

Enclosure 1

Frequently Asked Questions by Indian, Tribal, and Urban Indian Health Programs on section 330 Funding

1. Q: What is the section 330 Community Health Centers Program?

A: The section 330 Consolidated Health Centers Program is a program of grant support authorized under section 330 of the Public Health Service Act (PHSA). The Bureau of Primary Health Care (BPHC) within the Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS), manages the program. The Health Centers Consolidation Act of 1996 combined several health center programs into a single Act and all are now authorized under section 330. Other sections of the Act provide support for primary care services to migrant and seasonal farm workers, the homeless and residents of public housing. But the largest section provides support through section 330(e) to community health centers (CHCs) that provide services to the underserved throughout a community, including the uninsured and low-income populations, regardless of ability to pay. For the purposes of this document, all FAQs will refer to the section 330(e).

2. Q: Who is eligible to apply for section 330 CHC funding?

A: Any public or non-profit private entity may apply for section 330 CHC funds. This includes, but is not limited to, federally recognized Tribes, Tribal Organizations and Urban Indian Health Programs.

3. Q: What governing board structure do we need to apply for section 330 CHC funds?

A: Under the terms of section 330, Tribes and Tribal Organizations are exempt from the governing board requirements applicable to other section 330 applicants and grantees. Exemption from the section 330 CHC governing board requirements does not exempt Tribes or Tribal Organizations from any other requirements of the section 330 CHC program.

4. Q: What is the definition of “Tribe or Tribal Organization” to qualify for exemption from the governing board requirements of section 330?

A: Eligibility for the exemption is determined by whether the applicant organization receives funds under either the Indian Health Care Improvement Act or the Indian Self-Determination and Assistance in Education Act. If IHS supports an organization under either of these Acts, it is exempt from the governing board requirements of the section 330 program.

However, even with the exemption, a section 330 CHC should establish a mechanism for broad-based consumer input into center operations. The consumer input mechanism should include input from the total population served and to be served by the section 330 CHC. Before receiving section 330 funding, many CHCs serve only a specially defined population. To bridge the gap between the past and the broader future role of serving the entire community, many section 330 CHCs deliberately augment their boards or create advisory groups with representatives of the larger community and new population groups to be served.

The Tribes and Tribal Organizations now receiving section 330 CHC support have already implemented a variety of such consumer input mechanisms and are finding the total service delivery program has benefited. Input from these new representatives is critical in enabling the new section 330 CHC to meet the needs of the total community. They can 1) create linkages with new patient populations; 2) create linkages with new organizations; 3) provide credibility for the new CHC; 4) identify underserved population groups not previously served; 5) identify the health service needs of the populations not previously served; 6) advise the board on how best to design services to meet the needs of the newly served population groups in a culturally competent manner; and 7) provide access to other health care resources.

5. Q: Where must we locate or whom must we serve to qualify for section 330 CHC funds?

A: By law, section 330 CHCs must serve a federally designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP). Tribal health centers located on or near Indian reservations have an automatic designation as a Health Professions Shortage Area (HPSA) but there is no automatic designation for a Medically Underserved Area (MUA) or Medically Underserved Population (MUP).

The Bureau of Health Professions (BHPr) designates MUAs and MUPs using criteria published in the Federal Register including the medical provider to population ratio and the rate of low infant birth weights. A designation can be granted for an entire geographic area or for a population with specific circumstances within the geographic area, e.g. the homeless, the low income, or migrant/seasonal farm workers. The Primary Care Office (PCO) in your State can help develop a request for MUA or MUP designation if your area or population is not currently designated. A list of currently designated MUAs and MUPs is found at <http://bphc.hrsa.gov/databases/newmua/default.cfm>.

6. Q: What services must a section 330 CHC provide?

A: By law, a section 330 CHC must, at minimum, provide the following primary care services:

- 1) Physician and mid-level practitioner services related to family medicine, internal medicine, and pediatrics, obstetrics and gynecology;
- 2) Diagnostic laboratory and radiology services;
- 3) Preventive health services including prenatal and perinatal services; screening for cancer, high blood lead levels, communicable diseases and cholesterol; well-child services and immunizations; pediatric eye, ear, and dental screenings; voluntary family planning services; and preventive dental services;
- 4) Emergency medical services;
- 5) Pharmaceutical services as appropriate for particular centers;
- 6) Referrals to medical, substance abuse, mental health and other health-related providers;
- 7) Case management (counseling, referral, and follow-up) and services to assist patients establish coverage for Federal, State, and local programs of support for medical, social, housing, educational, or related services;

- 8) Outreach, transportation, appropriate interpretation/translation and other services that enable patients to use the services of the health center; and
- 9) Patient and community education on availability and proper use of CHC services.

7. Q: If we receive IHS funds to provide additional services to AI/AN, do we have to provide those same services to everyone?

A: No. When specific non-section 330 funds, e.g. IHS funds, are available to support additional services to specific patient groups, the terms under which those funds are made available must be honored. Beyond the required services (see FAQ #6), a section 330 CHC is expected to make a reasonable, good faith effort to arrange for necessary services for those not covered by special funds but is not required to provide the additional services to population groups not covered by the special funds.

8. Q: Is there a minimum community size to qualify for section 330 CHC funds?

A: Not specifically, however, section 330 CHCs are expected to have no, or limited, excess capacity. Experience with over 850 section 330 CHCs shows that communities of less than about 2,000 persons are not able to provide the full range of services and meet the requirements to be a section 330 CHC without extraordinary cost and significant excess capacity. Urban section 330 CHCs generally have at least 5 medical providers and rural section 330 CHCs generally have at least 3 medical providers.

Experience also shows that communities of less than about 2000 persons are best served as part of a larger organization with a central administration. Often this is as a satellite of a larger section 330 CHC with all required services and linkages in place. Some section 330 CHCs have found it advantageous to contract with organizations that have historically served a specifically targeted population group, such as Native Americans, and that therefore can better reach that specific population. In urban areas, this might mean contracting with an existing section 330 CHC specifically to serve NA/AIs because the existing section 330 CHC is already open to serve all population groups. In a rural area with a small population, this could mean contracting with a larger section 330 CHC to serve the total population of the smaller community.

When determining the size of a community, we look at the total underserved community without regard to whether or not the individuals have any tribal affiliation.

9. Q: Who is eligible for services at a section 330 CHC?

A: A section 330 CHC must target services to meet the primary care needs of the entire community including all age groups, genders and ethnicities. Although section 330 CHCs should specifically target those with the greatest need, they may not provide services to any group on a preferential basis or define a subset of the community as “their community” even if only a part of the population is designated as a MUP.

A section 330 CHC must have a plan and make arrangements to deliver services, to the extent practicable, in the language and cultural context most appropriate to its patient population groups. This may mean designing multiple service delivery strategies when serving a multi-racial, multi-lingual or multi-cultural community.

If your organization is not ready to target the total community population, it is not appropriate for you to consider this joint funding opportunity at this time.

10. Q: Can the Tribe through its PL 93-638 Contract or Compact provide services to non-eligible persons within the service area?

A: The Indian Health Care Improvement Act, Section 813(b)(1)(A) requires tribes and IHS to agree to offer services to non-beneficiaries through tribal programs. The Tribe should contact the IHS Area Office for the necessary procedures to make the request.

11. Q: How can section 330 CHC funds help provide services to the underserved?

A: By law, a section 330 CHC must implement a) a cost-based fee schedule and b) a schedule of discounts to be applied to the fee schedule. The discount schedule adjusts the amount for which the patient is actually responsible based on family size and income. The section 330 CHC funds are used to cover the part of the fee for which the patient is not responsible because the discount schedule is applied. The discount schedule must provide for a) full discount to those below 100% of the Federal poverty level, and b) full charges to those at or above 200% of the Federal poverty level. For consistency with reporting requirements, section 330 CHCs most often use divisions at 100%, 125%, 150%, 175% and 200% of the Federal poverty level. The discount schedule must be applied equally to all patients.

12. Q: How can we implement a sliding discount schedule when IHS requires that we serve AI/AN without charge?

A: Applying the discount schedule to all patients does not mean that each patient must actually receive a bill. If funds are available from sources other than section 330 to cover the part of the fee for which the patient would otherwise be responsible, (e.g. IHS), these non-section 330 funds may be used to cover the patient's portion of the charge. In this instance, the amount for which the patient would be responsible may not be charged to the section 330 CHC program funds. The mixing and accounting for the two sources of funds is an administrative function and is the responsibility of the section 330 CHC; the patient need never know the difference except that the discount information must be collected and reported (see FAQ #13).

13. Q: Other than grant funds, are there any other benefits of being a section 330 CHC?

A: Yes. A section 330 CHC is eligible to participate in a low cost pharmaceuticals acquisition program for malpractice coverage under the Federal Tort Claims Act (FTCA) and to compete for additional funds to support expansion of services.

Urban Indian Organizations receiving funds under Title V of the Indian Health Care Improvement Act and section 330 CHCs are authorized by section 340B of the PHS Act to participate in an outpatient discount drug-pricing program. Those participating in the 340B program may see significant savings on pharmaceuticals.

Any section 330 CHC can apply to be deemed covered by the FTCA. This deeming process allows CHC employees to be treated as Public Health Service

employees for the purposes of the FTCA malpractice coverage. The FTCA will apply to the grantee, and its directors, officers, employees, and primary care or full time (minimum 32.5 hours/week) contractors who are physicians or licensed certified health care practitioners. It does not include malpractice coverage for any volunteers, any referral providers or certain contractors. FTCA does not cover losses or liability generally covered by other types of insurance such as fire, general liability, or theft.

Periodically, funds are available to expand services, e.g. enhance the dental or mental health services, although these opportunities are available only to organizations already receiving section 330 CHC funds.

14. Q: What are the reporting requirements for the section 330 program?

A: There are two groups of reporting requirements: program reporting and grants management reporting. The first program report is the annual Uniform Data Set (UDS) report. This report includes selected financial, utilization and clinical information and is used by BPHC to assess the effectiveness of the section 330 program, report to Congress and justify the use of the appropriation of funds. The second program report is the annual application; it includes both a summary of progress to date and a projection of the budget and plan for the use of next year's funds. The grants management reports are those required by the Payment Management System for disbursement of and accountability for Federal funds. Special, though infrequent, reports may be required if specific issues are raised.

15: Q: How much support is available and how do I apply for section 330 CHC funds?

A: Applicants for funds to establish a new access point can request up to \$650,000 per year for operating costs including costs associated with subsidizing low income patients who are expected to pay only part of the cost of the service. However, the amount of money that will be awarded is dependent on several factors such as service population, current operating budget and proposed services.

There is also an initiative by President Bush to increase the number of community health centers and the patients they serve nationwide. To establish new or expand existing community health centers, this initiative received a funding increase of \$175 million for FY 2004 and a further increase is expected for FY 2005. President Bush's initiative goal is to establish 1,200 new "access points" (i.e. community health centers) between FY 2002 and FY 2006. This initiative is supported by both the President and Congress. Applying for section 330 CHC funds is a highly competitive process. Applications are accepted throughout the year but there are cut off dates for applications to be reviewed in given cycles. The applications are reviewed by non-Federal objective reviewers and ranked according to the criteria stated in the program announcement. Following this review, BPHC considers other factors (e.g. urban/rural and geographic distribution), applies the preference factors stated in the program announcement and makes the final funding decisions.

16. Q: How can I get help in putting together an application for section 330 CHC support?

A: Tips for developing a new access point applications are enclosed. Applicants are encouraged to submit a Letter of Interest (LOI) to BPHC as soon as it begins considering an application for Federal support of a new access point. The submission of an LOI is recommended but not required. Past history has shown that applicants have benefited from the feedback provided through the LOI process. BPHC uses the LOI process to provide feedback to the organization to improve the quality of its application. Through this process, BPHC will examine whether the proposal is consistent with the objectives of the Consolidated Health Center Program, demonstrates readiness to initiate the project and assures the completeness of the need for assistance data. For more information about what to include in an LOI, please review the application guidances. It is also recommended that a copy of the LOI be sent to the appropriate PCA and PCO. After an LOI is submitted and feedback is provided, applicants are encouraged to work with the PCAs and PCOs to develop the strongest possible application for funding.

