OASH | Office of Population Affairs

Family Planning Annual Report 2.0 Implementation Guide

Revised January 2025

Replaces version published December 2024

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Exhibits

I. Introduction

A. Purpose of implementation guide

This implementation guide is designed to be a resource for grantees as they transition to Family Planning Annual Report (FPAR) 2.0.[1] It provides grantees with guidance for collecting and submitting FPAR data, including information about data elements and data submission options. Readers should review Appendix A: FPAR 2.0 Forms and Instructions for more information about the intended use of each FPAR table. Readers interested in instructions for interacting with the FPAR 2.0 system should read the FPAR 2.0 User Guide (accessible when logged into the web based FPAR 2.0 system).

B. Understanding the transition to FPAR 2.0

Family Planning Annual Report (FPAR) is the only source of annual, uniform reporting by all grantees funded under Section 1001 of the Title X Public Health Service Act (42 United States Code 300).[2] The transition to FPAR 2.0 encounter-level data will help improve data collection, reporting, and analysis, and better describe the services provided under Title X. Title X Family Planning Service grantees must submit data to the Office of Population Affairs (OPA) annually for monitoring and reporting purposes (45 Code of Federal Regulations Part 75).[3] Under FPAR 2.0, grantees report many of the same FPAR 1.0 data elements, but at the encounter level (instead of the aggregate level). The enhanced data collection will provide information and metrics that OPA and grantees can use to improve access and quality.

C. Goals for FPAR 2.0

As with FPAR 1.0, the goals of FPAR 2.0 are to (1) monitor compliance with statutory requirements, regulations, and operational guidance in Title X program requirements; (2) comply with accountability and federal performance requirements; and (3) guide strategic and financial planning and responses to inquiries from policymakers and Congress. FPAR 2.0 will enable OPA and grantees to improve access and quality in Title X family planning services.[4] It will create opportunities to better understand the diverse needs of the people who receive Title X services, provide focused support to Title X providers, and help identify successes and gaps to improve the Title X program overall and the services provided at the grantee and sub-recipient levels.

The system automates procedures currently done manually by some grantees and OPA staff, such as tabulating and checking basic counts of the number of clients served and types of services provided. In addition, the data collected with FPAR 2.0 will contribute to a learning environment in the health care field by expanding the options for data analysis and reporting—for example, through interactive data dashboards and visualizations and application of statistical analyses to the encounter-level data files.

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[1] FPAR 2.0 received OMB clearance under OMB control number 0990-0479. Expires 2/28/2025.
[2] 42 United States Code (USC) 300 et seq. (1970). Title X–Population research and voluntary family planning programs: Project grants and contracts for family planning services (Section 1001[300]). Retrieved from: https://opa.hhs.gov/sites/default/files/2020-07/title-x-statute-attachment-a_0.pdf
[3] 45 Code of Federal Regulations (CFR) Part 75. (2024, May 13). Uniform administrative requirements, cost principles, and audit requirements for HHS awards. Retrieved from: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-75
[4] The Title X Program Handbook provides information critical to managing a Title X project in one place and serves as a one-stop reference document for new and existing Title X recipients: https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/title-x-program-expectations

FPAR 2.0 data are presented in summary form to protect the confidentiality of individuals who receive Title X-funded services.[5]

FPAR 2.0 data submitted by grantees includes (1) a grantee profile cover sheet, (2) encounter-level data, (3) a project revenue report, and (4) a report on providers of family planning clinical services. These data continue to give OPA information on the characteristics of the Title X service network and the people who receive Title X services, including information on contraceptive use and receipt of related preventive health services. FPAR 2.0 data will be used to generate most tables produced in FPAR 1.0, and they will leverage some new and revised data elements related to quality measures and the Quality Family Planning Guidelines. The new and revised data elements will provide information about the client and the services provided at a specific encounter, including their contraceptive method at the time of intake and whether the family planning program provided tests for sexually transmitted diseases at the visit. These data allow OPA to better monitor access to and use of Title X services in the diverse populations these programs serve. Please see the section on Data Elements (Section VI) of this implementation guide for more information.

D. Updates in this version

The following is a summary of updates in this version of the implementation guide:

January 2025

- Removed data elements 42 and 43 from FPAR data reporting.

December 2024

- Revised the updated definition of a family planning encounter to align with 42 CFR § 59.2 and updated related questions and answers in the Terms and Definitions (Section III).

October 2024

- Updated the definition of a family planning encounter to align with 42 CFR § 59.2 and updated related questions and answers in the Terms and Definitions (Section III).
- Added new sections about FPAR 2.0 system updates on the Data Validation Explorer Tool, due date for submitting FPAR 2.0 data, and user account management in the General Instructions (Section II).
- Updated the definition of a family planning encounter to align with 42 CFR § 59.2 and updated related questions and answers in the Terms and Definitions (Section III).
- Added the definition for a virtual family planning encounter.
- Added example contraceptives to definition of primary method of family planning for Tables 7 and 8 in Appendix A: FPAR 2.0 Forms and Instructions.

[5] 42 Code of Federal Regulations (CFR) Part 59 Subpart A. (2024, October 2). Project grants for family planning services. Retrieved from: https://www.ecfr.gov/current/title-42/chapter-I/subchapter-D/part-59/subpart-A

II. General Instructions

This section provides general instructions and the due date for completing the FPAR.

A. Who submits data to FPAR 2.0?

Grantees funded under Section 1001 of the Title X Public Health Service Act (42 USC 300) must submit FPAR 2.0 data. The family planning service grantee is the direct recipient of the Title X grant and is therefore responsible for reporting all FPAR 2.0 data for the grant. Subrecipients (delegates or subcontractors) of the grantee receive Title X funds from the grantee. Subrecipients should submit FPAR 2.0 data to the grantee, and the grantee in turn submits to OPA on behalf of all subrecipients.

B. Activities to report in FPAR 2.0

FPAR 2.0 aims to provide a comprehensive view of the family planning activities executed under the grant. The FPAR reporting period is the prior calendar year (January through December). If the grantee's funding started in a month other than January, Title X funded services should be reported from the time the funding started through the end of that calendar year. Grantees should review the Terms and Definitions (Section III), which provides guidance on the scope of activities relevant to family planning encounters. **Note to grantees: If you have questions about what is in scope and therefore should be included in the FPAR report, please contact your Project Officer (PO).**

C. Data Validation Explorer Tool

Prior to the submission period opening, grantees may utilize the Data Validation Explorer (DVE) tool. This tool was created for grantees to validate encounter-level data file structure and formatting prior to submission. Grantees can upload encounter-level data directly into the DVE tool that will produce a list of data validation errors and/or warnings. **Any data uploaded in the DVE tool are not saved in the system.**

D. Submitting the FPAR

Grantees submit the FPAR electronically using the web based FPAR 2.0 system: https://fpar.opa.hhs.gov. An authorized user account is required to use the system to submit and manage your FPAR data. Each grant will have at least one Grant Admin account holder who can create additional accounts for that grant. New users will receive an automated email confirming their registration, a link to the FPAR 2.0 system website, a username, and a temporary password that must be changed at first log-in. An FPAR 2.0 User Guide, which is available within the system, provides step-by-step instructions for navigating the system to submit FPAR data.

E. Due date for submitting FPAR 2.0 data

Grantees submit FPAR 2.0 data annually. Grantees typically have a six-week submission period. OPA communicates reporting timelines each fall.

F. Request for FPAR Remediation

After submitting your grant's FPAR data, OPA will review your submission and may ask you to make corrections or provide additional information. If the FPAR Data coordinator or your PO requests a

revision, the FPAR Grant Admin users for your agency will receive an automated email from the FPAR 2.0 system that includes revision instructions.

If you are unable to revise your submission using the FPAR 2.0 system, please contact your PO to request assistance. Grantees should consult with their PO regarding any requirements or deadlines for submitting revised FPAR tables.

G. User account management

Accounts become inactive after 60 days of inactivity. Users will receive a system email five days in advance that warns them that their account will become inactive. Accounts shall remain active if users log in within 60 days of their previous log in. Users also must update their password every 60 days.

III. Terms and Definitions

A. Terms and definitions

OPA provides definitions for key FPAR 2.0 terms to ensure uniform reporting by Title X grantees.

- **Client**. A client is an individual who seeks services at a health center regardless of the type of service, whereas a family planning user refers to an individual who seeks family planning and related services.
- **Family planning user**. A family planning user is an individual who has at least one family planning encounter during the reporting period. The same individual may have more than one encounter but can only be counted as a family planning user once during a reporting period.
- **Family planning provider.** A family planning provider is the individual who assumes primary responsibility for assessing a client (family planning user) and documenting services in the client's record. Providers include those agency staff who exercise independent judgment about 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 service providers.
  - *Clinical service providers.* Includes physicians, 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 physical assessments recommended for contraceptive, related preventive health, and basic infertility care.
  - *Other service providers.* Includes other agency staff (for example, registered nurses, public health nurses, licensed vocational or licensed practical nurses, certified nurse assistants, health educators, social workers, or clinic aides) who offer client education, counseling, referral, or follow-up services relating to the client's proposed or adopted method of contraception, general reproductive health, or infertility treatment, as described in the Title X program requirements. Other service providers may also perform or obtain samples for routine laboratory tests (for example, urine, pregnancy, sexually transmitted infections, and cholesterol and lipid analysis), give contraceptive injections (for example, Depo-Provera®), and perform routine clinical procedures that may include some aspects of the user physical assessment (for example, blood pressure evaluation), in accordance with the Title X program requirements.
- **Family planning encounter.** A family planning encounter is a documented contact between an individual and a family planning provider that is either face-to-face in a Title X service site or virtual

through telehealth technology. The purpose of a family planning encounter is to provide family planning and related preventive health services that align with the definition of family planning services in 42 CFR § 59.2.[5] A written record of the services provided during the family planning encounter must be documented in the client record for FPAR.

