Form Approved
OMB No.0990-0221
Exp. Date 01/31/2014

TITLE X FAMILY PLANNING ANNUAL REPORT

FORMS AND INSTRUCTIONS

U.S. Department of Health and Human Services
Office of Public Health and Science
Office of Population Affairs
Office of Family Planning

REISSUED OCTOBER 2007

Form Approved
OMB No.0990-0221
Exp. Date 01/31/2014

EFFECTIVE JANUARY 2005
REISSUED OCTOBER 2007

NOTE

Title X service grantees are to use the 2007 version of the *Family Planning Annual Report: Forms and Instructions (Reissued October 2007)* to report FPAR data for the 2010 reporting period (January 1–December 31, 2010) by February 15, 2011. Grantees that submit data electronically using the FPAR reporting module on GrantSolutions.gov should submit the 2010 FPAR data using the tables as posted.

Form Approved
OMB No.0990-0221
Exp. Date 01/31/2014

TABLE OF CONTENTS

PAPERWORK REDUCTION ACT (PRA) PUBLIC BURDEN STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-0221. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OIRM/PRA, 200 Independence Ave., S.W., Suite 336–E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer.

This page intentionally left blank.

INTRODUCTION

This annual reporting requirement is for family planning services delivery projects authorized and funded under the Population Research and Voluntary Family Planning Programs (Section 1001 of Title X of the Public Health Service Act, 42 United States Code [USC] 300).[1] The Office of Family Planning (OFP) within the Office of Population Affairs (OPA) administers the Title X Family Planning Program.

Annual submission of the Family Planning Annual Report (FPAR) is required of all Title X family planning services grantees for purposes of monitoring and reporting program performance (45 Code of Federal Regulations [CFR] Part 74[2] and 45 CFR Part 92[3]). FPAR data are presented in summary form, which protects the confidentiality of individuals who receive Title X-funded services (42 CFR Part 59).[4]

The FPAR is the only source of annual, uniform reporting by all Title X family planning services grantees. It provides consistent, national-level data on the Title X Family Planning Program and its users. Information from the FPAR is important to OPA for several reasons. First, FPAR data are used to monitor compliance with statutory requirements, regulations, and operational guidance set forth in the *Program Guidelines for Project Grants for Family Planning Services ("Program Guidelines")*,[5] which include:

- Monitoring compliance with legislative mandates, such as giving priority in the provision of services to low-income persons [Section 1006(c) of Title X of the Public Health Service Act, 42 USC 300], and
- Ensuring that Title X grantees and their subcontractors provide a broad range of family planning methods and services [Section 1001(a) of Title X of the Public Health Service Act, 42 USC 300].

Second, OPA uses FPAR data to comply with accountability and federal performance requirements for Title X family planning funds as required by the 1993 Government Performance and Results Act (GPRA). Current GPRA performance goals for the Title X Family Planning Program include priority in the provision of family planning services to low-income individuals, access to and utilization of cervical and breast cancer screening, and access to on-site human immunodeficiency virus (HIV) testing at Title X-funded clinics.

Finally, OPA relies on FPAR data to guide strategic and financial planning, to monitor performance, and to respond to inquiries from policymakers and Congress about the program. The FPAR allows OPA to assemble comparable and relevant program data to answer questions about the characteristics of the population served by Title X projects, utilization of services offered, composition of revenues, and program impact. FPAR data are the basis for objective grant reviews, program evaluation, and assessment of program technical needs.

---

[1] Retrieved February 28, 2011, from http://www.hhs.gov/opa/familyplanning/toolsdocs/xstatut.pdf

[2] Retrieved February 28, 2011, from http://www.hhs.gov/opa/grants/toolsdocs/45cfr74.pdf

[3] Retrieved February 28, 2011, from http://www.hhs.gov/opa/grants/toolsdocs/45cfr92.pdf

[4] Retrieved February 28, 2011, from http://www.hhs.gov/opa/familyplanning/toolsdocs/ofp_regs_42cfr59_10-1-2000.pdf

[5] *Program Guidelines for Project Grants for Family Planning Services,* January 2001, Bethesda, MD: U.S. Department of Health and Human Services, Office of Public Health and Science/Office of Population Affairs/Office of Family Planning, 30 p. Retrieved February 28, 2011, from http://www.hhs.gov/opa/familyplanning/toolsdocs/index.html

- This version of the FPAR consists of a Grantee Profile Cover Sheet and 14 tables. The data collected include demographic, social, and economic user characteristics; utilization of family planning and related preventive health services; utilization of health personnel; and project revenues. New FPAR data elements include information on such user characteristics as health insurance coverage and limited English proficiency (LEP); utilization of contraception and related preventive health services by male family planning users; summary Pap (abnormal) and confidential HIV (positive) test results; and disease-specific information on sexually transmitted disease (STD) screening.

GENERAL INSTRUCTIONS

This section provides general instructions for completing the FPAR. They should be used in conjunction with the table-specific instructions, and are cross-referenced as appropriate.

WHO SUBMITS AN FPAR

Grantees funded under Section 1001 of the Title X Public Health Service Act (42 USC 300) should prepare and submit the FPAR. The family planning services grantee is the direct recipient of the Title X grant. Delegates or subcontractors to the grantee receive Title X funds via the grantee. Delegate or subcontractor agencies should **not** submit an FPAR report; rather, they should follow the instructions provided to them by the grantee.

SCOPE OF ACTIVITIES REPORTED IN THE FPAR

The purpose of the FPAR is to provide a comprehensive view of the family planning activities within the scope of the grantee's Title X-funded project. Family planning services grantees should report the total, unduplicated number of users, encounters, and other outputs from activities that are within the scope of a grantee's approved grant application. **If you have questions about whether to include certain data in this report, contact your Regional Program Consultant (RPC).** An updated list of RPCs can be found on the OPA/OFP website at http://www.hhs.gov/opa/familyplanning/rcontacts/rcontacts_rpc.html.

SUBMITTING THE FPAR

The FPAR should be prepared and submitted no later than **February 15** after the end of the reporting period. If February 15 falls on a weekend, the FPAR is due on the following Monday.

The FPAR can be submitted electronically or in hardcopy. The two options for electronic submission include the OPA *GrantSolutions* System (encouraged) or as an electronic file attached to an e-mail message. Grantees should select one of the following methods.

PAPER SUBMISSION – Submit **three (3)** paper copies of the complete FPAR to the RPC for your region.

E-MAIL SUBMISSION – Attach **one (1)** electronic file to an e-mail message and mail **one (1)** paper copy of the complete FPAR to the RPC for your region.

GRANTSOLUTIONS SUBMISSION – Follow the instructions in the *GrantSolutions Applicant Manual* for preparing and submitting the FPAR.

Current RPC postal and e-mail addresses are available on the OPA/OFP website at http://www.hhs.gov/opa/familyplanning/rcontacts/rcontacts_rpc.html.

SUBMITTING REVISED FPAR TABLES

Grantees should consult with their RPC regarding any region-specific requirements and/or deadlines for submitting revised FPAR tables. To ensure that data from revised tables are included in the national *Family Planning Annual Report*, grantees should submit revised tables by **April 1**.

Grantees submitting revised FPAR tables may submit the revised table(s) using any of the following methods, regardless of the method used to submit the initial tables.

PAPER SUBMISSION – Submit **three (3)** paper copies of the revised table(s) to your RPC. Indicate that the table is a revised submission by checking the appropriate box in the table header (top of the page). Include a completed Grantee Profile Cover Sheet with each set of revised tables.

E-MAIL SUBMISSION – Attach **one (1)** electronic file to an e-mail message and mail **one (1)** paper copy of the revised table(s) to your RPC. Indicate that the table is a revised submission by checking the appropriate box in the table header (top of the page). Include a completed Grantee Profile Cover Sheet with each set of revised tables.

GRANTSOLUTIONS SUBMISSION – Follow the instructions in the *GrantSolutions Applicant Manual* for revising and resubmitting one or more FPAR tables.

FPAR CONSISTENCY

To improve FPAR consistency (1) do not leave any cells blank—if the value for the cell is zero, enter "0"; and (2) do not report percentages—enter only whole numbers.

The numbers reported in Table 1 of the hardcopy of the FPAR will serve as a reference for consistency checkpoints in subsequent tables in the report. The values in these tables are identified with unique, double-letter identifiers (i.e., AA, BB, and CC). The *GrantSolutions* system also has built-in consistency checks to ensure that key cells in each table are consistent with one another.

If additional written information accompanies the table, or if one or more figures in the table are estimated rather than actual, use the "See Notes" box or use the "Notes" option in *GrantSolutions*. For each note, please indicate the table and cell to which the note applies. For estimated figures, describe the rationale and method for generating the estimate.

FPAR IDENTIFICATION

Key identifying information must be reported on all FPAR tables, including the Grantee Profile Cover Sheet. This information includes:

FPAR NUMBER – Enter the **four-digit** number assigned to the grantee by the regional Department of Health and Human Services (HHS) office. Do **not** use your HHS grant number.

DATE SUBMITTED – Specify the date that your agency (i.e., grantee) submits the report.

REPORTING PERIOD – The reporting period for the FPAR is the **calendar** year (i.e., **January 1 through December 31**). Title X grantees that begin operating after January 1 or stop operating before December 31 should indicate which portion of the year their Title X-funded projects are active.

INITIAL SUBMISSION OR REVISION – Check the appropriate box at the top of each table, indicating whether the table is an initial or revised submission. If you submit the FPAR using *GrantSolutions*, follow the instructions in the *GrantSolutions Applicant Manual* for indicating whether a table is an initial or revised submission.

TERMS AND DEFINITIONS

Definitions for key FPAR terms are provided to ensure uniform reporting among Title X grantees. The terms describe the individuals receiving family planning and related preventive health services at Title X-funded service sites, the range and scope of the services provided, and the family planning providers who render care.

FAMILY PLANNING USER

A family planning user is an individual who has at least one family planning encounter at a Title X service site during the reporting period. The same individual may be counted as a family planning user only once during a reporting period. Grantees should follow the table-specific instructions to identify applicable users.

FAMILY PLANNING PROVIDER

A family planning provider is the individual who assumes primary responsibility for assessing a client and documenting services in the client record. Providers include those agency staff that exercise independent judgment as to the services rendered to the client during an encounter. Two general types of providers deliver Title X family planning services: clinical services providers and non-clinical services providers.

