



Families as Partners Application

Today's Date: _____

Name: _____
(Please Print)

Home Address: _____

City: _____ ST: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____ Is it ok to call you at work: _____

Email Address: _____

Applicant Birthday (month and day only): _____
(month/day)

Relationship to Child(ren): _____

Children: If you would like to share any other information about your children, please feel free to include it on a separate sheet of paper.

Name: _____
Birth Date: _____
Has he/she been a patient at Children's Hospital of Wisconsin? _____ Y ___ N
If yes, how many times in the past year: ___ 1-2 ___ 3-5 ___ 6+

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Within the past 2 years, have you used any of the following services at Children's Hospital and Health System (CHHS)? (Check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Inpatient Unit: | <input type="checkbox"/> Outpatient Clinic (please list): |
| <input type="checkbox"/> Day Surgery | ___ HOT ___ 5W | _____ |
| <input type="checkbox"/> Lab | ___ NICU ___ 7W | _____ |
| <input type="checkbox"/> X-ray | ___ PICU ___ 8E | _____ |
| <input type="checkbox"/> Urgent Care | ___ 4W ___ 8W | _____ |

This section is optional. The questions are designed to help us make our committees as diverse as possible:

Ethnicity:

- Hispanic/Latino
 Non Hispanic/Latino

Race:

- American Indian/Alaskan Black
 Asian White
 Other _____

Primary Language Spoken: _____

What other language(s), do you speak (Check all that apply):

- American Sign Language English Hmong
 Spanish Other (specify): _____

Reference:

Please include the name of a Children's Hospital and Health System staff member with whom you have worked (doctor, nurse, social worker, housekeeper, secretary, care partner, physical therapist, etc.)

Name: _____ Department: _____

I give permission to Families as Partners to discuss my application with the above person.

Name (Signature)

Date

The following list reflects the activities that families may be involved in. We do not expect you to have experience. Time commitments are approximate and cannot be guaranteed. Please check the activities below that you have done or would like to do.

Focus Group Participant: One-time family/patient group meeting to give feedback or suggestions on a specific topic.

Time Commitment: 1-2 hours each.

- I have done this
- I am interested in doing this

Children's Hospital Champion: Being interviewed or featured by Children's staff or the media about Children's Hospital services.

Time commitment: Depends on need.

- I have done this
- I am interested in doing this

Committee Member: Ongoing group meetings. As a member you will represent the families who come to Children's Hospital.

Time commitment: 6-12 meetings/year for 1-2 hours each. Committee member for at least 1 year.

- I have done this
- I am interested in doing this

Program and Facility Advisor: Workgroup that works on developing and improving programs.

Time Commitment: short term meetings, 1-2 times/month.

- I have done this
- I am interested in doing this

Conference or Event Planner: Committee that plans a conference, educational series, event, etc.

Time commitment: 1-2 meetings /month for 3-6 months.

- I have done this
- I am interested in doing this

Resident Teaching: Host a pediatric resident in your home to share your experiences as a family with a child with special health needs.

Time commitment: 2-4 times/year for 1½-2 hours in your home.

- I have done this
- I am interested in doing this

Material Reviewer: Review brochures, websites, policies, educational materials from the family/patient perspective. Some materials can be reviewed at home.

Time commitment: 1 or more times/year.

- I have done this
- I am interested in doing this

Formal Presenter:

Participate on a parent panel or give an individual presentation

Time commitment: Depends on need.

- I have done this
- I am interested in doing this

TELL US MORE ABOUT YOURSELF AND YOUR EXPERIENCES

Why would you like to be involved in Families as Partners?

Family Partners should reflect the cultural diversity of families who use hospital services. **Please share anything about your family that you think would add to the diversity of this program.** You might consider your diversity to be ethnic, racial, spiritual, social, economic, educational, geographic, gender, sexual orientation, unique family structure, disability-related, chronic illness, single parent, full-time parent, grandparent, etc.

Is there anything else you would like us to know?

****If you need additional room for any of the questions, please feel free to attach another sheet.****

I understand that completion of this application does not bind the applicant or the program coordinators in any way. FAP reserves the right to choose participants that best meet the needs of the program. Before participating in Families as Partners, you will be asked to sign a confidentiality agreement.

Signature

Date

Thank you for your time and interest. If you have any questions please feel to contact:
Anne Juhlmann phone 414-266-3196; email ajuhlmann@chw.org
Karen Schaefer phone 414 266-3198; email kschaefer@chw.org

Please return forms to: Families as Partners
Special Needs Family Center
Children's Hospital of Wisconsin
PO Box 1997 MS 939
Milwaukee, WI 53201-1997