

**FREE CLINICS FTCA PROGRAM APPLICATION**

**The following tables provide the information that will be collected in the initial, redeeming, and supplemental deeming sponsorship applications through the EHBs:**

<b>Section I. Contact Information*</b>	
<b>Executive Director</b> <ul style="list-style-type: none"> <li>● First Name:</li> <li>● Last Name:</li> <li>● E-mail:</li> <li>● Phone Number:</li> <li>● Fax Number:</li> </ul>	
<b>Medical Director</b> <ul style="list-style-type: none"> <li>● First Name:</li> <li>● Last Name:</li> <li>● E-mail:</li> <li>● Phone Number:</li> <li>● Fax Number:</li> </ul>	
<b>Risk Management Coordinator</b> <ul style="list-style-type: none"> <li>● First Name:</li> <li>● Last Name:</li> <li>● E-mail:</li> <li>● Phone Number:</li> <li>● Fax Number:</li> </ul>	
<b>FTCA Contact</b> <ul style="list-style-type: none"> <li>● First Name:</li> <li>● Last Name:</li> <li>● E-mail:</li> <li>● Phone Number:</li> <li>● Fax Number:</li> </ul>	
<b>*Upload state documentation indicating legal name change if legal name change occurred since last deeming sponsorship application.</b>	

<b>Section II. Site Information</b>	
<ul style="list-style-type: none"> <li>● Name:</li> <li>● Address:</li> <li>● Phone Number:</li> <li>● Fax Number:</li> <li>● E-mail:</li> <li>● Site Type:</li> <li>● Days/Hours of Operations:</li> </ul>	
<b>*All free clinic sites must be listed. Each site must be appropriately identified as the main site or as an additional site.</b>	

<b>Section III. Sponsoring Free Clinic Eligibility</b>	
	<b>1. (Required for initial and redeeming applicants). The sponsoring free clinic is a registered nonprofit organization. Please attach nonprofit documentation.)</b>
<b>Attachment Control (Attachment A. Non-Profit Documentation (Maximum 5))</b>	
<input type="checkbox"/>	Yes
	<b>2. The sponsoring free clinic and its sponsored individuals comply with the definitions relative to covered individuals (employees, contractors, volunteer health professionals, and board member and officers) as set forth in section III, “Covered Individuals”, of the <a href="#">Free Clinics FTCA Program Policy Guide</a>.</b>
<input type="checkbox"/>	Yes
	<b>3. The free clinic does not accept reimbursement from any third-party payor (including but not limited to reimbursement from an insurance policy, health plan, or other Federal or State health benefits program).</b>
<input type="checkbox"/>	Yes
	<b>4. The free clinic does not impose charges on patients either based on service provided or the ability to pay. (The free clinic may accept only volunteer donations from patients and other third parties.)</b>
<input type="checkbox"/>	Yes
	<b>5. The free clinic is licensed or certified in accordance with applicable law regarding the provision of health services.</b>
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No (If no, then explain)
	<b>6. The free clinic and/or individual health care professional provides each patient with a written notification explaining that the legal liability of the deemed individual is limited pursuant to section 224(o) of the Public Health Service Act, 42 U.S.C. 233(o).</b>
<input type="checkbox"/>	Yes

<b>Section IV. Credentialing and Privileging Systems*</b>	
	<b>1. The free clinic verifies licensure, certification, and/or registration of each licensed and/or certified individual according to the instructions in the <a href="#">Free Clinics FTCA Program Policy Guide</a>. (Please remember all volunteer health professionals must be licensed or certified to be eligible for deeming.)</b>
<input type="checkbox"/>	Yes
	<b>2. The free clinic has a copy of the current license, certification, and/or registration on file at the free clinic for each licensed and/or certified individual. (Please remember all volunteer health professionals must be licensed or certified to be eligible for deeming.)</b>
<input type="checkbox"/>	Yes
	<b>3. If the free clinic contracts with a Credentialing Verification Organization (CVO) for CVO services, there is a written contractual agreement stating the specifics of these services.</b>
<input type="checkbox"/>	Yes
<input type="checkbox"/>	N/A
	<b>4. The free clinic utilizes peer review activities when it privileges each licensed and/or certified individual according to the instructions in the <a href="#">Free Clinics FTCA Program Policy Guide</a>.</b>

