NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE
P.O. Box 11117 • Chicago, Illinois 60611 • (773) 880-1460

APPLICATION AND CONTRACT FOR ACCREDITATION OF CORRECTIONAL HEALTH SERVICES

____
Legal name of facility (to appear on certificate of accreditation)

Check one: ____Jail ____Prison ____Juvenile facility

We hereby apply to the National Commission on Correctional Health Care (NCCHC) for the accreditation of the institution named above for compliance of its health services, including mental health, dental and substance abuse services, with the relevant *Standards for Health Services.* The survey and review of health care practices at this facility will be guided by the NCCHC standards (originally developed by the American Medical Association and revised by NCCHC). We agree to abide by NCCHC accreditation policies and to permit, during the site survey, private and confidential interviews with correctional officers, inmates/residents, and health care personnel; a review of all pertinent documentation, including health records; and a tour of the facility, including general population and segregated and/or other special housing areas, health care locations, and satellite locations. We acknowledge that if the facility is accredited, the health care program must be maintained during the period of accreditation. We agree to notify NCCHC in writing of any substantive change in the management of the health care program within 30 days of such change. We understand that although NCCHC may come on site at any time, a site visit will take place at least once every three years. We will submit Annual Maintenance Reports and be billed annually for approximately half the initial accreditation cost. We understand that **this application constitutes a contract for services** in the NCCHC accreditation program, and that the facility may terminate participation in the accreditation program at any time upon 60 days written notice.

____
Signature of person legally responsible Date

____
Name and title (printed or typed)

A nonrefundable check or voucher for $250, payable to the National Commission on Correctional Health Care, should accompany this application. Should this application be cancelled, the applicant agrees to be responsible for any expense incurred by NCCHC in the scheduling of the on-site visit.

____Check enclosed ____Invoice requested ($30 processing fee will be added)

Application expiration: One year from date of this application

FACILITY INFORMATION

1. ______________________________
   Name of facility

2. ______________________________
   Mailing address (if a PO Box, please also provide physical address of facility)

3. ______________________________
   City State Zip

4. Year facility was constructed __________

5. Is this a multijurisdictional facility? Yes____ No____

   If yes, which jurisdictions (i.e., counties/states) do you draw from?__________________

   ____

6. Major renovations/expansions (completed and/or in planning process):

   ____

   ____

   ____

7. Has this facility been accredited before by NCCHC? Yes____ No____

   If yes, what was the facility name?______________________________

   During which year(s) was the facility accredited?______________________________

	Name	Miles from main unit	Design-rated capacity	Most recent population
8.	Main Unit:________________________		________	________
	Satellite #1:________________________	________	________	________
	Satellite #2:________________________	________	________	________
	Satellite #3:________________________	________	________	________
	Satellite #4:________________________	________	________	________
	TOTALS:		________	________

A satellite is defined as a separate building where inmates are housed for which the main facility has both administrative and health service responsibilities, but that generally has a specific function different from the main building, such as work release.

BILLING INFORMATION

9. Invoices for accreditation should be sent to the following:

____
Name Title

____
Address

____
City State Zip

PERSONNEL INFORMATION

10. ____________________________________ (_____)_______________
Government official responsible for the facility Telephone

____
E-mail

11. ____________________________________ (_____)_______________
Physician responsible for medical care Telephone

____
E-mail

12. ____________________________________ (_____)_______________
Health administrator/supervisor Telephone

____________________________________ (_____)_______________
E-mail Fax

13. ____________________________________ (_____)_______________
Accreditation manager/coordinator Telephone
(if different from health administrator)

____________________________________ (_____)_______________
E-mail Fax

INMATE DATA

14. Total number of admissions in the prior year (or most recent 12-month period available) for main and satellite units:____________________

15. Average daily intake:____________________

16. Most recent population (main and satellite units):
Adult males__________________ Juvenile males________________
Adult females________________ Juvenile females______________
Juveniles adjudicated as adults________________

17. Is housing provided for inmates from jurisdiction other than this? Yes___ No___
If yes, what is the average daily population for nonjurisdictional inmates?

Federal/state__________ Other counties__________ Other states__________

HEALTH CARE SERVICES DATA

18. Are health services contracted? Yes____ No____
If yes, name of contractor and contract expiration date:______________________________
____
Contractor contact:____
Phone____________________Fax________________E-mail_________________________
Name of facility/system contract monitor, if any:_____________________________________

Are mental health or substance abuse services contracted to a different authority?
Yes____ No____
If yes, name of contractor and contract expiration date:______________________________
____
Contractor contact:____
Phone____________________Fax________________E-mail_________________________

19. List any special on-site health services programs (e.g., hospice, dialysis, therapeutic community for substance abusers):____
____
____
____

20. Number of health providers on-site (full-time equivalents*):

	Main Unit	Satellites			
		#1	#2	#3	#4
Administrators	________	____	____	____	____
Physicians	________	____	____	____	____
Physician assistants	________	____	____	____	____
Nurse practitioners	________	____	____	____	____
Registered nurses	________	____	____	____	____
Licensed practical nurses	________	____	____	____	____
EMTs/MAs	________	____	____	____	____
Psychologists	________	____	____	____	____
Psychiatrists	________	____	____	____	____
Dentists	________	____	____	____	____
Dental assistants	________	____	____	____	____
Dental hygienists	________	____	____	____	____
Health records personnel	________	____	____	____	____
X-ray technicians	________	____	____	____	____
Lab technicians	________	____	____	____	____
Pharmacists/pharm techs	________	____	____	____	____
Mental health workers	________	____	____	____	____
Other (specify _______________)	________	____	____	____	____

*Someone working a regular 40-hour week is considered 1.0 FTE. To calculate FTEs, take the total number of hours by employee category and divide by 40 (or the jurisdiction's equivalent of a full-time work week). For example, someone working 16 hours would be a .40 FTE (16/40=.40); 5 part-time LPNs working a total of 60 hours would be 1.5 FTE (60/40=1.5).

21. Type and hours per month of regular off-site health consultants (e.g., dentist, 10 hours):
____
____
____

22. Does the facility operate an infirmary? Yes____ No____
If yes, total number of beds:____

Medical:	Male________________	Female________________
Mental health:	Male________________	Female________________

23. Are separate housing/programs available for mental health patients? Yes____ No____
If yes, number of beds: ________________

24. List any community hospitals, clinics, or other health care facilities used for inpatient, mental health, or emergency services provided outside the facility: ________________________
____
____

25. Please describe any plans for substantial changes in the health care delivery system:
____
____
____

26. Is the facility currently involved in any of the following?

A. Legal action alleging inadequate medical or other health care for inmates
Yes____ No____ If yes, when was the action filed? ________________

Please summarize information about the case(s) and furnish a copy of any judgment, order, or decree entered by the court, as well as all master, monitor, or facility reports filed in the last 12 months. If no reports have been filed in the last 12 months, provide a copy of the last such substantive report issued.

Summary description:____
____
____
____

B. Action by a community, government, or quasigovernment/public agency or group to review or investigate health services provided at the facility? Yes____ No____
If yes, state the group's name and describe its purpose. If any reports have been issued by this group, please provide a copy.
____
____
____

27. (Jails and Prisons only) Indicate which type of health assessment (E-04) is conducted:
___Full population ___Individual assessment when clinically indicated

28. (Optional) What is your annual health services budget (current fiscal year)?

$ total	___________________
% medical services	___________________
% mental health services	___________________
% dental services	___________________
% medications	___________________

I certify that the above is true and correct to the best of my knowledge and belief.

____
Signature Date