There are two types of family planning encounters: (1) family planning encounters with a clinical services provider and (2) family planning encounters with other service providers as described above. 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 nonclinical assessment and care during the encounter, should be the provider of record for the encounter.

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

Reporting encounter-level data involves submitting FPAR 2.0 data elements that capture information pertaining to the family planning user, provider, services, and site from unique encounters.

- **Virtual family planning encounter.** A virtual family planning encounter uses telecommunications and information technology to provide distanced access to Title X family planning and related preventive health services, including assessment, diagnosis, intervention, consultation, education and counseling, and supervision. Telehealth technologies include telephones, facsimile machines, electronic mail systems, videoconferencing, store-and-forward imaging, streaming media, remote monitoring devices, and terrestrial and wireless communications.
- **Family planning services**. Family planning services include a broad range of medically approved services, which includes Food and Drug Administration (FDA)-approved contraceptive products and natural family planning methods, for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, sexually transmitted infection (STI) services, and other preconception health services.
- **Related preventive health services**. Related preventive health services include screening for breast and cervical cancer.
- **Family planning service site.** Service site is a clinic or other location where Title X services are provided to clients. Title X recipients and/or their subrecipients may have service sites.
- **Client records.** Title X projects must establish a medical record for every family planning user who obtains clinical services or other screening or laboratory services (such as blood pressure check, urine-based pregnancy test, or STD test). The medical record contains personal data; a medical history; physical exam data; laboratory test orders, results, and follow-up; treatment and special instructions; scheduled revisits; informed consent forms; documentation of refusal of services; and information on allergies and untoward reactions to identified drugs. The medical record also contains clinical findings; diagnostic and therapeutic orders; and documentation of continuing care, referral, and follow-up. The client's 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. The client medical record must also include data that enable the Title X site to complete their required FPAR reporting. 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.

If a family planning user receives no clinical services during a face-to-face or virtual family planning encounter, the provider must still 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.

B. Questions about FPAR terms and definitions

OPA provides the following clarifications to questions on FPAR 2.0 terms and definitions.

QUESTION – Are the definitions for any of the key FPAR terms different from their definitions in the Title X FPAR Forms and Instructions (Reissued November 2021)?

ANSWER – OPA has made no changes to the definitions of key FPAR terms in this version of Appendix A: FPAR 2.0 Forms and Instructions.

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 nonclinical assessment and care during the visit.

QUESTION – Who is and who is not considered a family planning user?

ANSWER – A family planning user is an individual who has at least one family planning encounter during the reporting period.

QUESTION – In the scenarios listed in the table below, when is a client a Title X family planning user?

Scenario	**Is the client a family planning user?**
A person receives a pregnancy test and STI testing at the same time from through the Title X-project, tests are positive. Would Title X cover STI treatment?	Yes
If a person of reproductive age is part of the LGBTQI+ community and is seeking sexual and reproductive health services, is that person a Title X family planning user and is this a Title X family planning encounter?	Yes
An individual of reproductive age is seeking only STI services, are they eligible to be a Title X family planning user?	Yes
Does a Title X family planning encounter include in vitro fertilization or surrogacy?	No

QUESTION – If a client is sterilized under a service site's Title X-funded project, can follow-up care related to the sterilization be counted as a family planning encounter?

ANSWER –Yes, follow-up care related to a sterilization conducted by a site's Title X-funded project can be covered by the Title X-funded project and counted as a family planning encounter.

QUESTION – If an individual receives gynecological or related preventive health services (such as a pelvic exam, Pap test, pregnancy test, or 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 – The 2021 Title X Rule (42 CFR §59.2) defines family planning services as services that include a broad range of medically approved services, which includes Food and Drug Administration (FDA)-approved contraceptive products and natural family planning methods, for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, sexually transmitted infection (STI) services, and other preconception health services.

An individual is a family planning user and an encounter is a family planning encounter if it meets the definitions included the Terms and Definitions (Section III). If the individual visits a Title X service site to obtain any family planning or related preventive health service, the encounter is considered a family planning encounter, and the client is considered a family planning user. Additional counseling and education not related to the service provided is not required for the service to count as a family planning encounter.

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 a family planning user, and the encounter is a family planning encounter.

QUESTION – If a clinic aide or nurse is trained and authorized to give contraceptive injections (for example, 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 they may be trained and authorized to give contraceptive injections. Only physicians, physician assistants, 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 assessments recommended for contraceptive, related preventive health, and basic infertility care 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.

IV. Reporting Pathways

To accommodate grantees' varying degrees of readiness to transition to FPAR 2.0, OPA is providing a three-year transition period, which started with data collection year 2022 (2023 submission) for data collected from January through December 2022. **This option will be available to grantees through data collection year 2024 (2025 submission).** By data collection year 2025 (2026 submission), grantees need to have completed a full transition to FPAR 2.0, reporting all required and clinically appropriate data elements at the encounter-level (Section VI). Exhibit A and the following subsections describe the two available reporting pathways.

Exhibit A. Preferred and alternate approaches for FPAR 2.0 transition

A. Preferred approach

In the **preferred approach**, grantees that can submit any FPAR 2.0 encounter-level data. The encounter-level submission does not have to reflect complete data. Grantees should report as many data elements as possible for each encounter. Grantees will upload encounter-level and lab results data into the system as CSV files. Once the data file is validated, the FPAR 2.0 system will aggregate the data and pre-populate the FPAR tables. Grantees will have two options for addressing incomplete data or data quality issues:

- Correct encounter data and resubmit the data.
- Edit the FPAR tables produced by the FPAR 2.0 system. Grantees will have the option to edit tables that are similar to the tables submitted for FPAR 1.0 to ensure totals for each table accurately represent services provided.

B. Alternate approach

In the **alternate approach**, grantees that cannot report any encounter-level data should apply for a waiver from OPA to request approval to submit aggregate-level data. The waiver request will ask grantees to present a plan for how they will transition to FPAR 2.0 encounter-level submissions. **Grantees are required to submit a waiver for each year they are reporting aggregate data.** Each transition year, OPA will provide guidance about the waiver requirements and submission timelines.

After OPA has approved a grantee's waiver request for that transition year, the FPAR 2.0 system will allow Title X grantees to manually enter aggregate data for the tables similar to those used by FPAR 1.0. The alternate approach will be available for data collected through December 2024, which grantees will submit in 2025. However, grantees should make the transition to FPAR 2.0 as soon as they can. Grantees do not have to wait until data collection year 2025 (submission year 2026) to transition to the preferred approach.

Exhibit B includes a few example scenarios and recommended next steps for both approaches from the grantee perspective.

Exhibit B. Example scenarios and recommended next steps for FPAR 2.0 transition

Scenario	Recommended next steps
We are a grantee with an EHR system and can submit *all* data for FPAR 2.0 at the encounter level.	**Preferred pathway** Collect FPAR 2.0 data during the data collection year 2024. Submit data on FPAR 2.0 encounters in 2025. Edit summary tables in the FPAR 2.0 system as needed.
We are a grantee with an EHR system and can collect *some* FPAR 2.0 encounter-level data from our subrecipients and service sites.	**Preferred pathway** Collect FPAR 2.0 data during data collection year 2024 Submit data on FPAR 2.0 encounters in 2025. Edit summary tables in the FPAR 2.0 system as needed Work with technical assistance providers to address any data quality issues and thereby improve the quality of future submissions.
We have an EHR system, but cannot create FPAR 2.0 encounter-level data at this time.	**Alternative pathway** Submit a new waiver to OPA for data collection year 2024. Develop a plan with the PO to support service sites that will update their EHR systems to better support FPAR 2.0. Work with your EHR vendor to map data to FPAR 2.0 and create FPAR 2.0 encounters. Collect FPAR 2.0 data during data collection year 2024 and submit in 2025. Transition to FPAR 2.0 submission during data collection year 2025 (submission in 2026).
We have no EHR system.	**Alternative pathway** Submit a new waiver to OPA for data collection year 2024. Develop a plan with the PO to support service sites with an EHR system. Implement electronic records into your practice, and modify workflow as necessary. Transition to FPAR 2.0 submission during data collection year 2025 (submission in 2026).

EHR = electronic health record.

V. Submitting Data

A. Preparing to submit data

To prepare to submit FPAR 2.0 data, grantees should:

- Review the data requirements for encounter-level FPAR 2.0 reporting.
- Assess their workflow and documentation practices to ensure they routinely capture relevant data.
- Review guidelines for protecting data privacy and security.

The following sections provide guidance for submitting FPAR 2.0 data elements in acceptable file formats while adhering to best practices for privacy and security. **Note:** Please refer to the General Instructions (Section II) for details related to timelines for submitting FPAR 2.0 data.

B. Guidance materials for submission

FPAR 2.0 accepts comma separated value (CSV). Several technical assistance (TA) materials, such as the FPAR 2.0 Sample Files and Data Quality Checks, are available on OPA's website. These materials are geared toward a technical audience to help staff develop files for FPAR data submissions. Please check the OPA website regularly for new and updated materials. Grantees will also be notified when new technical TA materials are available.

C. Data quality checks

Automated data quality checks are part of the data submission process for FPAR 2.0. Once the FPAR tables are populated, either through the preferred or alternate approach, grantee users run a data quality check. If the check identifies any issues, users must update the data and/or add a comment that explains the issue. The FPAR 2.0 system data quality checks are grouped into three main categories:

1. **Within-table checks.** These are checks of data values within a single FPAR table. For example, in Table 2, if race is unknown or not reported for 10 percent or more of female users, the system will note a data quality issue. As another example, in Table 5, if all users are reported in a single insurance status category, the system will note a data quality issue.
2. **Across-table checks.** Some data values should match across FPAR tables. Otherwise, the system will note a data quality issue. For example, if the total number of women reported in Table 1 does not equal the total number of women reported in Table 2, the system will note a data quality issue for Tables 1 and 2.
3. **Previous-year checks.** Substantial changes in data values across years might indicate a data quality issue. The system will note a data quality issue if a value changes by +/- 50 percent or more compared with the previous year. For example, in Table 9, the system will note a data quality issue if the number of Pap tests performed increases from 1,000 in 2021 to 2,000 in 2022.

Please review the Data Quality Checklist for a detailed list of FPAR 2.0 data quality checks.

D. Guidance materials for FPAR 2.0 navigation

The FPAR 2.0 system launch webinars provide live demonstrations of key features of the FPAR 2.0 system. Recordings and Q&A documents from the webinars are available on Connect.gov. Please reach

out to your PO if need assistance accessing the Connect.gov system. Additionally, an FPAR 2.0 User Guide, which is available in the FPAR 2.0 system, provides step-by-step instructions for navigating the system to submit FPAR data.

VI. Data Elements

A. Overview of data elements

The **41 OPA-identified data elements** are accompanied by their respective standard terminology code and supporting value set, if available. The FPAR 2.0 Data Elements with Valid Values file provides the standard codes that electronic health record (EHR) vendors and grantees' IT staff need to support precise data identification and reporting.

OPA expects grantees to only collect data elements relevant to the care provided in an encounter. In other words, OPA does not expect each data element (for example, "chlamydia sp test performed at this visit") to be collected at every encounter. However, the FPAR 2.0 system does require each record to include complete data on select measures: **Facility Identifier, Patient Identifier, Visit Date, Birth Date, and Sex**—to uniquely identify an encounter. Files with missing values on any of these five data elements will not be accepted by the system. Please review the Encounter-level Data Reporting Guidelines and the Data Elements section of the FAQ page for more information about which elements allow for missing values and which do not for an encounter. Any measures with large amounts of missing data, will be returned to the grantee for completion.

B. Standard terminologies

Standardized codes for FPAR data elements promote consistent interpretation of data across disparate EHR systems. The two most commonly used standard terminologies to support reporting of the FPAR 2.0 data set are Logical Observation Identifiers Names and Codes (LOINC) and Systematic Nomenclature of Medicine Clinical Terms (SNOMED CT). EHR systems use LOINC and SNOMED CT together to provide a common framework for identifying and exchanging FPAR 2.0 data.

- LOINC: Consists of codes for observations made on patients and populations.
- SNOMED CT: Consists of concepts, terms, and relationships that enable effective representation of clinical information.

In summary, LOINC codes ask the questions (that is, "What is it that is observed?") and SNOMED CT codes provide the possible answers for what has been observed. For example, LOINC code 16601-7 represents the test "Chlamydia trachomatis rRNA [Presence] in Urine by Probe," and the SNOMED CT code 10828004 represents the finding "Positive." However, not all data elements have a defined answer list or value set. For a quantitative data element, such as Systolic Blood Pressure, grantees should report a numerical value.

Please refer to the **READ ME tab** in the FPAR 2.0 Data Elements with Valid Values file, which explains the contents and use of the contents in the file. Grantees must confirm their data are appropriately mapped to codes in the data element file to ensure they report accurate and reliable FPAR 2.0 data. Appropriate mapping will likely require coordination between staff knowledgeable about documentation patterns and staff responsible for updating data collection systems (that is, EHRs).

VII. Data Security Plan

FPAR 2.0 will comply with all federal and U.S. Department of Health and Human Services (HHS) regulations regarding the handling of sensitive data, protected health information, and personally identifiable information. All encounter-level data submitted to FPAR 2.0 will undergo an anonymization process by a contractor. The contractor will apply the methodology developed by Integrating the Healthcare Enterprise (IHE) to de-identify FPAR 2.0 data, and will ensure they are encrypted both in transit and at rest. **HHS and OPA staff, including POs, will not have access to the original or de-identified encounter-level data;** they will view only aggregated data at the national and regional levels, and data for each grantee. In addition, all public FPAR 2.0 reports will provide summary-level information and, as a result, will not identify individuals. For more information, please review the OPA brief, "How are FPAR Data Kept Safe?"

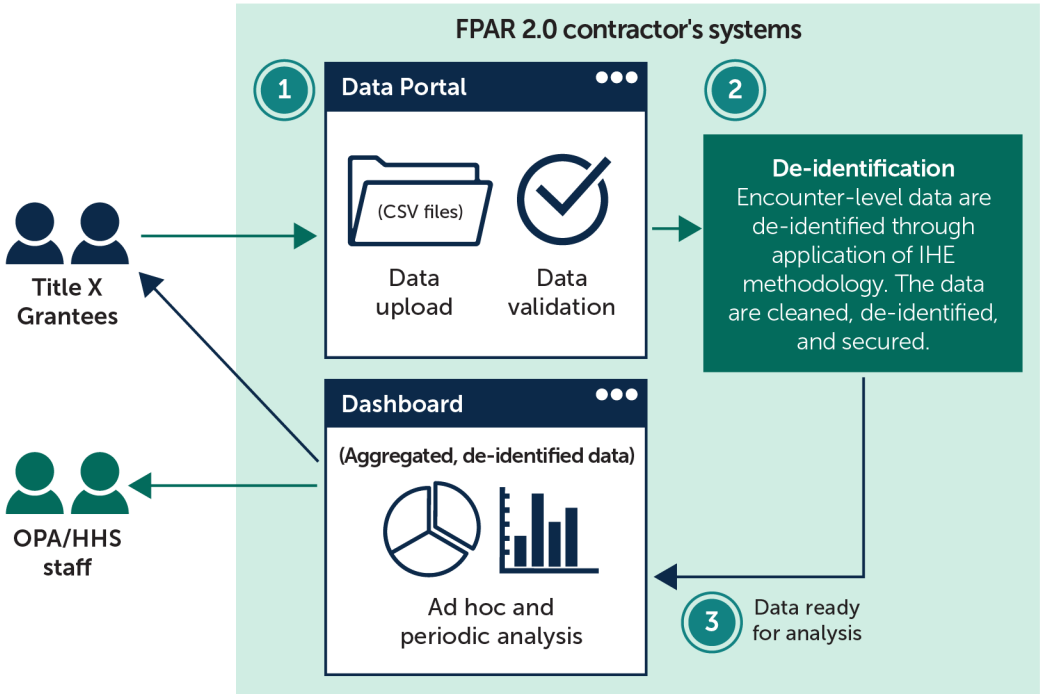
A. Data access

Exhibit C summarizes the steps for (1) uploading, (2) processing, (3) analyzing, and (4) accessing data through FPAR 2.0. Title X grantees will submit data through the FPAR 2.0 system; both authorized Grant Admin and Grant User accounts will have access only to the data visualizations and downloadable reports specific to their network and/or service site on the FPAR 2.0 dashboard. Grantees will define the level of access provided to their subrecipients.

OPA and grantees will have access to a dashboard and other reporting tools that use filters to display summarized data at the grantee, subrecipient, and site levels. OPA and grantees will not access encounter-level data. The reporting tools will enforce safeguards against showing results that represent a sample of only a few people. OPA develops the dashboards and rules for safeguarding privacy with direct input from grantees.

Grantees will be able to view aggregate-level data for their network only. They will have access to reports aggregated at the national level, but they will not be able to directly view grantees' data outside their network. Grantees should adhere to best practices for data privacy and security when preparing FPAR 2.0 data before submission and during any use of data they access when using the FPAR 2.0 system. The FPAR contractor will destroy the original data submitted by grantees within one year of submission. The system will securely store de-identified data for purposes of data quality and historical comparisons.

