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TITLE X FAMILY PLANNING ANNUAL REPORT

FORMS AND INSTRUCTIONS

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Health
Office of Population Affairs
Office of Family Planning

REISSUED OCTOBER 2013

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PAPERWORK REDUCTION ACT (PRA) PUBLIC BURDEN STATEMENT

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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 to protect 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, OPA uses FPAR data 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 the following:

- monitoring compliance with legislative mandates, such as giving priority in the provision of services to low-income persons [42 USC 300 §1006(c)][1]
- ensuring that Title X grantees and their subcontractors provide a broad range of family planning methods and services [42 USC 300 §1001(a)][1]

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 performance goals for the Title X Family Planning program include giving priority in the provision of family planning services to low-income individuals, reducing invasive cervical cancer through Pap testing, reducing infertility through chlamydia screening, and increasing program efficiency by monitoring the cost of care.

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1 42 United States Code (USC) 300. *Population research and voluntary family planning programs*, *section 1001 of Title X of the Public Health Service Act*. Retrieved December 9, 2013, from http://www.hhs.gov/opa/pdfs/title-x-statute-attachment-a.pdf.

2 45 Code of Federal Regulations (CFR) Part 74. *Uniform administrative requirements for awards and subawards to institutions of higher education, hospitals, other nonprofit organizations, and commercial organizations; and certain grants and agreements with states, local governments, and Indian tribal governments.* Retrieved December 9, 2013, from http://www.hhs.gov/opa/pdfs/45-cfr-74.pdf.

3 45 CFR Part 92. *Uniform administrative requirements for grants and cooperative agreements to state and local governments*. Retrieved December 9, 2013, from http://www.hhs.gov/opa/pdfs/45-cfr-92.pdf.

4 42 CFR Part 59. *Grants for family planning services*. Retrieved December 9, 2013, from http://www.hhs.gov/opa/pdfs/42-cfr-59-b.pdf.

5 U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Population Affairs, Office of Family Planning. (2001, January). *Program guidelines for project grants for family planning services*. Rockville, MD: Author. Retrieved December 9, 2013, from http://www.hhs.gov/opa/pdfs/2001-ofp-guidelines-complete.pdf.

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, use of family planning and related preventive health services offered, the amount and composition of revenues, and program impact. FPAR data are the basis for objective grant reviews, program evaluation, and assessment of program technical needs.

This version (January 2014) of the FPAR consists of 15 tables, including a Grantee Profile Cover Sheet and 14 data tables. The data collected include demographic, social, and economic characteristics of family planning users; use of family planning and related preventive health services; use of health personnel; and project revenues. Minor corrections or clarifications to this version of the *FPAR Forms and Instructions* include the following:

- updates to the submission and revision guidance in the "General Instructions" to account for grantees' use of the Web-based *FPAR Data System*
- review and updates to the "Questions About" entries for all sections of the *FPAR Forms and Instructions*
- clarification or correction of the instructions or tables for the following:
  - **Grantee Profile Cover Sheet –** Replaced the term "Delegates/Subcontractors" with "Subrecipients"
  - **Table 5 –** Corrected and clarified the definitions for reporting users' principal health insurance coverage status, including reclassifying health insurance for military personnel and their dependents as private rather than public health insurance
  - **Table 6 –** Added two new rows, including one for reporting the unduplicated number of users who are not LEP and a second for reporting the unduplicated number of users with unknown or not reported LEP status
  - **Tables 7 and 8 –** Changed the row heading from "IUD" to "IUD or IUS," provided a definition for the Lactational Amenorrhea Method (LAM), and clarified the definition of the "No method–Other reason" category to include users who exit the encounter with no method because they have a sexual partner of the same sex
  - **Table 10 –** Clarified the instructions and modified the row headings to collect clinical breast exam and related referrals for female users only
  - **Table 13 –** Clarified the instructions for reporting full-time equivalent data for Clinical Services Providers
  - **Table 14 –** Corrected and clarified the instructions for reporting "Other Public" and "Private" third-party revenue, and changed the table row heading from "State Children's Health Insurance Program (SCHIP)" to "Children's Health Insurance Program (CHIP)"

GENERAL INSTRUCTIONS

This section provides general instructions for completing the FPAR. Grantees should use the general instructions in conjunction with the table-specific instructions; they are cross-referenced where appropriate. If you need additional information or guidance, please refer to the Title X *Program Guidelines* (http://www.hhs.gov/opa/pdfs/2001-ofp-guidelines-complete.pdf) or the *Program Instruction Series* (http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program-instructions/) available on the OPA Website.

WHO SUBMITS AN FPAR

Grantees funded under Section 1001 of the Title X Public Health Service Act (42 USC 300) are required to submit the FPAR. The family planning services grantee is the direct recipient of the Title X grant. Subrecipients (delegates or subcontractors) to the grantee receive Title X funds via the grantee. Subrecipients should **not** submit an FPAR report; instead, subrecipients should follow grantee instructions for data collection and reporting.

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, as defined in the approved grant application. 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 Title X-funded project. **If you have questions about whether to include certain data in this report, contact your Regional Program Consultant (RPC)**. A current list of RPCs and their contact information is available on the OPA Website at http://www.hhs.gov/opa/regional-contacts/.

FPAR SUBMISSION DUE DATE

Grantees should prepare and submit the FPAR no later than February 15 after the end of the reporting period. If February 15 is a weekend day, the FPAR is due on the following Monday or next business day.

SUBMITTING THE FPAR

OPA encourages grantees to submit the FPAR electronically using the Web-based *FPAR Data System*, which is located at https://fpar.opa.hhs.gov/. You must have an authorized user account to submit and manage your FPAR using the system. Contact your RPC (http://www.hhs.gov/opa/regional-contacts/) to request a user account. Once OPA authorizes your account, you will receive an automated e-mail confirming your registration and providing a link to the *FPAR Data System* Website, your user name, and a temporary password that you will be required to change at first login.

Visit the *FPAR Data System* Training page (https://fpar.opa.hhs.gov/Training.aspx) to learn about and register for upcoming training webinars and to access recordings, handouts, and scripts for past webinars. An *FPAR Data System User Guide,* accessed from the Support page, provides step-by-step instructions for using the system to submit and manage your FPAR.

If you are unable to submit the FPAR using the *FPAR Data System,* contact your RPC (http://www.hhs.gov/opa/regional-contacts/) to determine the best way (e.g., e-mail or fax) to send them

an electronic or hardcopy version of the completed FPAR tables. Once the RPC receives the completed tables, they will record the date of receipt and enter the FPAR into the *FPAR Data System*. All subsequent actions related to your FPAR will be performed using the *FPAR Data System.*

FPAR DATA VALIDATION

FPAR data undergo rigorous electronic and manual validations prior to tabulation. For FPARs submitted through the *FPAR Data System,* the system automatically validates the data as you complete each table to ensure consistency within and across tables. Each validation procedure is based on a validation rule that defines which table cells to compare and what condition or validation test to apply (e.g., =, < , >, ≤, or ≥). The values reported in FPAR **Table 1**, Row 10, indicated by the double-letter identifiers (AA, BB, and CC), serve as important checkpoint references to ensure consistency across multiple FPAR tables. The automated validation procedures include cross-table comparisons to these three FPAR checkpoints, as well as comparisons between other table cells. The system will flag blank cells; if the value for a cell is zero, enter "0."

