

**Application for Health Center Program Award Recipients
for Deemed Public Health Service Employment with
Liability Protections Under the
Federal Tort Claims Act (FTCA)**

(This application is illustrative and the actual application may appear differently ~~in the HRSA
Electronic Handbooks (EHBs) System~~
in the HRSA Electronic Handbooks (EHBs) System)

Please note: The deeming application of a health center that does not provide sufficient information necessary to demonstrate compliance with the prescribed requirements as described below will not be approved.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	Award Recipient 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/CHIEF EXECUTIVE OFFICER (<i>Must electronically sign and certify the FTCA application</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:		

CONTACT INFORMATION (Please include a preferred title next to the name) All the fields marked with * are required.

<p>PRIMARY DEEMING CONTACT <i>(Individual responsible for completing the deeming application)</i> * Name: * Email: * Direct Phone: Fax:</p>	
<p>ALTERNATE DEEMING CONTACT <i>(Individual responsible for assisting with the deeming application)</i> * Name: * Email: * Direct Phone: Fax:</p>	
<p>CREDENTIALING/PRIVILEGING CONTACT <i>(Individual responsible for managing the credentialing and privileging process)</i> * Name: * Email: * Direct Phone: Fax:</p>	
<p>CLAIMS MANAGEMENT CONTACT <i>(Individual responsible for the health center's administrative support to HHS/DOJ, as appropriate, for FTCA claims)</i> * Name: * Email: * Direct Phone: Fax:</p>	
<p>QUALITY IMPROVEMENT/QUALITY ASSURANCE (QI/QA) CONTACT <i>(Individual responsible for overseeing the QI/QA program)</i> * Name: * Email: * Direct Phone: Fax:</p>	

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

REVIEW OF RISK MANAGEMENT SYSTEMS

Applicants must respond to all questions in this section. Health Center FTCA Program risk management requirements are also described in the [Manual Compliance Program Health Center HYPERLINK "https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html" \l "titletop" \h](https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html) , Chapter 21: Federal Tort Claims Act (FTCA) Deeming Requirements.

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 this program requires 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 governing 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”, provide an explanation as to any discrepancies from the information identified above.

[2,000 character comment box]

1(B). By checking “Yes,” below, I also acknowledge that failure to implement an ongoing risk management program and provide documentation of such implementation upon request may result in disapproval of this deeming application and/or other administrative remedies.

Yes []

2(A). I attest that my health center has implemented risk management 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 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 within 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. Documenting, analyzing, and addressing clinically-related complaints, "near misses", and sentinel events reported by health center employees, patients, and other individuals;

REVIEW OF RISK MANAGEMENT SYSTEMS

All questions in this section are required.

- iii. Setting annual risk management goals and tracking progress toward those goals;
- iv. Developing and implementing an annual health care risk management training plan for all staff members that addresses the following identified areas/activities of clinical risk: medical record documentation, follow-up on adverse test results, obstetrical procedures, and infection control, as well as training in Health Insurance Portability and Accountability Act (HIPAA) and other applicable medical record confidentiality requirements; and
- v. Completing an annual risk management report for the governing board and key management staff that addresses the risk management program activities, goals, assessments, trainings, incidents and procedures.

Yes [] No []

If "No", provide an explanation as to any discrepancies from the information identified above.

[2,000 character comment box]

2(B). I also acknowledge that failure to implement and maintain risk management procedures 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 []

2(C). Upload the risk management procedures that address mitigating risk in tracking of referrals, 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)]

3(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, continuing education for electronic fetal monitoring (such as the online course available through ECRI Institute), 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;

REVIEW OF RISK MANAGEMENT SYSTEMS

All questions in this section are required.

- ii. Infection control and sterilization (for example, Blood Borne Pathogen Exposure protocol, Infection Prevention and Control policies, Hand Hygiene training and monitoring program, 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 []

If "No", provide an explanation as to any discrepancies from the information identified above.

[2,000 character comment box]

3(B). Upload the health center's current annual risk management training plans for all staff, including all clinical and non-clinical staff, based on identified areas/activities of highest clinical risk for the health center and that include the items outlined in risk management question 3(A).i-iv of this application. The risk management training plans should also document completion of all required training.

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']

3(C). Upload all tracking/documentation tools used to ensure trainings have been completed by all staff, at least annually (for example, excel sheets, training reports).

All documents must be from the last 12 months. Any documents dated outside of this period will not be accepted. The documentation tools provided must be completed and demonstrate that health center staff have completed all required trainings. Blank tools and documentation are not sufficient.

[Attachment control named 'Risk Management Training Plan Tracking and Documentation Tool']

4. Upload documentation (for example, data/trends, reports, risk management committee minutes) that demonstrates that the health center has completed quarterly risk management assessments reflective of the last 12 months.

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

5(A). Upload the annual 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. Please note separate quarterly or monthly reports are not that

REVIEW OF RISK MANAGEMENT SYSTEMS

All questions in this section are required.

acceptable for this report, which must be a consolidated report include the following information for a 12 month period: must report The .covering an entire 12 month period

- 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.

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

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 'Proof of Board Review of Annual Risk Management Report']

6. Upload the relevant Position Description of the risk manager who is responsible for the coordination of health center risk management activities and any other associated risk management activities. Please note: 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 Description’]

7(A). Has the health center risk manager completed health care risk management training in the last 12 months?

[] Yes [] No

If “No”, provide an explanation.

[2,000 character comment box]

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

[Attachment control named ‘Annual Risk Manager Training’]

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	Award Recipient Name	Application Type
QUALITY IMPROVEMENT/QUALITY ASSURANCE PLAN (QI/QA)		
	Application Tracking Number	Grant Number
<p align="center">QUALITY IMPROVEMENT/QUALITY ASSURANCE (QI/QA)</p> <p>Applicants must respond to all questions in this section. Health Center FTCA Program QI/QA requirements are also described in the Manual Compliance Center Program Health HYPERLINK "https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html" \l "titletop" \h , Chapter 10: Quality Improvement/Assurance.</p>		
<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 that, at a minimum, demonstrates that the QI/QA program addresses the following:</p> <ul style="list-style-type: none"> i. The quality and utilization of health center services; ii. Patient satisfaction and patient grievance processes; and iii. Patient safety, including adverse events. Yes [] No [] <p>If "No", provide an explanation as to any discrepancies from the information identified above.</p> <p>[2,000 character comment box]</p>		
<p>1(B). I attest that my health center has QI/QA program operating procedures or processes that, at a minimum, address the following:</p> <ul style="list-style-type: none"> i. Adhering to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable; ii. Identifying, analyzing, and addressing patient safety and adverse events and implementing follow-up actions, as necessary; iii. Assessing patient satisfaction; iv. Hearing and resolving patient grievances; v. Completing periodic QI/QA assessments on at least a quarterly basis to inform the modification of the provision of health center services, as appropriate; and vi. 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. <p>Yes [] No []</p> <p>If "No", provide an explanation as to any discrepancies from the information identified above.</p> <p>[2,000 character comment box]</p>		

QUALITY IMPROVEMENT/QUALITY ASSURANCE (QI/QA)

All questions in this section are required.

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

Yes No

If No, 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.

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3requirements. state and federal with use, consistent or unauthorized confidentiality of patient information and safeguarding this information against loss, destruction, . I attest that my health center has implemented systems and procedures for protecting the

[No] [Yes]

If "No",above. information identified the from discrepancies any to explanation as an provide

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4application. deeming this of disapproval in , may resultrequirements stateinformation against loss, destruction, or unauthorized use, consistent with federal and procedures for protecting the confidentiality of patient information and safeguarding this . I also acknowledge and agree that failure to implement and maintain systems and

[Yes]

5QI/QA. to related Program award Center your Health . Indicate whether you currently have an active condition or any other enforcement action on

[No] [Yes]

If Yes, indicate the datecondition was imposed. that the condition was imposed why the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	Award Recipient Name	Application Type
CREDENTIALING AND PRIVILEGING		
	Application Tracking Number	Grant Number
<p align="center">CREDENTIALING AND PRIVILEGING</p> <p>Applicants must respond to all questions in this section. Health Center FTCA Program credentialing and privileging requirements are also described in the Manual Compliance Center Program Health HYPERLINK "https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html" \l "titletop" \h, Chapter 5: Clinical Staffing.</p>		
<p>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, and other clinical staff providing services on behalf of the health center 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:</p> <ul style="list-style-type: none"> i. Current licensure, registration, or certification using a primary source; ii. Education and training for initial credentialing, using: <ul style="list-style-type: none"> a. Primary sources for licensed independent practitioners; b. Primary or other sources for other licensed or certified practitioners and any other clinical staff; iii. Completion of a query through the National Practitioner Databank (NPDB); iv. Clinical staff member's identity for initial credentialing using a government issued picture identification; v. Drug Enforcement Administration registration (if applicable); and vi. Current documentation of Basic Life Support training. <input type="checkbox"/> Yes <input type="checkbox"/> No <p>If "No", provide an explanation.</p> <p>[2,000 character comment box]</p>		
<p>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.</p> <p><input type="checkbox"/> Yes</p>		

2(A). I attest that my health center has implemented privileging 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 health center employees, individual contractors, and volunteers). I also attest that my health center has privileging procedures that address all of the following:

- i. Verification of fitness for duty, immunization, and communicable disease status;**
- ii. For initial privileging, verification of current clinical competence via training, education, and, as available, reference reviews;**

CREDENTIALING AND PRIVILEGING
All questions in this section are required.