CLINICAL SERVICES PROVIDER – Includes physicians (family and general practitioners, specialists), physician assistants, nurse practitioners, certified nurse midwives, and other licensed health providers (e.g., registered nurses) who are trained and permitted by state-specific regulations to perform *all aspects* of the user (male and female) physical assessment, as described in Section 8.3 of the *Program Guidelines.*[6] Clinical services providers are able to offer client education,[7] counseling,[8] referral,[9] follow-up,[9] and/or clinical services (physical assessment, treatment, and management) relating to a client's proposed or adopted method of contraception, general reproductive health, or infertility treatment.

NON-CLINICAL SERVICES PROVIDER – Includes other agency staff (e.g., nurses, health educators, social workers, or clinic aides) that are able to offer client education,[7] counseling,[8] referral,[9] and/or follow-up[9] services relating to the client's proposed or adopted method of contraception, general reproductive health, or infertility treatment. Non-clinical services providers may also perform or obtain samples for routine laboratory tests (e.g., urine, pregnancy, STD, and cholesterol and lipid analysis),[6] give contraceptive injections (e.g., Depo Provera), and perform routine clinical procedures that may include *some aspects* of the user physical assessment (e.g., blood pressure evaluation), as described in Section 8.3 of the *Program Guidelines*.[6]

---

[6] Refer to "8.3 History, Physical Assessment, and Laboratory Testing" in *Program Guidelines*, pp. 21–23 (see footnote 5).

[7] Refer to "8.1 Client Education" in *Program Guidelines*, pp. 17–18 (see footnote 5).

[8] Refer to "8.2 Counseling" in *Program Guidelines*, pp. 18–19 (see footnote 5).

[9] Refer to "7.4 Referrals and Follow-up" in *Program Guidelines*, p. 16 (see footnote 5).

FAMILY PLANNING ENCOUNTER

A family planning encounter is a documented, face-to-face contact between an individual and a family planning provider that takes place in a Title X service site. The purpose of a family planning encounter—whether clinical or non-clinical—is to provide family planning and related preventive health services to female and male clients who want to avoid unintended pregnancies or achieve intended pregnancies. To be counted for purposes of the FPAR, a written record of the service(s) provided during the family planning encounter must be documented in the client record.

There are two types of family planning encounters at Title X service sites: (1) family planning encounters with a clinical services provider and (2) family planning encounters with a non-clinical services provider. The type of family planning provider who renders the care, regardless of the services rendered, determines the type of family planning encounter.

FAMILY PLANNING ENCOUNTER WITH A CLINICAL SERVICES PROVIDER – A face-to-face, documented encounter between a family planning client and a clinical services provider that takes place in a Title X service site.

FAMILY PLANNING ENCOUNTER WITH A NON-CLINICAL SERVICES PROVIDER – A face-to-face, documented encounter between a family planning client and a non-clinical services provider that takes place in a Title X service site.

Laboratory tests and related counseling and education, in and of themselves, do not constitute a family planning encounter unless there is face-to-face contact between the client and provider, the provider documents the encounter in the client's record, and the test(s) is/are accompanied by family planning counseling or education.

FAMILY PLANNING SERVICE SITE

A family planning service site refers to an established unit where grantee or delegate agency staff provides Title X services (clinical, counseling, educational, and/or referral) that comply with the Title X *Program Guidelines,* and where at least some of the encounters between the family planning provider(s) and the individual(s) served meet the requirements of a *family planning encounter*. Established units include clinics, hospital outpatient departments, homeless shelters, detention and correctional facilities, and other locations where Title X agency staff provides these family planning services. Service sites may also include equipped mobile vans or schools.

CLIENT RECORDS

Title X projects **must** establish a medical record for every client who obtains clinical services or other screening or laboratory services (e.g., blood pressure check, urine-based pregnancy or STD test). The medical record contains personal data; a medical history; physical exam data; laboratory test orders, results, and follow-up; treatment and special instructions; scheduled revisits; informed consent forms; documentation of refusal of services; and information on allergies and untoward reactions to identified drug(s). The medical record also contains clinical findings; diagnostic and therapeutic orders; and documentation of continuing care, referral, and follow-up. The medical record allows for entries by counseling and social service staff. The medical record is a confidential record, accessible only to authorized staff and secured by lock when not in use. The client medical record **must** contain sufficient

information to identify the client, indicate where and how the client can be contacted, justify the clinical impression or diagnosis, and warrant the treatment and end results.[10]

If a family planning user receives no clinical services, a record still must be established for that client. Like a medical record, this client record **must** contain sufficient information to identify the client, indicate where and how the client can be contacted, and document fully the encounter. This record is confidential, accessible only to authorized staff, and secured by lock when not in use.

QUESTIONS ABOUT FPAR TERMS AND DEFINITIONS

1. **QUESTION –** Can a client have more than one family planning encounter during a single family planning visit?

   ANSWER – A client may have **only one** family planning encounter **per visit.** In the family planning services setting, the term "encounter" is synonymous with "visit." Although a client may meet with both clinical and non-clinical family planning providers during an encounter, only one provider is credited with the encounter. The provider with the highest level of training who takes ultimate responsibility for the client's clinical or non-clinical assessment and care during the visit is credited with the encounter.

2. **QUESTION –** If an individual receives gynecological or related preventive health services (e.g., pelvic exam, Pap test, pregnancy test, STD screening) in a Title X-funded clinic, but does not receive services aimed at avoiding unintended pregnancy or achieving intended pregnancy (e.g., contraceptive or fertility counseling), is the encounter considered a family planning encounter?

   ANSWER – If a client is an ongoing family planning user who visits the clinic to obtain any type of family planning or related preventive health services, the encounter is considered a family planning encounter.

   If a client has been sterilized, but continues to seek gynecological or related preventive health services, the encounter is considered a family planning encounter and the agency may continue to count the client as a family planning user.

   If a client obtains gynecological or related preventive health services, but the client is neither an ongoing family planning user nor seeks or receives services (clinical, counseling, educational, and/or referral) to help avoid unintended pregnancy or achieve intended pregnancy, the encounter is not a family planning encounter and the client is not a family planning user.

   If a post-menopausal client obtains gynecological or related preventive health services, the encounter is not a family planning encounter and the client is not a family planning user.

3. **QUESTION –** If a clinic medical aide is trained and authorized to give contraceptive injections (e.g., Depo Provera), should an agency report the aide as an "other" clinical services provider?

   ANSWER – No. For FPAR reporting purposes, a clinic medical aide is defined as a non-clinical services provider even though he or she may be trained and authorized to give contraceptive injections.

[10] Refer to "10.3 Medical Records" in *Program Guidelines*, pp. 28–29 (see footnote 5).

This page intentionally left blank.

GRANTEE PROFILE COVER SHEET

The Grantee Profile Cover Sheet provides important contact and summary information about each grantee and the network of service providers supported through the Title X grant. A completed Grantee Profile Cover Sheet must accompany the initial submission of the FPAR, as well as submission of any revised tables.

INSTRUCTIONS

GRANTEE LEGAL NAME – Provide the name of the legal recipient of the Title X family planning services grant.

ADDRESS OF GRANTEE ADMINISTRATIVE OFFICES – Provide the grantee's complete address, including nine-digit zip code.

TITLE X PROJECT DIRECTOR – Provide the name, title, mailing address, phone and fax numbers, and e-mail address for the agency representative responsible for directing the grantee's Title X project.

GRANTEE CONTACT PERSON (PERSON COMPLETING FPAR) – Provide the name, title, mailing address, phone and fax numbers, and e-mail address for the agency representative with primary responsibility for preparing the FPAR.

NUMBER OF DELEGATES/SUBCONTRACTORS SUPPORTED BY THE TITLE X GRANT – Report the number of delegate or subcontractor agencies that receive funding through the grantee's Title X service grant.

NUMBER OF FAMILY PLANNING SERVICE SITES SUPPORTED BY THE TITLE X GRANT – Report the total number of family planning service sites supported by the Title X grant and represented in the FPAR data. A family planning service site refers to an established unit where grantee or delegate agency staff provides Title X services (clinical, counseling, educational, and/or referral) that comply with the Title X *Program Guidelines,* and where at least some of the encounters between the family planning provider(s) and the individual(s) served meet the requirements of a *family planning encounter*. Established units include clinics, hospital outpatient departments, homeless shelters, detention and correctional facilities, and other locations where Title X agency staff provides these family planning services. Service sites may also include equipped mobile vans or schools.

If the number of service sites supported by the Title X grant is different from the number provided in the grant application, the grantee should check the box in the last row of the Cover Sheet, check the "See Notes" box, and explain the reason for this difference in the reported number of service sites.

QUESTIONS ABOUT THE GRANTEE PROFILE

1. **QUESTION –** If agency staff provides Title X services at a clinic and two non-clinic sites, should the agency report a total of one or three service sites on the Grantee Profile Cover Sheet?

   ANSWER – For purposes of the FPAR, the agency should count and report any established unit, clinic or non-clinic, where its staff provides Title X services and where at least some of the encounters between the family planning provider(s) and the individual(s) served meet the requirements of a *family planning encounter*. OPA assumes that each of the sites reported in the Grantee Profile contributes data to the FPAR. If all three sites in this example contribute data to the FPAR, the agency should report three service sites on the Grantee Profile Cover Sheet.

Form Approved
OMB No.0990-0221
Exp. Date 01/31/2014

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

GRANTEE PROFILE COVER SHEET

GRANTEE LEGAL NAME		
ADDRESS OF GRANTEE ADMINISTRATIVE OFFICES	Street	
	City	
	State	Zip code –
TITLE X PROJECT DIRECTOR	Name	
	Title	
	Street	
	City	
	State	Zip code –
	Phone	
	Fax	
	E-Mail	
GRANTEE CONTACT PERSON (PERSON COMPLETING FPAR)	Name	
	Title	
	Street	
	City	
	State	Zip code –
	Phone	
	Fax	
	E-Mail	
NUMBER OF DELEGATES/SUBCONTRACTORS SUPPORTED BY THE TITLE X GRANT		
NUMBER OF FAMILY PLANNING SERVICE SITES SUPPORTED BY THE TITLE X GRANT	_____	[ ] Check if total numberof sites is different from application (Provide explanation)

FAMILY PLANNING USER DEMOGRAPHIC PROFILE

Data reported in Tables 1 through 3 allow program administrators to monitor access to and use of Title X services among the diverse population these projects aim to serve. Tables 1, 2, and 3 describe the demographic characteristics of family planning users, including the distribution of users by age, gender, ethnicity, and race.

The numbers reported in Table 1 serve as a reference for consistency checkpoints in subsequent tables in the report. The values in these tables are identified with **unique, double-letter identifiers** (i.e., AA, BB, and CC).

INSTRUCTIONS

TABLE 1 – Report the **unduplicated number of family planning users** by age group and gender.

