Application for Health Center Program Grantees for
Medical Malpractice Coverage Under the
Federal Tort Claims Act
(This application is illustrative and the actual application may appear differently in the HRSA Electronic Handbook (EHB) System)

DEPARTMENT OF HEALTH AND HUMAN SERVICES **Health Resources and Services Administration**	**FOR HRSA USE ONLY**	
	Grantee Name	Application Type
CONTACT INFORMATION		
	Application Tracking Number	Grant Number

CONTACT INFORMATION (Please include a preferred title next to the name) **All the fields marked with * are required.**	
EXECUTIVE DIRECTOR *(Must electronically sign and certify the FTCA application prior to submission)* * Name: * Email: * Direct Phone: Fax:	
GOVERNING BOARD CHAIRPERSON * Name: * Email: * Direct Phone: Fax:	
MEDICAL DIRECTOR * Name: * Email: * Direct Phone: Fax:	
RISK MANAGER * Name: * Email: * Direct Phone: Fax:	

CONTACT INFORMATION (Please include a preferred title next to the name) **All the fields marked with * are required.**	
PRIMARY DEEMING CONTACT *(Individual responsible for completing application)* * Name: * Email: * Direct Phone: Fax:	
ALTERNATE DEEMING CONTACT *(Individual responsible for assisting with the application)* * Name: * Email: * Direct Phone: Fax:	
CREDENTIALING CONTACT *(Individual responsible for managing updating credentialing information)* * Name: * Email: * Direct Phone: Fax:	
CLAIMS MANAGEMENT CONTACT *(Individual responsible for the management and processing of FTCA and other medical malpractice claims)* * Name: * Email: * Direct Phone: Fax:	
QUALITY IMPROVEMENT/QUALITY ASSURANCE CONTACT (Individual responsible for overseeing the QI/QA program) * Name: * Email: * Direct Phone: Fax:	

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	Grantee Name	Application Type
REVIEW OF RISK MANAGEMENT SYSTEMS		
	Application Tracking Number	Grant Number

REVIEW OF RISK MANAGEMENT SYSTEMS
All fields marked with * are required.

1. *I attest that my health center has implemented an ongoing risk management program to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation. I also acknowledge and agree that failure to implement an ongoing risk management program and provide documentation of such implementation is grounds for disapproval of this application.

Yes [ ] No [ ]

If "No", please enter an explanation.

[2,000 character comment box]

2. *I attest that my health center has implemented risk management policies to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation. At a minimum, these policies specifically address the following:

i. Risk management across the full range of health center activities (for example, patient management including scheduling, triage, intake, tracking, and follow-up);
ii. Health care risk management training for health center staff;
iii. Completion of quarterly risk management assessments by the health center; and
iv. Annual reporting to the board of: completed risk management activities; status of the health center's performance relative to established risk management goals; and proposed risk management activities that relate and/or respond to identified areas of high organizational risk.

Yes [ ] No [ ]

If "No", please enter an explanation.

[2,000 character comment box]

3. *I attest that my health center has implemented risk management operating procedures to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation. At a minimum, these operating procedures specifically address the following:

i. Identifying the areas/activities of highest risk for health center patient safety consistent with the health center's HRSA-approved scope of project;
ii. Mitigating the areas/activities of highest risk for health center patient safety consistent with the health center's HRSA-approved scope of project, through clinical protocols, training, and medical staff supervision);
iii. Documenting, analyzing, and addressing clinically-related complaints, and "near misses" reported by health center employees, patients, and other individuals;
iv. Setting and tracking progress related to annual risk management goals;
v. Developing and implementing an annual health care risk management training plan for all staff members based on identified areas/activities of highest clinical risk for the health center (including, but not limited to obstetrical procedures, infection control) and any non-clinical trainings appropriate for health center staff (including Health Insurance Portability and Accountability Act (HIPAA) medical record confidentiality requirements); and
vi. Completing an annual risk management report for the board and key management staff.

Yes [ ] No [ ]

If "No", please enter an explanation.

[2,000 character comment box]

4. *Upload policies or procedures for the following, in order to demonstrate how the health center has mitigated risk for health center patient safety in these areas/activities consistent with the health center's HRSA-approved scope of project:

- Referral tracking
- Hospitalization tracking
- Diagnostic tracking (x-ray, labs)

[Attachment control named 'Referral Tracking']
[Attachment control named 'Hospitalization Tracking']
[Attachment control named 'Diagnostic Tracking (must include labs and x-rays)']

5(A). *I attest that my health center has developed and implemented health care risk management training plans for staff members based on identified areas/activities of highest clinical risk for the health center. These training plans include the health center's tracking/documentation methods

to ensure that trainings have been completed by the appropriate staff, including all clinical staff, at least annually.

