HEALTH SYSTEMS

CIVIL RIGHTS COMPLIANCE CHECKLIST

Program/Provider/Facility	County	Region/Circuit
CDS Family & Behavavioral Health Services, Inc.	Alachua	4/ 3 & 8
Address		
1218 N.W. 6th Street		
City, State, Zip Code	**Date**	**Telephone**
Gainesville, Fl. 32601	5/13/14	352-244-0628

PART I. 1. Briefly describe the geographic area served by the program/provider/facility and the type of service(s) provided:

2. POPULATION OF AREA SERVED. List source of data: U.S. Census 2010

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	
641577	74	19	6	1	46	54	

3. STAFF CURRENTLY EMPLOYED. Effective date:

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	% Disabled
105	38	55	5	1	78	22	

4. CLIENTS CURRENTLY ENROLLED OR REGISTERED. Effective date: 8/19/13

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	% Disabled
2086	61	21	8	10	45	55	

5. ADVISORY OR GOVERNING BOARD, IF APPLICABLE.

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	
15	87	13			13	87	

PART II.

NA YES NO

6. Is an Assurance of Compliance in file with the Department of Children and Families? If NA or NO, explain ☐ ☐ ☐

NA YES NO

7. Compare staff composition to the population. Are staff representative of the population? If NA or NO, explain ☐ ☒ ☐

NA YES NO

8. Compare the client composition to the population. Are race/gender composition representative of the population? ☐ ☒ ☐
If NA or NO, explain.

NA YES NO

9. Are employees, applicants and recipients informed of their protection against discrimination? ☐ ☐ ☐
If YES, how? ☒ Verbal ☒ Written ☒ Poster If NA or NO, explain.

NA YES NO

10. Do recruitment and notification materials advise applicants, employees and recipients of your non-discrimination policy? ☐ ☒ ☐
If NO, explain.

NA YES NO

11. Is there an established grievance/complaint procedure to resolve complaints of discrimination regarding service ☐ ☒ ☐
delivery or employment decisions? If NO, explain.

NA NUMBER

12. Provide the number and current status of any discrimination complaints regarding services or employment ☒
filed against the program/provider/facility within the last year.

NA YES NO

13. Are eligibility requirements for services applied to clients and applicants without regard to race, color, national origin ☐ ☒ ☐
gender, age, religion or disability? If NA or NO, explain.

14. Are benefits, services, and facilities available to applicants and participants in an equally effective manner regardless of race, gender, age, national origin, religion or disability? If NA or NO, explain. NA ☐ YES ☒ NO ☐

15. Are room assignments made without regard to race, color, national origin or disability for in-patient services? If NA or NO, explain. NA ☐ YES ☒ NO ☐

16. Are Limited-English Proficient (LEP) applicants and recipients provided equal access to benefits including free interpreter services? If NA or NO, explain. NA ☐ YES ☒ NO ☐

17. Are the programs/facilities/services accessible to mobility, hearing, and sight impaired individuals? If NA or NO, explain NA ☐ YES ☒ NO ☐

18. Are auxiliary aids available to assure accessibility of services to hearing and sight impaired individuals? If NO, explains YES ☒ NO ☐

19. Has a self-evaluation been conducted to identify any barriers to serving individuals with disabilities? If NO, explain YES ☒ NO ☐

20. State the name of the designated Section 504 Coordinator for compliance activities: Liz Tschumy

21. Has Civil Rights training been conducted for local staff? If NA or NO, explain NA ☐ YES ☒ NO ☐

22. **SIGNATURE:**

COO

Signature and Title of Person Completing This Form

5-13-14

Date Signed

LSF HEALTH SYSTEMS-NETWORK MANAGEMENT USE ONLY	
Date of Receipt Signature of Network Manager	Notice of Corrective Action Required: ☐ YES ☐ NO If "Yes", attach list of corrective actions.
Type of Review: ☐ On-Site ☐ Desk Review Comments:	Response Received:
Date of Last Compliance Review:	Response Due: