: Patient Service Revenue - Program Income						
Line #	Payer Category	Patients	Billable Visits	Income Per Visit	Projected Income	Prior FY Income Mo/Yr: ___
		(a)	(b)	(c)	(d)	(e)
1	Medicaid					
2	Medicare					
3	Other Public					
4	Private					
5	Self Pay					
6	Total (lines 1-5)					
Part 2: Other Income - Other Federal, State, Local and Other Income						
7	Other Federal					
8	State Government					
9	Local Government					
10	Private Grants/Contracts					
11	Contributions					
12	Other					
13	Applicant (Retained Earnings)					
14	Total Other (lines 7-13)					
Total Non-Federal (Non-section 330) Income (Program Income Plus Other)						
15	Total Non-Federal (lines 6 + 14)	0				
Comments/Explanatory Notes (if applicable)						

6. To upload the updated template, click the **Attach File** button provided in the **Income Analysis** section on **Form 3** (**Figure 32, 1**).
 - The system displays an attachment panel with the **Browse** and **Upload** buttons.
7. Click the **Browse** button to navigate to the location where the completed Income Analysis form is saved on your computer and select it (**Figure 32, 2**).
8. Click the **Upload** button (**Figure 32, 3**) to attach the document to the form.
 - The system displays the attached document in the **Income Analysis** section (**Figure 33**).

Note: You must upload exactly 2 Income Analysis documents for Year 1 and Year 2 each of the proposed project.

Figure 32: Upload Attachment

Note: You can delete the uploaded document to replace it with another document by expanding the **Options** and selecting **Delete** link (**Figure 33**).

Figure 33: Document uploaded to the form

Download Template						
Name	Description				Options	
Form 3: Income Analysis	Template for Income Analysis				Download ▾	
Income Analysis (Minimum 2) (Maximum 2)						Max 1 Allowed
Document Name	Size	Date Attached	Description	Uploaded By	Options	
Budget Justification-Prop 1.doc	22 kB	12/29/2013		Elizabeth Brown	Action Update Description Save X Delete	

9. After completing **Form 3**, 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 how the required and additional services will be provided by the applicant organization.

4.7.1 Completing Form 5A: Required Services section

Use this form to specify how your organization provides required services. 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](#)).

Table 1: Modes of Service Provision

Mode of Service Provision	Your Organization Provides the Service	Your Organization Pays for the Service
Service provided directly by Health Center	Yes	Yes
Service provided by formal written agreement (Health Center pays for service)	No	Yes
Service provided by formal written referral arrangement (Health Center does not pay)	No	No

To specify service delivery modes,

1. Check one or more boxes to indicate the service delivery mode(s) for each service type.
2. Click the **Save and Continue** button to navigate to the **Additional Services** section OR click the **Save** button on **Required Services** section and select the **Additional Services** tab below the **Resources** section.

Figure 34: Form 5A, Services Provided – Required Services

Required Services		Additional Services		
Fields with * are required				
Service Type	Service provided directly by applicant	Service provided by formal written contract/agreement (Applicant pays for service)	Service provided by formal written referral arrangement/agreement (Applicant 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"/>	
Obstetrical Care				
* 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"/>	
HCH Required Substance Abuse Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* 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"/>	
* Translation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Notes:

- Select modes of provision for required services as applicable to the proposed NAP project.
- If you selected Health Care for the Homeless as one of the sub-programs in this NAP application, you will be required to select at least one mode of provision for HCH Required Substance Abuse Services. Otherwise, this selecting modes of provision for this service here is disabled and you may select Substance Abuse Services under Additional Services.

4.7.2 Completing Form 5A: Additional Services section

Figure 35: Additional Services Tab

Required Services		Additional Services		
Fields with * are required				
Clinical Services				
Service Type	Service provided directly by applicant	Service provided by formal written contract/agreement (Applicant pays for service)	Service provided by formal written referral arrangement/agreement (Applicant DOES NOT pay)	

Use this form to identify additional services that your organization provides.

Notes:

- This is an optional section. You are not required to identify modes of provision for any additional services listed in this section.
- You can complete this section by clicking the **Save** or **Save and Continue** button located at the bottom of the form.

If you wish to propose an additional service,

1. Indicate the service delivery mode(s) for the desired additional service.
2. Click the **Save** or **Save and Continue** button to save your work.

Figure 36: Form 5A - Additional Services

Service Type	Service provided directly by applicant	Service provided by formal written contract/agreement (Applicant pays for service)	Service provided by formal written referral arrangement/agreement (Applicant 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	<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 Alternative Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Enabling/Supportive Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: Form 5A will be complete when the status of Required Services and Additional Services sections is complete.

3. After completing both the sections on **Form 5A**, click the **Save and Continue** button to save your work and proceed to the next form.

4.8. Form 5B: Service Sites

Form 5B: Service Sites identifies the sites where you will provide services and/or perform administrative tasks for the NAP FY 2015 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

Note: You are required to propose at least one ‘Service Delivery’ or ‘Administrative/Service Delivery’ site in the FY 2015 NAP application.

To propose a new site, follow the steps below:

1. Click the **Add New Site** button (**Figure 37**) provided above the **Proposed Sites** section.

Figure 37: Add New Site Button

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

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

Notes:

- If the answer to question 1 is ‘No’ (**Figure 38, 1**), i.e. if the site being added is not an ‘Admin-only’ site,
 - To qualify as a service site, select ‘Yes’ for questions ‘a’ through ‘d’, AND
 - Indicate if the site being added is a domestic violence site by answering ‘Yes’ or ‘No’ to question 2 (**Figure 38, 2**). Domestic Violence site is a confidential site servicing 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 38, 1**), i.e. if the site being added is an ‘Admin-only’ site, questions 1 and 2 are not applicable.

Figure 38: Service Site Checklist page

Service Site Checklist

Due Date: [Date] (Due In: [Days])

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Fields with * are required

Site Qualification Criteria

* 1. Is the site an "admin-only" site? 1 Yes No

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.

a. Are/will health center encounters be generated by documenting in the patients records face-to-face contacts between patients and providers? Yes No NotApplicable

b. Do/will providers exercise independent judgment in the provision of services to the patient? Yes No NotApplicable

c. Are/will services be provided directly by or on behalf of the grantee, whose governing board retains control and authority over the provision of the services at the location? Yes No NotApplicable

d. Are/will services be provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every month)? Yes No NotApplicable

* 2. Is the site a Domestic Violence (Confidential) shelter? 2 Yes No NotApplicable

3 [Verify Qualification](#)

3. Click the **Verify Qualification** button (Figure 38, 3).
 - The system navigates to the **List of Pre-registered Performance Sites at HRSA Level** page displaying all the sites that are registered by your organization within EHB.

