

## National Commission on Correctional Health Care

### Annual Maintenance Report for 2009

Completion of this Annual Maintenance Report (AMR) and compliance with the NCCHC *Standards for Health Services in Prisons* are required to maintain health services accreditation.

For any question, use additional sheets as necessary.

To ensure accuracy of current information for correspondence and billing purposes, please review the following. Make changes or additions in the space provided. Thank you.	
Legal name of facility Facility type	
Mailing address (include street address for UPS shipping)	
Facility main phone number	
Facility fax number	
Overall legally responsible facility official Title Phone number	
Health services administrator Phone number Fax number Email address	
Responsible physician Phone number	
Mental health authority (if separate from health authority) Phone number Fax number Email address	

1) What was your facility's average daily population (ADP) for 2008, inclusive of any satellites? \_\_\_\_\_

2) If your facility has any satellites, please provide the information requested below.

No satellites

Satellite Name

Miles From Main Facility

Satellite ADP (2008)

3) Are any health services provided by an outside vendor (e.g., private company, health department, university)?

NO    YES

If yes, describe: \_\_\_\_\_

If this is a change in vendor since your last AMR, please indicate the date the change was effective (month/year): \_\_\_\_\_

- 4) Is the person responsible for managing health services an outside vendor (e.g., an employee of a private company, health department, university)?  NO  YES

If yes, describe: \_\_\_\_\_

- 5) Standard E-04 Initial Health Assessment offers two options for implementing and demonstrating compliance. With the "full population assessment," assessments are performed on 100% of inmates. With the "individual assessment when clinically indicated," assessments are performed only on those determined to be at high risk for significant health problems. Which option is employed at this facility?

Full Population Assessment  Individual Assessment When Clinically Indicated

- 6) Have there been any changes in the manner of health care delivery in 2008 (e.g., closing of an infirmary, acquiring new clinic space, changes in the sick-call process)?  NO  YES

If yes, describe: \_\_\_\_\_

- 7) Does the facility have on-site opioid treatment programs or services (using methadone, buprenorphine, LAAM)?  NO  YES (If yes, indicate responsible staff member's name and phone number)

Do you provide these services through arrangements with a community agency?  NO  YES

If yes, describe: \_\_\_\_\_

- 8) Is the facility under any court order or legal agreement relating to health care (regardless of the exact legal wording)?  NO  YES

If yes, provide details \_\_\_\_\_

Since the last report:

- a) Has there been a class action suit initiated relating to health care?  NO  YES

If yes, summarize: \_\_\_\_\_

- b) Has there been any judgment against the facility regarding health care?  NO  YES

If yes, summarize: \_\_\_\_\_

- c) Has a court entered a new or amended order, judgment, or decree that relates to health services?  
 NO  YES (If yes, attach a copy)

- d) Has a master or monitor been appointed with respect to health services?  
 NO  YES (If yes, attach a copy of the most recent report)

- e) Is the facility (or system) required to report to the court regarding health services?  
 NO  YES (If yes, attach a copy of the most recent report)

To the best of my knowledge, \_\_\_\_\_ remains in compliance with the current NCCHC *Standards for Health Services in Prisons*.

Printed Name of Responsible Health Authority

Signature of Responsible Health Authority

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