



Copy of WA Hands & Voices Family Needs Survey

**As part of a grant activity funded by Washington State Dept. of Health's Early Hearing-loss Detection, Diagnosis & Intervention (EHDDI) program, WA State Hands & Voices Board members are gathering information to identify needs of families who have deaf, hard of hearing, deaf-blind, or deaf plus (D/HH/DB/D+) children across the state. Your participation in this brief confidential and anonymous survey will allow us to provide support and information for families and inform systems of care and education in our state.**

**If you have questions about this survey, or wish to connect with us directly, please contact Christine Griffin at [gbys@wahandsandvoices.org](mailto:gbys@wahandsandvoices.org) or (425) 268-7087 (voice/text). For more information about Washington State Hands & Voices please visit our website [www.wahandsandvoices.org](http://www.wahandsandvoices.org)**

**We greatly appreciate your time to complete this 5-10 minute survey. Please complete by September 30, 2017. Thank you again for participating in this important survey.**

**If you are completing this survey on paper, please send via smart phone picture or scan as attachment to:  
[gbys@wahandsandvoices.org](mailto:gbys@wahandsandvoices.org)**

**Or mail hard copy to:  
Washington State Hands & Voices  
2950 Newmarket St., Suite 101-124  
Bellingham, WA 98226  
Thank you!**

1. I have a deaf, hard of hearing, deaf-blind, or deaf plus child/ren in my life because I am a (check all that apply)

- Parent or caregiver
- Relative
- Professional
- Parent Leader/ Support Parent
- Stakeholder/Community member

2. My hearing status is:

- Deaf
- Hard of Hearing
- Hearing

3. I am a member of WA Hands & Voices (If you are a professional or stakeholder/community member who does not have a Deaf/HH/DB/D+ child, answer #3 and then skip to #22).

- Yes
- No
- Don't know

4. How old is your child or children who are Deaf/HH/DB/D+?

5. How old was your child or children when you learned he/she is Deaf/HH/DB/DP?

6. Rate the information and resources you received from your medical providers regarding your child/ren's hearing loss?

No information or resources	Limited information or resources	Adequate information and resources	Good information and resources	Lots of information and resources
★	★	★	★	★

If more than one child, please rate and/or comment here:

7. What grade level is your child/ren in?

8. What school district do you live in?

9. Which birth-3 and/or school program does your child/ren attend?

10. These are the ways our family communicates at home (check all that apply)

- Spoken English
- Another spoken language
- American Sign Language (ASL)
- Signing Exact English (SEE)
- Combination of speech and sign
- Augmentative Communication Devices
- Other

11. At school my child/ren uses the following for communication (check all that apply)

	Child 1	Child 2	Child 3
Spoken English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other spoken language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
American Sign Language (ASL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Signing Exact English (SEE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Combination of speech and sign language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Augmentative Communication Device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cued Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Which hearing technologies does your child use? (Check all that apply)

	First child	Second child	Third child
Hearing Aid/s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cochlear Implant/s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BAHA or Ponto	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FM system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. What kinds of visual technologies does your child/ren and family use? (Check all that apply)

- Captioning
- Cell Phone
- Video Phone (VP)
- FaceTime, Skype or other
- Lighted doorbells
- Apps
- Tactile or Lighted Alarms

Other (please specify)

14. Does your child/ren have (check all that apply)

- IFSP
- IEP
- 504 Plan
- None of the above
- Don't know

15. Rate your satisfaction with the educational services your child/ren receives

	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
Child 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please comment more here - answers are anonymous and confidential.

16. Do you know other families who have children who are Deaf/HH/DB/D+?

- Yes
- No

17. Has your family met a deaf adult or had a Deaf Mentor?

- Yes
- No
- Don't know
- Comments welcomed:

18. What types of events and supports would you and your family be interested in attending? (Check all that apply)

- Family social gatherings
- Informational sessions and workshops
- One-on-one parent support
- Playdates

Please comment with additional programs or support wanted:

19. What days of the week and times are best for your family to attend events?

	Morning	Afternoon	Evening	Depends
Weekend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are there barriers that would prevent your family from attending? Please comment:

20. How far in advance would you like to know about events?

- 1 week
- 2 weeks
- 1 month
- More than 1 month

21. Which of the following accommodations will you need to attend a family social gathering or workshop? (Check all that apply)

- Interpreting (Spanish, other spoken language, ASL, SEE transliteration, other)
- Captioning
- FM system

If interpreting is needed, please specify which language.

22. Are you interested in becoming involved with WA State Hands & Voices?

- Yes
- No
- Don't know

If you would like us to contact you, please leave your contact information here. Your information will only be used for this purpose.

23. On a scale from 1 (highest importance) to 6 (least importance) please rank each activity you would like our state to provide.

⋮	▾	A formalized Deaf Mentors/Trained Deaf/HH Adult Role Model Program
⋮	▾	Access to non-biased Parent Support, information and resources for families with Deaf/HH/DB/D+ children.
⋮	▾	Access to family events to connect with other parents/caregivers of Deaf/HH/DB/D+ children.
⋮	▾	Access to connect via social media with other parents/caregivers of Deaf/HH/DB/D+ children.
⋮	▾	Access to workshops and training, as well as having opportunities to practice new skills (i.e. communication modalities and advocacy).
⋮	▾	Access to increasing leadership skills to improve systems of care for families of Deaf/HH/DB/D+ children.