FAMILY NETWORK ON DISABILITIES OF BROWARD COUNTY

Request for Services Questionnaire

ALL INFORMATION MUST BE COMPLETED

Student's Name_____ Date of Birth_____

Social Security Number (last 4 digits only) _____ Current Age_____

❑ Male ❑ Female US Citizen ❑ Yes ❑ No

Race: ❑ White ❑ Black ❑ Alaskan ❑ American Indian ❑ Asian ❑ Multiracial ❑ Hawaiian ❑ Pacific Islander ❑ Other_____

Ethnicity: ❑ Not Hispanic ❑ Mexican ❑ Puerto Rican ❑ Cuban ❑Other Spanish/Hispanic/Latino_____

Country of Birth: _____ Language(s) spoken in the home _____

Parents are: Married Never Married Divorced / Separated Domestic Partnership Other_____

Child lives with _____

Child is Medicaid eligible ❑ Yes ❑ No Child has private insurance ❑ Yes ❑ No

Mother's Name:_____	Father's Name:_____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Mobile Phone: _____	Mobile Phone: _____
E-mail: _____	E-mail: _____

Street Address_____

City_____ Zip_____

Referred by _____

Student's Primary Disability_____

Student's Current School _____School Phone _____

Teacher's Name _____ Current Grade _____ ESE Specialist_____

IEP Program Eligibility_____ Type of Class _____
(Example: ASD, IND, EBD, OHI, etc.) (Example: Cluster, General Education, Resource Room, etc.)

Emergency Contact Information

Name: _____ Phone_____ Relationship to child_____

Briefly explain why you feel you need assistance advocating for your child.

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 _____ INITIAL HERE

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 _____ INITIAL HERE

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

Initials_____ Date _____ INITIAL HERE

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 _____ SIGN HERE 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

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.

Annual Household Income $ _____

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
- ❑ Certification of income

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 _____

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

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

Physician's Signature: _____ SIGN HERE 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

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 ALL of 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 return this form to: FND of Broward County, Inc. by one of the following:
E-mail to: fndbroward@gmail.com
US mail to: P.O. Box 260909, Pembroke Pines, FL 33026 or
Fax to: 1-866-747-8693

OFFICE USE ONLY

Pre-Test November 2021 Date _____ Assigned to _____ Score _____

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:*

INFORMATION ONLY

Keep this 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 2012