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) XXX-XX _____ **Current Age**_____

❑ Male ❑ Female ❑ Other _____ US Citizen ❑ Yes ❑ No

Race: ☐ White ☐ Black ☐ Alaskan ☐ American Indian ☐ Asian ☐ Multiracial ☐ Hawaiian ☐ Pacific Islander ☐ Other (specify) _____

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

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

Cultural Influence: (Circle One) American British Central/South America Cuban Dominican German Haitian Irish Polish Puerto Rican Russian West Indian Declined

Parents are: Married Never Married Divorced Separated Domestic Partnership Other_____

Child lives with _____

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

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 # _____