



SERVICE PARTNERSHIP FOR CHILDREN OF HIGH CONFLICT FAMILIES

“A Service Partnership funded by The Children’s Trust”



Provider Survey

Agency: _____

Person completing this form: _____

Contact Information: (PH) _____

email _____

Service Provided:	Population served: (Please indicate any special populations served, i.e. children with disabilities)	How are services paid for? <input type="checkbox"/> Fully grant funded <input type="checkbox"/> Partially grant funded <input type="checkbox"/> Contracted <input type="checkbox"/> Fee for service <input type="checkbox"/> Sliding scale <input type="checkbox"/> Reimbursement Third party <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	Service delivery location: <input type="checkbox"/> home based <input type="checkbox"/> office/center <input type="checkbox"/> school based <input type="checkbox"/> inpatient <input type="checkbox"/> outpatient <input type="checkbox"/> other Length of service:	Wait list <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, wait time: _____ Evidenced based service? <input type="checkbox"/> Yes <input type="checkbox"/> No Comment: _____ _____ _____	<i>Additional Info:</i>
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Please list any other collaborative your agency is affiliated with:

Agency Location: _____ **Agency Location:** _____

Agency Location: _____ **Agency Location:** _____

***Please attach a copy of the agency’s referral form and intake form.**

Additional comments, concerns or suggestions:

Thank you for completing this survey your information and feedback is valued and appreciated.

Please return completed survey to:

Advocate Program Inc.

5040 N.W. 7th Street, 3rd Floor

Miami, FL 33126

Attn: Service Partnership

Fax: 305 513-5689

Email: belindap@advocateprogram.com