XYZ
Civil Rights Corporate Agreement
for Participation in Medicare Part A
(Agreement)
XYZ CIVIL RIGHTS POLICIES AND PROCEDURES

A. The attached XYZ Corporation policies and procedures demonstrate XYZ’s agreement and the agreement of XYZ’s facilities to comply with the following civil rights statutes and regulations:

1. Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d-1 et seq., and its implementing regulation, Title 45 Code of Federal Regulations (CFR) Part 80, which prohibit discrimination on the ground of race, color, or national origin by recipients of Federal financial assistance (Title VI);

2. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and its implementing regulation, 45 CFR Part 84, which prohibit discrimination on the basis of handicap by recipients of Federal financial assistance (Section 504); and


B. The attached policies and procedures include:

1. The signed Form HHS-690, Assurance of Compliance with Title VI, Section 504, and the Age Act (Attachment A);

2. The designation of XYZ’s Administrator or other designee as the person to coordinate its efforts to ensure compliance with Title VI, Section 504, and the Age Act at the facility level, and the designation of XYZ’s Corporate Manager to coordinate its efforts to comply with these laws at the corporate level;

3. A list of each of XYZ’s existing facilities by name and address, with the facility Administrator’s name and telephone number (Attachment B);

4. A copy of the facilities’ Policy of Nondiscrimination under Title VI, Section 504, and the Age Act (Attachment C), which indicates that each facility provides equal access to its programs, benefits, and services and that it does not discriminate against persons qualified for its services on the basis of race, color, national origin, disability, or age;

5. A copy of the facilities’ Section 504 Grievance Procedures (Attachment D), which provides for prompt and equitable resolution of complaints including any action prohibited by the Federal regulations at 45 CFR Part 84 and includes notice of the right to file a written complaint with the Office for Civil Rights;
6. A copy of the facilities' Notice of Program Accessibility indicating the existence of services, activities, and facilities which are accessible to and usable by persons with disabilities, including the availability of auxiliary aids to persons with disabilities (Attachment E);

7. A copy of the facilities’ Policy for Providing Auxiliary Aids and Services to Persons with Disabilities, to ensure effective communication with and equal access to services to persons who are deaf, hard of hearing, blind, of low vision, and speech and manually impaired, all provided, where necessary, at no cost to such persons (Attachment F);

8. A copy of the facilities' policy and procedures for effective communication with limited English proficient persons (Attachment G), which allows for the provision of language services, including interpreter services and written materials in non-English languages, all provided, where necessary, at no cost to such persons.

9. A copy of the facilities’ Admission Policy (Attachment H);

10. A copy of the notification letter (Attachment I) that XYZ will send to its existing facilities (listed in Attachment B) and any facilities that it acquires in the future, which:

   a. Informs the Administrator that the facility is subject to the provisions and requirements of the attached polices and procedures; and

   b. Requires the Administrator to complete and timely submit the following documentation for civil rights clearance for Medicare certification in accordance with this Agreement:

      i. Acknowledgement/Certification Letter (Attachment J),

      ii. Facility-specific data sheet (Attachment K), and

      iii. Charts for listing interpreter services (Attachment L).

The notification letter will be sent to existing facilities within 30 days after the signing of this Agreement and to facilities that it acquires in the future within 30 days after the date of acquisition.

C. XYZ agrees that:

1. XYZ and its facilities will adopt and implement the attached policies and procedures.
2. The Policy of Nondiscrimination (see #4 above) will be posted at (identify location in facilities)…… and disseminated through (brochures, etc…………). 

3. Facility staff will receive training regarding the policies discussed above during orientation and at other times as appropriate.

Signature Block for XYZ
**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 policies and procedures, to your State Health Department, along with your other Medicare application materials.

### I. Healthcare Provider Information

<table>
<thead>
<tr>
<th>CMS Medicare Provider Number:</th>
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<tbody>
<tr>
<td>Name of Facility:</td>
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<tr>
<td>Address:</td>
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<tr>
<td>Street Number and Name</td>
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<tr>
<td>City or Town</td>
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<td>State or Province</td>
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<tr>
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<tr>
<td>Administrator’s Name:</td>
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<tr>
<td>Contact Person:</td>
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<td>Telephone: ( ) - TDD: ( ) -</td>
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<td>FAX: ( ) - E-mail:</td>
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<td>Type of Facility:</td>
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<td>Corporate Affiliation:</td>
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<td>Number of employees:</td>
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<td>Reason for Application:</td>
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### II. Documents Required for Submission


1. **Assurance of Compliance Form**, HHS 690 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 (see sample policy). Learn more about regulatory requirements.
3. Description of methods used to disseminate your nondiscrimination policies/notice:
   - a) Describe where you post your Nondiscrimination Policy; and
   - 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. Learn more about regulatory requirements.
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 (see sample policy). Learn more about regulatory requirements.

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.
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; and
   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
   vision, 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; and
   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. 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
Nondiscrimination Policy

As a recipient of Federal financial assistance, *(insert facility name)* does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by *(insert facility name)* directly or through a contractor or any other entity with which *(insert facility name)* arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Facility Name:

Contact Person/Section 504 Coordinator:

Telephone number:

TDD or State Relay number:
Dissemination of Nondiscrimination Policy

For the purposes of complying with the rules and regulations set forth and enforced by the Office for Civil Rights, (Insert name of facility) informs the public, patients, and employees that the agency does not discriminate on the basis of race, color, national origin, disability, or age.

(Insert name of facility) disseminates the nondiscrimination statement in the following ways:

**For the General Public:**

- A copy of the nondiscrimination statement is posted in our facility for visitors, clients/patients to view.
- The nondiscrimination statement is printed in the company brochure and is routinely distributed to patients, referral sources and the community.
- The nondiscrimination statement is included in newspaper advertisements for the facility.

**For the Patients:**

- The nondiscrimination statement is included in patient admissions packet.
- The nondiscrimination statement is discussed with patients upon their initial visit with the facility.
- A copy of the nondiscrimination statement is available upon request.

**For the Employees:**

- The nondiscrimination statement is included in employee advertisements.
- The nondiscrimination statement is included in the employee handbook.
- The nondiscrimination statement is discussed and distributed during employee orientation.
- The nondiscrimination statement is posted in employee break rooms.

(Insert name of facility) has also posted its Nondiscrimination Policy of the company website. Please visit [Provide website address here] for more details and to find additional information about (Insert name of facility).

Please view accompanying documents that incorporate the Nondiscrimination clause.
POLICY AND PROCEDURES FOR COMMUNICATION WITH PERSONS WITH LIMITED ENGLISH PROFICIENCY

POLICY:

(Insert name of your facility) will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of (Insert name of your facility) is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc. (include those documents applicable to your facility). All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.

(Insert name of your facility) will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

PROCEDURES:

1. IDENTIFYING LEP PERSONS AND THEIR LANGUAGE

(Insert name of your facility) will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or “I speak cards,” available online at www.lep.gov) or posters to determine the language. In addition, when records are kept of past interactions with patients (clients/residents) or family members, the language used to communicate with the LEP person will be included as part of the record.

2. OBTAINING A QUALIFIED INTERPRETER

(Identify responsible staff person(s), and phone number(s)) is/are responsible for:

(a) Maintaining an accurate and current list showing the name, language, phone number and hours of availability of bilingual staff (provide the list);
(b) Contacting the appropriate bilingual staff member to interpret, in the event that an interpreter is needed, if an employee who speaks the needed language is available and is qualified to interpret;
(c) Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language. (Identify the agency(s) name(s) with whom you have contracted or made arrangements) have/has
agreed to provide qualified interpreter services. The agency’s (or agencies’) telephone number(s) is/are (insert number(s)), and the hours of availability are (insert hours).

Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and after the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person’s file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person.

Children and other clients/patients/residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication.

3. PROVIDING WRITTEN TRANSLATIONS

(a) When translation of vital documents is needed, each unit in (insert name of your facility) will submit documents for translation into frequently-encountered languages to (identify responsible staff person). Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.

(b) Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.

(c) (Insert name of your facility) will set benchmarks for translation of vital documents into additional languages over time.

4. PROVIDING NOTICE TO LEP PERSONS

(Insert name of your facility) will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will understand. At a minimum, notices and signs will be posted and provided in intake areas and other points of entry, including but not limited to the emergency room, outpatient areas, etc. (include those areas applicable to your facility). Notification will also be provided through one or more of the following: outreach documents, telephone voice mail menus, local newspapers, radio and television stations, and/or community-based organizations (include those areas applicable to your facility).

5. MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

On an ongoing basis, (insert name of your facility) will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures. In addition, (insert name of your facility) will regularly assess the efficacy of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from patients and community organizations, etc. (include those areas applicable to your facility)
AUXILIARY AIDS AND SERVICES FOR PERSONS WITH DISABILITIES

POLICY:

(Insert name of your facility) will take appropriate steps to ensure that persons with disabilities, including persons who are deaf, hard of hearing, or blind, or who have other sensory or manual impairments, have an equal opportunity to participate in our services, activities, programs and other benefits. The procedures outlined below are intended to ensure effective communication with patients/clients involving their medical conditions, treatment, services and benefits. The procedures also apply to, among other types of communication, communication of information contained in important documents, including waivers of rights; consent to treatment forms, financial and insurance benefits forms, etc. (include those documents applicable to your facility). All necessary auxiliary aids and services shall be provided without cost to the person being served.

All staff will be provided written notice of this policy and procedure, and staff that may have direct contact with individuals with disabilities will be trained in effective communication techniques, including the effective use of interpreters.

PROCEDURES:

1. Identification and assessment of need:

(Insert name of your facility) provides notice of the availability of and procedure for requesting auxiliary aids and services through notices in our (brochures, handbooks, letters, print/radio /television advertisements, etc.) and through notices posted (in waiting rooms, lobbies, etc.). When an individual self-identifies as a person with a disability that affects the ability to communicate or to access or manipulate written materials or requests an auxiliary aid or service, staff will consult with the individual to determine what aids or services are necessary to provide effective communication in particular situations.

2. Provision of Auxiliary Aids and Services:

(Insert name of your facility) shall provide the following services or aids to achieve effective communication with persons with disabilities:

A. For Persons Who Are Deaf or Hard of Hearing

(i) For persons who are deaf/hard of hearing and who use sign language as their primary means of communication, the (identify responsible staff person or position with a telephone number) is responsible for providing effective interpretation or arranging for a qualified interpreter when needed.

In the event that an interpreter is needed, the (identify responsible staff person) is responsible for:

Maintaining a list of qualified interpreters on staff showing their names, phone numbers, qualifications and hours of availability (provide the list);

Contacting the appropriate interpreter on staff to interpret, if one is available and qualified to interpret; or obtaining an outside interpreter if a qualified interpreter on staff is not available. (Identify the agency(s) name with whom you have
contracted or made arrangements) has agreed to provide interpreter services. The agency's/agencies’ telephone number(s) is/are (insert number(s) and the hours of availability). [Note: If video interpreter services are provided via computer, the procedures for accessing the service must be included.]

(ii) Communicating by Telephone with Persons Who Are Deaf or Hard of Hearing

[Listed below are three methods for communicating over the telephone with persons who are deaf/hard of hearing. Select the method(s) to incorporate in your policy that best applies/apply to your facility.]

(Insert name of facility) utilizes a Telecommunication Device for the Deaf (TDD) for external communication. The telephone number for the TDD is (insert number). The TDD and instructions on how to operate it are located (insert location) in the facility; OR

(Insert name of provider) has made arrangements to share a TDD. When it is determined by staff that a TDD is needed, we contact (identify the entity e.g., library, school or university, provide address and telephone numbers); OR

(Insert name of facility) utilizes relay services for external telephone with TTY users. We accept and make calls through a relay service. The state relay service number is (insert telephone for your State Relay).

(iii) For the following auxiliary aids and services, staff will contact (responsible staff person or position and telephone number), who is responsible to provide the aids and services in a timely manner: Note-takers; computer-aided transcription services; telephone handset amplifiers; written copies of oral announcements; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning; telecommunications devices for deaf persons (TDDs); videotext displays; or other effective methods that help make aurally delivered materials available to individuals who are deaf or hard of hearing.

(iv) Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the person will not be used as interpreters unless specifically requested by that individual and after an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person’s file. If the person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided.

NOTE: Children and other residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication.

B. For Persons who are Blind or Who Have Low Vision

(i) Staff will communicate information contained in written materials concerning treatment, benefits, services, waivers of rights, and consent to treatment forms by reading out loud and explaining these forms to persons who are blind or who have
low vision [in addition to reading, this section should tell what other aids are available, where they are located, and how they are used].

The following types of large print, taped, Braille, and electronically formatted materials are available: (description of the materials available). These materials may be obtained by calling (name or position and telephone number).

(ii) For the following auxiliary aids and services, staff will contact (responsible staff person or position and telephone number), who is responsible to provide the aids and services in a timely manner:

Qualified readers; reformatting into large print; taping or recording of print materials not available in alternate format; or other effective methods that help make visually delivered materials available to individuals who are blind or who have low vision. In addition, staff are available to assist persons who are blind or who have low vision in filling out forms and in otherwise providing information in a written format.

C.  For Persons with Speech Impairments

To ensure effective communication with persons with speech impairments, staff will contact (responsible staff person or position and telephone number), who is responsible to provide the aids and services in a timely manner:

Writing materials; typewriters; TDDs; computers; flashcards; alphabet boards; communication boards; (include those aids applicable to your facility) and other communication aids.

D.  For Persons with Manual Impairments

Staff will assist those who have difficulty in manipulating print materials by holding the materials and turning pages as needed, or by providing one or more of the following: note-takers; computer-aided transcription services; speaker phones; or other effective methods that help to ensure effective communication by individuals with manual impairments. For these and other auxiliary aids and services, staff will contact (responsible staff person or position and telephone number) who is responsible to provide the aids and services in a timely manner.
SECTION 504 NOTICE OF
PROGRAM ACCESSIBILITY

Please note that this does not apply to (Name of Facility). Clients do not come to our office. Employees of (Name of Facility) meet clients in their homes.
The following procedure incorporates appropriate minimum due process standards and may serve as a sample or be adapted for use by recipients in accordance with the Departmental regulation implementing Section 504 of the Rehabilitation Act of 1973.

Section 504 GRIEVANCE PROCEDURE

It is the policy of (insert name of facility/agency) not to discriminate on the basis of disability. (Insert name of facility/agency) has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act. The Law and Regulations may be examined in the office of (insert name, title, tel. no. of Section 504 Coordinator), who has been designated to coordinate the efforts of (insert name of facility/agency) to comply with Section 504.

Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure. It is against the law for (insert name of facility/agency) to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Procedure:

Grievances must be submitted to the Section 504 Coordinator within (insert timeframe) of the date the person filing the grievance becomes aware of the alleged discriminatory action.

A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

The Section 504 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records of (insert name of facility/agency) relating to such grievances.

The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.

The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the (Administrator/Chief Executive Officer/Board of Directors/etc.) within 15 days of receiving the Section 504 Coordinator’s decision. The (Administrator/Chief Executive Officer/Board of Directors/etc.) shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from
filing a complaint of discrimination on the basis of disability with the:

U. S. Department of Health and Human Services
Office for Civil Rights

(Insert name of facility/agency) will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.
Name of Facility

Age Restrictions Statement

It is the policy of (Name of Facility) to extend services to persons over the age of 18.

(Name of Facility) does not extend services for pediatric care. The facility is not properly equipped and staff members are not trained to cater to this particular demographic.
Age Restrictions Statement

It is the policy of (Name of Facility) to not deny or restrict access to services based on an individual’s age (unless age is a factor necessary to normal operations or the achievement of any statutory objective).
XYZ
Civil Rights Corporate Agreement
for Participation in Medicare Part A
(Agreement)
XYZ CIVIL RIGHTS POLICIES AND PROCEDURES

A. The attached XYZ Corporation policies and procedures demonstrate XYZ’s agreement and the agreement of XYZ’s facilities to comply with the following civil rights statutes and regulations:

1. Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d-1 et seq., and its implementing regulation, Title 45 Code of Federal Regulations (CFR) Part 80, which prohibit discrimination on the ground of race, color, or national origin by recipients of Federal financial assistance (Title VI);

2. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and its implementing regulation, 45 CFR Part 84, which prohibit discrimination on the basis of handicap by recipients of Federal financial assistance (Section 504); and


B. The attached policies and procedures include:

1. The signed Form HHS-690, Assurance of Compliance with Title VI, Section 504, and the Age Act (Attachment A);

2. The designation of XYZ’s Administrator or other designee as the person to coordinate its efforts to ensure compliance with Title VI, Section 504, and the Age Act at the facility level, and the designation of XYZ’s Corporate Manager to coordinate its efforts to comply with these laws at the corporate level;

3. A list of each of XYZ’s existing facilities by name and address, with the facility Administrator’s name and telephone number (Attachment B);

4. A copy of the facilities’ Policy of Nondiscrimination under Title VI, Section 504, and the Age Act (Attachment C), which indicates that each facility provides equal access to its programs, benefits, and services and that it does not discriminate against persons qualified for its services on the basis of race, color, national origin, disability, or age;

5. A copy of the facilities’ Section 504 Grievance Procedures (Attachment D), which provides for prompt and equitable resolution of complaints including any action prohibited by the Federal regulations at 45 CFR Part 84 and includes notice of the right to file a written complaint with the Office for Civil Rights;
6. A copy of the facilities' Notice of Program Accessibility indicating the existence of services, activities, and facilities which are accessible to and usable by persons with disabilities, including the availability of auxiliary aids to persons with disabilities (Attachment E);

7. A copy of the facilities’ Policy for Providing Auxiliary Aids and Services to Persons with Disabilities, to ensure effective communication with and equal access to services to persons who are deaf, hard of hearing, blind, of low vision, and speech and manually impaired, all provided, where necessary, at no cost to such persons (Attachment F);

8. A copy of the facilities' policy and procedures for effective communication with limited English proficient persons (Attachment G), which allows for the provision of language services, including interpreter services and written materials in non-English languages, all provided, where necessary, at no cost to such persons.

9. A copy of the facilities’ Admission Policy (Attachment H);

10. A copy of the notification letter (Attachment I) that XYZ will send to its existing facilities (listed in Attachment B) and any facilities that it acquires in the future, which:

   a. Informs the Administrator that the facility is subject to the provisions and requirements of the attached polices and procedures; and

   b. Requires the Administrator to complete and timely submit the following documentation for civil rights clearance for Medicare certification in accordance with this Agreement:

      i. Acknowledgement/Certification Letter (Attachment J),

      ii. Facility-specific data sheet (Attachment K), and

      iii. Charts for listing interpreter services (Attachment L).

The notification letter will be sent to existing facilities within 30 days after the signing of this Agreement and to facilities that it acquires in the future within 30 days after the date of acquisition.

C. XYZ agrees that:

1. XYZ and its facilities will adopt and implement the attached policies and procedures.
2. The Policy of Nondiscrimination (see #4 above) will be posted at (identify location in facilities)…… and disseminated through (brochures, etc…………).

3. Facility staff will receive training regarding the policies discussed above during orientation and at other times as appropriate.

Signature Block for XYZ
COMPASSIONATE CARE HOSPICE GROUP, LTD.'S CIVIL RIGHTS CORPORATE AGREEMENT FOR PARTICIPATION IN MEDICARE PART A
A. The attached Compassionate Care Hospice Group, Ltd. ("CCH") policies and procedures demonstrate CCH's agreement and the agreement of CCH's facilities to comply with the following civil rights statutes and regulations:

1. Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d-1 et seq., and its implementing regulations, Title 45 Code of Federal Regulations (CFR) Part 80, which prohibit discrimination on the ground of race, color, or national origin by recipients of Federal financial assistance at Title VI;

2. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and its implementing regulations at 45 CFR Part 84, which prohibit discrimination on the basis of handicap by recipients of Federal financial assistance (Section 504); and


B. The attached policies and procedures include:

1. The signed HHS-690, Assurance of Compliance with Title VI, Section 504, and the Age Act (Attachment A);

2. The designation of each CCH facility’s Administrator or other designee as the person to coordinate its efforts to ensure compliance with Title VI, Section 504, and the Age Act at the facility level, and the designation of CCH’s Corporate Compliance Officer to coordinate its efforts with these laws at the corporate level;

3. A list of each of CCH’s existing facilities by name and address, with the facility Administrator’s name and telephone number (Attachment B);

4. A copy of the facilities’ Policy of Discrimination under Title VI, Section 504, and the Age Act (Attachment C), which indicates that each facility provides equal access to its programs, benefits, and services and that it does not discriminate against persons qualified for its services on the basis of race, color, national origin, disability, or age;

5. A copy of the facilities’ Section 504 Grievance Procedures (Attachment D), which provides for prompt and equitable resolution of complaints including any action prohibited by the Federal regulations at 45 CFR Part 84 and includes notice of the right to file a written complaint with the Office for Civil Rights;
6. A copy of the facilities’ Notice of Program Accessibility indicating the existence of services, activities, and facilities which are accessible to and usable by persons with disabilities, including the availability of auxiliary aids to persons with disabilities (Attachment E);

7. A copy of the facilities’ Policy for Providing Auxiliary Aids and Services to Persons with Disabilities, to ensure effective communication with and equal access to services to persons who are deaf, hard of hearing, blind, of low vision, and speech and manually impaired, all provided, where necessary, at no cost to such persons (Attachment F);

8. A copy of the facilities’ policy and procedures for effective communication with limited English proficient persons (Attachment G), which allows for the provision of language services, including interpreter services and written materials in non-English languages, all provided, where necessary, at no cost to such persons.

9. A copy of the facilities’ Admission Policy (Attachment H);

10. A copy of the notification letter (Attachment I) that CCH will send to its existing facilities (Listed in Attachment B) and any facilities that it acquires in the future, which:

   a. Informs the Administrator that the facility is subject to the provisions and requirements of the attached policies and procedures; and

   b. Requires the Administrator to complete and timely submit the following documentation for civil rights clearance for Medicare certification in accordance with this Agreement:

      i. Acknowledgement/Certification Letter (Attachment J),

      ii. Facility-specific data sheet (Attachment K), and

      iii. Sign Language Interpreter Form (Attachment L)

      iv. LEP Interpreter Form (Attachment M)

The notification letter will be sent to existing facilities within 30 days after the signing of the Agreement and to facilities that it acquires in the future within 30 days after the date of acquisition.

C. CCH agrees that:

1. CCH and its facilities will adopt and implement the attached policies and procedures.

2. The Policy of Nondiscrimination (see #4 above) will be posted in a common area at each facility and distributed to patients upon admission.
3. Facility staff will receive training regarding the policies discussed above during orientation and at other times as appropriate.

COMPASSIONATE CARE HOSPICE GROUP, LTD.

______________________________
Signature of Authorized Representative

______________________________
Judith Grey
Typed/Printed Name

______________________________
Chief Operating Officer
Title

______________________________
Date
ASSURANCE OF COMPLIANCE


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

Date ____________________________

Signature of Authorized Official ____________________________

Name and Title of Authorized Official (please print or type) ______________________________________

Name of Healthcare Facility Receiving/Requesting Funding ______________________________________

Street Address ______________________________________

City, State, Zip Code ______________________________________

Please mail form to:
U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201

Form HHS-690
1/09
<table>
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<tr>
<th>Legal Name</th>
<th>Address</th>
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<th>Agency Director/Contact</th>
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<td>Hospice</td>
<td>7028 Kirkwood Highway, Wilmington, DE, 19805</td>
<td>Wilmington</td>
<td>DE</td>
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<td>Susan Millman</td>
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<td>Compassionate Care Hospice of Delmar Peninsula, LLC</td>
<td>28467 DuPont Boulevard, Suite 6, Millsboro, DE, 19966</td>
<td>Millsboro</td>
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<td>19966</td>
<td>Mariani Wolske</td>
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<td>Compassionate Care Hospice of Miami Dade, Inc.</td>
<td>2393 E. F. Griffin Road, Five Dunwoody Park, Suite 118, Bartow, FL, 33830</td>
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<td>Rana McClelland</td>
<td>863-709-0099</td>
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<td>138 Canal St, Ste's 304 &amp; 305, Atlanta, GA, 30338</td>
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<td>Georgia Morris</td>
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<td>2340 Prince Avenue, Suite B, Athens, GA, 30606</td>
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<td>Debbie Furbish</td>
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<td>Compassionate Care Hospice of Northern Georgia, LLC</td>
<td>4900 Mercer University Dr., Suite 2, Macon, GA, 31210</td>
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<td>Shannon Taylor</td>
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<td>10000 West 75th Street, Suite 231, Shawnee Mission, KS, 66204</td>
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<td>Donna Rollins</td>
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<td>Compassionate Care Hospice of Kansas City, LLC</td>
<td>5417 Jackson Street, Suite B, 800 West Cummings Park, Suite 3400, Alexandria, VA, 22314</td>
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<td>VA</td>
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<td>Dana Pias</td>
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<td>Compassionate Care Hospice of Central Louisiana, LLC</td>
<td>5730 N. Lilley Road, Suite A&amp;B, Woburn, MA, 01801</td>
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<td>Casey Cuthbert-Allman</td>
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<td>Compassionate Care Hospice of Massachusetts, LLC</td>
<td>31361 State Highway 266, Canton, MI, 48187</td>
<td>Canton</td>
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<td>Brenda Kassee</td>
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<td>Compassionate Care Hospice of Michigan, LLC</td>
<td>287 North 115th Street, Worthington, MN, 56187</td>
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<td>Laurie Timmer</td>
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<td>Pathways to Compassion, LLC</td>
<td>287 North 115th Street, Omaha, NE, 68154</td>
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<td>Kathleen Hanline</td>
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<td>Compassionate Care Hospice of New Hampshire, LLC</td>
<td>25 Nashua Road, Suite E-3, Londonderry, NH, 03053</td>
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<td>Linda Hotchkiss</td>
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<td>600 Highland Drive, Suite 624, Westampton, NJ, 08060</td>
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<td>08060</td>
<td>Anthony Bolden</td>
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<td>Compassionate Care Hospice of Clifton, LLC</td>
<td>6661-6663 Broadway, Bronx, NY, 10471</td>
<td>Bronx</td>
<td>NY</td>
<td>10471</td>
<td>Robert Aberman</td>
<td>718-601-6694</td>
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<tr>
<td>Compassionate Care Hospice of Northern New Jersey</td>
<td>1513 Cedar Cliff Drive, Suite 100, Camp Hill, PA, 17011</td>
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<td>Pat Heiland</td>
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<td>Compassionate Care Hospice of Gwynedd, Inc.</td>
<td>3331 Street Road, Suite 410</td>
<td>Bensalem</td>
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<td>Compassionate Care Hospice of Northwestern Pennsylvania, LLC</td>
<td>960 North Main Avenue</td>
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<td>Compassionate Care Hospice of Pittsburgh, LLC</td>
<td>10 Duff Road, Suite 215</td>
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<td>Compassionate Care Hospice of South Carolina, LLC</td>
<td>455 St. Andrews Road, Bldg D, Suite 1</td>
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<td>Tiffany Stamps</td>
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<td>Compassionate Care Hospice of the Midwest, LLC</td>
<td>3415 North Potsdam Avenue</td>
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<td>Compassionate Care Hospice of Houston, LLC</td>
<td>2020 North Loop West, Suite 140</td>
<td>Houston</td>
<td>TX</td>
<td>77018</td>
<td>Brandi Gabriel</td>
<td>713-667-3247</td>
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<td>Compassionate Care Hospice of Southeastern Texas, LLC</td>
<td>355 N. 18th Street, Suite 104</td>
<td>Beaumont</td>
<td>TX</td>
<td>77707</td>
<td>Tim Smith</td>
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<td>13612 Midway Road, Suite 294</td>
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<td>Scott Caldwell</td>
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<td>Compassionate Care Hospice of Bryan Texas, LLC</td>
<td>3833 South Texas Avenue, Suite 100</td>
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<td>Stacey Rowse</td>
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<td>Compassionate Care Hospice of the Chesapeake Bay, LLC</td>
<td>4425 Portsmouth Blvd., Suite 110</td>
<td>Chesapeake</td>
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<td>Bryan Dinges</td>
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<td>Compassionate Care Hospice of Wisconsin, LLC</td>
<td>2514 South 102nd Street, Suite 276</td>
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<td>Linda Kritikos</td>
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<td>Compassionate Home Care of Northeastern Pennsylvania, LLC</td>
<td>281 Pierce Street</td>
<td>Kingston</td>
<td>PA</td>
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ATTACHMENT C

COMPASSIONATE CARE HOSPICE
NON-DISCRIMINATION POLICY

As a recipient of Federal financial assistance, Compassionate Care Hospice does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability or age in admission to, participation in or receipt of services and benefits under any of its programs or activities, whether carried out by Compassionate Care Hospice directly or through a contractor or any other entity with which Compassionate Care Hospice arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal regulations Parts 80, 84, and 91.

In case of questions, you may contact the Facility Administrator, who will serve as the Section 504 Coordinator; or the Corporate Compliance Officer at (973) 402-4712.
PURPOSE

To assure organizational compliance with Section 504 of the Rehabilitation Act of 1973 [29 U.S.C. 794]

POLICY

CCH does not discriminate on the basis of handicap.

It is the policy of Compassionate Care Hospice not to discriminate on the basis of disability. Compassionate Care Hospice has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 prohibits discrimination on the basis of disability in any program or activity receiving Federal financial assistance. The Law and Regulations may be examined in the office of Stella Hardy, Corporate Compliance Officer, (973) 402-4712, who has been designated to coordinate the efforts of Compassionate Care Hospice to comply with Section 504.
PROCEDURE

1. Any person who believes that he or she has been subjected to discrimination on the basis of handicap in violation of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and its implementing regulations, 45 C.F.R. parts 80, 84, and 91 may file a grievance.

2. The organization will not retaliate against any individual who files a grievance or cooperates in the investigation of a grievance.

3. Grievances must be filed to the Section 504 Coordinator within thirty (30) days of the date that the individual filing the grievance becomes aware of the alleged discriminatory action.

4. All complaints must be submitted in writing, including the name and address of the individual filing the complaint.

5. The written complaint must state the problem or action alleged to be discriminatory.

6. The written complaint must state the remedy or relief sought by the individual filing the complaint.

7. The Section 504 Coordinator/designee will conduct an investigation of the complaint to determine its validity.
   (a) The investigation may be informal.
   (b) The investigation must allow all interested parties an opportunity to submit evidence relevant to the complaint.