After a grantee submits an FPAR, it goes through two levels of review by HHS staff. First, an RPC reviews the FPAR and either accepts it or returns it to the grantee for correction or clarification. Once the RPC accepts the FPAR, the FPAR Data Coordinator performs a second and final review, either accepting the FPAR or returning it to the RPC and grantee for correction or clarification. When the FPAR Data Coordinator has accepted all FPARs, the FPAR data contractor performs additional electronic validations ("post-submission validations") to identify reporting errors and highlight reporting issues (e.g., missing or out-of-range values). The contractor also performs a manual review of all "Note" field comments.

REQUEST FOR FPAR REVISION

During the HHS review of FPARs or after post-submission validations, HHS staff may ask you to correct or provide additional information about the reported data. If the RPC requests a revision, the FPAR contact for your agency will receive an automated e-mail from the *FPAR Data System* that includes revision instructions. If the FPAR Data Coordinator requests a revision, the RPC will receive the automated e-mail and will contact you to determine who (RPC or grantee) will correct or clarify the data using the *FPAR Data System.*

If you are unable to revise the FPAR using the *FPAR Data System,* contact your RPC (http://www.hhs.gov/opa/regional-contacts/) to request assistance. Grantees should consult with their RPC regarding any region-specific requirements or deadlines for submitting revised FPAR tables. Grantees should submit revised tables by **April 1** to ensure that data from revised tables are included in the national and regional reports.

FPAR NOTE FIELD

OPA encourages grantees to include information about the data reported in the FPAR tables, including grantee observations and information about trends or any issues affecting the quality or completeness of the reported data. Please use the table-specific "Note" field to enter a comment and reference the cell or cells to which each comment applies. For estimated figures, describe the rationale and method for generating the estimate. In the *FPAR Data System*, the "Note" field appears under every FPAR table. The system also includes a "Note" field under the FPAR Preparation Checklist where grantees may enter comments about issues affecting data in all FPAR tables.

FPAR IDENTIFICATION

Each FPAR table includes a header with key identifying information. For grantees that use the *FPAR Data System* to submit the FPAR, these fields will populate automatically. For grantees that submit a hardcopy FPAR by fax or e-mail, you must enter this information on the Grantee Profile Cover Sheet. The identifying information includes the following:

FPAR NUMBER – Enter the unique, **four-digit** number assigned to your agency by the RPC. This number is different from your HHS grant number.

DATE SUBMITTED – Enter the report submission date.

REPORTING PERIOD – Enter the reporting period covered by your FPAR report. In most cases, the reporting period is the 12-month calendar year (i.e., **January 1 through December 31**). Title X grantees that begin operating after January 1, stop operating before December 31, or are reporting data for a different 12-month period (e.g., December to November) should enter the date range for the period during which their Title X project was active and for which they are reporting data. For grantees that submit the FPAR using the *FPAR Data System*, please consult the *FPAR Data System User Guide* for instructions about editing the reporting period on the FPAR Preparation Checklist.

INITIAL SUBMISSION OR REVISION – Check the appropriate box in the header of each table to indicate whether the table is an initial or revised submission. For grantees that submit the FPAR using the *FPAR Data System*, the system will automatically update the submission status (initial or revised) of each table.

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TERMS AND DEFINITIONS

OPA provides definitions for key FPAR terms to ensure uniform reporting by 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 deliver 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 Other Services Providers.

CLINICAL SERVICES PROVIDERS – Include physicians (family and general practitioners, specialists), physician assistants, nurse practitioners, certified nurse midwives, and registered nurses with an expanded scope of practice who are trained and permitted by state-specific regulations to perform *all aspects* of the user (male and female) physical assessment, as described in the *Program Guidelines*. Clinical Services Providers are able to offer client education, counseling, referral, followup, and clinical services (physical assessment, treatment, and management) relating to a client's proposed or adopted method of contraception, general reproductive health, or infertility treatment, in accordance with the *Program Guidelines*.

OTHER SERVICES PROVIDERS – Include other agency staff (e.g., registered nurses, public health nurses, licensed vocational or licensed practical nurses, certified nurse assistants, health educators, social workers, or clinic aides) that offer client education, counseling, referral, or followup services relating to the client's proposed or adopted method of contraception, general reproductive health, or infertility treatment, as described in the *Program Guidelines*. Other Services Providers may also perform or obtain samples for routine laboratory tests (e.g., urine, pregnancy, STD, and cholesterol and lipid analysis), 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), in accordance with the *Program Guidelines*.

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 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 services 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 an Other Services Provider. The type of family planning provider who renders the care, regardless of the services rendered, determines the type of family planning encounter. Although a client may meet with both Clinical and Other Services Providers during an 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.

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 AN OTHER SERVICES PROVIDER – A face-to-face, documented encounter between a family planning client and an Other 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 tests 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 provide Title X services (clinical, counseling, educational, or referral) that comply with the Title X *Program Guidelines,* and where at least some of the encounters between the family planning providers and the individuals 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 provide 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 followup; treatment and special instructions; scheduled revisits; informed consent forms; documentation of refusal of services; and information on allergies and untoward reactions to identified drugs. The medical record also contains clinical findings; diagnostic and therapeutic orders; and documentation of continuing care, referral, and followup. 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.

If a family planning user receives no clinical services, the provider still must establish a **client record** that enables the site to complete the required FPAR data reporting. 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 fully document 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 Other Services Providers during an encounter, the encounter is credited to 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.

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

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

   If a client of reproductive age is sterilized under the service site's Title X-funded project, or is an ongoing Title X user who was sterilized elsewhere but continues to receive gynecological or related preventive health services from the site, the encounter is considered a family planning encounter and the agency may continue to count the client as 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.

   If a client is not an ongoing family planning user and obtains a service that does not include counseling, education, or clinical services related to achieving intended pregnancy or avoiding unintended pregnancy, the encounter is not a family planning encounter and the client is not a family planning user.

   > **Example:** A new client who receives STD services, but no counseling, education, or clinical services aimed at avoiding an unintended pregnancy or achieving an intended pregnancy, is not a family planning user, and the encounter is not a family planning encounter. If, in addition to STD testing, this same client receives condoms or counseling about using condoms to prevent STD transmission, but does not receive counseling, education, or clinical services aimed at avoiding an unintended pregnancy, the client is not a family planning user and the encounter is not a family planning encounter.

3. **QUESTION** – If a clinic aide or nurse is trained and authorized to give contraceptive injections (e.g., Depo-Provera), should an agency report the encounter as an encounter with a Clinical Services Provider?

   ANSWER – No. For purposes of reporting on the FPAR, a clinic aide is classified as an Other Services Provider even though he or she may be trained and authorized to give contraceptive injections. Only advanced practice nurses (certified nurse midwife or nurse practitioner) or registered nurses with an expanded scope of practice who are trained and permitted by state-specific regulations to perform *all aspects* of the user (male and female) physical assessment as described in the *Program Guidelines* may be reported as Clinical Services Providers. Report full-time equivalents (FTEs) for each type of Clinical Services Provider in **Table 13**, Rows 1a to 1c, and the number of encounters with Clinical

Services Providers in **Table 13**, Row 1. Report the number of encounters with Other Services Providers in **Table 13**, Row 2.

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GRANTEE PROFILE COVER SHEET

The Grantee Profile Cover Sheet provides important identifying and contact information for the grantee and the grantee's FPAR contact. The Cover Sheet also provides information about the network of service providers supported by the Title X grant.

INSTRUCTIONS

If you are submitting the FPAR using the *FPAR Data System*, the system will automatically populate the following fields: grantee legal name; address of grantee administrative offices; and name, title, and contact information for the Title X Project Director. If there is an error in the pre-populated fields, enter the corrected information in the Grantee Profile Cover Sheet "Note" field and notify the RPC that key grant information has changed. Grantees can modify all other fields. For grantees submitting a hardcopy FPAR by e-mail or fax, follow these instructions:

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

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

TITLE X PROJECT DIRECTOR – Enter 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) – Enter 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 SUBRECIPIENTS (DELEGATES OR SUBCONTRACTORS) SUPPORTED BY THE TITLE X GRANT – Report the number of subrecipients (delegates or subcontractors) 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. If the number of service sites supported by the Title X grant is different from the number provided in the grant application, check the box and explain the reason for this difference in the Grantee Profile Cover Sheet "Note" field.

QUESTIONS ABOUT THE GRANTEE PROFILE

1. **QUESTION –** Is the Grantee Profile Cover Sheet different from the previous FPAR?

   ANSWER – Yes, there is a minor edit to a row heading. OPA has changed the row heading "Number of Delegates/Subcontractors Supported by the Title X Grant" to "Number of Subrecipients (Delegates or Subcontractors) Supported by the Title X Grant."

2. **QUESTION –** If Title X services are provided at a clinic and two non-clinic service sites, should the grantee report one or three sites as the total number of service sites supported by the Title X grant?

ANSWER – For purposes of FPAR reporting, the grantee should count and report any established unit, clinic, or non-clinic site where staff provide Title X services and where at least some of the encounters between the family planning providers and the individuals served meet the requirements of a *family planning encounter*. Refer to the definition of a "Family Planning Service Site" on page 8. OPA assumes that each of the sites reported in the Grantee Profile contributes data to the grantee's FPAR. If all three sites in this example contribute data to the FPAR, the grantee should include these three service sites in the total number of sites reported on the Grantee Profile Cover Sheet.

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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	Name	
Address of Grantee Administrative Offices	Street	
	City	
	State	ZIP + 4 –
Title X Project Director	Name	
	Title	
	Street	
	City	
	State	ZIP + 4 –
	Phone	
	Fax	
	E-Mail	
Grantee Contact (Person completing FPAR)	Name	
	Title	
	Street	
	City	
	State	ZIP + 4 –
	Phone	
	Fax	
	E-Mail	
Number of Subrecipients (Delegates or Subcontractors) Supported by the Title X Grant		
Number of Family Planning Service Sites Supported by the Title X Grant	❑ Check if total number of sites is different from application	

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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. These FPAR tables describe the demographic characteristics of family planning users, including the distribution of users by age group, sex, ethnicity, and race.

The numbers reported in Table 1, Row 10, serve as consistency checkpoints in subsequent FPAR tables. The values in these tables are identified with **unique, double-letter identifiers** (AA, BB, and CC).

INSTRUCTIONS

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

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 30 of the reporting period.

RACE AND ETHNICITY – 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*[6] 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 ethnicity 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 as follows:

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.

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

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.

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[6] 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 December 9, 2013, from http://www.whitehouse.gov/omb/fedreg_race-ethnicity.

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** – Are Tables 1 through 3 different from the previous FPAR?

   ANSWER – No. There are no changes to Tables 1 through 3.

2. **QUESTION** – What if a client self-identifies as Hispanic or Latino, but was born in the United States?

   ANSWER – Report as Hispanic or Latino family planning users of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, including those Hispanic or Latino users who were born in the United States.

3. **QUESTION** – Should clients from Brazil or Haiti or who are of Brazilian or Haitian descent be classified as Hispanic or Latino?

   ANSWER – All clients who self-identify as Hispanic or Latino should be classified as Hispanic or Latino regardless of country of origin. Clients who identify solely as Brazilian or Haitian should not be classified as Hispanic or Latino.

4. **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, a client may not self-identify with any of the OMB race categories or may refuse to report his or her race. Providers must respect a client's right to refuse to report his or her race or to self-identify with any of the race categories. Providers may wish to include the definition of each race category on their intake forms (if space and formatting permit) and to familiarize themselves with the OMB definitions for each race category so they can assist clients who have questions. Grantees should report the number of users with missing or unknown race information in the "unknown/not reported" race category.

   Hispanic or Latino clients account for a high proportion of family planning users for whom race data are unknown or not reported. The structure of Tables 2 and 3 allows OPA to identify the numbers of female and male Hispanic or Latino clients that do not self-identify with any of the OMB race categories.

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

   ANSWER – According to the 1997 OMB guidance, when self-identification is used, the data collection method should allow clients to self-report more than one race. A single "multiracial" category should not appear as an option on the intake form. At a minimum, the client intake form should list the five OMB race categories, and clients should be instructed to check or select "one or

more" or "all that apply." Report clients who self-identify with two or more races in Row 6 of Table 2 (female users) or Table 3 (male users).

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. Grantees interested in issues surrounding collection of race data should consult the resource list in Appendix A.

Table 1
Unduplicated Number of Family Planning Users by Age Group and Sex

	Age Group (Years)	Female Users (A)	Male Users (B)	Total Users (Sum Cols A + B) (C)
1	Under 15			
2	15 to 17			
3	18 to 19			
4	20 to 24			
5	25 to 29			
6	30 to 34			
7	35 to 39			
8	40 to 44			
9	Over 44			
10	**Total Users (sum rows 1 to 9)**			
		↓ **Checkpoint Reference AA**	↓ **Checkpoint Reference BB**	↓ **Checkpoint Reference CC**

Table 2
Unduplicated Number of Female Family Planning Users by Race and Ethnicity

	Race	Hispanic or Latino (A)	Not Hispanic or Latino (B)	Unknown/ Not Reported (C)	Total Female Users (Sum Cols A to 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)**				
					↓ **Checkpoint Reference AA**

Table 3
Unduplicated Number of Male Family Planning Users by Race and Ethnicity

	Race	Hispanic or Latino (A)	Not Hispanic or Latino (B)	Unknown/ Not Reported (C)	Total Male Users (Sum Cols A to 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)**				
					↓ Checkpoint Reference BB

FAMILY PLANNING USER ECONOMIC AND SOCIAL PROFILE

The data reported in Tables 4 through 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 service sites. OPA uses these data to monitor the program's role in supporting the health care safety net 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. [7]

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 family income data from all users in order to determine charges based on the schedule of discounts.[8] In determining a user's family income, agencies should refer to the poverty guidelines updated periodically in the *Federal Register* by HHS under the authority of 42 USC 9902(2).[9] Report the unduplicated number of users by income level, using the most current income information available. For additional guidance, see OPA Program Instruction Series documents *OPA 08-1: Verification of Income for Title X Clients* and *OPA 97-1: Fees and Charges to Title X Low-Income Clients and Teenagers (Revised*), which are available on the OPA Website at http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program-instructions/.

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.

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[7] U.S. Department of Health and Human Services. (August 8, 2003). *Guidance to federal financial assistance recipients regarding Title VI prohibition against national origin discrimination affecting limited English proficient persons ("Revised HHS LEP guidance"). Federal Register, 68*(153), 47311-47323. Retrieved December 9, 2013, from http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html.

