# *CHILDREN'S SPECIAL HEALTH SERVICES (CSHS)*

## Family Advisory Council Information Form

**PURPOSE:** This form will help CSHS select Family Advisory Council members. We are looking for the following:

1) Diverse membership that represents children with special health care needs and their famili statewide;
2) Individuals motivated by the desire to enhance quality services, programs and policies;
3) Members who can develop or enhance partnerships to improve collaboration;
4) Individuals with an interest in the health care delivery system.

**Potential Member Name**

| Street Address | City | State | Zip |
|---|---|---|---|
| County | Home Phone | Work Phone | |

**FAMILY UNIT** (Please include extended family if involved in caregiving role)

| Name | Gender (Circle One) | Relationship to child with special health care need | AGE | Grade in Sc Occupati |
|---|---|---|---|---|
| ______ (Child with Special Health Care Need) | M - F | ______ | ______ | ______ |
| ______ | M - F | ______ | ______ | ______ |
| ______ | M - F | ______ | ______ | ______ |
| ______ | M - F | ______ | ______ | ______ |
| ______ | M - F | ______ | ______ | ______ |
| ______ | M - F | ______ | ______ | ______ |

Please list your child's special health care needs or medical conditions.

______

______

______

Please list any health and related services utilized for your child.

______

______

______

______

(turn over)

Please share an important family experience with the health care delivery system when you received services for your child with special health care needs.

Why are you interested in membership?

What can you offer to the Family Advisory Council?

Please list any organizations in which you have been actively involved. Also include length of membership a[nd] your role within the organization.

If you have questions, please contact CSHS toll-free at 1-800-755-2714 or 701-328-2436 or at the followi[ng] address:

Children's Special Health Services
Department of Human Services
600 E. Boulevard Avenue
Bismarck, ND 58505-0269