FAMILY NETWORK ON DISABILITIES OF BROWARD COUNTY
Advocacy Program Questionnaire

Student's Name_____ Date of Birth_____

Social Security Number_____ Current Age_____ ❑Male ❑Female

Race (circle one)☐White ☐Black ☐American Indian ☐Asian ☐Other_____

US Citizen ❑Yes ❑ No Ethnicity ❑ Non-Hispanic ❑ Hispanic

Mother's Name_____ Father's Name _____

Home Phone_____ Work Phone _____
(Circle one) Mom or Dad

Mom's Cell Phone_____ Dad's Cell Phone_____

Complete Address_____

_____

E-mail 1._____ 2. _____

Emergency Contact Person _____ Relationship_____

Phone _____ Phone _____

Student's Primary Disability_____

Student's Current School _____ Phone _____

Teacher's Name _____ ESE Specialist_____

Current Grade _____ Type of Class _____
(Cluster, General Education, Resource Room, etc.)

Briefly describe the type of advocacy skills you would like to learn or list the concerns you have.

Office use only: Sibling Client ID # _____

Family Network on Disabilities of Broward County, Inc.

Consent for Services

Student's Last Name _____First Name_____

Student's DOB_____ Social Security # _____

Disability _____

Home Address: _____

City, State, Zip: _____

Parent's Name: _____

Phone # Home_____ Cell _____

Child's School: _____

School Phone #: _____ Teacher: _____

❶I hereby authorize the Family Education Project of Family Network on Disabilities of Broward County, Inc. to obtain and/or share in verbal and/or written form, information regarding the above named individual. I understand that all information will be kept confidential and will be used only to obtain appropriate services for my child and family. This authorization shall remain in effect until revoked in writing**.**

Initials_____ **Date** _____

❷I understand that participation in this project is voluntary. Part of my responsibility as a program participant is to complete evaluations to determine if the project / advocate is meeting its mission to educate parents of children with disabilities and learning challenges. I agree to complete and return follow-up questionnaires so that program staff can indentify program strengths and weaknesses.

Initials_____ **Date** _____

❸ I have received a copy of the BILL OF RIGHTS and COMPLAINT PROCEDURES, which were included in this packet.

Initials_____ **Date** _____

I consent to participate in the Family Education Project. I agree to provide all necessary documents to determine eligibility for this program. I understand that it is my responsibility to provide proof of eligibility and that without all necessary documents and my original signature on file, services may be delayed. I understand that the purpose of services is to assist me in learning to advocate for my child independently. I understand that services are limited and based on staff availability and available funding.

Signature_____ Date _____

Return this form with **original signature** by **mail** to:
Family Network on Disabilities of Broward County, Inc. P.O. Box 260909, Pembroke Pines, FL 33026

Attention: _____

Please complete all information and return ALL pages

ADVOCACY PROGRAM

Medical Evaluation Form

Name of Child: _____ DOB: _____

Parent/Guardian: _____

Address: _____

Home Phone: _____ Mobile Phone:_____

PHYSICAN TO COMPLETE THIS INFORMATION

(This information will only be used for the purpose of establishing eligibility for advocacy services.)

PLEASE CHECK AT LEAST ONE OF THE APPLICABLE DIAGNOSES FOR THIS PATIENT

- ❑ AUTISM SPECTRUM DISORDER
- ❑ CEREBRAL PALSY
- ❑ INTELLECTUAL DISABILITY (IQ Below 70)
- ❑ PRADER-WILLI SYNDROME
- ❑ SPINA BIFIDA
- ❑ DEVELOPMENTAL DELAY
- ❑ HIGH-RISK (Cognitive, language, or physical delay)
- ❑ EPILEPSY
- ❑ NEUROLOGICAL IMPAIRMENT
- ❑ PHYSICAL OR GENETIC ANOMALY with delay

SIGN HERE

Physician's Signature: _____ Date: _____

Print Physician's Name: _____

Phone Number: _____

Address: _____

Please return this form with **original signature** to:
Family Network on Disabilities, P.O. Box 260909, Pembroke Pines, FL 33026

Verification of Income

Students Name _____ **DOB** _____

I certify that the information provided is accurate for the purpose of verification of family income. I understand that income is used to determine eligibility for services.

Please provide at least one of the following forms of acceptable documentation of income:

- ❑ IRS tax forms from most recent year available – Form 1040
- ❑ W-2 forms
- ❑ Copies of current payroll stubs for one month
- ❑ Certifications of income from non-payroll sources such as:
  Unemployment
  Disability Compensation
  Worker's Compensation
  Aid to families of Dependent Children (AFDC) (WIC)
  Supplemental Security Income (SSI)
  Copies of Social Security earnings statements
- ❑ Proof of free/reduced lunch eligibility from Broward Schools

Please check all that apply.