I attest that the training plans incorporate the following:

i. Obstetrical procedures (e.g., continuing education for electronic fetal monitoring (such as, online course available through ECRI Institute), and dystocia drills);
ii. Infection control (e.g., Blood Borne Pathogen Exposure protocol, Infection Prevention and Control policies, Hand Hygiene training and monitoring program);
iii. HIPAA medical record confidentiality requirements.

Yes [ ] No [ ]

If "No", please enter an explanation.

[2,000 character comment box]

5(B). *Upload the health center's current risk management training plans for staff members based on identified areas/activities of highest clinical risk for the health center, as well as any and all tracking/documentation methods or tools used to ensure trainings have been completed by the appropriate staff, including all clinical staff, at least annually.

[attachment control named 'Risk Management Training Plans']

*6. Upload the most recent report to the board/key management staff on risk management activities, progress in meeting risk management goals and evidence that related follow up actions have been implemented.

All documents must be from the current or previous calendar year. Any documents dated outside of this period will not be accepted.

[Attachment control named 'Reports to Board and Key Management Staff']

7. *Upload the relevant Position Description(s) describing the person responsible for the coordination of health center risk management activities and any other associated activities.
[Attachment control named 'Risk Management Position Descriptions']

8. Has the designated individual(s) who oversees and coordinates the health center's risk management activities completed health care risk management training in the last 12 months?

[ ] Yes [ ] No

If "No", please enter an explanation.

[2,000 character comment box]

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	Grantee Name	Application Type
QUALITY IMPROVEMENT/QUALITY ASSURANCE PLAN (QI/QA)		
	Application Tracking Number	Grant Number

QUALITY IMPROVEMENT/QUALITY ASSURANCE (QI/QA)
All fields marked with * are required

1. *Upload the health center's policies and supporting documentation to demonstrate that the health center has established an ongoing QI/QA Program and supporting operating procedures. All supporting documentation must be from the current calendar year or the previous calendar year. Examples of supporting documentation include, but are not limited to QI/QA minutes and QI/QA reports. The policies and other documentation must, at a minimum, demonstrate that the health center's QI/QA program's operating procedures address:

a. Adherence to current evidence-based clinical guidelines, standards of care, and standards of practice, as applicable;
b. A process for identifying, analyzing, and addressing patient safety and adverse events and for implementing follow-up actions, as necessary;
c. A process for assessing patient satisfaction;
d. A process for hearing and resolving patient grievances;
e. Completion of periodic QI/QA assessments on at least a quarterly basis; and
f. A process for modifying the provision of health center services based on the findings of QI/QA assessments, as appropriate.

[Attachment control named 'Supporting QI/QA Documents]
[Attachment control named 'QI/QA Plan']

If you are unable to upload the QI/QA Plan and/or other documentation that demonstrates the above, please explain:

[2,000 character comment box]

2. *Upload documentation that the health center has performed QI/QA assessments (for example, through QI/QA report(s), QI/QA committee minutes, or QI/QA assessments).

All documents must be from the current or previous calendar year. Any documents dated outside of this period will not be accepted.

Such documentation must, at a minimum, demonstrate the following:

A. QI/QA assessments have been completed on at least a quarterly basis over the past calendar year;
B. QI/QA assessments over the past calendar year that include assessing the following:
    i. Provider adherence to current evidence-based clinical guidance, standards of care, and standards of practice in the provision of health center services, as applicable; and; and
    ii. The identification of any patient safety and adverse events and the implementation of related follow-up actions, as necessary.

[Attachment control named 'QI/QA Assessments']

If you are unable to upload documentation that demonstrates the above, please explain:
[2,000 character comment box]

3(A). *Upload the most recent QI/QA report that has been provided to key management staff and to the governing board. The report must be from the current calendar year or the previous calendar year.

[Attachment control named 'QI/QA Report']

3(B). *Upload governing board minutes that document that the report uploaded for question 3(A) was shared with and discussed by the governing board to support decision-making and oversight regarding the provision of health center services. The minutes must be from the current calendar year or the previous calendar year.

