# FAMILY ADVISORY COUNCIL APPLICATION

Children's Hospitals and Clinics of Minnesota

*Please contact the council if you have any questions or need this application in another form i.e. Language, Braille, or Spoken Word*

**Voicemail: 651-220-6402 Email: familyadvisorycouncil@childrensmn.org**

Today's date: _____

1. Your Name: _____
2. Home Address: _____
3. Phone Number: Daytime: _____ Evening: _____
4. Email Address: _____
5. Languages spoken in the home: _____
6. Occupation: _____

** New families who are recently bereaved are asked to wait two years after the death of their child before applying to the FAC **

7. Name of child with health needs/experiences *(if more than one child please add under question #)*

_____ Child's DOB: _____ Relation to you: _____

8. Child's Primary Diagnosis: _____
9. Other Children? ☐ Yes *(please enter names and dates of birth)* ☐ No

_____

10. What campus does your family primarily use? _____

    Has your family used other Children's locations *(check all that apply)* ☐Mpls ☐St. Paul ☐West ☐Roseville ☐Maple Grove ☐Woodwinds

11. Would you be able to make a commitment to attend 2 hour monthly meetins for a term of three years?

    ☐Yes ☐No

12. Would you be able to make a commitment to join other committees and project work groups that are held on various dates and times?

    ☐Yes ☐No

    If yes, what is your availability? Please indicate the hours you are available:

| Day: | Monday | Tuesday | Wednesday | Thursday | Friday | Weekends |
|---|---|---|---|---|---|---|
| Daytime: | | | | | | |
| Evening: | | | | | | |

Comments on availability? _____

13. What services has your family used? *(check all that apply)* Check **Past Year** if you have used this service within the past year or **Ever** if you have ever used this service.

| Past Year | Ever | | Past Year | Ever | |
|---|---|---|---|---|---|
| ☐ | ☐ | Emergency Room | ☐ | ☐ | Hematology/Oncology |
| ☐ | ☐ | Inpatient Unit _____ | ☐ | ☐ | Home Care or Hospice |
| ☐ | ☐ | Neonatal ICU | ☐ | ☐ | Immunology |
| ☐ | ☐ | Pediatric ICU | ☐ | ☐ | Integrative Medicine |
| ☐ | ☐ | Day/Outpatient Surgery | ☐ | ☐ | Lab |
| ☐ | ☐ | Short Stay | ☐ | ☐ | Nephrology |
| ☐ | ☐ | Infant Care Center (ICC) | ☐ | ☐ | Neurology |
| ☐ | ☐ | Special Care Nursery | ☐ | ☐ | NICU follow up Clinic |
| Specialty Services | | | ☐ | ☐ | Orthopedics |
| ☐ | ☐ | Asthma/Allergy | ☐ | ☐ | Pain Team/Palliative Care |
| ☐ | ☐ | Audiology | ☐ | ☐ | Pharmacy |
| ☐ | ☐ | Autism | ☐ | ☐ | Psychiatry |
| ☐ | ☐ | Birth Center | ☐ | ☐ | Psychology |
| ☐ | ☐ | Cardiology | ☐ | ☐ | Respiratory/Pulminology |
| ☐ | ☐ | Cath Lab | ☐ | ☐ | Radiology |
| ☐ | ☐ | Cleft/Craniofacial Clinic | ☐ | ☐ | Sleep Lab/Clinic |
| ☐ | ☐ | Cystic Fibrosis Clinic | ☐ | ☐ | Special Diagnostics |
| ☐ | ☐ | Developmental Clinic | ☐ | ☐ | Surgery |
| ☐ | ☐ | Down Syndrome Clinic | ☐ | ☐ | TAMS/Adolescent Medicine |
| ☐ | ☐ | Ear, Nose, and Throat | ☐ | ☐ | Urology |
| ☐ | ☐ | Endocrine/Diabetes | ☐ | ☐ | Other: _____ |
| ☐ | ☐ | Epilepsy Clinic | ☐ | ☐ | |
| ☐ | ☐ | Feeding Clinic | Rehabilitation | | |
| ☐ | ☐ | Gastroenterology/GI | ☐ | ☐ | Physical Therapy |
| ☐ | ☐ | General Pediatric Clinic | ☐ | ☐ | Occupational Therapy |
| ☐ | ☐ | Genetics | ☐ | ☐ | Speech/Language Therapy |

Have you ever used the following Non-Medical Services? *(check all that apply)*

| | | |
|---|---|---|
| ☐ Family Resource Center | ☐ Interpretive Services | ☐ Children's Medical Organizer |
| ☐ Financial Resources | ☐ Ethics Consult | ☐ Healing Quilt |
| ☐ Sibling Play | ☐ Social Work | ☐ Caring Bridge Website |
| ☐ Child Life | ☐ Children's Webpage | ☐ Chaplaincy |
| ☐ Other _____ | | |

13. What do you feel you could bring to the Family Advisory Council?

I acknowledge that I have provided accurate information to the best of my ability.

Applicant Signature _____ Date _____

Please send the completed application to:

Family Advisory Council – Mail Stop 70-403
Children's Hospitals and Clinics of Minnesota
345 North Smith Avenue
St. Paul, MN 55102