8. The Section 504 Coordinator will issue a written decision on the grievance no later than thirty (30) days after the complaint is filed.

9. The Section 504 Coordinator will maintain all files and records related to the complaint in the organization’s administrative files.

10. The individual filing the complaint may appeal the decision of the Section 504 Coordinator by filing an appeal in writing to the organization within fifteen (15) days of receiving the Section 504 Coordinator’s decision.

11. The organization will issue a written response to the appeal no later than thirty (30) days after the appeal is filed.
13. The organization will make appropriate arrangements to assure that disabled individuals can participate in or make use of this grievance process on the same basis as the non-disabled. His/her arrangements may include, but are not limited to, interpreters, provision of appropriate materials for deaf and/or blind individuals and a barrier free location for the proceedings.

(a) The Section 504 Coordinator will be responsible for providing such arrangements.
Attachment E

Section 504 - Notice of Program Accessibility

Compassionate Care Hospice does not service patients in its own facility. The patients are serviced in their homes, nursing homes, long term care facilities and/or what the patient considers their home, within the geographical boundaries established by Compassionate Care Hospice. If there is a need for the patient to meet with an employee, nurse, or caretaker outside of the home, Compassionate Care Hospice will make reasonable accommodations by selecting a meeting area that is accessible to those who are disabled. Auxiliary aids needed to provide effective communication between staff and the patient will also be available and present at these scheduled meetings. Patients are asked to call in advance so that appropriate arrangements can be made.

Disabled employees who require assistive devices and accessible meeting rooms in order to attend employee training, meetings and/or any other gatherings should contact the Facility Administrator to ensure appropriate arrangements will be made in a timely manner.
ATTACHMENT F

COMPASSIONATE CARE HOSPICE
AUXILIARY AIDS AND SERVICES FOR PERSONS WITH DISABILITIES

POLICY 1028

Compassionate Care Hospice will take appropriate steps to ensure that persons with disabilities, including persons who are deaf, hard of hearing or blind, or who have other sensory or manual impairments, have an equal opportunity to participate in our services, activities, programs and other benefits. The procedures outlined below are intended to ensure effective communication with patients/clients involving their medical conditions, treatment, services and benefits. The procedures also apply to, among other types of communication, communication of information contained in important documents, including waivers of rights; consent to treatment forms; financial and insurance benefits forms, etc. All necessary auxiliary aids and services shall be provided without cost to the person being served.

All staff will be provided written notices of this policy and procedure, and staff that may have direct contact with individuals with disabilities will be trained in effective communication techniques, including the effective use of interpreters.

PROCEDURES

1. Identification and Assessment of Need

Compassionate Care Hospice provides notices of the availability of and procedure for requesting auxiliary aids and services through notices in our written information and when an individual self-identifies as a person with a disability that affects the ability to communicate or to access or manipulate written materials or requests an auxiliary aid or service, staff will consult with the individual to determine what aids or services are necessary to provide effective communication in particular situations.

2. Provision of Auxiliary Aids and Services

Compassionate Care Hospice shall provide the following services or aids to achieve effective communication with persons with disabilities:

A. For Persons Who Are Deaf or Hard of Hearing

(i) For persons who are deaf/hard of hearing and who use sign language as their primary means of communication, the Facility Administrator is responsible for providing effective interpretation or arranging for a qualified interpreter when needed.
(ii) In the event a sign language interpreter is needed, the Facility Administrator is responsible for contacting the appropriate agency.

(See attachment L for Sign Language Interpreter Form).

(iii) Communicating by Telephone With Persons Who Are Deaf or Hard of Hearing

Compassionate Care Hospice utilizes relay services for external telephone with TTY users. We accept and make calls through a relay service. The service providers and numbers are:

Sprint Relay – For Provider TTY Relay Services
Customer Service: 1-800-682-8706

Access #s:
Voice: 1-800-676-3777
TTY: 1-800-676-3777
Spanish: 1-800-676-4290

(iv) For the following auxiliary aids and services, staff will contact the Facility Administrator, who is responsible to provide the aids and services in a timely manner: Note-takers, computer-aided transcription services; telephone handset amplifiers; written copies of oral announcements; assistive listening devise; assistive listening systems; telephone compatible with hearing aids; closed caption decoders; open and closed captioning; telecommunication devices for deaf persons (TDDs); videotext displays; or other effective methods that help make aurally delivered materials available to individuals who are deaf or hard of hearing.

(v) Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the person will not be used as interpreters unless specifically requested by that individual and after an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person’s file. If the person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided.

Note: Children and other residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication.

B. For Persons who are Blind or have Low Vision

(i) Staff will communicate information contained in written materials concerning treatment, benefits, services, waivers of rights, and consent to treatment forms by reading out loud and explaining these forms to persons who are blind or who have low vision.
The following types of large print materials are available: handbook, family guide and consent for treatment. These materials may be obtained by calling the compliance director at 1-888-898-8989.

(ii) For the following auxiliary aids and services, staff shall contact the Facility Administrator who is responsible to provide the aids and services in a timely manner.

Qualified readers, formatting into large print, taping or recording of print materials not available in alternate format; or other effective methods that help make visually delivered materials available to individuals who are blind or who have low vision. In addition, staff is available to assist persons who are blind or who have low vision in filling out forms and in otherwise providing information in a written format.

C. **For Persons With Speech Impairments**

To ensure effective communication with persons with speech impairments, staff will contact the Facility Administrator who is responsible to provide the following aids and services in a timely manner:

Writing materials, typewriters, TDD, Computers, flashcards, alphabet boards, communication boards and other communication aids.

D. **For Person With Manual Impairments**

Staff will assist those who have difficulty in manipulating print materials by holding the materials and turning pages as needed, or by providing one or more of the following: note-takers, computer-aided transcription services, speaker phones, or other effective methods that help to ensure effective communication by individuals with manual impairments. For these and other auxiliary aids and services, staff will contact the Facility Administrator who is responsible to provide the aids and services in a timely manner.
ATTACHMENT G

COMPASSIONATE CARE HOSPICE
POLICY AND PROCEDURE FOR COMMUNICATING WITH PERSONS WITH LIMITED ENGLISH PROFICIENCY

POLICY:

Compassionate Care Hospice will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of CCH is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waiver of rights, consent to treatment forms, financial and insurance benefit forms, etc. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or informal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.

Compassionate Care Hospice will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

PROCEDURES:

1. IDENTIFYING LEP PERSONS AND THEIR LANGUAGE

Compassionate Care Hospice will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or “I speak cards,” available online at www.lep.gov) or posters to determine the language. In addition, when records are kept of past interactions with patients (clients/residents) or family members, the language used to communicate with the LEP person will be included as part of the record.

2. OBTAINING A QUALIFIED INTERPRETER

The Facility Administrator is responsible for:

(a) Maintaining an accurate and current list showing the name, language, phone number and hours of availability of bilingual staff.
(b) Contacting the appropriate bilingual staff member to interpret, in the event that an interpreter is needed, if an employee who speaks the needed language is available and is qualified to interpret.

(c) Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language. Language Line has agreed to provide qualified interpreter services. The agency's telephone number is 1-800-752-6096 and service is available 24 hours a day/7 days per week.

(See Attachment M for LEP Interpreter Form)

Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and after the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person's file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person. (See attached chart L for a list of other interpreters).

Children and other clients/patients/residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication.

3. PROVIDING WRITTEN TRANSLATIONS

(a) When translation of vital documents is needed, Compassionate Care Hospice will submit documents for translation into frequently-encountered languages to the governing body. Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.

(b) Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.

(c) Compassionate Care Hospice will set benchmarks for translation of vital documents into additional languages over time.

4. PROVIDING NOTICE TO LEP PERSONS

Compassionate Care Hospice will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will understand. At a minimum, in the written materials they receive from Compassionate Care Hospice.

5. MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

On an ongoing basis, Compassionate Care Hospice will assess changes in demographics, types of services or other needs that may require re-evaluation of this policy and its procedures. In addition, Compassionate Care Hospice will regularly assess the efficiency of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from patients and community organizations, etc.
ATTACHMENT H

COMPASSIONATE CARE HOSPICE
ADMISSION POLICY STATEMENT

Compassionate Care Hospice accepts all patients regardless of race, color and national origin, nature of disability, age or religious background. Patients will be assessed on clinical presentation. Potential patients will be accepted if the patient’s needs can be met by Compassionate Care Hospice.
PURPOSE

To establish the process and procedure for evaluation and admission of patients into hospice or referral to another more appropriate agency.

POLICY

Patients are accepted for hospice care on the basis that the patient meets all admission criteria and that there is a reasonable expectation that the patient’s needs can be adequately met by CCH in the patient’s place of residence.

<table>
<thead>
<tr>
<th>Effective</th>
<th>Reviewed</th>
<th>Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>03-06-2008</td>
<td>01-15-2007</td>
</tr>
<tr>
<td></td>
<td>01-15-2007</td>
<td>12-01-2006</td>
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<tr>
<td></td>
<td>12-01-2006</td>
<td>04-03-2003</td>
</tr>
<tr>
<td></td>
<td>03-24-2003</td>
<td>10-01-1998</td>
</tr>
<tr>
<td></td>
<td>10-01-1998</td>
<td></td>
</tr>
</tbody>
</table>
COMPASSIONATE CARE HOSPICE

ADMISSION PROCESS
Policy No: 2002

PROCEDURE

1. Patients 18-years or older (individual sites may admit pediatric/adolescent patients when there is available staff knowledgeable of the specialized care necessary) will be accepted for care if the following criteria are met:
   (a) The patient must be under the care of a physician who will order and approve the provision of hospice care, sign a Certificate of Terminality and be willing to sign or who has a representative who will sign a death certificate.
   (b) The patient may identify a family/caregiver or legal representative who agrees to be a primary support care person if and when needed. **In the State of Delaware, a primary caregiver must be named.**
   (c) The patient has a life-threatening illness as determined by the attending physician and the hospice Medical Director.
   (d) The patient/family desire hospice services and is aware of the diagnosis and prognosis.
   (e) The focus of the care desired will be palliative, not curative.
   (f) The patient must have a prognosis of six months or less if the disease takes its normal course.
   (g) The patient/family agree to hospice care and will participate in the plan of care and sign the consent form and Election of Hospice form.
   (h) The patient/family/caregiver agrees that the hospice care will be provided primarily in the home.
   (i) The physical facilities and equipment in the patient’s home will be adequate for safe and effective care.
   (j) The patient will reside within the geographical area which CCH services.
   (k) Any person under the age of 18 must have consent signed by the parent or legal guardian.

2. Referral information provided by family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies and physician offices will assist in the determinate of eligibility for admission to the program. If the request for service is not made by the patient’s physician, he/she will be consulted prior to the evaluation visit/initiation of services.

3. During the initial assessment visit, the clinician will re-explain the philosophy, mission and purpose of hospice care and assess the patient’s eligibility for hospice services according to the admission criteria to determine/confirm:
   (a) Level of services required;
   (b) Eligibility;
   (c) Source of payment; and
   (d) Service available in defined geographic area.
ATTACHMENT I

Date:
Administrator Name:
Facility Name:
Street Address:
City, State, Zip Code:

Re: Facility Notification and Acknowledgement of Compliance with Civil Rights Statutes

Health care facilities that receive federal funds through participation in the Medicare program must comply with applicable civil rights statutes and regulations to ensure that their policies or procedures do not exclude or limit the participation of individuals on the basis of race, color, national origin, disability, or age, consistent with applicable civil rights statutes and regulations.

Compassionate Care Hospice (“CCH”) and the Office For Civil Rights (OCR) of the U.S. Department of Health and Human Services, the agency charged with enforcing the civil rights statutes and regulations, have entered into a cooperative agreement (the “Agreement”) to facilitate the civil rights clearance process for your facility.

Your facility is covered by the terms of the Agreement and subject to CCH’s signed Assurance of Compliance (HHS Form 690) and the corporate policies and procedures which, among other things, prohibit discrimination on the basis of race, color, national origin, disability and age. To finalize this process, you will be required to:

1. Post the Non-Discrimination Policy and Grievance Procedure on your bulletin board; and
2. Review, complete, sign and return the four documents listed below within the next ten (10) days, and retain a copy for your files:

   • Facility Acknowledgement of Compliance
   • Facility Specific Data Form
   • Sign Language Interpreter Form
   • LEP Interpreter Form

Your assistance with this matter is greatly appreciated. Should you have any questions or concerns, please contact me at (973) 402-4712 or shardy@cchnet.net.

Sincerely,

Stella Hardy
Director of Corporate Compliance
Compassionate Care Hospice
ATTACHMENT J

Facility Notification and Acknowledgement of Compliance

Date:
Administrator Name:
Facility Name:
Street Address:
City, State, Zip Code:

Re: Facility Acknowledgement of Compliance

Health care facilities that receive federal funds through participation in the Medicare program must comply with applicable civil rights statutes and regulations to ensure that their policies or procedures do not exclude or limit the participation of individuals in a federally-funded program. Compassionate Care Hospice (CCH) and the Office For Civil Rights, U.S. Department of Health and Human Services, have entered into a cooperative agreement (Agreement) to facilitate the civil rights clearance process for your facility.

Your facility is covered by the terms of the Agreement and subject to CCH’s signed Assurance of Compliance (HHS Form 690) and the corporate policies and procedures which, among other things, prohibit discrimination on the basis of race, color, national origin, disability and age.

Please acknowledge the facility’s adoption of and compliance with the following Compassionate Care Hospice corporate policies and procedures:

- Non-Discrimination Policy
- Section 504 Grievance Procedure
- Section 504 Notice of Program Accessibility
- Auxiliary Aids Services For Persons With Disabilities
- Policy For Communication With Persons With Limited English Proficiency
- Admission Policy

Facility Name: ___________________________________________

Acknowledged by: _________________________________________
Signature - Facility Administrator

Name: ____________________________________________________
Print

Date: __________________________

Provider #: _____________
ATTACHMENT K

Office For Civil Rights: Facility Specific Data/Documentation Requirements

Data about the Facility:

Name of Facility: (Legal and DBA name)

Address:

Administrator’s name:

Telephone number:

Fax Number:

Email Address:

Type of Facility (circle):     Home Health     Hospice

Reason For Application (circle): Initial Medicare Certification or Change of ownership

CMS Certification Number (CCN):

Certification

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

Signature: ________________________________

(Administrator)

Date: __________________________
Attachment L

Sign Language Interpreter Form
Compassionate Care Hospice

Staff Members:

We currently have:

no staff members who are qualified to interpret American Sign Language.
the following staff member(s) who are qualified to interpret American Sign Language:

Name: ____________________________
Title: ____________________________
Phone Number: ____________________
Hours of
Availability: ______________________

Name: ____________________________
Title: ____________________________
Phone Number: ____________________
Hours of
Availability: ______________________

Contractors:

The Administrator ______________________ is responsible for
(First name, last name, phone number

obtaining an outside interpreter when required.