- ❑ My child currently receives free / reduced lunch.
- ❑ I have more than one child with disabilities.
- ❑ I recently lost my job and I am currently unemployed.
- ❑ I have an immediate family member living in the home who is terminally ill.
- ❑ Parent is currently deployed by armed forces.

_____ Number of family members, including parent (s) and children living in the home.

My signature below indicates that I, _____, have read, understood and agree to comply with the program guidelines and requirements. It is my understanding that I will be asked to complete questionnaires that measure the effectiveness of this program. I agree to participate in the process by filling out / answering these questionnaires. Failure to do so may result in service being terminated.

Signed _____ **Date** _____ SIGN HERE

Return with all attachments to: Family Network on Disabilities of Broward County, Inc., P. O. Box 260909, Pembroke Pines, FL 33026

DO NOT WRITE BELOW THIS LINE

Annual Household Income _____ Number of persons living in home _____

Income Documentation _____ Copies provided _____

ADVOCACY PROGRAM ♥ SERVICE PLAN

Child's Name:_____ DOB _____

Goals for Parent Training	OFFICE USE ONLY			
1. I want to **increase my knowledge** of:	**Start Date**	**Target Date** (3 months)	**Date Complete**	**Notes**
a.				
b.				
2. I want to **learn how** to:	**Start Date**	**Target Date** (3 months)	**Date Complete**	**Notes**
a.				
b.				
3. To be a more effective advocate, I need to **learn** to:	**Start Date**	**Target Date** (3 months)	**Date Complete**	**Notes**
a.				
b.				
4. The **service** I would like my child to receive is:	**Start Date**	**Target Date** (3 months)	**Date Complete**	**Notes**
a.				
b.				
5. Other:	**Start Date**	**Target Date** (3 months)	**Date Complete**	**Notes**
a.				
b.				

Parent Signature _____ SIGN HERE Date _____

Advocacy Staff Signature _____

OFFICE USE ONLY

Advocacy skills demonstrated:	*Date:*
Services received:	*Date:*

ADVOCACY PROGRAM

Pre-Test

Child's Name:_____ DOB:_____ Date:_____

Parent's Name: _____

Quarter: ☐ (Oct. 1 - Dec. 31) ☐ (Jan. 1 - March 31) ☐ (April 1 - June 30) ☐ (July 1 - Sept. 30)

The goal of the Advocacy Program is to provide you with the knowledge and skills that will assist you to be an effective advocate for your child.

Please answer the following questions:
1. I would rate my understanding of the special education system as: Poor ① ◯ Fair ② ◯ Good ③ ◯ Very Good ④ ◯
2. I would rate my understanding of my child's educational rights as: Poor ① ◯ Fair ② ◯ Good ③ ◯ Very Good ④ ◯
3. I would rate my current ability to advocate for my child as: Poor ① ◯ Fair ② ◯ Good ③ ◯ Very Good ④ ◯
4. I would rate my current ability to approach a professional about a concern as: Poor ① ◯ Fair ② ◯ Good ③ ◯ Very Good ④ ◯

Please complete and return to:
Family Network on Disabilities of Broward County, Inc. P.O. Box 260909, Pembroke Pines, FL 33026

OFFICE USE ONLY

Pre-Test October 2013 Date _____ Assigned to _____ Score _____

INFORMATION ONLY

Keep this page for your records.

FAMILY NETWORK ON DISABILITIES OF BROWARD COUNTY, INC.

BILL OF RIGHTS

CONFIDENTIALITY:
A client / family has the right, within the law, to personal privacy and confidentiality of information.

QUESTIONS:
A client / family has the right to prompt and reasonable response to questions and requests.

INFORMATION:
A client / family has the right to obtain complete and accurate information.

ACCESS TO CARE:
A client / family has the right to impartial access to services and accommodations, regardless of race, creed, sex, or national origin.

GRIEVANCE RIGHTS:
A client / family has the right to express grievances regarding any violations of his right, through the grievance procedure.

GRIEVANCE PROCEDURE / FILING COMPLAINTS

*If you have a complaint regarding services provided through the Family Network on Disabilities of Broward County, Inc., please contact the Executive Director in **writing**.*

FAMILY NETWORK ON DISABILITIES OF BROWARD COUNTY, INC.
P.O. Box 260909
Pembroke Pines, FL 33026
Attention: Executive Director

Bill of Rights August 2016

KEEP THIS PAGE FOR FUTURE REFERENCE!