UCSF Benioff Children's Hospital San Francisco

Family Advisory Council

Application for Family Members

Today's Date: _____

Welcome! Thank you for your interest in joining the UCSF Benioff Children's Hospital Family Advisory Council. We believe the family perspective is essential to providing quality care for children and their families and our family advisory council plays an integral role in patient satisfaction efforts.

We recognize that families have busy lives and we appreciate the time and energy that it takes to volunteer for the FAC role. In an effort to best represent the population that UCSF Benioff Children's Hospital serves, we have three types of FAC members. Please check the role blow that you are most interested in.

- ☐ FAC full time member – Attends monthly meetings on a regular and consistent basis. May hold officer and/or leadership position. Provides education on parent panels and/or support at Parent Support Dinners. May also hold membership on UCSF Benioff Children's Hospital committees.

- ☐ FAC quarterly members – Attends 4 meetings a year (Sept., Nov., Jan, and May). May also sit on FAC project task force groups as requested and time permits. May also choose to provide education on parent panels and/or support at Parent Support Dinners.

- ☐ FAC list serve consultant – Attends yearly orientation and welcome – Fall (October)and/or Spring (May) meeting as well. May also choose to provide education on parent panels and/or support at Parent Support Dinners.

Please take a moment to fill out the following application and let us know what areas of focus interest you most.

Name: _____
(Please Print)

Home Address: _____

_____

County: _____

Daytime Phone: (___) _____ **Best day/time to call:** _____

Evening Phone: (___) _____ **Best day/time to call:** _____

E-mail Address: _____

Children:

Name: ________________ Birth Date: ________________

Does your child have special needs? ☐ Yes ☐ No

Has he/she been a patient at UCSF Benioff Children's Hospital, San Francisco? ☐ Yes ☐ No

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Name: ________________ Birth Date: ________________

Does your child have special needs? ☐ Yes ☐ No

Has he/she been a patient at UCSF Benioff Children's Hospital, San Francisco? ☐ Yes ☐ No

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Name: ________________ Birth Date: ________________

Does your child have special needs? ☐ Yes ☐ No

Has he/she been a patient at UCSF Benioff Children's Hospital, San Francisco? ☐ Yes ☐ No

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Information Form for Family Members

Within the last two years have you used any of the following services at UCSF Benioff Children's Hospital, San Francisco?

- ☐ Emergency Room
- ☐ Urgent Care
- ☐ Outpatient Clinic
- ☐ Children's Surgery Center
- ☐ Inpatient
- ☐ Radiology
- ☐ Lab
- ☐ Other ________________

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
- ☐ Asian
- ☐ African American
- ☐ White
- ☐ Other ________________

Primary Language Spoken:

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

- ☐ **American Sign Language**
- ☐ **English**
- ☐ **Spanish**
- ☐ **Cantonese**
- ☐ **Other** _____

Reference:

Please include the name of a UCSF Benioff Children's Hospital staff member with whom you have worked (doctor, nurse, social worker, child life specialist, case manager, housekeeper, physical therapist, etc.)

Name: _____ **Department:** _____

If you would like to provide additional references please attach an additional paper.

Tell Us More About Yourself and Your Family Experience

The Family Advisory Council provides input, education, parent to parent support, hospital wide committee representation.

How would you like to be involved on the Family Advisory Council?

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We believe the Family Advisory Council should reflect cultural diversity of families who are consumers of UCSF Benioff Children's 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, geographical, gender, sexual orientation, unique family structure, disability related, chronic illness, single parent, full time parent, grandparent, etc.

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Is there anything else you would like us to know?

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Please feel free to attach another sheet if necessary.

Signature	**Date**

Thank you for your time and interest. If you have any questions, please feel free to contact Becky Higbee Sumner (415-353-1410) becky.higbee@ucsfmedctr.org.

Please mail this information form in the enclosed self-addressed stamped envelope to:

Becky Higbee Sumner, MA, CCLS
Coordinator, The Center for Families
Family Advisory Council
UCSF Benioff Children's Hospital
1975 4th Street, Room C1940A, Box 4012
San Francisco, CA 94158
(415) 353-1410

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