69-CRC-FSH

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
OFFICE FOR CIVIL RIGHTS
WASHINGTON, D.C. 20201

Form Approved
Budget Bureau No. 85-R0030

HOSPITAL COMPLIANCE REPORT
(Civil Rights Act Title VI)

Please read the accompanying instructions before completing this form. If your answers to any of th questions b low requir an explanation, use Part IV REMARKS and identify comment by part and item numb r.

I. IDENTIFYING INFORMATION

A

NAME OF HOSPITAL [redacted]

STREET ADDRESS

CITY, COUNTY AND STATE [redacted]

MEDICARE PROVIDER NO. _____

ZIP CODE [redacted]

TELEPHONE NUMBER (INCLUDE AREA CODE) [redacted]

B

Type of Control (Check one)

VOLUNTARY (NON-PROFIT)
1 ☐ Church
2 ☐ Other (Specify) _____

GOVERNMENT (NON-FEDERAL)
3 ☒ State
4 ☐ County
5 ☐ City
6 ☐ City-County

7 ☐ Proprietary
8 ☐ Other (Specify) _____

C

1 Licensed Bed Capacity [redacted]

2 Current Bed Capacity [redacted]

II. PATIENT ADMISSION AND DISTRIBUTION

D

1 Does your facility have a policy of nondiscrimination that provides for patient admissions, services, staff privileges and training programs without regard to race, color, or national origin? 1 ☐ Yes 2 ☐ No

2 If "yes" indicate date of policy [redacted]

3 Is this policy in writing? 3 ☒ Yes 4 ☐ No

4 Has it been announced to the public? 5 ☒ Yes 6 ☐ No

E

Describe briefly any amendments to your civil rights policy or any implementation efforts made since the last compliance report. (Use part IV REMARKS or the reverse side of this form)

F

Indicate the number of patients by race of patient receiving any of the following types of care on one day. (Preferably *the day before this report is prepared*) *Indicate date* _____

TYPE OF CARE	TOTAL (ALL) 1	NEGRO 2	AMERICAN INDIAN 3	ORIENTAL 4	SPANISH SURNAMED AMERICAN 5
1 OUT-PATIENT SERVICE	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
a CLINIC SERVICE					
b EMERGENCY					
c OTHER					
2 IN-PATIENT CARE	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
3 TOTAL	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

G

Indicate below the number of minority group in-patients in the above census by type of room assignment according to the following breakdown:

TYPE OF ROOM ASSIGNMENT	NEGRO 1	AMERICAN INDIAN 2	ORIENTAL 3	SPANISH SURNAMED AMERICAN 4
1 Number of minority patients in single rooms or in room alone				
2 Number of minority patients in semi-private or ward rooms having only minority patients				
3 Number of minority patients in semi-private or ward rooms with one or more non-minority pati nts				
4 TOTAL				

[redacted]

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H Indicate the number of patients in today's in-patient census whose charges are paid in part or full by Medicare or Public Welfare.

TYPE OF AID	TOTAL (ALL)	NEGRO	AMERICAN INDIAN	ORIENTAL	SPANISH SURNAMED AMERICAN
	1	2	3	4	5
1 Medicare	[redacted]				
2 Public Welfare					

I What is the approximate percentage of minority group population in the geographic service area from which most of your patients are drawn? [redacted]%

II. SERVICE AND FACILITY UTILIZATION

J Are all services and facilities used routinely by all persons without regard to race, color or national origin? (i.e. entrances, admission offices, waiting rooms, dining areas and cafeterias, recreation areas, beauty salons, barber shops, toilet and lavatory facilities, other general service facilities, etc.)
[redacted] Yes ☐ No If "no" specify which are not (Use part IV Remarks)

K Present status of Facility's Medical and Dental staff - indicate in each category the number of persons who are either on the staff or attending patients in this facility.

STAFF CATEGORIES	TOTAL (ALL)	NEGRO	AMERICAN INDIAN	ORIENTAL	SPANISH SURNAMED AMERICAN
	1	2	3	4	5
PHYSICIANS					
1 Full Staff Members	[redacted]				
2 Courtesy Staff					
3 Others					
DENTISTS					
4 Staff Members					
5 Others					
6 TOTAL					

L Indicate the number and status of applications for medical and dental staff positions received by your facility during the last two years.

STATUS OF APPLICATIONS	TOTAL (ALL)	NEGRO	AMERICAN INDIAN	ORIENTAL	SPANISH SURNAMED AMERICAN
	1	2	3	4	5
1 Pending prior year and returned	[redacted]				
2 Received during last 2 years					
3 Denied during last 2 years					
4 Approved during last 2 years					
5 Pending now				[redacted]	[redacted]
6 TOTAL					

M To the best of your knowledge, how many physicians of the minority groups are in active practice in your geographic service area? [redacted]

N Do you have a training program? ☐ Yes ☐ No
If "yes" indicate the number of persons currently in training in each category by race of the participant. *(If this reporting period is between training sessions, give training data for last training classes).*

TRAINING CATEGORIES	TOTAL (ALL)	NEGRO	AMERICAN INDIAN	ORIENTAL	SPANISH SURNAMED AMERICAN
	1	2	3	4	5
1 Interns	[redacted]				
2 Residents					
3 Student Nurses					
4 Practical Nurses in Training		[redacted]	[redacted]	[redacted]	[redacted]
5 Medical Technologists					
6 Therapists					
7 Social Workers					
8 Other					
9 TOTAL	[redacted]				

IV. REMARKS *(Use reverse side of form if necessary)*

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 18, Sec., 1001).*

SIGNATURE OF AUTHORIZED OFFICIAL	TITLE	DATE
[redacted]	[redacted]	[redacted]

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