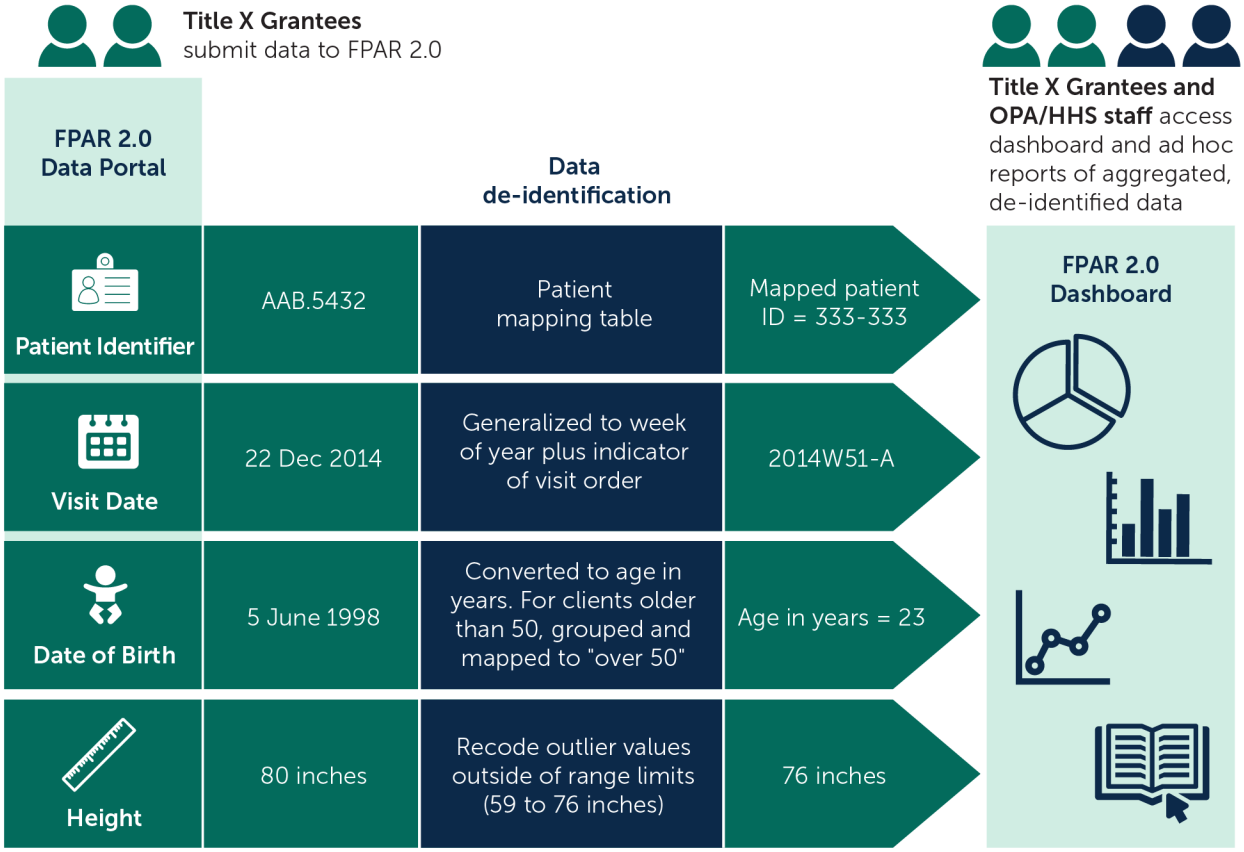
Exhibit C. Overview of FPAR 2.0 data flow



B. Data anonymization

For details on the data anonymization process for FPAR, please refer to the IHE IT Infrastructure white paper, Analysis of Optimal De-Identification Algorithms for Family Planning Data Elements, published in December 2016. The paper shows how specific data elements (for example, patient identifiers) are de-identified from the original file submitted by grantees. FPAR 2.0 will ensure the data are encrypted both in transit and at rest, using algorithms and methods approved by the National Institute of Standards and Technology, and securely store the encryption keys outside the control of OPA and HHS. Exhibit D shows the process for anonymizing example data elements through the FPAR 2.0 system.

Exhibit D. Examples of data elements undergoing data de-identification



VIII. Technical Assistance

OPA and its contractors will use a collaborative, coordinated approach to provide comprehensive technical assistance designed to help grantees transition to the FPAR 2.0 system. These activities include group and individualized technical assistance to end users of the system via formal trainings, written materials and documentation, and a help desk. Exhibit E summarizes the type of technical assistance OPA and its contractors provide for various types of support.

A. Group-based technical assistance

Group-based assistance will be in the form of webinar with the opportunity for Q&A sessions. The webinars will be recorded, and Q&As will be captured for each session. The recordings and the Q&As will be available on Connect.gov or through other OPA dissemination channels. Participation in these group webinars is voluntary, and there is no associated cost to grantees. Grantees can access materials from past webinars and notifications of upcoming sessions on Connect.gov.

B. Technical support from the help desk

OPA maintains a help desk to assist end users, including EHR vendors. Help desk staff will troubleshoot any issues users might have logging into and using the FPAR 2.0 system. The staff will also respond to inquiries about submission requirements from users. The help desk operates from Monday through Friday, 9:00 a.m. to 5:00 p.m. Eastern time, excluding federal holidays. Help desk staff will address all

email and phone inquiries within two to three business days. During the FPAR 2.0 submission period, help desk staff will hold TA help sessions where they will answer questions on program rules, file submission, data elements, and system functions.

C. Technical assistance reference materials

Based on feedback from federal staff, grantees, help desk tickets, and other contractors, OPA has developed user-friendly reference materials to address technical assistance needs, which can be found on the OPA website. OPA also maintains an FAQ page that is updated regularly.

D. Technical assistance for EHR vendors

The Vendor Discussion Quick Start is designed for Title X administrators and serves as a discussion starter for conversations with EHR vendors about FPAR 2.0 reporting.

OPA also encourages grantees to share the EHR Reference Document with their EHR vendors. This document provides a list of resources vendors may use to support Title X grantees as they collect encounter-level data and submit files to the FPAR 2.0 system. To access the guide, please reach out to your Project Officer.

E. Technical assistance: points of contact

There are several opportunities for grantees to receive technical assistance. Exhibit E provides a few examples of support they might need, and potential points of contact.

Exhibit E. Contact information for technical assistance

Technical assistance contact	TA support need
Reproductive Health National Training Center: RHNTC@JSI.com	Understanding required data elements and potential workflows for supporting quality improvement objectives
Project Officers	Questions about Title X policies or technical requirements
Help Desk: FPARSupport@mathematica-mpr.com (855) 813-0010	Guidance on selecting and using appropriate codes in the data element file Question about de-identified data and secure file transfer Questions about accessing and navigating the FPAR 2.0 system Questions about troubleshooting file submission issues Questions from EHR vendors about Title X policies or technical requirements

Appendix A.

FPAR 2.0 Forms and Instructions

This version (January 2025) of the FPAR consists of 14 tables, including a Grantee Profile Cover Sheet and 13 data tables.[6] 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. This appendix provides forms and instructions needed for completing the FPAR.

Grantee profile cover sheet

The Grantee Profile Cover Sheet provides important identifying and contact information for the grantee and the grantee's FPAR contact.

Instructions

If you are submitting the FPAR using the FPAR 2.0 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 PO 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.

For grantees submitting the FPAR using the FPAR 2.0 system or in hardcopy, follow these instructions:

GRANTEE CONTACT PERSON (PERSON COMPLETING THE 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.

Questions about the Grantee Profile

QUESTION – Is the Grantee Profile Cover Sheet different from the previous version of the table in the *Title X FPAR Forms and Instructions (Reissued November 2021)?*

ANSWER – Information about "Number of Subrecipients Supported by the Title X Grant" and "Number of Family Planning Services Sites Support by the Title X Grant" were previously provided by grantees in the Grantee Cover Profile Sheet. Grantees should provide that information in the Supplemental Information Section of FPAR 2.0.

[6] Data associated with clinical breast exams and referrals (Table 10) are no longer collected in FPAR 2.0 due to changes in clinical guidance.

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	

FPAR Number:

Date Submitted:

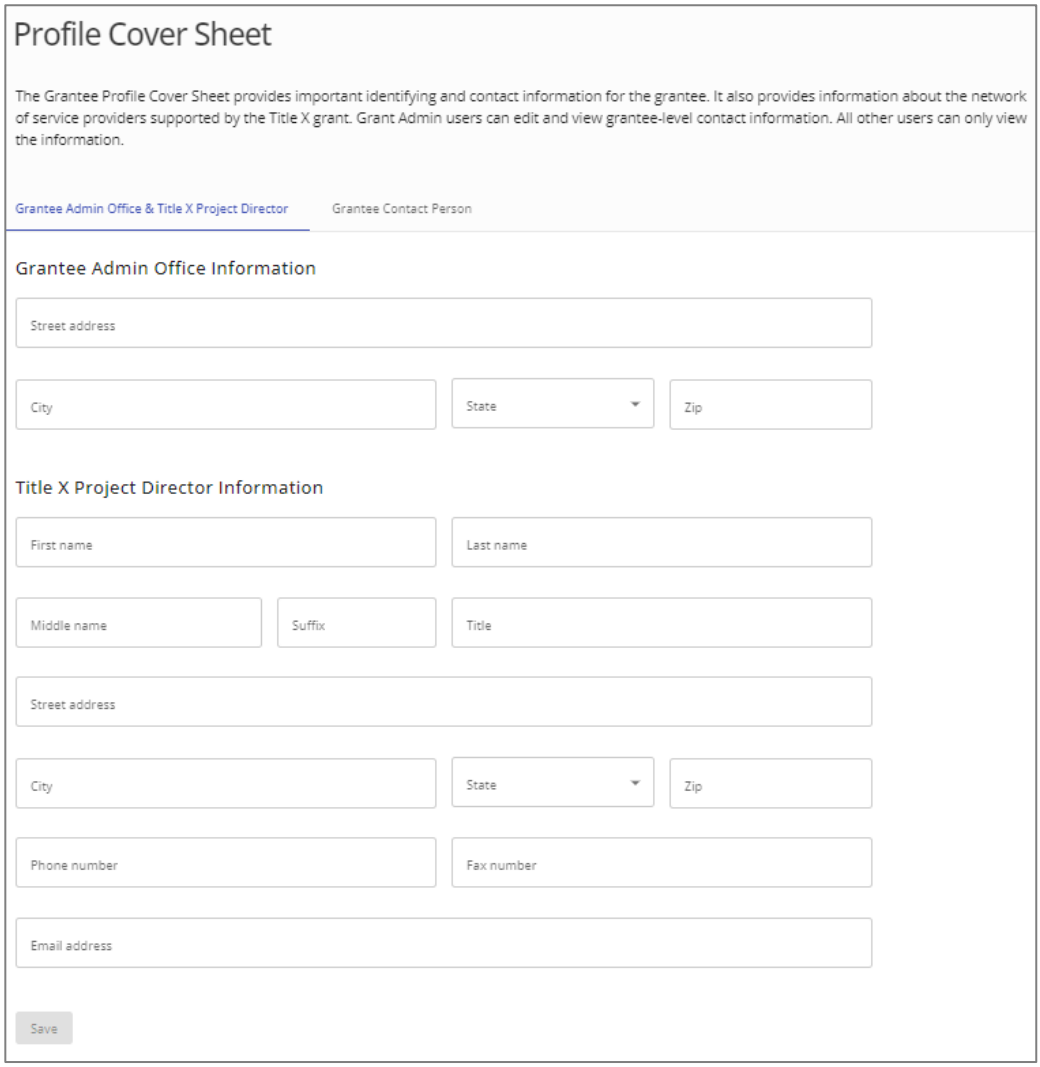
Reporting Period: **January 1, 20_____through December 31, 20_____**

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

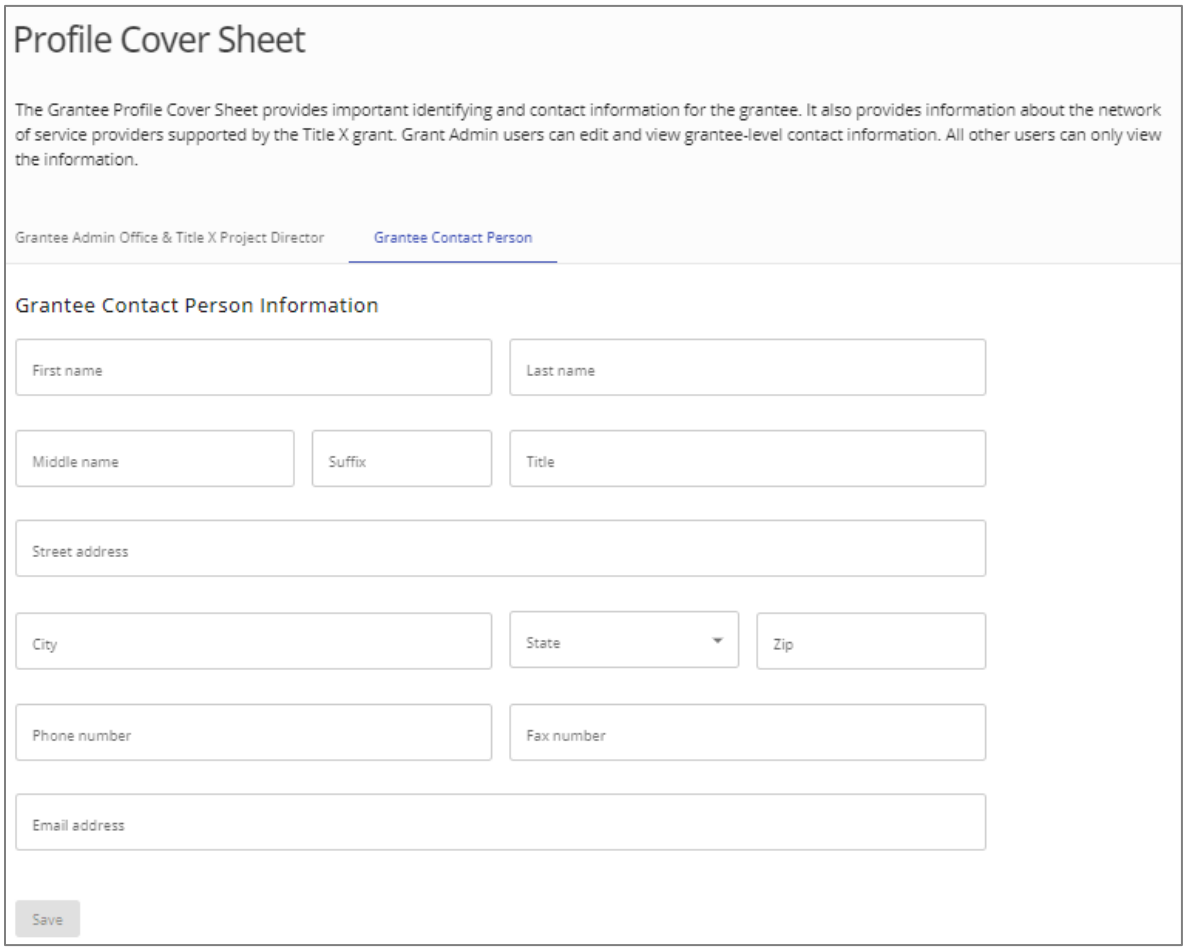
Grantee Profile Cover Sheet in the FPAR 2.0 system

In the Profile Cover Sheet of the FPAR 2.0 system, grantees will need to complete the two tabs: 1) Grantee Admin & Title X Project Director and 2) Grantee Contact Person.

Grantee Admin Office & Title X Project Director:



Grantee Contact Person:



Supplemental Information

The Supplemental Information section provides information about the network of service providers supported by the Title X grant.

Instructions

For grantees submitting the FPAR using the FPAR 2.0 system or in hardcopy, follow these instructions:

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.

NUMBER OF TITLE X CLINICS OFFERING TELEHEALTH SERVICES – Report the total number of Title X clinics offering telehealth services. Telehealth services refer to services provided through telehealth technologies, which include telephone, facsimile machines, electronic mail systems, videoconferencing, store-and-forward imaging, streaming media, remote monitoring devices, and terrestrial and wireless communications.

Questions about the Supplemental Information section

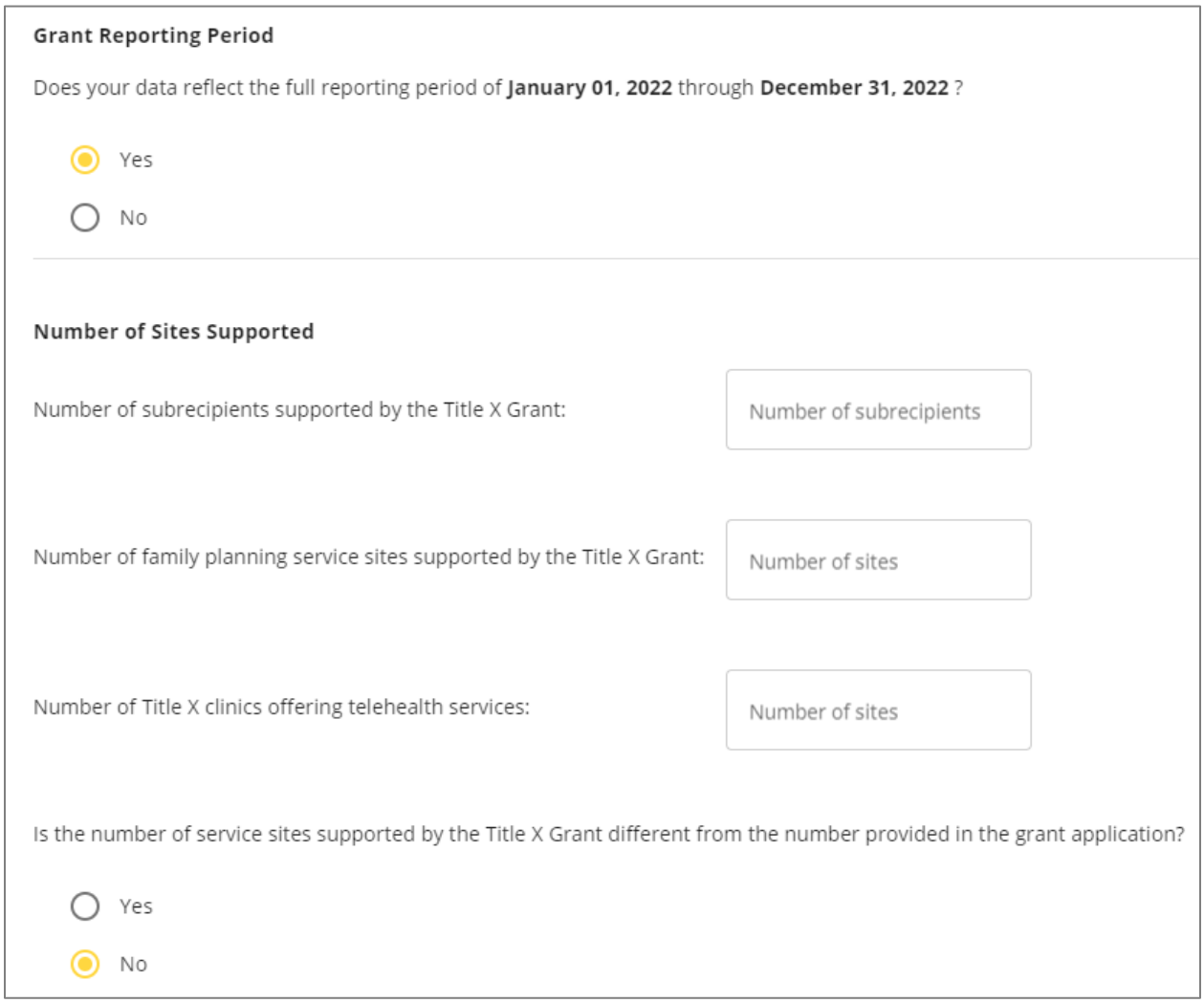
QUESTION – If Title X services are provided at a clinic and two non-clinic service sites, should the grantee report one or three sites as the total number of service sites supported by the Title X grant?