If you need further information, please contact your PCA and visit the Web site to access proposal and guidance materials. If you would like to speak to someone, please contact the following IHS and HRSA staff:

Ms. Tonya Bowers, HRSA, at 301-594-4300 or tbowers@hrsa.gov

Elmer Brewster, HIS, at 301-443-2419 or elmer.brewster@mail.ihs.gov

Denise Exendine, Acting Director, Urban Indian Health Programs, at 301-443-4680 or dexendin@hqe.ihs.gov.

Enclosure 2

Tips for Writing a Strong Application For HRSA Funding

Include DUNS Number. You must include DUNS Number to have your application reviewed. Applications will not be reviewed without a DUNS number. To obtain a DUNS number, access www.dunandbradstreet.com or call 1-866-705-5711. Please include the DUNS number next to the OMB Approval Number on the application face page.

Keep your audience in mind. Reviewers will use only the information contained in the application to assess the application. Therefore, the applicant should be sure the application and responses to the program requirements and expectations are complete and clearly written. Do not assume that reviewers are familiar with the applicant organization. Keep the review criteria in mind when writing the application.

Start preparing the application early. Allow plenty of time to gather required information from various sources.

Follow the instructions in this guidance carefully. Place all information in the order requested in the guidance. Organizations submitting an application electronically should make sure all attachments print in the correct order prior to submission. If the information is not placed in the requested order, you may receive a lower score.

Be brief, concise, and clear. Make your points understandable. Provide accurate and honest information, including candid accounts of problems and realistic plans to address them. If any required information or data is omitted, please explain why.

Be consistent. Make sure the data provided in each table, chart, attachment, etc., is consistent with the information in other tables and required forms. Be sure information provided in the health care plan, business plan and budget presentation accurately reflect information within the program narrative.

Be organized and logical. Many applications fail to receive a high score because the reviewers cannot follow the thought process of the applicant or because parts of the application do not fit together.

Be careful in the use of appendices. Do not use the appendices for information that is required in the body of the application. Be sure to cross-reference all tables and attachments located in the appendices to the appropriate text in the application.

Carefully proofread the application. Misspellings and grammatical errors will impede reviewers in understanding the application. Be sure pages are numbered (including all attachments) and that page limits are followed. Limit the use of abbreviations and acronyms, and define each one at its first use and periodically throughout application.

Enclosure 3



HOW TO WRITE EFFECTIVE SECTION 330 FUNDING PROPOSALS

Where to build it? Who to serve? What funding opportunities are out there and how do you think strategically about applying for them? Organizing a health center or expansion program is complex enough...but how do you also present that program plan in an effective funding application. And now, there is a whole new section 330 application format!

This training is a two and a half day intensive in how to logically develop your program model starting with doing a comprehensive needs assessment through developing health and business plans and budgets. Tips on how to present information in the proposal, what review committees look for and how to help improve your opportunities for funding will be covered.

Day 1 offers two special sessions. The first focuses on the basics of Federally Qualified Health Centers (FQHCs). The target audience for this is people who have never worked on an FQHC before and need to understand statutory requirements and program expectations. Experienced grantees may find it a good refresher course as well. The second session addresses FQHC Look-Alikes – what are the benefits of going this route and the requirements to become designated, and the requirements for Public Entities that are applying for FQHC status or funding.

Days 2 and 3 start with plenary sessions in the morning and then hands-on workshops in the afternoon in the areas of data and needs assessments, writing goals and objectives for health and business plans, successful collaborations, and developing budgets.

A comprehensive handbook and resource cd are provided to training participants along with samples of many of the documents discussed in the workshops and plenaries.

Who Should Attend?

- Administrative, clinical, finance and development staff and Board Members of:
 - Health Centers facing Service Area Competition applications
 - Communities interested in starting new health centers
 - Health center grantees interested in expanding sites and/or services

- Primary Care Association and Primary Care Office staff
- Anyone seeking to brush up on section 330 program requirements, program development and proposal preparation.