[8] 42 CFR Part 59.5(a)(8). *Subpart A–Project grants for family planning services.* Retrieved December 9, 2013, from http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program-guidelines/final-rules-42-cfr-59.html.

[9] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, (2010). *Poverty guidelines, research, and measurement*. Retrieved December 9, 2013, from http://aspe.hhs.gov/poverty/index.shtml.

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 care), Medicare, the Children's Health Insurance Program (CHIP), and other state or local government programs that provide a broad set of benefits (e.g., Washington's Basic Health or Massachusetts's Commonwealth Care plans). Also included are public-paid or public-subsidized private insurance programs.

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). Private insurance includes insurance purchased for public employees or retirees or military personnel and their dependents (e.g., TRICARE or CHAMPVA).

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 PROFICIENT (LEP) USERS – Refers to family planning users who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English.[7] Because of their limited English proficiency, LEP users derive little benefit from Title X services and information provided in English. In Table 6, report the unduplicated number of family planning users who required language assistance services (interpretation or translation) to optimize their use of Title X services. **Include as LEP any user** who received Title X services from bilingual staff in the user's preferred non-English language, who was assisted by a competent agency or contracted interpreter, or who opted to use a family member or friend as an interpreter after refusing the provider's offer of free language assistance services. Service providers should consult the *Revised HHS LEP Guidance*[7] for further information about identifying LEP individuals and complying with language assistance requirements. Unless they are also LEP, **do not include users** who are visually or hearing impaired or have other disabilities.

QUESTIONS ABOUT TABLES 4 TO 6

1. **QUESTION** – Are Tables 4 through 6 different from the previous FPAR?

   ANSWER – There are no changes to Table 4.

   In Table 5, OPA corrected the definition of private health insurance to include plans for military personnel and their dependents (e.g., TRICARE or CHAMPVA). In addition, OPA corrected the definition of public health insurance to include state or local government programs (e.g., Washington's Basic Health, Massachusetts's Commonwealth Care), including public-paid or public-subsidized health plans.

   In Table 6, OPA included two additional rows: one row for reporting the unduplicated number of users who are not LEP and one row for reporting the unduplicated number of users with an unknown or not reported LEP status.

2. **QUESTION** – If a client has 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 the type of health insurance coverage (public or private) that he or she has.

3. **QUESTION –** Are Title X agencies required to verify client health insurance status?

   ANSWER – No. The information required to complete Table 5 is based on clients' self-reported insurance coverage. However, as stipulated in the program regulations (see 42 CFR Part 59.5(a)(9)),[4] service providers are required to bill all third parties authorized or legally obligated to pay for services and to make reasonable efforts to collect charges without jeopardizing client confidentiality.

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's services are paid by a state's Medicaid family planning expansion program (i.e., waiver demonstration project or State Plan Amendment [SPA]), is he or she considered insured for purposes of Table 5?

   ANSWER – A client whose services are paid by a Medicaid family planning expansion is considered **uninsured** if he or she has **no coverage under another public or private insurance plan** that covers a broad set of primary medical care benefits. A Medicaid family planning expansion program that covers **only** family planning services does not cover a "broad set of primary medical care benefits."

   A client whose services are paid by a Medicaid family planning expansion is considered **insured** if he or she has a public or private insurance plan that covers a **broad set of primary medical care benefits**.

6. **QUESTION –** In Table 6, should a user be reported as LEP if he or she receives care from a bilingual provider in his or her preferred, non-English language or if he or she receives language assistance from a trained (agency, contracted, or telephonic) or informal (friend or family member) interpreter?

   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 or received language assistance from trained or informal interpreters.

   Confidentiality, privacy, conflicts of interest, and competence as medical services interpreters are several limitations of using family members or friends as interpreters in the Title X clinic setting. While in some cases an LEP client 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 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.[7]

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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% to 150%	
3	151% to 200%	
4	201% to 250%	
5	Over 250%	
6	Unknown/not reported	
7	**Total Users (sum rows 1 to 6)**	
		Checkpoint Reference CC

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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	
3	Uninsured (no public or private health insurance)	
4	Unknown/not reported	
5	**Total Users (sum rows 1 to 4)**	
		Checkpoint Reference CC

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Table 6
Unduplicated Number of Family Planning Users with Limited English Proficiency (LEP)

		Number of Users (A)
1	LEP users	
2	Not LEP users	
3	Unknown/not reported	
4	**Total Users (sum rows 1 to 3)**	

Checkpoint Reference CC

FAMILY PLANNING METHOD USE

Title X projects are required to provide a broad range of acceptable and effective, medically approved family planning methods and services.[4] Tables 7 and 8 provide sex- and age-specific information on the types of family planning methods that female and male clients use to prevent unintended pregnancy. In addition, the tables provide information on the numbers of female and male clients who reported using no method, including the reason for nonuse.

Information on method use by age group for female (Table 7) and male (Table 8) users allows OPA to track patterns in method use over time at the state, regional, and national levels. In addition, these data allow OPA to examine the extent to which Title X providers contribute to increased access to and use of newer family planning technologies and assess the program's contribution to national health objectives (i.e., Healthy People) for family planning and disease prevention. These data also permit OPA to compare the data from Title X clinics with other sources of information, including the National Survey of Family Growth.

INSTRUCTIONS

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

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

TERMS AND DEFINITIONS

AGE GROUP – Use the client's age as of June 30 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 the following:

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

INTRAUTERINE DEVICE OR SYSTEM (IUD/IUS) – In Table 7, report the number of female users who use a long-term hormonal or other type of intrauterine device (IUD) or system (IUS) 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.

CONTRACEPTIVE PATCH – In Table 7, report the number of female users who use a transdermal 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 OR 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) OR LACTATIONAL AMENORRHEA METHOD (LAM) – Fertility awareness methods (FAMs) refer to family planning methods that rely on identifying the fertile days in each menstrual cycle when intercourse is most likely to result in a pregnancy. FAMs include Standard Days, Calendar Rhythm, TwoDay, Billings Ovulation, and SymptoThermal methods. The Lactational Amenorrhea Method (LAM) is the proactive application of exclusive breastfeeding during lactational amenorrhea for the first 6 months after delivery. To be effective, LAM requires full (i.e., no other liquid or solid given to infant) or nearly full (i.e., infrequent supplementation in small amounts, but not by bottle) breastfeeding.[10] In Table 7, report the number of female users who use one or a combination of the FAMs listed above or who rely on LAM as their primary family planning method. In Table 8, Row 3, report male users who rely on a FAM as their primary method. Report male users who rely on LAM as their primary method in Table 8, Row 6, "Rely on female method(s)."

ABSTINENCE – In Tables 7 and 8, report the number of female and male users, respectively, who rely on abstinence as their primary family planning method or who are not currently sexually active and therefore not using contraception. For purposes of FPAR reporting, abstinence is defined as refraining from oral, vaginal, and anal intercourse.[11]

WITHDRAWAL AND OTHER METHODS – 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 OR NOT REPORTED – In Tables 7 and 8, report the number of female and male users, respectively, for whom the primary family planning method at exit from the last family planning encounter is unknown or not reported.

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[10] Kennedy, K. I., & Trussell, J. (2011). Postpartum contraception and lactation. In R. A. Hatcher, J. Trussell, A. L. Nelson, W. Cates, D. Kowal, & M. S. Policar (Eds.), *Contraceptive technology* (20th ed., pp. 483-511). New York, NY: Ardent Media.

