

Application for Health Center Program ~~Grantee~~**Award Recipients** for  
~~Medical Malpractice Coverage~~**Liability Protections** Under the  
 Federal Tort Claims Act

(This application is illustrative and the actual application may appear differently in the HRSA  
 Electronic Handbook (EHB<sub>s</sub>) System)

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	<del>Grantee</del> <b>Award Recipient</b> Name	Application Type
CONTACT INFORMATION	Application Tracking Number	Grant Number

<b>CONTACT INFORMATION (Please include a preferred title next to the name)</b> All the fields <b>in the Contact Information section</b> marked with * are required.	
EXECUTIVE DIRECTOR <i>(Must electronically sign and certify the FTCA application prior to submission)</i> * 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:	

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

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

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**REVIEW OF RISK MANAGEMENT SYSTEMS**  
**All questions in this section fields marked with \* are required.**

1(A). \*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 and that requires the following: ~~n. I also acknowledge and agree that failure to implement an ongoing risk management program and provide documentation of such implementation may result in disapproval of this deeming application.~~

- 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~~provide an explanation.

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1(B). I also acknowledge ~~and agree~~ that failure to implement an ongoing risk management program and provide documentation of such implementation may result in disapproval of this deeming application and/or other remedies.

Yes [ ] No [ ]

If “No”, provide an explanation.

**[2,000 character comment box]**

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	<del>Grantee</del> <u>Award Recipient</u> Name	Application Type
REVIEW OF RISK MANAGEMENT SYSTEMS	Application Tracking Number	Grant Number

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**REVIEW OF RISK MANAGEMENT SYSTEMS**  
**All questions in this section fields marked with \* are required.**

~~2. \*I attest that my health center has implemented and maintains board approved (by the board or designated approving official of the board) risk management policies and procedures to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation. The policy and procedures may be in either a single document or maintained separately, but At a minimum, the policyse policies should 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.~~

~~I also acknowledge and agree that failure to implement and maintain a risk management policy and procedures as further described above to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation may result in disapproval of this deeming application.~~

~~Yes [ ] No [ ]~~

~~If "No", please enter an explanation.~~

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23(A). \*I attest that my health center has implemented ~~board-approved~~ 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 and mitigating (for example, through clinical protocols, medical staff supervision) the health care areas/activities of highest risk ~~for within health center patient safety consistent with~~ the health center's HRSA-approved scope of project, including but not limited to tracking referrals, diagnostics, and hospital admissions ordered by health center providers;
- ~~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.ii.~~ Documenting, analyzing, and addressing clinically-related complaints, and "near misses" reported by health center employees, patients, and other individuals;
- ~~iv.iii.~~ Setting and tracking progress related to annual risk management goals;
- ~~v.iv.~~ 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.v.~~ Completing an annual risk management report for the board and key management staff.

Yes [ ] No [ ]

If "No", provide an explanation.

**[2,000 character comment box]**

2(B). I also acknowledge ~~and agree~~ that failure to implement and maintain risk management procedures ~~as further described above~~ to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation, as further described above, may result in disapproval of this deeming application.

Yes [ ] No [ ]

If "No", provide please enter an explanation.

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2(C). Upload the risk management procedures that address the items outlined in question 2(A).i above, specifically risk management procedures that address mitigating risk in referral tracking, diagnostics, and hospital admissions ordered by health center providers or initiated by the patient.

[Attachment control named 'Referral Tracking']

[Attachment control named 'Hospitalization Tracking']

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

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)']

35(A). \*I attest that my health center has developed and implemented an annual health care risk management training plan for staff members based on identified areas/activities of highest clinical risk for the health center. These training plans include detailed information related to 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 at a minimum also incorporate the following:

- i. Obstetrical procedures (for example-g., continuing education for electronic fetal monitoring (such as, the online course available through ECRI Institute), and dystocia drills). Please note: Health centers that provide obstetrical services through health center providers need to include obstetrical training as part of their risk management training plans to demonstrate compliance. This includes health centers that provide prenatal and postpartum care through health center providers, even if they do not provide labor and delivery services;
- ii. Infection control and sterilization (for example-g., Blood Borne Pathogen Exposure protocol, Infection Prevention and Control policies, Hand Hygiene training and monitoring program, and dental equipment sterilization);
- iii. HIPAA medical record confidentiality requirements; and,
- iv. Specific trainings for groups of providers that perform various services which may lead to potential risk (for example, dental, pharmacy, family practice).

