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

I. PURPOSE:

The 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). This document serves only as an overview of the PIN.

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 and 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 sponsored 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.
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 provided in accordance with applicable law

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 various program requirements. Clinic program requirements related to risk management systems is described in the PIN application. See descriptions of the credentialing and privileging requirements of volunteer health care professionals below:

1. Credentialing and Privileging
    i. Credentialing is the process of assessing and confirming the qualifications of licensure, certification and / or registration of a licensed or certified health care practitioner.
    ii. 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:
    i. 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 organization. (CVO). *The clinic makes request with authorization & consent*
    ii. 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 (copy)
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 (copy)
9. Querying the National Practitioner Data Bank (Clinic may perform)

Mercy Clinic of Fort Worth

HEALTH CARE PROFESSIONAL'S RESPONSE NOTICE

TO: Mercy Clinic

FROM:

DATE:

__ **YES,** 1 am interested in the Federal Tort Claims Act (FTCA) medical malpractice protection while volunteering at Mercy Clinic.

Please contact me-
Phone:
E Mail address:

Please contact my office/practice manager, Name_____
Phone_____

____ **NO,** 1 am not interested in pursuing the Federal Tort Claims Act (FTCA) medical malpractice protection.

. . . . . .

Please email or email response to:

Credentialing Coordinator Mercy Clinic
775 W Bowie Street
Fort Worth, Texas 76110

E Mail: mercyclinic@mercy-clinic.org

Mercy Clinic of Fort Worth

LICENSED & CERTIFIED HEALTH CARE PROFESSIONALS
APPLICATION FOR CREDENTIALING & PRIVILEGING

PERSONAL INFORMATION

Name _____

Home Address _____

_____

Home Phone (_____ Cell Phone ( ) _____

E-mail Address_____

Date of Birth _____Social Security Number _____

PRIMARY PRACTICE INFORMATION, if applicable

Practice Name _____

Practice Address_____

_____

Mailing address if different from above:

_____

Phone ( ) _____ Fax( ) _____

Pager(_____

Type of Practice

Dental _ Family Practice Internal Medicine

_ Specialty_____

Practice Manager _____

Practice Contact, if other than Manager_____

_____

SECONDARY PRACTICE INFORMATION, if applicable

Address_____

_____

Phone( ) _____ Fax( ) _____

Contact Name_____

MEDICAL/DENT AL EDUCATION

Medical/Dental School

Institution,_____

Address._____

Date of Graduation _____

Type of Training/Specialty_____

Residency

Institution._____

Address_____

Date of Completion _____

Type of Training/Specialty_____

Institution,_____

Address._____

Date of Completion_____

Type of Training/Specialty_____

Internship

Institution,_____

Address._____

Date of Completion_____

Type of Training/Specialty_____

Institution_____

Address._____

Date of Completion,_____

Type of Training/Specialty_____

Fellowship

Institution._____

Address_____

Date of Completion_____

Type of Training/Specialty_____

Institution._____

Address._____

Date of Completion._____

Type of Training/Specialty_____

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 have been 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.

PROFESSIONAL MALPRACTICE INSURANCE

Present Carrier's Name_____

Address_____

Policy Number_____

Dates of Coverage From_____ **To**_____

Coverage Amounts_____

CLAIMS INFORMATION

1. Have you ever been denied professional liability insurance or has your coverage ever been canceled? ☐ Yes D No

If yes, please explain:

_____

_____

2. Are there currently pending or have there been any malpractice claims, judgments or settlements involving your professional practice in the last 3 years? D Yes D No

If Yes, please explain

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

REQUIRED COPIES & REFERENCES

The following documents must be made available for photocopy

- ☐ Identification (via government issued picture id-driver's license)
- ☐ License/Certification
- ☐ DEA Registration, as applicable
- ☐ Malpractice Insurance
- ☐ CPR Certification
- ☐ Current C.V., for LIP

The specific scope/content of patient care service I request to practice at Mercy Clinic is: (See Clinic listing for Scope of Practice)

_____

_____

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 Mercy 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 Mercy 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 Mercy 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

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

Please see attached FORMS () requiring signature(s) and/or completion

() Request to Verify Medical/Dental Staff Membership and/or Privileges.

() LIP's Health Fitness Statement
Only the top portion of this FORM is to be completed by the applicant. The bottom portion is to be completed by the clinic's Medical Director or physician of applicant's choice.

() Health Care Professionals Medical Questionnaire
Please address highlighted areas of this Form and as applicable attached Hep. B declination

() Application for Credentialing & Privileging, as applicable Pages 1 - 6 or Pages 1,4,5 & 6 (Credentialing Coordinator to circle applicable pages)

Required Copies Of:

Identification (via government issued picture id, i.e. driver's license)
Current CV, if available
DEA Registration, as applicable
CPR Certification, as applicable _____
Declaration of current malpractice insurance protection

Mercy Clinic of Fort Worth

PHYSICIAN and DENTIST
NURSE PRACTITIONER and PHYSICIAN ASSISTANT
SCOPE OF PRACTICES

General Medicine

They provide medical care, health maintenance, and preventive services for patients for adults. Medical concerns are managed through diagnosis, treatment and prevention of common illnesses and chronic diseases. They do not provide pregnancy and delivery care. They also coordinate and manage patient care with other specialists. They may be allowed to perform joint aspirations and steroid injections.