Figure 39: List of Pre-registered Performance Sites at HRSA Level page

List of Pre-registered Performance Sites at HRSA Level

Note(s):
 Please click on 'Register Performance Site' to register a new Performance Site at HRSA level. Select a site and click on 'Update the Registered Performance Site' button to update the site information. Select a site and click on 'Select This Location' button to complete adding the site.

Due Date: [Date] (Due In: [Days])

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1 [Register Performance Site](#)

List of Pre-registered Performance Sites

Site Name	Performance Site Type	Performance Site Address	Options
Greely County Community Health Center	Fixed	1212 E. Union St. Harney, OR 97102-7540	4 1. This site is already in your scope or in scope of another H80 grantee. 3 Select Site Location
Russell Co. Health Department	Fixed	14840 US HWY 16 S STE 174 HENNINGVILLE, GA 31757-4811	Select Site Location
Albany Area Primary Health Care	Fixed	602 N. Madison Blvd. Albany, GA 31707-2188	2 Select Site Location
East Albany Medical Center Annex	Fixed	1712 E. Broad Ave. Ste Embassy, GA 31708-2811	Select Site Location
Albany Health Department	Fixed	1712 E. Broad Ave. Ste Embassy, GA 31708-2811	Select Site Location

Note: If there are no sites registered to your organization, or to use a new location for the site you are proposing in **Form 5B**, click the **Register Performance Site** button (Figure 39, 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 physical address you entered on the **Address – Enter** page along with the standardized format of the address. Select the option you want to proceed with and click the **Confirm** button.
- On the **Register – Result** page, click the **Finish** button to finally register the site to your organization.

4. Select a site for the NAP from the list of pre-registered performance sites and click its **Select Site Location** link (Figure 39, 2).

➤ The system navigates to the **Form 5B - Edit** page.

Notes: The system disables the **Select Site Location** link (Figure 39, 3) for the sites under any of the categories mentioned below. You will not be able to select such a site location:

- If the site is already included in the current application.
- If the site is already in your H80 scope or in another grantee’s H80 scope with active or pending verification status.
- If the site is a Mobile site and 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 any of these cases, the system provides you the reasons for which the site is disabled when you hover over the **Select Site Location** link (Figure 39, 4).

5. If you wish to update the name of any site listed on this page, click the **Update the Registered Performance Site** link (Figure 40) and update the site name.

Figure 40: Update the Registered Performance Site link

Site Name	Performance Site Type ⓘ	Performance Site Address	Performance Site Address Category	Options
Test 1	Fixed	300 WALK ST/END THORNTON, VA 21027-2077	Accurate	Select Site Location ▼
Test 2	Fixed	307 LIBERTY ST/PRINCETON, VA 21130-2713	Accurate	Select Site Location ▼
Third Site	Fixed	4000 Village Park Blvd/Harting, VA 20186	Approximate	Select Site Location ▼
Test1	Fixed	1410 HURON CT/HERNDON, VA 20179-8804	Accurate	<div style="border: 1px solid gray; padding: 2px;"> Action Select Site Location Update the Registered Performance Site </div>
Test location	Fixed	4000 Village Park Pl 2 # PETERLAND, VA 20186-2077	Accurate	

6. When you click the **Select Site Location** link of a site, the system navigates to the **Form 5B – Edit** page where you must provide all the required information for the site (Figure 41).

Figure 41: Form 5B – Edit page

Site Information		Status: Not Started	
* Name of Service Site	Albany Area Primary Health Care Change Site Name	* Site Physical Address	800 N. Westwood Blvd, Albany, GA 31707 Change Location
* Service Site Type	Service Delivery Site	* Location Setting (Required for Service Site)	Select Location Setting
* Location Type	Select Location Type	* Date Site was Added to Scope	N/A
Number of Contract Service Delivery Locations (Voucher Screening Only)		* Site Operational By	
* Web URL		Number of Intermittent Sites (Intermittent Only)	
* Site Phone Number	() - Ext.	* Administration Phone Number	() - Ext.
* Site Fax Number	N/A	* Medicare Billing Number	
* Medicaid Billing Number		* Medicaid Pharmacy Billing Number	
* Service Area Population Type	Select Service Area Populati	* Operational Schedule	N/A
* Calendar Schedule	Select Calendar Schedule	* Total Hours of Operation when Patients will be Served per Week	
* Site Operated by	Select Site Operated By		
Add Sub-Recipient/Contractor			
Sub-Recipient/Contractor Organization Information			
Organization Name	Address (Physical)	Address (Mailing)	EIN Comments Options
No records to display.			
Service Area Zip Code (Include only those from which the majority of the patient population will come)			
* Service Area Zip Codes			
	Save Zip Code(s)		
Saved Service Area Zip Code(s)			
Service Area Census Tracts (Include only those from which the majority of the patient population will come)			
* Service Area Census Tracts			
	Save Census Tracts		
Saved Census Tracts			
Months of Operation (Required for Permanent and Seasonal Locations)			
Months of Operation			
Saved Months of Operation			
Go to Previous Page		Save Save and Continue	

Note: You must add the zip code included in the physical address of the site in the Service Area Zip Codes field of **Form 5B – Edit** page.

- After providing the complete information on **Form 5B – Edit** page, click the **Save and Continue** button.
 - Form 5B – Service Sites** list page opens with the newly added site displayed in the **Proposed Site** section (**Figure 42**).

Figure 42: Newly added site displayed under Proposed Sites section

Site Name	Physical Address	Service Site Type	Location Type	Site Status	Options
		All	All	All	Update

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 Budget Summary form within the standard section of this FY 2015 NAP 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 Budget Summary form within the standard section of this FY 2015 NAP 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 NAP project.

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 new activities or locations, follow the steps below:

1. Click the **Add New Activity/Location** button provided at the top of the form (**Figure 43**).

Figure 43: Add New Activity/Location button

- The system navigates to the **Activity/Location - Add** page (**Figure 44**).