TABLE 2 – Report the **unduplicated number of *female* family planning users** by race and ethnicity.

TABLE 3 – Report the **unduplicated number of *male* family planning users** by race and ethnicity.

TERMS AND DEFINITIONS

AGE GROUP – Categorize family planning users based on their age as of June 30th of the reporting period.

ETHNICITY AND RACE – The categories for reporting ethnicity and race in the FPAR conform to the Office of Management and Budget (OMB) 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*,[11] and are used by other HHS programs and compilers of such national data sets as the National Survey of Family Growth. If an agency wants to collect data for ethnic or race subcategories, the agency must be able to aggregate the data reported into the OMB minimum standard set of ethnicity and race categories.

OMB encourages self-identification of race. When respondents are allowed to self-identify or self-report their race, agencies should adopt a method that allows respondents to mark or select more than one of the five minimum race categories. Appendix A to this form provides general guidance and a list of resources regarding collection of multi-race responses.

The **two** minimum OMB categories for reporting ethnicity are:

HISPANIC OR LATINO (ALL RACES) – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

NOT HISPANIC OR LATINO (ALL RACES) – A person **not** of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

[11] Office of Management and Budget, October 30, 1997, *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*, *Federal Register Notice*. Retrieved February 28, 2011, from http://www.whitehouse.gov/omb/fedreg_race-ethnicity

The **five** minimum categories for reporting race are:

AMERICAN INDIAN OR ALASKA NATIVE – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

ASIAN – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

BLACK OR AFRICAN AMERICAN – A person having origins in any of the black racial groups of Africa.

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

WHITE – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

QUESTIONS ABOUT TABLES 1 TO 3

1. **QUESTION –** How are these tables different from the previous FPAR?

   ANSWER – In the revised FPAR, the age, ethnicity, and racial characteristics of family planning users are reported using three tables instead of two as in the previous FPAR.

2. **QUESTION –** What if a client does not self-identify with any of the OMB minimum standard race categories?

   ANSWER – According to the 1997 OMB guidance, all races are represented in Tables 2 and 3, and technically every client should be included in one of these categories. Nevertheless, agency staff must respect the client's right to not report his or her race. Agencies should report the number of users with missing or unknown race information in the "unknown/not reported" race category. Agency staff should be familiar with the OMB definitions for each race category so that they can assist clients who may have questions. Further, agencies should consider providing the definition of each race category in their data collection forms if space and formatting permit.

   Hispanic or Latino clients account for a high proportion of family planning users for whom race data are unknown (i.e., not reported). The structure of Tables 2 and 3 will allow OPA to identify the number of female and male Hispanic or Latino clients who do not report race data.

3. **QUESTION –** What if a client self-identifies with more than one of the OMB minimum race categories?

   ANSWER – According to the 1997 OMB guidance, when self-identification is used agencies should adopt a data collection method that allows respondents to self-report more than one race. Appendix A to this form provides general guidelines and a sample question for collecting multi-race responses. Please note that the information in Appendix A is not comprehensive, and serves only to highlight important considerations and ideas for handling multi-race response. Agencies interested in issues surrounding collection of race data should consult the resource list in Appendix A.

Form Approved
OMB No.0990-0221
Exp. Date 01/31/2014

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

TABLE 1
UNDUPLICATED NUMBER OF FAMILY PLANNING USERS BY AGE AND SEX

	AGE GROUP (YEARS)	FEMALE USERS (A)	MALE USERS (B)	TOTAL USERS (SUM COLS A + B) (C)
1	Under 15			
2	15–17			
3	18–19			
4	20–24			
5	25–29			
6	30–34			
7	35–39			
8	40–44			
9	Over 44			
10	TOTAL USERS (SUM ROWS 1 TO 9)			
		↓ CHECKPOINT REFERENCE **AA**	↓ CHECKPOINT REFERENCE **BB**	↓ CHECKPOINT REFERENCE **CC**

Form Approved
OMB No.0990-0221
Exp. Date 01/31/2014

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

TABLE 2
UNDUPLICATED NUMBER OF FEMALE FAMILY PLANNING USERS BY ETHNICITY AND RACE

	RACE	HISPANIC OR LATINO (A)	NOT HISPANIC OR LATINO (B)	UNKNOWN/ NOT REPORTED (C)	TOTAL FEMALE USERS (SUM COLS A + B + C) (D)
1	American Indian or Alaska Native				
2	Asian				
3	Black or African American				
4	Native Hawaiian or Other Pacific Islander				
5	White				
6	More than one race				
7	Unknown/not reported				
8	**TOTAL FEMALE USERS (SUM ROWS 1 TO 7)**				

↓
SEE CHECKPOINT REFERENCE AA

Form Approved
OMB No.0990-0221
Exp. Date 01/31/2014

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

TABLE 3
UNDUPLICATED NUMBER OF MALE FAMILY PLANNING USERS BY ETHNICITY AND RACE

	RACE	HISPANIC OR LATINO (A)	NOT HISPANIC OR LATINO (B)	UNKNOWN/ NOT REPORTED (C)	TOTAL MALE USERS (SUM COLS A + B + C) (D)
1	American Indian or Alaska Native				
2	Asian				
3	Black or African American				
4	Native Hawaiian or Other Pacific Islander				
5	White				
6	More than one race				
7	Unknown/not reported				
8	**TOTAL MALE USERS (SUM ROWS 1 TO 7)**				

↓
SEE CHECKPOINT REFERENCE BB

This page intentionally left blank.

FAMILY PLANNING USER ECONOMIC AND SOCIAL PROFILE

The data reported in Tables 4, 5, and 6 provide OPA with information on key social and economic characteristics of individuals who receive family planning and related preventive health care in Title X-funded clinics. OPA uses these data to monitor the program's role as a social safety net health provider for individuals who confront financial or sociocultural barriers to care due to low income, lack of health insurance, or limited English proficiency (LEP). In addition, OPA uses these data to assess the program's compliance with legislative or regulatory mandates, including priority care to individuals who are low-income, and ensuring meaningful access to clients with LEP. [12]

INSTRUCTIONS

TABLE 4 – Report the **unduplicated number of family planning users** by income level.

TABLE 5 – Report the **unduplicated number of family planning users** by their principal health insurance coverage status.

TABLE 6 – Report the **unduplicated number of family planning users** with LEP.

TERMS AND DEFINITIONS

INCOME LEVEL AS A PERCENTAGE OF THE HHS POVERTY GUIDELINES – Grantees are required to collect income data on all users at least annually. In determining user income, agencies should use the poverty guidelines updated periodically in the *Federal Register* by HHS under the authority of 42 USC 9902(2).[13] Report the unduplicated number of users by income level, using the most current income information available.

PRINCIPAL HEALTH INSURANCE COVERING PRIMARY MEDICAL CARE – Refers to public and private health insurance plans that provide a **broad set of primary medical care benefits** to enrolled individuals. Report the most current health insurance coverage information available for the client even though he or she may not have used this health insurance to pay for family planning services received during his or her last encounter. For individuals who have coverage under more than one health plan, **principal insurance** is defined as the insurance plan that the agency would bill first (i.e., primary) if a claim were to be filed. Categories of health insurance covering primary medical care include public and private sources of coverage.

PUBLIC HEALTH INSURANCE COVERING PRIMARY MEDICAL CARE – Refers to federal, state, or local government health insurance programs that provide a **broad set of primary medical care benefits** for eligible individuals. Examples of such programs include Medicaid (both regular and managed

[12] See U.S. Department of Health and Human Services, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons ("Revised HHS LEP Guidance")*, August 8, 2003, *Federal Register,* 68(153), 47311–47323. Retrieved February 28, 2011, from http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html

[13] See U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Poverty Guidelines, Research, and Measurement*. Retrieved February 28, 2011, from http://aspe.hhs.gov/poverty/index.shtml

care), Medicare, state Children's Health Insurance Programs (CHIPs), and health plans for military personnel and their dependents (e.g., TRICARE or CHAMPVA).

PRIVATE HEALTH INSURANCE COVERING PRIMARY MEDICAL CARE – Refers to health insurance coverage through an employer, union, or direct purchase that provides a **broad set of primary medical care benefits** for the enrolled individual (beneficiary or dependent).

(OPTIONAL) PRIVATE HEALTH INSURANCE COVERAGE FOR FAMILY PLANNING SERVICES – Title X grantees have the **option** of reporting additional information on the level of private health insurance coverage for family planning services. Family planning services are defined broadly as any services—physical exam, lab tests, counseling and education, contraceptive supplies, and/or prescription medication—that a client receives during a family planning encounter with a clinical or non-clinical services provider. Levels of family planning coverage are defined as follows:

PRIVATE INSURANCE/ALL OR SOME FAMILY PLANNING SERVICES COVERAGE – The user reports that his or her private health insurance plan **covers all or some family planning services**.

PRIVATE INSURANCE/NO FAMILY PLANNING SERVICES COVERAGE – The user reports that his or her private health insurance plan **covers no family planning services**.

PRIVATE INSURANCE/UNKNOWN FAMILY PLANNING SERVICES COVERAGE – The user reports that he or she **does not know about family planning service coverage** under his or her private health insurance plan.

UNINSURED – Refers to clients who **do not have a public or private health insurance plan that covers broad, primary medical care benefits**. Clients whose services are subsidized through state or local indigent care programs, or clients insured through the Indian Health Service who obtain care in a non-participating facility, are considered uninsured.

LIMITED ENGLISH PROFICIENCY (LEP) – Refers to clients whose native or dominant language is not English and whose skills in listening to, speaking, reading, or writing English are such that they derive little benefit from family planning and related preventive health services provided in English.[14] In Table 6, report the unduplicated number of family planning users who required oral language assistance services to optimize their use of Title X services. Include those users who received family planning and related preventive health services from bilingual staff or who were assisted by a competent agency or contracted interpreter. Also include users who opted to use a family member or friend as interpreter after refusing an agency's offer to provide a qualified interpreter at no cost to the user. Agencies should consult the *Revised HHS LEP Guidance,* referenced in footnote 12, for further information about identifying LEP individuals who need language assistance.

ENGLISH PROFICIENCY – Refers to an individual's adeptness at English, as indicated by reading skills (the ability to comprehend and interpret text); listening skills (the ability to understand verbal expressions of the language); writing skills (the ability to produce written text with content and format); and speaking skills (the ability to use oral language appropriately and effectively).[15]

---

[14] Adapted from the U.S. Department of Education, *Survey of Classes that Serve Children Prior to Kindergarten in Public Schools*, p. 1. Retrieved February 28, 2011, from http://nces.ed.gov/surveys/frss/publications/2003019/pdf/questionnaire.pdf.