Yes [ ] No [ ]

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If "No", ~~provide please enter~~ an explanation.

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~~35(B).- \*Upload the health center's current annual risk management training plans for all staff members, including all clinical and non-clinical staff, based on identified areas/activities of highest clinical risk for the health center and that include at a minimum the items outlined in risk management question 3(A).i-iv of this application. The risk management training plans should also include procedures on how document completion of all attendance at required training, to account for and address individuals who miss scheduled trainings.~~

**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 'Risk Management Training Plan']

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~~3(C). Upload, 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 all staff, at least annually (for example, excel sheet, Relias training reports).~~

**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 'Risk Management Training Plan Tracking and Documentation Tools']

~~\*46. Upload documentation (for example, data/trends, reports, risk management committee minutes) that demonstrates that the health center has completed quarterly risk management assessments.~~

[Attachment control named 'Risk Management Quarterly Assessments Documentation']

~~— 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.~~

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~~5(A). Upload the most recent report provided to the board and key management staff on health care risk management activities and progress in meeting goals at least annually, and documentation provided to the board and key management staff showing that any related follow-up actions have been implemented. **The report must be from the current or previous calendar year and must be reflective of the activities related to risk over a 12-month period. Any documents dated outside of this period will not be accepted.** The report must include:~~

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- i. Completed risk management activities (for example, risk management projects, assessments).
- ii. Status of the health center’s performance relative to established risk management goals (for example, data and trends analyses, including, but not limited to, sentinel events, adverse events, near misses, falls, wait times, patient satisfaction information, other risk management data points selected by the health center), and
- iii. Proposed risk management activities for the next 12-month period that relate and/or respond to identified areas of high organizational risk.

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[Attachment control named ‘Annual Risk Management Report to Board and Key Management Staff’]

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5(B). Upload proof that the health center board has received and reviewed the report uploaded for risk management question 5(A) of this application (for example, minutes signed by the board chair/board secretary, minutes and signed letter from board chair/board secretary).

**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~~Proof of Board Review of Annual Risk Management Report’]

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~~7.~~\*

6. Upload the relevant Position Description(s) of the risk manager who is describing the person responsible for the coordination of health center risk management activities and any other associated risk management activities. The job description must clearly detail that the risk management activities are a part of the risk manager’s daily responsibilities.

[Attachment control named ‘Risk Management Position Descriptions’]

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~~7~~8(A). Has the designated individual(s) who oversees and coordinates the health center’s risk management activities the health center risk manager completed health care risk management training in the last 12 months (CY2018 or CY2019)?

[ ] Yes [ ] No

If “No”, ~~provide please enter~~ an explanation.

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7(B). Upload evidence that the risk manager has completed health care risk management training in the last 12 months (CY2018 or CY2019).