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" in the Terms and Definitions (Section III). 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.

Supplemental Information Section

Does your data reflect the full reporting period of January 01, 20XX through December 31, 20XX?	-
Number of subrecipients supported by the Title X grant	-
Number of family planning service sites supported by the Title X grant	-
Number of Title X clinics offering telehealth services	-
Is the number of service sites supported by the Title X Grant different from the number provided in the grant application?	-

Supplemental Information section in the FPAR 2.0 system



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*[7] 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. By 2029, all Title X grantees will report Race & Ethnicity in compliance with OMB's 2024 updated Statistical Policy Directive No. 15.[8]

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 OMB 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.

ASIAN – A person having origins in any of the original peoples of East Asia, 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 through 3

QUESTION – Is Table 1, Table 2, or Table 3 different from the previous version of the table in the *Title X FPAR Forms and Instructions (Reissued November 2021)?*

[7] Office of Management and Budget. (1997, October 30). Revisions to the standards for the classification of federal data on race and ethnicity. Federal *Register, 62*(210), 58782-58790. Retrieved from: https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf

[8] Office of Management and Budget. (2024, June, 20). Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. Retrieved from: https://spd15revision.gov

ANSWER – OPA has made no changes to Table 1, Table 2, or Table 3 in this version of the *Title X FPAR Forms and Instructions*.

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.

QUESTION – Should clients from Brazil, Haiti, or Portugal or who are of Brazilian, Haitian, or Portuguese 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 the country of origin. Clients who identify solely as Brazilian, Haitian, or Portuguese should not be classified as Hispanic or Latino.

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 five minimum OMB race categories or may refuse to report their race. Providers must respect a client's right to refuse to report their 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 who do not self-identify with any of the OMB race categories.

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 minimum 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 B to this form provides general guidelines and a sample question for collecting multi-race responses. Please note that the information in ***Appendix B*** 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 B***.

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.[9]

Instructions

TABLE 4 – Report the unduplicated number of family planning users by family/household 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.[5] In determining a user's family/household income, agencies should refer to the poverty guidelines updated periodically in the *Federal Register* by HHS under the authority of 42 USC 9902(2).[10] Report the unduplicated number of users by family/household income level, using the most current income information available.

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

PUBLIC HEALTH INSURANCE COVERING PRIMARY MEDICAL CARE – Refers to federal, state, or local government health insurance programs that provide a **broad set of primary medical care benefits** for eligible individuals. Examples of such programs include Medicaid (both regular and managed care), Medicare, the Children's Health Insurance Program (CHIP), and other state or local government programs that provide a broad set of benefits. Also included are public-paid or public-subsidized private insurance programs.

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[9] U.S. Department of Health and Human Services. (2003, August 4). 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 from: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-vi/index.html

[10] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, (2020). U.S. federal poverty guidelines used to determine financial eligibility for certain federal programs. Retrieved from: https://aspe.hhs.gov/poverty-guidelines

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 Civilian Health and Medical Program of the Department of Veterans Affairs [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 nonparticipating facility, are considered uninsured. **Do not count** users as uninsured if they did not use their medical insurance to pay for their visit.

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.[8] 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*[8] 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 through 6

QUESTION – Is Table 4, Table 5, or Table 6 different from the previous version of the table in the *Title X FPAR Forms and Instructions (Reissued November 2021)?*

ANSWER – OPA has made no changes to Table 4, Table 5, or Table 6 in this version of the *Title X FPAR Forms and Instructions.*

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 they choose not to use their 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 their health insurance to pay for services, they are 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 they have.

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)),[5] 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.

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.

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

ANSWER – A client whose services are paid by a Medicaid family planning eligibility expansion (waiver or SPA) is considered **uninsured** if they have **no coverage under another public or private insurance plan** that covers a broad set of primary medical care benefits. A Medicaid family planning eligibility 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 eligibility expansion is considered **insured** if they have a public or private insurance plan that covers a **broad set of primary medical care benefits**.

QUESTION – In Table 6, should a user be reported as LEP if they receive care from a bilingual provider in their preferred, non-English language or if they receive 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 their 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.[8]

FPAR Number: _____

Date Submitted: _____

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

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

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	Below 101%	
2	101% to 150%	
3	151% to 200%	
4	201% to 250%	
5	Above 250%	
6	Unknown/not reported	
7	**Total Users (sum rows 1 to 6)**	**Checkpoint Reference CC**

FPAR Number: _____

Date Submitted: _____

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

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

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**

FPAR Number: _____

Date Submitted: _____

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

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

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

	Family Planning Users' level of 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.[5] 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 non-use.

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 a broad range of acceptable and effective contraceptive methods, to monitor performance on contraceptive care measures,[11] and to 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 of family planning and age group.

TABLE 8 – Report the unduplicated number of male family planning users by primary method of family planning 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 their last encounter in the reporting period. If the user reports that they are using more than one family planning method, report the most effective one as the primary method.[12] 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 nonsurgical (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 (IUDs including Mirena®, Liletta®, Kyleena®, Skyla®, and ParaGard®) 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 (including Nexplanon®) 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.

[11] Office of Population Affairs. (2019). Performance measures: Contraceptive care measures. Retrieved from: https://opa.hhs.gov/evaluation-research/title-x-services-research/contraceptive-care-measures
[12] Office of Population Affairs. (2024). Contraceptive Options and Effectiveness - Most or Moderately Effective Contraception. Retrieved from: https://opa.hhs.gov/contraceptive-options-and-effectiveness-highlight1-text-only

3-MONTH HORMONAL INJECTION – In **Table 7**, report the number of female users who use 3-month injectable hormonal contraception (including Depo-Provera®) 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 (including Xulane®, Twirla®) as their primary family planning method.

VAGINAL RING – In **Table 7**, report the number of female users who use a hormonal vaginal ring (including NuvaRing®, Annovera®) 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 a spermicide or non-spermicidal gel) as their primary family planning method.

ANY SPERMICIDE OF NON-SPERMICIDAL GEL (USED ALONE) – In **Table 7**, report the number of female users who use only (i.e., not in conjunction with another contraceptive method) spermicidal jelly, cream, gel, foam, film, or suppository or non-spermicidal gel as their primary family planning method (including Phexxi®).

FERTILITY AWARENESS METHOD (FAM) OR LACTATIONAL AMENORRHEA METHOD (LAM) – Fertility awareness-based 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.[13] For LAM to ensure adequate protection from an unplanned pregnancy, the following conditions must be met: (1) infant is less than 6 months of age, (2) no periods or spotting since delivery (i.e., amenorrhea), (3) exclusive or fully breastfeeding (i.e., no other liquid or solid given to infant) or nearly fully breastfeeding (i.e., infrequent supplementation in small amounts, but not by bottle), and (4) frequent or on-demand breastfeeding (i.e., no interval longer than 4 to 6 hours between breastfeeds).[14]

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

[13] Kennedy, K. I., & Goldsmith, C. (2018). Contraception after pregnancy. In R. A. Hatcher, A. L. Nelson, J. Trussell, C. Cwiak, P. Cason, M. S. Policar, A. R. A. Aiken, J. Marrazzo, & D. Kowal (Eds.), *Contraceptive technology* (21st ed., pp. 511–542). New York, NY: Ayer Company Publishers, Inc.
[14] Centers for Disease Control and Prevention. (2024). U.S. Medical Eligibility Criteria for Contraceptive Use. Retrieved from: https://www.cdc.gov/mmwr/volumes/73/rr/rr7304a1.htm

therefore not using contraception. For purposes of FPAR reporting, abstinence is defined as refraining from oral, vaginal, and anal intercourse.[15]

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.

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 them 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 a spermicide or non-spermicidal gel) as their primary family planning method. In **Table 8**, report the number of male users who use male condoms (with or without a spermicide or non-spermicidal gel) 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, spermicides, and non-spermicidal gel.

