HRSA's New Scope of Project Policy Manual:

What It Means for Michigan Health Centers

Prepared by the Michigan Primary Care Association (MPCA) for member health centers. This guide summarizes HRSA's Health Center Program Scope of Project Policy Manual ("Scope Manual," last updated August 11, 2026) and compares it to the prior scope of project guidance it replaces, so your team can quickly see what has changed and what to review before your next change-in-scope (CIS) request.

Why This Matters

HRSA has consolidated years of separate scope of project guidance, Policy Information Notices (PINs) 2007-09, 2008-01, 2009-02, and 2009-05, into a single Scope of Project Policy Manual. This is not a revision of the Health Center Program Compliance Manual ("Compliance Manual"), which remains a separate, active 21-chapter document last substantively updated in 2018 with a technical revision in November 2025. The Scope Manual covers scope of project topics only, and it explicitly supersedes the four PINs listed below.

Much of the Scope of Project Policy Manual restates and modernizes existing policy rather than changing it outright. But it also introduces meaningful new requirements, numeric benchmarks, and organizational structure that Michigan health centers should build into their compliance and CIS planning now.

Effective dates run on two tracks. The policy in the Scope Manual took effect upon publication on August 11, 2026, so HRSA is evaluating current and future CIS requests against the new standards now. EHB system changes and the Form 5A/5B migration follow on November 20, 2026, under Program Assistance Letter (PAL) 2026-04 (issued August 14, 2026).

A new Site Visit Protocol aligned with the Scope Manual is expected in February 2027; health centers with an Operational Site Visit scheduled before that date will continue to be evaluated under the current Site Visit Protocol. The Scope Manual does not separately restate an effective date beyond the publication date on its cover, so health centers with a CIS request already in progress should confirm timing directly with their Project Officer.

What the Scope Manual Replaces

The Scope Manual expressly supersedes four PINs, each issued 17 to 19 years ago. The table below shows where that subject matter now lives.

Superseded Guidance	Prior Subject Matter	Now Addressed In
PIN 2007-09	Service Area Overlap: Policy and Process	Chapter 6.A (Service Area Overlap Considerations) and Chapter 6.B (Factors for Adding a Service Site)
PIN 2008-01	Defining Scope of Project and Policy for Requesting Changes	Chapter 1 (Definition of Scope of Project and Overview) and Chapter 10 (Changes in Scope of Project)
PIN 2009-02	Specialty Services and Health Centers' Scope of Project	Chapter 3, Section D (Criteria Required for Additional Health Services)
PIN 2009-05	Policy for Special Populations-Only Grantees Requesting a CIS to Add a New Target Population	Chapter 10.C (Special Medically Underserved Population-Only Health Centers Adding a New Statutory Population)

Because the superseded PINs are retired, this mapping reflects where each subject now lives, not a line-by-line comparison. If your health center has relied on specific language or examples from one of these PINs, for example a numeric example under PIN 2007-09, confirm current expectations against the corresponding Scope Manual chapter rather than the retired PIN.

Guidance That Remains in Effect

Not every prior scope-related resource has been retired. Several PALs and one additional PIN continue to apply, and the Scope Manual cross-references them directly.

Guidance	Status Under the Scope Manual	Where Referenced
PAL 2020-01, Telehealth and Health Center Scope of Project	Remains in effect; telehealth policy is now integrated directly into the Scope Manual, but the PAL is cited for further considerations	Chapter 4, Services Provided via Telehealth
PAL 2020-05, Adding Temporary Sites for Emergency Events	Remains in effect for the streamlined request process; the Scope Manual adds formal eligibility criteria not previously stated in this form	Chapter 7, Temporary Service Sites Added in Response to Emergency Events
PAL 2024-01, Temporary Privileging of Clinical Providers	Remains in effect for FTCA-related privileging during emergencies	Chapter 7.B and Chapter 9 footnotes
PIN 2024-05 (TCCS)	Remains in effect; governs Transitional Care in a Carceral Setting locations	Chapter 5.A and 5.E, Other Sites, and Form 5B documentation

Guidance	Status Under the Scope Manual	Where Referenced
PIN 2011-02, Free Clinics FTCA Program Policy Guide	Remains in effect; referenced for the definition of licensed independent practitioner	Chapter 8.A, Providers
PAL 2026-04, Health Center Program Scope of Project System Improvements	Effective November 20, 2026; updates and supersedes five prior process PALs (PAL 2009-11, PAL 2013-03, PAL 2014-06, PAL 2014-07, PAL 2014-10); operationalizes the Scope Manual's Form 5A and Form 5B structure in HRSA's EHBs scope module	Form 5A: Services Provided and Form 5B: Sites, and the CIS checklist process referenced throughout Chapter 10

Effective November 20, 2026, HRSA will administratively migrate each health center's existing Form 5A and Form 5B data into updated formats; no action is required for the migration itself.

