**Example Family Needs Assessment Survey**

*This survey was developed by the National Center on Deaf-Blindness for state deaf-blind projects to use as part of family technical assistance. Fill in bracketed information, replace with your own logo and disclaimer, and adapt the survey as needed for your project.*

You are receiving this survey because your child is registered with the [insert project name]. As our project plans upcoming activities, we would like input from families throughout the state to ensure we meet the needs of families and children on our registry. Please respond by [insert date].

**Name of family member completing the survey:**

**Email:**

**Phone:**

**1. What are the top 3 needs you have for your child (select from the following list or add your own)?**

* Communication development
* Qualified knowledgeable personnel at local level
* Social engagement
* Health and well-being
* Independent living and functional living skills
* Supports in the home and community
* Parent training
* Technology use
* Transition
* Recreation and leisure
* Vision supports
* Hearing supports
* Other (fill in blank)

**2. In what areas do you need to increase your knowledge and skills or would like training (select all that apply)?**

* Assistive technology
* Communication methods and instruction
* Advocacy skills to support child in school and community
* Impact of vision and hearing loss
* Understanding child’s etiology
* Helping child build social skills and friendships
* Creating a network of support for child and family
* Transition to adult life
* Supporting child with complex medical needs
* Advocating for intervener services
* Role of the intervener
* Managing challenging behaviors
* Person-centered planning
* Planning for adult life
* Family role in IEP and evaluation processes
* Movement and orientation and mobility
* Employment
* Sibling support
* Transition from early intervention to school
* Long-term supports, including Medicaid Waivers
* Other (fill in blank)

**3. Are current family training opportunities in your state meeting your needs?**

* Yes
* No
* Somewhat

**4. Please explain how current training opportunities could be improved.**

**5. What service providers—public or private—have worked with your child in the past?**

* Special education agency
* School district (local education agency)
* Vocational rehabilitation services
* Private therapy (e.g., [add state examples])
* Hospital-based therapy clinic (e.g., [add state examples])
* Early intervention services
* Helen Keller National Center (HKNC) regional representative
* Medicaid Waiver
* Other (fill in blank)

**6. What service providers—both public or private—currently work with your child?**

* Special education agency
* School district (local education agency)
* Vocational rehabilitation services
* Private therapy (e.g., [add state examples])
* Hospital-based therapy clinic (e.g., [add state examples])
* Early intervention services
* Helen Keller National Center (HKNC) regional representative
* Medicaid Waiver
* Other (fill in blank)

**The next set of questions relate to your experiences with other agencies and organizations that we sometimes refer families to for support and training, as well as [insert state deaf-blind project name]. We want to ensure that other agencies and our project are responsive to your needs.**

**7. Have you sought or received support from [add agency name and repeat this block to cover as many agencies as needed]?**

* Yes, they were responsive and helpful
* Yes, they were responsive, but not helpful
* Yes, but they were not responsive or helpful
* No, I have not interacted with this agency
* I was not aware of or referred to this agency
* Other (fill in blank)

**8. What [insert state deaf-blind project name] supports have been most helpful?**

* Parent workshops/trainings/education
* One-to-one support
* Access to resources and information
* Technical assistance to school teams
* Networking with other families
* Referral(s) to other organizations
* I have not accessed state deaf-blind project supports
* Other (fill in blank)

**9. Do you know about the [insert state deaf-blind project name] family resource library?**

* Yes, I have used it
* Yes, I am aware of it, but haven’t used it
* No, I wasn’t aware of it

Comment:

**10. Have you used the [insert state deaf-blind project name] website?**

* Yes, it was very helpful
* Yes, I visited it, but didn’t find what I needed
* No, I wasn’t aware of the website

Comment:

**11. Where do you go for information and resources?**

**12. How would you like information about resources to be presented to you?**

* Through an educator (e.g., deaf-blind specialist, teacher of the visually impaired or teacher of the deaf/hard of hearing, orientation and mobility specialist)
* Email
* Training
* Printed material sent via regular mail
* Facebook
* Twitter
* Text
* [Insert state deaf-blind project name] website
* Other (please specify)

**13. How can we help you access [insert state deaf-blind project name] and other local resources?**

**14. Are you aware of the National Center on Deaf-Blindness (NCDB)?**

* Yes
* No
* Unsure

**15. Are you presently volunteering for or serving on boards or committees of any local, state, or national organizations? If yes, please list the name of the organization and your role.**

**16. Are you interested in participating in future advocacy opportunities at the following levels (check all that apply)?**

* Yes, local community opportunities
* Yes, state opportunities
* Yes, national opportunities
* I need more information
* I’m not interested

**17. How many times per month, on average, do you have an opportunity to communicate with another family member of a person who is deaf-blind?**

* 1 to 3
* 4 to 9
* 10 to 15
* More than 15
* I do not connect with other families of children with deaf-blindness

**18. Would you like to be connected to other families of children with deaf-blindness or increase your current connections?**

* Yes
* No

**19. Are you interested in participating in a family network/support system in collaboration with the [insert state deaf-blind project name]?**

* Yes
* No
* Maybe

**20. If interested in participating in a family network, how would you like those interactions to happen?**

* Face-to-face
* Video chats
* Phone only
* Private Facebook group
* Other (please specify)

**21. Do you feel that you have a good understanding of your child's diagnosis?**

* Yes
* No
* Unsure

**22. What is our child’s age?**

* 0 to 3
* 4 to 6
* 7 to 13
* 14 to 18
* 19 to 21

**23. What is the primary language spoken in your home?**

**24. Please share any additional comments you have regarding [insert state deaf-blind name] and its services.**

Thank you for taking the time to respond to this survey. The information will help us in planning future services and activities. If you’d like support from (insert state deaf-blind project name) or would like to be connected to other families, contact: (insert name and contact info).

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