

Department of Health and Human Services Health Resources and Services Administration	OMB#	
Application for Federally Supported Health Centers Assistance Act (FSHCAA) / Federal Tort Claims Act (FTCA) Particularized Determination of Coverage	Award Recipient Name	Grant Number
Contact Information		
Include an honorific (Ms., Mrs., Mr., Dr., etc.) before the name. All fields marked with an * are required.		
EXECUTIVE DIRECTOR (Must electronically sign and certify the Application for Particularized Determination) * Name: * Email: * Direct Phone:	Application for Federally Supported Health Centers Assistance Acts of 1992 and 1995 (FSHCAA) / Federal Tort Claims Act (FTCA) Particularized Determination of Coverage	
Health Center Point of Contact * Name: * Email: * Direct Phone:		

Section I. Particularized Determination Requirements, Information and Documentation

This document elicits applications for a particularized determination of coverage pursuant to 42 U.S.C. 233(g)(1)(B)-(C). Health centers should be aware that a request for particularized determination of coverage does not constitute a request for a change in their approved scope of Health Center Program-funded project. Thus, health centers may not seek to amend or expand their scope of project through an application for a particularized determination of coverage. Health centers may apply for a particularized determination of coverage only insofar as it relates to previously approved in-scope health services that are provided to a specified community or target population on behalf of the health center.

- 1. I am submitting the application for a particularized determination of coverage pursuant to 42 U.S.C. § 233(g)(1)(B)-(C) as the authorized representative for the following organization, which has been deemed as an employee of the Public Health Service pursuant to the Federally Supported Health Centers Assistance Acts of 1992 and 1995 (42 U.S.C. § 233(g)-(n)) for the period of time for which this particularized determination is submitted:**

>>Drop down selection

- Primary grantee
- Sub-recipient

- 2. I affirm that this application for a particularized determination has been approved by the health center's governing board.**

Yes No

(If NO, a particularized determination of coverage is not available for such applications, and this application will be disapproved by HRSA without further consideration on that basis alone.)

(If YES, you must submit documentation demonstrating governing board approval as an

Attachment (Required); if such documentation is not provided, this application will be disapproved by HRSA without further consideration on that basis alone.)

- 3. I affirm that this application for a particularized determination of coverage does not, or does not appear to, “fit squarely” within the regulatory examples set forth in 42 C.F.R. § 6.6(e)(4) (note: the full text of 42 CFR 6.6(e) can be found at Appendix A).**

Yes No

(If NO, a particularized determination of coverage is not available for such applications, and this application will be disapproved by HRSA without further consideration on that basis alone.)

(If YES, further explanation is provided in the Comment box below (Required).)

- 4. I affirm that this application for a particularized determination of coverage involves only the provision of in-scope health services to individuals who are not established health center patients (under the authorizing statute, particularized determinations of coverage are not available for services provided to health center patients under the authorizing statute).**

Yes No

(If NO, a particularized determination of coverage is not available for such applications, and this application will be disapproved by HRSA without further consideration on that basis alone.)

- 5. I affirm that this application for a particularized determination of coverage is for an activity that is related to the Health Center Program grant-supported activities of the health center.**

Yes No

>> Comment box (Required)

>> Attachment (Optional)

(If NO, a particularized determination of coverage is not available for such requests, and this application will be disapproved by HRSA without further consideration on that basis alone.)

- 6. I affirm that this application for a particularized determination of coverage is for activities that are not compensated by any third-party entity, whether by salary, contractual compensation, or otherwise. (Note: This statement does not include the potential availability of private insurance procured directly by the health center or the health center provider but does include any such insurance paid for or otherwise compensated by the third-party entity.)**

Yes No

>> Comment box (Required)

>> Attachment (Required if Yes)

- 7. I affirm that this application for a particularized determination of coverage is for activities conducted solely on behalf of the health center, and that the health center will exercise oversight and control of the services provided by health center providers through this activity, including, for example, maintenance of confidential patient records and billing for services provided.**

Yes No

>> Comment box (Required)

8. Please describe the specific nature of the proposed activity, including the specific health services, the location of such services, the dates of providing such services, and the reasons that the health center wishes to provide such services.

>> Comment Box

9. Please list the health center employees, individual contractors, and/or volunteer health professionals who will be delivering services, including the following information:

- **Prefix:**
- **First Name:**
- **Middle Name:**
- **Last Name:**
- **Professional Designation (e.g., MD, RN, etc.):**
- **Role(s) in Health Center:**
- **Specialty:**
- **Others:**

OR

If the application involves individual health center providers that may change over the course of the activity or arrangement, please describe the providers (e.g., internal medicine physicians, nurse practitioners, and physician assistants; dentists, dental hygienists, and dental technicians, etc.):

>>Drop Down Selection with other option as fill in.

10. Please identify the specific location where the health center's in-scope services are proposed to be provided?

- **Name of location**
- **Street Address**
- **Suite Number**
- **City**
- **State**
- **Zip Code**
- **Phone**

>> Structured List, with option to add more than one location

11. Please indicate whether there are any agreements, contracts, or other arrangements (written or unwritten) between the health center and any third party that describes or defines any relationship between the health center or the health center's provider(s) and any third-party entity in undertaking this activity. If such documentation exists, please provide a copy.

Yes **No**

>> Comment box (Required)

>>Attachment (Required if Yes)

12. Please indicate the date when the health center would like to start the activities outlined in this application.

>> Calendar Drop Down

13. Please indicate the date by which the health center plans to conclude the activities outlined in this request.

>> Calendar Drop Down

14. Please indicate how many total hours per week health center providers (in the aggregate) would spend on the activities outlined in this application?

>> Number selection

15. Please describe how the health center believes the particularized determination relates to activities that meet one or more of the following criteria:

1. The provision of the services to individuals who are not patients of the health center benefits patients of the health center and general populations that could be served by the health center through community-wide intervention efforts within the communities served by such entity;

2. The provision of the services individuals who are not patients of the health center facilitates the provision of services to patients of the health center;

3. Such services are otherwise required to be provided to individuals who are not patients of the health center under an employment contract (or similar arrangement) between the health center and an officer, governing board member, employee, or contractor of the health center.

>> Comment Box

16. Please indicate whether the health center or the health center provider or a third party has obtained medical malpractice insurance for the planned activity.

17. Please describe what procedures or plans have been or will be put in place to ensure patient safety and reduce the risk of medical malpractice for this activity.

>> Comment Box

18. Please provide any other supporting documentation that is relevant to the proposed activity or arrangement.

>> Attachment

Section IV. Signatures

Certification and Signature

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

***The application must be signed by the Executive Director, as indicated in Section I. Contact Information.**