Two changes health centers should plan for ahead of that date:

- CIS requests to add a medically underserved population will move out of the scope module into a general HRSA Prior Approval module request
- A new Replace Service Site checklist will allow a health center to delete and add a comparable service site within a single CIS request

Health centers with migrant health, homeless, or public housing scope activity should also note that the "Intermittent" and "Migrant Voucher Screening" service site location types are being retired and recategorized as Seasonal or Permanent.

- New Form 5B scope adjustment options that do not require a formal CIS: removing a temporary site added for an emergency, updating a site's suite, floor, room, or building information, and adding or deleting an Other Site.
- PAL 2026-04, Appendix A designates twenty specific service-delivery-method combinations, nine involving required services and eleven involving additional services, as "self-updates" that require no formal HRSA review at all.

Key Terminology and Form Changes

Most updates align scope of project language with terms already used in the Compliance Manual and in statute. They are largely administrative, but they will show up throughout your Form 5A/5B submissions.

Prior	Current	Effect
Target population	Medically underserved population / special	Aligns vocabulary with statutory terms already used in the Compliance

Prior	Current	Effect
	medically underserved population; "patient population" for patients actually served	Manual; not a substantive eligibility change
Service sites (umbrella term)	"Sites," includes both Service Sites and Other Sites	Broadens the umbrella category so locations that do not meet the service-site definition, such as stand-alone pharmacy sites, still require a defined Form 5B entry
Form 5, Parts A - Services Provided / B – Service Sites / C – Other Locations and Activities	Form 5A: Services Provided Form 5B: Sites Form 5C Eliminated	Form 5C was eliminated and new parameters for activities for outside approved service sites, including when services may be provided to individuals who are not established health center patients.
Form 5A, **Column I**: Direct (Health Center Pays) **Column II**: Formal Written Contract/Agreement (Health Center Pays) **Column III**: Formal Written Referral Arrangement (Health Center Does NOT pay)	**Column I:** Direct **Column II:** Contracts/Subawards **Column III:** Cooperative Arrangements	Column labels updated to match the Scope Manual's terminology; effective November 20, 2026
Form 5B: Service Sites	"Other Site" site type on Form 5B, with three settings: - Administrative Site, - Patient Support Services Site, Pharmacy-Only Site	Confirms Form 5B's scope now formally includes service delivery sites and non-service-site locations. Give the "Sites" umbrella concept in the Scope Manual its operational form-level counterpart; effective November 20, 2026
"Established arrangement" (used interchangeably for contracts and cooperative arrangements)	Distinct "Contracts and Subawards" (Column II) and "Cooperative Arrangements" (Column III)	More precise separation of delivery methods, each with its own, in places expanded, list of required provisions
Specialty Services (separate category); Additional Enabling Services	Specialty Services integrated under Additional Services; renamed Additional Patient Support Services	Form-level implementation of the Scope Manual's consolidation of specialty services into Chapter 3.D; effective November 20, 2026

Form 5B also recognizes a third site type alongside Service Site and Other Site: the Transitional Care in a Carceral Setting (TCCS) Site, which comes with its own CIS checklist. Service site settings are refined to Freestanding, Co-located with Hospital, Co-located with School, Co-located with Behavioral Health Organization, Co-located with Domestic Violence Shelter, and Co-located with Another Organization. Location types are reduced to three: Permanent, Seasonal, and Mobile.

Substantive Changes Worth Flagging

Beyond consolidation and renaming, the Scope Manual introduces or formalizes several requirements that were not previously stated at this level of detail. These are the changes most likely to affect how your health center prepares a CIS request.