Questions about Tables 7 and 8

QUESTION – Is Table 7 or Table 8 different from the previous version of the table in the *Title X FPAR Forms and Instructions (Reissued November 2021)?*

ANSWER – OPA has made no changes to Table 7 or Table 8 in this version of the Title X FPAR Forms and Instructions.

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?

[15] Centers for Disease Control and Prevention. (2024). How to Prevent STIs. Retrieved from: https://www.cdc.gov/sti/prevention/index.html

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, spermicide, or non-spermicidal gel), 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.

QUESTION – How should a grantee report a user who exits the encounter with no method because they or their 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)	8 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 Any spermicide or non-spermicidal gel (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)										**Checkpoint Reference AA**

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

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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)										**See Checkpoint Reference BB**

Note: FAM = Fertility Awareness Method.

Cervical cancer screening

Table 9 provides information on the cervical cancer screening activities that are performed within the scope of a grantee's approved Title X project. Data from Table 9 permits OPA to monitor achievement of program performance objectives and adoption of cervical cancer screening recommendations established by federal agencies and professional medical organizations.[16] In addition, OPA uses these data to assess the number of abnormal results that require further follow-up and to assess the program's contribution to national health objectives (i.e., Healthy People) related to early cancer detection and health promotion. Data associated with clinical breast exams and referrals (Table 10) are no longer collected in FPAR 2.0 due to changes in clinical guidance.

Instructions

TABLE 9 – Report the following information on cervical cancer screening activities. Refer to the chart in ***Exhibit F*** 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 2014 Bethesda System[17] (see ***Exhibit F***). ASC or higher results include ASC-US; ASC-H; LSIL; HSIL; squamous cell carcinoma; AGC; AGC, favor neoplastic; endocervical AIS; adenocarcinoma; or other malignant neoplasms

Number of Pap tests with an HSIL or higher result according to the 2014 Bethesda System[17] (see ***Exhibit F***). HSIL or higher results include HSIL; squamous cell carcinoma; AGC; AGC, favor neoplastic; endocervical AIS; adenocarcinoma; or other malignant neoplasms

TABLE 10 – Skip Table 10. Data associated with clinical breast exams and referrals are no longer collected in FPAR 2.0 due to changes in clinical guidance.

Terms and Definitions

TESTS or Exams – Report the number of Pap tests performed during the reporting period that are provided within the scope of the grantee's Title X project.

SQUAMOUS CELL ABNORMALITIES – The 2014 Bethesda System[17] (see ***Exhibit F*** classifies squamous cell abnormalities into the following categories:

Atypical squamous cells of undetermined significance (ASC-US) or **atypical squamous cells, cannot exclude HSIL (ASC-H) – ASC** is a finding of abnormal squamous cells in the tissue lining the outer part of the cervix. **ASC-US** is the most common abnormal finding in a Pap test. An ASC-US result may be caused by a human papillomavirus (HPV), a benign growth (e.g., cyst or polyp), or low hormone levels in menopausal women. **ASC-H** may be a sign of a high-grade squamous intraepithelial lesion (HSIL), which may become cervical cancer if untreated.[18]

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[16] Centers for Disease Control and Prevention (2023, October). Screening for Cervical Cancer? Retrieved from: https://www.cdc.gov/cervical-cancer/screening/?CDC_AAref_Val=https://www.cdc.gov/cancer/cervical/basic_info/screening.htm The American College of Obstetricians and Gynecologists. (2021, April). *Updated cervical cancer screening guidelines.* Retrieved from: https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2021/04/updated-cervical-cancer-screening-guidelines

[17] Nayar, R., & Wilbur, D. C. (2015). The Pap test and Bethesda 2014. *Acta Cytologica*, *59*, 121-132. Retrieved from: https://www.karger.com/Article/Pdf/381842

[18] National Cancer Institute. (2016). *NCI dictionary of cancer terms.* Retrieved from: https://www.cancer.gov/publications/dictionaries/cancer-terms

Low-grade squamous intraepithelial lesion (LSIL) is a finding of slightly abnormal cells on the surface of the cervix caused by certain types of HPV. LSIL is a common abnormal finding on a Pap test. Mild dysplasia and cervical intraepithelial neoplasia (CIN) 1 are other terms for referring to LSILs.[18]

High-grade squamous intraepithelial lesion (HSIL) is a growth on the surface of the cervix with moderately or severely abnormal cells. HSILs are usually caused by certain types of HPV. If not treated, these abnormal cells may become cancer and spread to normal tissue.[18] HSIL encompasses moderate dysplasia (CIN 2) or severe dysplasia and carcinoma in situ (CIN 3).[18]

Squamous cell carcinoma is a finding of cancer in the squamous cells of the cervix.

GLANDULAR CELL ABNORMALITIES – The 2014 Bethesda System[17] (see ***Exhibit F***) classifies glandular cell abnormalities into the following categories:

Atypical glandular cells (AGCs) is a finding of abnormal cells that come from glands in the walls of the cervix. The presence of these abnormal cells may be a sign of more serious lesions or cancer.[16] The 2014 Bethesda System[17] (see ***Exhibit F***) subdivides AGCs into two categories:

AGC—endocervical, endometrial, or glandular cells—not otherwise specified

AGC—endocervical or glandular cells—favor neoplastic.

Endocervical adenocarcinoma in situ (AIS) is a finding of abnormal cells found in the glandular tissue lining the endocervical canal. AIS may become cancer and spread to nearby normal tissue.[16]

Adenocarcinoma is a finding of cancer in endocervical, endometrial, extrauterine, or not otherwise specified glandular tissue.[18]

Questions about Tables 9

QUESTION – Is Table 9 different from the previous version of the table in the *Title X FPAR Forms and Instructions (Reissued November 2021)?*

ANSWER – OPA has made no changes to Table 9 in this version of the *Title X FPAR Forms and Instructions.*

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 F. The 2014 Bethesda System

SPECIMEN TYPE:

Indicate conventional smear (Pap smear) vs. liquid-based preparation vs. other

SPECIMEN ADEQUACY

- ❑ Satisfactory for evaluation (*describe presence or absence of endocervical/transformation zone component and any other quality indicators, e.g., partially obscuring blood, inflammation, etc.*)
- ❑ Unsatisfactory for evaluation (*specify reason*)
  - ❑ Specimen rejected/not processed (*specify reason*)
  - ❑ Specimen processed and examined, but unsatisfactory for evaluation of epithelial abnormality because of (*specify reason*)

GENERAL CATEGORIZATION (*optional*)

- ❑ Negative for Intraepithelial Lesion or Malignancy
- ❑ Other: See Interpretation/Result (*e.g., endometrial cells in a woman ≥45 years of age*)
- ❑ Epithelial Cell Abnormality: See Interpretation/Result (*specify* 'squamous' *or* 'glandular' *as appropriate*)

INTERPRETATION/RESULT

NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY

(When there is no cellular evidence of neoplasia, state this in the General Categorization above and/or in the Interpretation/Result section of the report—whether or not there are organisms or other non-neoplastic findings)

Non-Neoplastic Findings (optional to report)

- ❑ Non-neoplastic cellular variations
  - o Squamous metaplasia
  - o Keratotic changes
  - o Tubal metaplasia
  - o Atrophy
  - o Pregnancy-associated changes
- ❑ Reactive cellular changes associated with:
  - ➢ Inflammation (includes typical repair)
    - o Lymphocytic (follicular) cervicitis
  - ➢ Radiation
  - ➢ Intrauterine contraceptive device (IUD)
- ❑ Glandular cells status post hysterectomy

Organisms

- ❑ *Trichomonas vaginalis*
- ❑ Fungal organisms morphologically consistent with *Candida* spp.
- ❑ Shift in flora suggestive of bacterial vaginosis
- ❑ Bacteria morphologically consistent with *Actinomyces* spp.
- ❑ Cellular changes consistent with herpes simplex virus
- ❑ Cellular changes consistent with cytomegalovirus

OTHER

- ➢ Endometrial cells (in a woman ≥45 years of age) (*Specify if "negative for squamous intraepithelial lesion"*)

EPITHELIAL CELL ABNORMALITIES

SQUAMOUS CELL

- ➢ Atypical squamous cells
  - of undetermined significance (ASC-US)
  - cannot exclude HSIL (ASC-H)
- ➢ Low-grade squamous intraepithelial lesion (LSIL) (*encompassing: HPV/mild dysplasia/CIN 1*)
- ➢ High-grade squamous intraepithelial lesion (HSIL) (*encompassing: moderate and severe dysplasia, CIS; CIN 2 and CIN 3*)
  - with features suspicious for invasion (*if invasion is suspected*)
- ➢ Squamous cell carcinoma

GLANDULAR CELL

- ➢ Atypical
  - endocervical cells (NOS *or specify in comments*)
  - endometrial cells (NOS *or specify in comments*)
  - glandular cells (NOS *or specify in comments*)
- ➢ Atypical
  - endocervical cells, favor neoplastic
  - glandular cells, favor neoplastic
- ➢ Endocervical adenocarcinoma in situ
- ➢ Adenocarcinoma
  - endocervical
  - endometrial
  - extrauterine
  - not otherwise specified (NOS)

OTHER MALIGNANT NEOPLASMS: *(specify)*

Report in Table 9 Row 4

Report in Table 9 Row 3

ADJUNCTIVE TESTING

Provide a brief description of the test method(s) and report the result so that it is easily understood by the clinician.

