CHILDREN WITH SPECIAL NEEDS FOCUS GROUPS

REGISTRATION FORM

This information will be kept confidential and is being collected for research purposes only.

Your Name: _____

Address: _____

Town_____ **State** _____ **Zip** _____

Phone # _____

Your Age: _____

Your Race/Ethnicity: _____

What are the first names and ages of your children?

Name	**Age**	**Special Need, if any**

Your Work

(please answer questions about your spouse or partner's work on next page)

Do you work outside the home? Yes ☐ No ☐

If yes, what is your job? _____

If yes, do you work full-time or part-time? Full-time ☐ Part-time ☐

What hours do you usually work? (ex. 9AM-5PM, 3PM-11AM) _____

Please check the type of benefits you receive at work: *(all that apply)*

☐Medical insurance	☐Dental insurance	☐Short-term disability
☐Long-term disability	☐Life Insurance	☐Vacation Days
☐Sick Days	☐Flexible work schedule (can work different hours if needed)	☐None

Can you use your sick days to care for your child? Yes ☐ No ☐ No Sick Days☐

Spouse/Partner

Do you have a spouse or partner? Yes ☐ → Please answer questions below
No ☐ → Go to "Your Household" questions

Does your spouse or partner work outside the home? Yes ☐ No ☐

If yes, what is their job? _____

If yes, does he/she work full-time or part-time? Full-time ☐ Part-time ☐

What hours does he/she usually work? (ex. 9AM-5PM, 3PM-11AM) _____

Please check the type of benefits he/she receives at work: *(all that apply)*

☐ Medical insurance	☐ Dental insurance	☐ Short-term disability
☐ Long-term disability	☐ Life Insurance	☐ Vacation Days
☐ Sick Days	☐ Flexible work schedule (can work different hours if need to)	☐ Don't know
		☐ None

Your Household

How many people live in your household? _____ Adults and _____Child/ren

About how much income does your household have? (please include everyone who lives in your household) Include income from wages, TANF, SSI or any other sources of income. *(Fill in any of the following)*

$_____ a week or $_____a month or $_____a year

Please check the highest level of education you have:

☐ Grade school or less
☐ Some high school
☐ High school graduate/G.E.D.
☐ Some graduate school
☐ Technical or vocational school graduate or associate degree
☐ College graduate, Bachelor's degree
☐ Some college or vocational school
☐ Graduate/professional degree (MA, PhD, JD, MD, etc.)

Special Needs

(If you have more than one child with special needs, please answer the following questions for your child with the most severe special needs)

My child has a diagnosis of:

My child's age is: _____

Below is a list of possible issues or situations that may affect your child and require special care. Please check all that currently affect your child.

Mobility

- ❑ My child needs help with walking or stair climbing, more than other children the same age
- ❑ My child currently uses a wheel chair

Eating

- ❑ My child needs help with eating more than other children the same age
- ❑ My child needs intubation

Allergies

- ❑ My child has allergies to certain foods and/or pets
- ❑ My child has life-threatening allergies (such as bee stings, severe food allergy)

Toileting

- ❑ My child needs more help toileting than other children who are the same age
- ❑ My child needs catheterization

Medications

- ❑ My child needs medication on a regular basis during the work day
- ❑ My child needs shots on a regular basis during the work day

Neurological

- ❑ My child has seizures that are mostly controlled by medication
- ❑ My child has seizures that currently cannot be controlled by medication
- ❑ My child rocks or does other repetitive actions that cancut my child off from other people
- ❑ My child usually does not relate or respond to others and seems to be in her/his own world

Eyes/Ears

- ❑ My child is partially blind
- ❑ My child is legally blind
- ❑ My child has chronic ear infections
- ❑ My child is partially deaf
- ❑ My child is deaf

Asthma

- ❑ My child needs to use a nebulizer for asthma
- ❑ My child has asthma that sometimes requires treatment at the ER or in a doctor's office

Speech and Language

- ❑ My child has trouble understanding what people say
- ❑ My child has a speech impairment
- ❑ My child's speech can't be understood by most people
- ❑ My child can't speak

Social/Behavioral

- ❑ My child is hyper-active
- ❑ My child has trouble paying attention, more so than other children who are the same age
- ❑ My child has problems with hitting or bullying others
- ❑ My child has problems with social skills that make it hard to make or keep friends
- ❑ My child is much more withdrawn than other children of the same age
- ❑ My child is much more fearful than other children of the same age

None of the above (please explain)_____

Your Day Care

(please answer the following questions for all of your children)

Are any of your children in day care while you work or go to school?

Yes ☐ for how many hours per week?
Child One_____ Child Two_____ Child Three_____

No ☐ → Please go to the "**Benefits and Services**" section

If YES, please check the types of care you have right now for your children. (Please fill in the age of child at top of column)

Type of Care	Child One (Age:)	Child Two (Age:)	Child Three (Age:)
Family member, neighbor or friend in *their* home	☐	☐	☐
Family member, neighbor or friend in *your* home	☐	☐	☐
Family Day Care home	☐	☐	☐
Day Care Center	☐	☐	☐
Program only for Children with Special Needs	☐	☐	☐
Head Start	☐	☐	☐
Nursery School/ Preschool	☐	☐	☐
Elementary School	☐	☐	☐
After School Program	☐	☐	☐
Other Please Describe _____	☐	☐	☐

What is the total amount of money that you spend for day care for all of your children?

(Fill in either of the following.)

Weekly, I pay $_____ **Monthly, I pay $ _____**

Is your day care in the same town where you live? Yes ☐ No ☐

Benefits and Services

Did you know that some working parents can get help to pay for certain types of day care?	Yes☐	No☐	
Are you getting help from any program in paying for day care?	Yes☐	No☐	
Are you receiving TANF or welfare benefits?	Yes☐	No☐	Don't Know☐
If no, have you received TANF or welfare benefits in the last 2 years?	Yes☐	No☐	Don't Know☐
Are you receiving SSI (social security insurance) for your child?	Yes☐	No☐	Don't Know☐
Does your child receive early intervention services such as speech therapy or occupational therapy (OT)?	Yes☐	No☐	
Are these services delivered where the child goes to day care or at home?	Day care or School Program☐	Home☐	Both Places☐
Is your child receiving regular treatment from a medical specialist?	Yes☐	No☐	
Would you like a copy of the report about these meetings sent to you?	Yes☐	No☐	

Thank you for your time!