Service Area Overlap and Adding a Service Site

The underlying three-part service area test (size and accessibility, conformity to political and program boundaries, elimination of access barriers) and the requirement that Form 5B ZIP codes include at least 75 percent of current patients carry forward unchanged. What is new in Chapter 6 is specificity:

- Numeric, named benchmarks: a penetration rate above the 75th percentile of service areas, and named distance triggers, roughly 1 mile (urban) or 5 miles (rural) from another health center's site for added scrutiny, and roughly 15 miles (urban) or 30 miles (rural) from the existing service area for a different scrutiny.
- A formal community-input requirement for sites in a new service area: documented board-member consultation, a petition (2 percent or 200 residents, whichever is less), a statistically significant survey (100 residents at 90 percent confidence), or a comparable mechanism.
- Explicit factors for public housing–targeted sites under section 330(i), whether HRSA has previously disapproved a site at the same location, and a named factor for inaccurate, false, or misleading information in a proposal.

Health centers proposing sites near another center's service area, or in a new service area, should expect HRSA review to reference these named thresholds.

These items are part of an eleven-factor list in Chapter 6.B on which HRSA may request more information or disapprove a request to add a service site, including HRSA's Unmet Need Score.

Where Service Area Overlap Review Has Been Streamlined

PIN 2007-09's detailed service area overlap process, mapping, data gathering, and board-endorsed letters of support from neighboring health centers, is replaced by a two-factor test: the extent to which a proposed site serves an area where unmet need exceeds the capacity of existing sites or other safety net providers, and the degree to which the site will complement rather than duplicate existing services. Data requirements have decreased, and letters of support from neighboring providers are now optional supporting documentation rather than an expected step.

Contractor- and Subrecipient-Operated Sites

This is a genuinely new limitation. HRSA will not approve a new contractor- or subrecipient-operated service site unless the health center currently delivers General Primary Medical Care directly through its own employees or volunteers and directly operates at least one service site. A new, explicit "good cause justification" is also required to choose a contractor or subrecipient over direct operation. Health centers that do not currently meet this floor are not out of compliance retroactively, but cannot add further contractor- or subrecipient-operated sites until they add a directly operated one.

Two categories of health centers are excluded from this requirement: public agency award recipients whose co-applicant delivers services, and health centers funded solely under section 330(g). Existing contractor- and subrecipient-operated sites are grandfathered; no health center is required to close a site to comply. Selecting a contractor or subrecipient over direct operation now also requires a "good cause justification" documenting that entity's qualifications to operate the site on the health center's behalf.

Contracts, subawards, and cooperative arrangements are also now subject to mandatory provision checklists: nine required provisions for Contracts and Subawards (Column II), five for Cooperative Arrangements (Column III), and a further nine-item compliance checklist specific to contractor-operated sites, including a requirement that at least one person trained and certified in basic life support be present during regularly scheduled hours. Health centers should paper existing agreements against these lists.

Co-Located Service Sites (Chapter 6.C)

A health center operating at a location shared with another organization, for example a hospital, school, or behavioral health facility, must meet a defined set of criteria, including an agreement ensuring independent clinical and fiscal operations and a retrievable patient health record. A new operational requirement applies specifically to these sites: the health center must inform patients, through signage, information on its website, and direct verbal or written notice, that they are in a health center location and can access services regardless of ability to pay.

Telehealth Fully Integrated (Chapter 4)

Telehealth was not addressed in PIN 2008-01 at all; it previously lived only in PAL 2020-01. The Scope Manual now defines telehealth as a service delivery mechanism, with a formal criteria list covering patient location, intake documentation, and continued service after a patient leaves the service area, and a defined concept of areas "adjacent" to the service area.

The Manual sets six criteria for telehealth delivery, covering a documented intake process, steps to determine and record patient location and comply with licensure, confirmation that the service is in scope, patient location in or a resident of the service area or an adjacent area, delivery on behalf of the health center by a provider who may be located anywhere, and a patient health record documenting each visit. An established patient who moves outside the service area or an adjacent

area may continue receiving telehealth for a limited period, the Manual's example is up to one year, subject to licensure requirements.

Providers, Patients, and Visits (Chapter 8)

The Manual broadens the definition of "provider" beyond individuals who exercise independent clinical judgment, and it defines "visit" for scope purposes for the first time: a provider delivers an in-scope service on behalf of the health center to a health center patient and documents it in the patient's health center record. It also clarifies that pre-visit triage of a caller who is not yet a registered patient may establish the relationship for FTCA purposes but is not itself a "service" for scope purposes. These definitions apply solely for Health Center Program scope purposes and do not extend to FTCA, 340B, or FQHC reimbursement, each of which has its own patient-relationship rules.

Services Outside a Service Site (Chapter 9)

PIN 2008-01's brief "Other Activities" list is now a structured, five-category framework, each with its own documentation and eligibility conditions and direct citations to 42 CFR 6.6(e)(4):

- Portable Care and Outreach
- Hospital-Related Activities
- Coverage-Related Activities
- Emergency Response Activities
- Certain Individual Emergencies

This is a genuine build-out, not just a reorganization. For example, the manual now specifies that scheduled surgeries for non-established patients are not in scope, a level of detail absent from the old PIN.

Established Patient-Provider Relationship (Chapter 8.B)

The Scope Manual defines, for the first time as a named scope-of-project concept, an "established health center patient" and "patient-provider relationship" through a three-part test: an in-scope service delivered on behalf of the health center; delivered in person or via telehealth to someone physically located in, or a resident of, the service area or an adjacent area; and documented in a health record the health center maintains. This definition is separate from, and not a guarantee of, eligibility for other federal benefit programs, including FTCA coverage.

Specialty Services Consolidated (formerly PIN 2009-02)

PIN 2009-02's freestanding specialty-services framework, its four-part test, additional considerations, and its 10-point plus 4-point approval checklist, is now folded into the general "Criteria Required for Additional Health Services" in Chapter 3, Section D: the service must meet the general in-scope criteria, support a required primary health service the health center currently provides, and demonstrate need in the population served. The specialty-service examples and the

standalone approval checklist do not appear to carry forward as a distinct list. Health centers with an in-progress or planned specialty-service change-in-scope request should expect to build their narrative against the more general Chapter 3.D criteria rather than a specialty-specific checklist.

The prior specialty-service-specific tests, including a financial-risk analysis and a requirement that the service be located proximate to available FQHC services, do not carry forward as distinct requirements under the Scope Manual.

Special Population-Only Grantees Adding a New Population (formerly PIN 2009-05)

The 25-percent threshold and the funding-reallocation mechanism carry forward essentially unchanged: a special medically underserved population-only health center may serve a limited number of patients outside its funded population, but once that group exceeds 25 percent of total patients, prior HRSA approval and a funding reallocation are required. Section 330(e) grantees remain exempt. What has changed is the evaluation standard: PIN 2009-05's five factors are condensed in Chapter 10.C to two required showings, maintaining the existing level of service to the original population, and meeting all Health Center Program requirements applicable to both populations. The standalone unmet-need documentation and neighboring-health-center support letter are not carried forward as named requirements. Michigan migrant health, health care for the homeless, and public housing primary care programs approaching this threshold should still expect a needs rationale to come up in general program integrity review, but should not assume the old PIN 2009-05 checklist items are independently required.

Formal Change in Scope vs. Scope Adjustment (Chapter 10.B)

A new two-track structure, "Formal" CIS requests versus "scope adjustments," replaces PIN 2008-01's "significant vs. not considered significant" framework. The categories map closely to the old list, with at least one genuinely new scope-adjustment scenario: correcting a required service that a newly funded or newly designated health center failed to verify as implemented within 120 days of its initial funding or designation notice. All change requests must now document that the change will not shift resources away from the current HRSA-approved scope of project. The core mechanics, EHB submission, 60-day HRSA goal, 120-day implementation window, are unchanged.

PAL 2026-04, Appendix A designates twenty specific service-delivery-method combinations as "self-updates" that require no formal HRSA review at all. For example, deleting a Cooperative Arrangement (Column III) for a service also delivered directly or under contract no longer requires a CIS request.

Crosswalk to the Health Center Program Compliance Manual

The Scope Manual states it was updated specifically to align with the Compliance Manual. Where the Scope Manual repeatedly points to a specific Compliance Manual chapter as the authoritative source for how to demonstrate compliance, while retaining ownership of what counts as in-scope.

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Scope of project questions belong to the Scope Manual; documentation and demonstration-of-compliance questions largely still route to the Compliance Manual chapter noted below.