HOW TO WRITE AN EFFECTIVE SECTION 330 PROPOSAL FY 2005 TRAINING AGENDA

Day 1: 3:00 p.m.-6:00 p.m.

FQHC 101: Introductory session covering the basic statutory requirements and program expectations for becoming a Federally Qualified Health Center (FQHC)

FQHC Look-Alikes and Public Entity Proposals: A special session covering FQHC Look-Alikes – the benefits and requirements and the ins and outs of being an FQHC public entity applicant.

Day 2: 8:00 a.m. – 5:30 p.m. (Continental Breakfast provided at 7:30 a.m.)

- Introduction - Overview of the New Guidance format: The Program/Proposal Logic Model
- Section 330 Funding Opportunities in FY 05
- Identifying the Problem: Doing Community Needs Assessments
- Thinking through the Options: Strategic Planning
- The Response: Service Delivery Models
- Governance and Readiness: Complying with program requirements
- Resources and Capabilities: Showing that you can do it
- Breakouts 1 & 2: Breakouts are repeated so everyone can attend both each day
 - Describing Your Target Population
 - Developing Successful Collaborations

Day 3: 7:30 a.m. – 4:45 p.m. (Continental Breakfast provided at 7:00 a.m.)

- The Evaluation: How do we know if we are doing it?
 - Developing the Health Plan
 - Developing the Business Plan
- The Impact: What effect does it actually have?
- Support Requested: The Budget
- The Proposal Work Plan: Pulling it together
- Breakout Sessions 1 & 2: Breakouts are repeated so everyone can attend both each day
 - The Art of Doing Health and Business Plan Charts
 - Up Close with the Budget



REGIONAL TRAININGS WILL (tentatively) BE HELD IN:

BILOXI, MISSISSIPPI – August 30 – September 1, 2004
SAN FRANCISCO, CALIFORNIA – September 16 – 18, 2004
SALT LAKE CITY, UTAH – October 22 – 24, 2004

CLEVELAND, OHIO - TBD
KANSAS CITY, MISSOURI – TBD
WASHINGTON, DC – March, 2005

CHECK THE NACHC WEB SITE UNDER UPCOMING EVENTS FOR SPECIFIC DATES AND PLACES AND REGISTRATION INFORMATION (www.Nachc.com).

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For more information

Enclosure 4

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STATES	PCO DIRECTOR	DEPARTMENT & ADDRESS	HPSA CONTACT AND EMAIL									
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15 GEORGIA	Sondra Hampton Email: Shampton@dch.state.ga.us	State Office of Rural Health Georgia Dept. of Community Health 502 South 7th Street Cordele, GA 31015-4214	Contact: Sondra Hampton Phone: (229) 401-3095 Fax: (229)401-3077 Email: shampton@dch.state.ga.us								
16 GUAM	Dennis G. Rodriguez, M.D.	Director of Health Department of Public Health and Social Services P.O. Box 2816 Agana, Guam 96910	Contact: Cynthia Naval Phone: (671) 735-7399 (671) 735-7307 Fax: (671) 735-2066								
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18 IDAHO	Laura Rowen Email: rowenl@idhw.state.id.us	Office of Resource Development Idaho Dept. of Health & Welfare P.O. Box 83720, 4th Floor Boise, ID 83720-0036	Contact: Laura Rowen Phone: (208) 334-5993 Fax: (208) 334-6581 Email: ROWENL@IDHW.STATE.ID.US								
19 ILLINOIS	Mary C. Ring, Program Administrator Email: mring@idph.state.il.us	Center for Rural Health Illinois Department of Public Health 535 West Jefferson Street Springfield, IL 62761	Contact: Mary C. Ring Phone: (217) 782-1624 Fax: (217) 782-2547 Email: MRING@IDPH.STATE.IL.US								
20 INDIANA	Patrick Durkin Email: pdurkin@isdh.state.in.us	Indiana State Department of Health 2 North Meridian Street St. 8-B Indianapolis, IN 46204-3006	Contact: Randall Ritter Phone: (317) 233-78460 Fax: (317) 233-7761 Email: rritter@ori.net								
21 IOWA	Doreen Chamberlin Email: dchamberlin@idph.state.ia.us	Iowa Department of Public Health Bureau of Community Health Development Lucas State Office Building 321 East 12th., 5th Floor Des Moines, IA 50319-0075	Contact: Carl Kulczyk Phone: (515) 242-6879 Fax: (515)242-6384 Email: ckulcayk@isph.state.ia.us								
22 KANSAS	Barbara Gibson, Director Email: BGIBSON@KDHE.STATE.KS.US	Office of Local & Rural Health Kansas Department of Health and Environment 1000 Southwest Jackson, Suite 340 Topeka, KS 66612-1365	Contact: Barbara Huske Phone: (785) 296-1200 Fax: (785) 296-1231 Email: bhuske@kdhe.state.ks.us								
23 KENTUCKY	John Hensley Email: john.hensley@mail.state.ky.us	Health Care Access Branch 275 E. Main Street Mail Stop HS2GW-A Frankfort, KY 40621	Contact: Tammy Hutcherson Phone: (502) 564-4830 X 3783 (502) 564-6533 Fax Email: tammy.hutcherson@mail.state.ky.us								
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STATES	PCO CONTACT	DEPARTMENT & ADDRESS	HPSA CONTACT AND EMAIL	F	G	H	I	J	K	L	M
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26 MAINE	Sophie Glidden SOPHIE.E.GLIDDEN@Maine.gov Email:	Office of Rural Health & Primary Care Maine Department of Human Services office of Rural Health and Primary Care 167 Capital Street Augusta, ME 04333-0011	Contact: Sophie Glidden Phone: (207) 287-5524 Fax: (207) 287-5431 Email: gldavis@dhh.state.la.us								
27 MARYLAND	Antoinette Coward, Administrator Email: cowarda.dhnh.state.md.us	Dept. of Health & Mental Hygiene Primary Care Planning & Policy Development Office 201 West Preston Street, Room 225 Baltimore, MD 21201	Contact: Carolyn Alexander Phone: (410) 767-5602 Fax: (410) 33-7501 Email: Calexander@dhmh.state.md.us								
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29 MICHIGAN	Lonnie Barnett Email: BarnettL@michigan.gov	Health Legislation & Policy Development Michigan Dept. of Community Health 320 S. Walnut Street Lewis Cass Building, 6th Floor Lansing, MI 48913	Contact: Monica Balderson Phone: (517) 241-9947 Fax: (517) 241-2962 Email: Balderson.mo@michigan.gov								
30 MINNESOTA	Debbie Jahnke Email: Debra.Jahnke@health.mn.us	Office of Rural Hlth & Primary Care Minnesota Department of Health P.O. Box 64975 St. Paul, MN 55164	Contact: Debbie Jahnke Phone: (651) 282-6334 Fax: (651) 297-5808 Email: Debra.Jahnke@health.mn.us								
