

# Overview of Free Clinics FTCA Program Information Notice For Health Care Professionals

## I. PURPOSE:

This Program Information Notice (PIN) provides detailed information regarding the implementation of the *Free Clinics Federal Tort Claims Acts (FTCA) Medical Malpractice Program* as described in Section 194 of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

## II. OVERVIEW:

Congress enacted FTCA for volunteer free clinic health care professionals. If a volunteer health care professional meets all the requirements of the Program, the related free clinic can sponsor him/her to be a “deemed” federal employee for the purpose of FTCA medical malpractice coverage. FTCA deemed status provides the volunteer with immunity from medical malpractice lawsuits resulting from his/her subsequent performance of medical, surgical, dental or related functions within the scope of his/her work at the free clinic. Claimants alleging acts of medical malpractice against a deemed volunteer would have to file their claims against the United States according to FTCA requirements. Free clinics must submit an annual FTCA deeming application on behalf of their volunteer professionals to the Department of Health and Human Services’ (HHS) Health Resources and Services Administration, Bureau of Primary Health Care (HRSA, BPHC) that administers the program.

## III. WHO IS COVERED?

HHS will deem a volunteer free clinic health care professional to be a federal employee for the purposes of FTCA coverage for medical malpractice claims **if** the free clinic and health professional meet certain requirements.

A free clinic is a health care facility operated by a nonprofit private entity that:

1. Does not accept reimbursements from any third party payer.
2. Does not impose charges on patients whom they service.
3. May accept patients voluntary donations for health services
4. Is licensed or certified to provide health care in accordance with applicable law.

A volunteer free clinic health care professional must:

1. Provide services to patients at a free clinic or offsite program or events carried out by the free clinic.
2. Is sponsored by the free clinic.
3. Provides qualifying health service (i.e., any medical assistance required or authorized to be provided under Title XIX of the Social Security Act (42 U.S.C. 1396 et. seq) without regard to whether the medical assistance is included in the plan submitted by the State in which the health care practitioner provides the service;
4. Does not receive compensation for provided services from patients directly or from any third-party payor;
5. Is licensed or certified to provide health care services at the time of services provision in accordance with applicable law; and

6. Provides patients with written notification before service provision of the extent to which his/her legal liability is limited to pursuant to the PHS Act if his/her associated free clinic has not already provided such notification.

#### IV. WHAT SERVICES ARE COVERED?

FTCA deemed volunteers are eligible for medical malpractice coverage for health care services acts or omissions that:

Arise from the provision of medical, surgical, dental or related services at the free clinic site or through offsite programs or events carried out by the free clinic; and occur on or after the effective date that the HHS secretary approved the FTCA deeming application submitted by the free clinic on behalf of its volunteer professionals.

#### V. WHAT ARE THE PROGRAM REQUIREMENTS?

Free clinics and their FTCA deemed volunteers must satisfy the following program requirements.

##### 1. Credentialing and Privileging

- Credentialing is the process of assessing and confirming the qualifications of licensure, certification and /or registration of a licensed or certified health care practitioner.
- Privileging is the process of authorizing the specific scope and content of patient care services of a licensed or certified practitioner.

##### 2. Free clinics must satisfy these requirements by utilizing:

- Primary source verification: verification by the original source or an approved agent. A local hospital where a practitioner is credentialed can serve as a credentials verification organizations (CVO). *We will contact them, with your permission*
- Secondary source verification: verification by methods like viewing the original document or a notarized copy of a credential

The following information must be obtained for each health care practitioner desiring to become deemed through the FTCA. Examples include:

1. Current licensure
2. Relevant education, training or experience
3. Health Fitness Statement, ability to perform the requested privileges
4. Government issued photo identification, driver's license
5. DEA registration, as applicable
6. Hospital admitting privileges, as applicable
7. Immunization (Hep. B) & PPD (TB Skin Test) status
8. CPR training, as applicable
9. Querying the National Practitioner Data Bank (Clinic may perform)
10. Completion of the application for HHS

3126 Blue Ridge Rd.  
Raleigh NC 27612

**Mariam Clinic**

919-332-0834

**List of Required Information/Documentation for Licensed or Certified  
Health Care Professional FTCA Credentialing Process**