Scope Manual Topic	Compliance Manual Chapter(s)	Nature of the Connection
Governing board authorities over scope of project; board role in changes in scope	Ch. 19: Board Authority	The Scope Manual sets the board approval list and oversight requirement; the Compliance Manual governs how that authority is demonstrated
"On behalf of" criteria and organizational structure changes	Ch. 4: Required and Additional Health Services; Ch. 1: Eligibility	Cross-referenced for board oversight of sites/services and documentation of non-profit or public agency status
Contracts/subawards (Form 5A, Column II); subrecipient-operated sites	Ch. 12: Contracts and Subawards	Scope Manual sets what must be in the contract; Compliance Manual governs underlying procurement and monitoring standards
Sliding fee discounts within contracts and cooperative arrangements	Ch. 9: Sliding Fee Discount Program	Cross-referenced for how discounts apply to services delivered by a contractor, subrecipient, or Column III provider
Total budget for the scope of project	Ch. 17: Budget	Referenced for the annual budget documenting scope of project funding
Accessible locations, hours of operation, service site criteria	Ch. 6: Accessible Locations and Hours of Operation	Statutory basis for the "regularly scheduled basis" and accessibility requirements
Coordination when adding a site (service area overlap factor)	Ch. 14: Collaborative Relationships	Standard for demonstrating coordination with other recipients and designees serving the same area
Documentation of non-profit/public agency status; entity type	Ch. 1: Health Center Program Eligibility	Cross-referenced for eligible entity types and documentation when organizational structure changes
Provider staffing, clinical staff types, credentialing context	Ch. 5: Clinical Staffing	Fuller detail on clinical staff types and credentialing/privileging
Patient health records and the patient-provider relationship	Ch. 10: Quality Improvement/Assurance	Connected to the health record requirement that helps establish a patient-provider relationship

Note: FTCA-related content in the Scope Manual (Chapters 3, 7, 8, and 9) points to the separate FTCA Health Center Policy Manual and specific PALs, for example PAL 2024-01, rather than to Compliance Manual Chapter 21 (FTCA Deeming Requirements) by name. Keep this in mind if you are building an FTCA-focused crosswalk.

Site Visit Protocol Timing

A new Site Visit Protocol aligned with the Scope Manual is expected in February 2027. Health centers with an Operational Site Visit scheduled before that date will continue to be evaluated under the current Site Visit Protocol.

What This Means for Your Health Center

MPCA recommends Michigan health centers prioritize the following as they review the Scope Manual:

- Review the contractor/subrecipient site floor requirement and the numeric service-area-overlap benchmarks first. These are the two changes most likely to change your actual change-in-scope strategy, as opposed to terminology and structural updates, which are largely administrative.
- If you have an in-progress or planned specialty-service change-in-scope request, revisit your documentation plan against Chapter 3, Section D, since the PIN 2009-02 specialty-services checklist is no longer a standalone framework. Because the CIS module will be down for system updates from October 20 through November 19, 2026, requests that are not time-sensitive may be able to wait until the module reopens on November 20. Any site or service change tied to a time-sensitive effective date should still be submitted as soon as possible to avoid the closure window.
- If your health center is a migrant health, health care for the homeless, or public housing primary care program approaching the 25-percent special population threshold, revisit any member guidance built on the old PIN 2009-05 five-factor checklist. The funding-reallocation mechanics are unchanged, but the old checklist is no longer stated as a formal requirement in Chapter 10.C.
- Review Chapter 9's five-category framework for services provided outside a service site with your Operations leadership. It replaces a loosely structured example list with defined, auditable criteria.
- Confirm current expectations against the Scope Manual chapter itself, not a retired PIN, before relying on any older example or numeric threshold in a change-in-scope narrative.
- If your health center operates a co-located site, review your agreement with the other party and confirm signage, website language, and patient notification practices meet the new Chapter 6.C requirements.

- Review contract, subaward, and cooperative arrangement templates against the new mandatory provision checklists, and confirm at least one person trained and certified in basic life support is present at contractor-operated sites during regularly scheduled hours.

Resources and Disclaimer

This guide is provided as a compliance education resource for MPCA member health centers and reflects a review of the Scope Manual's own text, the four PINs it supersedes, and the Health Center Program Compliance Manual. It does not substitute for a full independent review of HRSA's current guidance. Health centers remain responsible for reviewing the full Scope Manual, the Compliance Manual, and any applicable PINs or PALs directly, and should consult HRSA's Scope of Project Resources webpage for the most current process instructions and forms.