Figure 44: Activity/Location – Add page

Fields with * are required

Activity/Location Information

* Type of Activity Select Option
 If Other, Please Specify

* Frequency of Activity Approximately 1/2 page(s) (Max 600 Characters): 600 Characters left

* Description of Activity Approximately 1/2 page(s) (Max 600 Characters): 600 Characters left

* Type of Location(s) where Activity is Conducted Approximately 1/2 page(s) (Max 600 Characters): 600 Characters left

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 on the form (**Figure 45**).

Figure 45: Activity/Location added

Activity Type	Description	Frequency	Type of Location	Status	Options
<input type="text" value="Y"/>	<input type="text" value="Y"/>	<input type="text" value="Y"/>	<input type="text" value="Y"/>	All <input type="text"/>	
Hospital Admitting	Admitting patients to hospitals	Daily	Permanent	Complete	<input type="button" value="Update"/>

Note: Once the activity is added, it can be updated or deleted as needed.

3. After completing **Form 5C**, click the **Save and Continue** button to save your work and proceed to the next form.

4.10. Alteration/Renovation (A/R) Information

Notes: If you requested One-Time Funding for Year 1 in **Form 1B: Funding Request Summary** and indicated that you will be using these funds for minor alteration and renovation (with or without equipment), you will be required to complete the **Alteration/Renovation (A/R) Information** form, consisting of the **Alteration/Renovation (A/R) Project Cover Page** and **Other Requirements for Sites** section for at least one service site proposed in Form 5B of this FY 2015 NAP application. Otherwise, this form will not apply to you (**Figure 46**). If the form is not applicable to you, click the **Continue** button to proceed to the next form.

Figure 46: A/R Information Page – “Not Applicable” Message

When the **Alteration/Renovation (A/R) Information** form is applicable to you, the system populates all the ‘Service Delivery’ and ‘Administrative/Service Delivery’ sites you proposed in **Form 5B – Service Sites** form of this FY 2015 NAP application (**Figure 47, 1**). Follow the steps below to complete this form:

Notes:

- You must propose at least one ‘Service Delivery’ or ‘Administrative/Service Delivery’ site in **Form 5B: Service Sites** form of this application in order to work on the **A/R Information** page.
- Any ‘Administrative-only’ sites proposed in **Form 5B: Service Sites** will *not* be listed on the **A/R Information** page because you cannot use one-time funds to perform alteration or renovation of an ‘Administrative-only’ site.

Figure 47: A/R Information Page when Applicable

1. Answer whether you are requesting federal one-time funding for minor alteration/renovation at each site by clicking “Yes” or “No” (**Figure 47, 2**).
2. For each site for which you clicked “Yes”, click the **Update** button (**Figure 47, 3**) to update the **Alteration/Renovation (A/R) Project Cover Page** section of the site (**Figure 48**).

Notes:

- If you requested One-Time Funding for Year 1 in **Form 1B: Funding Request Summary** and indicated that you will be using these funds for minor alteration and renovation, you must answer ‘Yes’ for the one-time funding question for at least one site listed on this form.
- You will be required to complete the Alteration/Renovation (A/R) Proposal Cover Page and Other Requirements for Sites sections for each site for which you answer ‘Yes’ for the one-time funding question.

- You will not be able to provide A/R information for sites for which you answer ‘No’ for the one-time funding question.

4.10.1 Alteration/Renovation (A/R) Project Cover Page

1. On the **A/R Project Cover Page**, answer all the questions and attach the documents as requested. Fields and attachments marked with an asterisk (*) are required.

Notes:

- In question 1, enter a positive number of up to 10 digits with a maximum of 2 decimal places in the **Improved Square Footage** field.
- For the **Environmental Information Documentation (EID)** checklist, download the template to your computer, complete the form, and attach it to your application.

2. After you have completed the **A/R Project Cover Page (Figure 48)**, click the **Save and Continue** button at the bottom of the screen to save your work and proceed to the **Other Requirements for Sites** section.

Figure 48: A/R Project Cover Page

Alteration/Renovation (A/R) Project Cover Page

DEPARTMENT OF ALABAMA PRIMARY HEALTH CARE, INC. Due Date: 10/30/2014 (Due In: 54 Days) | Section Status: Not Started

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Fields with * are required

Alteration/Renovation (A/R) Project Cover Page **Other Requirements for Sites**

*** 1. Site Information**

Name of Service Site	Albany Area Primary Health Care
Site Address	602 N. Woodrow Blvd Albany GA 31707-2188
Improved Project Square Footage	

*** 2. Project Description**

Provide a detailed description of the scope of work for the A/R project. Identify the major clinical and non-clinical spaces that will result from the project. Include the area (in square feet) or dimensions of the spaces to be altered, or renovated. The description should also list major improvements, such as permanently affixed equipment to be installed; modifications and repairs to the building exterior (including windows); heating, ventilation and air conditioning (HVAC) modifications (including the installation of climate control and duct work); electrical upgrades; plumbing work; and any work outside the building. Describe how the applicant will reduce the project's potential adverse impacts on the environment. Indicate whether or not the project will implement green/sustainable design practices/principles (e.g., using project materials, design/renovation strategies, equipment selection, etc.).

Approximately 2 pages (Max 4000 Characters): 4000 Characters left.

Design Preview

*** Attachments**

A/R Budget Justification (Minimum 1) (Maximum 1) **Attach File**

No documents attached

Environmental Information Documentation (EID) Checklist

Download Template

Name	Description	Options
EID Checklist	Template for EID Checklist	Download

EID Checklist (Minimum 1) (Maximum 1) **Attach File**

No documents attached

Floor Plans/Schematic Drawings (Minimum 1) (Maximum 2) **Attach File**

No documents attached

Other Project Documents (Minimum 0) (Maximum 1) **Attach File**

No documents attached

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

4.10.2 Other Requirements for Sites

1. Answer all the questions on the form.
2. If the site is a leased property, you must attach a Landlord Letter of Consent for performing the alterations and renovations on the site in the Attachments section. Otherwise, do not upload any document in the Attachments section.
3. Click the **Save and Continue** button at the bottom of the form.
 - You will be returned to the **A/R Information Page** with the list of proposed sites.

Figure 49: Other Requirements for Sites

Alteration/Renovation (A/R) Project Cover Page Other Requirements for Sites

Site Information

Name of Service Site	Albany Area Primary Health Care
Site Address	400 N. Westover Blvd Albany, GA 31707-2100

*** 1. Site Control and Federal Interest**

1a. Identify current status of property site (If 'Leased', please answer Question 1b)

Owned Leased

1b. If Leased, please check the following:

The applicant certifies the following:

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

*** 2. Cultural Resource Assessment and Historic Preservation Considerations**

2a. Was the project facility constructed prior to 1975?

