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?** □ Fully grant funded □ Partially grant funded □ Contracted □ Fee for service □ Sliding scale □ Reimbursement Third party □ Medicaid □ Medicare	**Service delivery location:** □ home based □office/center □school based □ inpatient □ outpatient □ other **Length of service:**	**Wait list** □ Yes □ No **If yes, wait time:** _____ **Evidenced based service?** □ Yes □ No **Comment:** _____ _____ _____ _____	***Additional Info:***
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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:

_____

_____

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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, 3 rd Floor
Miami, FL 33126
Attn: Service Partnership
Fax: 305 513-5689
Email: belindap@advocateprogram.com