SECURITY RISK ANALYSIS COMPLIANCE FORM

This form is intended to be used by a Provider [an Eligible Professional (EP) or Eligible Hospital (EH)] as documentation in support of the Meaningful Use (MU) Measure for "Protect Patient Health Information". Protecting "Patient Health Information (PHI)" includes conducting and/or reviewing a "risk analysis" of the Provider's or organization's activities, policies and procedures for handling and maintaining the security of PHI. All responses included in this form are subject to verification during an on-site post-payment audit and any responses found to be inaccurate, unsupportable or false may result in a failure of the MU measure and recoupment of the incentive payment. (This form may be completed by an authorized staff person on behalf of the Provider.)

1. **Provider Information**

Provider's Name & Professional Title:_____NPI:_____

If EP, Name of Practice or Organization:

_____NPI:_____

2. **My Organization**

a) Type

____FQHC/RHC
____Group Practice
____Individual or Shared Office
____Outpatient Clinic
____Hospital

b) Size (number of staff including Professional, Technical, Clerical & other support, FT, PT & volunteers)

____5 or less
____6 – 10
____11 – 25
____26 – 50
____51 – 100
____100+

3. **Written Policies and Procedures**

a) My organization has at least one formal written policy on the handling and security of PHI.____Yes____No

b) We have the following written policies and procedures (check all that apply):

____HIPAA Compliance
____IT Security
____Maintaining and Protecting PHI
____Business Associate's Agreement (BAA)
____Other (describe):_____

c) We have required staff training on security and protecting PHI on at least an annual basis.____Yes____No

If "Yes", then (check all that apply):

(i) ____Training is conducted on a group/seminar basis
(ii) ____Individual, self-study basis
(iii) ____Other (explain)

_____

4. **CEHRT**

a) Date my organization's CEHRT was installed*:_____(mm/yyyy)

b) Date of the most recent upgrade of my organization's CEHRT:_____(mm/yyyy)

*If you have not changed your CEHRT product/vendor since your very first EHR Incentive Program attestation, this will be the original implementation date. If you changed product/vendor since your very first attestation, indicate the implementation date of the current CEHRT.

5. **Risk Analysis**

(Defined as: **Phase I** - auditing, reviewing and/or evaluating the organization's written and informal practices, policies and procedures regarding the handling, maintenance and protection of PHI, and **Phase II** – making a critical evaluation of the results of Phase I, and taking any appropriate actions to mitigate or address any deficiencies noted in Phase-I including making appropriate changes or improvements in the organization's existing formal/written practices, policies and procedures.)

The SRA must be completed within the calendar year (Jan 1-Dec 31) of the Program Year. A SRA must be done on an annual basis and include the entire reporting period; the same SRA cannot be used for two different Program Years

a) Risk Analyses for my organization, whether Phase-I and/or Phase-II, are conducted by (check all that apply):

_____Staff within the organization* _____Contractors
_____Other (describe):_____

b) When was the last Phase-I Risk Analysis conducted for your organization?_____(mm/yyyy)

c) What period did the Phase-I Risk Analysis cover?

Review Period Begin Date:_____Review Period End Date:_____

d) When was the last Phase-II Risk Analysis conducted for your organization?_____(mm/yyyy)

Review Period Begin Date:_____Review Period End Date:_____

*This may include staff within the Provider's immediate office. If the organization has different divisions, sections, offices, etc., or dedicated staff for internal audits or compliance reviews, and staff from such areas of the organization perform the risk analyses, they should be viewed as "staff within the organization".

This form is being submitted in support of the attestation of the above named Provider for Program Year _____.

If applicable, initial here: _____"I am authorized to complete and sign this form on the Provider's behalf".

Printed Name & Title:_____

Signature: _____ Date:_____