State of Illinois
Department of Healthcare and Family Services

COMPLIANCE REPORT FOR SKILLED NURSING, INTERMEDIATE CARE AND OTHER 24-HOUR FACILITIES (Civil Rights Act Title VI)

If any of the questions below require an explanation, use PART IV REMARKS and identifying comments by Item Number.

I. IDENTIFYING INFORMATION

Name of Facility _____ Street Address _____ City, County, State and Zip code _____

MEDICARE PROVIDER NO. _____

MEDICAID PROVIDER NO. _____

Phone Number _____

Bed Capacity

Licensed Bed Capacity _____ Medicare Beds Approved _____

Medicaid Beds Approved _____ Current Bed Capacity _____

Name, Address and Telephone Number of Owner of Facility

TYPE OF FACILITY

- ☐ Skilled Nursing Facility
- ☐ Intermediate Care Facility
- ☐ Intermediate Care Facility for the Mentally Retarded
- ☐ Mental Health Facility
- ☐ Other (Specify) _____

TYPE OF CONTROL

- ☐ Religious
- ☐ Fraternal
- ☐ Other non-profit
- ☐ County
- ☐ Proprietary
- ☐ Other (Specify) _____

II. RESIDENT ADMISSION AND DISTRIBUTION

Does your facility have a written policy of nondiscrimination that provides for resident admission and service without regard to race, color, or national origin? Yes ☐ No ☐

Is this policy displayed in areas of the facility accessible to employees, residents, and the public? Yes ☐ No ☐

Describe briefly any amendments to your civil rights policy or any implementation efforts made since the last compliance report. (Use PART IV REMARKS)

Has the community been notified of your policy to accept residents and render services without regard to race, color or national origin? Yes ☐ No ☐

If "yes" is checked enter date and check method of communication: _____ ☐ Newspaper ☐ Radio ☐ Letter ☐ Other (Specify) _____

Is use of your facility limited to membership in a defined group? (i.e. fraternal organization, religious denomination, employees of a corporation, etc.) Yes ☐ No ☐

If "yes" explain and describe membership requirements. (Use PART IV REMARKS)

Estimate the number of residents of minority groups (African American, American Indian, Oriental and Hispanic) admitted during the last year. ☐ 0 ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ Over 50

Total number of minority group residents in today's census _____

II. RESIDENT ADMISSION AND DISTRIBUTION (continued)

Indicate below the number of minority group residents in today's census by type and room assignment according to the following breakdown:

Type of Room Assignment	African	American	Oriental	Hispanic
Number in single rooms or in room alone.				
Number in semi-private or ward rooms having only minority persons.				
Number in semi-private or ward rooms with one or more non-minority persons.				
TOTAL				

Indicate the number of residents in today's census whose charges made by your facility are paid in part or full by Medicare or Medicaid.

Type of Aid	TOTAL	African	American	Oriental	Hispanic
Medicare					
Medicaid					

What is the approximate percentage of minority group population in the geographic service area from which most of your residents are drawn? _____

III. SERVICE AND FACILITY UTILIZATION

Are all services and facilities used routinely by all persons without regard to race, color, or national origin? (i.e. nursing care, social services, occupational therapy, dining area, barber shop, beauty salons, etc.) Yes ☐ No ☐

If "no" specify which are not. _____

Are services rendered in this 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 are not. _____

Estimate below the number of physicians and other licensed paramedical personnel not on your payroll that gave resident service in this facility during the last month by race of the physician or person rendering the service.

Physicians and Other Non-Salaried Paramedical Personnel				
TOTAL	**African**	**American**	**Oriental**	**Hispanic**

IV. REMARKS

I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF (A willfully false statement is punishable by law: U.S. Code, Title 18, Sec. 1001).

Signature of Authorized Official	Title	Date