[Attachment control named ‘Annual Risk Manager Training’]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	Grantee/Award Recipient Name	Application Type
QUALITY IMPROVEMENT/QUALITY ASSURANCE PLAN (QI/QA)	Application Tracking Number	Grant Number
<b>QUALITY IMPROVEMENT/QUALITY ASSURANCE (QI/QA)</b> <u>All questions in this section fields marked with * are required.</u>		
<p>1(A). I attest that my health center has board-approved policies (for example, a QI/QA plan) that demonstrate that the health center has an established QI/QA program. Such documentation must, at a minimum, demonstrate that the QI/QA program addresses the following:</p> <ul style="list-style-type: none"> <li>i. <u>The quality and utilization of health center services;</u></li> <li>ii. <u>Patient satisfaction and patient grievance processes; and</u></li> <li>iii. <u>Patient safety, including adverse events.</u></li> </ul> <p>[Attachment control named 'QI/QA Policies']</p> <p>If you are unable to upload the QI/QA Policies that demonstrate the above, provide an explanation:</p> <p>[2,000 character comment box]</p>		
<p>1(B). <del>1. *</del> I attest that my health center has <u>Upload the health center's QI/QA program operating procedures or processes that, at a minimum, address the following: policies and supporting documentation to demonstrate that the health center has established an ongoing QI/QA Program and supporting operating procedures.</u></p> <p><del>All supporting documentation must be from the current calendar year or the previous calendar year.</del> 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 <u>operating procedures address:</u></p> <ul style="list-style-type: none"> <li>a.i. <u>Adherence</u> to current evidence-based clinical guidelines, standards of care, and standards of practice <u>in the provision of health center services</u>, as applicable;</li> <li>b.ii. <u>A process for</u> identifying, analyzing, and addressing patient safety and adverse events and <u>for</u> implementing follow-up actions, as necessary;</li> </ul>		

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- ~~e-iii. A process for a~~Assessing patient satisfaction;
- ~~d-iv. A process for h~~Hearing and resolving patient grievances;
- ~~e-v. Completin~~g of periodic QI/QA assessments on at least a quarterly basis to inform the modification of the provision of health center services, as appropriate; and
- ~~f. A process for modifying the provision of health center services based on the findings of QI/QA assessments, as appropriate~~Producing and sharing reports on QI/QA to support decision-making and oversight by key management staff and by the governing board regarding the provision of health center services.
- ~~vi.~~

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

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If you are unable to upload the QI/QA ~~Plan-Operating Procedures and/or other documentation~~ that demonstrates the above, please explainprovide an explanation:

[2,000 character comment box]

2. \*Upload documentation that the health center has performed QI/QA assessments on a quarterly basis (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.**

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

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- ~~A-i.~~ QI/QA assessments have been completed on at least a quarterly basis over the ~~past~~ calendar year by the health center's physicians or other licensed health care professionals; and
- ~~B-ii.~~ QI/QA assessments over the past calendar year that include assessing the following:
  - ~~i-a.~~ 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-b.~~ The identification of any patient safety and adverse events and the implementation of related follow-up actions, as necessary.

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[Attachment control named 'QI/QA Assessments']

If you are unable to upload documentation that demonstrates the above, provide an explanationplease explain:

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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.**

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[Attachment control named 'QI/QA Report']

3(B). \*Upload governing board minutes or other documentation to demonstrate that document that the QI/QA report uploaded for question 3(A) was shared with and discussed by key management staff and by the governing board to support decision-making and oversight regarding the provision of health center services. The minutes should include reference to the report uploaded for QI/QA question 3(A) in this application. **The minutes must be from the current calendar year or the previous calendar year.**

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[Attachment control named 'Governing Board Minutes']

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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']

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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(A). \*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", ~~provide please enter~~ an explanation.

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6(B). I also acknowledge and agree that failure to implement and maintain systems and procedures for protection the confidentiality of patient information and safeguarding this information against loss, destruction, or unauthorized use, consistent with federal and state requirements, may result in disapproval of this deeming application.

Yes  No

If "No", ~~provide please enter~~ an explanation.

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7. \*~~Please~~ indicate whether you currently have an active condition or any other enforcement action on your Health Center Program award related to QI/QA.

Yes  No

If Yes, ~~please~~ indicate the date that the condition was imposed and its source (for example, Operational Site Visit, Service Area Competition application) through which your ~~organization-entity~~ received this condition. ~~Please also~~ Also indicate the specific nature of the condition, including the finding and reason why the condition was imposed. ~~Please also d~~ Describe your ~~organization's-entity's~~ plan to remedy the deficiency that led to imposition of the condition and the anticipated timeline by which the plan is expected to be fully implemented.

**[2,000 character comment box]**

**Please note:** The presence of certain award conditions and/or enforcement actions 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 questions in this section fields marked with \* are required.**

**1(A).** \*I attest that my health center has implemented a credentialing process for all clinical staff members (including for licensed independent practitioners and other licensed or certified health care practitioners) 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.i.** Current licensure, registration, or certification using a primary source;
- b.ii.** Education and training for initial credentialing, using:
  - a.** Primary sources for licensed independent practitioners;
  - b.** Primary or other sources for other licensed or certified practitioners and any other clinical staff;
- c.iii.** Completion of a query through the National Practitioner Databank (NPDB);
- d.iv.** Clinical staff member's identity for initial credentialing using a government issued picture identification;
- e.v.** Drug Enforcement Administration registration (if applicable); and
- f.vi.** Current documentation of Basic Life Support trainingskills.

Yes  No

If "No", provide an explanation.

**[2,000 character comment box]**

**1(B).** I also acknowledge and agree that failure to implement and maintain a credentialing process as further described above may result in disapproval of this deeming application.

Yes  No

If "No", provide please enter an explanation.

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2(A). I attest that my health center has implemented a privileging process-procedures for the initial granting and renewal of privileges for clinical staff members (including for licensed independent practitioners and other licensed or certified health care practitioners who are, including health center employees, individual contractors, and volunteers). I also attest that my health center has operating-privileging procedures that address all of the following:

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

Yes  No

If "No", provide an explanation.

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2(B). I also acknowledge and agree that failure to implement and maintain a privileging process for the initial granting and renewal of privileges for clinical staff members, including operating procedures as further described above, may result in disapproval of this deeming application.

Yes  No

If "No", provide please enter an explanation.

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3. Please upload the health center's credentialing and privileging operating procedures that address all credentialing and privileging elements-components listed in questions 1(A) & 2(A) 1 & 2 above. (Please note: Procedures that are missing any of the components referenced in the credentialing and privileging section questions 1(A) & 2(A) of this application will be interpreted as the health center not implementing those missing components.)

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

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

Yes  No

If "No", ~~provide please enter~~ an explanation.

**[2,000 character comment box]**

5. \*I attest that if my health center has contracts with provider organizations (for example, group practices, staffing agencies) ~~or has~~ formal, written referral agreements with other provider organizations ~~that provide services within its scope of project, the health center ensures (for example, through provisions in, such contracts and/or~~ formal, written referral agreements, ~~contracts, other documentation)~~ contain provisions that such providers are:

- i. ~~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
- ii. ~~b. Ensure that the providers are assessed as e~~ Competent and fit to perform the contracted or referred services, as assessed 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, ~~provide 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, for example-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.

**Commented [MK(1):** FTCA recommends keeping this parenthetical statement as is: this parenthetical statement slightly differs from the Compliance Manual's "(for example, group practices, locum tenens staffing agencies, training programs)"- because FTCA does not apply for locum tenens providers or training programs providers.

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6.\* ~~Indicate whether you currently have an active condition or any other enforcement action on your Health Center Program award related to~~ Please indicate whether you currently have a condition on your Health Center Program award or other enforcement action related to credentialing or privileging.

Yes  No

If Yes, ~~please~~ indicate the date and source (for example, Operational Site Visit, Service Area Competition application) through which you received this condition or other enforcement action. ~~Please Also~~ indicate the specific nature of the condition or other enforcement action, including the finding and reason why ~~it~~ the condition was imposed, such as failure to verify licensure, etc. ~~Please also d~~ Describe your organization's entity's plan to remedy the deficiency that led to imposition of the condition or enforcement action and the anticipated timeline by which the plan is expected to be fully implemented.

**[2,000 character comment box]**

**Please note:** The presence of certain award conditions and/or enforcement actions 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	
		<del>Grantee</del> Award Recipient Name	Application Type
CLAIMS MANAGEMENT		Application Tracking Number	Grant Number
<b>CLAIMS MANAGEMENT</b>			
<b>All questions with an * in this section fields marked with * are required.</b>			
<p><b>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.</b></p> <p>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.</p>			

1(A). ~~2.~~ ~~1.~~ ~~2.~~ 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~~ ~~which~~ 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.i. The preservation of all health center documentation related to any actual or potential claim or complaint (for example, 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.ii. 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", provide an explanation.

