NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE
P.O. Box 11117, Chicago, Illinois 60611, (773) 880-1460

APPLICATION AND CONTRACT FOR ACCREDITATION OF CORRECTIONAL HEALTH SERVICES

LFUCG - Division of Community Corrections
Legal Name of Facility (to appear on certificate of accreditation)

Check facility type: ✓ Jail ____Prison ____Juvenile

We hereby apply to the National Commission on Correctional Health Care (NCCHC) for the accreditation of the facility named above, for compliance with NCCHC's *Standards for Health Services*. The survey and review of health care practices at this facility will be guided by standards originally developed by the American Medical Association and adopted and revised by NCCHC. We agree to abide by NCCHC accreditation policies and to permit, at the time of the site survey, private and confidential interviews with correctional officers, health care and other personnel, and inmates/residents; a review of all pertinent documentation, including health records; and a tour of the facility, including general population and segregated and/or other special housing areas, health care locations, satellite locations, and other areas necessary for NCCHC to properly conduct its survey.

We hereby acknowledge that if the facility is accredited, compliance with NCCHC standards must be maintained and we agree to notify NCCHC in writing of any substantive change in the scope, management, or delivery of health care services within 30 days of such occurrence. We understand that this application constitutes a contract for services in the NCCHC accreditation program. We shall submit Annual Maintenance Reports. We further understand that although NCCHC may come on site at any time, a site visit will take place approximately once every three years, and that the facility may terminate participation in the NCCHC accreditation program at any time upon 60 days written notice.

We are liable for compliance with the obligations of this application and, if applicable, the accreditation requirements, including but not limited to payment for the cost of accreditation and any expense incurred by NCCHC in scheduling the on-site visit if this application is cancelled or withdrawn. Invoices from NCCHC for the accreditation fee will be sent annually in the first quarter of every year and, if requested, NCCHC will provide an estimate of the anticipated fee in the last quarter of the prior year.

____ __________
Signature of Person Legally Responsible Date

____
Name and Title (Printed or typed)

A nonrefundable check or voucher for $250, payable to the National Commission on Correctional Health Care, should accompany this application.

____Check enclosed ____Invoice requested ($30 processing fee will be added)

FACILITY INFORMATION

LFUCG - DIVISION of COMMUNITY CORRECTIONS
Name of facility

600 Old FRANKfort Cr
Mailing address (If this is a PO Box, please also provide physical address of facility)

Lexington | KY | 40510
City | State | ZIP

2000
Year facility was built

Major renovations or expansions anticipated in the next 12 months

Has this facility ever been accredited before by NCCHC? Yes___ No ✓

If yes, what was the name of the facility? ____________________

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

	Name	Miles from Main Unit	Design-rated Capacity	Average Daily Population (ADP)
Main Unit	FAYETTE COUNTY DETENTION Ctr	N/A	1280	1205
Satellite #1				
Satellite #2				
Satellite #3				
Satellite #4				

TOTAL ADP 1205

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

Total number of admissions in the prior 12 months: 17,883

Average daily intake: 49

Most recent population for the facility (include main and satellite units):

Adult males 1003
Juvenile males Ø

Adult females 249
Juvenile females Ø

BILLING INFORMATION

Invoices for accreditation should be sent to the following:

GINA C. DULIN, Admin SPECIALIST PRINCIPAL
Name and title

600 Old FRANKFORT Cr
Mailing address

Lexington | KY | 40510
City | State | ZIP

PERSONNEL INFORMATION

Rodney Ballard, Director — 859-425-2611
Government official responsible for the facility — Telephone number

rballard2@lexingtonky.gov
Email address

Dr. Imhotep Carter, MD — 815-501-6314
Physician responsible for medical care — Telephone number

Imhotep.Carter@corizonhealth.com
Email address

Jammie Garner — 859-425-2740
Health services administrator/supervisor — Telephone number

jammie.Garner@corizonheath.com — 859-367-0307
Email address — Fax number

Accreditation manager (if different from above) — Telephone number

Email address

Describe how many hours per day health staff is on site: 24 hrs

Describe the regular off-site health consultants (e.g., dentist at 10 hours/month, psychiatrist at 12 hours/month via telepsychiatry, optometrist as needed): optometrist as needed

Number of On-Site Health Staff (Full-Time Equivalents*)

Employee Category	Main Unit	Satellites			
		1	2	3	4
Administrator	1.0				
Physician	1.0				
Physician Assistant	—				
Nurse Practitioner	1.0				
Registered Nurse	9.2				
Licensed Practical Nurse	11.5				
Psychiatrist	.5				
Psychologist	—				
Dentist	.5				
Pharmacist	—				
Dental Assistant/Hygienist	.5				
Mental Health Worker	10.5				
Health Records Personnel	.65				
Lab/X-ray Technician	—				
~~EMT or MA~~ Director of Nursing	1.0				
Other (specify) Office Staff	3.0				

*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).

PROVISION OF HEALTH SERVICES

Are health services contracted? Yes ✓ No____

If yes, provide name of contractor and expiration date of current contract: 06/30/2016

Corizon Health
Health services contractor

Major Jim Capillo
Name of facility/system contract monitor, if applicable

859-425-2730
Telephone number

jimc@lexingtonky.gov
Email address

(Jails and Prisons only) Please indicate which type of health assessment (E-04) is conducted:

✓ Full population ___Individual assessment when clinically indicated

Are mental health services contracted to a different authority? Yes ✓ No____

bluegrass.org
Mental health services contractor

List any special on-site health services programs (e.g., infirmary, hospice, dialysis, therapeutic community for substance abusers, separate housing or program for mental health patients).

Infirmary, therapeutic community for substance abusers

Are there any plans to make substantial changes in the health care delivery system at this facility? If so, please describe: ____________________

Is the facility currently involved in any of the following:

1. Legal action alleging inadequate medical or other health care for inmates? Yes ✓ No____

If yes, when was the action filed? 1/31/2012 6/12/2012 11/13/2012

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 12 months pursuant to such order, judgment, or decree. If no reports have been issued within the last 12 months, please provide a copy of the last such substantive report issued.

Summary description: litigation still pending

2. Action by a community, government, or quasigovernment/public agency or group to review or investigate health services provided at the facility? Yes____ No____

If yes, please report the name of the group: ____________________

Please describe the purpose of the review or investigation. If any reports have been issued by this group, please provide a copy with your application.

Summary description: ____________________

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

(signed) ____________________ (date) ____________________

Name (printed) ____________________

Title ____________________