Health Center Staff

Documents Checklist

**NOTE:** This consolidated checklist contains documents used to assess multiple program requirements during Operational Site Visits. Please refer to the Health Center Program Site Visit Protocol: [https://www.bphc.hrsa.gov/programrequirements/svprotocol.html](https://www.bphc.hrsa.gov/programrequirements/svprotocol.html).
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Governance

**Program Requirements**: Key Management Staff, Board Authority, Board Composition and Federal Tort Claims Act (FTCA) Deeming Requirements

Pre-Site Visit
- ☐ Co-applicant agreement (if applicable) (if updated since last application submission to HRSA/BPHC)
- ☐ Articles of Incorporation (if updated since last application submission to HRSA/BPHC)
- ☐ Bylaws (if updated since last application submission to HRSA/BPHC)
- ☐ Form 6A or Board Roster (if updated since last application submission to HRSA/BPHC)

On-Site Visit
- ☐ Board minutes [health center to research and provide relevant minutes] for:
  - most recent 12 months and
  - any prior meetings in the past three years to demonstrate that board authorities were explicitly exercised, including approving key policies on:
    - Sliding Fee Discount Program,
    - Quality Improvement/ Assurance Program, and
    - Billing and Collections (policy for waiving or reducing patient fees and if applicable, refusal to pay)
    - Financial Management and Accounting Systems
    - Personnel
- ☐ Board meeting minutes and/or most recent report(s) (within past 12 months) to the board that include the status of risk management activities
- ☐ Board committee minutes OR committee documents from the past 12 months
- ☐ Sample Board packets from two board meetings within the past 12 months
- ☐ Board calendar or work plan
- ☐ Strategic Plan or Long term planning documents within the past three years
- ☐ Most recent CEO Evaluation
- ☐ Board Member Applications, Bios and Disclosure Forms
- ☐ Clinical or billing records within the past 24 months to verify board member patient status
- ☐ For health centers with approved waivers, examples of the use of special populations input (e.g., board minutes, board meeting handouts, board packets, etc.)

Management and Administration

**Program Requirements**: Needs Assessment, Clinical Staffing, Accessible Locations and Hours of Operation, Key Management Staff, Collaborative Relationships, Board Authority, Board Composition, and Federal Tort Claims Act (FTCA) Deeming Requirements

Pre-Site Visit
- ☐ Website URL (if applicable)
- ☐ List of health center sites, including site addresses, hours of operation by site, and information on what general services (e.g., medical, oral health, behavioral health) are
offered at each service site (Note: these may be presented in separate documents or as references to health center websites.)

☐ UDS Mapper Service Area Map (if updated since last application submission to HRSA/BPHC)

☐ Documentation of collaboration efforts between area health centers (e.g., email or other correspondence requests from the health center to one or more area health centers regarding collaboration; responses to other area health centers regarding their requests to collaborate with the health center)

☐ Documentation of established collaboration or coordination with other providers and organizations in the health center’s service area (e.g., memorandum of agreement or understanding, letters, monthly collaboration meeting agendas with local health center leaders, cross-referral of patients between health centers, membership on a city-wide community health planning council)

☐ Health center organization chart(s) with names of key management staff

☐ Corporate organization chart(s) (only applicable for public agencies or for organizations with a parent or subsidiary)

☐ Position descriptions of key management staff (if updated since last submission to HRSA/BPHC)

☐ Bios or resumes for key management staff (if updated since last application submission to HRSA/BPHC)

☐ HR procedures relevant to recruiting and hiring of key management staff (if applicable, for health centers with key management staff vacancies)

On-Site Visit

☐ Service area reports or analysis documentation

☐ Documentation associated with filling key management staff vacancies (if applicable) (e.g., job advertisements, revised position description)

☐ Example(s) of methods used to inform patients of the health center’s deemed status (e.g., website, promotional materials, statements posted within an area(s) of the health center visible to patients)

☐ CEO employment contract or related agreement (for the purposes of provisions regarding CEO selection, evaluation, and dismissal or termination)

☐ Collaborative or contractual agreements with outside entities

Fiscal

*Program Requirements:* Required and Additional Health Services, Sliding Fee Discount Program, Contracts and Subawards, Conflict of Interest, Financial Management and Accounting Systems, Billing and Collections, Budget, and Board Authority

Pre-Site Visit

☐ Sliding Fee Discount Program (SFDP) policy(ies)

☐ Sliding Fee Discount Program procedure(s)

☐ Sliding Fee Discount Schedule, including, if applicable, SFDSs that differ by service or service delivery method
☐ Any related policies, procedures, forms and materials that support the SFDP (e.g., registration and scheduling, financial eligibility, screening, enrollment, patient notifications, billing and collections)

☐ List of provider and program/site billing numbers for Medicare, Medicaid and CHIP or any other documentation of participation (e.g., individual provider NPIs)

☐ Current Fee Schedule for each service area (medical, dental, behavioral health, etc.)

