DEPARTMENT OF HEALTH & HUMAN SERVICES

Office for Civil Rights (OCR)

Civil Rights Information Request For Medicare Certification

Form Approved: OMB No. 0990-0243

Expiration Date: 10/31/2010

Instructions: Complete all fields and return this form, with the required documents, to your State Health Department, along with your other Medicare Application Materials.

I. Healthcare Provider Information

CMS Medicare Provider Number:

Name of Facility:

Address: _____
Street Number and Name

_____ - _____
City or Town *State or Province* *Zip Code*

Administrator's Name: _____ Contact Person: _____

Telephone: ( ) - TDD: ( ) -

FAX: ( ) - E-mail: _____

Type of Facility: _____ Number of employees: _____

Corporate Affiliation: _____ Reason for Application: Circle One
Initial Medicare Certification or Change of Ownership

II. Documents Required for Submission

(Additional guidance is available at: (www.hhs.gov/ocr/crclearance.html)

1.	**Two signed and completed originals of the form HHS-690, Assurance of Compliance.**
2.	**Your Nondiscrimination Policy that provides for admission and services without regard to race, color, national origin, disability, or age, as required by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 (see example).**
3.	**Description of methods used to disseminate your nondiscrimination policies/notices (e.g., describe where you post your Nondiscrimination Policy, and include brochures, postings, ads, etc.).**
4.	**Facility admissions policy that describes eligibility requirements for your services.**
5.	**Copies of brochures, pamphlets, etc. with general information about your services.**
6.	**Procedures to effectively communicate with persons who are limited English proficient (LEP), including (see example):** **a) Process for how you identify individuals who need language assistance;** **b) Procedures to provide services (interpreters, written translations, bilingual staff, etc.). Include the name(s) and telephone number(s) of your interpreter(s) and/or interpreter service(s);** **c) Methods to inform LEP persons that language assistance services are available at no cost to the person being served;** **d) Appropriate restrictions on the use of family and friends as LEP interpreters;** **e) A list of all written materials in other languages, if applicable. Examples may include consent and complaint forms, intake forms, written notices of eligibility criteria, nondiscrimination notices, etc.**
7.	**Procedures used to communicate effectively with individuals who are deaf, hard of hearing, blind, have low vision, or who have other impaired sensory, manual or speaking skills, including (see example):** **a) Process to identify individuals who need sign language interpreters or other assistive services;** **b) Procedures to provide interpreters and other auxiliary aids and services. Include the name(s) and telephone number(s) of your interpreter(s) and/or interpreter service(s);** **c) Procedures used to communicate with deaf or hard of hearing persons over the telephone, including the telephone number of your TTY/TDD or State Relay System;** **d) A list of available auxiliary aids and services;** **e) Methods to inform persons that interpreter or other assistive services are available at no cost to the person being served;** **f) Appropriate restrictions on the use of family and friends as sign language interpreters.**

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8.	**Notice of Program Accessibility and methods used to disseminate information to patients/clients about the existence and location of services and facilities that are accessible to persons with disabilities (see example).**
9.	**For healthcare providers with 15 or more employees: the name/title and telephone number of the Section 504 coordinator.**
10.	**For healthcare providers with 15 or more employees: copy of your procedures used for handling disability discrimination grievances (see example).**
11.	**A description/explanation of any policies or practices restricting or limiting your facility's admissions or services on the basis of age. In certain narrowly defined circumstances, age restrictions are permitted.**

III. Certification

I certify that the information provided to the Office for Civil Rights is true, complete, and correct to the best of my knowledge.

_____	_____	_____
Name and Title of Authorized Official	Signature	Date