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

CIVIL RIGHTS IMPACT ANALYSIS

RELOCATING A CLINIC

LOCAL AGENCY/CLINIC NAME	AGENCY/SITE NUMBER

1. EFFECTIVE DATE

2. ADDRESS OF CURRENT CLINIC

3. ADDRESS OF PROPOSED CLINIC

4. PHONE NUMBER OF PROPOSED CLINIC

5. CURRENT OPERATING HOURS/DAYS OF THE WEEK

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

6. PROPOSED OPERATING HOURS/DAYS OF THE WEEK

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

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

8. JUSTIFICATION FOR RELOCATING CLINIC (INCLUDE EXPECTED CASELOAD PER MONTH AT PROPOSED CLINIC)

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

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

10. PUBLIC TRANSPORTATION AVAILABLE?

☐ Yes ☐ No

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

☐ Yes ☐ No

12. RENOVATIONS? IF YES, INCLUDE COST OF RENOVATIONS

☐ Yes _____ ☐ No

Electronic Signature

SUBMITTED BY	DATE

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STATE AGENCY USE ONLY

13. DISTANCE BETWEEN CURRENT CLINIC, PROPOSED CLINIC, AND OTHER CLINICS IN PROPOSED AREA (INCLUDE MAP VIEW)

14. NUMBER OF POTENTIAL ELIGIBLE INDIVIDUALS IN THE AREA

15 PARTICIPATION BY CATEGORY

WOMEN	
INFANTS	
CHILDREN	

16. PARTICIPATION BY RACE/ETHNICITY (INCLUDE REPORT)

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

17. RECOMMENDATION

TECHNICAL ASSISTANT NAME	DATE
REVIEWER NAME	DATE

☐ Approved ☐ Not Approved