<b>Section IV. Credentialing and Privileging Systems*</b>	
<input type="checkbox"/> Yes	
<b>This section is required for all initial deeming and redeeming sponsorship applications. This section is required for supplemental deeming sponsorship applications if the free clinic has changed its credentialing and privileging system since the annual deeming or initial sponsorship application.</b>	
<b>5. The free clinic annually reviews any history of prior and current medical malpractice claims for each individual for whom deeming is sought.</b>	
<input type="checkbox"/> Yes	
<b>6. A National Practitioner Data Bank (NPDB) query is obtained and evaluated on a recurring basis (for example, every two years) for each licensed and/or certified individual according to the instructions in the <a href="#">Free Clinics FTCA Program Policy Guide</a>. Note: do NOT submit a copy of the NPDB report for any individual to HRSA.</b>	
<input type="checkbox"/> Yes	
<b>7. Name and contact information of the person and organization conducting credentialing/privileging.</b>	
Enter the name and contact information in the Comments section of this question.	

<b>Section V. Risk Management Systems*</b>	
<b>1. The free clinic maintains and implements policies and procedures for the provision of appropriate supervision and back-up of clinical staff.</b>	
<input type="checkbox"/> Yes	
<input type="checkbox"/> No (If no, then explain)	
<b>2. The free clinic maintains a medical record for each patient receiving care from its organization.</b>	
<input type="checkbox"/> Yes	
<input type="checkbox"/> No (If no, then explain)	
<b>3. The free clinic has policies and procedures that address:</b>	
a. Triage <input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Walk-in patients <input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Telephone triage <input type="checkbox"/> Yes <input type="checkbox"/> No	
If No for any of the above, then explain.	
<b>4. The free clinic has protocols that identify appropriate treatment and diagnostic procedures based on current standards of care.</b>	
<input type="checkbox"/> Yes	
<input type="checkbox"/> No (If no, then explain)	
<b>5. The free clinic has a tracking system for patients who miss appointments or require follow-up of referrals, hospitalization, diagnostics (for example, x-rays), or laboratory results.</b>	
<input type="checkbox"/> Yes	
<input type="checkbox"/> No (If no, then explain)	
<b>6. The free clinic periodically reviews patients' medical records to verify quality, completeness, and legibility of written entries.</b>	

<input type="checkbox"/> Yes
<input type="checkbox"/> No (If no, then explain)
<b>7. The free clinic has a written, current QI/QA or Risk Management plan othat clearly addresses the clinic’s credentialing and privileging process and has been signed by a board authorized representative on a recurring basis (for example, every three (3) years) (please attach a copy of the plan with documentation of board approval, including date of approval).</b>
<input type="checkbox"/> Yes
<input type="checkbox"/> No (If no, then explain)
Attach the free clinic’s QI/QA or Risk Management Plan that has been approved, signed, and dated by a board authorized representative on a recurring basis (for example, every three (3) years):
<ul style="list-style-type: none"> <li>This attachment is required for initial deeming and redeeming sponsorship applications. This attachment is required for supplemental deeming sponsorship applications if the free clinic has changed its QI/QA Plan since the annual redeeming sponsorship application.</li> </ul>
Attachment Control (Attachment B. Copy of Clinic’s QI/QA or Risk Management Plan (Maximum 1))
<b>8. The free clinic has regular, periodic meetings to review and assess quality assurance issues.</b>
<input type="checkbox"/> Yes (If yes, briefly describe the structure (e.g., frequency of meetings, individuals required to attend, etc.) of the committee that meets periodically to review and assess quality assurance issues.)
<input type="checkbox"/> No (If no, then explain)
<b>9. The free clinic considers findings from its peer review activities when reviewing and/or revising its QI/QA plan.</b>
<input type="checkbox"/> Yes (If yes, explain what information and process is utilized by the clinic when updating and revising the QI/QA plan.)
<input type="checkbox"/> No (If no, then explain)
<b>10. The free clinic utilizes quality assurance findings to modify policies to improve patient care.</b>
<input type="checkbox"/> Yes
<input type="checkbox"/> No (If no, then explain)
<b>11. The free clinic’s FTCA-deemed individuals annually participate in risk management continuing education activities.</b>
<input type="checkbox"/> Yes (If yes, briefly describe the annual risk management educational activities that are available to health professionals.)
<input type="checkbox"/> No (If no, then explain)
<b>12. The free clinic has assured that each individual sponsored for FTCA deemed status has a copy of the <a href="#">Free Clinics FTCA Program Policy Guide</a>, and that his/her questions regarding FTCA medical malpractice coverage have been addressed.</b>
<input type="checkbox"/> Yes
<input type="checkbox"/> No (If no, then explain)