[11] Centers for Disease Control and Prevention. *Sexually transmitted diseases: Prevention.* Retrieved December 9, 2013, from http://www.cdc.gov/std/prevention/default.htm.

NO METHOD–[PARTNER] PREGNANT OR SEEKING PREGNANCY – In Tables 7 and 8, report the number of female and male users, respectively, 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 female and male users, respectively, 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, if either partner has had a non-contraceptive surgical procedure that has rendered him or her unable to conceive or impregnate, or if the user has a sexual partner of the same sex.

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 partners' family planning methods as their primary methods. "Female" contraceptive methods include female sterilization, IUD/IUS, hormonal implants, 1- and 3-month hormonal injections, oral contraceptives, the contraceptive patch, the vaginal ring, cervical cap or diaphragm, the contraceptive sponge, female condoms, LAM, and spermicides.

QUESTIONS ABOUT TABLES 7 AND 8

1. **QUESTION** – Are Tables 7 and 8 different from the previous FPAR?

   ANSWER – No. OPA has made no substantive changes to Tables 7 or 8. However, OPA has clarified instructions for reporting some methods. In Table 7, OPA changed the Row 2 heading from "IUD" to "IUD or IUS." In addition, for both Tables 7 and 8, OPA added an explanation of the Lactational Amenorrhea Method (LAM) to the definition of the "FAM or LAM" reporting category and added users having a sexual partner of the same sex to the definition of the "No method–Other reason" reporting category.

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 Table 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 in Table 7, Row 16 or 17. If the female user relies on withdrawal, report this user in Table 7, Row 15 ("Withdrawal or other method").

   If a male family planning user relies on a "female" family planning method for pregnancy prevention (i.e., female sterilization, IUD, hormonal implant, 1- or 3-month hormonal injection, oral contraceptives, contraceptive patch, vaginal ring, cervical cap or diaphragm, contraceptive sponge, female condoms, LAM, or spermicides), report this user in Table 8, Row 6.

   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(s)" (Table 8, Row 6). 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 this client's primary contraceptive method.

3. **QUESTION** – How should a grantee report a user who exits the encounter with no method because he or she, or his or her sexual partner, has had a non-contraceptive surgical procedure that has rendered one of the two sexual partners unable to conceive or impregnate?

   ANSWER – Report female users in Table 7, Row 19 ("No method–Other reason") and male users in Table 8, Row 8 ("No method–Other reason").

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Table 7
Unduplicated Number of Female Family Planning Users by Primary Method and Age Group

Primary Method	Under 15 (A)	15 to 17 (B)	18 to 19 (C)	20 to 24 (D)	25 to 29 (E)	30 to 34 (F)	35 to 39 (G)	40 to 44 (H)	Over 44 (I)	Total Female Users (Sum Cols A to I) (J)
1 Female sterilization										
2 IUD or IUS										
3 Hormonal implant										
4 1-Month hormonal injection										
5 3-Month hormonal injection										
6 Oral contraceptive										
7 Contraceptive patch										
8 Vaginal ring										
9 Cervical cap or diaphragm										
10 Contraceptive sponge										
11 Female condom										
12 Spermicide (used alone)										
13 FAM or LAM										
14 Abstinence										
15 Withdrawal or other method										
Rely on Male Method 16 Vasectomy										
17 Male condom										
No Method 18 Pregnant/seeking pregnancy										
19 Other reason										
Unknown/Not Reported 20 Unknown/not reported										
21 Total Female Users (sum rows 1 to 20)										

Note: IUD=Intrauterine Device. **IUS=**Intrauterine System. **FAM=**Fertility Awareness Method. **LAM**=Lactational Amenorrhea Method.

See Checkpoint Reference AA

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Table 8
Unduplicated Number of Male Family Planning Users by Primary Method and Age Group

Primary Method	Under 15 (A)	15 to 17 (B)	18 to 19 (C)	20 to 24 (D)	25 to 29 (E)	30 to 34 (F)	35 to 39 (G)	40 to 44 (H)	Over 44 (I)	Total Male Users (Sum Cols A to I) (j)
1 Vasectomy										
2 Male condom										
3 FAM										
4 Abstinence										
5 Withdrawal or other method										
Rely on Female Method 6 Rely on female method(s)										
No Method 7 Partner pregnant/seeking pregnancy										
8 Other reason										
Unknown/Not Reported 9 Unknown/not reported										
10 TOTAL MALE USERS (SUM ROWS 1 TO 9)										

Note: FAM=Fertility Awareness Method.

See Checkpoint Reference BB

CERVICAL AND BREAST CANCER SCREENING

Tables 9 and 10 provide information on the cervical and breast cancer screening activities that are performed within the scope of a grantee's approved Title X project. Data from these tables permit OPA to monitor compliance with legislative mandates, achievement of program performance objectives, and adoption of cervical and breast cancer screening recommendations established by federal agencies and professional medical organizations. In addition, OPA uses these data to assess the number of abnormal results that require further followup and to assess the program's contribution to national health objectives (i.e., Healthy People) related to early cancer detection and health promotion.

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 female users who obtained a Pap test
- Number of Pap tests performed
- Number of Pap tests with an ASC or higher result according to the 2001 Bethesda System[12] (see ***Exhibit 1***). ASC or higher results include ASC-US; ASC-H; LSIL; HSIL; squamous cell carcinoma; AGC; AGC, favor neoplastic; AIS; adenocarcinoma; or other (e.g., endometrial cells in a woman ≥ 40 years of age)
- Number of Pap tests with an HSIL or higher result according to the 2001 Bethesda System (see ***Exhibit 1***). HSIL or higher results include HSIL; squamous cell carcinoma; AGC; AGC, favor neoplastic; AIS; adenocarcinoma; or other (e.g., endometrial cells in a woman ≥ 40 years of age)

TABLE 10 – Report the following information on breast cancer screening and referral activities:

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

TERMS AND DEFINITIONS

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

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:

[12] 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), 2114–2119.

- Atypical squamous cells of undetermined significance (ASC-US) – ASC-US refers to cytological changes that are suggestive of a squamous intraepithelial lesion, but lack criteria for a definitive interpretation.[13]
- Atypical squamous cells, cannot exclude HSIL (ASC-H) – ASC-H refers to cytological changes that are suggestive of a high-grade squamous intraepithelial lesion (HSIL), but lack criteria for a definitive interpretation.[13]

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.[13]

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.[13]

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:[14]

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

QUESTIONS ABOUT TABLES 9 AND 10

1. **QUESTION** – Are Tables 9 and 10 different from the previous FPAR?

   ANSWER – There are no changes to Table 9. In accordance with recommended screening practices, in Table 10 OPA has decided to collect clinical breast exam and referral data for female users only.

2. **QUESTION** – How should grantees count and report a CBE that is part of a "bundled" billing or service code (e.g., as part of a comprehensive exam)?

   ANSWER – Grantees who do not have a count of the actual number of CBEs performed because of the structure of the "bundled" billing or service code should report the *estimated* number of CBEs performed in Table 10, Row 1, and provide a brief explanation about the estimated figure in the Table 10 "Note" field.