Yes No

2b. Is the project facility 50 years or older?

Yes No

2c. Does any element of the overall work at the project site include:

- Any renovation/modifications to the exterior of the facility (for example: roof, HVAC, windows, siding, signage, exterior painting, generators, etc.) or
- Ground disturbance activity (for example: expansion of building footprint, parking lot, sidewalks, utilities, etc.)?

Yes No

2d. Does the project involve renovation to a facility that is, or near a facility that is, architecturally, historically, or culturally significant; or is the site located on or near Native American, Alaskan Native, Native Hawaiian, or equivalent culturally significant lands?

Yes No

Attachments

If property status is 'Leased', applicant must provide Landlord Letter of Consent.

▼ Landlord Letter of Consent (Minimum 0) (Maximum 1) Attach File

No documents attached

Go to Previous Page Save Save and Continue

4. After you have completed the A/R Information for each displayed site, click the **Save and Continue** button at the bottom of the form to save your work and proceed to the next form.

Notes:

- If you add a new 'Service Delivery' or an 'Administrative/Service Delivery' site in **Form 5B: Service Sites** after completing the **A/R Information** form, you will be required to revisit the **A/R Information** form to answer the one-time funding question for that site and provide the A/R information for the site, as applicable.
- If you remove a site from **Form 5B: Service Sites**, then the site will be removed from the A/R Information form.

4.11. Form 6A – Current Board Member Characteristics

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

Notes:

- This form is optional if you selected “Tribal” or “Urban Indian” as the **Business Entity** in **Form 1A: General Information Worksheet**. You can click the **Save** or the **Save and Continue** button at the bottom of the page to proceed to the next form.
- If you did not yet select a **Business Entity** in **Form 1A**, or if you chose a **Business Entity** other than “Tribal” or “Urban Indian,” you must enter all required information on **Form 6A**.
- If **Form 6A** is optional for you, but you choose to enter information, you must enter all required information.

Applicants are required to list all the current board members and provide the requested details. For existing grantees submitting a Supplemental FY 2015 NAP application, the system pre-populates the list of board members from their latest awarded H80 application. Grantees will have the option to update or delete the pre-populated information and add new board members as applicable.

Figure 50: Form 6A - Current Board Member Characteristics

Fields with * are required

1 Add New Board Member

Name	Current Board Office Position Held	Area of Expertise	>10% of income from health industry	Health Center Patient	Live or Work in Service Area	Years of Continuous Board Service	Special Population Representative	Options
Mark Stubbly	President	Small Business	No	Yes	Live, Work	9.00	No	2 Update
Mark Stubbly	Member	Marketing	No	Yes	Live	1.00	No	Update

3 Patient Board Member Classification

Gender	Number of Patient Board Members
* Male	5
* Female	9
* Unreported/Declined to Report	0

1. To add board member information click on the **Add New Board Member** button (**Figure 50, 1**).
 - The system navigates to the **Current Board Member - Add** page.
2. Provide the required board member information. Click the **Save and Continue** button to save the information and navigate back to the **Form 6A** list page (**Figure 51, 1**), or the **Save and Add New** button to save the information and add a new board member record (**Figure 51, 2**).

Figure 51: Current Board Member – Add Page

Patient Board Member Information	
* First Name	<input type="text"/>
* Last Name	<input type="text"/>
Middle Initial	<input type="text"/>
Current Board Office Position Held	<input type="text"/>
* Area of Expertise	<input type="text"/>
* Does member derive more than 10% of income from health industry ?	<input type="radio"/> Yes <input type="radio"/> No
* Is member a health center patient ?	<input type="radio"/> Yes <input type="radio"/> No
Live or work in service area ?	<input type="checkbox"/> Live <input type="checkbox"/> Work
* Years of continuous board service	<input type="text"/>
* Is member a special population representative (MHC, HCH, PHPC) ?	<input type="radio"/> Yes <input type="radio"/> No If Yes, please specify Special Population: <input type="checkbox"/> Migrant Health (MHC) <input type="checkbox"/> Homeless Health (HCH) <input type="checkbox"/> Public Housing (PHPC)
<input type="button" value="Cancel"/>	<input type="button" value="Save and Continue"/> <input type="button" value="Save and Add New"/>

To update or to delete information for any board member, click on **Update** or **Delete** link under the options column in the **List of Board Members** section (Figure 50, 2). You must provide a minimum of 9 and a maximum of 25 board members.

Indicate the gender, ethnicity, and race of board members who are patients of the health center. After providing complete information on **Form 6A**, click the **Save and Continue** button to save the information and proceed to the next form.

4.12. Form 8 - Health Center Agreements

Form 8 indicates whether you will have any agreements with other organizations that impact the Board’s composition, authorities, functions, or responsibilities or provide a substantial number of services, sites, and/or activities in your organization’s approved scope of project. To complete Form 8, follow the steps below:

1. In Part I, Question 1 (Figure 52), inform HRSA of any current or proposed agreements with another organization to carry out a substantial portion of your organization’s approved scope of project.

Notes:

- If any of the new sites proposed in **Form 5B: Service Sites** are being operated by a “Subrecipient” or a “Contractor”, the system sets the answer of question 1 to ‘Yes’ and makes it non-editable (Figure 52, 1).
- If you answer Yes to Question 1, indicate the number of each agreement type in 2a (Figure 52, 2) and 2b (Figure 52, 3).

Figure 52: Form 8, Part I

Part I

★ 1. Do you have, or propose to establish as part of this application, an agreement with another organization to carry out a substantial portion of the proposed scope of project?
If Yes, indicate the number of each agreement type in questions 2a and/or 2b below and complete Parts II and III. If No, skip to Part II.

2a. Number of contracts for a substantial portion of the proposed scope of project for any of the following: core primary care providers, non-provider health center staff, Chief Medical Officer (CMO), or Chief Financial Officer (CFO).

2b. Number of Memoranda of Understanding (MOU)/Agreement (MOA) for a substantial portion of the proposed scope of project via a sub-recipient/subaward arrangement.

1: Radio buttons for Yes/No
2: Input field for 2a (integer up to 4 digits)
3: Input field for 2b (integer up to 4 digits)

2. In Part II, Question 1 (Figure 53), complete the Governance Checklist to determine if any affiliations or agreements limit or compromise the Board’s authorities, functions, or responsibilities.

