



MISSOURI DEVELOPMENTAL DISABILITIES COUNCIL
PARTNERS IN POLICYMAKING 2018 APPLICATION FOR PARTICIPATION

If you need help with completing this form, please call 1-800-500-7878
APPLICATIONS ARE DUE NOT LATER THAN DECEMBER 10, 2017
INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

NOTE: Please attach additional sheets if more space is needed.

Name:		Address:	
City:	County:	State:	Zip Code:
Home phone (Include area code):		Work/cell phone. (Include area code):	
Are you: Male Female		Race/ethnic background:	
E-mail address:			

1. Are you a person with a disability? Yes No (If no, proceed to Question 2.)
 a. If so, please specify your disability and provide information about how it affects your daily life:

 b. What kinds of support services or technology services/devices do you use or do you receive?

2. Are you a parent of a child with a developmental disability? Yes No
 b. If so, what services do you, your family or your son/daughter receive from the county where you live?

 c. Check one for each child with a developmental disability:
 Child #1 AGE: Birth - 3 ; 3 - 7 ; 7 - 10 ; 10 - 14 ; 14+
 Disability: Physical ; _Cognitive ; _Emotional/Behavioral ; Sensory ; Other

 Child #2 AGE: Birth - 3 ; 3 - 7 ; 7 - 10 ; 10 - 14 ; 14+
 Disability: Physical ; _Cognitive ; _Emotional/Behavioral ; Sensory ; Other

 Child #3 AGE: Birth - 3 ; 3 - 7 ; 7 - 10 ; 10 - 14 ; 14+
 Disability: Physical ; _Cognitive ; _Emotional/Behavioral ; Sensory ; Other

 d. Please specify by child his/her disability and provide information about how it affects his/her daily life and that of your family.

 e. Please provide some specific information on how this diagnosis or disability affects your access to necessary or needed services.

 f. Is your son/daughter receiving special education services? YES NO
 g. If yes, describe those services.

3. Identify one or two specific problems or issues that are of greatest concern to you.
4. Sessions begin with sign-in on Fridays at 12:00 pm and end on Saturday at 3:30 p.m. Double occupancy rooms (you will be roomed with another class member) and meals will be provided. a. Attendance is required at each weekend session. Will you make a time commitment of two days one weekend a month (February through September) for eight months? YES NO Please place the session dates on your calendar at thistime. b. If you are employed, have you talked with your employer about session attendance and made necessary arrangements so you can attend all weekend sessions? YES NO
5. If you have a disability, what accommodations do you need to help you actively participate in the weekend sessions (such as wheelchair access or larger print)?
5. Do you require interpreter services (such as signing or language translation)? YES NO
6. If yes, please specify:
7. If you are a parent, will you be using respite/child care services, so you can participate in the Partners program? YES NO If you are a person with a disability, will you be using personal care attendant services during the weekend sessions? YES NO PLEASE NOTE: The Partners program does not provide on-site respite/child care or personal care attendant services, but reimbursement for these costs may be provided if no other source of funds are available to you.
8. Are you currently a member of, do volunteer work for, or are involved with an advocacy organization? YES NO If yes, what is the name of the organization(s) and what role(s) do you play?
9. Please tell us about yourself/your family. (for example: the kind of work you do, community/volunteer activities are you involved, personal interests, & share any life experiences that have been special joys or challenges for you, your child or your family.)
10. Tell us why you want to participate in the Partners in Policymaking program.
11. How did you learn about the Partners in Policymaking Program?

3.

APPLICATIONS MUST BE POSTMARKED BY DECEMBER 10, 2017 TO BE ELIGIBLE

Please mail completed application to:
 Mo DD Council
 PO Box 687
 Jefferson City MO 65102
 or fax: 573526-2755 or email to cgerman@moddcouncil.org