[Attachment control named 'Governing Board Minutes']

4. *Upload the relevant Position Description(s) that describe the responsibilities of the individual(s) who oversee the QI/QA program, including ensuring the implementation of QI/QA operating procedures and completion of QI/QA assessments, monitoring QI/QA outcomes, and updating QI/QA operating procedures. The job description must clearly detail that the QI/QA activities are a part of the individual's daily responsibilities.

[Attachment control named 'QI/QA Position Descriptions']

5. *Has the health center implemented a certified Electronic Health Record for all health center patients?

[ ] Yes [ ] No

If No, please describe the health center's systems and procedures for maintaining a retrievable health record for each patient, the format and content of which is consistent with both federal and state law requirements.

[4,000 character comment box]

6. *I attest that my health center has implemented systems and procedures for protecting the confidentiality of patient information and safeguarding this information against loss, destruction, or unauthorized use, consistent with federal and state requirements.

[ ] Yes [ ] No

If "No", please enter an explanation.

[2,000 character comment box]

7. *Please indicate whether you currently have an active condition on your Health Center Program award related to QI/QA.

[ ] Yes [ ] No

If Yes, please indicate the source (for example, Operational Site Visit, Service Area Competition application) through which your received this condition. Please also indicate the specific nature of the condition, including the finding and reason why the condition was imposed.

[2,000 character comment box]

Please note: The presence of certain award conditions related to Quality Improvement / Quality Assurance may demonstrate noncompliance with FTCA Program requirements and may result in disapproval of deemed status.

CREDENTIALING AND PRIVILEGING
All fields marked with * are required

1. *I attest that my health center has implemented a credentialing process for all clinical staff members who are health center employees, individual contractors, or volunteers. I also attest that my health center has operating procedures for the initial and recurring review of credentials, and responsibility for ensuring verification of all of the following:

a. Current licensure, registration, or certification using a primary source;
b. Education and training for initial credentialing, using:
    - Primary sources for licensed independent practitioners;
    - Primary or other sources for other licensed or certified practitioners and any other clinical staff;
c. Completion of a query through the National Practitioner Databank (NPDB);
d. Clinical staff member's identity for initial credentialing using a government issued picture identification;
e. Drug Enforcement Administration registration (if applicable); and
f. Current documentation of Basic Life Support skills.

[ ] Yes [ ] No

If "No", please enter an explanation.

[2,000 character comment box]

2.*I attest that my health center has implemented a privileging process for the initial granting and renewal of privileges for clinical staff members (including health center employees, individual contractors, and volunteers). I also attest that my health center has operating procedures that address all of the following:

a. Verification of fitness for duty, immunization, and communicable disease status;
b. For initial privileging, verification of current clinical competence via training, education, and, as available, reference reviews;
c. For renewal of privileges, verification of current clinical competence via peer review or other comparable methods (for example, supervisory performance reviews); and
d. Process for denying, modifying or removing privileges based on assessments of clinical competence and/or fitness for duty.

[ ] Yes [ ] No

If "No", please enter an explanation.

[2,000 character comment box]

3. * Please upload the health center's credentialing and privileging operating procedures that address all credentialing and privileging elements listed in questions 1 & 2 above.

[attachment control named 'Credentialing and Privileging Operating Procedures']

4. *I attest that my health center ensures that the files or records for our clinical staff (employees, individual contractors, and volunteers) contain documentation of licensure and credentialing verification and recording of privileges, consistent with the health center's operating procedures.

[ ] Yes [ ] No

If "No", please enter an explanation.

[2,000 character comment box]

5. *I attest that if my health center contracts with provider organizations (for example, group practices, staffing agencies) or has formal, written referral agreements with other provider organizations, such contracts and/or formal, written referral agreements contain provisions that:

a. Ensure that the providers are licensed, certified, or registered as verified through a credentialing process, in accordance with applicable federal, state, and local laws; and
b. Ensure that the providers are assessed as competent to perform the contracted or referred services through a privileging process

Select N/A if the health center does not contract with provider organizations or have any formal, written referral agreements with other provider organizations.

[ ] Yes [ ] No [ ] N/A

If No, please enter an explanation.

[2,000 character comment box]

Please note: "A contract between a covered entity and a provider's corporation does not confer FTCA coverage on the provider. Services provided strictly pursuant to a contract between a covered entity and any corporation, including eponymous professional corporations (defined as a professional corporation to which one has given one's name, e.g., John Doe, LLC, and consisting of only one health care provider), are not covered under FSHCAA and the FTCA." See FTCA Health Center Policy Manual, Section B.3.