COMPUTER-ASSISTED INTERPRETATION OF CERVICAL CYTOLOGY

If case examined by an automated device, specify device and result.

EDUCATIONAL NOTES AND COMMENTS APPENDED TO CYTOLOGY REPORTS (*optional*)

Suggestions should be concise and consistent with clinical follow-up guidelines published by professional organizations (references to relevant publications may be included).

Source: Nayar, R., & Wilbur, D. C. (2015). *The Pap test and Bethesda 2014. Acta Cytologica*, *59*, 121-132. doi:10.1159/000381842 (Copyright 2015, S. Karger AG. 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	

Table 10: Clinical Breast Exams and Referrals

Starting in 2022, Title X service sites were not required to provide breast cancer screening data (Table 10) as a part of the Family Planning Annual Report due to changes in clinical guidance. Tables 11–14 retain their designations for consistency with prior years' reporting.[19]

[19] The American College of Obstetricians and Gynecologists. (2017, July, Reaffirmed 2021). Breast Cancer Risk Assessment and Screening in Average-Risk Women. Practice Bulletin No. 179. Retrieved from: https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/07/breast-cancer-risk-assessment-and-screening-in-average-risk-women

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 human immunodeficiency virus (HIV) screening recommendations established by federal agencies and professional medical organizations.[20] 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

QUESTION – Is Table 11 or Table 12 different from the previous version of the table in the *Title X FPAR Forms and Instructions (Reissued November 2021)?*

ANSWER – OPA has made no changes to Table 11 or Table 12 in this version of the *Title X FPAR Forms and Instructions.*

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 Section III).

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)?

[20] Centers for Disease Control and Prevention. (2021, July 21). *Sexually transmitted infections treatment guidelines, 2021.* Retrieved from: https://www.cdc.gov/std/treatment-guidelines/STI-Guidelines-2021.pdf

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.

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	Not applicable	Not applicable	
5 HIV – Anonymous tests	Not applicable	Not applicable	

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 number of full-time equivalent (FTE) Clinical Services Providers who deliver Title X–funded family planning and related preventive health services.

Instructions

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

- Number of FTE family planning Clinical Services Providers, by type of provider
- Number of family planning encounters (face-to-face and virtual) with Clinical Services Providers
- Number of family planning encounters (face-to-face and virtual) with Other Services Providers
- In the Table 13 Note field, please describe the number of total family planning encounters with Clinical Services Providers (Row 1, Column B) that are virtual encounters and the number of total encounters with Other Services Providers (Row 2, Column B) that are virtual encounters.

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 who 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 assessments recommended for contraceptive, related preventive health, and basic infertility care. Clinical Services Providers are able to offer client education, counseling, referral, follow-up, 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 Title X program requirements.[4]

OTHER SERVICES PROVIDERS – Include other agency staff (e.g., registered nurses, public health nurses, licensed vocational or LPNs, certified nurse assistants, health educators, social workers, or clinic aides) that offer client education, counseling, referral, or follow-up services relating to the client's proposed or adopted method of contraception, general reproductive health, or infertility treatment, as described in the Title X program requirements.[4] 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 Title X program requirements.[4]

FAMILY PLANNING ENCOUNTER – A family planning encounter is a documented contact between an individual and a family planning provider that is either face-to-face in a Title X service site or virtual using telehealth technology. The purpose of a family planning encounter—whether clinical or nonclinical—is to provide family planning and related preventive health services to female and male

clients that align with the definition of family planning services in 42 CFR § 59.2.[5] Family planning services include a broad range of medically approved services, which includes FDA-approved contraceptive products and natural family planning methods, for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, STI services, and other preconception health services). 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: (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 nonclinical assessment and care during the encounter, is credited with the encounter.

FAMILY PLANNING ENCOUNTER WITH A CLINICAL SERVICES PROVIDER – A documented, face-to-face or virtual encounter between a family planning client and a Clinical Services Provider.

FAMILY PLANNING ENCOUNTER WITH AN OTHER SERVICES PROVIDER – A documented, face-to-face or virtual encounter between a family planning client and an Other Services Provider.

Laboratory tests and related counseling and education, in and of themselves, do not constitute a family planning encounter unless there is face-to-face or virtual 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.

VIRTUAL FAMILY PLANNING ENCOUNTER – A virtual family planning encounter uses telecommunications and information technology to provide distanced access to Title X family planning and related preventive health services, including assessment, diagnosis, intervention, consultation, education and counseling, and supervision. Telehealth technologies include telephones, facsimile machines, electronic mail systems, videoconferencing, store-and-forward imaging, streaming media, remote monitoring devices, and terrestrial and wireless communications.

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

QUESTION – Is Table 13 different from the previous version of the table in the *Title X FPAR Forms and Instructions (Reissued November 2021)?*

ANSWER – OPA has made no changes to Table 13 in this version of the *Title X FPAR Forms and Instructions.*

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 nonclinical assessment and care during the visit is credited with the encounter.

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 Title X program requirements,[4] 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, licensed vocational nurse [LVN], or public health nurse), then the encounter should be reported as an encounter with an Other Services Provider in Table 13, Row 2.

FPAR Number: _____

Date Submitted: _____

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

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

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	Not applicable	
1a Physicians		Not applicable
1b Physician assistants/nurse practitioners/ certified nurse midwives		Not applicable
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		Not applicable
2 Other Services Providers	Not applicable	
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.[1] 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] **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 (both federal and state shares) from family planning waivers and State Plan Amendments (SPAs) in Row 3a, Column B. If the amount reported in Row 3a, Column B includes revenue from a family planning waiver or SPA, 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 (CHIP) – 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. Other public health insurance programs include state or local government programs that provide a broad set of benefits and 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 (BPHC), 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 CDC 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

QUESTION – Is Table 14 different from the previous version of the table in the *Title X FPAR Forms and Instructions (Reissued November 2021)?*

ANSWER – OPA has made no changes to Table 14 in this version of the *Title X FPAR Forms and Instructions.*

QUESTION – Can a grantee report an estimate of the monetary value of in-kind donations of goods, services, or other non-cash 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.

FPAR Number: _____

Date Submitted: _____

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

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

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	**Amount**
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
DHHS	Department of Health and Human Services
FAM	fertility awareness method
FDA	Food and Drug Administration
FPAR	Family Planning Annual Report
FTE	full-time equivalent
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HMO	health maintenance organization
HPV	human papillomavirus
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
OIRM	Office of Information Resource Management
OMB	Office of Management and Budget
OPA	Office of Population Affairs
OS	Office of the Secretary
PO	Project Officer
PRA	Paperwork Reduction Act
QFP	Report: *Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs*
SPA	State Plan Amendment
STD	sexually transmitted disease
TANF	Temporary Assistance for Needy Families
USC	United States Code

Appendix B. Collecting Race Data From Family Planning Users Who Self-Identify With More Than One Race

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*.[21] 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 non-discrimination 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*,[22] and any subsequent revisions, as the standard for racial and ethnic reporting categories in HHS-funded programs. The FPAR race and ethnicity categories reflect the OMB standards. By 2029, all Title X grantees will report Race & Ethnicity in compliance with OMB's 2024 updated Statistical Policy Directive No. 15.[8]

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.
- When a list of races is provided to respondents, the list should not contain a "multiracial" category.
- Two recommended forms for the instruction accompanying a single race question that allows for multiple responses 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. FPAR Tables 2 and 3 allow grantees to report the number of users who self-identify with two or more of the five minimum OMB race categories.

Agencies should consult with their PO if they have questions about collecting multiple responses to a single race question.

Below is a sample question for collecting race data that is based on the 2011 HHS guidance[23] and uses the minimum set of OMB race categories. A list of resources on this topic is included below.

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[21] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (1997, October 24). Policy statement on inclusion of race and ethnicity in DHHS data collection activities. Retrieved from: https://aspe.hhs.gov/policy-statement-inclusion-race-and-ethnicity-dhhs-data-collection-activities

[22] Office of Management and Budget. (1997, October 30). Revisions to the standards for the classification of federal data on race and ethnicity. *Federal Register, 62*(210), 58782-58790. Retrieved from: https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf

[23] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2011, October). U.S. Department of Health and Human Services implementation guidance on data collection standards for race, ethnicity, sex, primary language, and disability status. Retrieved from: https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

What is your race? (*One or more categories may be selected*)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander

Resource List

Office of Management and Budget. (1997, October 30). Revisions to the standards for the classification of federal data on race and ethnicity. *Federal Register*, 62(210), 58782-58790. Federal Register notice. Retrieved from: https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf

U.S. Census Bureau. (2012). *The two or more races population: 2010*. 2010 Census Briefs No. C2010BR–13. Retrieved from: https://www2.census.gov/library/publications/cen2010/briefs/c2010br-13.pdf

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2011, October). *U.S. Department of Health and Human Services implementation guidance on data collection standards for race, ethnicity, sex, primary language, and disability status.* Retrieved from: https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (1997, October 24). *Policy statement on inclusion of race and ethnicity in DHHS data collection activities*. Retrieved from: https://aspe.hhs.gov/policy-statement-inclusion-race-and-ethnicity-dhhs-data-collection-activities