OMB No: 0906-0040
Expiration Date: XX/XX-XXX

APPENDIX A: Survey Instruments

FAMILY SURVEY
(One-to-One Service)

Data from this survey will be kept private to the extent allowed by law.

What kind of information/services did you receive from [F2F name]? Select all that apply.

○◯ Answers to questions about my child's health condition, which is _____
○◯ Help finding other families with a child with special needs like mine
○◯ Help finding services for my child in my community
○◯ Help finding a doctor or health care provider
○◯ Help with insurance
○◯ Other (please list): _____
○◯ **I do not remember contacting you.** Thank the family member for his/her time, and end the survey or call.

Thinking about the services you received from [F2F name], please tell us how much you agree or disagree with the following statements:*	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
1. The information or services I received met my needs.	◯	◯	◯	◯	◯
2. The information or services I received will help me work with those who serve my child (e.g., health care providers, service providers, and other professionals).	◯	◯	◯	◯	◯
3. I will use what I learned to help my child/family.	◯	◯	◯	◯	◯
4. I would recommend [F2F name] to other families.	◯	◯	◯	◯	◯

Please share any other comments or concerns with us:
_____

Insert OMB Form Approval Information

**Evaluator Note: If conducting this survey by phone, please repeat the rating scale after each question.*

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0906-0040. Public reporting burden for this collection of information is estimated to average xx hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857.

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APPENDIX A: Survey Instruments

PROFESSIONAL SURVEY
(One-to-One Service)

Data from this survey will be kept private to the extent allowed by law.

What kind of information/services did you receive from [F2F name]? Select all that apply.

○◯ Help talking to a child's family about the child's health condition
○◯ Help connecting the family with other families with a child with disabilities/special health care needs
○◯ Help finding community services for a child
○◯ Help finding a doctor or health care provider
○◯ Help with insurance for a child's family
○◯ Other (please list): _____
○◯ **I do not remember contacting you.** Thank the family member for his/her time, and end the survey or call.

Thinking about the services you received from [F2F name], please tell us how much you agree or disagree with the following statements after receiving information or services from them: *	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
1. The information or assistance I received met my needs.	○◯	○◯	○◯	○◯	○◯
2. The information or services I received will help me work better with families of children and youth with disabilities/special health care needs.	○◯	○◯	○◯	○◯	○◯
3. The information or services I received will help me work better with other health service professionals (e.g., health care providers, service providers, etc.).	○◯	○◯	○◯	○◯	○◯
4. I would recommend [F2F name] to families and other professionals.	○◯	○◯	○◯	○◯	○◯

Please share any other comments or concerns with us:

_____

Insert OMB Form Approval Information

**Evaluator Note: If conducting this survey by phone, please repeat the rating scale after each question.*

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APPENDIX A: Survey Instruments

TRAINING SURVEY

Data from this survey will be kept private to the extent allowed by law.

[Insert Training Name or Topic]

Have you responded to a survey about other trainings, services or assistance received from [F2F name] this year?

○◯ If Yes, STOP HERE. We do not want to burden you by asking for your feedback more than once per year, so we need no further information at this time. Thank you for your time.

○◯ If No. Please answer the next set of questions to tell us about your training experience with [F2F name].

Thinking about the training you received on [insert date], please tell us how much you agree or disagree with the statements below.*	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
1. The information provided met my training needs.	○◯	○◯	○◯	○◯	○◯
2. The information I received will help me work better (one-on-one or in workgroups) with others who serve children and youth with disabilities/special health care needs (e.g., health care providers, service providers, etc.).	○◯	○◯	○◯	○◯	○◯
3. I will use what I learned in the training to better support my child and/or children and families I serve.	○◯	○◯	○◯	○◯	○◯
4. I would recommend [F2F name] to other families or professionals.	○◯	○◯	○◯	○◯	○◯

Please share any other comments or concerns with us:

_____

Insert OMB Form Approval Information

**Evaluator Note: If conducting this survey by phone, please repeat the rating scale after each question.*

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0906-0040. Public reporting burden for this collection of information is estimated to average xx hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857.

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