Cardiology

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

Dermatology

They provide diagnosis and treatment of diseases and tumors of the skin and its appendages, including removal of skin lesions.

Endocrinology

They provide medical care for disorders of the endocrine glands such as the thyroid and adrenal glands. Endocrinology also deals with diabetes, metabolic and nutritional disorders, pituitary disease and other metabolic disorders.

Gas trocn terology

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 esophagi tis, 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. 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 ce11ain 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.

Internal medicine

They provide diagnosis and non-surgical treatment of diseases in adults.

Ophthalmology

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

Otolaryngology

They provide diagnosis and non-surgical treatment of diseases of the ear, nose, throat as well as certain conditions of the head and neck, including chronic ear infection, sinusitis, snoring and sleep apnea,

hearing loss, allergies and hay fever, swallowing disorders, nosebleeds, hoarseness, dizziness, and head and neck cancer.

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.

Radiology
They assist in the detection and diagnosis of medical conditions, utilizing diagnostic tools such as X-rays.

Surgery
They provide diagnosis and treatment of certain conditions of the skin and subcutaneous tissue only. It may include office- based procedures such as biopsies, resection of skin and subcutaneous lesions, and other minor procedures that can be performed under local anesthesia.

Dental
They provide evaluation, diagnosis, prevention and/or treatment of diseases and conditions of the oral cavity and maxillofacial area, limited to extractions and xray evaluation.

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 a physician assistant is based on their competency. Recognition of skill is the responsibility of the supervising physician and the clinic.

Date

Dear Dr. .....

Please see the attached Physician Scope of Practices for Mercy Clinic. Per this listing please note below which specific scope/content of patient care services you request to provide. Please return this notice to _____

General Medicine

__ Cardiology

__ Dermatology

__ Endocrinology

__ Gastroenterology

__ Gynecology

__ Podiatry

__ Psychiatry

Internal Medicine

__ Ophthalmology

__ Optometry

Pediatrics

__ Radiology

__ Surgery

_____ _____

Physician Signature Date

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 oflast CXR_____

Immunization Status:
Please provide copy of Immunization history ___ _
including **Hep B** vaccines, titer results or declination 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 recent heart attack.
If so, please explain_____
_____

Emergency Contact:
Name_____
Relationship_____
Address_____
_____
Home_____Cell_____Work_____

Mercy Clinic of Fort Worth

Licensed Independent Practitioner's Health Fitness Statement

Applicant/Practitioner Name: _____

Title _____ Date of Birth _____

_____(applicant's/practitioner's name) attest that am fit to perform the care, treatment and other services provided at Mercy 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 Mercy Clinic.

_____ _____

Applicant/Practitioner Signature Date

ApplicanUPractitioner to complete above ONLY

****

I confirm that the above individual is:

☐ Fit to provide services at Mercy Clinic without limitation

☐ Fit to provide services at Mercy Clinic under the following conditions:

_____

_____

_____

Signature of Confirmation Print Name & Title Date

_____

Address City

Confidential

Informed Refusal for Hepatitis B Vaccination/Lack of Documentation

I, _____ volunteer as a health care practitioner at Mercy Clinic. I am aware and understand the effectiveness of Hepatitis B immunization, the risk of contracting Hepatitis B, and the importance of taking active prevention to reduce the risk.

However, I, of my own free will and volition, and despite the Clinic's urging, have elected not to be vaccinated against Hepatitis 8. I have personal reasons for making the decision not to be vaccinated.

OR

I have received Hepatitis B Vaccination in the past but unable to produce supporting documentation of immunization and I do not wish for any further intervention at this time.

_____ _____

Employee/Volunteer Signature Date

_____

Printed Name

_____

_____

Address

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

Date _____ __

TO: _____-----:------:---:---: ----- ::
Name of Hospital/Institution/Credentials Verification Organizations *(CVO)*

_____

_____

Phone Number _____ __

RE: **Verify Hospital/Institution Membership and/or Privileges - Authorization** & **Consent**

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 **Mercy 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 **Mercy 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 partof the practitioner's Confidential File. Please complete this portion of this form and forward to the below assigned Credentialing Coordinator.

_____
Signature of Mercy Clinic Credentialing Coordinator

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

Medical/Dental Staff Status: ☐ **Active** ☐ **Other:** _____
Dates of Medical/ Dental 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 Hospital/Organization/CVO Verifying Agent Date

Background Check Authorization

Print Name: _____
(First) (Middle) (Last)

Former Name(s) and Dates Used: _____

Current Address Since: _____
(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: _____
(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: _____
(Mo/Yr) (Street) (City) (Zip/State)

Social Security Number: _____ DOB: _____

Telephone Number: _____

Drivers License Number/State: _____

The information contained in this application is correct to the best of my knowledge. I hereby authorize **Mercy Clinic of Fort Worth** and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment and/or volunteer purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number ; current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me, to **Mercy Clinic of Fort Worth** or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources.

Mercy Clinic of Fort Worth and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicant's personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: _____ Date: _____

Signature of Parent: _____ Date: _____

(Required if applicant is a minor)