Form Approved OMB No. 0990-0243 Exp. Date XX/XX/20XX



Name of Facility:

Administrator's Name: _

Address:

I. Healthcare Provider Information CMS Medicare Provider Number:

Street Number and Name

City or Town

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

State or Province

Contact Person:



Zin Code

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.

Telephone:	_() -	TDD:	() -	
FAX:	() -	E-mail:		
Type of Faci	ility:	_ Number of employees:		
Corporate Af	ffiliation:	_		
1			Initial Medicare or Change of Certification Ownership	
	ents Required for Submission			
Addition	nal guidance is available at:(http://www.hhs.gov		oviders/medicare_providers/index.html)	
1.	Assurance of Compliance form, HHS 690 com	pleted, 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		Section 504 of the Rehabilitation Act of	
	1973, and the Age Discrimination Act of 1975	<u>see sample policy)</u> .		
	Learn more about regulatory requirements			
3.	Description of methods used to disseminate you		cies/notices:	
	a) Describe where you post your Nondiscri			
	b) Include brochures, websites, pamphlets,			
4.	Facility admissions policy that describes eligibi	lity requirements for you	r services.	
5.	A description/explanation of any policies or pro-	actices restricting or limit	ing your facility's admissions or services	
	on the basis of age. In certain narrowly defined	l circumstances, age restr	ictions are permitted. <u>Learn more about</u>	
	regulatory requirements			
6	For healthcare providers with 15 or more emp			
	discrimination grievances along with the name		er of the Section 504 coordinator (see	
	sample policy). Learn more about regulatory r	<u>equirements</u> .		

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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



7.	Procedures to effectively communicate with persons who are limited English proficient (LEP), including:			
	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 (see			
	sample policy). Learn more about regulatory requirements			
8.	Procedures used to communicate effectively with individuals who are deaf, hard of hearing, blind, have low vi			
	or who have other impaired sensory, manual or speaking skills, including:			
	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 (see sample policy).			
	Learn more about regulatory requirements.			
9.	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 sample policy).			
	Learn more about regulatory requirements.			
III. Certif				
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 T	Citle of Authorized Official Signature Date			