Questionnaire Instructions & Objective

Form Approved
OMB No 0945-0007
Exp. Date 03/31/2018

Screening Questionnaire Instructions:

Please complete the screening questionnaire by providing the requested information below. After checking the appropriate boxes to indicate your entity type, please respond to the referenced questions. Answer questions to the best of your knowledge.

Please submit your responses by the deadline provided.

Screening Questionnaire Objective:

This screening questionnaire is intended to gather data about the size, complexity, and operations of potential auditees for the HIPAA Privacy, Security and Breach Notification Audit Program. This data will be used with other information to make audit subject selections. This information helps us to more accurately target the audits to the types, size, and locations we are seeking.

Data will be kept private to the extent allowed by law. Please note that if your entity is selected for audit, communications from OCR will be sent to the email addresses of the contact persons identified below.

A. Contact information

*1. Please provide the following information:

Entity Name:	
Privacy Officer or Primary Contact Name:	
Title:	
Email address:	
Phone Number:	
Address for official correspondence:	

*2. Please designate an additional individual as an alternate or backup for the primary contact:

Name:	
Title:	
Email address:	
Phone Number:	

B. Basic descriptive information about your organization

***3. Entity is:**

- ◯ Public
- ◯ Private

***4. Entity is:**

- ◯ Multi-location (the organization has multiple service delivery sites and/or separate support facilities)
- ◯ Single location only (the primary operations and any support activities are co-located)

***5. Is your organization part of, affiliated with, or otherwise owned or controlled by another organization?**

- ◯ No
- ◯ Yes

B. Basic descriptive information about your organization (cont'd)

***6. If your organization is a part of, affiliated with, or otherwise owned or controlled by another organization, identify the organization and describe the relationship to your entity:**

Name of other organization:

Nature of relationship:

C. Health Care Providers

***7. Are you a health care provider?**

- ◯ Yes
- ◯ No

C. Health Care Providers (cont'd)

***8. Are you a HIPAA covered entity?**

- ◯ Yes
- ◯ No
- ◯ Not sure

***9. Does your organization, or another entity on your behalf, conduct health care transactions (such as submitting a claim for payment, checking patient health plan eligibility or benefit coverage, receipt of payment or remittance advice) in electronic form?**

- ◯ Yes
- ◯ No

***10. What type of health care provider are you (hospital, urgent care, skilled nursing, etc.)?**

***11. How many patient visits in the prior fiscal year?**

***12. How many patient beds do you have (if applicable)?**

***13. What is the current number of clinicians on staff or with privileges in the facility(ies)?**

***14. Do you maintain or transmit protected health information in electronic format?**

- ◯ Yes
- ◯ No

***15. Do you use electronic medical records?**

- ◯ Yes
- ◯ No

***16. What is the total revenue for the most recent fiscal year?**

D. Health Plans

***17. Are you a health plan?**

(If you are an employer who sponsors a group health plan, select yes.)

- ◯ Yes
- ◯ No

18. If you are a health plan, are you a Group Health Plan sponsor responding on its behalf?

- ◯ Yes
- ◯ No

D. Health Plans (cont'd)

***19. What is the total number of members within your health plan(s)?**

***20. What is the average number of claims processed monthly in the most recent fiscal year?**

***21. What is the total revenue for the most recent fiscal year?**

***22. Do you utilize a third party administrator (TPA) or other entity to perform most of the health plan functions?**

- ◯ No
- ◯ Yes
- ◯ If yes, please provide the name, address, email address, phone number, an alternate contact and an appropriate contact person at the TPA or other entity (e.g., health insurance issuer or HMO):

***23. If you are a group health plan sponsor, do you receive only summary data from the group health plan, health insurancer issuer, or HMO?**

- ◯ Yes
- ◯ No

E. Health Care Clearinghouses

24. Are you a health care clearinghouse?

- ☐ Yes
- ☐ No

E. Health Care Clearinghouses (cont'd)

***25. What is the total number of transactions processed monthly in the most recent fiscal year?**

***26. What is the current number of health care providers, health plans, and other entities served?**

***27. What is the total revenue for the most recent fiscal year?**

***28. Do you operate only as a business associate and do not maintain protected health information or perform covered functions as a covered entity apart from your activities as a business associate?**

- ◯ Yes
- ◯ No

F. Business Associates

***29. Are you a business associate of a health care provider, a health plan, or a health care clearinghouse?**

- ◯ Yes
- ◯ No

F. Business Associates (cont'd)

***30. Please briefly describe the nature of your business associate activities (e.g., billing, third party administrator, information technology support, legal services, etc.)?**

***31. Identify the type(s) of covered entity(ies) for which you provide business associate functions (choose all that apply):**

- [ ] Health Care Provider
- [ ] Health Plan
- [ ] Health Care Clearinghouse

***32. Identify whether any of the covered entity(ies) for which you provide business associate functions are Organized Health Care Arrangements (OHCA) or Affiliated Covered Entities (ACE) (choose all that apply).**

- [ ] OHCA
- [ ] ACE
- [ ] Neither
- [ ] Not sure

***33. Identify the approximate number of each type covered entity for which you provide business associate functions (please indicate a number for each option selected):**

NOTE: If you provide business associate functions for OHCA's or ACE's, please add the component covered entities separately into the totals below. For example, if you are a business associate to an OHCA comprised of 10 covered providers, add 10 to the covered provider total option below.

Health Care Provider:

Health Plan:

Health Care Clearinghouse:

***34. Do your business associate activities involve maintaining or transmitting protected health information in electronic form?**

- ◯ Yes
- ◯ No

***35. Do you perform business associate functions in more than one State?**

***36. What is the approximate total revenue from all of your business associate activities in the most recent fiscal year?**