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:

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 INTEPRETER

(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:

(Name of facility) provides notice of the availability of and procedure for requesting auxiliary aids and services through notices in our ***(brochures, handbooks, letters, print/radio /televison 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: **(d*escription 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.

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.

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 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).

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.

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:

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:

(Name of facility) provides notice of the availability of and procedure for requesting auxiliary aids and services through notices in our ***(brochures, handbooks, letters, print/radio /televison 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: **(d*escription 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.

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 INTEPRETER

(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)***

ATTACHMENT J

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 # _____

ATTACHMENT L

Sign Language Interpreter Form

(Insert your corporation's name)

We currently have:

- o No staff members available who are qualified to interpret American Sign Language

- o The following staff member(s) who are qualified to interpret American Sign Language

Name	Title	Phone Number	Hours of Availability

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:

Company	
Contact Person	
Street Address	
City/State/Zip	
TTY	
Email	

ATTACHMENT M

Language Interpreter Services Form

(Insert your corporation's name)

We currently have:

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

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

Name	Title	Language(s)	Phone Number	Hours of Availability

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:

Company	
Contact Person	
Street Address	
City/State/Zip	
TTY	
Email	

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

3. Age Discrimination Act of 1975 , 42 U.S.C. § 6101 et seq., and its implementing regulation, 45 CFR Part 91, which prohibit discrimination on the basis of age by recipients of Federal financial assistance (Age Act).

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

3. Age Discrimination Act of 1975, 42 U.S.C. § 6101 et seq., and its implementing regulations at 45 CFR Part 91, which prohibit discrimination on the basis of age by recipients of Federal financial assistance (Age Act).

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

Attachment A

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

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 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

ATTACHMENT B

Legal Name	Address	City	State	Zip	Agency Director/Contact	Phone
Hospice						
Compassionate Care Hospice of Delaware, LLC	702B Kirkwood Highway	Wilmington	DE	19805	Susan Millman	302-993-9090
Compassionate Care Hospice of the Delmar Peninsula, LLC	28467 DuPont Boulevard, Suite 6	Millsboro	DE	19966	Mariann Wolskee	302-934-5900
Compassionate Care Hospice of Miami Dade, Inc.	2393 E. F. Griffin Road	Bartow	FL	33830	Rana McClelland	863-709-0099
Compassionate Care Hospice of Atlanta, LLC	Five Dunwoody Park, Suite 118	Atlanta	GA	30338	Georgia Morris	770-220-2723
Compassionate Care Hospice of Savannah,LLC	138 Canal St, Ste's 304 & 305	Pooler	GA	31322	Barbara Chal	912-691-5755
Compassionate Care Hospice of Northern Georgia, LLC	2340 Prince Avenue, Suite B	Athens	GA	30606	Debbie Furbish	706-369-3550
Compassionate Care Hospice of Central Georgia, LLC	4900 Mercer University Dr., Suite 2	Macon	GA	31210	Shannon Taylor	478-405-7576
Compassionate Care Hospice of Kansas City, LLC	10000 West 75th Street, Suite 231	Shawnee Mission	KS	66204	Donna Rollins	913-671-6740
Compassionate Care Hospice of Central Louisiana, LLC	5417 Jackson Street, Suite B	Alexandria	LA	71303	Dana Pias	318-487-9400
Compassionate Care Hospice of Massachusetts, LLC	800 West Cummings Park, Suite 3400	Woburn	MA	01801	Casey Cuthbert-Allman	781-935-5550
Compassionate Care Hospice of Michigan, LLC	5730 N. Lilley Road, Suite A&B	Canton	MI	48187	Brenda Kassees	734-983-9050
Compassionate Care Hospice of Minnesota, LLC	31361 State Highwway 266	Worthington	MN	56187	Laurie Timmer	507-372-7003
Pathways to Compassion, LLC	287 North 115th Street	Omaha	NE	68154	Kathleen Hanline	402-333-3149
Compassionate Care Hospice of New Hampshire, LLC	25 Nashua Road, Suite E-3	Londonderry	NH	03053	Linda Hotchkiss	603-421-9887
Compassionate Care Hospice of Marlton, LLC	600 Highland Drive, Suite 624	Westampton	NJ	08060	Anthony Bolden	609-267-1178
Compassionate Care Hospice of Clifton	6 Prospect Village Plaza, Suite 200	Clifton	NJ	07013	Lillian Montalvo	973-916-1400
Compassionate Care Hospice of Northern New Jersey	350 Sparta Avenue, Building B, Suite 2	Sparta	NJ	07871	Ginny Montella	973- 383-7510
Compassionate Care Hospice of New York	6661-6663 Broadway	Bronx	NY	10471	Robert Aberman	718-601-6694
Compassionate Care Hospice, Inc.	1513 Cedar Cliff Drive, Suite 100	Camp Hill	PA	17011	Pat Heiland	717-944-4466

Compassionate Care Hospice of Gwynedd, Inc.	3331 Street Road, Suite 410	Bensalem	PA	19020	Kathy Moskowitz	215-245-3525
Compassionate Care Hospice of Northwestern Pennsylvania, LLC	960 North Main Avenue	Scranton	PA	18508	Karen Kaville	570-346-2241
Compassionate Care Hospice of Pittsburgh, LLC	10 Duff Road, Suite 215	Penn Hills	PA	15235	Caitlin McNamee	724-869-2000
Compassionate Care Hospice of South Carolina, LLC	455 St. Andrews Road, Bldg D, Suite 1	Columbia	SC	29210	Tiffany Stamps	803-731-8110
Compassionate Care Hospice of the Midwest, LLC	3415 North Potsdam Avenue	Sioux Falls	SD	57104	Laurie Timmer	605-338-2066
Compassionate Care Hospice of Houston, LLC	2020 North Loop West, Suite 140	Houston	TX	77018	Brandi Gabriel	713-667-3247
Compassionate Care Hospice of Southeastern Texas, LLC	355 N. 18th Street, Suite 104	Beaumont	TX	77707	Tim Smith	409-835-3300
Compassionate Care Hospice of North Texas, LLC	13612 Midway Road, Suite 294	Dallas	TX	75244	Scott Caldwell	972-547-3600
Compassionate Care Hospice of Bryan Texas, LLC	3833 South Texas Avenue, Suite 100	Bryan	TX	77802	Stacey Rowse	979-260-9700
Compassionate Care Hospice of the Chesapeake Bay, LLC	4425 Portsmouth Blvd., Suite 110	Chesapeake	VA	23321	Bryan Dingus	757-405-3203
Compassionate Care Hospice of Wisconsin,LLC	2514 South 102nd Street, Suite 276	West Allis	WI	53227	Linda Kritikos	414-257-1708
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.

SECTION 504 GRIEVANCE PROCEDURE
Policy No: 1012

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.

SECTION 504 GRIEVANCE PROCEDURE
Policy No: 1012

Effective	Reviewed	Revised
01-19-1996	01-05-2009 10-01-1998	10-01-1998

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.

Compassionate Care Hospice

ADMISSION PROCESS
Policy No: 2002

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.

Effective	Reviewed	Revised
09-19-1995	01-05-2009 03-06-2008 01-15-2007 12-01-2006 03-24-2003 10-01-1998	03-06-2008 01-15-2007 12-01-2006 04-03-2003 10-01-1998

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 statues 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: _____