

Transit Public Participation Plan Outline

1. Brief description of provider's activities and services

Great Plains Health Alliance dba Cheyenne County Hospital provides specialized transportation services for the elderly and disabled persons within the borders of Cheyenne County, Kansas, and neighboring communities. Non-emergency or non-emergency unplanned services are not provided on hospital observed holidays or during inclement weather closures.

2. Brief description of activities that would warrant public participation (i.e. fare changes, changes to service hours, route adjustments, service area changes).

Great Plains Health Alliance dba Cheyenne County Hospital will notify the public regarding any fare changes, service hour changes, and policy or procedure changes.

3. Brief description of the proactive public participation strategies would be used.

All public notifications would be planned as follows:

- Public hearings, meetings, or workshops to be held at convenient times and accessible locations.
- Various advertising platforms would be utilized (St. Francis Herald, Bird City Times, Eagle Communications advertising channel, Cheyenne County Hospital Website, and Social Media)
- A contact list to include: interested members of the public, key hospital staff members and board members, elected officials, local government staff, KDOT public transit staff, and local media.

4. Brief description of outreach methods to engage minority and Limited English Proficiency (LEP) individuals (i.e. translation of public meeting materials, providing translation services if requested, targeted media messages in low income neighborhoods of service area, Work with existing neighborhood and advocacy organizations).

Online translation tools, Braille services, as well as interpreters will be used if requested. Documents will be translated as requested.

5. Brief description of the desired outcomes of the agency's public participation efforts.

In general, desired outcomes could include, but are not limited to, the following:

- The agency strives to have given adequate public notice of public participation activities and allowed proper time for public review and comment at key decision points.

- The agency desires to provide timely information about transportation issues and processes to transit riders, stakeholders and members of the general public
- The agency will provide responses to all public input as appropriate.
- The agency will have facilitated effective communication among a diverse group of stakeholders.

6. *Brief summary of recent outreach efforts over the past three years.*

Cheyenne County Hospital conducts a community health needs assessment every two to three years including a survey of the community at large. The results are compiled and published in the local newspapers and on the hospital website. This process is utilized in making decisions related to services provided by the hospital and clinic.

As we move forward, we will continually seek feedback from our ridership on how they feel the program is working and if they feel any changes need to be made or have any suggestions to make things work better.

Language Assistance Plan

Limited English Proficiency (LEP) Plan

Introduction

On August 11, 2000, President Bill Clinton issued Executive Order 13166 "Improving Access to Services for Persons with Limited English Proficiency," (65 FR 50121). The intent of this Executive Order is to improve access to federally conducted and federally assisted programs and activities for persons who are limited in their English proficiency. The purpose of developing an LEP plan, as a recipient of federal funds, is to identify the extent of LEP individuals in the region and identify ways that the transit agency can reduce and/or eliminate the barriers to LEP individuals. The starting point for developing this plan is to perform a four-factor analysis to determine the individualized needs of the region. After these needs are identified, the transit agency should develop a language assistance plan addressing the mix of services that will be provided.

Four Factor Analysis

(1) Identify number of or proportion of LEP individuals that can utilize the service provided by the Cheyenne County Hospital Specialized Transportation for Elderly and Disabled Persons program.

Using the 2007-2011 American Community Survey data, we find that there are no language groups that fit the criteria of more than 5% of total population and more than 50 persons who speak English less than very well.

(2) Identify the frequency in which LEP individuals come in contact with the service:

There are no language groups that currently qualify as an LEP group at the present time.

(3) Identify the importance of the service to the LEP community:

There are no language groups that currently qualify as an LEP group at the present time.

(4) Identify the resources available and the respective costs of these resources:

Interpreters used would be one of the following: Cheyenne County Hospital employees, volunteers, faith based or family members of the individuals who speak English less than very well. There would be minimal or no cost associated with interpreters. The use of online translation tools would be used to translate documents. The cost associated would be determined by the number of pages required to be reprinted.

Limited English Proficiency Plan

Utilizing the information gathered from the Four Factor Analysis, the following plan is developed in order to provide the necessary assistance to LEP persons.

Identified LEP individuals

There are no specific population groups that meet the criteria of more than 5% and more than 50 persons.

Language Assistance Measures

We would utilize an interpreter to help us with communication and scheduling of rides for those who have language barriers. We would use online translation tools, Braille services, as well as a sign language interpreter.

Training Staff

Schedulers will communicate with the interpreter to schedule rides. Drivers will communicate as best as possible with the riders during the route.

Providing Notice

The LEP Plan will be posted on the agency’s website: www.cheyennecountyhospital.com. An LEP Plan will be provided to any person or agency requesting a copy. The person of contact in regards to the LEP Plan is the Human Resources Director and can be reached by phone at (785) 332-2104.

Monitoring and Updating LEP Plan

Cheyenne County Hospital’s specialized transportation for elderly and disabled persons will update the plan according to the Title VI update schedule, which is every three years. The plan will also be updated any time changes in the demographics of the agency’s service area are deemed significant in regards to LEP persons.

Table Depicting Membership Broken Down by Race

Cheyenne County

Body	Caucasian	Latino	African American	Asian American	Native American	Other
Population within service area	93.3%	5.2% <i>(49 who speak English less than very well)</i>	.1%	.7%	.2%	.5%

Title VI Complaint Procedure

The following pertains only to Title VI complaints regarding the services of Cheyenne County Hospital's specialized transportation for elderly and disabled persons.

Title VI, 42 U.S.C. §2000d et seq., was enacted as part of the Civil Rights Act of 1964. At the heart of the regulation is the statement that:

No person in the United States shall, on the ground of race, color; or national origin, be excluded from participation in, be denied the benefits of or be subjected to discrimination under any program or activity receiving Federal financial assistance.

Cheyenne County Hospital Specialized Transportation for Elderly and Disabled Persons program has in place a Title VI Complaint Procedure, which outlines a process for local disposition of Title VI complaints and is consistent with guidelines found in Chapter III of the Federal Transit Administration Circular 4702.IB, dated October 1, 2012.

http://www.fta.dot.gov/documents/FTA_Title_VI_FINAL.pdf

If you believe that Cheyenne County Hospital's specialized transportation for the elderly and disabled person's federally funded programs have discriminated your civil rights on the basis of race, color, or national origin you may file a written complaint by following the procedure outlined below:

1. Submission of Complaint.

Any person who feels that he or she, individually or as a member of any class of persons, on the basis of race, color, or national origin has been excluded from or denied the benefits of, or subjected to discrimination caused by the Cheyenne County Hospital Specialized Transportation for Elderly and Disabled Persons Program, may file a written complaint with the Cheyenne County Hospital Human Resources Director. A sample complaint form is available for download at www.cheyennecountyhospital.com and is available in hard copy at the Cheyenne County Hospital's Human Resources Director's office. Upon request, the director will mail the complaint form. **Such complaints must be filed within 180 calendar days after the date the discrimination occurred.**

Assistance in the preparation of any complaints will be provided to a person or persons upon request and as appropriate. **If information is needed in another language please contact the Human Resources Director at (785) 332-2104.**

Necesitamos la informacion en otro lenguaje, contacto (785) 332-2104.

Complaints should be mailed to or submitted by hand to:

Cheyenne County Hospital
Attn: Human Resources Director
210 W 1st Street
St. Francis, KS 67756

2. Referral to Review Officer

Upon receipt of the complaint, the Human Resources Director, will evaluate and investigate the complaint. If necessary, the Complainant shall meet with the Human Resources Director to further explain his or her complaint. The Human Resources Director shall complete his/her review no later than 45 calendar days after the date the agency received the complaint. If more time is required, the Human Resources Director shall notify the Complainant of the estimated time frame for completing the review. Upon completion of the review, the Human Resources Director shall make a recommendation regarding the merit of the complaint and whether remedial actions are available to provide redress. Additionally, the Human Resources Director may recommend improvements to the Cheyenne County Hospital Administrator relative to Title VI, as appropriate. The Human Resources Director will issue a written response to the Complainant in regard to his/her findings. This final report should include a summary of the investigation, all findings with recommendations, corrective measures where appropriate,

Upon receipt of a complaint, Cheyenne County Hospital's Human Resources Director shall forward a copy of this complaint and the resulting written response to the appropriate KDOT and FT A Region 7 contacts.