[15] Adapted from the U.S. Department of Education National Center for Education Statistics (NCES). *Nonfiscal Data Handbook for Early Childhood, Elementary, and Secondary Education*, p. 10. Retrieved February 28, 2011, from http://nces.ed.gov/pubs2003/2003419f.pdf.

NATIVE LANGUAGE – Refers to the language or dialect first learned by an individual or first used by the parent/guardian with a child. The terms "native" and "primary" language are used interchangeably.[16]

DOMINANT LANGUAGE – Refers to the language or dialect an individual best understands and with which he or she is most comfortable. A person may be dominant in one language in some situations and dominant in another language in other situations.[17]

INTERPRETER COMPETENCE – Competency to interpret does not necessarily mean formal certification as an interpreter, although certification is helpful. To be considered competent, interpreters must:

- Demonstrate proficiency in and ability to communicate information accurately in both English and in the other language, and identify and employ the appropriate mode of interpreting;
- Have knowledge in both languages of any specialized family planning or reproductive health terms or concepts, and of any particularized vocabulary and phraseology used in the LEP person's country of origin;
- Understand and follow confidentiality and impartiality rules to the same extent as the recipient employee for whom they are interpreting and/or to the extent their position requires; and
- Understand and adhere to their role as interpreter without deviating into other roles—such as counselor or legal advisor—where such deviation would be inappropriate.[18]

QUESTIONS ABOUT TABLES 4 TO 6

1. **QUESTION –** How are these tables different from the previous FPAR?

   ANSWER – The table on distribution of users by income level (Table 4) extends from 100% and below the HHS poverty guidelines to more than 250% of the guidelines. The income range in the previous FPAR extended to only 200% of the guidelines. Further, the revised FPAR includes two additional tables on the health insurance coverage status and English language proficiency of family planning users. Together, this set of tables provides information on the extent to which individuals with financial and other social barriers to preventive health services, including family planning, utilize Title X-funded services.

2. **QUESTION –** If a client has private health insurance that covers a broad set of primary medical care benefits, including some or all family planning services, but he or she chooses not to use his or her health insurance plan to pay for some or all of the cost of services, how should an agency classify this client for purposes of Table 5 reporting?

   ANSWER – Although an insured client may elect not to use his or her health insurance to pay for services, he or she is considered insured and should be reported in either Row 1 or Row 2 of the table according to type of health coverage (public or private).

---

[16] See footnote 15.

[17] See footnote 15.

[18] Adapted from *Revised HHS LEP Guidance*, p. 47316 (see footnote 12).

3. **QUESTION –** Are Title X agencies required to verify client health insurance status and, if insured, the level of family planning service coverage under the health plan?

   ANSWER – No. The information required to complete Table 5 is based on clients' self-reported insurance coverage. Other than asking clients and recording their response, the agency should make no additional effort to verify coverage and levels of family planning service coverage unless clients intend to use their health insurance to pay for services rendered.

4. **QUESTION –** How do I classify a client who has coverage for a specific type of care or health condition—for example, dental services or expanded Medicaid coverage under the Breast and Cervical Cancer Prevention and Treatment Act of 2000—but has no health insurance that provides a broad set of primary medical care benefits?

   ANSWER – Users who do not have a health insurance plan that provides a broad set of primary medical care benefits, even though they may have coverage for a specific condition, are considered uninsured.

5. **QUESTION –** If a client has coverage for family planning services under a Medicaid family planning expansion program (i.e., 1115 waiver demonstration project), is he or she considered insured for purposes of FPAR reporting?

   ANSWER – A **client is insured** if (1) he or she is enrolled in a Medicaid family planning expansion program that covers a **broad set of primary medical care benefits**, in addition to family planning, or (2) he or she is enrolled in a Medicaid expansion program that covers only family planning services and he or she has coverage under another plan that covers a **broad set of primary medical care benefits**.

   A **client is uninsured** if he or she is enrolled in a Medicaid family planning expansion program that covers only family planning services and he or she has no coverage under another plan that covers a **broad set of primary medical care benefits**.

   Title X grantees operating in states where the family planning expansion program is limited to family planning services may check the "See Notes" box for Table 5 if they wish to provide clarifying remarks.

6. **QUESTION –** In Table 6 should an agency report clients who received care from a bilingual provider in their preferred, non-English language?

   ANSWER – In Table 6 report the number of users who are **best served** in a language other than English, including clients who received care from bilingual providers in their preferred, non-English language; clients for whom competent agency or contracted interpreters were required; and clients for whom friends or family members served as interpreters.

7. **QUESTION –** Is it permissible to allow friends, family, or minor children to serve as interpreters?

   ANSWER – According to the August 2003 HHS guidance, "…when a recipient encounters an LEP person attempting to access its services, the recipient should make the LEP person aware that he or she has the option of having the recipient provide an interpreter for him or her without charge, or of using his or her own interpreter. Although recipients should not plan to rely on an LEP person's family members, friends, or other informal interpreters to provide meaningful access to

important programs and activities, the recipient should, except as noted below, respect an LEP person's desire to use an interpreter of his or her own choosing (whether a professional interpreter, family member, or friend) in place of the free language services expressly offered by the recipient. However, a recipient may not require an LEP person to use a family member or friend as an interpreter."[19]

Confidentiality, privacy, conflicts of interest, and competence as a medical services interpreter are several limitations of using family members or friends as interpreters in the Title X clinic setting. While in some cases an individual with LEP may feel more comfortable when a trusted family member or friend acts as an interpreter, the family member or friend may not be competent to provide quality and accurate interpretations, particularly if the service provided is complex and/or not of a routine nature. If a client opts to provide his or her own interpreter, and the service provider determines at any point during the service that the client's interpreter is not competent in this role, the service provider should obtain the services of a competent interpreter.

[19] *Revised HHS LEP Guidance*, p. 47317 (see footnote 12).

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

TABLE 4
UNDUPLICATED NUMBER OF FAMILY PLANNING USERS BY INCOME LEVEL

	INCOME LEVEL AS A PERCENTAGE OF THE HHS POVERTY GUIDELINES	NUMBER OF USERS (A)
1	100% and below	
2	101%–150%	
3	151%–200%	
4	201%–250%	
5	Over 250%	
6	Unknown/not reported	
7	**TOTAL USERS (SUM ROWS 1 TO 6)**	

SEE CHECKPOINT REFERENCE CC

Form Approved
OMB No.0990-0221
Exp. Date 01/31/2014

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

TABLE 5
UNDUPLICATED NUMBER OF FAMILY PLANNING USERS BY PRINCIPAL HEALTH INSURANCE COVERAGE STATUS

	PRINCIPAL HEALTH INSURANCE COVERING PRIMARY MEDICAL CARE		NUMBER OF USERS (A)
1	Public health insurance covering primary medical care		
2	Private health insurance covering primary medical care **(SUM ROWS 2a TO 2c)**		
2a	(Optional) Coverage for all or some family planning services		
2b	(Optional) Coverage for no family planning services		
2c	(Optional) Coverage unknown for family planning services		
3	Uninsured (no public or private health insurance)		
4	Unknown/not reported		
5	**TOTAL USERS (SUM ROWS 1 TO 4)**		

SEE CHECKPOINT REFERENCE CC

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

TABLE 6
UNDUPLICATED NUMBER OF FAMILY PLANNING USERS WITH LIMITED ENGLISH PROFICIENCY (LEP)

		NUMBER OF USERS (A)
1	***Number of users*** with limited English proficiency (LEP)	

FAMILY PLANNING METHOD USE

Title X projects are required to provide a broad range of acceptable and effective family planning methods and services.[20] Tables 7 and 8 provide gender- and age-specific information on the types of family planning methods that clients use to prevent unintended pregnancy. The method, age, and gender data allow OPA to compare the data from Title X clinics with other sources of information, including the National Survey of Family Growth. These data also permit OPA to track patterns in method use over time at the state, regional, and national levels; to examine the extent to which Title X providers contribute to increased access to and use of newer family planning technologies; and to assess the program's contribution to Healthy People 2010 objectives.

INSTRUCTIONS

TABLE 7 – Report the **unduplicated number of female family planning users** by primary method and age.

TABLE 8 – Report the **unduplicated number of male family planning users** by primary method and age.

TERMS AND DEFINITIONS

AGE – Use the client's age as of June 30th of the reporting period.

PRIMARY METHOD OF FAMILY PLANNING – The primary method of family planning is the user's method—adopted or continued—at the time of exit from his or her last encounter in the reporting period. If the user reports that he or she is using more than one family planning method, report the most effective one as the primary method. Family planning methods include:

FEMALE STERILIZATION – Refers to surgical (tubal ligation) or non-surgical (Essure™ implants) sterilization procedures performed on a female user in the current or any previous reporting period. In Table 7, report the number of female users who rely on female sterilization as their primary family planning method.

INTRAUTERINE DEVICE (IUD) – In Table 7, report the number of female users who use a long-term hormonal or other type of intrauterine device (IUD) or system as their primary family planning method.

HORMONAL IMPLANT – In Table 7, report the number of female users who use a long-term, subdermal hormonal implant as their primary family planning method.

1-MONTH HORMONAL INJECTION – In Table 7, report the number of female users who use 1-month injectable hormonal contraception as their primary family planning method.

3-MONTH HORMONAL INJECTION – In Table 7, report the number of female users who use 3-month injectable hormonal contraception as their primary family planning method.

ORAL CONTRACEPTIVE – In Table 7, report the number of female users who use any oral contraceptive, including combination and progestin-only ("mini-pills") formulations, as their primary family planning method.

[20] See 42 CFR Part 59.5(a)(1) (see footnote 4).

HORMONAL/CONTRACEPTIVE PATCH – In Table 7, report the number of female users who use a transdermal hormonal contraceptive patch as their primary family planning method.

VAGINAL RING – In Table 7, report the number of female users who use a hormonal vaginal ring as their primary family planning method.

CERVICAL CAP/DIAPHRAGM – In Table 7, report the number of female users who use a cervical cap or diaphragm (with or without spermicidal jelly or cream) as their primary family planning method.

CONTRACEPTIVE SPONGE – In Table 7, report the number of female users who use a contraceptive sponge as their primary family planning method.

FEMALE CONDOM – In Table 7, report the number of female users who use female condoms (with or without spermicidal foam or film) as their primary family planning method.

SPERMICIDE (USED ALONE) – In Table 7, report the number of female users who use only spermicidal jelly, cream, foam, or film (i.e., not in conjunction with another method of contraception) as their primary family planning method.

