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)

*****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 *(Must electronically sign and certify the FTCA application)* * Name: * Email: * Direct Phone: Fax:	
GOVERNING BOARD CHAIRPERSON * Name: * Email: * Direct Phone: Fax:	
MEDICAL DIRECTOR * Name: * Email: * Direct Phone: Fax:	
RISK MANAGER * Name: * Email: * Direct Phone: Fax:	

CONTACT INFORMATION (Please include a preferred title next to the name) All the fields marked with * are required.	
PRIMARY DEEMING CONTACT *(Individual responsible for completing the deeming application)* * Name: * Email: * Direct Phone: Fax:	
ALTERNATE DEEMING CONTACT *(Individual responsible for assisting with the deeming application)* * Name: * Email: * Direct Phone: Fax:	
CREDENTIALING/PRIVILEGING CONTACT *(Individual responsible for managing the credentialing and privileging process)* * Name: * Email: * Direct Phone: Fax:	
CLAIMS MANAGEMENT CONTACT *(Individual responsible for the health center's administrative support to HHS/DOJ, as appropriate, for FTCA claims)* * Name: * Email: * Direct Phone: Fax:	
QUALITY IMPROVEMENT/QUALITY ASSURANCE (QI/QA) CONTACT *(Individual responsible for overseeing the QI/QA program)* * Name: * Email: * Direct Phone: Fax:	

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

The Health and Resources Services Administration, Bureau of Primary Health Care, requires that Health Center Program award recipients and subrecipients verify in their applications for deemed Public Health Service employment under the Federally Supported Health Centers Assistance Act (FSHCAA), 42 U.S.C. § 233(g)-(n), that they have provided mandatory training to their employees and staff on certain specified topics. Meeting these training requirements does not guarantee that a health center or its employees will qualify for FTCA coverage under the Federal Tort Claims Act (FTCA), 28 U.S.C. §§ 1346(b), 2401(b), 2671-80, in the event that a claim or suit is filed. Determinations of eligibility for FTCA coverage are made on a case-by-case basis by the U.S. Department of Justice and federal courts. Health centers must meet the program requirements set forth in FSHCAA to be eligible to be deemed as PHS employees under FSHCAA.

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 Health Center Program Compliance Manual, 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 ongoing 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;
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 clinical staff, at least annually. I attest that the training plans at a minimum incorporate obstetrical procedures (for example, continuing education for electronic fetal monitoring (such as the online course available through ECRI Institute), and shoulder dystocia drills).

Note: health centers that provide obstetrical services directly or through individual health center contractors are required to include obstetrical training as part of their risk management training plans to demonstrate compliance.

All health centers that are currently deemed as PHS employees, as well as those seeking deemed or redeemed status, must conduct OB training on an annual basis if they provide clinical services to any of the following individuals (even if they do not provide labor and delivery services):

1. Pre-natal patients
2. Post-partum patients
3. Patients who are of reproductive age

All health centers that provide any health services to patients of reproductive age, even if they do not offer obstetrical services directly, must include obstetrical training as part of their annual required trainings to demonstrate compliance.

Health centers should consider the following:

1. **Which staff must complete the OB training:** The health center should consider each staff member's role, responsibilities, and their level of clinically related contact with patients of reproductive age in determining the employee's specific training needs. The health center must clearly document which staff members are required to complete OB training and the process used to determine inclusion or exclusion from the OB training requirement.
2. **Source of the training:** Health centers may choose from various training sources, such as HRSA trainings, HRSA supported ECRI trainings, in-house trainings, or other public or private training resources.
3. **Delivery method and format:** Health centers have the flexibility to choose the delivery method and format of the OB training. Options may include in-person, virtual, or hybrid trainings. Additionally, health centers may utilize different training formats, such as lectures, videos, presentations, labs, or online modules.
4. **Content covered during OB training:** Health centers can determine the specific content covered during each OB training session. OB topics and content must be selected based on health center data, assessments, and other available health center information.

Yes [ ] No [ ]

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

[2,000-character comment box]

3	3(B) 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 incorporate 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). Yes [ ] No [ ] If "No", provide an explanation as to any discrepancies from the information identified above. **[2,000-character comment box]**
4	3(C) 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 incorporate HIPAA medical record confidentiality requirements. Yes [ ] No [ ] If "No", provide an explanation as to any discrepancies from the information identified above. **[2,000-character comment box]**
5	3(D). 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 incorporate specific training 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]**
6	

3(E). 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) – 3(D) of this application. The annual risk management educational training plan must clearly include OB, Infection Control, HIPAA and specific training for areas of high-risk.

Note: The annual risk management educational training plan must cover the period from January 1st to December 31st of the previous calendar year of submission of the application (for example, application submitted in 2024 must include the complete training plan that was used in 2023).

[Attachment control named 'Risk Management Educational Training Plan']

7

3(F). Enter the following information for one completed **obstetrical** training for clinical and non-clinical staff who provide any health services to patients of reproductive age (even if not OB services**).**

i. Title of Training
ii. Topic Area
iii. Brief description of training
iv. Date training initially offered

Note: FTCA may request additional information about course completion (for example, proof of training certificates, attendance records, continuing education documentation, and/or training completion reports).

Note: Non-clinical staff should only be included if the health center has determined that they are required to complete OB training because of clinically related contact with patients of reproductive age.

Note: All training must cover the period from January 1st to December 31st of the previous calendar year of submission of the application (for example, applications submitted in 2024 must demonstrate training was completed in 2023).

Upload your OB training tracking documentation that demonstrates attendance and training completion of the training entered above. Use the FTCA Educational Training Tracking Form to demonstrate compliance. The form can be downloaded by clicking on the following link: *(Add Link)*

[Attachment control named 'Risk Management Proof of Attendance and Training Completion Documentation']

If multiple OB training courses are offered at your health center, use a separate FTCA Educational Training Tracking Form for each additional course to document those trainings. The FTCA Educational Training Tracking Form(s) can be downloaded by clicking on the following link: *(Add Link)*

[Attachment control named 'Additional Risk Management FTCA Educational Training Tracking Form(s)']

8

3(G). Enter the following information for at least one completed **Infection Control** training for clinical and non-clinical staff.

i. Title of Training
ii. Topic Area
iii. Brief description of training
iv. Date training initially offered

Note: FTCA may request additional information about course completion (for example, proof of training certificates, attendance records, continuing education documentation, and/or training completion reports).

Note: All training must cover the period from January 1st to December 31st of the previous calendar year of submission of the application (for example, applications submitted in 2024 must demonstrate training was completed in 2023).

Upload your Infection Control training tracking documentation that demonstrates attendance and training completion of the training entered above. Use the FTCA Educational Training Tracking Form to demonstrate compliance. The form can be downloaded by clicking on the following link: *(Add Link)*

[Attachment control named 'Risk Management Proof of Attendance and Training Completion Documentation']

If multiple Infection Control training courses are offered at your health center, use a separate FTCA Educational Training Tracking Form for each additional course to document those trainings. The FTCA Educational Training Tracking Form(s) can be downloaded by clicking on the following link: *(Add Link)*

[Attachment control named 'Additional Risk Management FTCA Educational Training Tracking Form(s)']

3(H). Enter the following information for at least one completed **HIPAA** training for clinical and non-clinical staff**.**

i. Title of Training
ii. Topic Area
iii. Brief description of training
iv. Date training initially offered

Note: FTCA may request additional information about course completion (for example, proof of training certificates, attendance records, continuing education documentation, and/or training completion reports).

Note: All training must cover the period from January 1st to December 31st of the previous calendar year of submission of the application (for example, applications submitted in 2024 must demonstrate training was completed in 2023).

Upload your HIPAA training tracking documentation that demonstrates attendance and training completion of the training entered above. Use the FTCA Educational Training Tracking Form to

demonstrate compliance. The form can be downloaded by clicking on the following link: *(Add Link)*

[Attachment control named 'Risk Management Proof of Attendance and Training Completion Documentation']

If multiple HIPAA training courses are offered at your health center, use a separate FTCA Educational Training Tracking Form for each additional course to document those trainings. The FTCA Educational Training Tracking Form(s) can be downloaded by clicking on the following link: *(Add Link)*

[Attachment control named 'Additional Risk Management FTCA Educational Training Tracking Form(s)']

11

3(I). Enter the following information for at least one completed **Areas of High-Risk** training for clinical and non-clinical staff.

i. Title of Training
ii. Topic Area
iii. Brief description of training
iv. Date training initially offered

Note: FTCA may request additional information about course completion (for example, proof of training certificates, attendance records, continuing education documentation, and/or training completion reports).

Note: All training must cover the period from January 1st to December 31st of the previous calendar year of submission of the application (for example, applications submitted in 2024 must demonstrate training was completed in 2023).