**\*Required for initial deeming and redeeming sponsorship applications. Required for supplemental deeming sponsorship applications if the free clinic has changed its QI/QA Plan since the annual redeeming sponsorship application.**

<b>Section VI. Free Clinic Volunteer Health Care Professionals, Board Members, Officers, Employees, and Individual Contractors*</b>	
<b>Add Individual Details</b> <ul style="list-style-type: none"> <li>• Prefix:</li> </ul>	
<ul style="list-style-type: none"> <li>• First Name:</li> <li>• Middle Name:</li> <li>• Last Name:</li> <li>• Professional Designation:</li> </ul>	
<b>Contact Information</b> <ul style="list-style-type: none"> <li>• Email Address:</li> <li>• Phone Number:</li> <li>• Fax Number:</li> <li>• Mailing Address:</li> </ul>	
<p><b>Is this volunteer a COVID-19 vaccination volunteer who will be volunteering solely to administer COVID-19 vaccinations?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Roles and Specialty</b></p> <ul style="list-style-type: none"> <li>• Role(s) in Free Clinic:</li> <li>• Specialty:</li> <li>• Others:</li> </ul> <p><b>[Upload a signed volunteer agreement for each individually named volunteer that clearly states that the sponsored health professional is a volunteer of the health center, outlines the terms and conditions of the services that the volunteer will provide, acknowledges that the health professional will not receive any compensation including reimbursement from any third party payor, and documents each off-site program or event where the health professional will provide</b></p>	

<p>services.]</p> <p><b>Note: For volunteers that are solely administering COVID-19 vaccines, the volunteer agreement should clearly include that information and should also any other state or federal requirements that must be met for the individual to volunteer as a COVID-19 vaccinator.</b></p> <p><b>Please estimate, how many hours on average will the volunteer work per month?</b></p>	
<p><b>Individual Type (select one):</b></p> <ul style="list-style-type: none"><li>• New Applicant</li><li>• Renewal Applicant</li></ul> <p><b>Service Type</b></p> <ul style="list-style-type: none"><li>• Clinical Work activities (Individuals that provide clinical care or participate in the supervision and oversight of clinical care)</li><li>• Non-Clinical Activities (Individuals who conduct purely non-clinical or administrative activities)</li><li>• Both Clinical and Non-Clinical (Individuals who conduct both clinical and non-clinical/administrative activities)</li></ul> <p><b>Please select the status of the individual from the options below:</b></p> <ul style="list-style-type: none"><li>• Employee</li><li>• Individual contractor</li><li>• Officer/Governing Board Member</li><li>• Licensed or Certified Health Professional Volunteer</li></ul>	
<p><b>Credentialing and Privileging</b></p> <ul style="list-style-type: none"><li>• Date of Licensure/Certification</li></ul>	