FERTILITY AWARENESS METHOD (FAM) – Refers to family planning methods that rely on identifying potentially fertile days in each menstrual cycle when intercourse is most likely to result in a pregnancy. Fertility awareness methods include rhythm/calendar, Standard Days™, Basal Body Temperature, Cervical Mucus, and Sympto-Thermal methods. In Tables 7 and 8, report the number of users who use one or a combination of the FAMs listed above as their primary family planning method. Post-partum women who are practicing the lactational amenorrhea method (LAM) should also be reported with users of fertility awareness methods in Tables 7 and 8.

ABSTINENCE – For purposes of FPAR reporting, abstinence is defined as refraining from oral, vaginal, and anal intercourse. In Table 7, report the number of female users who rely on abstinence as their primary family planning method or who are not currently sexually active and therefore not using contraception. In Table 8, report the number of male users who rely on abstinence as their primary family planning method or who are not currently sexually active.

OTHER METHOD – In Tables 7 and 8, report the number of female and male users, respectively, who use withdrawal or other methods not listed in the tables as their primary family planning method.

METHOD UNKNOWN – In Tables 7 and 8, report the number of users for whom documentation exists that the users adopted or continued use of a family planning method, but information about the specific method(s) used is unavailable.

NO METHOD–[PARTNER] PREGNANT OR SEEKING PREGNANCY – In Tables 7 and 8, report the number of users who are not using any family planning method because they (Table 7) or their partners (Table 8) are pregnant or seeking pregnancy.

NO METHOD–OTHER REASON – In Tables 7 and 8, report the number of users who are not using any family planning method to avoid pregnancy due to reasons other than pregnancy or seeking pregnancy, including if either partner is sterile without having been sterilized surgically.

VASECTOMY – Refers to conventional incisional or no-scalpel vasectomy performed on a male user, or the male partner of a female user, in the current or any previous reporting period. In Table 7, report the number of female users who rely on vasectomy as their (partner's) primary family planning method. In Table 8, report the number of male users on whom a vasectomy was performed in the current or any previous reporting period.

MALE CONDOM – In Table 7, report the number of female users who rely on their sexual partner to use male condoms (with or without spermicidal foam or film) as their primary family planning method. In

Table 8, report the number of male users who use male condoms (with or without spermicidal foam or film) as their primary family planning method.

RELY ON FEMALE METHOD(S) – In Table 8, report the number of male family planning users who rely on their female partner's family planning method(s) as their primary method. "Female" contraceptive methods include female sterilization, IUDs, hormonal implants, 1- and 3-month hormonal injections, oral contraceptives, hormonal/contraceptive patches, vaginal rings, cervical caps/diaphragms, contraceptive sponges, female condoms, and spermicides.

QUESTIONS ABOUT TABLES 7 AND 8

1. **QUESTION –** How are these tables different from the previous FPAR?

   ANSWER – Changes to the collection of primary family planning method data in the FPAR include the addition of a new table (Table 8) for reporting primary family planning method use among male users, the addition of new, FDA-approved family planning methods to the list for female users (Table 7), and collection of data on primary method use by age group.

2. **QUESTION –** If family planning users, male or female, rely on their partners' family planning method for pregnancy prevention, how should the grantee report this information in Tables 7 or 8?

   ANSWER – If a female family planning user relies on a "male" family planning method (e.g., vasectomy or male condoms) for pregnancy prevention, report this user on Row 19 or 20 of Table 7, respectively. If the female user relies on withdrawal, report this user on Row 15 of Table 7 (other method).

   If a male client relies on a "female" family planning method for pregnancy prevention, report this client on Row 9 of Table 8 if his partner's method is female sterilization, IUD, hormonal implant, 1- or 3-month hormonal injection, oral contraceptives, hormonal/contraceptive patch, vaginal ring, cervical cap or diaphragm, contraceptive sponge, female condoms, or spermicide.

   If a male client and his female sexual partner rely on pills (for pregnancy prevention) and condoms (for STD or pregnancy prevention), record the method that is most effective in terms of pregnancy prevention (i.e., pills). In this example, the male user's family planning method would be "rely on female method" (Table 8, Row 9).

   If this same male client were to report that he relies on condoms for pregnancy prevention because of his partner's inconsistent pill use, report male condoms (Table 8, Row 2) as the client's primary contraceptive method.

Form Approved
OMB No.0990-0221
Exp. Date 01/31/2014

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

TABLE 7
UNDUPLICATED NUMBER OF FEMALE FAMILY PLANNING USERS BY PRIMARY METHOD AND AGE

	PRIMARY METHOD	UNDUPLICATED NUMBER OF FEMALE USERS BY AGE									TOTAL FEMALE USERS (SUM COLS A TO I) (J)
		< 15 (A)	15–17 (B)	18–19 (C)	20–24 (D)	25–29 (E)	30–34 (F)	35–39 (G)	40–44 (H)	> 44 (I)	
1	Female sterilization										
2	Intrauterine device (IUD)										
3	Hormonal implant										
4	1-Month hormonal injection										
5	3-Month hormonal injection										
6	Oral contraceptive										
7	Hormonal/contraceptive patch										
8	Vaginal ring										
9	Cervical cap/diaphragm										
10	Contraceptive sponge										
11	Female condom										
12	Spermicide (used alone)										
13	Fertility awareness method (FAM)										
14	Abstinence										
15	Other method										
16	Method unknown										
NO METHOD											
17	Pregnant or seeking pregnancy										
18	Other reason										
RELY ON MALE METHOD											
19	Vasectomy										
20	Male condom										
21	**TOTAL FEMALE USERS (SUM ROWS 1 TO 20)**										

SEE CHECKPOINT REFERENCE AA

Form Approved
OMB No.0990-0221
Exp. Date 01/31/2014

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

TABLE 8
UNDUPLICATED NUMBER OF MALE FAMILY PLANNING USERS BY PRIMARY METHOD AND AGE

	PRIMARY METHOD	UNDUPLICATED NUMBER OF MALE USERS BY AGE									TOTAL MALE USERS (SUM COLS A TO I) (J)
		< 15 (A)	15–17 (B)	18–19 (C)	20–24 (D)	25–29 (E)	30–34 (F)	35–39 (G)	40–44 (H)	> 44 (I)	
1	Vasectomy										
2	Male condom										
3	Fertility awareness method (FAM)										
4	Abstinence										
5	Other method										
6	Method unknown										
	NO METHOD										
7	Partner pregnant or seeking pregnancy										
8	Other reason										
9	**RELY ON FEMALE METHOD(S)**										
10	**TOTAL MALE USERS (SUM ROWS 1 TO 9)**										

SEE CHECKPOINT REFERENCE BB

This page intentionally left blank.

CERVICAL AND BREAST CANCER SCREENING

Tables 9 and 10 provide information on the cervical and breast cancer screening activities that are performed in Title X-funded clinics. Data from these tables permit OPA to monitor compliance with legislative mandates, measure achievement of program performance objectives, and assess the program's contribution to national health objectives (i.e., Healthy People 2010) related to early cancer detection and health promotion. Data from these tables are also used to monitor the number of abnormal results that require further follow-up by Title X providers.

INSTRUCTIONS

TABLE 9 – Report the following information on cervical cancer screening activities. Refer to the chart in Exhibit 1 for reporting information on Pap test results.

- Unduplicated number of users who obtained a Pap test.
- Number of Pap tests performed.
- **Number of Pap tests** with an ASC or higher result, including ASC-US, ASC-H, LSIL, HSIL, AGC, adenocarcinoma, and presence of endometrial cells in a woman 40 years of age or over *(see Exhibit 1)*.
- **Number of Pap tests** with an HSIL or higher result (i.e., HSIL, AGC, adenocarcinoma, and presence of endometrial cells in a woman 40 years of age or over) *(see Exhibit 1)*.

TABLE 10 – Report the following information on breast health screening and referral activities.

- **Unduplicated number of users** receiving a clinical breast exam (CBE).
- **Unduplicated number of users** referred for further evaluation based on CBE results.

TERMS AND DEFINITIONS

TESTS – Report Pap tests and CBEs that are documented in the client medical record and provided within the scope of the agency's Title X project during the reporting period.

ATYPICAL SQUAMOUS CELLS (ASC) – ASC refers to cytological changes that are suggestive of a squamous intraepithelial lesion. The 2001 Bethesda System *(see Exhibit 1)* subdivides atypical squamous cells into two categories:[21]

- Atypical squamous cells of undetermined significance (ASC-US) – Cytological changes that are suggestive of a squamous intraepithelial lesion, but lack criteria for a definitive interpretation.
- Atypical squamous cells, cannot exclude HSIL (ASC-H) – Cytological changes that are suggestive of a high-grade squamous intraepithelial lesion, but lack criteria for a definitive interpretation.

[21] T.C. Wright, Jr., J.T. Cox, L.S. Massad, L.B. Twiggs, E.J. Wilkinson, "2001 Consensus Guidelines for the Management of Women with Cervical Cytological Abnormalities," *Journal of the American Medical Association* Vol. 287, No. 16 (2002): 2122.

LOW-GRADE SQUAMOUS INTRAEPITHELIAL LESIONS (LSIL) – LSIL refers to low-grade squamous intraepithelial lesions encompassing human papillomavirus, mild dysplasia, and cervical intraepithelial neoplasia (CIN) 1 *(see Exhibit 1)*.[22]

HIGH-GRADE SQUAMOUS INTRAEPITHELIAL LESIONS (HSIL) – HSIL refers to high-grade squamous intraepithelial lesions encompassing moderate and severe dysplasia, carcinoma in situ, CIN 2, and CIN 3 *(see Exhibit 1)*.[23]

ATYPICAL GLANDULAR CELLS (AGC) – AGC refers to glandular cell abnormalities, including adenocarcinoma. The 2001 Bethesda System *(see Exhibit 1)* classifies AGC less severe than adenocarcinoma into three categories.[24]

- Atypical glandular cells, either endocervical, endometrial, or "glandular cells" not otherwise specified (AGC NOS).
- Atypical glandular cells, either endocervical or "glandular cells" favor neoplasia (AGC "favor neoplasia").
- Endocervical adenocarcinoma in situ (AIS).

QUESTIONS ABOUT TABLES 9 AND 10

1. **QUESTION –** Are there any changes to these tables?

   ANSWER – Yes. OPA is requesting additional information about the utilization and outcome of cervical and breast cancer screening activities that are performed within the scope of the agency's Title X project. This additional information includes information on the unduplicated number of female users that obtain a Pap test, the number of Pap tests with an ASC or higher result, the number of Pap tests with an HSIL or higher result, and the unduplicated number of clients who are referred for further evaluation based on their CBE. Pap test result reporting is based on the 2001 Bethesda System that is summarized in *Exhibit 1*.

