

URI HIPAA INVENTORY:
COVERED COMPONENTS AND BUSINESS ASSOCIATES

The purpose of this information gathering tool is to identify departments, offices or other units within the University of Rhode Island which either: 1) will be considered a “Covered Provider Component” under HIPAA; or 2) will be considered a “Business Associate Component” under HIPAA, and to gather necessary information from them about their information privacy practices, policies and forms. The information requested on this form is critical to the University's HIPAA compliance efforts. Your assistance in collecting this information is greatly appreciated.

Name: _____

Title: _____

Department/Office/Unit Name: _____

Date: _____

I. URI “HEALTHCARE PROVIDER” UNITS/COMPONENTS

1. Please list below your department, office, or unit if it is responsible for or involved in **providing, billing for, or receiving payment for, health care services and/or mental health services**, including, but not limited to, preventative, diagnostic, therapeutic, rehabilitative, palliative care, and counseling services or assessment. If your unit is not involved in such activities, answer “N/A”, skip Questions 2-8 and proceed to Section II.

2. Briefly describe the specific healthcare services (including healthcare provision, billing and payment) your department/office/unit is involved in.

3. Since personal health information about **URI students** is technically exempt from HIPAA, we also need to know specifically what category (ies) of individuals your department/office/unit provides health services to, whether to (a) URI Students only, (b) what we call “Non-Students” only (with the term “Non-Student” referring to basically anyone **other than** enrolled URI students, and includes any individuals from the community, as well students from **other colleges/universities**, and students in grades K-12), or (c) both URI Students and Non-Students. It will also be helpful to know your best estimate of the number of each category (if any) you treat/serve annually.

Do you provide health services to URI Students? YES NO.

If yes, roughly what number annually: _____

Do you provide health services to Non-Students? YES NO.

If yes, roughly what number annually: _____

4. Briefly describe your medical/health record system (whether paper or electronic).

5. Please check **any and all** of the below to inform us whether your department/office/unit (that you identified in Section I) sends or receives any health information via electronic means for any of the following reasons: [Note: "Electronic means" generally means by computer (e.g. via email, internet, web), and does not include sending information via telephone or fax machine]. If none, check **NONE**, skip Questions 6-8 and proceed to Section II.]

- Health care claims filing or status
- Health care payment and remittance
- Coordination of insurance benefits
- Enrollment or disenrollment in a health plan
- Eligibility for a health plan
- Health plan premium payments
- Referral certification and authorization by a health plan
- NONE

6. Please identify and list all of the **internal** departments, offices and other units of the University to which (or with which) your department/office/unit (identified in Question 1 above) sometimes or regularly discloses or shares access to the personal health information about your patients/clients (e.g. IT, Legal, other) to assist you with one of your functions or obligations (e.g. update or troubleshoot your computerized medical record system, assist you with a legal matter). These other departments/offices/units will be considered your "internal business associates."

7. Please identify all of the **external** entities (e.g. medical billing or coding companies) with which your department/office/unit (identified in Question 1 above) shares or discloses protected health information to assist you with one of your business functions or obligations (e.g. insurance billing), and attach all of your agreements (business-type agreements, as well as data-sharing or confidentiality type agreements) you have with those external entities. These outside vendors will be considered your “external business associates.”

8. Please **attach any and all** of the following: (1) Standard consent or authorizations your unit uses and your patients are asked to sign from time to time; (2) Any general “privacy notices” you provide to your patients, or post in your clinic/office/unit; (3) Your written policies and procedures relating in some way to health information privacy, or your medical records or medical records system.

II. URI POSSIBLE “BUSINESS ASSOCIATE” UNITS/COMPONENTS

1. If you have not listed your department, office, or unit as a “health care provider” in Section I above, we still need to know if your department/office/unit has nonetheless entered into any kind of a contract, or arrangement, under which your department/office/unit is obligated to (or has agreed to) **provide services to** -- including research, public health, or healthcare operations type services (e.g., quality assurance, quality improvement, health data analysis, health care or pharmaceutical utilization, health care quality assessment) --- any external third party that is a health care provider, governmental health program, or a health insurance plan, and which services involve the creation, use or disclosure of personal health information. *[Note: This does not include academic or clinical affiliation agreements involving student practical or clinical training].* Please indicate whether the above is true for your department/office/unit:

YES **NO**

2. If you circled **YES**, please list (a) the external party providing the data to your department/office/unit; AND (b) the specific service(s) being provided to them.

Please also attach all of your agreements (business-type, as well as data-sharing or confidentiality- type, agreements) with those external entities:
