

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration		FOR HRSA USE ONLY				
		Grant Number		Application Tracking Number		
SUMMARY PAGE						
Summary Information						
1. I am applying as a new start applicant.						
Suggested Resource(s): Form 1A						
<input type="checkbox"/> Yes <input type="checkbox"/> No Note: <ul style="list-style-type: none"> • “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/supplemental applicant. 						
2. I am proposing the following sites, which will be open within 120 days of award:						
These are the NAP proposed sites and service area. If changes are required, revisit Form 5B.						
Site Name	Physical Street Address for Site	Service Site Type	Location Type	Service Area Zip Codes		
3. Total number of unduplicated patients projected to be served in calendar year 2018 (by December 31, 2018):						
This is this NAP patient projection. If you are a satellite applicant, this figure will be added to your Patient Target. If changes are required, revisit Form 1A.						
4. I am requesting for the following types of Health Center funding:						
This is this NAP Federal funding request. If changes are required, revisit Form 1A and/or Form 1B.						
Type of Health Center	Program	Operational funds for Year 1 (a)	Operational funds for Year 2 (b)	Funding Population % for Year 2 (c)	Number of Patients at 12/31/2018 (d)	Federal Dollars per Patient (e=b/d)
Community Health Centers	CHC-330 (e)					
Health Care for the Homeless	HCH-330 (h)					
Migrant Health Centers	MHC-330 (g)					
Public Housing Primary Care	PHPC-330 (i)					
Total						

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5. I am requesting the following amount for one-time funding:		
This is this NAP one-time Federal funding request. If changes are required, revisit Form 1B.		
One time funding requested for Year 1: <input type="checkbox"/> Equipment Only <input type="checkbox"/> Minor alteration/renovation with equipment <input type="checkbox"/> Minor alteration/renovation without equipment <input type="checkbox"/> N/A		
6. Total number of full time equivalent (FTE) staff at full capacity:		
This is this proposed FTE staff for the NAP project. If changes are required, revisit Form 2.		
7. Total score from Form 9, Need for Assistance worksheet:		
The converted score represents up to 20 points of the 30 available points in the Need section. If changes are required, revisit Form 9.		
NFA Score: Converted Score:		
Certification		
<input type="checkbox"/> 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 in calendar year 2018 (by December 31, 2018).		

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915 0285. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-29, Rockville, Maryland, 20857.