2. **QUESTION –** What if the CBE appears on the clinic encounter form or "super bill" as part of a "bundled" billing or service code (e.g., as part of a comprehensive exam)?

   ANSWER – If an agency does not have a separate count of the number of CBEs performed due to the structure of the "bundled" billing/service code, report the *estimated* number of CBEs performed in Row 1 of Table 10, mark the "See Notes" box in the header of the table, and provide a brief explanation about the reported figure.

3. **QUESTION –** In Table 9, does the total number of Pap tests reported in Row 3 include tests reported in Row 4?

   ANSWER – Yes. In Table 9, Row 3 will include the tests reported in Row 4 because tests with a result of HSIL and higher are also tests with a result of ASC and higher.

---

[22] D. Solomon, D. Davey, R. Kurman, A. Moriarty, D. O'Connor, M. Prey, S. Raab, M. Sherman, D. Wilbur, T. Wright, Jr., and N. Young, "The 2001 Bethesda System: Terminology for Reporting Results of Cervical Cytology," *Journal of the American Medical Association* Vol. 287, No. 16 (2002): 2116.

[23] See footnote 22.

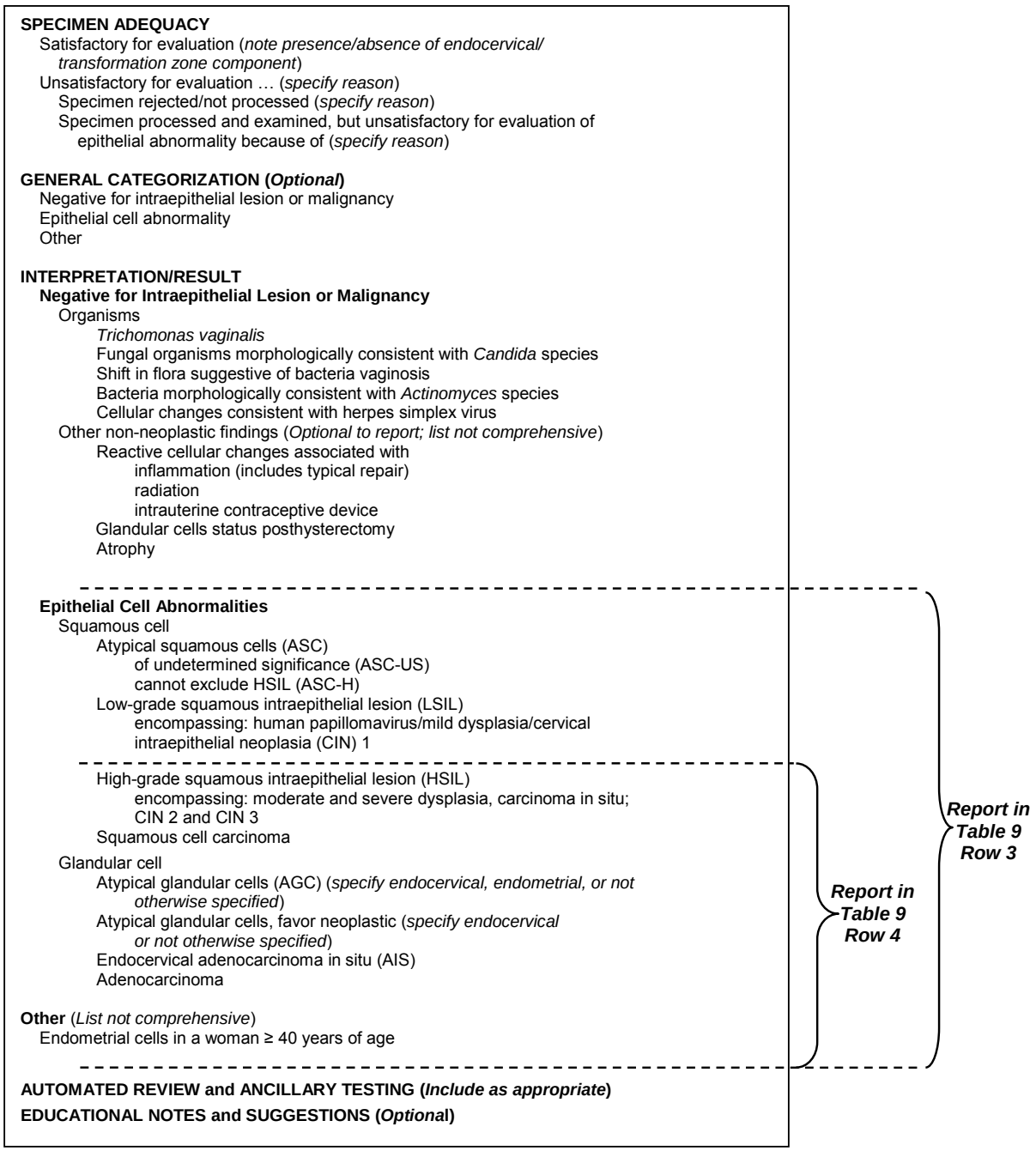
[24] Wright et al., p. 2124 (see footnote 21).

4. **QUESTION –** How should a grantee complete Table 9 if it does not receive the results of Pap tests performed at the end of the reporting period in time to be included in the FPAR?

   ANSWER – Agencies have two options for dealing with delayed Pap test results. Under the first option, the agency can report the Pap testing (Table 9, Rows 1 and 2) and results (Table 9, Rows 3 and 4) figures that are available at the time it prepares the FPAR. If results data for Pap tests performed at the end of the reporting period are delayed, check the "See Notes" box, and explain that the figures reported in Rows 3 and 4 are estimated rather than actual due to delayed laboratory reporting.

   Under the second option, the agency can report testing and results data for a 12-month period that has complete results data and is close in time to the reporting period. For example, if Pap testing and results data are complete for the 12-month period from December to November, but not for January to December, report the figures for December to November, check the "See Notes" box, and explain that Table 9 data are for a different 12-month period than the reporting period. Consult your RPC if you have any questions about reporting Table 9 data when Pap testing results are delayed.

EXHIBIT 1. THE 2001 BETHESDA SYSTEM (Abridged)



Source: Solomon, D., Davey, D., Kurman, R., Moriarty, A., O'Connor, D., Prey, M., et al. (2002). The 2001 Bethesda System: Terminology for reporting results of cervical cytology. *Journal of the American Medical Association,* 287(16), 2116. (Copyright 2002, American Medical Association. All rights reserved. Reprinted with permission.)

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

TABLE 9
CERVICAL CANCER SCREENING ACTIVITIES

	SCREENING ACTIVITY	NUMBER OF USERS OR NUMBER OF TESTS (A)
1	***Unduplicated number of users*** who obtained a Pap test	
2	***Number of Pap tests*** performed	
3	***Number of Pap tests*** with an ASC or higher result	
4	***Number of Pap tests*** with an HSIL or higher result	

Form Approved
OMB No.0990-0221
Exp. Date 01/31/2014

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

TABLE 10
CLINICAL BREAST EXAMS AND REFERRALS

	SCREENING ACTIVITY	NUMBER OF USERS (A)
1	***Unduplicated number of users*** who received a clinical breast exam (CBE)	
2	***Unduplicated number of users*** referred for further evaluation based on their CBE	

SEXUALLY TRANSMITTED DISEASE (STD) SCREENING

Tables 11 and 12 provide information on the utilization of STD testing services provided in Title X clinics. Data from these tables permit OPA to monitor compliance with legislative mandates, measure achievement of program performance objectives, and assess the program's contribution to national health objectives for disease prevention (e.g., STDs and HIV) and health promotion.

INSTRUCTIONS

TABLE 11 – Report the **unduplicated number of family planning users** tested for chlamydia by age group (under 15, 15–17, 18–19, 20–24, and 25 and over) and gender.

TABLE 12 – Report the **number of gonorrhea, syphilis, and HIV tests** performed by gender.

Report the **number of positive, confidential HIV tests** and the **number of anonymous HIV tests** performed.

TERMS AND DEFINITIONS

AGE – Use the client's age as of June 30th of the reporting period.

TESTS – Report STD (chlamydia, gonorrhea, and syphilis) and HIV (confidential and anonymous) tests that an agency performs within the scope of its Title X project. Do not report tests performed in an STD clinic operated by the Title X-funded agency, unless the activities of the STD clinic are within the defined scope of the agency's Title X project.

QUESTIONS ABOUT TABLES 11 AND 12

1. **QUESTION –** Are there any changes to these tables?

   ANSWER – The revised FPAR requires that agencies report additional information about STD and HIV tests performed within the scope of their Title X projects, including gender- and age-specific information on users tested for chlamydia; gender-specific information on the number of gonorrhea, syphilis, and confidential HIV tests performed; information on the total number of confidential HIV tests that are positive; and information on the number of anonymous HIV tests performed. The revised FPAR table excludes STD test information for herpes simplex virus (HSV), hepatitis B virus (HBV), and trichomoniasis.

2. **QUESTION –** How should an agency complete Table 12 if the results for HIV tests performed at the end of the reporting period are not received in time to be included in the FPAR?

   ANSWER – An agency has two options for dealing with delayed HIV test results. Under the first option, the agency can report the HIV testing (Table 12, Row 3) and results (Table 12, Row 4) figures that are available at the time it prepares the FPAR. If results data for HIV tests performed at the end of the reporting period are delayed, check the "See Notes" box, and explain that the figure reported in Row 4 is estimated rather than actual due to delayed laboratory reporting.

   Under the second option, the agency can report testing and results data for a 12-month period that has complete results data and is close in time to the reporting period. For example, if HIV testing and results data are complete for the period December to November, but not for January to

December, report the figures for December to November, check the "See Notes" box, and explain that Table 12 data are for a different 12-month period than the reporting period. Consult your RPC if you have any questions about reporting Table 12 data when HIV testing results are delayed.

3. **QUESTION –** In Table 12 should an agency count and report confirmatory HIV tests separately from the initial HIV test (i.e., one versus two tests)?

   ANSWER – To the extent possible, an agency should report all HIV tests—initial and confirmatory—performed within the scope of its Title X project, including HIV tests performed onsite and tests for which a specimen is collected onsite and analyzed offsite (e.g., laboratory). If an offsite laboratory performs a confirmatory test using the same specimen obtained for the initial test, the agency should not count the confirmatory test unless (1) it has billing or other transaction records to document that the laboratory performed a second/confirmatory test and (2) compiling and reporting confirmatory test counts do not pose an undue burden. Agencies should check the "See Notes" box and explain if HIV test counts include or exclude confirmatory tests.

