



CIVIL RIGHTS COMPLIANCE CHECKLIST

Program/Provider/Facility CDS Family & Behavioral Health Services, Inc.	County Alachua	Region/District Circuits 3, 7, & 8
Address 1218 NW 6th Street		
City, State, Zip Code Gainesville, FL 32601	Date 03/03/2011	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:
 CDS Family & Behavioral Health Services is dedicated to providing services which address needs for youth, families and adults throughout our 14-county catchment area.

2. POPULATION OF AREA SERVED. List source of data: **2000 Census**

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	
507,351	72.0	17.8	4.9	5.3	49.5	50.5	

3. STAFF CURRENTLY EMPLOYED. Effective date: **02/28/2011**

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	% Disabled
117	43.6	50.4	4.3	1.7	71.8	28.2	0.0

4. CLIENTS CURRENTLY ENROLLED OR REGISTERED. Effective date: **12/31/2010**

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	% Disabled
641	54.0	38.0	6.0	2.0	46.0	54.0	

5. ADVISORY OR GOVERNING BOARD, IF APPLICABLE.

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	
16	81.3	18.7	0.0	0.0	12.5	87.5	

PART II. USE A SEPARATE SHEET OF PAPER FOR ANY EXPLANATIONS REQUIRING MORE SPACE.

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
 Our staff is over represented minorities; however, this is more representative of the population served. Additionally, it is well documented that females are generally over represented in the helping professions.

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? 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 delivery or employment decisions? If NO, explain. YES NO

PART II. USE A SEPARATE SHEET OF PAPER FOR ANY EXPLANATIONS REQUIRING MORE SPACE.

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 NUMBER
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. NA YES NO
14. Are benefits, services, and facilities available to applicants and participants in an equally effective manner regardless of race, gender, color, 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, 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: LaVonya Bryan
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

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:	