The Administrator has chosen the following interpreter referral agency to ensure that qualified
persons with disabilities, including those with impaired hearing, can adequately communicate
with staff members:

Company/Organization: ________________________________
Contact Person: ______________________________________
Address: ____________________________________________
City/State/Zip: ________________________________________
Voicemail: __________________________________________
Email: _______________________________________________
TTY: ________________________________________________
ATTACHMENT M

LEP Interpreter Form
Compassionate Care Hospice

Staff Members:

We currently have:

no staff members who are qualified to serve as Limited English Proficiency (LEP) interpreters.
the following staff member(s) who are qualified to serve as LEP interpreters:

Name: ____________________________
Title: ____________________________
Phone Number: ____________________
Hours of Availability: ______________

Name: ____________________________
Title: ____________________________
Phone Number: ____________________
Hours of Availability: ______________

Contractors:

The Administrator ________________________________ will arrange for
(First name, last name, phone number)

LEP interpreter services when required.

The Administrator has chosen the following interpreter agency to ensure that qualified persons
with limited English proficiency can adequately communicate with staff members:

Company/Organization: __________________________________________________________
Contact Person: ________________________________________________________________
Address: _____________________________________________________________________
City/State/Zip: __________________________________________________________________
Voicemail: _____________________________________________________________________
Email: _________________________________________________________________________
TTY: _________________________________________________________________________
Facility Notification & Acknowledgement of Compliance

Date: ____________________________  Date: ____________________________
Administrator Name: _________________________ Facility Name: _________________________
Facility Name: _________________________ Street Address: _________________________
City, State, Zip code: _________________________

Re: Facility Acknowledgement of Compliance

Healthcare facilities that receive federal funds through participation in the Medicare program must comply with applicable civil rights statutes and regulations that ensure their policies or procedures do not exclude or limit the participation of individuals in a federally funded program. (Insert Your Corporation’s Name) and the Office for Civil Rights (OCR), U.S. Department of Health and Human Services, have entered into a cooperative agreement (Agreement) to facilitate the civil rights clearance for your facility.

Your facility is covered by the terms of the Agreement and subject to the (Insert Your Corporation’s Name) signed Assurance of Compliance (HHS Form 690) and the corporate policies and procedures which, among other things, prohibit discrimination on the basis of race, color, national origin, disability, or age.

Please acknowledge the facility’s adoption of and compliance with the (Insert Your Corporation’s Name) corporate policies and procedures listed below:

- Non-Discrimination Policy
- Section 504 Grievance Procedure
- Section 504 Notice of Program Accessibility
- Auxiliary Aids Services for Persons with Disabilities
- Policies and Procedures for Effective Communications with Limited English Proficiency Persons
- Admission Policy

Acknowledged by: _________________________  Date: _________________________
Executive Director

Facility Name: _________________________  Provider #: _________________________
Office for Civil Rights: Facility Specific Data/Documentation Requirements

Facility Data
Name of the Facility: __________________________________
Street Address: _______________________________________
City, State, Zip code:  __________________________________
Administrator Name: ___________________________________
504 Coordinator Name: _________________________________
Telephone Number: ____________________________________
Fax Number: _________________________________________
Email Address: _______________________________________
Type of Facility (Circle One):
  Hospital
  Nursing Facility
  Home Health, or
  Hospice
Reason for Application (Circle One):
  Initial Medicare Certification
  Change of Ownership, or
  Existing Medicare Certification but New Regional OCR Agreement

CMS Certification Medicare Number (CCN):

Certification

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

Signature: ________________________________     Date: __________________

Executive Director
ATTACHMENT L

Sign Language Interpreter Form
(Insert your corporation’s name)

We currently have:

- No staff members available who are qualified to interpret American Sign Language
- The following staff member(s) who are qualified to interpret American Sign Language

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Phone Number</th>
<th>Hours of Availability</th>
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</table>

Contractors:

The Executive Director is responsible for obtaining an outside sign language interpretation service when necessary.

The Executive Director has chosen the following sign language interpretation service to ensure that qualified deaf or hard of hearing persons can adequately communicate with staff members:

<table>
<thead>
<tr>
<th>Company</th>
<th>Contact Person</th>
<th>Street Address</th>
<th>City/State/Zip</th>
<th>TTY</th>
<th>Email</th>
</tr>
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<tbody>
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</tbody>
</table>
ATTACHMENT M

Language Interpreter Services Form
(Insert your corporation’s name)

We currently have:

- No staff members available who are qualified to serve as Limited English Proficiency (LEP)

- The following staff member(s) who are qualified to serve as Limited English Proficiency

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Language(s)</th>
<th>Phone Number</th>
<th>Hours of Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Contractors:

The Executive Director is responsible for obtaining LEP interpreter services when necessary.

The Executive Director has chosen the following interpreter agency to ensure that qualified persons with limited English proficiency can adequately communicate with staff members:

<table>
<thead>
<tr>
<th>Company</th>
<th>Contact Person</th>
<th>Street Address</th>
<th>City/State/Zip</th>
<th>TTY</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
SECTION 504 NOTICE OF
PROGRAM ACCESSIBILITY

Please note that this does not apply to (Name of Facility). Clients do not come to our office. Employees of (Name of Facility) meet clients in their homes.
**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 policies and procedures, to your State Health Department, along with your other Medicare application materials.

### I. Healthcare Provider Information

<table>
<thead>
<tr>
<th>CMS Medicare Provider Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Facility:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
</tr>
</tbody>
</table>

- Street Number and Name
- City or Town
- State or Province
- Zip Code

<table>
<thead>
<tr>
<th>Administrator’s Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contact Person:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone: (     ) -</td>
</tr>
<tr>
<td>FAX: (     ) -</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Facility:</th>
</tr>
</thead>
</table>

| Number of employees: |

<table>
<thead>
<tr>
<th>Corporate Affiliation:</th>
</tr>
</thead>
</table>

| Reason for Application: |

Circle One
- Initial Medicare or Change of Certification Ownership

### II. Documents Required for Submission

**Additional guidance is available at:** ([http://www.hhs.gov/ocr/civilrights/clearance/index.html](http://www.hhs.gov/ocr/civilrights/clearance/index.html))

| 1. | Assuurance of Compliance Form, HHS 690 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 (see sample policy). [Learn more about regulatory requirements](#). |
| 3. | Description of methods used to disseminate your nondiscrimination policies/notifications: |
| | a) Describe where you post your Nondiscrimination Policy; and |
| | 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. [Learn more about regulatory requirements](#). |
| 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 (see sample policy). [Learn more about regulatory requirements](#). |

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.
<table>
<thead>
<tr>
<th>7.</th>
<th>Procedures to effectively communicate with persons who are limited English proficient (LEP), including:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Process for how you identify individuals who need language assistance;</td>
</tr>
<tr>
<td>b)</td>
<td>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);</td>
</tr>
<tr>
<td>c)</td>
<td>Methods to inform LEP persons that language assistance services are available at no cost to the person being served;</td>
</tr>
<tr>
<td>d)</td>
<td>Appropriate restrictions on the use of family and friends as LEP interpreters; and</td>
</tr>
<tr>
<td>e)</td>
<td>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</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8.</th>
<th>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:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Process to identify individuals who need sign language interpreters or other assistive services;</td>
</tr>
<tr>
<td>b)</td>
<td>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);</td>
</tr>
<tr>
<td>c)</td>
<td>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;</td>
</tr>
<tr>
<td>d)</td>
<td>A list of available auxiliary aids and services;</td>
</tr>
<tr>
<td>e)</td>
<td>Methods to inform persons that interpreter or other assistive services are available at no cost to the person being served; and</td>
</tr>
<tr>
<td>f)</td>
<td>Appropriate restrictions on the use of family and friends as sign language interpreters (see sample policy). Learn more about regulatory requirements</td>
</tr>
</tbody>
</table>

| 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. Certification

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

<table>
<thead>
<tr>
<th>Name and Title of Authorized Official</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
Nondiscrimination Policy

As a recipient of Federal financial assistance, *(insert facility name)* does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by *(insert facility name)* directly or through a contractor or any other entity with which *(insert facility name)* arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Facility Name:

Contact Person/Section 504 Coordinator:

Telephone number:

TDD or State Relay number:
Dissemination of Nondiscrimination Policy

For the purposes of complying with the rules and regulations set forth and enforced by the Office for Civil Rights, (Insert name of facility) informs the public, patients, and employees that the agency does not discriminate on the basis of race, color, national origin, disability, or age.

(Insert name of facility) disseminates the nondiscrimination statement in the following ways:

For the General Public:

- A copy of the nondiscrimination statement is posted in our facility for visitors, clients/patients to view.
- The nondiscrimination statement is printed in the company brochure and is routinely distributed to patients, referral sources and the community.
- The nondiscrimination statement is included in newspaper advertisements for the facility.

For the Patients:

- The nondiscrimination statement is included in patient admissions packet.
- The nondiscrimination statement is discussed with patients upon their initial visit with the facility.
- A copy of the nondiscrimination statement is available upon request.

For the Employees:

- The nondiscrimination statement is included in employee advertisements.
- The nondiscrimination statement is included in the employee handbook.
- The nondiscrimination statement is discussed and distributed during employee orientation.
- The nondiscrimination statement is posted in employee break rooms.

(Insert name of facility) has also posted its Nondiscrimination Policy of the company website. Please visit [Provide website address here] for more details and to find additional information about (Insert name of facility).

Please view accompanying documents that incorporate the Nondiscrimination clause.
POLICY AND PROCEDURES FOR COMMUNICATION WITH PERSONS WITH LIMITED ENGLISH PROFICIENCY

POLICY:

(Insert name of your facility) will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of (Insert name of your facility) is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc. (include those documents applicable to your facility). All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.

(Insert name of your facility) will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

PROCEDURES:

1. IDENTIFYING LEP PERSONS AND THEIR LANGUAGE

(Insert name of your facility) will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or “I speak cards,” available online at www.lep.gov) or posters to determine the language. In addition, when records are kept of past interactions with patients (clients/residents) or family members, the language used to communicate with the LEP person will be included as part of the record.

2. OBTAINING A QUALIFIED INTERPRETER

(Identify responsible staff person(s), and phone number(s)) is/are responsible for:

(a) Maintaining an accurate and current list showing the name, language, phone number and hours of availability of bilingual staff (provide the list);
(b) Contacting the appropriate bilingual staff member to interpret, in the event that an interpreter is needed, if an employee who speaks the needed language is available and is qualified to interpret;
(c) Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language. (Identify the agency(s) name(s) with whom you have contracted or made arrangements) have/has
agreed to provide qualified interpreter services. The agency’s (or agencies’) telephone number(s) is/are (insert number(s)), and the hours of availability are (insert hours).

Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and after the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person’s file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person.

Children and other clients/patients/residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication.

3. PROVIDING WRITTEN TRANSLATIONS

(a) When translation of vital documents is needed, each unit in (insert name of your facility) will submit documents for translation into frequently-encountered languages to (identify responsible staff person). Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.

(b) Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.

(c) (Insert name of your facility) will set benchmarks for translation of vital documents into additional languages over time.

4. PROVIDING NOTICE TO LEP PERSONS

(Insert name of your facility) will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will understand. At a minimum, notices and signs will be posted and provided in intake areas and other points of entry, including but not limited to the emergency room, outpatient areas, etc. (include those areas applicable to your facility). Notification will also be provided through one or more of the following: outreach documents, telephone voice mail menus, local newspapers, radio and television stations, and/or community-based organizations (include those areas applicable to your facility).

5. MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

On an ongoing basis, (insert name of your facility) will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures. In addition, (insert name of your facility) will regularly assess the efficacy of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from patients and community organizations, etc. (include those areas applicable to your facility)
AUXILIARY AIDS AND SERVICES FOR PERSONS WITH DISABILITIES

POLICY:

(Insert name of your facility) will take appropriate steps to ensure that persons with disabilities, including persons who are deaf, hard of hearing, or blind, or who have other sensory or manual impairments, have an equal opportunity to participate in our services, activities, programs and other benefits. The procedures outlined below are intended to ensure effective communication with patients/clients involving their medical conditions, treatment, services and benefits. The procedures also apply to, among other types of communication, communication of information contained in important documents, including waivers of rights; consent to treatment forms, financial and insurance benefits forms, etc. (include those documents applicable to your facility). All necessary auxiliary aids and services shall be provided without cost to the person being served.

All staff will be provided written notice of this policy and procedure, and staff that may have direct contact with individuals with disabilities will be trained in effective communication techniques, including the effective use of interpreters.

PROCEDURES:

1. Identification and assessment of need:

(Insert name of your facility) provides notice of the availability of and procedure for requesting auxiliary aids and services through notices in our (brochures, handbooks, letters, print/radio /television advertisements, etc.) and through notices posted (in waiting rooms, lobbies, etc.). When an individual self-identifies as a person with a disability that affects the ability to communicate or to access or manipulate written materials or requests an auxiliary aid or service, staff will consult with the individual to determine what aids or services are necessary to provide effective communication in particular situations.

2. Provision of Auxiliary Aids and Services:

(Insert name of your facility) shall provide the following services or aids to achieve effective communication with persons with disabilities:

A. For Persons Who Are Deaf or Hard of Hearing

(i) For persons who are deaf/hard of hearing and who use sign language as their primary means of communication, the (identify responsible staff person or position with a telephone number) is responsible for providing effective interpretation or arranging for a qualified interpreter when needed.

In the event that an interpreter is needed, the (identify responsible staff person) is responsible for:

- Maintaining a list of qualified interpreters on staff showing their names, phone numbers, qualifications and hours of availability (provide the list);
- Contacting the appropriate interpreter on staff to interpret, if one is available and qualified to interpret; or obtaining an outside interpreter if a qualified interpreter on staff is not available. (Identify the agency(s) name with whom you have
contracted or made arrangements) has agreed to provide interpreter services. The agency's/agencies’ telephone number(s) is/are (insert number(s) and the hours of availability). [Note: If video interpreter services are provided via computer, the procedures for accessing the service must be included.]

(ii) Communicating by Telephone with Persons Who Are Deaf or Hard of Hearing

[Listed below are three methods for communicating over the telephone with persons who are deaf/hard of hearing. Select the method(s) to incorporate in your policy that best applies/apply to your facility.]

(Insert name of facility) utilizes a Telecommunication Device for the Deaf (TDD) for external communication. The telephone number for the TDD is (insert number). The TDD and instructions on how to operate it are located (insert location) in the facility; OR

(Insert name of provider) has made arrangements to share a TDD. When it is determined by staff that a TDD is needed, we contact (identify the entity e.g., library, school or university, provide address and telephone numbers); OR

(Insert name of facility) utilizes relay services for external telephone with TTY users. We accept and make calls through a relay service. The state relay service number is (insert telephone for your State Relay).

(iii) For the following auxiliary aids and services, staff will contact (responsible staff person or position and telephone number), who is responsible to provide the aids and services in a timely manner: Note-takers; computer-aided transcription services; telephone handset amplifiers; written copies of oral announcements; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning; telecommunications devices for deaf persons (TDDs); videotext displays; or other effective methods that help make aurally delivered materials available to individuals who are deaf or hard of hearing.

(iv) Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the person will not be used as interpreters unless specifically requested by that individual and after an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person’s file. If the person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided.

NOTE: Children and other residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication.

B. For Persons who are Blind or Who Have Low Vision

(i) Staff will communicate information contained in written materials concerning treatment, benefits, services, waivers of rights, and consent to treatment forms by reading out loud and explaining these forms to persons who are blind or who have
low vision [in addition to reading, this section should tell what other aids are available, where they are located, and how they are used].