☐ Billing and Collections policies or procedures and systems including:
  • provision(s) to waive or reduce fees owed by patients;
  • third party payor billing procedures and/or contracts;
  • “refusal to pay” policy (if applicable); and
  • procedures for notifying patients of additional costs for supplies and equipment related to, but not included in the service (if applicable)

☐ Procedures for purchasing and procurement, including if applicable or separate, procedures for contracting and contract management

☐ Financial Management Procedures (for context and background on budget development process)

☐ Financial management and internal control procedures (may also be in the form of financial/accounting policies, manuals or other related documents)

☐ Procedures for drawdown, disbursement and expenditure of Federal award funds (may be included in the financial management and internal control procedures or may be separate)

☐ Policies and/or procedures that govern and track the use of non-grant funds, if applicable

☐ Registration, Eligibility, Outreach and Enrollment Procedures

☐ All sub-recipient agreements (if updated since last application submission to HRSA/BPHC) (not applicable to look-alikes and as applicable for awardees)

☐ Two most recent annual audits and management letters or audited financial statements (if audits are not available)

☐ Updated Annual Budget for the health center project (if updated since last application submission to HRSA/BPHC)

On-Site Visit

☐ Sample of key health center documents (for example, materials/application used to assess eligibility for the health center’s sliding fee discount program, intake forms for clinical services, instructions for accessing after-hours services) translated for patients with limited English proficiency

☐ Sample of five to ten records, files or other forms of documentation of patient income and family size (e.g., completed SFDS application or eligibility screening records). Ensure that the sample includes uninsured and insured patient categories

☐ Data, reports or any other relevant materials used to evaluate the Sliding Fee Discount Program

☐ Complete list of all contracts for goods or services that include costs directly attributable to the Federal Health Center Program Award (not applicable to look-alikes and as applicable for awardees)

  • From the above list of all contracts, a sample of current contracts and related supporting procurement documentation for procurement actions that were $25,000 or more. A sample of either half such procurements, but no more than five, would be sufficient (not applicable to look-alikes and as applicable for awardees)
☐ Sample of up to five final contracts that support the HRSA-approved scope of project (e.g., Column II service contracts, contract for CFO), regardless of whether the costs of such contracts are directly attributable to the Federal award (if applicable). If the health center contracts for one or more health center services (Column II), include these in the sample.
  
  • Sample of two to three reports or records from contractors selected for the sample above (e.g., monthly invoices or billing reports, data run of patients served, visits provided)

☐ Documentation of prior approval for contracts for the performance of substantive work under the Federal award (if applicable)

☐ Documentation of prior approval of sub-recipient arrangement(s) (not applicable to look-alikes and as applicable for awardees)

☐ Sample of sub-recipient monitoring methods and sample of financial and performance reports from the sub-recipient (not applicable to look-alikes and as applicable for awardees)

☐ Agreements with parent corporation, affiliate, subsidiary, or subrecipient organization (if applicable)

☐ Sample of supporting documentation for one to two procurements supported with Federal funds from the past 3 years (can be same sample as used for Contracts and Subawards)

☐ Manuals or documentation of the Financial Management System(s) used by the health center (e.g., financial accounting software, practice management system) Note: Some or all of the Financial Management System(s) may be contracted out or carried out via a Health Center Controlled Network

☐ Sample of periodic financial reports provided to the board and key management staff (selected form the past six months) including the most recent interim financial statements

☐ Sample of source documentation (e.g., financial records, receipts, invoices) to support expenditures made under the Federal Health Center Program award for the last quarter

☐ Aged Accounts Receivable (as of most recent interim financial statements)

☐ Aged Accounts Payable (as of most recent interim financial statements)

☐ Current data on the following metrics: collection ratios, bad debt write off as a percentage of total billing, collections per visit, charges per visit, percentage of A/R less than 120 days, days in A/R (for context on billing and collections efforts)

☐ Collection rate by payor source (Medicaid, CHIP, Medicare, and, as applicable, other public and private insurance) gathered from billing records for the past 1-2 years