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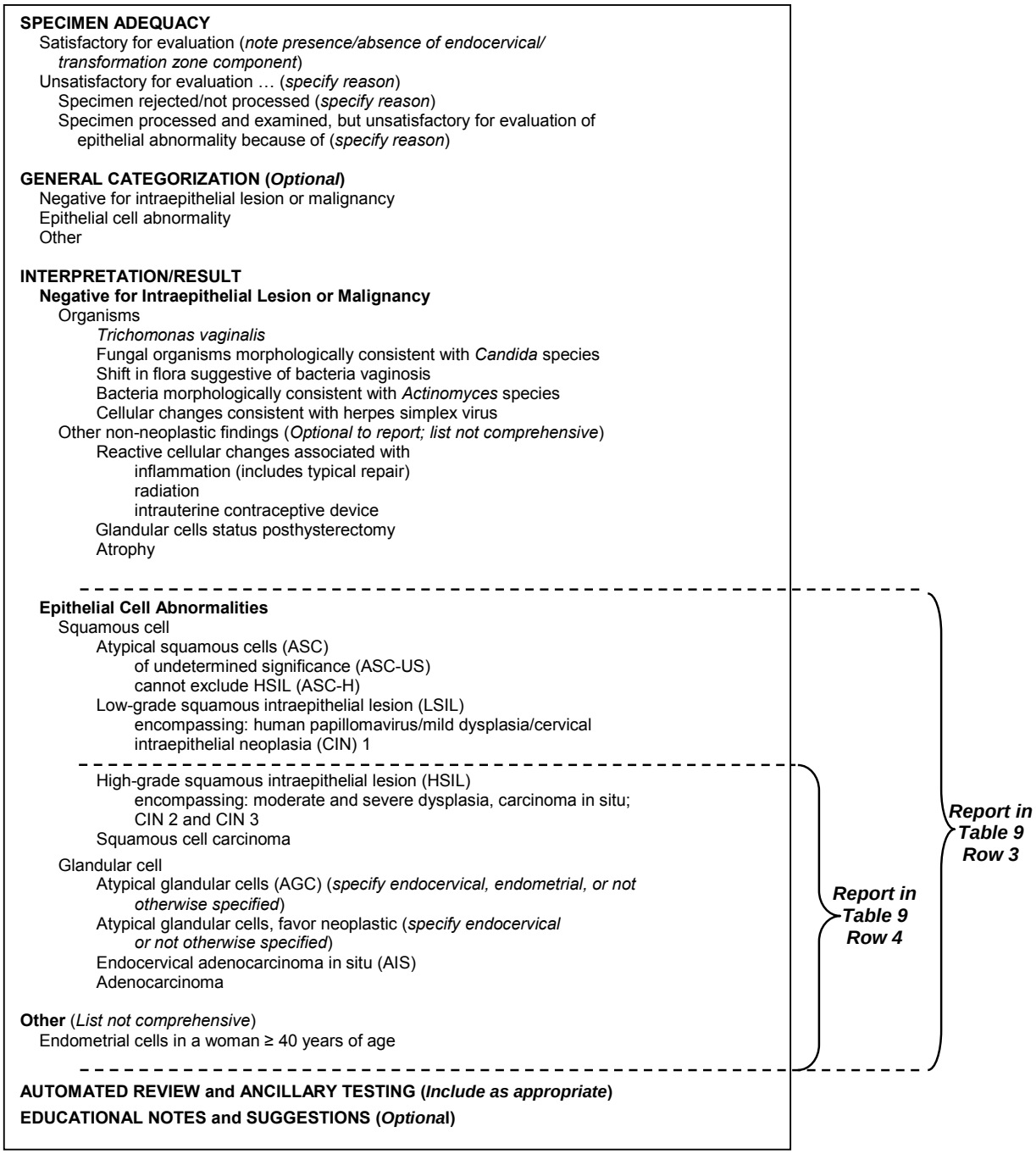
[13] Apgar, B. S., Zoschnick, L., & Wright, T. C. (2003). The 2001 Bethesda System terminology. *American Family Physician, 68,* 1992–1999.

[14] Wright, T. C., Cox, J. T., Massad, L. S., Twiggs, L. B., & Wilkinson, E. J. (2002). 2001 consensus guidelines for the management of women with cervical cytological abnormalities. *Journal of the American Medical Association, 287,* 2120–2129. For updated consensus guidelines for managing women with abnormal tests, see Wright, T. C., Massad, L. S., Dunton, C. J., Spitzer, M., Wilkinson, E. J., & Solomon, D. (2007). 2006 consensus guidelines for the management of women with abnormal cervical cancer screening tests. *American Journal of Obstetrics & Gynecology, 197*, 337–339.

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

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

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.)

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Table 9
Cervical Cancer Screening Activities

Screening Activity	Number of Female Users or Number of Tests (A)
1 Unduplicated number of female 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	

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Table 10
Clinical Breast Exams and Referrals

	Screening Activity	Number of Female Users (A)
1	Unduplicated number of female users who received a clinical breast exam (CBE)	
2	Unduplicated number of female users referred for further evaluation based on their CBE	

SEXUALLY TRANSMITTED DISEASE (STD) SCREENING

Tables 11 and 12 provide information on STD testing activities that are performed within the scope of a grantee's approved Title X project. Data from these tables permit OPA to monitor compliance with legislative mandate, achievement of program performance objectives, and adoption of STD and HIV screening recommendations established by federal agencies and professional medical organizations. In addition, OPA uses these data to assess the program's contribution to national health objectives (i.e., Healthy People) 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 sex.

TABLE 12 – Report the following STD testing information:

- Number of gonorrhea tests performed, by sex
- Number of syphilis tests performed, by sex
- Number of confidential HIV tests performed, by sex
- Number of confidential HIV tests with a positive result
- Number of anonymous HIV tests performed

TERMS AND DEFINITIONS

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

TESTS – Report STD (chlamydia, gonorrhea, and syphilis) and HIV (confidential and anonymous) tests performed during the reporting period that are provided within the scope of the grantee's 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 Tables 11 and 12 different from the previous FPAR?

   ANSWER – No. There are no changes to Tables 11 or 12.

2. **QUESTION** – How should grantees that fund agencies operating co-located Title X and STD clinics report STD tests?

   ANSWER – Do not report tests performed in an STD clinic operated by the Title X-funded agency or co-located with the Title X-funded service site unless (1) the activities of the STD clinic are within the defined scope of the grantee's Title X project and (2) the STD tests are provided to clients who meet the FPAR user and encounter definitions (see pages 7 and 8). A client seeking STD services, who refuses family planning counseling, information, or services that are offered, should not be reported as a family planning user.

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

   ANSWER – To the extent possible, a grantee should report all HIV tests—initial and confirmatory—performed within the scope of their Title X projects, including HIV tests performed on site and tests

for which a specimen is collected on site and analyzed off site (e.g., laboratory). If an offsite laboratory performs a confirmatory test using the same specimen obtained for the initial test, grantees should not count the confirmatory test unless (1) the provider 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. Grantees should use the Table 12 "Note" field to explain if HIV test counts exclude confirmatory tests.

4. **QUESTION –** Should grantees include *preliminary* positive rapid HIV tests in the total number of positive HIV test results reported in Table 12, Row 4?

   ANSWER – No. The total number of confidential positive HIV tests should include only the number of standard (i.e., not rapid) HIV tests with a positive result and the number of *preliminary* positive rapid HIV tests **confirmed** to be positive.

