**Special Health Services (SHS)**

**Family Advisory Council Application**

**Purpose**

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| 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; and4) Individuals with an interest in the health care delivery system. |

**Potential Member Demographics**

|  |  |
| --- | --- |
| Potential Member Name: |  |
| Street Address: |  |
| City, State, and Zip Code: |  |
| County: |  |
| Home/Cell Phone: |  |
| Email Address: |  |

**Family Unit**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: | Gender: | Relationship to child with special health care need:  | Age: | Grade in School or Occupation: |
| 1.(child with special health care need) |  |  |  |  |
| 2.  |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |
| 7. |  |  |  |  |

**Additional Questions**

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| Please list your child’s special health care needs or medical condition. |
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| Please list any health-related services used by your child. |
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| Please share an important family experience with the health care delivery system when you received services for your child with special needs. |
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| 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. Include length of membership and your role with the organization.  |
|   |

Please return this Application Form to: Special Health Services Unit

 North Dakota Dept. of Health and Human Services

 600 East Boulevard Avenue, Dept. 325

 Bismarck, ND 58505-0200

 Email: dohcshsadm@nd.gov

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