Form Approved
OMB No.0990-0221
Exp. Date 01/31/2014

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

TABLE 11
UNDUPLICATED NUMBER OF FAMILY PLANNING USERS TESTED FOR CHLAMYDIA BY AGE AND GENDER

AGE GROUP (YEARS)		NUMBER OF USERS	
		FEMALE USERS (A)	MALE USERS (B)
1	Under 15		
2	15–17		
3	18–19		
4	20–24		
5	25 and over		
6	**TOTAL USERS (SUM ROWS 1 TO 5)**		

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

TABLE 12
NUMBER OF GONORRHEA, SYPHILIS, AND HIV TESTS

	TEST TYPE	NUMBER OF TESTS		TOTAL TESTS (SUM COLS A + B) (C)
		FEMALE (A)	MALE (B)	
1	Gonorrhea			
2	Syphilis			
3	HIV – All confidential tests			
4	HIV – Positive confidential tests			
5	HIV – Anonymous tests			

FAMILY PLANNING ENCOUNTERS AND UTILIZATION OF CLINICAL SERVICES PROVIDERS

Table 13 provides information on the number and type of family planning encounters, as well as the utilization of clinical services providers in the delivery of Title X-funded family planning and related preventive health services.

INSTRUCTIONS

TABLE 13 – Report the following provider utilization and encounter data:

- **Number of full-time equivalent (FTE) family planning clinical services providers** by type of provider (*Column A)*.
- **Number of family planning encounters with clinical services providers** *(Column B, Row 1)*.
- **Number of family planning encounters with non-clinical services providers** *(Column B, Row 2)*.

TERMS AND DEFINITIONS

FAMILY PLANNING PROVIDER – A family planning provider is the individual who assumes primary responsibility for assessing a client and documenting services in the client record. Providers include those agency staff that exercise independent judgment as to the services rendered to the client during an encounter. Two general types of providers deliver Title X family planning services: clinical services providers and non-clinical services providers.

CLINICAL SERVICES PROVIDER – Includes physicians (family and general practitioners, specialists), physician assistants, nurse practitioners, certified nurse midwives, and other licensed health providers (e.g., registered nurses) who are trained and permitted by state-specific regulations to perform *all aspects* of the user (male and female) physical assessment, as described in Section 8.3 of the *Program Guidelines.*[25] Clinical services providers are able to offer client education,[26] counseling,[27] referral, [28] follow-up,[28] and/or clinical services (physical assessment, treatment, and management) relating to a client's proposed or adopted method of contraception, general reproductive health, or infertility treatment.

NON-CLINICAL SERVICES PROVIDER – Includes other agency staff (e.g., nurses, health educators, social workers, or clinic aides) that are able to offer client education,[26] counseling,[27] referral,[28] and/or follow-up[28] services relating to the client's proposed or adopted method of contraception, general reproductive health, or infertility treatment. Non-clinical services providers may also perform or obtain samples for routine laboratory tests (e.g., urine, pregnancy, STD, and cholesterol and lipid analysis),[25] give contraceptive injections (e.g., Depo Provera), and perform routine clinical procedures

[25] Refer to "8.3 History, Physical Assessment, and Laboratory Testing" in *Program Guidelines*, pp. 21–23 (see footnote 5).

[26] Refer to "8.1 Client Education" in *Program Guidelines*, pp. 17–18 (see footnote 5).

[27] Refer to "8.2 Counseling" in *Program Guidelines*, pp. 18–19 (see footnote 5).

[28] Refer to "7.4 Referrals and Follow-up" in *Program Guidelines*, p. 16 (see footnote 5).

that may include *some aspects* of the user physical assessment (e.g., blood pressure evaluation), as described in Section 8.3 of the *Program Guidelines*.[25]

FAMILY PLANNING ENCOUNTER – A family planning encounter is a documented, face-to-face contact between an individual and a family planning provider that takes place in a Title X service site. The purpose of a family planning encounter—whether clinical or non-clinical—is to provide family planning and related preventive health services to female and male clients who want to avoid unintended pregnancies or achieve intended pregnancies. To be counted for purposes of the FPAR, a written record of the service(s) provided during the family planning encounter must be documented in the client record.

There are two types of family planning encounters at Title X service sites: (1) family planning encounters with a clinical services provider and (2) family planning encounters with a non-clinical services provider. The type of family planning provider who renders the care, regardless of the services rendered, determines the type of family planning encounter.

FAMILY PLANNING ENCOUNTER WITH A CLINICAL SERVICES PROVIDER – A face-to-face, documented encounter between a family planning client and a clinical services provider that takes place in a Title X service site.

FAMILY PLANNING ENCOUNTER WITH A NON-CLINICAL SERVICES PROVIDER – A face-to-face, documented encounter between a family planning client and a non-clinical services provider that takes place in a Title X service site.

Laboratory tests and related counseling and education, in and of themselves, do not constitute a family planning encounter unless there is face-to-face contact between the client and provider, the provider documents the encounter in the client's record, and the test(s) is/are accompanied by family planning counseling or education.

FULL-TIME EQUIVALENT (FTE) – For each type of **clinical services provider**, report the time in FTEs that these providers are involved in the direct provision of Title X services (i.e., engaged in a family planning encounter).

QUESTIONS ABOUT TABLE 13

1. **QUESTION –** How is this table different from the previous FPAR?

   ANSWER – The revised table includes data for family planning encounters with both clinical and non-clinical services providers, and has expanded the types of clinical services providers to include other licensed health providers (e.g., registered nurses) who are trained and permitted by state-specific regulations to perform *all aspects* of the user (male and female) physical assessment, as described in Section 8.3 of the *Program Guidelines*. Further, agencies will no longer be required to report the number of encounters by type of clinical services provider. Instead, agencies will report the total number of family planning encounters with clinical services providers and the total number of family planning encounters with non-clinical services providers.

2. **QUESTION –** Can a client have more than one family planning encounter during a single family planning visit?

   ANSWER – As noted in the "Terms and Definitions" section of the report, a client may have **only one** family planning encounter **per visit**. In the family planning services setting, the term "encounter" is synonymous with "visit." Although a client may meet with both clinical and non-clinical family planning providers during an encounter, only one provider is credited with the encounter. The provider with the highest level of training who takes ultimate responsibility for

the client's clinical or non-clinical assessment and care during the visit is credited with the encounter.

3. **QUESTION –** If an individual receives gynecological or related preventive health services (e.g., pelvic exam, Pap test, pregnancy test, STD screening) in a Title X-funded clinic, but does not receive services aimed at avoiding unintended pregnancy or achieving intended pregnancy (e.g., contraceptive or fertility counseling), is the encounter considered a family planning encounter?

   ANSWER – If a client is an ongoing family planning user who visits the clinic to obtain any type of family planning or related preventive health services, the encounter is considered a family planning encounter.

   If a client has been sterilized, but continues to seek gynecological or related preventive health services, the encounter is considered a family planning encounter and the agency may continue to count the client as a family planning user.

   If a client obtains gynecological or related preventive health services, but the client is neither an ongoing family planning user nor seeks or receives services (clinical, counseling, educational, and/or referral) to help avoid unintended pregnancy or achieve intended pregnancy, the encounter is not a family planning encounter and the client is not a family planning user.

   If a post-menopausal client obtains gynecological or related preventive health services, the encounter is not a family planning encounter and the client is not a family planning user.

Form Approved
OMB No.0990-0221
Exp. Date 01/31/2014

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

TABLE 13
NUMBER OF FAMILY PLANNING ENCOUNTERS BY TYPE OF PROVIDER

	PROVIDER TYPE	NUMBER OF FTEs (A)	NUMBER OF FAMILY PLANNING ENCOUNTERS (B)
1	**CLINICAL SERVICES PROVIDERS**		
1a	Physicians		
1b	Physician assistants/nurse practitioners/ certified nurse midwives		
1c	Other clinical services providers (e.g., registered nurses)		
2	**NON-CLINICAL SERVICES PROVIDERS**		
3	**TOTAL FAMILY PLANNING ENCOUNTERS (SUM ROWS 1 + 2)**		

REVENUE REPORT

Title X grantees are required to maintain a financial management system that meets the standards for grant administration, and to document and keep records of all income and expenditures.[29] Table 14 identifies the source and amount of funds received during the reporting period that support activities within the scope of the grantee's Title X family planning services grant.

INSTRUCTIONS

TABLE 14 – Report the revenues (i.e., actual *cash* receipts or *drawdown* amounts) received during the reporting period, by funding source, even if the funds were not expended during the reporting period. Include (1) all receipts from federal grants; (2) collections from patients and third parties for services rendered; and (3) receipts from other sources such as state and local funds. If the value for a cell is zero, enter "0." The agency must retain for audit purposes all worksheets that document how the agency derived the reported amounts.[30]

TERMS AND DEFINITIONS

FEDERAL GRANTS (Rows 1–5) – Refers to funds the grantee received **directly** from the federal government. Do **not** include federal funds that were first received by a state government, local government, or other agency and then passed on to the grantee.

TITLE X GRANT (Row 1) – Enter the amount received during the reporting period from the Title X grant. Do not enter the amount of grant funds awarded unless this figure is the same as the actual *cash* receipts or *drawdown* amounts.

BUREAU OF PRIMARY HEALTH CARE (BPHC) (Row 2) – Specify the amount of revenue received from BPHC grants (e.g., Section 330) during the reporting period that supported services within the scope of the grantee's Title X project.

OTHER FEDERAL GRANT (Rows 3–4) – Specify the amount and source of any other federal grant revenue received during the reporting period that supported services within the scope of the grantee's Title X project.

PAYMENT FOR SERVICES (Rows 6–9) – Refers to revenues from public and private third parties (capitated or fee-for-service) and funds collected directly from clients.

TOTAL CLIENT COLLECTIONS/SELF-PAY (Row 6) – Report the amount collected directly from clients during the reporting period for services rendered within the scope of the grantee's Title X project.

THIRD-PARTY PAYERS (Rows 7a–7e) – For each third-party source listed, enter the amount of funds received during the reporting period for services rendered within the scope of the grantee's Title X project. Only revenue from pre-paid (capitated) managed care arrangements (e.g., capitated Medicare, Medicaid, and private managed care contracts) should be reported as "pre-paid." Revenues received after the service was rendered, even under managed care arrangements, should be reported as "not pre-paid."

[29] As specified in 45 CFR Part 74 and 45 CFR Part 92 (see footnotes 2 and 3).