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Table 11
Unduplicated Number of Family Planning Users Tested for Chlamydia by Age Group and Sex

	Age Group (Years)	Female Users (A)	Male Users (B)
1	Under 15		
2	15 to 17		
3	18 to 19		
4	20 to 24		
5	25 and over		
6	**Total Users (sum rows 1 to 5)**		

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Table 12
Number of Tests for Gonorrhea, Syphilis, and HIV and Number of Positive Confidential HIV Tests

Test Type	Female Tests (A)	Male Tests (B)	Total Tests (Sum Cols A and B) (C)
1 Gonorrhea			
2 Syphilis			
3 HIV – All confidential tests			
4 HIV – Positive confidential tests			
5 HIV – Anonymous tests			

FAMILY PLANNING ENCOUNTERS AND CLINICAL SERVICES PROVIDER STAFFING

Table 13 provides OPA with information on the number and type of family planning encounters, and the use of Clinical Services Providers to deliver Title X-funded family planning and related preventive health services.

INSTRUCTIONS

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

- Number of full-time equivalent (FTE) family planning Clinical Services Providers, by type of provider
- Number of family planning encounters with Clinical Services Providers
- Number of family planning encounters with Other Services Providers

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 Other Services Providers.

CLINICAL SERVICES PROVIDERS – Include physicians (family and general practitioners, specialists), physician assistants, nurse practitioners, certified nurse midwives, and registered nurses with an expanded scope of practice who are trained and permitted by state-specific regulations to perform *all aspects* of the user (male and female) physical assessment, as described in the *Program Guidelines*. Clinical Services Providers are able to offer client education, counseling, referral, followup, and clinical services (physical assessment, treatment, and management) relating to a client's proposed or adopted method of contraception, general reproductive health, or infertility treatment, in accordance with the *Program Guidelines*.

OTHER SERVICES PROVIDERS – Include other agency staff (e.g., registered nurses, public health nurses, licensed vocational or licensed practical nurses, certified nurse assistants, health educators, social workers, or clinic aides) that offer client education, counseling, referral, or followup services relating to the client's proposed or adopted method of contraception, general reproductive health, or infertility treatment, as described in the *Program Guidelines*. Other Services Providers may also perform or obtain samples for routine laboratory tests (e.g., urine, pregnancy, STD, and cholesterol and lipid analysis), 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), in accordance with the *Program Guidelines*.

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 services 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 an Other Services Provider. The type of family planning provider who renders the care, regardless of the services rendered, determines the type of family planning encounter. Although a client may meet with both Clinical and Other Services Providers during an 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.

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 AN OTHER SERVICES PROVIDER – A face-to-face, documented encounter between a family planning client and an Other 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 tests 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-funded services (i.e., engaged in a family planning encounter). A full-time equivalent (FTE) of 1.0 describes staff who, individually or as a group, work the equivalent of full time for 1 year. Each agency defines the number of hours for "full-time" work and may define it differently for different positions. For example, a physician hired as a full-time employee (i.e., 1.0 FTE) may be required to work only 36 hours per week. FTEs for positions with different time expectations, especially clinicians, should be calculated based on the organization's established base for that position. In addition, FTEs are adjusted for part-time work or for part-year employment. In an organization that has a 40-hour workweek (2,080 hours/year), a person who works 20 hours per week (i.e., 50% time) is reported as "0.5 FTE." Thus, a physician working 36 hours per week would be considered 1.0 FTE, and a physician working 18 hours per week would be considered 0.5 FTE, regardless of whether other employees work 40-hour weeks. FTE is also based on the part of the year that the employee works. An employee who works full time for 4 months out of the year would be reported as "0.33 FTE" (i.e., 4 months divided by 12 months).

QUESTIONS ABOUT TABLE 13

1. **QUESTION** – Is Table 13 different from the previous FPAR?

   ANSWER – No. However, OPA has provided additional guidance for defining and calculating what full-time equivalent means for 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 Other Services 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 a nurse provides a contraceptive injection (e.g., Depo-Provera), should the grantee report the encounter as an encounter with a Clinical Services Provider?

   ANSWER – If the nurse providing the injection is a registered nurse with an expanded scope of practice who is trained and permitted by state-specific regulations to perform *all aspects* of the user (male and female) physical assessment as described in the *Program Guidelines*, then the encounter is an encounter with a Clinical Services Provider and should be reported in Table 13, Row 1.

   However, if the nurse providing the injection is a registered nurse who does not have an expanded scope of practice or is another type of nurse (e.g., LPN, LVN, or public health nurse), then the encounter should be reported as an encounter with an Other Services Provider in Table 13, Row 2.

4. **QUESTION** – If an individual receives gynecological or related preventive health services (e.g., pelvic exam, Pap test, pregnancy test, STD screening) at a Title X-funded service site, but does not receive counseling, education, or clinical services aimed at avoiding unintended pregnancy or achieving intended pregnancy, is the encounter a family planning encounter? Is the client a family planning user?

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

   If a client of reproductive age is sterilized under the service site's Title X-funded project, or is an ongoing Title X user who was sterilized elsewhere but continues to receive gynecological or related preventive health services from the site, the encounter is considered a family planning encounter and the agency may continue to count the client as 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.

   If a client is not an ongoing family planning user and obtains a service that does not include counseling, education, or clinical services related to achieving intended pregnancy or avoiding unintended pregnancy, the encounter is not a family planning encounter and the client is not a family planning user.

   > **Example:** A new client who receives STD services—but no counseling, education, or clinical services aimed at avoiding an unintended pregnancy or achieving an intended pregnancy—is not a family planning user and the encounter is not a family planning encounter. If, in addition to STD testing, this same client receives condoms or counseling about using condoms to prevent STD transmission but does not receive counseling, education, or clinical services aimed at avoiding an unintended pregnancy, the client is not a family planning user and the encounter is not a family planning encounter.

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Table 13
Number of Full-Time Equivalent Clinical Services Providers and 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 Registered nurses with an expanded scope of practice who are trained and permitted by state-specific regulations to perform all aspects of the user physical assessment		
2 Other Services Providers		
3	**Total Family Planning Encounters (sum rows 1 + 2)**	

REVENUE REPORT

Title X Section 1001 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.[2, 3] Table 14 identifies the sources and amounts of financial support received during the reporting period that support activities within the scope of the grantee's Title X family planning services project ("Title X project").

INSTRUCTIONS

TABLE 14 – Report the revenues (i.e., actual *cash* receipts or *drawdown* amounts) received during the reporting period from each funding source to support activities within the scope of the grantee's Title X services grant (Section 1001), even if the funds were not expended during the reporting period. Include (1) all receipts from the Title X services grant; (2) collections from patients and reimbursements from third parties for services rendered; and (3) receipts from other sources, including block grants, state and local governments, and other sources. 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.[2, 3] **Do not report the monetary value of in-kind contributions as revenue in Table 14.**

TERMS AND DEFINITIONS

TITLE X GRANT – Refers to funds received from the Title X Section 1001 family planning services grant. Report the amount received (cash receipts or drawdown amounts) during the reporting period from the Title X services grant. Include base Title X grant funding and other Title X funding for special initiatives (e.g., HIV integration and male involvement). Do not report the amount of grant funds awarded unless this figure is the same as the actual *cash* receipts or *drawdown* amounts.

PAYMENT FOR SERVICES – Refers to funds collected directly from clients and revenues received from public and private third party payers (capitated or fee-for-service) for services provided within the scope of the grantee's Title X project.

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

THIRD-PARTY PAYERS – For each third-party source listed, report the amount received (i.e., reimbursed) during the reporting period for services provided 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 prepaid. Revenues received after the date of service, even under managed care arrangements, should be reported as not prepaid.

MEDICAID/TITLE XIX – Report the amount received from Medicaid (federal and state shares) during the reporting period for services provided within the scope of the grantee's Title X project, regardless of whether the reimbursement was 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. Include revenue from

family planning waivers (both federal and state shares) in Row 3a, Column B. If the amount reported in Row 3a, Column B includes family planning waiver revenue, indicate this in the Table 14 "Note" field.

MEDICARE/TITLE XVIII – Report the amount received from Medicare during the reporting period for services provided within the scope of the grantee's Title X project, regardless of whether the reimbursement was 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.

CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) – Report the amount of funds received during the reporting period from CHIP for services provided within the scope of the grantee's Title X project. If the grantee is unable to report CHIP revenue separately from Medicaid (Row 3a), indicate this in the Table 14 "Note" field.

OTHER PUBLIC HEALTH INSURANCE – Report the amount reimbursed by other federal, state, or local government health insurance programs during the reporting period for services provided within the scope of the grantee's Title X project. Examples of other public health insurance programs include state or local government programs that provide a broad set of benefits (e.g., Washington's Basic Health or Massachusetts's Commonwealth Care), including public-paid or public-subsidized private insurance programs.

PRIVATE HEALTH INSURANCE – Report the amount of funds received from private third-party health insurance plans during the reporting period for services provided within the scope of the grantee's Title X project. Private health insurance include plans obtained through an employer, union, or direct purchase, including insurance purchased for public employees or retirees or military personnel and their dependents (e.g., TRICARE or CHAMPVA) that provide a broad set of primary medical care benefits for the enrolled individual (beneficiary or dependent).

OTHER REVENUE – Refers to revenue received from other sources during the reporting period that supported services provided within the scope of the grantee's Title X project. Other revenue sources include block grants, TANF, state and local governments (e.g., contracts, state and local indigent care programs), the Bureau of Primary Health Care, private and client donations, or other public or private revenues.

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

SOCIAL SERVICES BLOCK GRANT/TITLE XX – Report the amount of Title XX funds received in the reporting period that supported services provided within the scope of the grantee's Title X project.

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

LOCAL GOVERNMENT REVENUE – Report 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 provided within the scope of the grantee's Title X project.

STATE GOVERNMENT REVENUE – Report the amount of funds from state government sources (including grants or contracts) that were received during the reporting period and that supported services provided within the scope of the grantee's Title X project. Do not report as "state government revenue" funding from sources like the Centers for Disease Control and Prevention

(CDC) (e.g., Infertility Prevention Project) or block grant funds that are awarded to and distributed by the state. Report these revenues as "Other revenue" and specify their sources.

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

OTHER REVENUE – Report the amount and specify the source of funds received during the reporting period from other sources that supported services provided within the scope of the grantee's Title X project. This may include revenue from such sources as the CDC (infertility, STD, or HIV prevention; breast and cervical cancer detection), private grants and donations, fundraising, interest income, or other sources.

QUESTIONS ABOUT TABLE 14

1. **QUESTION** – Is Table 14 different from the previous FPAR?

   ANSWER – Yes. OPA has corrected the instructions for reporting "Other Public" and "Private" third-party revenue. These corrections reflect similar changes to the insurance coverage definitions in FPAR **Table 5**. Grantees should report revenue (reimbursements) from health insurance for military personnel and their dependents (e.g., TRICARE or CHAMPVA) as "Private" rather than "Other Public" third-party revenue. In addition, grantees should report as "Other Public" third-party revenue reimbursements from state or local government programs that provide a broad set of benefits (e.g., Washington's Basic Health, Massachusetts's Commonwealth Care), including public-paid or public-subsidized private insurance programs. Finally, OPA changed the Row 3c heading for "State Children's Health Insurance Program (SCHIP)" to "Children's Health Insurance Program (CHIP)."

2. **QUESTION** – Can a grantee report an estimate of the monetary value of in-kind donations of goods, services, or other noncash contributions as revenue in Table 14?

   ANSWER – No. In Table 14, revenues include actual cash receipts or drawdown amounts only. Do not report the monetary value of in-kind contributions as revenue in Table 14.

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Table 14
Revenue Report

	Revenue Source	Amount	
Title X			
1	**Title X grant** (Section 1001: family planning services)		
Payment for Services			
2	**Total client collections/self-pay**		
3	**Third-party payers**	**Amount Prepaid (A)**	**Amount Not Pre-paid (B)**
3a	Medicaid (Title XIX)		
3b	Medicare (Title XVIII)		
3c	Children's Health Insurance Program (CHIP)		
3d	Other public health insurance		
3e	Private health insurance		
4	**Total – Third-Party Payers (sum rows 3a to 3e)**		
5	**Total – Payment for Services (sum row 2 + cell 4a + cell 4b)**		
Other Revenue			
6	Title V (MCH Block Grant)		
7	Title XX (Social Services Block Grant)		
8	Temporary Assistance for Needy Families (TANF)		
9	Local government revenue		
10	State government revenue		
11	Bureau of Primary Health Care (BPHC)		
12	Other (Specify:_____)		
13	Other (Specify:_____)		
14	Other (Specify:_____)		
15	Other (Specify:_____)		
16	Other (Specify:_____)		
17	**Total– Other Revenue (sum rows 6 to 16)**		
18	**Total Revenue (sum rows 1 + 5 + 17)**		

NOTES

NOTES (CONTINUED)

ABBREVIATIONS AND ACRONYMS

AGC	atypical glandular cells
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
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CHIP	Children's Health Insurance Program
CIN	cervical intraepithelial neoplasia
FAM	fertility awareness method
FPAR	Family Planning Annual Report
FTE	full-time equivalent
GPRA	Government Performance and Results Act
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HMO	health maintenance organization
HSIL	high-grade squamous intraepithelial lesion
IUD	intrauterine device
IUS	intrauterine system
LAM	Lactational Amenorrhea Method
LEP	limited English proficiency, limited English proficient
LPN	licensed practical nurse
LSIL	low-grade squamous intraepithelial lesion
LVN	licensed vocational nurse
MCH	maternal and child health
OFP	Office of Family Planning
OMB	Office of Management and Budget
OPA	Office of Population Affairs
PRA	Paperwork Reduction Act
RPC	regional program consultant
SPA	State Plan Amendment
STD	sexually transmitted disease
TANF	Temporary Assistance for Needy Families
USC	United States Code

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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*.[15] 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. Although programs that are directed to minority racial or ethnic populations have exemptions, these programs 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*,[16] 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, self-identification is the preferred means of obtaining information about an individual's race and ethnicity. When self-identification is used, Title X-funded agencies should adopt a method that allows users to mark or select more than one of the five minimum OMB race categories. The OMB guidance includes the following recommendations for collecting data from individuals who self-identify with more than one race:

- 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.
- 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 as long as the detail can be aggregated to the minimum standard set of race and ethnicity categories.

Agencies should consult with their Regional Program Consultant (RPC) if they have questions about collecting multiple responses to a single race question. 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.

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[15] 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 December 9, 2013, from http://aspe.hhs.gov/datacncl/inclusn.htm.

[16] 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 December 9, 2013, from http://www.whitehouse.gov/omb/fedreg_1997standards.

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.*

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