6.*Please indicate whether you currently have a condition on your Health Center Program award related to credentialing or privileging. [ ] Yes [ ]No If Yes, please indicate the source (for example, Operational Site Visit, Service Area Competition application) through which your received this condition. Please also indicate the specific nature of the condition, including the finding and reason why the condition was imposed, such as failure to verify licensure, etc. **[2,000 character comment box]**
Please note: The presence of certain award conditions related to credentialing and privileging may demonstrate noncompliance with FTCA Program requirements and may result in disapproval of deemed status.

DEPARTMENT OF HEALTH AND HUMAN SERVICES **Health Resources and Services Administration**	**FOR HRSA USE ONLY**	
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CLAIMS MANAGEMENT		
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CLAIMS MANAGEMENT
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Please note: Health centers are expected to maintain their own records of medical malpractice claims as part of their risk management systems and in accordance with local practice requirements and guidelines.

If a claim or lawsuit involving covered activities is presented to the covered entity/individual or filed in court, it is essential that the covered entity preserve all potentially relevant documents. Once a covered entity or covered individual reasonably anticipates litigation—and it is reasonable to anticipate litigation once a claim or lawsuit is filed, whether administratively or in state or federal district court—the entity or individual must suspend any routine destruction and hold any documents relating to the claimant or plaintiff so as to ensure their preservation for purposes of claim disposition or litigation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
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CLAIMS MANAGEMENT		
	Application Tracking Number	Grant Number

CLAIMS MANAGEMENT
All fields marked with * are required

1. *I attest that my health center has a claims management process for addressing any potential or actual health or health-related claims, including medical malpractice claims, that may be eligible for FTCA coverage. My health center's claims management process includes information related to how my health center ensures the following:
   a. The preservation of all health center documentation related to any actual or potential claim or complaint (e.g. medical records and associated laboratory and x-ray results, billing records, employment records of all involved clinical providers, clinic operating procedures); and
   b. That any service of process/summons that the health center or its provider(s) receives relating to any alleged claim or complaint is promptly sent to the HHS, Office of the General Counsel, General Law Division, per the process prescribed by HHS and as further described in the FTCA Health Center Policy Manual.

Yes [ ] No [ ]

If "No", please enter an explanation.

[2,000 character comment box]

2. *Has the health center had any history of claims under the FTCA? (Health centers should provide any medical malpractice claims or allegations that have been presented during the past 5 years.)

Yes [ ] No [ ]

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CLAIMS MANAGEMENT		
	Application Tracking Number	Grant Number

CLAIMS MANAGEMENT
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- If Yes, Upload a list of the claims. For each claim, include:
    a. Name of provider(s) involved
    b. Area of practice/Specialty
    c. Date of occurrence
    d. Summary of allegations
    e. Status or outcome of claim
    f. Documentation that the health center cooperated with the Attorney General for this claim, as further described in the FTCA Health Center Policy Manual
    g. Summary of health center internal analysis and implemented steps to mitigate the risk of such claims in the future (Please only submit a summary if the case is closed. If the case has not been settled do not include the summary.)

[Attachment control called 'History of Claims']

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
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CLAIMS MANAGEMENT		
	Application Tracking Number	Grant Number

CLAIMS MANAGEMENT
All fields marked with * are required

3(A). *I attest that my health center informs patients using plain language that it is a deemed federal Public Health Service employee via its website, promotional materials, and/or within an area(s) of the health center that are visible to patients. For example: "This health center receives HHS funding and has Federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals."

[ ] Yes [ ]No

If No, please enter an explanation.
[2,000 character comment box]

3(B). Please include a link to the exact location where this information is posted on your health center website, or please attach the relevant promotional material or pictures.

3(C). Upload the relevant Position Description(s) that describe the health center's designated individual(s) who is responsible for the management and processing of claims related activities and serves as the claims point of contact.

[Attachment control named 'Claims Management Position Descriptions']

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	Grantee Name	Application Type
ADDITIONAL INFORMATION		
	Application Tracking Number	Grant Number

CERTIFICATION AND SIGNATURES

Completion of this section by a typed name will constitute signature on this application.

* I [ ] declare under the penalty of perjury that all statements contained in this application and any accompanying documents are true and correct, with full knowledge that all statements made in this application are subject to investigation and that any false or dishonest answer to any question may be grounds for denial or subsequent revocation of coverage.

I understand that by printing my name I am signing this application.

Please note – this must be signed by the Executive Director, as indicated in the Contact Information Section of the FTCA application. If not signed by the Executive Director, the application will be returned to the health center.