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. WILL THE PROPOSED DAYS OF OPERATION CAUSE THE AGENCY, INCLUDING OPEN CLINICS, TO HAVE CLINIC DAYS MORE THAN 10 DAYS APART?

☐ Yes ☐ No

IF YES, HOW WILL YOU ENSURE COMPLIANCE WITH POLICY 8.1.110?

☐ SERVE PARTICIPANTS ON A NON-CLINIC DAY WITHIN 10 DAYS OF THE INITIAL REQUEST. *

☐ REQUEST AN EXTENSION TO SERVE PARTICIPANTS WITHIN 15 DAYS OF THE INITIAL REQUEST.*

*IF ADDITIONAL CLINIC ACCESS OPTIONS ARE NEEDED, REFER TO 7.1.050.

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

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

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

☐ Yes ☐ No

Electronic Signature

SUBMITTED BY	DATE

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STATE AGENCY USE ONLY

10. NUMBER OF POTENTIAL ELIGIBLE INDIVIDUALS IN THE AREA

11. PARTICIPATION BY CATEGORY

WOMEN	
INFANTS	
CHILDREN	

12. PARTICIPATION BY RACE/ETHNICITY (INCLUDE REPORT)

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

13. RECOMMENDATION

TECHNICAL ASSISTANT NAME	DATE
REVIEWER NAME	DATE

☐ Approved ☐ Not Approved