



**DEPARTMENT OF HEALTH & HUMAN SERVICES**

**Office for Civil Rights (OCR)  
 Civil Rights Information Request  
 For Medicare Certification**



**Instructions:** Healthcare providers applying for participation in the Medicare Part A program must receive a civil rights clearance from OCR. Complete all fields and return this form, with the required polices and procedures, to your State Health Department, along with your other Medicare application materials.

<b>I. Healthcare Provider Information</b>			
CMS Medicare Provider Number: _____			
Name of Facility: _____			
Address: _____			
_____ <i>Street Number and Name</i>		_____	
_____ <i>City or Town</i>		_____ <i>State or Province</i>	_____ <i>Zip Code</i>
Administrator's Name: _____	Contact Person: _____		_____
Telephone: ( ) - _____	TDD: ( ) - _____	_____	
FAX: ( ) - _____	E-mail: _____	_____	
Type of Facility: _____	Number of employees: _____		
Corporate Affiliation: _____	Initial Medicare or Change of Certification Ownership		

<b>II. Documents Required for Submission</b>	
Additional guidance is available at: ( <a href="http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/index.html">http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/index.html</a> )	
1.	<a href="#">Assurance of Compliance form, HHS 690</a> completed, signed and dated
2.	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 ( <a href="#">see sample policy</a> ). <a href="#">Learn more about regulatory requirements</a>
3.	Description of methods used to disseminate your nondiscrimination policies/notices: a) Describe where you post your Nondiscrimination Policy; b) Include brochures, websites, pamphlets, postings, or ads with general information about your services.
4.	Facility admissions policy that describes eligibility requirements for your services.
5.	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. <a href="#">Learn more about regulatory requirements</a>
6	For healthcare providers with 15 or more employees: copy of your procedures used for handling disability discrimination grievances along with the name/title and telephone number of the Section 504 coordinator ( <a href="#">see sample policy</a> ). <a href="#">Learn more about regulatory requirements</a> .

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-0243. The time required to complete this information collection is estimated to average 8 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer



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7.	<p>Procedures to effectively communicate with persons who are limited English proficient (LEP), including:</p> <ul style="list-style-type: none"> <li>a) Process for how you identify individuals who need language assistance;</li> <li>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);</li> <li>c) Methods to inform LEP persons that language assistance services are available at no cost to the person being served;</li> <li>d) Appropriate restrictions on the use of family and friends as LEP interpreters;</li> <li>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 (<a href="#">see sample policy</a>). <a href="#">Learn more about regulatory requirements</a></li> </ul>
8.	<p>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:</p> <ul style="list-style-type: none"> <li>a) Process to identify individuals who need sign language interpreters or other assistive services;</li> <li>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);</li> <li>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;</li> <li>d) A list of available auxiliary aids and services;</li> <li>e) Methods to inform persons that interpreter or other assistive services are available at no cost to the person being served;</li> <li>f) Appropriate restrictions on the use of family and friends as sign language interpreters (<a href="#">see sample policy</a>). <a href="#">Learn more about regulatory requirements</a>.</li> </ul>
9.	<p>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 (<a href="#">see sample policy</a>). <a href="#">Learn more about regulatory requirements</a>.</p>

**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.

<p>_____</p> <p>Name and Title of Authorized Official</p>	<p>_____</p> <p>Signature</p>	<p>_____</p> <p>Date</p>
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