Institute for Medical Quality
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ADULT & JUVENILE DETENTION FACILITIES HEALTH CARE ACCREDITATION PROGRAM

APPLICATION FOR ACCREDITATION OF HEALTH SERVICES

This Application for Accreditation of Health Services is based on the 2013 IMQ HEALTH CARE ACCREDITATION STANDARDS FOR ADULT DETENTION FACILITIES and the 2013 IMQ HEALTH CARE ACCREDITATION STANDARDS FOR JUVENILE DETENTION FACILITIES. Some of the items in this questionnaire may not apply to your facility. In such cases, please mark NA in the answer space. Please complete a separate application for each facility.

Return completed applications to Kevin C. Reeder, MPA: *KReeder@imq.org*. Questions may be addressed to Kevin 415.882.5132 or via e-mail.

FACILITY INFORMATION:

Name of Facility: _____

Address of Facility: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Official In Charge of Facility

Name of Official: _____

Title of Official: _____

Phone: _____

Email: _____

Facility Contact Person

Name of Contact: _____

Title of Contact: _____

Phone: _____

Email: _____

Year Facility was Built: _____

Have there been any major renovations? Yes ____ No ____

If yes, briefly describe:

FACILITY POPULATION STATISTICS:

Design Rated Capacity (DRC): _____

Average Daily Population (ADP) for Previous Year: _____

Number of Females: _____ Number of Males: _____

Average daily intake: _____

HEALTH PROVIDER INFORMATION:

Medical Services

Name of Medical Director or Responsible Physician: _____

Phone: _____

Email: _____

Names of other Physicians: _____

_____

Total number of Physicians: _____ Full Time: _____ Part Time: _____

Total number of RNs: _____ Full Time: _____ Part Time: _____

Total number of LVNs: _____ Full Time: _____ Part Time: _____

Total number of Mid-Level Practitioners: _____ Full Time: _____ Part Time: _____

Total number of Support Staff: _____

Number of Nursing/Medical Assistants: _____

Number of Medical Records Staff: _____

Number of Secretarial/Clerical Staff _____

Mental Health Services

Names of Psychiatric Medical Director: _____

Phone: _____

Email: _____

Total number of Psychiatrists: _____ Full Time: _____ Part Time: _____

Total number of Mental Health Clinicians: _____ Full Time: _____ Part Time: _____

Names and Licensure of other Mental Health Clinicians: _____

_____

Total number of Support Staff: _____

Total number of Psychiatric Technicians: _____

Total number of Secretarial/Clerical Staff: _____

Dental Services

Name of Dentist: _____

Phone: _____

Email: _____

Names of other Dentists: _____

Total number of Dentists: _____ Full Time: _____ Part Time: _____

Total number of Dental Assistants: _____ Full Time: _____ Part Time: _____

SCOPE OF HEALTH SERVICES:

How often are medical clinics held? _____

How often are mental health clinics held? _____

Who provides medical clinic services? (check all that apply)

RN _____ NP/PA _____ MD _____

What Specialty/Chronic Care Clinics are provided on-site?

What level(s) of licensure serve in the Chronic Care Clinics? (check all that apply)

RN _____ NP/PA _____ MD _____

What level(s) of licensure provide mental health services? (check all that apply)

MD _____ PhD _____ LCSW _____ MFT _____

Does your facility have any Medical/Mental Health Housing?

Yes _____ No _____

If yes, please indicate below:

Medical Patients:

Outpatient Sheltered/Home Health _____

Convalescent Care _____

Acute Care _____

Mental Health Patients:

Outpatient Sheltered/Home Health _____

Convalescent Care _____

Acute Care _____

Overlapping Responsibilities - Custody & Health Providers:

Does your facility conduct a medical receiving screening upon arrival at your facility?

Yes _____ No _____

If you answered No, please explain:

Who performs the receiving screening?

Nursing _____ Custody _____

Exactly, when is this screening done?

Immediately at entry _____

Within One hour of admission _____

Within four hours of admission _____

Other (please indicate) _____

Does your facility have a safety cell/room?

Yes _____ No _____

If yes, where is it located? (check all that apply):

Booking ____ Medical/Mental Health Housing ____ Other ____

Does your facility use Restraints as defined in Title 15 (Section1058 Adult or Section 1358 Juvenile)?

Yes _____ No _____

ORGANIZATIONAL CONCERNS:

Have there been any Lawsuits against your facility within the past five years?

Yes _____ No _____

Was the adequacy of the health care services an issue?

Yes _____ No _____

Is your facility currently under such a suit?

Yes _____ No _____

If yes, briefly explain:

What types of benefits do you think your facility will derive from being in the accreditation program?

Do you foresee difficulties in obtaining staff support (facility, medical or mental health) for making changes if necessary to attain accreditation?

Yes _____ No _____

If yes, briefly explain:

If improving the health care in your facility requires an increase in the health service budget, would you be willing to go to the funding body and request the additional funding?

Yes _____ No _____

I HEREBY APPLY TO THE INSTITUTE FOR MEDICAL QUALITY FOR ACCREDITATION OF THE MEDICAL CARE AND HEALTH SERVICES OF THE FACILITY FOR WHICH I AM LEGALLY RESPONSIBLE. I RECOGNIZE THAT IN ORDER TO KEEP ACCREDITATION IN FORCE, THE FACILITY'S HEALTH CARE PROGRAM MUST BE MAINTAINED ACCORDING TO THE IMQ STANDARDS DURING THE ACCREDITATION PERIOD.

Signature: _____ **Date:** _____

Title: _____