Upload your areas of high-risk training tracking documentation that demonstrates attendance and training completion of the training entered above. Use the FTCA Educational Training Tracking Form to demonstrate compliance. The form can be downloaded by clicking on the following link: *(Add Link)*

[Attachment control named 'Risk Management Proof of Attendance and Training Completion Documentation']

If multiple areas of high-risk training courses are offered at your health center, use a separate FTCA Educational Training Tracking Form for each additional course to document those trainings. The FTCA Educational Training Tracking Form(s) can be downloaded by clicking on the following link: *(Add Link)*

[Attachment control named 'Additional Risk Management FTCA Educational Training Tracking Form(s)']

12

4. Upload documentation for each quarter (for example, completed assessment tool or completed assessment checklist with detailed information, outcomes, and follow-up action) that demonstrates that the health center has completed quarterly risk management assessments reflective of health center activities that covers the period from January 1st to December 31st of the previous calendar year of submission.

4(A). Quarter 1

i. Name of assessment
ii. Area assessed
iii. Date completed
iv. Findings
v. [Attachment control named 'Assessments Quarter 1']
vi. Action Plan (attachment)

4(B). Quarter 2
i. Name of assessment
ii. Area assessed
iii. Date completed
iv. Findings
v. [Attachment control named 'Assessments Quarter 2']
vi. Action Plan (attachment)

4(C). Quarter 3
i. Name of assessment
ii. Area assessed
iii. Date completed
iv. Findings
v. [Attachment control named 'Assessments Quarter 3']
vi. Action Plan (attachment)

4(D). Quarter 4
i. Name of assessment
ii. Area assessed
iii. Date completed
iv. Findings
v. [Attachment control named 'Assessments Quarter 4']

13 Action Plan (attachment)
14

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 and documentation provided to the board and key management staff showing that any related follow-up actions have been implemented. **The report must cover the period from January 1st to December 31st of the previous calendar year of submission and must be reflective of the activities related to risk from the previous calendar year (for example, applications submitted in 2024 must demonstrate training was completed in 2023). Any documents dated outside of this period will not be accepted.**

Note: a consolidated report covering the previous calendar year is required. Separate quarterly or monthly reports are not acceptable. The report must include the following information:

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 that cover the previous calendar year (January 1st to December 31st) of submission for the next calendar year 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, or minutes and a signed letter from the board chair/board secretary that clearly indicate that the board received and reviewed the report and took any necessary actions).

All documents must cover the period from January 1st to December 31st of the previous calendar year of submission. 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.

Note: the job description must clearly detail that the risk management activities are 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 between January 1st to December 31st of the previous calendar year of submission?

[ ] 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 between January 1st to December 31st of the previous calendar year of submission.

[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

The Health and Resources Services Administration, Bureau of Primary Health Care, requires that Health Center Program award recipients and subrecipients verify in their applications for deemed Public Health Service employment under the Federally Supported Health Centers Assistance Act (FSHCAA), 42 U.S.C. § 233(g)-(n), that they have provided mandatory training to their employees and staff on certain specified topics. Meeting these training requirements does not guarantee that a health center or its employees will qualify for FTCA coverage under the Federal Tort Claims Act (FTCA), 28 U.S.C. §§ 1346(b), 2401(b), 2671-80, in the event that a claim or suit is filed. Determinations of eligibility for FTCA coverage are made on a case-by-case basis by the U.S. Department of Justice and federal courts. Health centers must meet the program requirements set forth in FSHCAA to be eligible to be deemed as PHS employees under FSHCAA.

QUALITY IMPROVEMENT/QUALITY ASSURANCE (QI/QA)

Applicants must respond to all questions in this section. Health Center FTCA Program QI/QA requirements are also described in the Health Center Program Compliance Manual, Chapter 10: Quality Improvement/Assurance.

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, ongoing QI/QA program that, at a minimum, demonstrates that the QI/QA program addresses the following:

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 [ ]

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

[2,000-character comment box]

1(B). I attest that my health center has ongoing QI/QA program operating procedures or processes that, at a minimum, address the following:

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.

Yes [ ] No [ ]

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

[2,000-character comment box]

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.

[4,000-character comment box]

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

[ ] Yes [ ] No

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

[2,000-character comment box]

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

[ ] Yes

5. 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”, indicate the date that the condition was imposed why the condition was imposed.