Figure 53: Form 8, Part II: Question 1 - Governance Checklist

Part II

★ 1. Governance Checklist: Does the health center affirm that the board exercises the authorities, legislative and regulatory mandated functions, and responsibilities listed below, without limitation or compromise due to an affiliation or agreement with another entity? ⓘ

A No response to any Governance Checklist item must result in a Yes response to question 2 below.

determines board composition	<input type="radio"/> Yes <input type="radio"/> No
determines executive committee function and composition	<input type="radio"/> Yes <input type="radio"/> No
selects board chairperson	<input type="radio"/> Yes <input type="radio"/> No
selects board members	<input type="radio"/> Yes <input type="radio"/> No
performs strategic planning	<input type="radio"/> Yes <input type="radio"/> No
approves the center's annual budget	<input type="radio"/> Yes <input type="radio"/> No
directly employs, selects/dismisses, and evaluates the CEO/Executive Director	<input type="radio"/> Yes <input type="radio"/> No
adopts policies and procedures for personnel and financial management	<input type="radio"/> Yes <input type="radio"/> No
establishes center priorities and allocates resources	<input type="radio"/> Yes <input type="radio"/> No

Note: If you answer ‘No’ to any Governance Checklist item, you must answer ‘Yes’ to question 2 in Part II of this form.

3. In Part II, Question 2 (Figure 54, 1), inform HRSA of any current or proposed agreements that affect the composition, authorities, functions, or responsibilities of your organization’s Board.
4. If you answer ‘Yes’ to question 2, specify the number of such agreements in question 3 (Figure 54, 2).

Figure 54: Form 8, Part II, Questions 2 and 3

★ 2. Do you have, or propose to establish as part of this application, an agreement/arrangement (noted in Part I or otherwise) that impacts the applicant’s governing board composition, authorities, functions, or responsibilities?
If Yes, indicate the number of such agreements/arrangements in question 3 below and complete Part III.

3. Number of agreements/arrangements that impacts the health center’s governing board composition, authorities, functions, or responsibilities (e.g., parent subsidiary model, bilateral board representation, outside nomination of board members, joint committees).

1: Radio buttons for Yes/No
2: Input field for 3 (integer up to 4 digits)

5. If you answered ‘Yes’ to Part I, question 1 or Part II, question 2, provide each agreement in Part III: Organization Agreement Details. The agreements will be organized by each organization with which your organization has an agreement. To add agreements, follow the steps below:
 - A. Click the **Add Organization Agreement** button located above Part III (Figure 55).

Figure 55: Form 8, Part III

- The system navigates to the **Organization Agreement - Add** page (Figure 56).

Figure 56: Health Center Agreement

- B. Provide the required information for the agreement in the **Organization Agreement Detail** and **Physical Location Address** sections on this page.
- C. Upload the agreement in the **Attachments** section at the bottom of this page by clicking the **Attach File** button (Figure 57).

Note: Before uploading a document for this affiliation, please rename the file to include the affiliated organization’s name e.g., ‘CincinnatiHospital_MOA.doc’.

Figure 57: Adding Attachments for the Organization Agreement

Note(s):

- You must upload at least one document for this affiliation.
- Before uploading a document for this affiliation, please rename the file to include the affiliated organization's name e.g. 'CincinnatiHospital_LocationDetails.doc'.

Attachment(s) (Minimum 1)(Maximum 5) Attach File

No documents attached.

Cancel Save Save and Continue

6. Click the **Save and Continue** button to return to **Form 8: Health Center Agreements** list page. Following the steps above, add as many organizations and corresponding agreements as required in Part III.
7. After completing **Form 8**, click the **Save and Continue** button to save your work and proceed to the next form.

4.13. Form 9 – Need for Assistance Worksheet

Form 9: Need for Assistance Worksheet documents objective measures of relative need for the proposed service area and target population.

4.13.1 Completing Section I – Core Barriers

Form 9, Section I requests information about core barriers to health care access in the proposed service area and for the target population. You must report on three of the following four core barriers listed.

- Population to One FTE Primary Care Physician
- Percent of Population Below 200 Percent of Poverty
- Percent of Population Uninsured
- Distance (miles) OR travel time (minutes) to nearest primary care provider accepting new Medicaid and uninsured patients

For those you will report on, respond **'Yes'** to the question 'Is this Core Barrier Applicable?' (**Figure 58, 1**). Provide information in all the fields of the core barrier.

Notes:

- Refer to the **Data Resource Guide** at <http://www.hrsa.gov/grants/apply/assistance/NAP> for guidance regarding appropriate data sources and extrapolation methodologies.
- If you answer 'No' to 'Is this Core Barrier Applicable?' question for any core barrier, you will **not** be able to enter any data for that barrier.

Figure 58: Form 9, Section I: Core Barriers

Click the **Save and Continue** button to proceed to **Section II – Core Health Indicators**, OR click the **Save** button at the bottom of **Section I – Core Barriers** and select the **Section II – Core Health Indicators** tab below the **Resources** section (**Figure 59**).

Figure 59: Section II - Core Health Indicators tab

4.13.2 Completing Form 9: Section II - Core Health Indicators

Use **Form 9**, Section II to supply information for one indicator in each of the following core health indicator categories:

- Diabetes
- Cardiovascular Disease
- Cancer
- Prenatal and Perinatal Health
- Child Health

- Behavioral Health

To provide information about the core health indicators, follow the steps below for each health indicator:

1. Select a **Core Health Indicator** from the drop-down menu (**Figure 60, 1**).
2. Click the **Refresh National Benchmark** button (**Figure 60, 2**).
 - The system refreshes the following fields with the values applicable to the selected indicator and makes them non-editable:
 - **National Benchmark** (**Figure 60, 3**)
 - Measure unit of the **Data Response** field (**Figure 60, 4**)

Note: Clicking the **Refresh National Benchmark** button refreshes the measuring unit of the **Data Response** field only. You will be required to provide the **Data Response** value (**Figure 60, 5**).

3. Provide information in all the remaining fields of the health indicator.

Note: Refer to the **Data Resource Guide** at <http://www.hrsa.gov/grants/apply/assistance/NAP> for guidance regarding appropriate data sources and extrapolation methodologies.