The following types of large print, taped, Braille, and electronically formatted materials are available: **(description of the materials available)**. These materials may be obtained by calling **(name or position and telephone number)**.

(ii) For the following auxiliary aids and services, staff will contact **(responsible staff person or position and telephone number)**, who is responsible to provide the aids and services in a timely manner:

- Qualified readers;
- Reformatting into large print;
- Taping or recording of print materials not available in alternate format;
- Or other effective methods that help make visually delivered materials available to individuals who are blind or who have low vision. In addition, staff are available to assist persons who are blind or who have low vision in filling out forms and in otherwise providing information in a written format.

**C. For Persons with Speech Impairments**

To ensure effective communication with persons with speech impairments, staff will contact **(responsible staff person or position and telephone number)**, who is responsible to provide the aids and services in a timely manner:

- Writing materials;
- Typewriters;
- TDDs;
- Computers;
- Flashcards;
- Alphabet boards;
- Communication boards; **(include those aids applicable to your facility)** and other communication aids.

**D. For Persons with Manual Impairments**

Staff will assist those who have difficulty in manipulating print materials by holding the materials and turning pages as needed, or by providing one or more of the following: note-takers; computer-aided transcription services; speaker phones; or other effective methods that help to ensure effective communication by individuals with manual impairments. For these and other auxiliary aids and services, staff will contact **(responsible staff person or position and telephone number)** who is responsible to provide the aids and services in a timely manner.
SECTION 504 NOTICE OF PROGRAM ACCESSIBILITY

Please note that this does not apply to (Name of Facility). Clients do not come to our office. Employees of (Name of Facility) meet clients in their homes.
The following procedure incorporates appropriate minimum due process standards and may serve as a sample or be adapted for use by recipients in accordance with the Departmental regulation implementing Section 504 of the Rehabilitation Act of 1973.

Section 504 GRIEVANCE PROCEDURE

It is the policy of (insert name of facility/agency) not to discriminate on the basis of disability. (Insert name of facility/agency) has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act. The Law and Regulations may be examined in the office of (insert name, title, tel. no. of Section 504 Coordinator), who has been designated to coordinate the efforts of (insert name of facility/agency) to comply with Section 504.

Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure. It is against the law for (insert name of facility/agency) to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Procedure:

Grievances must be submitted to the Section 504 Coordinator within (insert timeframe) of the date the person filing the grievance becomes aware of the alleged discriminatory action.

A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

The Section 504 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records of (insert name of facility/agency) relating to such grievances.

The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.

The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the (Administrator/Chief Executive Officer/Board of Directors/etc.) within 15 days of receiving the Section 504 Coordinator’s decision. The (Administrator/Chief Executive Officer/Board of Directors/etc.) shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from
filing a complaint of discrimination on the basis of disability with the:

U. S. Department of Health and Human Services
Office for Civil Rights

(Insert name of facility/agency) will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.
Age Restrictions Statement

It is the policy of (Name of Facility) to extend services to persons over the age of 18.

(Name of Facility) does not extend services for pediatric care. The facility is not properly equipped and staff members are not trained to cater to this particular demographic.
Name of Facility

Age Restrictions Statement

It is the policy of (Name of Facility) to not deny or restrict access to services based on an individual’s age (unless age is a factor necessary to normal operations or the achievement of any statutory objective).
XYZ
Civil Rights Corporate Agreement for Participation in Medicare Part A (Agreement)
XYZ CIVIL RIGHTS POLICIES AND PROCEDURES

A. The attached XYZ Corporation policies and procedures demonstrate XYZ’s agreement and the agreement of XYZ’s facilities to comply with the following civil rights statutes and regulations:

1. Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d-1 et seq., and its implementing regulation, Title 45 Code of Federal Regulations (CFR) Part 80, which prohibit discrimination on the ground of race, color, or national origin by recipients of Federal financial assistance (Title VI);

2. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and its implementing regulation, 45 CFR Part 84, which prohibit discrimination on the basis of handicap by recipients of Federal financial assistance (Section 504); and


B. The attached policies and procedures include:

1. The signed Form HHS-690, Assurance of Compliance with Title VI, Section 504, and the Age Act (Attachment A);

2. The designation of XYZ’s Administrator or other designee as the person to coordinate its efforts to ensure compliance with Title VI, Section 504, and the Age Act at the facility level, and the designation of XYZ’s Corporate Manager to coordinate its efforts to comply with these laws at the corporate level;

3. A list of each of XYZ’s existing facilities by name and address, with the facility Administrator’s name and telephone number (Attachment B);

4. A copy of the facilities’ Policy of Nondiscrimination under Title VI, Section 504, and the Age Act (Attachment C), which indicates that each facility provides equal access to its programs, benefits, and services and that it does not discriminate against persons qualified for its services on the basis of race, color, national origin, disability, or age;

5. A copy of the facilities’ Section 504 Grievance Procedures (Attachment D), which provides for prompt and equitable resolution of complaints including any action prohibited by the Federal regulations at 45 CFR Part 84 and includes notice of the right to file a written complaint with the Office for Civil Rights;
6. A copy of the facilities' Notice of Program Accessibility indicating the existence of services, activities, and facilities which are accessible to and usable by persons with disabilities, including the availability of auxiliary aids to persons with disabilities (Attachment E);

7. A copy of the facilities’ Policy for Providing Auxiliary Aids and Services to Persons with Disabilities, to ensure effective communication with and equal access to services to persons who are deaf, hard of hearing, blind, of low vision, and speech and manually impaired, all provided, where necessary, at no cost to such persons (Attachment F);

8. A copy of the facilities' policy and procedures for effective communication with limited English proficient persons (Attachment G), which allows for the provision of language services, including interpreter services and written materials in non-English languages, all provided, where necessary, at no cost to such persons.

9. A copy of the facilities’ Admission Policy (Attachment H);

10. A copy of the notification letter (Attachment I) that XYZ will send to its existing facilities (listed in Attachment B) and any facilities that it acquires in the future, which:

   a. Informs the Administrator that the facility is subject to the provisions and requirements of the attached polices and procedures; and

   b. Requires the Administrator to complete and timely submit the following documentation for civil rights clearance for Medicare certification in accordance with this Agreement:

      i. Acknowledgement/Certification Letter (Attachment J),

      ii. Facility-specific data sheet (Attachment K), and

      iii. Charts for listing interpreter services (Attachment L).

The notification letter will be sent to existing facilities within 30 days after the signing of this Agreement and to facilities that it acquires in the future within 30 days after the date of acquisition.

C. XYZ agrees that:

1. XYZ and its facilities will adopt and implement the attached policies and procedures.
2. The Policy of Nondiscrimination (see #4 above) will be posted at (identify location in facilities)…… and disseminated through (brochures, etc………….).

3. Facility staff will receive training regarding the policies discussed above during orientation and at other times as appropriate.

Signature Block for XYZ
COMPASSIONATE CARE HOSPICE GROUP, LTD.’S CIVIL RIGHTS CORPORATE AGREEMENT FOR PARTICIPATION IN MEDICARE PART A
COMPASSIONATE CARE HOSPICE GROUP, LTD.'S
CIVIL RIGHTS POLICIES AND PROCEDURES

A. The attached Compassionate Care Hospice Group, Ltd. ("CCH") policies and procedures demonstrate CCH’s agreement and the agreement of CCH’s facilities to comply with the following civil rights statutes and regulations:

1. Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d-1 et seq., and its implementing regulations, Title 45 Code of Federal Regulations (CFR) Part 80, which prohibit discrimination on the ground of race, color, or national origin by recipients of Federal financial assistance at Title VI;

2. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and its implementing regulations at 45 CFR Part 84, which prohibit discrimination on the basis of handicap by recipients of Federal financial assistance (Section 504); and


B. The attached policies and procedures include:

1. The signed HHS-690, Assurance of Compliance with Title VI, Section 504, and the Age Act (Attachment A);

2. The designation of each CCH facility’s Administrator or other designee as the person to coordinate its efforts to ensure compliance with Title VI, Section 504, and the Age Act at the facility level, and the designation of CCH’s Corporate Compliance Officer to coordinate its efforts with these laws at the corporate level;

3. A list of each of CCH’s existing facilities by name and address, with the facility Administrator’s name and telephone number (Attachment B);

4. A copy of the facilities’ Policy of Discrimination under Title VI, Section 504, and the Age Act (Attachment C), which indicates that each facility provides equal access to its programs, benefits, and services and that it does not discriminate against persons qualified for its services on the basis of race, color, national origin, disability, or age;

5. A copy of the facilities’ Section 504 Grievance Procedures (Attachment D), which provides for prompt and equitable resolution of complaints including any action prohibited by the Federal regulations at 45 CFR Part 84 and includes notice of the right to file a written complaint with the Office for Civil Rights;
6. A copy of the facilities’ Notice of Program Accessibility indicating the existence of services, activities, and facilities which are accessible to and usable by persons with disabilities, including the availability of auxiliary aids to persons with disabilities (Attachment E);

7. A copy of the facilities’ Policy for Providing Auxiliary Aids and Services to Persons with Disabilities, to ensure effective communication with and equal access to services to persons who are deaf, hard of hearing, blind, of low vision, and speech and manually impaired, all provided, where necessary, at no cost to such persons (Attachment F);

8. A copy of the facilities’ policy and procedures for effective communication with limited English proficient persons (Attachment G), which allows for the provision of language services, including interpreter services and written materials in non-English languages, all provided, where necessary, at no cost to such persons.

9. A copy of the facilities’ Admission Policy (Attachment H);

10. A copy of the notification letter (Attachment I) that CCH will send to its existing facilities (Listed in Attachment B) and any facilities that it acquires in the future, which:

   a. Informs the Administrator that the facility is subject to the provisions and requirements of the attached policies and procedures; and

   b. Requires the Administrator to complete and timely submit the following documentation for civil rights clearance for Medicare certification in accordance with this Agreement:

      i. Acknowledgement/Certification Letter (Attachment J),

      ii. Facility-specific data sheet (Attachment K), and

      iii. Sign Language Interpreter Form (Attachment L)

      iv. LEP Interpreter Form (Attachment M)

The notification letter will be sent to existing facilities within 30 days after the signing of the Agreement and to facilities that it acquires in the future within 30 days after the date of acquisition.

C. CCH agrees that:

1. CCH and its facilities will adopt and implement the attached policies and procedures.

2. The Policy of Nondiscrimination (see #4 above) will be posted in a common area at each facility and distributed to patients upon admission.
3. Facility staff will receive training regarding the policies discussed above during orientation and at other times as appropriate.

COMPASSIONATE CARE HOSPICE GROUP, LTD.

Signature of Authorized Representative

Judith Grey
Typed/Printed Name

Chief Operating Officer
Title

Date
ASSURANCE OF COMPLIANCE


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assigns for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

Date

Signature of Authorized Official

Name and Title of Authorized Official (please print or type)

Name of Healthcare Facility Receiving/Requesting Funding

Street Address

City, State, Zip Code

Please mail form to:
U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201

Form HHS-690
1/09
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<thead>
<tr>
<th>Legal Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Agency Director/Contact</th>
<th>Phone</th>
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<td>Hospice</td>
<td>7028 Kirkwood Highway, Suite 6</td>
<td>Wilmington</td>
<td>DE</td>
<td>19805</td>
<td>Susan Millman</td>
<td>302-993-9090</td>
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<td>28467 DuPont Boulevard, Suite 6</td>
<td>Millsboro</td>
<td>DE</td>
<td>19966</td>
<td>Mariann Wolske</td>
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<td>Bartow</td>
<td>FL</td>
<td>33830</td>
<td>Rana McClelland</td>
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<td>138 Canal St, Ste's 304 &amp; 305</td>
<td>Atlanta</td>
<td>GA</td>
<td>30338</td>
<td>Georgia Morris</td>
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<td>30606</td>
<td>Debbie Furbish</td>
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<td>56187</td>
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<td>600 Highland Drive, Suite 624</td>
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<td>NJ</td>
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<td>NY</td>
<td>10471</td>
<td>Robert Aberman</td>
<td>718-601-6694</td>
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<td>PA</td>
<td>17011</td>
<td>Pat Heiland</td>
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<td>State</td>
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<tr>
<td>Compassionate Care Hospice of Gwynedd, Inc.</td>
<td>3331 Street Road, Suite 410</td>
<td>Bensalem</td>
<td>PA</td>
<td>19020</td>
<td>Kathy Moskowitz</td>
<td>215-245-3525</td>
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<tr>
<td>Compassionate Care Hospice of Northwestern Pennsylvania, LLC</td>
<td>960 North Main Avenue</td>
<td>Scranton</td>
<td>PA</td>
<td>18508</td>
<td>Karen Kaville</td>
<td>570-346-2241</td>
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<tr>
<td>Compassionate Care Hospice of Pittsburgh, LLC</td>
<td>10 Duff Road, Suite 215</td>
<td>Penn Hills</td>
<td>PA</td>
<td>15235</td>
<td>Caitlin McNamee</td>
<td>724-869-2000</td>
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<tr>
<td>Compassionate Care Hospice of South Carolina, LLC</td>
<td>455 St. Andrews Road, Bldg D, Suite 1</td>
<td>Columbia</td>
<td>SC</td>
<td>29120</td>
<td>Tiffany Stamps</td>
<td>803-731-8110</td>
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<tr>
<td>Compassionate Care Hospice of the Midwest, LLC</td>
<td>3415 North Potsdam Avenue, 2020 North Loop West, Suite 140</td>
<td>Sioux Falls</td>
<td>SD</td>
<td>57104</td>
<td>Laurie Timmer</td>
<td>605-338-2066</td>
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<tr>
<td>Compassionate Care Hospice of Houston, LLC</td>
<td>355 N. 18th Street, Suite 104</td>
<td>Houston</td>
<td>TX</td>
<td>77018</td>
<td>Brandi Gabriel</td>
<td>713-667-3247</td>
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<tr>
<td>Compassionate Care Hospice of Southeastern Texas, LLC</td>
<td>13612 Midway Road, Suite 294</td>
<td>Beaumont</td>
<td>TX</td>
<td>77707</td>
<td>Tim Smith</td>
<td>409-835-3300</td>
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<tr>
<td>Compassionate Care Hospice of North Texas, LLC</td>
<td>3833 South Texas Avenue, Suite 100</td>
<td>Dallas</td>
<td>TX</td>
<td>75244</td>
<td>Scott Caldwell</td>
<td>972-547-3600</td>
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<tr>
<td>Compassionate Care Hospice of Bryan Texas, LLC</td>
<td>4425 Portsmouth Blvd., Suite 110</td>
<td>Bryan</td>
<td>TX</td>
<td>77802</td>
<td>Stacey Rowse</td>
<td>979-260-9700</td>
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<tr>
<td>Compassionate Care Hospice of the Chesapeake Bay, LLC</td>
<td>2514 South 102nd Street, Suite 276</td>
<td>Chesapeake</td>
<td>VA</td>
<td>23321</td>
<td>Bryan Dingus</td>
<td>757-405-3203</td>
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<td>Compassionate Care Hospice of Wisconsin, LLC</td>
<td></td>
<td>West Allis</td>
<td>WI</td>
<td>53227</td>
<td>Linda Kritikos</td>
<td>414-257-1708</td>
</tr>
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</table>

*Home Health Facility*

<table>
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<tr>
<th>Services</th>
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<th>State</th>
<th>Zip</th>
<th>Contact Person</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassionate Home Care of Northeastern Pennsylvania, LLC</td>
<td>281 Pierce Street</td>
<td>Kingston</td>
<td>PA</td>
<td>18704</td>
<td>Michele Taylor</td>
<td>570-287-2330</td>
</tr>
</tbody>
</table>
ATTACHMENT C

COMPASSIONATE CARE HOSPICE
NON-DISCRIMINATION POLICY

As a recipient of Federal financial assistance, Compassionate Care Hospice does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability or age in admission to, participation in or receipt of services and benefits under any of its programs or activities, whether carried out by Compassionate Care Hospice directly or through a contractor or any other entity with which Compassionate Care Hospice arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal regulations Parts 80, 84, and 91.