31 MISSISSIPPI	Perelia Taylor Email: ptaylor@msdh.state.ms.us	Bureau of Health Resources Mississippi Dept. of Health P.O. Box 1700 Jackson, MS 39215-1700	Contact: Alvin Harrion Phone: (601) 576- 7216 Fax: (601) 576-7230 Email: Aharrion@msdh.state.ms.us								
32 MISSOURI	Harold Kirbey Email: kirbeh@dhhs.state.mo.us	Health Care Access & Assessment Missouri Department of Health 920 Wildwood Drive P.O. Box 570 Jefferson City, MO 65102	Contact: Joanna Adamson Phone: (573) 526-0461 Fax: (573) 522-8146 Email: Adamsj@dhhs.mo.gov								
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35 NEVADA	Mark Hemmings, Program Manager Email: mhemmings@nvhd.state.nv.us	Nevada State Health Division Primary Care Development Centers 505 East King Street, Room 203 Carson City, NV 89701-3711	Contact: Mary Mackenzie (775) 684-4047 (775) 684-4220 FAX Email: mmackenzie@nvhd.state.nv.us								
36 NEW HAMPSHIRE	Brain Ayars Email: BAYARS.DHHS.STATE.NH.US	Division of Public Health New Hampshire Dept. of Health & Human Services 6 Hazen Drive Concord, NH 03301-6527	Contact: Bryan Ayars Phone: (603) 271-4741 Fax: (603) 271-1517 Email: bayars@dhhs.state.nh.us								
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STATES	PCO CONTACT	DEPARTMENT & ADDRESS	HPSA CONTACT AND EMAIL								
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40	NEW YORK	Barry Gray Email: bmg01@health.state.nh.us	N.Y. State Department of Health Corning Tower, Rm. 1084 Albany, NY 12237	Contact: Caleb Wistar Phone: (518) 473-4700 Fax: (518) 473- 6195 Email: ccw01@health.state.ny.us							
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53	TEXAS	Connie Berry, Chief Email: connie.berry@tdh.state.tx.us	Primary Care Office Texas Department of Health 1100 West 49th Street Austin, TX 78756	Contact: Vickie Hamilton Phone: (512) 458-7518 Fax: (512) 458-7658 Email: vickie.hamilton@tsh.state.tx.us							
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58	WASHINGTON	Mary Looker, Director Email: MARY.LOOKER@DOH.WA.GOV	Office of Community & Rural Health Washington State Dept. of Health P.O. Box 47834 Olympia, WA 98504-7834	Contact: Juno Whittaker Phone: (360) 236-2811 Fax: (360-664-9273 Fax Email: juno.whittaker@doh.wa.gov							
59	WEST VIRGINIA	Phil Schenk Email: Philschenk@wvdhhr.org	Division of Recruitment West Virginia Dept. of Health 1411 Virginia Street East Charleston, WV 25301	Contact: Melissa Wheeler Phone: (304) 558-4383 Fax: (304) 558-1437 Email: melissawheeler@wvdhhr.org							
60	WISCONSIN	Margeret Taylor Email: taylome@dhs.state.wi.us	Primary Care Section WI Dept. of Health & Social Services 1 W. Wilson, Room 218 Madison, WI 53701	Contact: Kathy Lenzen Phone: (608) 264-7735 Fax: (608)267-2832 Email: lenzel@dhs.state.wi.us							
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62	STATES	PCO CONTACT	DEPARTMENT & ADDRESS	HPSA CONTACT AND EMAIL	F	G	H	I	J	K	L	M
62	WYOMING	Lynne Weidel Email: lweide@state.wy.us	Office of Rural Health 2020 Carey Avenue, 5th Floor Cheyenne, WY 82002-0480	Contact: Douglas Thiede Phone: (307) 777-8651 Fax: (307) 777-8545 Email: Dthied@state.wy.us								
63	CNMI	James U. Hofschneider, MD HEALTH1@VZPACIFICA.NET	Secretary of Health Department of Public Health P.O. Box 409 C.K. Saipan, MP 96950	Contact: Pedro T. Untalan, MHA Phone: (670) 236-8950 Fax: (670) 236-8930								
64	FEDERATED STATES OF MICRONESIA	Eliuel K. Pretrick, M.O. Secretary	Department of Health P.O. Box 490 Palikir, Pohnpei, FM 96941	Contact: Eliuel K. Pretrick Phone: (691) 320-2619 (691) 320-2215 (691) 320-5394 Fax								
65	PALAU	Caleb Otto Email: cotto@palau-health.net	Bureau of Public Health Ministry of Health P.O. Box 6027 Koror, Republic of Palau PW 96940	Contact: Annable Lyman Phone: (680) 488-2813 (680) 488-3116 Fax: (680) 488-1211 Email: bhd@palau-health.net								
66	MARSHALL ISLAND	Justina Langidrik Email: Irene_cbeye@hotmail.com	Secretary of Health P.O. Box 16 Majuro, Marshall Islands 96960	Contact: Irene Paul Phone: (692) 625-5660/5661 Fax: (692) 625-3432								
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