



CIVIL RIGHTS COMPLIANCE CHECKLIST

Program/Provider/Facility CDS Family & Behavioral Health Services, Inc.	County Alachua	Region/Circuit 4/ 3 & 7& 8
Address 1218 NW 6th Street		
City, State, Zip Code Gainesville, FL 32601	Date 1/7/2015	Telephone 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	
641,577	74	19	6	1	46	54	

3. STAFF CURRENTLY EMPLOYED. Effective date: **01/07/2015**

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	% Disabled
121	45	67	7	2	72	28	

4. CLIENTS CURRENTLY ENROLLED OR REGISTERED. Effective date: **6/30/14**

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	% Disabled
3,260	58	29	1	12	46	54	

5. ADVISORY OR GOVERNING BOARD, IF APPLICABLE.

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	
14	86	14			14	86	

PART II.

6. Is an Assurance of Compliance on 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? NA YES NO
If NA or NO, explain.
9. Are employees, applicants and recipients informed of their protection against discrimination? NA YES NO
If YES, how? Verbal Written Poster If NA or NO, explain.
10. Do recruitment and notification materials advise applicants, employees and recipients of your non-discrimination policy? YES NO
If NO, explain.
11. Is there an established grievance/complaint procedure to resolve complaints of discrimination regarding service YES NO
delivery or employment decisions? If NO, explain.
12. Provide the number and current status of any discrimination complaints regarding services or employment NA NUMBER
filed against the program/provider/facility within the last year.
13. Are eligibility requirements for services applied to clients and applicants without regard to race, color, national origin, NA YES NO
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 NA YES NO
 regardless of race, gender, age, national origin, religion or disability? If NA or NO, explain.
15. Are room assignments made without regard to race, color, national origin or disability for in-patient services? NA YES NO
 If NA or NO, explain.
16. Are Limited-English Proficient (LEP) applicants and recipients provided equal access to benefits including free NA YES NO
 interpreter services? If NA or NO, explain.
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, explain. 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: _____
21. Has Civil Rights training been conducted for local staff? If NA or NO, explain. NA YES NO

22. SIGNATURE:

 Signature and Title of Person Completing This Form _____
 Date Signed

DEPARTMENT OF CHILDREN AND FAMILIES USE ONLY	
Date of Receipt Signature of Program Manager or Designee	Notice of Corrective Action Required: <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes", attach list of corrective actions.
Date Reviewed by Compliance Officer:	Response Due:
Type of Review: <input type="checkbox"/> On-Site <input type="checkbox"/> Desk Review Comments:	Response Received:
Date of Last Compliance Review:	