Figure 60: Form 9, Section II: Core Health Indicators

The screenshot shows a form titled 'Diabetes' under 'Section II: Core Health Indicators'. The form has several sections:

- Core Health Indicator:** A dropdown menu showing 'Age-adjusted diabetes prevalence' with a 'Refresh National Benchmark' button to its right.
- National Benchmark:** A text field displaying '8.1%'.
- Data Response:** A text input field with a '%' symbol to its right.
- Year to which Data Apply:** A text input field with '(yyyy)' as a placeholder.
- Data Source/Description:** A large text area with a character count '(You have 500 characters remaining out of maximum limit of 500)'.
- Methodology Utilized/Extrapolation Method:** A large text area with a character count '(You have 500 characters remaining out of maximum limit of 500)'.
- Identify Geographic Service Area or Target Population for Data:** A text input field with a character count '(You have 100 characters remaining out of maximum limit of 100)'.

Red callouts are placed over the form: '1' is over the Core Health Indicator dropdown; '2' is over the Refresh National Benchmark button; '3' is over the National Benchmark value; '4' is over the Data Response measure unit; and '5' is over the Data Response input field.

Note: If you choose to select 'Other' in the **Core Health Indicator** drop-down menu, when you click the **Refresh National Benchmark** button, the following occurs in the system:

- You must provide the description of the 'Other' health indicator that you wish to propose in the '**If Other, Please Specify**' text box (**Figure 61, 1**).
- You must choose a comparison criterion for the **National Benchmark** (e.g., greater than) and provide its value and measure unit (e.g., percent, ratio) (**Figure 61, 2, 3**).

- You must provide the data response value in the **Data Response** field and choose the measure unit in the dropdown box (**Figure 61, 4**).

Figure 61: Selecting 'Other' as Core Health Indicator

The screenshot shows the 'Diabetes' section of the HRSA Form 9. The 'Core Health Indicator' dropdown is set to 'Other'. A 'Refresh National Benchmark' button is visible. Below this, there are several fields with callouts:

- 1**: Points to the 'If 'Other', please specify:' text input field.
- 2**: Points to the 'National Benchmark' dropdown menu.
- 3**: Points to the 'National Benchmark' unit dropdown menu.
- 4**: Points to the 'Data Response' dropdown menu.

 Other fields include 'Year to which Data Apply', 'Data Source/Description', 'Methodology Utilized/Extrapolation Method', and 'Identify Geographic Service Area or Target Population for Data'.

- Click the **Save and Continue** button to proceed to **Section III – Other Health and Access Indicators**, OR click the **Save** button at the bottom of **Section II – Core Health Indicators** and select the **Section III – Other Health and Access Indicators** tab below the **Resources** section.

4.13.3 Completing Form 9: Section III - Other Health and Access Indicators

Use **Form 9**, Section III to provide information about two additional health indicators. To add information about health and access indicators, follow the steps below:

- Select a **Health and Access Indicator** from the drop-down menu (**Figure 62, 1**).
- Click the **Refresh National Benchmark** button (**Figure 62, 2**).
 - The system refreshes the following fields with the values applicable to the selected indicator and makes them non-editable:
 - National Benchmark** (**Figure 62, 3**)
 - Measure unit of the **Data Response** field (**Figure 62, 4**)

Note: Clicking the **Refresh National Benchmark** button refreshes the measure unit of the **Data Response** field only. You will be required to provide the **Data Response** value (**Figure 62, 5**).

3. Provide information in all the remaining fields of the health indicator.

Note: Refer to the **Data Resource Guide** at <http://www.hrsa.gov/grants/apply/assistance/NAP> for guidance regarding appropriate data sources and extrapolation methodologies.

Figure 62: Form 9, Section III: Other Health and Access Indicator

Note: You will only be able to select a standard, BPHC-defined indicator. You will not be provided with an “Other” option to define your own indicator in section III.

Form 9: Need for Assistance Worksheet will be complete when the status of all 3 sections is complete. After completing all the form sections, click the **Save and Continue** button to save your work and proceed to the next form.

Note: Applicants will be able to view the scores for each section of Form 9 in the read-only version of the form by clicking on Program Specific Forms under Review in the left navigation panel. The Program Review Form page will display all Program Specific Forms in the application. Click the **View** link in the Options column to view the form and the scores for each indicator.

4.14. Form 10: Annual Emergency Preparedness Report

The **Annual Emergency Preparedness Report** assesses your organization’s overall emergency readiness. Complete both sections of this form by selecting a ‘Yes’ or ‘No’ response.

Figure 63: Form 10 – Annual Emergency Preparedness Report

After providing complete information on **Form 10**, click the **Save and Continue** button to save the information and proceed to the next form.

4.15. Form 12- Organization Contacts

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

New applicants must provide the requested contact information.

For existing grantees submitting a Supplemental application, the system pre-populates the contact information from the latest awarded H80 application or progress report.

1. Enter contact information for chief executive officer, contact person, medical director, and dental director (optional) on this form. (Figure 64, 1, 2, 3).

Figure 64: Form 12 – Organization Contacts

* Chief Executive Officer	Name	Highest Degree	Phone	Email	Option
					1 Add Chief Executive Officer
* Contact Person	Name	Highest Degree	Phone	Email	Option
					2 Add Contact Person
* Medical Director	Name	Highest Degree	Phone	Email	Option
					3 Add Medical Director
Dental Director	Name	Highest Degree	Phone	Email	Option
					Add Dental Director

2. Click the [Add](#) or [Update](#) link to add or update the information for each type of contact. For example, click [Add Chief Executive Officer](#) to add a Chief Executive Officer.
 - The system directs the user to the data entry page for the corresponding contact.
3. Enter the required contact information.

Figure 65: Chief Executive Officer – Add page

4. Click the **Save** button to save the information and remain on the same page or click the **Save and Continue** button to save the information and proceed to the **Form 12 – Organizations Contact** page to add information for the next contact.
5. To delete the contact information already provided, click the [Delete](#) link under the options column.

Note: The [Update](#) and the [Delete](#) links will be displayed only when you have added the contact information or this information is pre-populated for Supplemental applications.

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

4.16. Clinical Performance Measures

The **Clinical Performance Measures** form collects the goals and performance measures for the NAP project.

Note: Refer to the FY 2015 NAP Funding Opportunity Announcement for more information on filling out the **Clinical Performance Measures** form.

The **Clinical Performance Measures** form displays standard measures and other measures. Applicants are required to provide requested information for all the standard measures. **Standard measures** are pre-defined, except for the Oral Health measure, which is defined by the applicant. **Other Measures** are additional measures that the applicant may wish to add.

In order to complete this form, follow the steps below:

1. In the **Project Period** section, provide the project period Start Date and End Date in ‘MM/DD/YYYY’ format. (Figure 66, 1)
2. Click the date picker icon (Figure 66, 2) to select the Start Date; similarly enter the End Date.

Figure 66: Project Period section

Notes:

- The system synchronizes the project period dates between the Clinical Performance Measures and Financial Performance Measures forms. Changes made to dates in one form are reflected in the other form.
- All the standard performance measures listed on this form will have a status of Not Complete. This form will be Complete when the status of all the standard performance measures and additional measures is Complete.

4.16.1 Completing the Standard Performance Measures

1. Click the **Update** link to start working on a performance measure.

Figure 67: Standard Measures section

Focus Area	Performance Measure	Baseline Data	Baseline Year	Projected Data	Status	Options
			All		All	
Standard Measures						
▶ Diabetes	Percentage of diabetic patients whose HbA1c levels are less than 8 percent, less than or equal to 9 percent, or greater than 9 percent.				Not Complete	Update
▶ Cardiovascular Disease	Percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90.				Not Complete	Update

- The system directs you to the **Clinical Performance Measure – Update** page. (Figure 68)

Figure 68: Clinical Performance Measure - Update page

Update Clinical Performance Measure Information	
Focus Area	Diabetes
Is this Performance Measure applicable to your Organization?	Yes
Performance Measure	Percentage of diabetic patients whose HbA1c levels are less than 8 percent, less than or equal to 9 percent, or greater than 9 percent.
* Target Goal Description (Sample Goals ↗)	Approximately 1/2 page(s) (Max 500 Characters): 500 Characters left <input type="text"/>
Numerator Description (Examples ↗)	Number of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent HbA1c level during the measurement year is <8%, <=9%, or >9%, among those patients in the denominator.
Denominator Description (Examples ↗)	Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have had a visit at least twice during the reporting year and do not meet any of the exclusion criteria.
* Baseline Data	Baseline Year: <input type="text"/> (yyyy) Measure Type: Percentage Numerator: <input type="text"/> Denominator: <input type="text"/> <input type="button" value="Calculate Baseline"/> ⓘ

2. Enter the description of the target goal for the performance measure. To view examples of target goals, click on the **Sample Goals** link (Figure 68, 1). Similarly, to view examples for Numerator and Denominator, click on **Examples** link.
3. Enter the Baseline Year and corresponding numerator and denominator values for that year. Click the **Calculate Baseline** button to calculate the baseline data based on the numerator and denominator values you provided. (Figure 68, 2)
4. Provide the information in the Projected Data (By End of Project Period) field (Figure 69, 1).
5. Select one of the available data sources and provide a description in the Data Source and Methodology field (Figure 69, 2, 3).

Figure 69: Projected Data, Data Source and Methodology fields

* Projected Data (by End of Project Period) (Sample Calculation ↗)	Projected Data: <input type="text"/> ⓘ Measure Type: Percentage <input type="radio"/> EHR ⓘ <input type="radio"/> Chart Audit <input type="radio"/> Other If 'Other', please specify: <input type="text"/> (maximum 100 characters)
* Data Source & Methodology	Approximately 1/4 page (Max 500 Characters): 500 Characters left. <input type="text"/> ⓘ

6. Click the **Add New Key Factor and Major Planned Action** button to add key factors.
 - The system directs you to the **Key Factor and Major Planned Action – Add** page.
7. Provide all of the required information (Figure 70).

Figure 70: Key Factors and Major Planned Action - Add page

Note: You have to provide information for at least one restricting and one contributing key factor type.

8. Click the **Save and Continue** button to save the information on this page and proceed to the **Clinical Performance Measure** list page, or click the **Save and Add New** button to save the key factor information you provided and proceed to add a new key factor.
9. Provide comments in the Comment field if needed.

Notes:

- The following three clinical measures have been newly introduced in FY 2015 NAP applications: Tobacco Use Screening and Cessation, New HIV Cases With Timely Follow Up, and Depression Screening and Follow Up.
- The general Behavioral Health measure has been removed from the Standard Measures section of the Clinical Performance Measures form. If you wish to propose a general Behavioral Health measure, you can do so by adding an Other performance measure.

4.16.2 Adding Other Performance Measure

To add 'Other' performance measure, follow the steps below:

1. Click the **Add Other Performance Measure** button on the **Clinical Performance Measures Form** list page.
 - The **Clinical Performance Measure - Add** page opens.

Figure 71: Clinical Performance Measure – Add page

2. Select a focus area from the drop-down menu ([Figure 71, 1](#)).
3. If your focus area is Oral Health or Behavioral Health, click the **Load Performance Measures Category** button to load the performance measure categories ([Figure 71, 2](#)). Otherwise, selecting Performance Measure Categories is not applicable.
4. Select one or more performance measure categories.
5. Provide the required information on this page.
6. Click the **Save** button to save the information on this page. To proceed to the performance measure list page, click the **Save and Continue** button.
 - The newly added measure will be added under the Other Measures group on the Clinical Performance Measures list page.

Note: The newly added 'Other' measures can be updated or deleted by using the [Update](#) and [Delete](#) links provided as options.

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

4.17. Financial Performance Measures

The **Financial Performance Measures** form collects the goals and performance measures for the NAP project.

Note: Refer to the FY 2015 NAP Funding Opportunity Announcement for more information on filling out the **Financial Performance Measures** form.

The **Financial Performance Measures** form displays standard measures and other measures. Standard measures are pre-defined and applicants are required to provide requested information for all the standard measures. Other measures are additional measures that the applicant may wish to add.

Complete this form by following steps described in sections [3.17.1, Completing the Standard Performance Measures](#) and [3.17.2, Adding an Other Measure](#) of the Clinical Performance Measures form section of this user guide.

Notes:

- In the Data Source and Methodology section, you will be required to provide a description only and will not have the option to select any data source for the financial measure.
- If you select "Tribal" or "Public" as the business entity in **Form 1A** of this FY 2015 NAP application, you will have the option to mark the Financial Viability related measures as Not Applicable along with providing justification in the Comments box. Otherwise, you will be required to provide complete information for these measures.

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

4.18. Equipment List

Note: If you requested **One-Time Funding** for **Year 1** in **Form 1B: Funding Request Summary** and indicated that you will be using these funds for ‘Equipment only’ or for ‘Minor Alteration and Renovation with Equipment’, you will be required to complete the **Equipment List** form. Otherwise, this form will not apply to you. If the form is not applicable to you, click the **Continue** button to proceed to the next form.

