



## West Virginia Covered Entity Assessment Tool

### SECTION 2: GOVERNMENTAL ENTITY AND COMPONENT INFORMATION

Please provide the following information.

**Governmental Entity:** \_\_\_\_\_

Head of **Governmental Entity:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Name of **Component:** (if applicable) \_\_\_\_\_

Head of **Component:** \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Persons Completing Covered Entity Assessment Tool

Names(s): \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Attach a current organizational chart delineating your **Governmental Entity** and the **Components**, if any.

If you checked the box in Section 8, C, page 12 of this Covered Entity Assessment Tool, you must designate a HIPAA Coordinator. This person will serve as the contact person for the State HIPAA Oversight Team.

HIPAA Coordinator

Name: \_\_\_\_\_

Title: \_\_\_\_\_

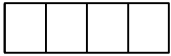
E-mail Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Entities or components the HIPAA Coordinator is responsible for coordinating:

\_\_\_\_\_



## West Virginia Covered Entity Assessment Tool

### SECTION 3: HEALTH INFORMATION

#### QUESTION 3.1:

Does your **Component** of this **Governmental Entity** create, receive, send, maintain or have access to **Health Information** as described in *Tables 3-A* and *3-B* above and defined by HIPAA in the Definitions Section?

Yes     No

### SECTION 4: HEALTH CARE PROVIDER

#### QUESTION 4.1:

Does your **Component** of this **Governmental Entity** meet the definition of a **Health Care Provider** by doing any of the following (**mark all that apply**)?

- Yes     No    Furnish health care services
- Yes     No    Bill for health care services
- Yes     No    Receive payment for health care services

#### QUESTION 4.2:

Does your **Component** of this **Governmental Entity** transmit Administrative or Financial Transactions that contain **Health Information** as described in *Table 4-D* ?

Yes     No

### SECTION 5: HEALTH PLAN

#### QUESTION 5.1:

Is your **Component** of this **Governmental Entity** considered an individual or Group Pla (e.g., governmental plan) that provides or pays for medical care according to the HIPAA definition and as listed in *Table 5*?

Yes     No

### SECTION 6: HEALTH CARE CLEARINGHOUSE

#### QUESTION 6.1:

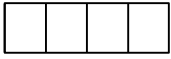
Does your **Component** of this **Governmental Entity** process or facilitate the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transactions?

Yes     No

#### QUESTION 6.2:

Does your **Component** of this **Governmental Entity** receive standard transactions from a **Covered Entity** and process or facilitate processing of **Health Information** into nonstandard format or nonstandard data content for the receiving entity?

Yes     No



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### SECTION 7: BUSINESS ASSOCIATE OR TRADING PARTNERS

#### QUESTION 7.1:

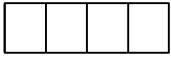
Does your **Component** of this **Governmental Entity** perform a service or function on behalf of a entity that has been deemed to be a **Covered Entity** as defined by the HIPAA Regulations?

Yes       No

#### QUESTION 7.2:

Does our **Component** of this **Governmental Entity** electronically exchange **Health Information**, as defined by HIPAA, with a **Covered Entity**?

Yes       No



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### SECTION 8: CONCLUSIONS AND DETERMINATIONS:

A. Refer to the answer to Question 3.1 - Health Information and enter that answer in one of the two choices below:

Yes     No

B. Refer to the answers in the Sections 4 through 7 and select all that apply from the following choices:

- Yes     No    Questions 4.1 - Health Care Provider  
 Yes     No    Questions 4.2 - Health Care Provider  
 Yes     No    Questions 5.1 - Health Plan  
 Yes     No    Questions 6.1 - Health Care Clearinghouse  
 Yes     No    Questions 6.2 - Health Care Clearinghouse  
 Yes     No    Questions 7.1 - Business Associate  
 Yes     No    Questions 7.2 - Trading Partner

**NOTE:** If there is a **YES** answer in any of the boxes in item B, then the answer to Item A should also be Yes. If the answer is **NO**, please go back to Section 1 - **Health Information**, and determine if the **NO** answer still applies based on your other responses.

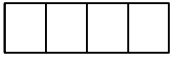
### DETERMINATION:

Choose the statement below that describes your **Component** of this **Governmental Entity**:

C.     **IF**            the **YES** box in Item A above is marked  
**AND**        **ANY** of the **YES** boxes in Item B above are marked,  
**THEN**       your **Component** of this **Governmental Entity** **MUST**  
                  comply with HIPAA Regulations.

D.     **IF**            the **NO** box in Item A above is marked:  
**AND**        **ALL** of the **NO** boxes in Item B above are marked,  
**THEN**       your **Component** of this **Governmental Entity** is not  
                  subject to the HIPAA Regulations.

E.     **IF**            the **YES** box in Item A above is marked:  
**AND**        **ALL** of the **NO** boxes in Item B above are marked,  
**THEN**       your **Component** of this **Governmental Entity** **DOES NOT** meet the definition of a  
                  HIPAA **Covered Entity**, **Business Associate** or **Trading Partner**. However, it will  
                  be noted in the assessment report that this **Component** **DOES** have access to  
                  **Health Information**.



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All questions have been answered to the best of my knowledge. This entity  IS  IS NOT a covered entity.

Governmental Entity Head: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Governmental Entity: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Attorney: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_