3. Request for Reconsideration

If the Complainant disagrees with the Human Resources Director's response, he or she may request reconsideration by submitting the request, in writing, to the Human Resources Director within 10 calendar days after receipt of the Human Resources Director's prior response. The request for reconsideration shall be sufficiently detailed to contain any items the Complainant feels were not fully understood by the Human Resources Director. The Human Resources Director will notify the Complainant of his or her decision in writing either to accept or reject the request for reconsideration within 10 calendar days. In cases where the Human Resources Director agrees to reconsider, the matter shall be reevaluated in accordance with Paragraph 2 above.

4. Appeal

If the request for reconsideration is denied, the Complainant may appeal the Human Resources Director's response by submitting a written appeal to the Cheyenne County Hospital Administrator no later than 10 calendar days after receipt of the Human Resources Director's written decision rejecting reconsideration. The Administrator will then make a determination to either request re-evaluation by the Human Resources Director or forward the complaint to KDOT for further investigation.

5. Submission of Complaint to the State of Kansas Department of Transportation

If the Complainant is dissatisfied with the Administrator's resolution of the complaint, he or she may also submit a written complaint within 180 days after the alleged date of discrimination to the State of Kansas Department of Transportation for further investigation.

KDOT Office of Contract Compliance
Eisenhower State Office Building

700 Southwest Harrison
3rd Floor West
Topeka, KS 66603

Great Plains dba Cheyenne County Hospital (CCH)
Title VI / ADA Complementary Paratransit Complaint Form

The purpose of this form is to assist you in filing a complaint with the (*agency*). You are not required to use this form; a letter containing the same information will be sufficient.

For questions about CCH's Americans with Disabilities Act (ADA) complaint procedures or complaint form contact Rance Ramsey, Hospital CEO, 785-332-2104 or rramsey@cheyennecountyhospital.com

Section I:				
Name:				
Address:				
Telephone (Home):			Telephone (Work):	
Electronic Mail Address:				
Accessible Format Requirements?	Large Print		Audio Tape	
	TDD		Other	
Section II:				
Are you filing this complaint on your own behalf?			Yes*	No
*If you answered "yes" to this question, go to Section III.				
If not, please supply the name and relationship of the person for whom you are complaining:				
Please explain why you have filed for a third party:				
Please confirm that you have obtained the permission of the aggrieved party if you are filing on behalf of a third party.			Yes	No
Section III:				
I believe the discrimination I experienced was based on (check all that apply):				
<input type="checkbox"/> Race <input type="checkbox"/> Color <input type="checkbox"/> National Origin <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Other (specify) _____				
Date of Alleged Discrimination (Month, Day, Year): _____				
Time of Day: _____				
Location: _____				
<i>(Continued on next page)</i>				
Explain as clearly as possible what happened and why you believe you were discriminated against. Describe all				

persons who were involved. Include the name and contact information of the person(s) who discriminated against you (if known) as well as names and contact information of any witnesses. If more space is needed, please attach additional pages.

Witness(es): YES NO

List Witness(es): *(Attach a separate sheet, if necessary)*

(1) Name:

Phone Number: ()

(2) Name:

Phone Number: ()

(3) Name:

Phone Number: ()

(4) Name:

Phone Number: ()

(Continued on next page)

Section IV

Have you previously filed a Title VI complaint with this agency?	Yes	No
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Section V

Have you filed this complaint with any other Federal, State, or local agency, or with any Federal or State court?
 Yes No

If yes, check all that apply:

Federal Agency: _____
 Federal Court _____ State Agency _____
 State Court _____ Local Agency _____

Please provide information about a contact person at the agency/court where the complaint was filed.

Name: _____

Title: _____

Agency: _____

Address: _____

Telephone: _____

Section VI

Name of agency complaint is against: _____

Contact person: _____

Title: _____

Telephone number: _____

You may attach any written materials or other information that you think is relevant to your complaint.

Signature and date required below:

Signature _____ Date _____

Please submit this form in person at the address below, or mail this form to:

CCH, Attn: Rance Ramsey
210 W 1st Street
St. Francis, KS 67756

INTERNAL USE ONLY
To be completed by Title VI Compliance Officer
Accepted for formal Investigation ____/____/____

Referred to another department on ____/____/____

Rejected ____/____/____

Reason for Rejection:

Rance Ramsey, Hospital CEO and Title VI Compliance Officer

Date