

CIVIL RIGHTS COMPLIANCE CHECKLIST

Program/Provider/Facility	County	Region/District
Address		
City, State, Zip Code	Date	Telephone

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:

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	
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3. STAFF CURRENTLY EMPLOYED. Effective date:

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	% Disabled
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4. CLIENTS CURRENTLY ENROLLED OR REGISTERED. Effective date:

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	% Disabled
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5. ADVISORY OR GOVERNING BOARD, IF APPLICABLE.

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

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. YES NO

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: _____
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:	