

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.

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: _____

❶ I 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


❷ I 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: _____

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.

TOTAL Annual Household Income \$ _____

We must be able to verify total household income.

Please provide proof of household income using 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: _____

—————→ **PHYSICIAN 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:  _____  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 <small>(3 months)</small>	Date Complete	Notes
a.				
b.				
2. I want to learn how to:	Start Date	Target Date <small>(3 months)</small>	Date Complete	Notes
a.				
b.				
3. To be a more effective advocate, I need to learn to:	Start Date	Target Date <small>(3 months)</small>	Date Complete	Notes
a.				
b.				
4. The service I would like my child to receive is:	Start Date	Target Date <small>(3 months)</small>	Date Complete	Notes
a.				
b.				
5. Other:	Start Date	Target Date <small>(3 months)</small>	Date Complete	Notes
a.				
b.				

Parent Signature _____ Date _____

Advocacy Staff Signature _____

OFFICE USE ONLY

<i>Advocacy skills demonstrated:</i>	<i>Date:</i>
<i>Services received:</i>	<i>Date:</i>

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