[30] See footnote 29.

MEDICAID (Row 7a) – Grantees should report as "Medicaid" all services paid for by Medicaid (Title XIX) regardless of whether they were paid directly by Medicaid or through a fiscal intermediary or a health maintenance organization (HMO). For example, in states with a capitated Medicaid program (i.e., the grantee has a contract with a private plan like Blue Cross), the payer is Medicaid, even though the actual payment may come from Blue Cross. Report revenue from state-only Medicaid programs in accordance with the services covered by the state plan. Report revenue (Federal and State shares) from family planning waivers with other Medicaid revenue on row 7a, column B. If the amount reported on row 7a, column B includes family planning waiver revenue, indicate this in the table-specific comment field.

MEDICARE (Row 7b) – Grantees should report as "Medicare" all services paid for by Medicare (Title XVIII) regardless of whether they were paid directly by Medicare or through a fiscal intermediary or an HMO. For clients enrolled in a capitated Medicare program (i.e., where the grantee has a contract with a private plan like Blue Cross), the payer is Medicare, even though the actual payment may come from Blue Cross.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) (Row 7c) – Enter the amount of funds received in the reporting period from the non-Medicaid, state CHIPs for services rendered within the scope of the grantee's Title X project.

OTHER PUBLIC HEALTH INSURANCE (Row 7d) – Enter the amount of funds received in the reporting period from other federal, state, and/or local government health insurance programs for services rendered within the scope of the grantee's Title X project. Examples of other public third-party insurance programs include health insurance plans for military personnel and their dependents (e.g., TRICARE, CHAMPVA).

PRIVATE HEALTH INSURANCE (Row 7e) – Refers to health insurance provided by commercial and non-profit companies. Individuals may obtain health insurance through employers, unions, or on their own.

OTHER REVENUE (Rows 10–18) – Enter the amount of funds from contracts, state and local indigent care programs, and other public or private revenues that were received during the reporting period and that supported services within the scope of the grantee's Title X project.

TITLE V (MATERNAL AND CHILD HEALTH [MCH] BLOCK GRANT) (Row 10) – Enter the amount of Title V funds received during the reporting period that supported services within the scope of the grantee's Title X project.

TITLE XX (SOCIAL SERVICES BLOCK GRANT) (Row 11) – Enter the amount of Title XX funds received during the reporting period that supported services within the scope of the grantee's Title X project.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) (Row 12) – Enter the amount of TANF funds received during the reporting period that supported services within the scope of the grantee's Title X project.

LOCAL GOVERNMENT REVENUE (Row 13) – Enter the amount of funds from local government sources, including county and city grants or contracts that were received during the reporting period and that supported services within the scope of the grantee's Title X project.

STATE GOVERNMENT REVENUE (Row 14) – Enter the amount of funds from state government sources, including grants or contracts that were received during the reporting period and that supported services within the scope of the grantee's Title X project. CDC (e.g., IPP funds) and block grant funds awarded to and distributed by the state are not considered "state revenues." Report these revenues as "Other" and indicate the specific program source.

OTHER REVENUE (Rows 15–17) – Enter the amount and specify the source of funds received during the reporting period from other sources that supported services within the scope of the grantee's Title X project. This may include revenue from private grants and donations, fundraising, interest income, or other sources.

QUESTION ABOUT TABLE 14

1. **QUESTION –** How is this table different from the revenue table in the previous FPAR?

   ANSWER – In the revised FPAR, only federal funds that are distributed directly to the grantee are included under the heading of "Federal Grants," while federal funds that are distributed by the state under such programs as Title V, Title XX, and TANF are reported under the heading of "Other Revenue."

FPAR Number: _____

Date Submitted: _____

Reporting Period: January 1, 20_____through December 31, 20_____

_____through _____
(Month/day/year) *(Month/day/year)*

Check One: [ ] Initial Submission [ ] See Notes
[ ] Revision

TABLE 14
REVENUE REPORT

	FEDERAL GRANTS	AMOUNT	
1	Title X (family planning services)	$	
2	Bureau of Primary Health Care (BPHC)	$	
3	Other federal grant (Specify: _____)	$	
4	Other federal grant (Specify: _____)	$	
5	**TOTAL– FEDERAL GRANTS (SUM ROWS 1 TO 4)**	**$**	
	PAYMENT FOR SERVICES		
6	**Total client collections/self-pay**	**$**	
7	**Third-party payers**	**PREPAID (A)**	**NOT PRE-PAID (B)**
7a	Medicaid (Title XIX)	$	$
7b	Medicare (Title XVIII)	$	$
7c	State Children's Health Insurance Program (state CHIP)	$	$
7d	Other public health insurance	$	$
7e	Private health insurance	$	$
8	**TOTAL – THIRD-PARTY PAYERS (SUM ROWS 7a TO 7e)**	**$**	**$**
9	**TOTAL – PAYMENT FOR SERVICES (SUM ROW 6 + CELL 8A + CELL 8B)**	**$**	
	OTHER REVENUE		
10	Title V (MCH Block Grant)	$	
11	Title XX (Social Services Block Grant)	$	
12	Temporary Assistance for Needy Families (TANF)	$	
13	Local government revenue	$	
14	State government revenue	$	
15	Other (Specify:_____)	$	
16	Other (Specify:_____)	$	
17	Other (Specify:_____)	$	
18	**TOTAL– OTHER REVENUE (SUM ROWS 10 TO 17)**	**$**	
19	**TOTAL REVENUE (SUM ROWS 5 + 9 + 18)**	$	

NOTES

NOTES (CONTINUED)

ABBREVIATIONS AND ACRONYMS

AGC	atypical glandular cells
AGC NOS	atypical glandular cells, not otherwise specified
AIS	adenocarcinoma in situ
ASC	atypical squamous cells
ASC-H	atypical squamous cells, cannot exclude HSIL
ASC-US	atypical squamous cells of undetermined significance
BPHC	Bureau of Primary Health Care
CBE	clinical breast exam
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CIN	cervical intraepithelial neoplasia
FAM fertility	awareness method
FPAR	Family Planning Annual Report
FTE full-tim	e equivalent
GPRA Government	Performance and Results Act
HBV	hepatitis B virus
HHS	Department of Health and Human Services
HIV hum	an immunodeficiency virus
HMO	health maintenance organization
HSIL	high-grade squamous intraepithelial lesion
HSV	herpes simplex virus
IUD intrauterine	device
LAM lactational	amenorrhea method
LEP	limited English proficiency, limited English proficient
LSIL	low-grade squamous intraepithelial lesion
MCH	maternal and child health
OFP	Office of Family Planning
OMB	Office of Management and Budget
OPA	Office of Population Affairs
RPC	regional program consultant
STD	sexually transmitted disease
TANF	Temporary Assistance for Needy Families
USC	United States Code

APPENDIX A:
COLLECTING AND TABULATING MULTI-RACE RESPONSES

Background. On October 24, 1997, the Department of Health and Human Services (HHS) issued a *Policy Statement on Inclusion of Race and Ethnicity in DHHS Data Collection Activities*.[31] This policy requires the inclusion of racial and ethnic categories in HHS-funded and -sponsored data collection and reporting systems. Implementation of this policy is intended to help to identify major health conditions of minority populations, monitor progress in meeting their needs, and ensure nondiscrimination in access to and provision of appropriate HHS services for various racial and ethnic groups. Though programs that are directed to minority racial or ethnic populations have exemptions, they are encouraged to collect and report data on subgroups within their target populations.

The HHS inclusion policy refers to the Office of Management and Budget (OMB) 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*,[32] and any subsequent revisions, as the standard for racial and ethnic reporting categories in HHS-funded programs. The FPAR race and ethnicity categories comply with the 1997 OMB revised minimum standards.

Reporting more than one race. According to the 1997 OMB revised standards, when respondents are allowed to self-identify with or self-report more than one race:

- Agencies should adopt a method that allows respondents to mark or select more than one of the five minimum race categories.
- The method for respondents to report more than one race should take the form of *multiple responses* to a single question and *not* a single "multiracial" category.
- When a list of races is provided to respondents, the list should not contain a "multiracial" category.
- Based on research conducted so far, two recommended forms for the instruction accompanying the multiple-response question are "Mark one or more…" and "Select one or more…."
- If the criteria for data quality and confidentiality are met, provision should be made to report, at a minimum, the number of individuals identifying with more than one race. Data producers are encouraged to provide greater detail about the distribution of multiple responses.

Agencies are encouraged to consult with their Regional Program Consultant (RPC) if they have further questions about collecting multi-race responses. On the following page is a sample question, designed to be self-administered, for collecting race data. A list of references on this topic is also included.

---

[31] U.S. Department of Health and Human Services, October 24, 1997, *Policy Statement on Inclusion of Race and Ethnicity in DHHS Data Collection Activities*. Retrieved February 28, 2011, from http://aspe.hhs.gov/datacncl/inclusn.htm

[32] Office of Management and Budget, October 30, 1997, *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*, *Federal Register Notice*. Retrieved February 28, 2011, from http://www.whitehouse.gov/omb/fedreg_race-ethnicity

What is your race? Select one or more.

- _ **American Indian or Alaskan Native:** *A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.*
- _ **Asian:** *A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.*
- _ **Black or African American:** *A person having origins in any of the black racial groups of Africa.*
- _ **Native Hawaiian or Pacific Islander:** *A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.*
- _ **White:** *A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.*

References

Office of Management and Budget, March 9, 2000, "Guidance on Aggregation and Allocation of Data on Race for Use in Civil Rights Monitoring and Enforcement," *OMB Bulletin No. 00-02*. Retrieved February 28, 2011, from http://www.whitehouse.gov/omb/bulletins/b00-02.html

Office of Management and Budget, 2000, *Provisional Guidance on the Implementation of the 1997 Standards for Federal Data on Race and Ethnicity*. Retrieved February 28, 2011, from http://www.ofm.wa.gov/pop/race/omb.pdf

Office of Management and Budget, October 30, 1997, *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*, *Federal Register Notice*. Retrieved February 28, 2011, from http://www.whitehouse.gov/omb/fedreg_race-ethnicity

U.S. Census Bureau, 2001, "The Two or More Races Population: 2000," *Census 2000 Brief, No. C2KBR/01-6*. Retrieved February 28, 2011, from http://www.census.gov/prod/2001pubs/c2kbr01-6.pdf

U.S. Department of Health and Human Services, October 24, 1997, *Policy Statement on Inclusion of Race and Ethnicity in DHHS Data Collection Activities*. Retrieved February 28, 2011, from http://aspe.hhs.gov/datacncl/inclusn.htm