



FCADV

Florida Coalition Against Domestic Violence

Civil Rights Compliance Questionnaire/Checklist

AGENCY NAME:	COUNTY/IES SERVED:	
POSTAL ADDRESS:	COMPLETED BY:	
CITY, STATE, ZIP CODE:	DATE:	TELEPHONE:

Part I.

1. Briefly describe the geographic area served by the program/facility and the type of service provided:

2. **POPULATION OF AREA SERVED.** Source of data: 2010 U.S. Census

Total #	% White	% Black/ African-American	% Hispanic	% Asian/ Pacific-Islander	% Native American	% Other	% Female	% Male

3. **STAFF CURRENTLY EMPLOYED.** Effective date:

Total #	% White	% Black/ African-American	% Hispanic	% Asian/ Pacific-Islander	% Native American	% Other	% Disabled	% Female	% Male

4. **INDIVIDUALS CURRENTLY PARTICIPATING IN STOP PROGRAMS.** Effective date:

Total #	% White	% Black/ African-American	% Hispanic	% Asian/ Pacific-Islander	% Native American	% Other	% Disabled	% Over 40 Yrs.	% Female	% Male

5. **GOVERNING OR ADVISORY BOARD.**

Total #	% White	% Black/ African-American	% Hispanic	% Asian/ Pacific-Islander	% Native American	% Other	% Disabled	% Female	% Male

Part II. USE A SEPARATE SHEET OF PAPER FOR ANY EXPLANATIONS REQUIRING MORE SPACE.

6. Compare staff composition to the population. Are staff representative of the population? If N/A or No, explain.

Yes	No	N/A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Compare the participant composition to the population. Are race and sex characteristics representative of the population? If N/A or No, explain.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- | | Yes | No | N/A |
|--|---------------------------------|--------------------------|--------------------------|
| 8. Are eligibility requirements for services applied to individuals without regard to race, color, national origin, sex, age, religion, or disability? If N/A or No, explain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are all benefits, services, and facilities available to individuals in an equally effective manner regardless of race, sex, color, age, national origin, religion, or disability? If N/A or No, explain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. For residential services, are room assignments made without regard to race, color, or national origin? (Disabled individuals should be admitted to shelter without regard to disability status but room assignment should accommodate the individual's disability.) If N/A or No, explain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Is the program/facility accessible to non-English speaking individuals? If yes, attach a copy of the Provider's Limited English Proficiency (LEP) plan. If N/A or No, explain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are employees, applicants, and participants informed of their protection against discrimination? If Yes, attach a copy of the means of information. Verbal <input type="checkbox"/> Written <input type="checkbox"/> Poster <input type="checkbox"/> If N/A or No, explain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Give the number and current status of any discrimination complaints regarding services or employment filed against the program facility. | N/A
<input type="checkbox"/> | Number | |
| 14. Is the program/facility physically accessible to mobility, hearing, and sight-impaired individuals? If N/A or No, explain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does the Provider have accessible parking, entrances and bathrooms as well as visual and audible fire alarms? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Does the Provider have additional services sites? If yes, attach a list of site locations. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Has Civil Rights training been conducted for Provider staff? If N/A or No, explain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Part III. THE FOLLOWING QUESTIONS APPLY TO PROGRAMS AND FACILITIES WITH 15 OR MORE EMPLOYEES.

- | | Yes | No | N/A |
|---|--------------------------|--------------------------|--------------------------|
| 18. Has a self-evaluation been conducted to identify any barriers to a person with a disability and to make any necessary modifications? If No, explain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Is there an established grievance procedure that incorporates due process into the resolution of complaints? If No, explain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Has a person been designated to coordinate Section 504 for Title VI compliance activities? If yes, attach a list of coordinators. If No, explain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No | N/A |
|--|--------------------------|--------------------------|--------------------------|
| 21. Do recruitment and notification materials advise applicants, employees, and participants of nondiscrimination on the basis of disability? If No, explain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Does the Provider have auxiliary aids to assure service accessibility to hearing and sight impaired individuals? If yes, attach a copy. If N/A or no, explain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Part IV. FOR PROGRAMS OR FACILITIES WITH 50 OR MORE EMPLOYEES AND FEDERAL CONTRACTS OF \$50,000 OR MORE.

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| 23. Does the program/facility have a written affirmative action program? If No, please complete the attached certification form and submit a copy. The original document should be maintained on file. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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STAFF ATTESTATION:

I attest that I, the undersigned, have read the above-listed questions and attest that the answers I provided are true, accurate, and complete to the best of my knowledge.

Printed Name of Individual Completing the Form

Date Completed

Signature of Individual Completing the Form