In case of questions, you may contact the Facility Administrator, who will serve as the Section 504 Coordinator; or the Corporate Compliance Officer at (973) 402-4712.
ATTACHMENT D

PURPOSE

To assure organizational compliance with Section 504 of the Rehabilitation Act of 1973 [29 U.S.C. 794]

POLICY

CCH does not discriminate on the basis of handicap.

It is the policy of Compassionate Care Hospice not to discriminate on the basis of disability. Compassionate Care Hospice has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 prohibits discrimination on the basis of disability in any program or activity receiving Federal financial assistance. The Law and Regulations may be examined in the office of Stella Hardy, Corporate Compliance Officer, (973) 402-4712, who has been designated to coordinate the efforts of Compassionate Care Hospice to comply with Section 504.
PROCEDURE

1. Any person who believes that he or she has been subjected to discrimination on the basis of handicap in violation of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and its implementing regulations, 45 C.F.R. parts 80, 84, and 91 may file a grievance.

2. The organization will not retaliate against any individual who files a grievance or cooperates in the investigation of a grievance.

3. Grievances must be filed to the Section 504 Coordinator within thirty (30) days of the date that the individual filing the grievance becomes aware of the alleged discriminatory action.

4. All complaints must be submitted in writing, including the name and address of the individual filing the complaint.

5. The written complaint must state the problem or action alleged to be discriminatory.

6. The written complaint must state the remedy or relief sought by the individual filing the complaint.

7. The Section 504 Coordinator/designee will conduct an investigation of the complaint to determine its validity.
   (a) The investigation may be informal.
   (b) The investigation must allow all interested parties an opportunity to submit evidence relevant to the complaint.

8. The Section 504 Coordinator will issue a written decision on the grievance no later than thirty (30) days after the complaint is filed.

9. The Section 504 Coordinator will maintain all files and records related to the complaint in the organization’s administrative files.

10. The individual filing the complaint may appeal the decision of the Section 504 Coordinator by filing an appeal in writing to the organization within fifteen (15) days of receiving the Section 504 Coordinator’s decision.

11. The organization will issue a written response to the appeal no later than thirty (30) days after the appeal is filed.
13. The organization will make appropriate arrangements to assure that disabled individuals can participate in or make use of this grievance process on the same basis as the non-disabled. His/her arrangements may include, but are not limited to, interpreters, provision of appropriate materials for deaf and/or blind individuals and a barrier free location for the proceedings.

(a) The Section 504 Coordinator will be responsible for providing such arrangements.
Attachment E

Section 504 - Notice of Program Accessibility

Compassionate Care Hospice does not service patients in its own facility. The patients are serviced in their homes, nursing homes, long term care facilities and/or what the patient considers their home, within the geographical boundaries established by Compassionate Care Hospice. If there is a need for the patient to meet with an employee, nurse, or caretaker outside of the home, Compassionate Care Hospice will make reasonable accommodations by selecting a meeting area that is accessible to those who are disabled. Auxiliary aids needed to provide effective communication between staff and the patient will also be available and present at these scheduled meetings. Patients are asked to call in advance so that appropriate arrangements can be made.

Disabled employees who require assistive devices and accessible meeting rooms in order to attend employee training, meetings and/or any other gatherings should contact the Facility Administrator to ensure appropriate arrangements will be made in a timely manner.
ATTACHMENT F

COMPASSIONATE CARE HOSPICE
AUXILIARY AIDS AND SERVICES FOR PERSONS WITH DISABILITIES

POLICY 1028

Compassionate Care Hospice will take appropriate steps to ensure that persons with disabilities, including persons who are deaf, hard of hearing or blind, or who have other sensory or manual impairments, have an equal opportunity to participate in our services, activities, programs and other benefits. The procedures outlined below are intended to ensure effective communication with patients/clients involving their medical conditions, treatment, services and benefits. The procedures also apply to, among other types of communication, communication of information contained in important documents, including waivers of rights; consent to treatment forms; financial and insurance benefits forms, etc. All necessary auxiliary aids and services shall be provided without cost to the person being served.

All staff will be provided written notices of this policy and procedure, and staff that may have direct contact with individuals with disabilities will be trained in effective communication techniques, including the effective use of interpreters.

PROCEDURES

1. Identification and Assessment of Need

Compassionate Care Hospice provides notices of the availability of and procedure for requesting auxiliary aids and services through notices in our written information and when an individual self-identifies as a person with a disability that affects the ability to communicate or to access or manipulate written materials or requests an auxiliary aid or service, staff will consult with the individual to determine what aids or services are necessary to provide effective communication in particular situations.

2. Provision of Auxiliary Aids and Services

Compassionate Care Hospice shall provide the following services or aids to achieve effective communication with persons with disabilities:

A. For Persons Who Are Deaf or Hard of Hearing

(i) For persons who are deaf/hard of hearing and who use sign language as their primary means of communication, the Facility Administrator is responsible for providing effective interpretation or arranging for a qualified interpreter when needed.
(ii) In the event a sign language interpreter is needed, the Facility Administrator is responsible for contacting the appropriate agency.

(See attachment L for Sign Language Interpreter Form).

(iii) **Communicating by Telephone With Persons Who Are Deaf or Hard of Hearing**

Compassionate Care Hospice utilizes relay services for external telephone with TTY users. We accept and make calls through a relay service. The service providers and numbers are:

Sprint Relay – For Provider TTY Relay Services  
Customer Service: 1-800-682-8706

Access #s:  
Voice: 1-800-676-3777  
TTY: 1-800-676-3777  
Spanish: 1-800-676-4290

(iv) For the following auxiliary aids and services, staff will contact the Facility Administrator, who is responsible to provide the aids and services in a timely manner: Note-takers, computer-aided transcription services; telephone handset amplifiers; written copies of oral announcements; assistive listening devise; assistive listening systems; telephone compatible with hearing aids; closed caption decoders; open and closed captioning; telecommunication devices for deaf persons (TDDs); videotext displays; or other effective methods that help make aurally delivered materials available to individuals who are deaf or hard of hearing.

(v) Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the person will not be used as interpreters unless specifically requested by that individual and after an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person’s file. If the person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided.

**Note: Children and other residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication.**

B. **For Persons who are Blind or have Low Vision**

(i) Staff will communicate information contained in written materials concerning treatment, benefits, services, waivers of rights, and consent to treatment forms by reading out loud and explaining these forms to persons who are blind or who have low vision.
The following types of large print materials are available: handbook, family guide and consent for treatment. These materials may be obtained by calling the compliance director at 1-888-898-8989.

(ii) For the following auxiliary aids and services, staff shall contact the Facility Administrator who is responsible to provide the aids and services in a timely manner.

Qualified readers, formatting into large print, taping or recording of print materials not available in alternate format; or other effective methods that help make visually delivered materials available to individuals who are blind or who have low vision. In addition, staff is available to assist persons who are blind or who have low vision in filling out forms and in otherwise providing information in a written format.

C. **For Persons With Speech Impairments**

To ensure effective communication with persons with speech impairments, staff will contact the Facility Administrator who is responsible to provide the following aids and services in a timely manner:

Writing materials, typewriters, TDD, Computers, flashcards, alphabet boards, communication boards and other communication aids.

D. **For Person With Manual Impairments**

Staff will assist those who have difficulty in manipulating print materials by holding the materials and turning pages as needed, or by providing one or more of the following: note-takers, computer-aided transcription services, speaker phones, or other effective methods that help to ensure effective communication by individuals with manual impairments. For these and other auxiliary aids and services, staff will contact the Facility Administrator who is responsible to provide the aids and services in a timely manner.
ATTACHMENT G

COMPASSIONATE CARE HOSPICE
POLICY AND PROCEDURE FOR COMMUNICATING WITH PERSONS WITH LIMITED ENGLISH PROFICIENCY

POLICY:

Compassionate Care Hospice will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of CCH is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waiver of rights, consent to treatment forms, financial and insurance benefit forms, etc. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or informal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.

Compassionate Care Hospice will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

PROCEDURES:

1. IDENTIFYING LEP PERSONS AND THEIR LANGUAGE

   Compassionate Care Hospice will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or “I speak cards,” available online at www.lep.gov) or posters to determine the language. In addition, when records are kept of past interactions with patients (clients/residents) or family members, the language used to communicate with the LEP person will be included as part of the record.

2. OBTAINING A QUALIFIED INTERPRETER

   The Facility Administrator is responsible for:

   (a) Maintaining an accurate and current list showing the name, language, phone number and hours of availability of bilingual staff.
(b) Contacting the appropriate bilingual staff member to interpret, in the event that an interpreter is needed, if an employee who speaks the needed language is available and is qualified to interpret.

(c) Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language. Language Line has agreed to provide qualified interpreter services. The agency’s telephone number is 1-800-752-6096 and service is available 24 hours a day/7 days per week.

(See Attachment M for LEP Interpreter Form)

Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and after the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person’s file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person. (See attached chart L for a list of other interpreters).

Children and other clients/patients/residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication.

3. PROVIDING WRITTEN TRANSLATIONS

(a) When translation of vital documents is needed, Compassionate Care Hospice will submit documents for translation into frequently-encountered languages to the governing body. Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.

(b) Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.

(c) Compassionate Care Hospice will set benchmarks for translation of vital documents into additional languages over time.

4. PROVIDING NOTICE TO LEP PERSONS

Compassionate Care Hospice will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will understand. At a minimum, in the written materials they receive from Compassionate Care Hospice.

5. MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

On an ongoing basis, Compassionate Care Hospice will assess changes in demographics, types of services or other needs that may require re-evaluation of this policy and its procedures. In addition, Compassionate Care Hospice will regularly assess the efficiency of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from patients and community organizations, etc.
ATTACHMENT H

COMPASSIONATE CARE HOSPICE
ADMISSION POLICY STATEMENT

Compassionate Care Hospice accepts all patients regardless of race, color and national origin, nature of disability, age or religious background. Patients will be assessed on clinical presentation. Potential patients will be accepted if the patient’s needs can be met by Compassionate Care Hospice.
PURPOSE

To establish the process and procedure for evaluation and admission of patients into hospice or referral to another more appropriate agency

POLICY

Patients are accepted for hospice care on the basis that the patient meets all admission criteria and that there is a reasonable expectation that the patient’s needs can be adequately met by CCH in the patient’s place of residence.

<table>
<thead>
<tr>
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<th>Reviewed</th>
<th>Revised</th>
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<tr>
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<td>10-01-1998</td>
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</tr>
</tbody>
</table>
PROCEDURE

1. Patients 18-years or older (individual sites may admit pediatric/adolescent patients when there is available staff knowledgeable of the specialized care necessary) will be accepted for care if the following criteria are met:
   (a) The patient must be under the care of a physician who will order and approve the provision of hospice care, sign a Certificate of Terminality and be willing to sign or who has a representative who will sign a death certificate.
   (b) The patient may identify a family/caregiver or legal representative who agrees to be a primary support care person if and when needed. In the State of Delaware, a primary caregiver must be named.
   (c) The patient has a life-threatening illness as determined by the attending physician and the hospice Medical Director.
   (d) The patient/family desire hospice services and is aware of the diagnosis and prognosis.
   (e) The focus of the care desired will be palliative, not curative.
   (f) The patient must have a prognosis of six months or less if the disease takes its normal course.
   (g) The patient/family agree to hospice care and will participate in the plan of care and sign the consent form and Election of Hospice form.
   (h) The patient/family/caregiver agrees that the hospice care will be provided primarily in the home.
   (i) The physical facilities and equipment in the patient’s home will be adequate for safe and effective care.
   (j) The patient will reside within the geographical area which CCH services.
   (k) Any person under the age of 18 must have consent signed by the parent or legal guardian.

2. Referral information provided by family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies and physician offices will assist in the determinate of eligibility for admission to the program. If the request for service is not made by the patient’s physician, he/she will be consulted prior to the evaluation visit/initiation of services.

3. During the initial assessment visit, the clinician will re-explain the philosophy, mission and purpose of hospice care and assess the patient’s eligibility for hospice services according to the admission criteria to determine/confirm:
   (a) Level of services required;
   (b) Eligibility;
   (c) Source of payment; and
   (d) Service available in defined geographic area.
ATTACHMENT I

Date:
Administrator Name:
Facility Name:
Street Address:
City, State, Zip Code:

Re: Facility Notification and Acknowledgement of Compliance with Civil Rights Statutes

Health care facilities that receive federal funds through participation in the Medicare program must comply with applicable civil rights statutes and regulations to ensure that their policies or procedures do not exclude or limit the participation of individuals on the basis of race, color, national origin, disability, or age, consistent with applicable civil rights statutes and regulations.

Compassionate Care Hospice ("CCH") and the Office For Civil Rights (OCR) of the U.S. Department of Health and Human Services, the agency charged with enforcing the civil rights statutes and regulations, have entered into a cooperative agreement (the "Agreement") to facilitate the civil rights clearance process for your facility.

Your facility is covered by the terms of the Agreement and subject to CCH’s signed Assurance of Compliance (HHS Form 690) and the corporate policies and procedures which, among other things, prohibit discrimination on the basis of race, color, national origin, disability and age. To finalize this process, you will be required to:

1. Post the Non-Discrimination Policy and Grievance Procedure on your bulletin board; and
2. Review, complete, sign and return the four documents listed below within the next ten (10) days, and retain a copy for your files:

   • Facility Acknowledgement of Compliance
   • Facility Specific Data Form
   • Sign Language Interpreter Form
   • LEP Interpreter Form

Your assistance with this matter is greatly appreciated. Should you have any questions or concerns, please contact me at (973) 402-4712 or shardy@cchnet.net.

Sincerely,

Stella Hardy
Director of Corporate Compliance
Compassionate Care Hospice
ATTACHMENT J

Facility Notification and Acknowledgement of Compliance

Date:
Administrator Name:
Facility Name:
Street Address:
City, State, Zip Code:

Re: Facility Acknowledgement of Compliance

Health care facilities that receive federal funds through participation in the Medicare program must comply with applicable civil rights statutes and regulations to ensure that their policies or procedures do not exclude or limit the participation of individuals in a federally-funded program. Compassionate Care Hospice (CCH) and the Office For Civil Rights, U.S. Department of Health and Human Services, have entered into a cooperative agreement (Agreement) to facilitate the civil rights clearance process for your facility.

Your facility is covered by the terms of the Agreement and subject to CCH’s signed Assurance of Compliance (HHS Form 690) and the corporate policies and procedures which, among other things, prohibit discrimination on the basis of race, color, national origin, disability and age.

Please acknowledge the facility’s adoption of and compliance with the following Compassionate Care Hospice corporate policies and procedures:

- Non-Discrimination Policy
- Section 504 Grievance Procedure
- Section 504 Notice of Program Accessibility
- Auxiliary Aids Services For Persons With Disabilities
- Policy For Communication With Persons With Limited English Proficiency
- Admission Policy

Facility Name: ____________________________________________

Acknowledged by: _________________________________________
Signature - Facility Administrator

Name: ____________________________________________________
Print

Date: ________________

Provider #: ____________
ATTACHMENT K

Office for Civil Rights: Facility Specific Data/Documentation Requirements

Data about the Facility:

Name of Facility: (Legal and DBA name)
Address:
Administrator’s name:
Telephone number:
Fax Number:
Email Address:

Type of Facility (circle):       Home Health       Hospice

Reason For Application (circle):  Initial Medicare Certification  or Change of ownership

CMS Certification Number (CCN):

Certification

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

Signature: ____________________________
             (Administrator)

Date: ____________________________
Attachment L

Sign Language Interpreter Form
Compassionate Care Hospice

Staff Members:

We currently have:

no staff members who are qualified to interpret American Sign Language.
the following staff member(s) who are qualified to interpret American Sign Language:

Name: __________________________
Title: __________________________
Phone Number: ______________________
Hours of
Availability: ______________________

Name: __________________________
Title: __________________________
Phone Number: ______________________
Hours of
Availability: ______________________

Contractors:

The Administrator ___________________________ is responsible for
(First name, last name, phone number)

obtaining an outside interpreter when required.

The Administrator has chosen the following interpreter referral agency to ensure that qualified persons with disabilities, including those with impaired hearing, can adequately communicate with staff members:

Company/Organization: ___________________________
Contact Person: ___________________________
Address: ___________________________
City/State/Zip: ___________________________
Voicemail: ___________________________
Email: ___________________________
TTY: ___________________________
ATTACHMENT M

LEP Interpreter Form
Compassionate Care Hospice

Staff Members:

We currently have:

no staff members who are qualified to serve as Limited English Proficiency (LEP) interpreters.
the following staff member(s) who are qualified to serve as LEP interpreters:

Name: _____________________________
Title: _____________________________
Phone Number: _____________________
Hours of
Availability: ______________________

Name: _____________________________
Title: _____________________________
Phone Number: _____________________
Hours of
Availability: ______________________

Contractors:

The Administrator ________________________________ will arrange for
(First name, last name, phone number)
LEP interpreter services when required.

The Administrator has chosen the following interpreter agency to ensure that qualified persons with limited English proficiency can adequately communicate with staff members:

Company/Organization: ___________________________________________________________
Contact Person: _________________________________________________________________
Address: ______________________________________________________________________
City/State/Zip: __________________________________________________________________
Voicemail: _____________________________________________________________________
Email: _________________________________________________________________________
TTY: __________________________________________________________________________
Facility Notification & Acknowledgement of Compliance

Date: ______________________
Administrator Name: ______________________
Facility Name: ______________________
Street Address: ______________________
City, State, Zip code: ______________________

Re: Facility Acknowledgement of Compliance

Healthcare facilities that receive federal funds through participation in the Medicare program must comply with applicable civil rights statutes and regulations that ensure their policies or procedures do not exclude or limit the participation of individuals in a federally funded program. 
(Insert Your Corporation’s Name) and the Office for Civil Rights (OCR), U.S. Department of Health and Human Services, have entered into a cooperative agreement (Agreement) to facilitate the civil rights clearance for your facility.

Your facility is covered by the terms of the Agreement and subject to the (Insert Your Corporation’s Name) signed Assurance of Compliance (HHS Form 690) and the corporate policies and procedures which, among other things, prohibit discrimination on the basis of race, color, national origin, disability, or age.

Please acknowledge the facility’s adoption of and compliance with the (Insert Your Corporation’s Name) corporate policies and procedures listed below:

- Non-Discrimination Policy
- Section 504 Grievance Procedure
- Section 504 Notice of Program Accessibility
- Auxiliary Aids Services for Persons with Disabilities
- Policies and Procedures for Effective Communications with Limited English Proficiency Persons
- Admission Policy

Acknowledged by: ________________________ Date: ________________________
Executive Director

Facility Name: ________________________ Provider # ________________________
Office for Civil Rights: Facility Specific Data/Documentation Requirements

Facility Data
Name of the Facility: __________________________________
Street Address: _______________________________________
City, State, Zip code: __________________________________
Administrator Name: ___________________________________
504 Coordinator Name: _________________________________
Telephone Number: ____________________________________
Fax Number: _________________________________________
Email Address: _______________________________________
Type of Facility (Circle One):
   Hospital
   Nursing Facility
   Home Health, or
   Hospice
Reason for Application (Circle One):
   Initial Medicare Certification
   Change of Ownership, or
   Existing Medicare Certification but New Regional OCR Agreement

CMS Certification Medicare Number (CCN):

Certification

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

Signature: ___________________________  Date: ________________

Executive Director
ATTACHMENT L

Sign Language Interpreter Form
(Insert your corporation’s name)

We currently have:

- No staff members available who are qualified to interpret American Sign Language
- The following staff member(s) who are qualified to interpret American Sign Language

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Phone Number</th>
<th>Hours of Availability</th>
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<tbody>
<tr>
<td></td>
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</table>

Contractors:

The Executive Director is responsible for obtaining an outside sign language interpretation service when necessary.

The Executive Director has chosen the following sign language interpretation service to ensure that qualified deaf or hard of hearing persons can adequately communicate with staff members:

<table>
<thead>
<tr>
<th>Company</th>
<th>Contact Person</th>
<th>Street Address</th>
<th>City/State/Zip</th>
<th>TTY</th>
<th>Email</th>
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<tbody>
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</table>
ATTACHMENT M

Language Interpreter Services Form

(Insert your corporation’s name)

We currently have:

- No staff members available who are qualified to serve as Limited English Proficiency (LEP)

- The following staff member(s) who are qualified to serve as Limited English Proficiency

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Language(s)</th>
<th>Phone Number</th>
<th>Hours of Availability</th>
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</thead>
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<tr>
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</tbody>
</table>

Contractors:

The Executive Director is responsible for obtaining LEP interpreter services when necessary.

The Executive Director has chosen the following interpreter agency to ensure that qualified persons with limited English proficiency can adequately communicate with staff members:

<table>
<thead>
<tr>
<th>Company</th>
<th>Contact Person</th>
<th>Street Address</th>
<th>City/State/Zip</th>
<th>TTY</th>
<th>Email</th>
</tr>
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</table>
COMPASSIONATE CARE HOSPICE GROUP, LTD.'S CIVIL RIGHTS CORPORATE AGREEMENT FOR PARTICIPATION IN MEDICARE PART A
A. The attached Compassionate Care Hospice Group, Ltd. ("CCH") policies and procedures demonstrate CCH’s agreement and the agreement of CCH’s facilities to comply with the following civil rights statutes and regulations:

1. Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d-1 et seq., and its implementing regulations, Title 45 Code of Federal Regulations (CFR) Part 80, which prohibit discrimination on the ground of race, color, or national origin by recipients of Federal financial assistance at Title VI;

2. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and its implementing regulations at 45 CFR Part 84, which prohibit discrimination on the basis of handicap by recipients of Federal financial assistance (Section 504); and


B. The attached policies and procedures include:

1. The signed HHS-690, Assurance of Compliance with Title VI, Section 504, and the Age Act (Attachment A);

2. The designation of each CCH facility’s Administrator or other designee as the person to coordinate its efforts to ensure compliance with Title VI, Section 504, and the Age Act at the facility level, and the designation of CCH’s Corporate Compliance Officer to coordinate its efforts with these laws at the corporate level;

3. A list of each of CCH’s existing facilities by name and address, with the facility Administrator’s name and telephone number (Attachment B);

4. A copy of the facilities’ Policy of Discrimination under Title VI, Section 504, and the Age Act (Attachment C), which indicates that each facility provides equal access to its programs, benefits, and services and that it does not discriminate against persons qualified for its services on the basis of race, color, national origin, disability, or age;

5. A copy of the facilities’ Section 504 Grievance Procedures (Attachment D), which provides for prompt and equitable resolution of complaints including any action prohibited by the Federal regulations at 45 CFR Part 84 and includes notice of the right to file a written complaint with the Office for Civil Rights;
6. A copy of the facilities’ Notice of Program Accessibility indicating the existence of services, activities, and facilities which are accessible to and usable by persons with disabilities, including the availability of auxiliary aids to persons with disabilities (Attachment E);

7. A copy of the facilities’ Policy for Providing Auxiliary Aids and Services to Persons with Disabilities, to ensure effective communication with and equal access to services to persons who are deaf, hard of hearing, blind, of low vision, and speech and manually impaired, all provided, where necessary, at no cost to such persons (Attachment F);

8. A copy of the facilities’ policy and procedures for effective communication with limited English proficient persons (Attachment G), which allows for the provision of language services, including interpreter services and written materials in non-English languages, all provided, where necessary, at no cost to such persons.

9. A copy of the facilities’ Admission Policy (Attachment H);

10. A copy of the notification letter (Attachment I) that CCH will send to its existing facilities (Listed in Attachment B) and any facilities that it acquires in the future, which:
   
   a. Informs the Administrator that the facility is subject to the provisions and requirements of the attached policies and procedures; and

   b. Requires the Administrator to complete and timely submit the following documentation for civil rights clearance for Medicare certification in accordance with this Agreement:

   i. Acknowledgement/Certification Letter (Attachment J),

   ii. Facility-specific data sheet (Attachment K), and

   iii. Sign Language Interpreter Form (Attachment L)

   iv. LEP Interpreter Form (Attachment M)

The notification letter will be sent to existing facilities within 30 days after the signing of the Agreement and to facilities that it acquires in the future within 30 days after the date of acquisition.

C. CCH agrees that:

1. CCH and its facilities will adopt and implement the attached policies and procedures.

2. The Policy of Nondiscrimination (see#4 above) will be posted in a common area at each facility and distributed to patients upon admission.
3. Facility staff will receive training regarding the policies discussed above during orientation and at other times as appropriate.

COMPASSIONATE CARE HOSPICE GROUP, LTD.

_______________________________
Signature of Authorized Representative

Judith Grey
Typed/Printed Name

Chief Operating Officer
Title

_______________________________
Date
ASSURANCE OF COMPLIANCE


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assigns for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

Date

Signature of Authorized Official

Name and Title of Authorized Official (please print or type)

Name of Healthcare Facility Receiving/Requesting Funding

Street Address

City, State, Zip Code

Please mail form to:
U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201

Form HHS-690
1/09
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<td>Wilmington</td>
<td>DE</td>
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<td>302-993-9090</td>
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<td>Athens</td>
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<td>30606</td>
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<td>48187</td>
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<td>Worthington</td>
<td>MN</td>
<td>56187</td>
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<td>Compassionate Care Hospice of Pennsylvania, LLC</td>
<td>287 North 115th Street</td>
<td>Omaha</td>
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<td>68154</td>
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<td>Compassionate Care Hospice of Pennsylvania, LLC</td>
<td>25 Nashua Road, Suite E:3</td>
<td>Londonderry</td>
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<td>600 Highland Drive, Suite 624</td>
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<td>Bronx</td>
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<td>10471</td>
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<td>Compassionate Care Hospice, Inc.</td>
<td>1513 Cedar Cliff Drive, Suite 100</td>
<td>Camp Hill</td>
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<td>3331 Street Road, Suite 410</td>
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<td>Brandi Gabriel</td>
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**Home Health Facility**

| Compassionate Home Care of Northeastern Pennsylvania, LLC | 281 Pierce Street | Kingston | PA | 18704 | Michele Taylor | 570-287-2330 |
ATTACHMENT C

COMPASSIONATE CARE HOSPICE
NON-DISCRIMINATION POLICY

As a recipient of Federal financial assistance, Compassionate Care Hospice does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability or age in admission to, participation in or receipt of services and benefits under any of its programs or activities, whether carried out by Compassionate Care Hospice directly or through a contractor or any other entity with which Compassionate Care Hospice arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal regulations Parts 80, 84, and 91.

In case of questions, you may contact the Facility Administrator, who will serve as the Section 504 Coordinator; or the Corporate Compliance Officer at (973) 402-4712.
PURPOSE

To assure organizational compliance with Section 504 of the Rehabilitation Act of 1973 [29 U.S.C. 794]

POLICY

CCH does not discriminate on the basis of handicap.

It is the policy of Compassionate Care Hospice not to discriminate on the basis of disability. Compassionate Care Hospice has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 prohibits discrimination on the basis of disability in any program or activity receiving Federal financial assistance. The Law and Regulations may be examined in the office of Stella Hardy, Corporate Compliance Officer, (973) 402-4712, who has been designated to coordinate the efforts of Compassionate Care Hospice to comply with Section 504.
PROCEDURE

1. Any person who believes that he or she has been subjected to discrimination on the basis of handicap in violation of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and its implementing regulations, 45 C.F.R. parts 80, 84, and 91 may file a grievance.

2. The organization will not retaliate against any individual who files a grievance or cooperates in the investigation of a grievance.

3. Grievances must be filed to the Section 504 Coordinator within thirty (30) days of the date that the individual filing the grievance becomes aware of the alleged discriminatory action.

4. All complaints must be submitted in writing, including the name and address of the individual filing the complaint.

5. The written complaint must state the problem or action alleged to be discriminatory.

6. The written complaint must state the remedy or relief sought by the individual filing the complaint.

7. The Section 504 Coordinator/designee will conduct an investigation of the complaint to determine its validity.
   (a) The investigation may be informal.
   (b) The investigation must allow all interested parties an opportunity to submit evidence relevant to the complaint.

8. The Section 504 Coordinator will issue a written decision on the grievance no later than thirty (30) days after the complaint is filed.

9. The Section 504 Coordinator will maintain all files and records related to the complaint in the organization’s administrative files.

10. The individual filing the complaint may appeal the decision of the Section 504 Coordinator by filing an appeal in writing to the organization within fifteen (15) days of receiving the Section 504 Coordinator’s decision.

11. The organization will issue a written response to the appeal no later than thirty (30) days after the appeal is filed.
13. The organization will make appropriate arrangements to assure that disabled individuals can participate in or make use of this grievance process on the same basis as the non-disabled. His/her arrangements may include, but are not limited to, interpreters, provision of appropriate materials for deaf and/or blind individuals and a barrier free location for the proceedings.
   (a) The Section 504 Coordinator will be responsible for providing such arrangements.
Attachment E

Section 504 - Notice of Program Accessibility

Compassionate Care Hospice does not service patients in its own facility. The patients are serviced in their homes, nursing homes, long term care facilities and/or what the patient considers their home, within the geographical boundaries established by Compassionate Care Hospice. If there is a need for the patient to meet with an employee, nurse, or caretaker outside of the home, Compassionate Care Hospice will make reasonable accommodations by selecting a meeting area that is accessible to those who are disabled. Auxiliary aids needed to provide effective communication between staff and the patient will also be available and present at these scheduled meetings. Patients are asked to call in advance so that appropriate arrangements can be made.

