

NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

P.O. Box 11117, Chicago, Illinois 60611, (773) 880-1460



**APPLICATION AND CONTRACT FOR ACCREDITATION OF
CORRECTIONAL MENTAL HEALTH SERVICES**

Legal Name of Facility (to appear on certificate of accreditation)

Check one: Jail Prison Other: _____

Note: NCCHC Mental health services accreditation is available only to correctional facilities whose mental health services are provided by a legal authority apart from that which provides medical health services.

We hereby apply to the National Commission on Correctional Health Care (NCCHC) for the accreditation of the institution named above, for its compliance with NCCHC's *Standards for Mental Health Services in Correctional Facilities*. We agree to abide by NCCHC accreditation policies and to permit, at the time of the site survey, private and confidential interviews with facility employees, including those contracted to provide services to the facility, and inmates/residents/patients; a review of all pertinent documentation, including clinical records; and a tour of the facility including general population and segregated and/or other special housing areas, mental health care locations, and satellite locations. We hereby acknowledge that if the facility is accredited, the ongoing compliance with the *Standards* is required to maintain accreditation. We agree to notify NCCHC in writing of any substantive change in the management of the mental health care program within 30 days of such occurrence. We understand that **this application constitutes a contract for services** in the NCCHC accreditation program. We further understand that although NCCHC may come on site at any time to verify compliance with the *Standards*, a site visit will likely take place at least once every three years. We will submit in a timely fashion Annual Maintenance Reports and other documents requested by NCCHC. We agree to pay in a timely fashion NCCHC fees for accreditation services, generally billed annually, and may request an estimate of those fees at any time. We may terminate our participation in the NCCHC accreditation program at any time upon 60 days written notice.

Signature of Person Legally Responsible For Facility

Date

Name and Title (Printed or typed)

A non-refundable check or voucher for \$250.00, payable to the National Commission on Correctional Health Care or NCCHC, should accompany this application. Upon its review and acceptance, NCCHC will initiate a site survey to be conducted at a mutually agreed upon time. In the event of cancellation of this application for accreditation, the applicant agrees to be responsible for any expense incurred by NCCHC in the scheduling of the on-site visit.

Check enclosed Invoice requested (\$30 processing fee will be added)

Application Expiration: one year from date of this application

FACILITY INFORMATION

1. _____
Name of facility

2. _____
Mailing address (If this is a PO Box, please also provide physical address of facility)

3. _____
City State ZIP

4. _____
Year facility was constructed

5. Is this a multijurisdictional facility? Yes___ No___

6. If yes, which jurisdictions (i.e., counties/states) do you draw from? _____

7. Major renovations/expansions (completed since construction and/or in planning process):

8. Has this facility ever before been accredited by NCCHC? Yes___ No___

If yes, under what name? _____

During which year(s) was the facility accredited? _____

	Name		Design- rated Capacity	Most Recent Population
9.	Main Unit: _____	_____	_____	_____
	Satellite #1: _____ Miles from Main Unit	_____	_____	_____
	Satellite #2: _____ Miles from Main Unit	_____	_____	_____
	Satellite #3: _____ Miles from Main Unit	_____	_____	_____
	Satellite #4: _____ Miles from Main Unit	_____	_____	_____
TOTALS:			_____	_____

A satellite is defined as a separate building where inmates are housed for which the main facility has both administrative and mental health service responsibilities.

BILLING INFORMATION

10. Invoices for accreditation should be sent to the following:

Name		Title	
Address			
City	State	Zip	

PERSONNEL INFORMATION

11. _____ (_____) _____
Person legally responsible for the facility Telephone number

_____ (_____) _____
E-mail address Fax number

12. _____ (_____) _____
Name of clinician responsible for mental health care Telephone number

_____ (_____) _____
E-mail address Fax number

13. _____ (_____) _____
Name of mental health administrator/supervisor Telephone number

_____ (_____) _____
E-mail address Fax number

14. _____ (_____) _____
Name of accreditation manager/coordinator Telephone number
if different from mental health administrator

_____ (_____) _____
E-mail address Fax number

INMATE DATA

15. Total number of admissions in the prior year (or most recent 12-month period available) for main and satellite units: _____

16. Average daily intake: _____

17. Most recent population for the entire facility (main and satellite units):
Adult males: _____ Juvenile males: _____
Adult females: _____ Juvenile females: _____

MENTAL HEALTH CARE SERVICES DATA

18. Are mental health services contracted? _____ If yes, give name of contractor and expiration date of current contract: _____

Contractor contact person: _____

Phone _____ Fax _____ E-mail _____

Name of any facility/system contract monitor: _____

List any special on-site mental health services programs (e.g., acute mental health residential units, nonacute residential units, therapeutic community for substance abusers). _____

19. Number of health providers on-site (Full-Time Equivalents*):

	<u>Main Unit</u>	<u>Satellites</u>			
		#1	#2	#3	#4
Administrators	_____	_____	_____	_____	_____
Physicians	_____	_____	_____	_____	_____
Physician Assistants	_____	_____	_____	_____	_____
Nurse Practitioners	_____	_____	_____	_____	_____
Registered Nurses	_____	_____	_____	_____	_____
Licensed Practical Nurses	_____	_____	_____	_____	_____
Psychologists	_____	_____	_____	_____	_____
Psychiatrists	_____	_____	_____	_____	_____
Licensed Social Workers	_____	_____	_____	_____	_____
Health Records Personnel	_____	_____	_____	_____	_____
Pharmacists/Pharm Techs	_____	_____	_____	_____	_____
Mental Health Workers	_____	_____	_____	_____	_____
Other (please specify)	_____	_____	_____	_____	_____

*Someone working a regular 40 hour week is considered 1.0 FTE. To calculate FTEs, take the total number of hours by employee category and divide by 40 (or the jurisdiction's equivalent of a full-time work week). For example, someone working 16 hours would be a .40 FTE (16/40=.40); 5 part-time LPNS working a total of 60 hours would be 1.5 FTE (60/40=1.5).

20. Type and number of hours per month of regular off-site mental health consultants (e.g., psychologist, 10 hours):

21. Does the facility operate an inpatient psychiatric hospital unit? _____ If yes, total number of beds: Male _____ Female _____

22. List any community hospital(s), clinic(s), and/or other mental health care facilities used for mental health services provided outside the facility: _____

23. Are there any plans to make substantial changes in the mental health care delivery system at the facility? If so, please describe: _____

24. Is the facility currently involved in any of the following:

A. Legal action alleging inadequate mental health care for inmates? _____
If yes, when was the action filed? _____

Please (1) submit summary information about the case(s); and (2) furnish a copy of any judgment, order or decree entered by the court, and all master, monitor or facility reports filed in the last twelve (12) months pursuant to such order, judgment, or decree. If no reports have been issued within the last twelve months, please provide a copy of the last such substantive report issued.

Summary description: _____

I certify that the above is true and correct to the best of my knowledge and belief.

Type name and title, then sign

Date