Figure 72: Equipment List Page

The screenshot shows the 'Equipment List' page for 'SENYONISH ALBANY AREA PRIMARY HEALTH CARE, INC'. The 'Section Status' is 'Complete'. Under 'Resources', there are links for 'View', 'NAP FY 2015 User Guide', and 'Funding Opportunity Announcement'. A yellow alert box contains the following text:

Alert:
 This form is not applicable to you as in Form 1B of this application, one of the following is true:

- You have not requested one-time funding, or
- You have requested one-time funding but not indicated how you plan to use these funds, or
- You have requested one-time funding for minor alteration/renovation without equipment use

Buttons at the bottom include 'Go to Previous Page' and 'Continue'.

To complete the **Equipment List** form when it is applicable to you, follow the steps below:

Figure 73: Equipment List Page

The screenshot shows the 'Equipment List' page with 'Section Status' as 'Not Complete'. The 'Add' button is highlighted with a red box. Below the resources, there is a table titled 'List of Equipment' with columns: Type, Description, Unit Price, Quantity, Total Price, and Options. The table is currently empty with the text 'No equipment added.' below it. Buttons at the bottom include 'Go to Previous Page', 'Save', and 'Save and Continue'.

1. Click the **Add** button to add a piece of equipment (**Figure 73**).
 - The system navigates to the **Add Equipment Information Page** (**Figure 74**). Fields marked with an asterisk (*) are required.

Figure 74: Equipment Information - Add Page

The screenshot shows the 'Add Equipment Information' page. At the top, it says 'Fields with * are required'. The form has the following fields:

- * Type: A dropdown menu with options 'Clinical' and 'Non-Clinical'.
- * Description: A text input field with a note '(Maximum 50 Characters)'.
- * Unit Price (\$): A text input field.
- * Quantity: A text input field.

Buttons at the bottom include 'Cancel' and 'Save and Continue'.

2. Select an equipment type and enter the Description, Unit Price (\$), and Quantity.
3. When you have completed the entries, click the **Save and Continue** button at the bottom of the screen. You will be returned to the **Equipment List Page** (Figure 75).

➤ The system lists the equipment you entered and calculates the **Total Price**.

Figure 75: Equipment List Page (With Equipment Added)

Description	Unit Price	Quantity	Total Price	Options
Stethoscope	\$500.00	10	\$5,000.00	Update
Total		10	\$5,000.00	

4. When you are finished entering equipment, click the **Save and Continue** button at the bottom of the screen to save your work and navigate to the next form.

Note:

- If you are requesting one-time funds in **Form 1B: Funding Request Summary** for ‘Equipment only’, the total price of equipment requested in this form must be equal to the **One-Time Funds** request. Otherwise, the total price can be less than the one-time funds requested.
- The newly added ‘**Equipment**’ can be updated or deleted by using the **Update** and **Delete** links provided as options.

4.19. Summary Page

This form displays read-only information provided in the following program specific forms of the FY 2015 NAP application: **Form 1A, Form 1B, Form 2, Form 5B** and **Form 9**. You are required to acknowledge that the information displayed in this form is correct.

1. Review the data displayed on the **Summary** page for accuracy. If any information is incorrect, edit the forms by clicking on the form name in the left navigation panel. Be advised that the information in the forms should be consistently identified throughout the entire application.
2. When all information is complete and accurate, click the check box to certify the form and then click the **Save and Continue** button.

Notes:

- On the **Summary Page**, you will be required to certify that all data in the application is accurate by checking the confirmation box after you have completed **Form 1A, Form 1B, Form 2, Form 5B, and Form 9**.
- If you update the information in **Form 1A, Form 1B, Form 2, Form 5B, or Form 9** after completing the **Summary Page**, you will be required to revisit the **Summary Page** to review and acknowledge the updated information.

Figure 76: Summary Page

Summary Page

Note(s):
 The information below is pre-populated based on data that you provided in the forms of this NAP application. If any information is incorrect, please edit the forms by clicking on the form name in the Menu on the left of the screen. Be advised that the information in the forms should be consistently identified throughout the entire application.

▶ **REVIEWING: SOUTH CAROLINA PRIMARY HEALTH CARE ASSOCIATION** Due Date: 12/31/2016 (Due In: 37 Days) | Section Status: Not Started

▼ **Resources** [↗](#)

View
[NAP FY 2015 User Guide](#) | [Funding Opportunity Announcement](#)

Summary Information

1. I am applying as a new start applicant.
 Suggested Resource(s): [Form 1A](#) [↗](#)

[X] Yes [] No
 Note:
 • "Yes" indicates that you are a new organization applying for section 330 operational funds.
 • "No" indicates that you are a current section 330 grantee. Therefore, you are applying as a Satellite applicant.

2. I am proposing the following sites:
 Suggested Resource(s): [Form 5B](#) [↗](#)

6. Total Score from Form 9, Need For Assistance worksheet:
 Suggested Resource(s): [Form 9](#) [↗](#)

NFA Score: 0
 Converted Score: 0

Certification

By checking this box, I certify that information provided in this application is complete and accurate, including the Need for Assistance (NFA) data sources and calculations. I certify that, if funded, all sites included on Form 5B will be open and operational within 120 days of Notice of Award and I acknowledge that the health center will be held accountable for reaching the patient projections on Form 1A by December 31, 2016.

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

5. Submitting the FY 2015 NAP Application to HRSA

1. Review the information displayed in the **Table of Contents** by clicking the **Review** link under the Review and Submit section in the left menu. If you are ready to submit the application to HRSA, follow the steps below:

Note: To submit an application, you must have the Submit privilege. This privilege must be given by the Project Director (PD) to the Authorizing Official (AO) or designee.

2. Click the **Proceed to Submit** button at the bottom of the **Table of Contents**.
 - The system navigates to the **Application - Submit Certify** page.
3. Click the **Submit to HRSA** button at the bottom of the **Application - Submit Certify** page to finally submit the application to HRSA.

Note: If you are not the AO, the system displays a **Submit to AO** button at the bottom of the **Application - Submit Certify** page. Click the button to notify the AO that the application can be submitted to HRSA. Only the AO can submit the application to HRSA.

4. To troubleshoot problems submitting the application, contact the BPHC Helpline at BPHCHelpline@hrsa.gov or 877-974-2742.