



STATE OF MISSOURI
 DEPARTMENT OF HEALTH AND SENIOR SERVICES - WIC AND NUTRITION SERVICES
CIVIL RIGHTS IMPACT ANALYSIS

OPENING A NEW CLINIC

LOCAL AGENCY/CLINIC NAME	AGENCY/SITE NUMBER
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1. EFFECTIVE DATE

2. ADDRESS OF PROPOSED CLINIC

3. PHONE NUMBER OF PROPOSED CLINIC

4. PROPOSED CLINIC OPERATING HOURS/DAYS OF THE WEEK

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

5. NUMBER OF STAFF BY TITLE THAT WILL STAFF CLINIC (E.G., CLERK, NUTRITIONIST)

6. JUSTIFICATION FOR OPENING A NEW CLINIC (INCLUDE EXPECTED CASELOAD PER MONTH AT PROPOSED CLINIC)

7. HOW WILL PARTICIPANTS BE NOTIFIED? (SELECT ALL THAT APPLY)

Email
 Handout
 In-Person
 Mail
 Telephone
 Text

8. PUBLIC TRANSPORTATION AVAILABLE?

Yes
 No

9. EQUIPMENT NEEDED? (SUBMIT EQUIPMENT REQUEST FORM WITH THIS FORM.)

Yes
 No

Electronic Signature

SUBMITTED BY	DATE
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STATE AGENCY USE ONLY

10. DISTANCE BETWEEN PROPOSED CLINIC AND OTHER CLINICS IN PROPOSED AREA (INCLUDE MAP VIEW)

11. NUMBER OF POTENTIAL ELIGIBLE INDIVIDUALS IN THE AREA

12 PARTICIPATION BY CATEGORY

WOMEN	
INFANTS	
CHILDREN	

13. PARTICIPATION BY RACE/ETHNICITY (INCLUDE REPORT)

WHITE	
AMERICAN INDIAN/ALASKAN NATIVE	
HISPANIC/LATINO	
ASIAN	
BLACK/AFRICAN AMERICAN	
NATIVE HAWAIIAN PACIFIC ISLANDER	
OTHER	

14. RECOMMENDATION

TECHNICAL ASSISTANT NAME

DATE

REVIEWER NAME

DATE

Approved

Not Approved