☐ Sample of billing and payment records for charges requested from patients. For the sample, randomly choose five records for patient visits from across at least three unique services (e.g., routine primary care, preventive dental, behavioral health, OB) for a total of at least 15 total records reviewed:
  
  • Ensure the sample includes patients that are eligible for the health center’s sliding fee discount program (i.e., incomes at or below 200% FPG)
  
  • If applicable, include records for patients that are not eligible for the sliding fee discount program (i.e., incomes above 200% FPG)

☐ Sample of two to three billing records where patient fees were waived or reduced

☐ Documentation of methods for notifying patients of additional costs for supplies and equipment related to, but not included in the Service (if applicable)

☐ Documentation of cases where the health center has applied its refusal-to-pay policy within the past two years (if applicable)

☐ Documentation related to Determination of Fee schedule based on health center costs and locally prevailing rates (e.g., operating costs for service delivery, relative value units (RVUs) or other relevant data sources, Medicare/ Medicaid cost reports)
☐ If applicable, documentation of participation in other public or private program or health insurance plans (e.g., list or copy of third party payor contracts including any managed care contracts)

☐ If applicable, contracts with outside organizations that conduct billing or collections on behalf of the health center

☐ Budget to Actual Comparison Reports for the Current Fiscal Year and the Prior Fiscal Year

☐ Separate organizational budget(s) (if applicable) (in situations where the health center has an organizational budget that is separate from the budget for the health center project)

Clinical

Program Requirements: Required and Additional Health Services, Clinical Staffing, Coverage for Medical Emergencies During and After Hours, Continuity of Care and Hospital Admitting, Quality Improvement/Assurance, and Federal Tort Claims Act (FTCA) Deeming Requirements

Pre-Site Visit

☐ For health centers with Column III services, operating procedures for tracking and managing referred services (as applicable for health centers that do not manage referrals electronically)

☐ Credentialing and privileging procedures (including Human Resource procedures, if applicable)

☐ Current Staffing Profile (name, position, FTE, hire date). Indicate staff with interpretation/translation capabilities (i.e., bilingual, multilingual)

☐ Operating procedures for addressing medical emergencies during health center’s hours of operation

☐ Operating procedures for responding to patient medical emergencies after-hours

☐ Health center's internal operating procedures and/or documentation from arrangements with non-health center provider(s) for tracking of patient hospitalization and continuity of care

☐ Policy(ies) that establish the QI/QA program

☐ QI/QA-related operating procedures or processes that address:
  • clinical guidelines, standards of care, and/or standards of practice
  • patient safety and adverse events, including implementation of follow-up actions
  • patient satisfaction
  • patient grievances
  • periodic QI/QA assessments
  • QI/QA report generation and oversight

☐ Systems and/or procedures for maintaining and monitoring the confidentiality, privacy and security of patient records

☐ Risk management policy(ies) and related operating procedures or protocols (including but not limited to procedures for tracking referrals, diagnostics, and hospital admissions ordered by health center providers, incident reporting for clinically-related complaints and “near misses”). Note: Health centers may have distinct “risk management” operating procedures OR these may be included or integrated within other health center operating procedures or protocols (e.g., HR, QI/QA, Admin, Clinical, Infection Control)

☐ Claims Management process policy(ies)/procedures

☐ Most recent HRSA-approved FTCA deeming application

☐ Risk management training plan and related tracking of training completion
☐ Documentation (e.g., board/committee minutes, supporting data, reports) of the last two quarterly risk management assessments of health center activities designed to reduce the risk of adverse outcomes (e.g., environment of care, incident tracking, infection control, patient safety) that could result in medical malpractice or other health or health-related litigation

On-Site Visit

☐ List of one to two health center sites where the majority of services provided directly by the health center are offered (Form 5A, Column I) to be toured by the Site Visit Team

☐ Health center selection of three to five health center patient records (e.g., using live navigation of the EHR, screenshots from the EHR, or actual records if the records are not electronic/EHR records) that document the provision of various Required and Additional Services offered only via formal written contracts/agreements (Form 5A, Column II)

☐ Log or list of patients referred for one or more Required service(s) in the past 12-24 months and, if time permits, a sample list of patients referred for one or more Additional service(s) provided ONLY via Form 5A, Column III) in the past 12-24 months. Using log/list(s), Clinical expert will select three to five records to review and health center will provide these as health center patient records (e.g., using live navigation of the EHR, screenshots from the EHR, or actual records if the records are not electronic/EHR records) to assess referral process. Note: This excludes follow-up from hospital admissions or hospital visits that will be reviewed in Continuity of Care and Hospital Admitting

