CIVIL RIGHTS COMPLIANCE REVIEW
(TITLE VI, SECTION 504, ADA)

THIS FORM IS TO BE COMPLETED ANNUALLY BY THE ADMINISTRATOR OF THE AGENCY/FACILITY (OR DESIGNEE).

1. a. Name of agency/facility | Medi-Cal provider number | Date

Address (number, street) | County | ZIP code | Number of patients | Number of employees

Administrator | Telephone number ( )

b. Name of agency/facility staff providing information | Telephone number ( )

Title | Email Address | Telephone number ( )

c. Name of licensee/parent corporation (if applicable) | License number | Telephone number ( )

Address (number, street) | City | State | ZIP code

2. **TYPE OF AGENCY/FACILITY**

- ❒ General Acute Care Hospital
- ❒ Acute Psychiatric Hospital
- ❒ General Acute Care/Rehabilitation Hospital
- ❒ Other (specify) _____
- ❒ Skilled Nursing Facility
- ❒ Intermediate Care/other
- ❒ Intermediate Care Facility/Developmentally Disabled
- ❒ County/local health department
- ❒ Health clinic

3. **TYPE OF CONTROL/OWNERSHIP**

- ❒ State government
- ❒ Voluntary nonprofit (other than church)
- ❒ Local government
- ❒ Proprietary
- ❒ Voluntary nonprofit (church)
- ❒ Other (specify) _____

4. **CURRENT CENSUS**

Licensed bed capacity_____ Long-term care beds certified_____ Number of resident/patient rooms _____

5. **BILINGUAL SERVICES**

a. Do you have bilingual persons on staff? ❒ Yes ❒ No
If yes, please identify by name, second language, and shift (use additional paper, if necessary).

Language	Name of Staff Person	Written	Spoken	Shift (Day, Swing, Grave, etc.)
Spanish				
Vietnamese				
Cambodian				
Lao				
Chinese (Cantonese)				
Chinese (Mandarin)				
Sign Language				
Other				

b. What is your agency's/facility's procedure for identifying the language needs of residents/patients?

c. Attach copies of interpreter policies and procedures.

6. **SERVICES FOR DISABLED EMPLOYEES/RESIDENTS**

Deaf and/or Speech/Hearing Impaired

a. Does facility use sign language interpreters? ❒ Yes ❒ No

b. Does facility use text phones (TTYs, formerly TDDs) ❒ Yes ❒ No

c. Does facility use other auxiliary aids for persons with visual, motor, or speech impairments? ❒ Yes ❒ No
If yes, identify aid utilized: _____

d. Identify community resources for interpreter services: _____

Mobility Impaired

a. Have public telephones been lowered for use by persons in wheelchairs? ❒ Yes ❒ No

b. Are drinking fountains accessible to persons in wheelchairs? ❒ Yes ❒ No

c. Are public restrooms accessible to persons in wheelchairs? ❒ Yes ❒ No

7. **ETHNIC/DISABILITY/GENDER COMPOSITION OF STAFF (Enter number of staff in each category.)**

Type of Occupation	White	Black	Hispanic	Asian	Filipino	Native American	Disabled	Male	Female
Managerial									
Professional									
Technicians									
Office/Clerical									
Service Workers									
Laborers									

8. **RESIDENT CHARACTERISTICS**

a. Current number of residents/patients: _____

b. Is use of your agency/facility limited to membership in a defined group? (e.g., fraternal organization, religious denomination, employees of a corporation, union, etc.) ❒ Yes ❒ No
If yes, attach the membership requirements and any other material that further explains the limitation.

c. Estimate the number of patients or beneficiaries belonging to the following groups admitted during the past year.
_____ White _____ Black _____ Filipino _____ Other _____ Female
_____ Native American _____ Hispanic _____ Asian _____ Male

d. What is the approximate age range of the residents? _____

e. If your agency/facility assigns rooms to residents/patients, complete the following information.
Indicate below the number of minority group patients in today's census by type of room assignment according to the following breakdown:

	White	Black	Hispanic	Asian	Native American	Filipino	Other
Number of residents in single rooms or alone							
Number of minority residents in semiprivate rooms or wards having only minority persons							
Number of minority residents in semiprivate rooms or wards with one or more nonminority persons							
TOTAL							