**Forms requiring signature and/or completion**

- Application for Credentialing & Privileging (or CV)**
- Request to Verify Medical Staff Membership and/or Privileges**
- Verification of Fitness**
- Peer Evaluation Form**
- Health Care Professionals Medical Questionnaire**

**Copies Of:**

- Identification (via government issued picture id., driver's license)**
- Current CV (if available)**
- DEA Registration**
- CPR Certification, as applicable \_\_\_\_\_**
- Declaration of current malpractice insurance**

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**LICENSED & CERTIFIED HEALTH CARE PROFESSIONALS  
APPLICATION FOR CREDENTIALING & PRIVILEGING**



**PERSONAL INFORMATION**

Name(as appearing on your licensing documents): \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

E-mail Address \_\_\_\_\_ Date Of Birth \_\_\_\_\_

**PRIMARY PRACTICE INFORMATION, if applicable**

Practice Name \_\_\_\_\_

PracticeAddress \_\_\_\_\_

Mailing address if different from above: \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

**Type of Practice**

\_\_\_ Family Practice    \_\_\_ Internal Medicine    \_\_\_ Specialty \_\_\_\_\_

Practice Manager or Contact person \_\_\_\_\_

**SECONDARY PRACTICE INFORMATION, if applicable**

Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Contact Name \_\_\_\_\_

**LICENSURE & REGISTRATIONS**

List all active professional licenses:

\_\_\_\_\_  
State            Type                                  Number            Date of Issue            Expiration Date

\_\_\_\_\_  
State            Type                                  Number            Date of Issue            Expiration Date

\_\_\_\_\_  
State            Type                                  Number            Date of Issue            Expiration Date

Federal DEA number \_\_\_\_\_

Unique Physician Identification Number (UPIN) \_\_\_\_\_

**CERTIFICATIONS**

Specialty \_\_\_\_\_

Board Name \_\_\_\_\_

Current Certification Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

**FACILITY AFFILIATIONS &/OR SCHOOL AFFILIATIONS**

(List all hospital/health system affiliations where you are credentialed and privileged.  
Also please list any school affiliations/appointments.)

Facility Name \_\_\_\_\_

Address \_\_\_\_\_

Department/Service/Position \_\_\_\_\_

Dates of Appointment From \_\_\_\_\_ To \_\_\_\_\_

Facility Name \_\_\_\_\_

Address \_\_\_\_\_

Department/Service/Position \_\_\_\_\_

Dates of Appointment From \_\_\_\_\_ To \_\_\_\_\_

List any additional relevant information as an attachment



**REQUIRED COPIES & REFERENCES**

**The following documents are required (photocopy acceptable)**

Identification (via government issued picture id-driver's license)

License/Certification

DEA Registration, as applicable

Malpractice Insurance

CPR Certification (as applicable)

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The specific scope/content of patient care service I request to practice at Mariam Clinic:

\_\_\_\_\_  
\_\_\_\_\_

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-----  
**I affirm that:**

- \* **I have never been convicted of a felony.**
- \* **I have never been charged with sexual harassment.**
- \* **I have not and will not provide patient care under the influence of drugs or alcohol.**
- \* **I do not have any communicable disease. I further understand that if at any time I am considered to be infectious I will notify the clinic medical director and or executive director.**
- \* **I will not release any information regarding patient's diagnosis, finance, etc. unless authorized to do so. I will strictly adhere to patient confidentiality and privacy standards.**

-----  
**Signature of Applicant**

\_\_\_\_\_  
**Date**

## **Authorization and Consent**

**In making this application:**

- **I acknowledge my obligation to fulfill my responsibilities to provide continuous quality care to patients of Mariam Clinic,**
- **to make decisions as appropriate to the patient's needs, to maintain practice knowledge and skills current through continuing education opportunities,**
- **to abide by the bylaws, rules and regulations, policies and procedures of the clinic,**
- **to participate in and cooperate fully with the Quality Assurance Program and all programs to improve quality and reduce risks.**

**I agree to participate**

- **in the review of records and documents relating to patient care and services, and**
- **to subject my performance to the review by the Clinic and its representatives for the purpose of improving the quality of care and services and reducing risk.**

**I hold the Clinic and its representatives free of all liability for such actions.**

**I hereby release from liability Mariam Clinic and all its representatives for their acts performed while evaluating my application, credentials and qualifications.**

**I hereby release from any liability any and all individuals and organizations that provide information to Mariam Clinic or its representatives concerning my professional competence, character, ethics, and other qualifications for employment and/or privileges and I hereby consent to the release of such information.**

**As applicable, I hereby accept that I will abide by the requirements for medical malpractice coverage for the Federal Tort Claims Act. I will cooperate fully in all measures to improve quality and reduce risks, and with any investigations and defense of liability claims.**

**I understand that I have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. I fully understand that any misstatements or omissions in the application constitute cause for denial or termination of privileges and/or employment. All information submitted by me in the application is true to the best of my knowledge.**

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name & Title**

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Raleigh, NC 27612

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919-824-4672

**Request to Verify Medical/Dental Staff Membership and/or Privileges**

Date \_\_\_\_\_

TO: American Medical Association /NPDB

RE: **Verify Hospital/Institution Membership and/or Privileges**

APPLICANT/PRACTITIONER \_\_\_\_\_  
Print Name and Title

**AUTHORIZATION AND CONSENT  
TO VERIFY MEDICAL/DENTAL STAFF MEMBERSHIP AND/OR PRIVILEGES**

I hereby authorize and release from any liability any and all individuals and organizations that provide information to Mariam Clinic or its representatives concerning my professional competence, character, ethics, and other qualifications for employment and/or privileges and I hereby consent to the release of such information.

\_\_\_\_\_  
Signature of Applicant/Practitioner Date



The above applicant/practitioner is authorizing you to provide information concerning his/her medical/dental membership and/or privileges for Mariam Clinic use in considering his/her request for privileges and/or employment at the Clinic. This information is requested at the direction of the Clinic's Clinical Services Committee and will become a part of the practitioner's Confidential File. Please complete this portion of this form and forward to the below assigned Credentialing Coordinator.

\_\_\_\_\_  
Signature of Mariam Clinic Credentialing Coordinator

**Below to be completed by Hospital/Organization/CVO Agent:**

**Medical Staff Status:**     Active                     Other: \_\_\_\_\_

**Dates of Medical Staff Membership**    \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

**Privileges granted in the practice/scope of service of** \_\_\_\_\_

**The following primary source verification has been obtained per JCAHO standards and supporting documentation is attached**

- a) Current licensure;
- b) Documentation of relevant education, training, or experience.

\_\_\_\_\_  
Signature of CVO Verifying Agent Date

\*\*\*\*\*In lieu of signature above, the AMA/NPDB will provide a copy of verification via the internet\*\*\*\*\*

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**Mariam Clinic**  
**Licensed Independent Practitioner's Health Fitness Statement**

Applicant/Practitioner Name: \_\_\_\_\_

Title \_\_\_\_\_ Date of Birth \_\_\_\_\_

I \_\_\_\_\_ (applicant's/practitioner's name) attest that I am fit to perform the care, treatment and other services provided at Mariam Clinic. Further, the substantiation of this fitness may be confirmed by the Clinic's dental/medical director, the hospital where I may be privileged or any other individual designated by the organization.

I further attest that I meet ongoing continuing education requirements not only to maintain any licensure or certification, but also to maintain practice skills and knowledge in the specific scope/content of patient care services I provide to patient's at Mariam Clinic.

\_\_\_\_\_  
Applicant/Practitioner Signature \_\_\_\_\_  
Date

Applicant/Practitioner to complete above ONLY

\*\*\*\*\*

I confirm that the above individual is:

- Fit to provide services at Mariam Clinic without limitation
- Fit to provide services at Mariam Clinic under the following conditions:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Confirmation Print Name & Title  
Date

\_\_\_\_\_  
Address City State Zip

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**EVALUATION FORM FOR PRIVILEGING OF HEALTH CARE PROFESSIONAL**

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\_\_\_\_\_  
Health Care Professionals Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Scope of Practice – Content of patient services

Medical Director, Dental Director, Peer in Specialty, Supervisor:

I have considered the above named practitioner’s education, relevant training and experience, professional performance, competence and clinical judgment in the treatment of patients within the listed scope of practice and content of patient services, his/her ethics and conduct, his/her compliance with clinic policies & procedures, cooperation with clinic staff & volunteers, his/her general attitude toward patients, the clinic and the public, as well as his/her physical and mental capabilities.