☐ Provider contracts, agreements and sub-recipient arrangements (if applicable, based on service delivery methods indicated on Form 5A)

☐ Provider employee contracts or other documentation of hospital privileges

☐ Formal arrangements with provider(s) or entity(ies) that address health center patient hospital admissions

☐ Sample of files that contain credentialing and privileging information: 4-5 licensed independent practitioners (LIP) files; 4-5 other licensed independent practitioners (OLCPs) files; and, only if applicable, 2-3 files for other clinical staff. The selected files should include:
  - Representation from different disciplines and sites
  - Directly employed and contracted providers in addition to volunteers (if applicable)
  - Providers who do procedures beyond core privileges for their discipline(s)
  - Newest provider (to assess timeliness of process and whether clinician was credentialed and privileged prior to delivering patient care)
  - Re-credentialed/re-privileged provider

☐ Contract or agreement with Credentialing Verification Organization (CVO) or other entity used to perform credentialing functions (such as primary source verification) on behalf of the health center (if applicable)

☐ Recruitment and retention plan or related documents for clinical staff

☐ Provider on-call schedules and answering service contract (if applicable; for health centers whose own providers cover after-hours calls)

☐ Written arrangements with non-health center providers/entities (e.g., formal agreements with other community providers, “nurse call” lines) for after-hours coverage (if applicable; for health centers that utilize non-health center providers)

☐ List of service delivery sites with names of at least one individual (clinical or non-clinical staff member) at each site trained and certified in basic life support, including a copy of that individual’s current certification (e.g., credentialing file for LIP or OLCP, certification of training if non-clinical staff)
☐ Instructions or information provided to patients for accessing after-hours coverage
☐ Three samples of either after-hours clinical advice documentation in the patient record (e.g., screenshots selected by the health center)
☐ If applicable, documentation demonstrating systems/methods of tracking, recording and storing of after-hours coverage interactions and follow-up (e.g., log of patient calls)
☐ Sample of five to ten health center patient records (e.g., using live navigation of the EHR, screenshots from the EHR, or actual records if the records are not electronic/EHR records) who have been hospitalized or had ED visits within the past 12 months
☐ Schedule of QI/QA assessments
☐ Sample of two QI/QA assessments from the past year and/or the related reports resulting from these assessments
☐ If applicable, documentation for related systems that support QI/QA (e.g., event reporting system, tracking resolutions & grievances, dashboards)
☐ Job or position description(s) of individual(s) who oversee the QI/QA program
☐ For health centers with closed claims from within the past five years under the FTCA: For each closed claim, documentation of steps implemented to mitigate the risk of such claims in the future (e.g., targeted staff training, improved records management, implementation of new clinical protocols)

Other

Program Requirements: Needs Assessment, Required and Additional Health Services, Clinical Staffing, Accessible Locations and Hours of Operation, Sliding Fee Discount Program, Quality Improvement/Assurance, Conflict of Interest, and Program Monitoring and Data Reporting Systems

On-Site Visit
☐ Needs Assessment(s) or related studies or resources
☐ For services in Column II of the health center’s current Form 5A (if applicable):
  o Sample of up to three written contracts/agreements for EACH Required and EACH Additional service provided via Column II but NOT provided via Column I
  o Sample of up to two written contracts/agreements for EACH Required and EACH Additional service provided via Column I AND Column II
☐ For services in Column III of the health center’s current Form 5A (if applicable):
  o Sample of up to three written referral arrangements for EACH Required and EACH Additional service provided via Column III but NOT provided via Column I
  o Sample of up to two written referral arrangements for EACH Required and EACH Additional service provided via Column I AND Column III
☐ Patient satisfaction surveys or other forms of patient input
☐ Sample of patient satisfaction results
☐ Documentation containing the health center’s standards of conduct (e.g., articles of incorporation, bylaws, board manual, employee manual, standards of conduct, policies and procedures, disclosure forms)
☐ Sample of written disclosures with respect to real or apparent conflicts of interest completed by officers, employees, board members and agents of the health centers (e.g., forms, signed statements, employment contracts)
☐ Sample of program reports generated by the health center for the governing board or key management staff (e.g., board packets from the past few months, reports provided to the
Finance or Quality Improvement Committee, routine reports generated by the health center for key management staff) that include information on:

- Patient service utilization
- Trends and patterns in the patient population
- Overall health center clinical, financial, or operational performance