- ii. For renewal of privileges, verification of current clinical competence via peer review or other comparable methods (for example, supervisory performance reviews); and**
- iii. 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 as to any discrepancies from the information identified above.

[2,000 character comment box]

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

3. Upload the health center's credentialing and privileging operating procedures that address all credentialing and privileging components listed in questions 1(A) & 2(A) 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']

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

Yes No

If "No", provide an explanation as to any discrepancies from the information identified above.

[2,000 character comment box]

**CREDENTIALINGPRIVILEGING AND
Allrequired. are section questions in this**

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completed for all applicable staff members. The required components are:

- **First Name**
- **Last Name**
- **Title**
- **Clinical Staff Type (i.e., Licensed Independent Practitioner (LIP), Other Licensed or Certified Practitioners (OLCP), and Other Clinical Staff (OCS)**
- **Most recent credentialing date**
- **Most recent privileging date**

Note, at this time, you do not need to submit verification or supporting materials in this list, however, it should reflect that the following elements from Chapter 5 of the Health Center Program Compliance Manual were verified for each staff member, as applicable:

Credentialing:

- **Current licensure, registration, or certification using a ;primary source HYPERLINK "<https://bphc.hrsa.gov/programrequirements/compliancemanual/glossary.html>" \l "primary-source-verification"**
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- **fitness for duty HYPERLINK "<https://bphc.hrsa.gov/programrequirements/compliancemanual/glossary.html>" \l "fitness-for-duty"**
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- ii.

[HYPERLINK "https://bphc.hrsa.gov/sites/default/files/bphc/ftca/pdf/ftcahcpcpolicymanualpdf.pdf" \h](https://bphc.hrsa.gov/sites/default/files/bphc/ftca/pdf/ftcahcpcpolicymanualpdf.pdf)

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

Yes No

If Yes, indicate the date and source (for example, Operational Site Visit, Service Area Competition application) through which you received this condition or other enforcement action. Also, indicate the specific nature of the condition or other enforcement action, including the finding and reason why it was imposed, such as failure to verify licensure, etc. Describe your 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	
	Award Recipient Name	Application Type
CLAIMS MANAGEMENT		
	Application Tracking Number	Grant Number
CLAIMS MANAGEMENT		
<p>Applicants must respond to all questions with an * in this section. Health Center FTCA Program claims management requirements are also described in the Compliance Center Program Health HYPERLINK "https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html" \l "titletop" \h Manual HYPERLINK "https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html" \l "titletop" \h, Chapter 21: Federal Tort Claims Act (FTCA) Deeming Requirements.</p> <p>Please note: 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>		
<p>1(A). *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, 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:</p> <ul style="list-style-type: none"> i. The preservation of all health center documentation related to any actual or potential claim or complaint (for example, medical records and associated laboratory and x-ray results, billing records, employment records of all involved clinical providers, clinic operating procedures); and 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. <p>Yes [] No []</p> <p>If “No”, provide an explanation as to any discrepancies from the information identified above.</p> <p>[2,000 character comment box]</p>		

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 []

CLAIMS MANAGEMENT

All questions with an * in this section are required.

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. Please note: This process must include the items outlined in Claims Management question 1(A) 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(A). *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, provide a list of the claims. For each claim, include:

- i. Name of provider(s) involved;
- ii. Area of practice/Specialty;
- iii. Date of occurrence;
- iv. Summary of allegations;
- v. Status or outcome of claim;
- 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
- vii. Summary of health center internal analysis and implemented steps to mitigate the risk of such claims in the future (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.).

[Attachment control named 'History of Claims']

2(B). *I agree that the health center will cooperate with all applicable Federal government representatives in the defense of any FTCA claims.

Yes No

If “No”, provide an explanation.

[2,000 character comment box]

CLAIMS MANAGEMENT

All questions with an * in this section are required.

3(A). *I attest that my health center informs patients using plain language that it is a deemed Federal PHS employee via its website, promotional materials, and/or within an area(s) of the health center that is visible to patients. For example: “This health center receives HHS funding and has Federal 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, provide an explanation as to any discrepancies from the information identified above.

[2,000 character comment box]

3(B). Include a screenshot to the exact location where this information is posted on your health center website or attach the relevant promotional material or pictures.

[Attachment control named 'Screenshot']

[Attachment control named 'FTCA Promotional Materials']

(If answer to 3(A) is Yes, either Screenshot control or FTCA Promotional Materials required; if answer to 3(A) is No, no free response control or attachment is required.)

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. The job description must clearly detail that the claims management activities are a part of the individual’s daily responsibilities.

[Attachment control named 'Claims Management Position Descriptions']

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	Award Recipient Name	Application Type
ADDITIONAL INFORMATION		
	Application Tracking Number	Grant Number
<p align="center">CERTIFICATION AND SIGNATURES</p> <p align="center">Completion of this section by a typed name will constitute signature on this application. This field is required.</p>		
<p>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 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>		