

National Commission on Correctional Health Care

Annual Maintenance Report for 2010

This Annual Maintenance Report (AMR) and compliance with the NCCHC *Standards for Health Services in Jails/Prisons/Juvenile Detention and Confinement Facilities* is required to maintain your health services accreditation.

To ensure accuracy of current information for correspondence and billing purposes, please provide the requested information. This form must be fully completed and signed. Thank you.	
Legal name of facility Facility type	
Mailing address (please include street address for UPS shipping purposes)	
Facility main phone number	
Facility fax number	
Overall legally responsible facility official Title Phone number	
Health Services Administrator Phone number Fax number Email address	
Responsible Physician Phone number	
Mental Health Authority (if separate from Health Authority) Phone number Fax number Email address	

1) What was your facility's average daily population (ADP) for 2009, inclusive of any satellites? _____

2) If your facility has any satellites, please provide the requested information below. Please provide the average daily population for each satellite for 2009; use a separate sheet if necessary. No satellites

Satellite Name	Miles from Main Unit	Satellite ADP
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3) Is the responsible health authority an outside vendor or contractor (i.e., private company, health department, university)?
 NO YES (If yes, please describe):

If this is a change in the primary health services contractor since your last AMR, please indicate the date the change was effective (month/year): _____

4) ALL FACILITIES-please provide current billing address, contact person, and his or her telephone number:

5) For jails and prisons: When conducting the initial health assessment under the E-04 Initial Health Assessment standard, there are two options for implementing and demonstrating compliance. The "full population assessment" option involves performing assessments on 100% of inmates. The "individual assessment when clinically indicated" option involves performing assessments on only those determined to be at high risk for significant health problems. Which option is employed at this facility?

- Full Population Assessment Individual Assessment When Clinically Indicated

6) Have there been any changes in the manner of health care delivery in 2009 (e.g., closing of an infirmary, acquiring new clinic space, changes in the sick call process, etc.)? NO YES (If yes, please describe):

7) Does the facility have any on-site opioid treatment programs or services (using methadone, buprenorphine, LAAM)?
 NO YES Name and phone contact for responsible staff member:

Do you provide these services through arrangements with a community agency? NO YES

(If yes, please describe): _____

8) Is the facility under any court order or legal agreement relating to health care (regardless of the exact legal wording)?
 NO YES (If yes, please provide details):

Since the last report:

a) Has there been a class action suit initiated relating to health care?
 NO YES (If yes, please summarize):

b) Has there been any judgment against the facility regarding health care? NO YES (If yes, please summarize):

c) Has a court entered a new or amended order, judgment, or decree that relates to health services?
 NO YES (If yes, please attach a copy).

d) Has there been a Master or Monitor appointed with respect to health services?
 NO YES (If yes, please attach a copy of the most recent report).

e) Is the facility (or system) required to report to the court regarding health services?
 NO YES (If yes, please attach a copy of the most recent report).

To the best of my knowledge, _____ remains in compliance with the current NCCHC *Standards for Health Services in Prisons/Jails/Juvenile Detention and Confinement Facilities* (circle one).

Printed Name of Responsible Health Authority

Signature of Responsible Health Authority

Please return to:
NCCHC, Accreditation Department
1145 W. Diversey Pkwy.
Chicago, IL 60614
Fax: (773) 880-2424