Disabled employees who require assistive devices and accessible meeting rooms in order to attend employee training, meetings and/or any other gatherings should contact the Facility Administrator to ensure appropriate arrangements will be made in a timely manner.
ATTACHMENT F

COMPASSIONATE CARE HOSPICE
AUXILIARY AIDS AND SERVICES FOR PERSONS WITH DISABILITIES

POLICY 1028

Compassionate Care Hospice will take appropriate steps to ensure that persons with disabilities, including persons who are deaf, hard of hearing or blind, or who have other sensory or manual impairments, have an equal opportunity to participate in our services, activities, programs and other benefits. The procedures outlined below are intended to ensure effective communication with patients/clients involving their medical conditions, treatment, services and benefits. The procedures also apply to, among other types of communication, communication of information contained in important documents, including waivers of rights; consent to treatment forms; financial and insurance benefits forms, etc. All necessary auxiliary aids and services shall be provided without cost to the person being served.

All staff will be provided written notices of this policy and procedure, and staff that may have direct contact with individuals with disabilities will be trained in effective communication techniques, including the effective use of interpreters.

PROCEDURES

1. Identification and Assessment of Need

Compassionate Care Hospice provides notices of the availability of and procedure for requesting auxiliary aids and services through notices in our written information and when an individual self-identifies as a person with a disability that affects the ability to communicate or to access or manipulate written materials or requests an auxiliary aid or service, staff will consult with the individual to determine what aids or services are necessary to provide effective communication in particular situations.

2. Provision of Auxiliary Aids and Services

Compassionate Care Hospice shall provide the following services or aids to achieve effective communication with persons with disabilities:

A. For Persons Who Are Deaf or Hard of Hearing

(i) For persons who are deaf/hard of hearing and who use sign language as their primary means of communication, the Facility Administrator is responsible for providing effective interpretation or arranging for a qualified interpreter when needed.
(ii) In the event a sign language interpreter is needed, the Facility Administrator is responsible for contacting the appropriate agency.

(See attachment L for Sign Language Interpreter Form).

(iii) **Communicating by Telephone With Persons Who Are Deaf or Hard of Hearing**

Compassionate Care Hospice utilizes relay services for external telephone with TTY users. We accept and make calls through a relay service. The service providers and numbers are:

Sprint Relay – For Provider TTY Relay Services
Customer Service: 1-800-682-8706

Access #s:
Voice: 1-800-676-3777
TTY: 1-800-676-3777
Spanish: 1-800-676-4290

(iv) For the following auxiliary aids and services, staff will contact the Facility Administrator, who is responsible to provide the aids and services in a timely manner: Note-takers, computer-aided transcription services; telephone handset amplifiers; written copies of oral announcements; assistive listening devise; assistive listening systems; telephone compatible with hearing aids; closed caption decoders; open and closed captioning; telecommunication devices for deaf persons (TDDs); videotext displays; or other effective methods that help make aurally delivered materials available to individuals who are deaf or hard of hearing.

(v) Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the person will not be used as interpreters unless specifically requested by that individual and after an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person’s file. If the person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided.

*Note: Children and other residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication.*

B. **For Persons who are Blind or have Low Vision**

(i) Staff will communicate information contained in written materials concerning treatment, benefits, services, waivers of rights, and consent to treatment forms by reading out loud and explaining these forms to persons who are blind or who have low vision.
The following types of large print materials are available: handbook, family guide and consent for treatment. These materials may be obtained by calling the compliance director at 1-888-898-8989.

(ii) For the following auxiliary aids and services, staff shall contact the Facility Administrator who is responsible to provide the aids and services in a timely manner.

Qualified readers, formatting into large print, taping or recording of print materials not available in alternate format; or other effective methods that help make visually delivered materials available to individuals who are blind or who have low vision. In addition, staff is available to assist persons who are blind or who have low vision in filling out forms and in otherwise providing information in a written format.

C. **For Persons With Speech Impairments**

To ensure effective communication with persons with speech impairments, staff will contact the Facility Administrator who is responsible to provide the following aids and services in a timely manner:

Writing materials, typewriters, TDD, Computers, flashcards, alphabet boards, communication boards and other communication aids.

D. **For Person With Manual Impairments**

Staff will assist those who have difficulty in manipulating print materials by holding the materials and turning pages as needed, or by providing one or more of the following: note-takers, computer-aided transcription services, speaker phones, or other effective methods that help to ensure effective communication by individuals with manual impairments. For these and other auxiliary aids and services, staff will contact the Facility Administrator who is responsible to provide the aids and services in a timely manner.
ATTACHMENT G

COMPASSIONATE CARE HOSPICE
POLICY AND PROCEDURE FOR COMMUNICATING WITH PERSONS WITH
LIMITED ENGLISH PROFICIENCY

POLICY:

Compassionate Care Hospice will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of CCH is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waiver of rights, consent to treatment forms, financial and insurance benefit forms, etc. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or informal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.

Compassionate Care Hospice will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

PROCEDURES:

1. IDENTIFYING LEP PERSONS AND THEIR LANGUAGE

   Compassionate Care Hospice will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or “I speak cards,” available online at www.lep.gov) or posters to determine the language. In addition, when records are kept of past interactions with patients (clients/residents) or family members, the language used to communicate with the LEP person will be included as part of the record.

2. OBTAINING A QUALIFIED INTERPRETER

   The Facility Administrator is responsible for:

   (a) Maintaining an accurate and current list showing the name, language, phone number and hours of availability of bilingual staff.
(b) Contacting the appropriate bilingual staff member to interpret, in the event that an interpreter is needed, if an employee who speaks the needed language is available and is qualified to interpret.

(c) Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language. Language Line has agreed to provide qualified interpreter services. The agency’s telephone number is 1-800-752-6096 and service is available 24 hours a day/7 days per week.

(See Attachment M for LEP Interpreter Form)

Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and after the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person’s file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person. (See attached chart L for a list of other interpreters).

Children and other clients/patients/residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication.

3. PROVIDING WRITTEN TRANSLATIONS

(a) When translation of vital documents is needed, Compassionate Care Hospice will submit documents for translation into frequently-encountered languages to the governing body. Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.

(b) Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.

(c) Compassionate Care Hospice will set benchmarks for translation of vital documents into additional languages over time.

4. PROVIDING NOTICE TO LEP PERSONS

Compassionate Care Hospice will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will understand. At a minimum, in the written materials they receive from Compassionate Care Hospice.

5. MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

On an ongoing basis, Compassionate Care Hospice will assess changes in demographics, types of services or other needs that may require re-evaluation of this policy and its procedures. In addition, Compassionate Care Hospice will regularly assess the efficiency of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from patients and community organizations, etc.
ATTACHMENT H

COMPASSIONATE CARE HOSPICE
ADMISSION POLICY STATEMENT

Compassionate Care Hospice accepts all patients regardless of race, color and national origin, nature of disability, age or religious background. Patients will be assessed on clinical presentation. Potential patients will be accepted if the patient’s needs can be met by Compassionate Care Hospice.
PURPOSE

To establish the process and procedure for evaluation and admission of patients into hospice or referral to another more appropriate agency

POLICY

Patients are accepted for hospice care on the basis that the patient meets all admission criteria and that there is a reasonable expectation that the patient’s needs can be adequately met by CCH in the patient’s place of residence.

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PROCEDURE

1. Patients 18-years or older (individual sites may admit pediatric/adolescent patients when there is available staff knowledgeable of the specialized care necessary) will be accepted for care if the following criteria are met:
   (a) The patient must be under the care of a physician who will order and approve the provision of hospice care, sign a Certificate of Terminality and be willing to sign or who has a representative who will sign a death certificate.
   (b) The patient may identify a family/caregiver or legal representative who agrees to be a primary support care person if and when needed. **In the State of Delaware, a primary caregiver must be named.**
   (c) The patient has a life-threatening illness as determined by the attending physician and the hospice Medical Director.
   (d) The patient/family desire hospice services and is aware of the diagnosis and prognosis.
   (e) The focus of the care desired will be palliative, not curative.
   (f) The patient must have a prognosis of six months or less if the disease takes its normal course.
   (g) The patient/family agree to hospice care and will participate in the plan of care and sign the consent form and Election of Hospice form.
   (h) The patient/family/caregiver agrees that the hospice care will be provided primarily in the home.
   (i) The physical facilities and equipment in the patient’s home will be adequate for safe and effective care.
   (j) The patient will reside within the geographical area which CCH services.
   (k) Any person under the age of 18 must have consent signed by the parent or legal guardian.

2. Referral information provided by family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies and physician offices will assist in the determinate of eligibility for admission to the program. If the request for service is not made by the patient’s physician, he/she will be consulted prior to the evaluation visit/initiation of services.

3. During the initial assessment visit, the clinician will re-explain the philosophy, mission and purpose of hospice care and assess the patient’s eligibility for hospice services according to the admission criteria to determine/confirm:
   (a) Level of services required;
   (b) Eligibility;
   (c) Source of payment; and
   (d) Service available in defined geographic area.
ATTACHMENT I

Date:
Administrator Name:
Facility Name:
Street Address:
City, State, Zip Code:

Re: Facility Notification and Acknowledgement of Compliance with Civil Rights Statutes

Health care facilities that receive federal funds through participation in the Medicare program must comply with applicable civil rights statutes and regulations to ensure that their policies or procedures do not exclude or limit the participation of individuals on the basis of race, color, national origin, disability, or age, consistent with applicable civil rights statutes and regulations.

Compassionate Care Hospice ("CCH") and the Office For Civil Rights (OCR) of the U.S. Department of Health and Human Services, the agency charged with enforcing the civil rights statutes and regulations, have entered into a cooperative agreement (the "Agreement") to facilitate the civil rights clearance process for your facility.

Your facility is covered by the terms of the Agreement and subject to CCH’s signed Assurance of Compliance (HHS Form 690) and the corporate policies and procedures which, among other things, prohibit discrimination on the basis of race, color, national origin, disability and age. To finalize this process, you will be required to:

1. Post the Non-Discrimination Policy and Grievance Procedure on your bulletin board; and
2. Review, complete, sign and return the four documents listed below within the next ten (10) days, and retain a copy for your files:

   • Facility Acknowledgement of Compliance
   • Facility Specific Data Form
   • Sign Language Interpreter Form
   • LEP Interpreter Form

Your assistance with this matter is greatly appreciated. Should you have any questions or concerns, please contact me at (973) 402-4712 or shardy@echnet.net.

Sincerely,

Stella Hardy
Director of Corporate Compliance
Compassionate Care Hospice
ATTACHMENT J

Facility Notification and Acknowledgement of Compliance

Date:
Administrator Name:
Facility Name:
Street Address:
City, State, Zip Code:

Re: Facility Acknowledgement of Compliance

Health care facilities that receive federal funds through participation in the Medicare program must comply with applicable civil rights statutes and regulations to ensure that their policies or procedures do not exclude or limit the participation of individuals in a federally-funded program. Compassionate Care Hospice (CCH) and the Office For Civil Rights, U.S. Department of Health and Human Services, have entered into a cooperative agreement (Agreement) to facilitate the civil rights clearance process for your facility.

Your facility is covered by the terms of the Agreement and subject to CCH’s signed Assurance of Compliance (HHS Form 690) and the corporate policies and procedures which, among other things, prohibit discrimination on the basis of race, color, national origin, disability and age.

Please acknowledge the facility’s adoption of and compliance with the following Compassionate Care Hospice corporate policies and procedures:

- Non-Discrimination Policy
- Section 504 Grievance Procedure
- Section 504 Notice of Program Accessibility
- Auxiliary Aids Services For Persons With Disabilities
- Policy For Communication With Persons With Limited English Proficiency
- Admission Policy

Facility Name: __________________________________________

Acknowledged by: _______________________________________

Signature - Facility Administrator

Name: ___________________________________________________

Print

Date: __________________

Provider #: __________________
ATTACHMENT K

Office For Civil Rights: Facility Specific Data/Documentation Requirements

Data about the Facility:

Name of Facility: (Legal and DBA name)

Address:

Administrator’s name:

Telephone number:

Fax Number:

Email Address:

Type of Facility (circle): Home Health Hospice

Reason For Application (circle): Initial Medicare Certification or Change of ownership

CMS Certification Number (CCN):

Certification

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

Signature: ________________________________

(Administrator)

Date: __________________________
Attachment L

Sign Language Interpreter Form
Compassionate Care Hospice

Staff Members:

We currently have:

no staff members who are qualified to interpret American Sign Language.
the following staff member(s) who are qualified to interpret American Sign Language:

Name: __________________________
Title: __________________________
Phone Number: _________________
Hours of
Availability: ____________________

Name: __________________________
Title: __________________________
Phone Number: _________________
Hours of
Availability: ____________________

Contractors:

The Administrator ____________________________ is responsible for
(First name, last name, phone number
obtaining an outside interpreter when required.

The Administrator has chosen the following interpreter referral agency to ensure that qualified
persons with disabilities, including those with impaired hearing, can adequately communicate
with staff members:

Company/Organization: ____________________________
Contact Person: ____________________________
Address: ____________________________
City/State/Zip: ____________________________
Voicemail: ____________________________
Email: ____________________________
TTY: ____________________________
ATTACHMENT M

**LEP Interpreter Form**
Compassionate Care Hospice

**Staff Members:**

We currently have:

- no staff members who are qualified to serve as Limited English Proficiency (LEP) interpreters.
- the following staff member(s) who are qualified to serve as LEP interpreters:

  Name: __________________________
  Title: __________________________
  Phone Number: _________________
  Hours of Availability: __________

Name: __________________________
Title: __________________________
Phone Number: _________________
Hours of Availability: __________

**Contractors:**

The Administrator ____________________________ will arrange for
(First name, last name, phone number

LEP interpreter services when required.

The Administrator has chosen the following interpreter agency to ensure that qualified persons with limited English proficiency can adequately communicate with staff members:

Company/Organization: ____________________________
Contact Person: ____________________________
Address: ____________________________
City/State/Zip: ____________________________
Voicemail: ____________________________
Email: ____________________________
TTY: ____________________________
Section 504 Notice of Program Accessibility

The regulation implementing Section 504 requires that an agency/facility "...adopt and implement procedures to ensure that interested persons, including persons with impaired vision or hearing, can obtain information as to the existence and location of services, activities, and facilities that are accessible to and usable by disabled persons." (45 C.F.R. §84.22(f))

(Insert name of facility) and all of its programs and activities are accessible to and usable by disabled persons, including persons who are deaf, hard of hearing, or blind, or who have other sensory impairments. Access features include:

- Convenient off-street parking designated specifically for disabled persons.
- Curb cuts and ramps between parking areas and buildings.
- Level access into first floor level with elevator access to all other floors.
- Fully accessible offices, meeting rooms, bathrooms, public waiting areas, cafeteria, patient treatment areas, including examining rooms and patient wards.
- A full range of assistive and communication aids provided to persons who are deaf, hard of hearing, or blind, or with other sensory impairments. There is no additional charge for such aids. Some of these aids include:
  - Qualified sign language interpreters for persons who are deaf or hard of hearing.
  - A twenty-four hour (24) telecommunication device (TTY/TDD) which can connect the caller to all extensions within the facility and/or portable (TTY/TDD) units, for use by persons who are deaf, hard of hearing, or speech impaired.
  - Readers and taped material for the blind and large print materials for the visually impaired.
  - Flash Cards, Alphabet boards and other communication boards.
  - Assistive devices for persons with impaired manual skills.

If you require any of the aids listed above, please let the receptionist or your nurse know.