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 "security 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 pre-payment or post-payment verification, 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/dd/yyyy)

b) Date of the most recent upgrade of my organization's 2015 CEHRT: _____ (mm/dd/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

The Security Risk Analysis must include the following:

* Auditing, reviewing and/or evaluating the organization's written and informal practices
*Review of policies and procedures regarding the handling, maintenance and protection of PHI
*Review and identify an analysis of the CEHRT addressing encryption/security of data & implement updates as necessary
*Making a critical evaluation of the results identifying risks and developing a risk mitigation plan that includes appropriate actions that address deficiencies noted include, but not limited to, updated policies and procedures, employee training and system changes.

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, are conducted by (check all that apply):

_____Staff within the organization* _____Contractors

_____Other (describe): _____

b) When was the Security Risk Analysis performed? Please provide a date: _____

c) What is the provider's MU reporting period? Please provide date range used: _____

d) What period in 2020 did the Security Risk Analysis cover? Please select one of the following:

____January 1- December 31, 2020
_____January 1-March 31, 2020
____ April 1- June 30, 2020
_____ July 1- September 30, 2020
____ October 1-December 31, 2020
_____Other (provide date range): _____

*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:_____