[2,000 character comment box]

1(B). \*I also acknowledge and agree that failure to implement and maintain a claims management process as described above may result in disapproval of this deeming application.

Yes [ ] No [ ]

If "No", provide ~~please enter~~ an explanation.

[2,000 character comment box]

1(C). \*Upload documentation of the health center's claims management process (for example, claims management procedures) for addressing any potential or actual health or health-related claims, including medical malpractice claims, that may be eligible for FTCA coverage. In addition, this process includes the items outlined in Claims Management question 1(A).a-b of this application.

[Attachment control named 'Claims Management Procedures'] (If answer to 1(A) is Yes, attachment required; if answer to 1(A) is No, no attachment is required.)

~~2.~~ 2(A). ~~2.~~ ~~1.~~ ~~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 [ ]

- If Yes, uUpload a list of the claims. For each claim, include:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	<del>Grantee</del> <u>Award Recipient</u> Name	Application Type
CLAIMS MANAGEMENT	Application Tracking Number	Grant Number

**CLAIMS MANAGEMENT**  
**All questions with an \* in this section fields marked with \* are required.**

- a-i. Name of provider(s) involved;
- b-ii. Area of practice/Specialty;
- c-iii. Date of occurrence;
- d-iv. Summary of allegations;
- e-v. Status or outcome of claim;
- f-vi. Documentation that the health center cooperated with the Attorney General for this claim, as further described in the FTCA Health Center Policy Manual; and
- g-vii. 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. Do not submit a copy of the NPDB report in this section.).

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[Attachment control name called 'History of Claims']

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2(B). \*I agree ~~attest that the health center have, will, and must cooperate with all FTCA division officials, Health and Human Services officials, Department of Justice officials, and any other applicable Federal government representatives in the defense of any FTCA claims and understand that failure to do so may result in the disapproval of this FTCA application and future FTCA applications.~~

Yes [ ] No [ ]

If "No", provide an explanation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	<u>Grantee/Award Recipient Name</u>	Application Type
CLAIMS MANAGEMENT	Application Tracking Number	Grant Number
<p align="center"><b>CLAIMS MANAGEMENT</b>  All questions with an * in this section fields marked with * are required.</p>		
<p>3(A). <del>I</del> <b>**</b> I attest that my health center informs patients using plain language that it is a deemed <del>f</del> <b>Federal Public Health Service</b> PHS employee via its website, promotional materials, and/or within an area(s) of the health center that <del>are</del> <b>is</b> visible to patients. For example: "This health center receives HHS funding and has <del>f</del> <b>Federal Public Health Service</b> (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals."</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If No, <del>provide please enter</del> an explanation.</p> <p><b>[2,000 character comment box]</b></p> <p>3(B). <del>Please</del> include a link to the exact location where this information is posted on your health center website, or <del>please</del> attach the relevant promotional material or pictures.</p> <p><u>[Free Response Control to type in link]</u></p> <p><u>[Attachment control named 'FTCA Promotional Materials']</u></p> <p><u>(If answer to 3(A) is Yes, either free response control or attachment required; if answer to 3(A) is No, no free response control or attachment is required.)</u></p> <p>3(C). <b>*</b> 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. <u>The job description must clearly detail that the claims management activities are a part of the individual's daily responsibilities.</u></p> <p><u>[Attachment control named 'Claims Management Position Descriptions']</u></p>		

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

<b>CERTIFICATION AND SIGNATURES</b>
<b>Completion of this section by a typed name will constitute signature on this application.</b>
<b><u>This field is required.</u></b>
<p>*1 [            ] 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 material false statement or omission in response to any question may result in denial or subsequent revocation of coverage.</p> <p>I understand that by printing my name I am signing this application.</p> <p><i>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.</i></p>

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