Special Health Services (SHS)
Family Advisory Council Information Form

Purpose: This form will help SHS select Family Advisory Council members. We are looking for the following:

1) Diverse membership that represents children with special health care needs and their families 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 Code

County	Home/Cell Phone	Work Phone	E-mail Address

Family Unit (Please include extended family if involved in care giving role)

Name	Gender (Circle One)	Relationship to child with special health care need	Age	Grade in School or Occupation
_____ (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 condition.

_____

_____

_____

_____

Please list any health-related services used by 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 needs.

Why are you interested in membership?

What can you offer the Family Advisory Council?

Please list any organizations in which you have been actively involved. Also, include length of membership and your role with the organization.

Please return this Information Form to:

Special Health Services Division
North Dakota Department of Health
600 East Boulevard Avenue, Dept. 301
Bismarck, ND 58505-0200
E-mail: dohcshsadm@nd.gov

If you have questions, please contact SHS toll free at 1-800-755-2714 or 701-328-2436.