9. **ETHNIC COMPOSITION OF THE GENERAL SERVICE POPULATION. Retrieve this data from your county census bureau.**

_____% White _____ % Black _____ % Hispan _____ Other

_____ % Native American _____ % Asian _____% Filipino

10. **LANGUAGE GROUP COMPOSITION OF THE GENERAL SERVICE POPULATION (List by percentage and list only those language groups comprising 5 percent or more of the population.) Retrieve this data from your county census bureau.**

_____ Spanish _____ Cambodian _____ Cantonese _____ Sign Language

_____ Vietnamese _____ Lao _____ Mandarin _____ Other (describe) _____

11. **ETHNIC/DISABILITY COMPOSITION OF ADVISORY BOARD/BOARD OF DIRECTORS**

Describe the method used to recruit and select board members. (Provide a copy of your eligibility criteria for board membership.)

List the facility's Advisory Boards and/or Board of Directors and state the ethnic and disability composition of each Advisory Board/Board of Directors.

Advisory Board/Board of Directors	Ethnic/Disability Composition

12. **EQUAL ACCESS PRACTICES**

a. What is your agency's/facility's policy on admission of persons with HIV/AIDS? (Use additional paper, if necessary.)

b. Does your facility have any restrictions on admissions of persons with HIV/AIDS? . . . . . ❒ Yes ❒ No

c. Do you have policies and procedures for caring for persons with HIV/AIDS? . . . . . ❒ Yes ❒ No

d. What records are kept by your facility about admission inquiries? _____

e. Have any prospective residents diagnosed with HIV/AIDS been denied admission or care and treatment during the last 12 months? . . . . . ❒ Yes ❒ No
If yes, please explain why (use additional paper, if necessary):

f. Do you have policies and procedures governing the number of heavy care residents you can care for at any one time? . . . . . ❒ Yes ❒ No

g. Have you ever denied admission or care and treatment to an HIV/AIDS patient because he/she was considered heavy care?
❒ Yes ❒ No
If yes, please explain:

h. What is your agency's/facility's criteria or practice for **nonadmission** of persons with HIV/AIDS? (Use additional paper, if necessary.)

i. What infection control procedures do you use for persons with HIV/AIDS?

j. Have you provided any specific training to staff on the rights of persons with HIV/AIDS or their care and treatment? Please describe.

k. Does your agency/facility limit admission to the facility to persons over a specific age? . . . . . ❒ Yes ❒ No
If yes, describe the age requirement (use additional paper, if necessary):

l. Have any prospective residents been denied admission during the last 12 months because of their age? . . . . . ❒ Yes ❒ No
If yes, please explain why (use additional paper, if necessary):

m. What is your agency/facility's criteria or practice for **nonadmission** of persons because of their age? (Use additional paper, if necessary.)

n. Are services rendered in your agency/facility without regard to race, color, or national origin of either the resident or the person rendering the service? . . . . . ❒ Yes ❒ No
If no, specify which services are not (use additional paper, if necessary):

o. Are all facilities and services provided and used without regard to race, color, or national origin (e.g., room assignment policy, use of recreational facilities, etc.)? . . . . . ❒ Yes ❒ No
If no, please explain (use additional paper, if necessary):

p. Have any prospective residents **NOT** of the race, color, or national origin of the primary group in your agency/facility been denied admission during the last 12 months? . . . . . ❒ Yes ❒ No

If yes, complete the following:

Number of admissions during the last 12 months _____

Number of admission denials during the last 12 months _____

Indicate race, color, or national origin of prospective residents denied admission _____

13. **SMALL AND MINORITY/FEMALE/DVBE-OWNED BUSINESSES**

What efforts has your facility taken to ensure nondiscrimination in informal and formal contracted relationships/agreements.

Has your facility identified any contractual provision with potential or actual discriminatory effects? . . . . . ❒ Yes ❒ No
If yes, explain the provision and the facility decision to continue or discontinue contractual agreements.

14. Please return the completed Civil Rights Compliance Review form with attached copies of your facility's admission policies and procedures within 15 days to:

Department of Health Care Services
Office of Civil Rights
P.O. Box 997413
1501 Capitol Avenue, MS 0009
Sacramento, CA 95899-7413
(916) 440-7370