STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES - WIC AND NUTRITION SERVICES

CIVIL RIGHTS IMPACT ANALYSIS

REDUCING HOURS/DAYS OF A CLINIC

LOCAL AGENCY/CLINIC NAME	AGENCY/SITE NUMBER

1. EFFECTIVE DATE

2. ADDRESS OF CLINIC

3. CURRENT OPERATING HOURS/DAYS OF THE WEEK

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

4. PROPOSED 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 REDUCTION IN HOURS/DAYS (INCLUDE CURRENT CASELOAD PER MONTH AT CLINIC)

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

☐ Email ☐ Handout ☐ In-Person ☐ Mail ☐ Telephone ☐ Text

8. EQUIPMENT NEEDED/RETURNED? (SUBMIT EQUIPMENT REQUEST OR RETURN FORM WITH THIS FORM.)

☐ Yes ☐ No

Electronic Signature

SUBMITTED BY	DATE

STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES - WIC AND NUTRITION SERVICES

CIVIL RIGHTS IMPACT ANALYSIS

STATE AGENCY USE ONLY

9. NUMBER OF POTENTIAL ELIGIBLE INDIVIDUALS IN THE AREA

10. PARTICIPATION BY CATEGORY

WOMEN	
INFANTS	
CHILDREN	

11. PARTICIPATION BY RACE/ETHNICITY (INCLUDE REPORT)

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

12. RECOMMENDATION

TECHNICAL ASSISTANT NAME	DATE
REVIEWER NAME	DATE

☐ Approved ☐ Not Approved