[2,000-character comment box]

Note: The presence of certain award conditions and/or enforcement actions related to quality improvement/quality assurance may demonstrate non-compliance 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
CREDENTIALING AND PRIVILEGING		
	Application Tracking Number	Grant Number

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CREDENTIALING AND PRIVILEGING

Applicants must respond to all questions in this section. Health Center FTCA Program credentialing and privileging requirements are also described in the Health Center Program Compliance Manual, Chapter 5: Clinical Staffing.

1(A). I attest that my health center has implemented an ongoing credentialing process for all clinical staff members (including for licensed independent practitioners and other licensed or certified healthcare 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:

i. Current licensure, registration, or certification using a primary source;
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;
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);
vi. Current documentation of Basic Life Support training; and
vii. Any other credentialing information required by applicable law to be completed for health care providers (e.g., state laws requiring background checks).

[ ] 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

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, which may include immunization, and communicable disease status to the extent applicable to health care providers by applicable law;
ii. For initial privileging, verification of current clinical competence via training, education, and, as available, reference reviews;
iii. For renewal of privileges, verification of current clinical competence via peer review or other comparable methods (for example, supervisory performance reviews); and
iv. Process for denying, modifying or removing privileges based on assessments of clinical competence and/or fitness for duty.

Note: If the health center chooses to submit a policy and procedure that incorporates temporary credentialing and/or privileges, those temporary credentialing and privileging procedures must align with the guidelines in the current Temporary Privileging of Clinical Providers by Federal Tort Claims Act (FTCA) Deemed Health Centers in Response to Certain Declared Emergency Situations - PAL 2017-07. Use of temporary credentialing and privileging is not allowed for situations not outlined in PAL 2017-07 and therefore should not appear in the health center's general policies and procedures. Language that indicates use of temporary credentialing and privileging that is not aligned with PAL 2017-07 may be considered as non-compliant with FTCA credentialing and privileging requirements.

[ ] 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 an ongoing 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.

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 certify that my health center reviews the credentials and privileges of all Licensed Independent Practitioners (LIP), Other Licensed or Certified Practitioners (OLCP), and Other Clinical Staff (OCS) at least every two years, in compliance with the FTCA credentialing and privileging requirements. I understand that failure or refusal to demonstrate compliance will result in the denial of this application for FTCA deemed status.

[ ] Yes [ ] No

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

[2,000-character comment box]

5. 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 the verification, at least every two years, of credentialing and privileging requirements outlined in Chapter 5 of the Health Center Compliance Manual, 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]

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

i. Licensed, certified, or registered as verified through a credentialing process, in accordance with applicable federal, state, and local laws; and
ii. Competent and fit to perform the contracted or referred services, as assessed through a privileging process.

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, John Doe, LLC), are not eligible for coverage under FSHCAA and the FTCA. This is further described in the FTCA Health Center Policy Manual.

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 an explanation as to any discrepancies from the information identified above.

[2,000-character comment box]

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

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.

[ ] 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]

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY	
	Award Recipient Name	Application Type
CREDENTIALING AND PRIVILEGING LIST		
	Application Tracking Number	Grant Number

The Health and Resources Services Administration, Bureau of Primary Health Care, requires that Health Center Program award recipients and subrecipients verify in their applications for deemed Public Health Service employment under the Federally Supported Health Centers Assistance Act (FSHCAA), 42 U.S.C. § 233(g)-(n), that they have provided mandatory training to their employees and staff on certain specified topics. Meeting these training requirements does not guarantee that a health center or its employees will qualify for FTCA coverage under the Federal Tort Claims Act (FTCA), 28 U.S.C. §§ 1346(b), 2401(b), 2671-80, in the event that a claim or suit is filed. Determinations of eligibility for FTCA coverage are made on a case-by-case basis by the U.S. Department of Justice and federal courts. Health centers must meet the program requirements set forth in FSHCAA to be eligible to be deemed as PHS employees under FSHCAA.

CREDENTIALING AND PRIVILEGING LIST

Credentialing and Privileging information must be entered into the EHBs system. This information should not be uploaded as an attachment. Please enter all Licensed Independent Practitioners (LIP), Other Licensed or Certified Practitioners (OLCP), and Other Clinical Staff (OCS) at all health center sites, including employed or individual contracted practitioners (which the health center is responsible for credentialing and privileging), and volunteers. Health Center FTCA Program Credentialing and Privileging requirements are described in the **Health Center Program Compliance Manual,** Chapter 5: Clinical Staffing.