**Recommendation to Clinical Services Committee:**

\_\_\_\_\_ **Grant/Renew privileges as requested**

\_\_\_\_\_ **Grant privileges with change of status, expand or limit**

\_\_\_\_\_ **Deny or Terminate privileges**

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Evaluator’s Name (Print)**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Evaluator’s Signature**

\_\_\_\_\_  
**Date**

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**Health Care Professionals**  
**Medical Questionnaire**

Today's Date \_\_\_\_\_

I, \_\_\_\_\_ verify that the information below is truthful and honest to the best of my knowledge.

**PPD TB Skin Test) Status**

Date of most recent PPD (TB Skin Test) \_\_\_\_\_

Do you have a history of a positive PPD (TB Skin Test) \_\_\_ Yes \_\_\_ No,

If yes, date of last CXR \_\_\_\_\_

**Immunization Status:**

Please provide copy of Immunization history to include (HEP. B) Vaccines, titer results or declaration statement.

Allergies: \_\_\_\_\_  
\_\_\_\_\_

Are you allergic to Latex? \_\_\_ Yes \_\_\_ No, If Yes, describe reaction \_\_\_\_\_  
\_\_\_\_\_

Do you have any medical history or conditions that could cause you difficulties while working @ the Clinic? i.e., insulin dependent diabetic or heart attack a year ago.

If so, please explain \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Emergency Contact:**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone Contact \_\_\_\_\_

**MARIAM CLINIC  
PHYSICIAN  
SCOPE OF PRACTICES**

**Cardiology**

They provide diagnosis and non-surgical treatment of heart and vascular conditions of all ages, including those that require cardiologic methods of study and treatment.

**General Practice/Primary Care**

They provide medical care, health maintenance, and preventive services for patients from birth to advanced age. Medical concerns are managed through diagnosis, treatment and prevention of common illnesses and chronic diseases. They occasionally provide pregnancy and delivery care. They also coordinate and manage patient care with other specialists. They sometimes perform office based procedures.

**Gastroenterology**

They provide clinical services related to diseases of the digestive tract, liver and pancreas, including chronic gastrointestinal disorders such as acid peptic disease, ulcerative colitis, Crohn's disease, reflux esophagitis, esophageal stricture management, hepatic diseases and motor disorders of the gastrointestinal tract.

**Gynecology**

They provide well woman and preventive care as well as diagnosis and treatment of most conditions of the reproductive organs. They provide Primary Care services for female patients as well. Some of these conditions may include treating abnormal pap smears, sexually transmitted diseases, or pain in the pelvis or urethra. They do not manage pregnancy, labor or the period just after delivery. Office based procedures are usually performed to diagnose or treat certain conditions resulting from an abnormal pap smear, biopsy or irregular bleeding.

**Psychiatry**

They provide differential diagnosis and treatment of mental illness. Treatment can involve medication, psychotherapy and psychosocial interventions.

**Ophthalmology**

They provide medical care for the eyes and visual system and prevention of eye disease.

**Optometry**

They provide exclusively care related with vision problems. They determine visual acuity and prescribe spectacles, contact lenses and eye exercises. They may provide limited treatments of some eye conditions according to the state regulation.

**Mid-level Providers Scope of Practice**

**Nurse Practitioner**

They provide basic health care for children and adults, including performing physical exams, diagnosis and treatment of acute and chronic common illnesses, ordering diagnostic tests, performing procedures, and prescribing and dispensing certain medications under the supervision of a medical doctor.

**Physician Assistant**

The scope of practice of every physician assistant is based on their competency. Recognition of skill is the responsibility of the supervising physician and the clinic.