<p>Expiration</p> <ul style="list-style-type: none"><li>• Is Licensure/Certification Currently Active? Yes/No. If No, please stop here. Select N/A if this individual is not licensed or certified.</li><li>• Date of Last Credentialing:</li><li>• Date of Last Privileging: [Please remember that all state licensed and/or certified health professionals need to be credentialed and privileged on a recurring basis (for example, every two years). Not mandatory for 'Board Members' and 'Executive' role.]</li></ul>	
<p><b>Licensure and/or Certification</b></p> <p>Each sponsored VHP is required to be licensed or certified in accordance with applicable Federal and State laws to perform the services that are requested. [Note: <u>If the answer is No, this volunteer is not eligible for coverage under the Health Center Volunteer Health Professional Program, and should not be included in this application.</u>]</p> <p><b>Or</b></p> <p>For VHPs that are solely administering COVID-19 Vaccines, the individual is operating under a state or federal legislation, declaration, or exemption that permits the VHP to administer COVID-19 vaccinations under a special grant of authority due to the ongoing COVID-19 pandemic.</p> <p>[ ] Yes [ ] No</p> <p><b>Please upload one of the following:</b></p> <p><b>1) Upload primary source verification of current licensure</b></p>	

<p><b>and/or certification, or Upload all applicable documentation that demonstrates the VHP is allowed to provide services under a state or federal legislation, declaration, or exemption that permits the VHP to administer COVID-19 vaccinations under a special grant of authority due to the ongoing COVID-19 pandemic.</b></p>	
<p><b>Medical Malpractice History</b></p> <ul style="list-style-type: none"><li>• <b>For initial or supplemental applicants:</b> Does the sponsored VHP have any history of state board disciplinary actions and/or state or federal court (including any FTCA) malpractice claims within ten (10) years prior to the submission of this FTCA volunteer health professional deeming application? Include both pending and resolved administrative and civil claims.</li></ul> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No [N/A]</p> <ul style="list-style-type: none"><li>• <b>For redeeming applicants:</b> Does the sponsored VHP have any history of state board disciplinary actions and/or state or federal court (including any FTCA) malpractice claims within five (5) years prior to the submission of this FTCA volunteer health professional deeming application? Include both pending and resolved administrative and civil claims.</li></ul> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No [N/A]</p> <p><b>If yes, attach a list of the claims or actions (include probationary</b></p>	



<p><b>actions). For each claim, suit, or action, include the following details and explanation:</b></p> <ul style="list-style-type: none"><li>• <b>Area of practice/specialty</b></li><li>• <b>Date of occurrence</b></li><li>• <b>Summary of allegations</b></li><li>• <b>Status or outcome of claim or action</b></li></ul> <p><b>Summary of how the sponsoring health center and sponsored individual volunteer have/will implement steps to mitigate the risk of such claims or actions in the future (if FTCA-related, only submit a summary if the case is closed. If the case has not been resolved, indicate this and do not include the summary).</b> For disciplinary actions, you must include:</p> <ul style="list-style-type: none"><li>• nature and reason for the disciplinary action,</li><li>• timeframe (where applicable); and</li><li>• documentation from the appropriate professional board that states the individual is in good standing and/or a description of any practice restrictions on the licensee.</li></ul> <p>Do not submit an NPDB report for any individual. <b>Attachment Control (Attachment C. Medical Malpractice Claims and Disciplinary Actions)</b></p>	
<p><b>Enter Your Comments</b></p> <ul style="list-style-type: none"><li>• <b>Comments:</b> (Comments and an attachment with an explanation of each medical malpractice claim or disciplinary action are required for individuals where medical malpractice claims or disciplinary actions are indicated. Do NOT</li></ul>	

submit an NPDB report for any individual.)	
<p><b>*Notes:</b></p> <ul style="list-style-type: none"> <li>• Provide a list of ALL free clinic volunteer health professionals, board members, officers, employees, and individual contractors on whose behalf the free clinic is submitting an application for FTCA deemed status. Please note that free clinic volunteer health professionals must be licensed and/or certified by state or federal law to perform the services that are requested.</li> <li>• Provide a physical address for ALL individuals on whose behalf the free clinic is submitting an application for FTCA deemed status. Physical addresses and phone numbers provided for individuals must be personal mailing addresses that are different than that of the clinic.</li> <li>• Specify the role in the free clinic for any individual the free clinic is sponsoring for FTCA deemed status. For each individual sponsored for deeming, disclose past medical malpractice claims or disciplinary actions for the past ten (10) years if submitting an initial or supplemental deeming sponsorship application or for the past five (5) years for redeeming sponsorship applications.</li> <li>• List the professional designation (for example: MD, NP, LPN) for all licensed and/or certified individuals for any individual the free clinic is sponsoring for FTCA deemed status. If the individual is not licensed and/or certified and does not have a professional designation, then enter “N/A” for “not applicable.”</li> <li>• Attach an explanation of each medical malpractice claim or disciplinary action (to include probationary actions) including explanations of the suit or allegation, medical specialty involved, and a brief statement of whether the clinic implemented appropriate risk management actions as needed in response to allegations to reduce the risk of future malpractice and future such claims. Documentation related to a disciplinary action must include: nature and reason for the disciplinary action; timeframe (where applicable); documentation from the appropriate professional board that states the individual is in good standing and/or a description of any practice restrictions on the licensee. Do NOT submit an NPDB report for any individual.</li> </ul>	

<b>Section VII. Patient Visit Data*</b>	
1. Total number of Free Clinics FTCA Program deemed individuals, in the recently closed calendar year:	
2. Total number of Free Clinics FTCA Program deemed providers, in the recently closed calendar year:	
3. Total number of patient visits conducted by Free Clinics FTCA Program deemed providers, in the recently closed calendar year:	
*Only required for the annual redeeming sponsorship application.	

<b>Section VIII. Attachments</b>
<b>Attachment D. Other supporting Documentation (Maximum 5)</b>
Please attach any other supporting documentation.

Section IX. Remarks
<p><b>Are you interested in receiving FREE access to the Clinical Risk Management website? Registration provides you with continuing medical education training opportunities, sample policies and tools, e-newsletters covering current topics in patient safety and risk management, and more!</b></p> <p><b>*You may opt out of receiving email notifications at any time by contacting: <a href="mailto:freeclinicsftca@hrsa.gov">freeclinicsftca@hrsa.gov</a>.</b></p>
<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Section X. Signatures
<p><b>Certification and Signature</b></p>
<p>I, _____ (Executive Director)*, certify that this sponsoring free clinic meets the definition of a free clinic found in Section III of the HRSA/BPHC <a href="#">Free Clinics FTCA Program Policy Guide</a> and that the information in this application and the related attachments is complete and accurate.</p>
<p><b>*The application must be signed by the Executive Director, as indicated Section I. Contact Information.</b></p>

Public Burden Statement: Congress enacted FTCA medical malpractice protection for volunteer Free Clinic health professionals through Section 194 of HIPAA of 1996 (Public Law 104-191) by amending Section 224 of the Public Health Service (PHS) Act (42 U.S.C. 233). However, Congress appropriated funds for the Free Clinic FTCA Program for the first time in late January 2004. In 2010, the Patient Protection and Affordable Care Act (Affordable Care Act) (Public Law 111-148) expanded eligible individuals to include employees, officers, board members, and contractors, in addition to volunteers. The application submissions provide BPHC with the information required to determine whether an individual meets the requirements for deemed PHS employment for purposes of providing liability protections under section 224(q) of the PHS Act. The OMB control number for this information collection is 0915-0293 and it is valid through 1/31/2024. This information collection is required to verify that the free clinic meets the criteria to sponsor a deeming application and that the individual being sponsored is eligible to be deemed as a PHS employee with associated FTCA coverage for their activities within the scope of deemed employment on behalf of the health center. Public reporting burden for this collection of information is estimated to average 2 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857

or [paperwork@hrsa.gov](mailto:paperwork@hrsa.gov).

OMB No. 0915-0293  
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