The following fields are **required** for each practitioner:

- First Name
- Last Name
- Professional Designation
- Clinical Staff Type
- Most Recent Credentialing Date
- Most Recent Privileging Date
- Credentialing Type: Initial Credentialing or Recredentialing

Note: For the FTCA Program's purposes, practitioners' credentialing and privileging must occur at least every two years.

Note: Inclusion in this list indicates that the health center has properly credentialed the individual in accordance with the application requirements and the Health Center Program Compliance Manual. However, inclusion of practitioners on this list does not guarantee that a health center or its employees will qualify for coverage under the Federal Tort Claims Act (FTCA), 28 U.S.C. §§ 1346(b), 2401(b), 2671-80, in the event that a claim or suit is filed. Determinations of eligibility for FTCA coverage are made on a case-by-case basis by the U.S. Department of Justice and federal courts. Health centers must meet the program requirements set forth in FSHCAA to be eligible for deeming under the FTCA.

1. I attest that the documents noted below, as outlined in Chapter 5 of the Health Center Compliance Manual, have been collected and verified in the form and manner prescribed by HRSA and the individual is fully credentialed and privileged. Furthermore, I am able to provide documented proof of full credentialing and privileging upon request.

Credentialing:

- Current licensure, registration, or certification using a primary source;
- Education and training for initial credentialing, using:
    - Primary sources for LIPs
    - Primary or other sources (as determined by the health center) for OLCPs and any other clinical staff;
- Completion of a query through the National Practitioner Data Bank (NPDB);
- Clinical staff member's identity for initial credentialing using a government-issued picture identification; [Redact sensitive information; leaving only Name and Picture present]
- Drug Enforcement Administration (DEA) registration (if applicable); and
- Current documentation of basic life support training.

Privileging:

- Verification of fitness for duty
- Process for denying, modifying or removing privileges based on assessments of clinical competence and/or fitness for duty.
- For initial privileging, verification of current clinical competence via training, education, and, as available, reference reviews OR
- For renewal of privileges, verification of current clinical competence via peer review or other comparable methods (for example, supervisory performance reviews)

Yes [ ] No [ ]

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

[2,000-character comment box]

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

The Health and Resources Services Administration, Bureau of Primary Health Care, requires that Health Center Program award recipients and subrecipients verify in their applications for deemed Public Health Service employment under the Federally Supported Health Centers Assistance Act (FSHCAA), 42 U.S.C. § 233(g)-(n), that they have provided mandatory training to their employees and staff on certain specified topics. Meeting these training requirements does not guarantee that a health center or its employees will qualify for FTCA coverage under the Federal Tort Claims Act (FTCA), 28 U.S.C. §§ 1346(b), 2401(b), 2671-80, in the event that a claim or suit is filed. Determinations of eligibility for FTCA coverage are made on a case-by-case basis by the U.S. Department of Justice and federal courts. Health centers must meet the program requirements set forth in FSHCAA to be eligible to be deemed as PHS employees under FSHCAA.

CLAIMS MANAGEMENT

Applicants must respond to all questions with an * in this section. Health Center FTCA Program claims management requirements are also described in the Health Center Program Compliance Manual, Chapter 21: Federal Tort Claims Act (FTCA) Deeming Requirements.

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.

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:

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.

Yes [ ] No [ ]

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

[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 [ ]

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.

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?

Note: Health centers must 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. Role(s) in Health Center
iii. Specialty
iv. Others
v. Nature of Allegation
vi. Date of occurrence
vii. Date Claim Filed
viii. Summary of allegations
ix. Has the claim or allegation been resolved or settled?
x. 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.)

[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]

2(C). I attest and agree that upon HHS OGC request, the health center, will provide requested documentation, in a separate PDF or electronic file for each of the individual items outlined in Section K.1 (1-13) of the FTCA Health Center Policy Manual and will retain copies. I will keep all records until HHS OGC notifies the health center that an administrative claim or lawsuit has been finally resolved either by settlement, denial, or final judgment in litigation, including any post-judgment reconsideration request or appeal. I will use the method to transmit the records that HHS OGC requests, including a secure digital portal for electronic submission of the requested documents. I will ensure that the dates of the documents correspond to the dates of the incident.

Yes [ ] No [ ]

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

[2,000-character comment box]

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 Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals."

[ ] Yes [ ] No

If "No", 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']

[2,000-character comment box]

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

CERTIFICATION AND SIGNATURES

Completion of this section by a typed name will constitute signature on this application. This field is required.

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.

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.