PARTNERS in POLICYMAKING®

Year Class

APPLICATION FOR PARTICIPATION

CLASS SCHEDULE

Note: All sessions are Friday and Saturday EXCEPT the State Legislative Weekend, which is Sunday and Monday.

Session 1:

Session 2:

Session 3:

Session 4:

Session 5:

Session 6:

Session 7:

Session 8:

MINNESOTA TENNESSEN WARNING

The information requested on this application is for the purpose of selecting individuals who meet the criteria for participation in the Partners in Policymaking program. The list of names and addresses of Partners graduates that is prepared for each Partners class is taken from applications and considered public data under the Minnesota Government Data Practices Act. This list may be requested and will be released upon request.

APPLICATION DEADLINE:

Note: This application is for Minnesota applicants only.

Application decision by:

To apply by mail:

To apply online:

PLEASE PRINT IN INK

Name

Street Address

City

County

State Zip

Email

Home Phone ( )

Work Phone ( )

Cell Phone ( )

Email

1. Are you a person with a disability? ○ yes ○ no (If no, please proceed to Question 2.)

a. If so, please specify your disability and provide information about how it affects your daily life:

b. What kinds of support services or technology services/devices do you use or do you receive?

2. Are you a parent of a child with a developmental disability?
○ yes ○ no (If no, please proceed to Question 3.)

a. If so, what services do you, your family, or your son/daughter receive from the county where you live?

b. Fill in one circle in each column for each child with a developmental disability:

CHILD 1		CHILD 2		CHILD 3	
Age	**Disability**	**Age**	**Disability**	**Age**	**Disability**
○ B – 3	○ Physical	○ B – 3	○ Physical	○ B – 3	○ Physical
○ 4 – 7	○ Cognitive	○ 4 – 7	○ Cognitive	○ 4 – 7	○ Cognitive
○ 8 – 10	○ Emotional/ Behavioral	○ 8 – 10	○ Emotional/ Behavioral	○ 8 – 10	○ Emotional/ Behavioral
○ 11 – 14	○ Sensory	○ 11 – 14	○ Sensory	○ 11 – 14	○ Sensory
○ 15+	○ Other	○ 15+	○ Other	○ 15+	○ Other

c. Please specify by child his/her disability and provide information about how it affects his/her daily life and that of your family.

d. Please provide specific information on how this diagnosis or disability affects your access to necessary or needed services.

e. Is your son/daughter receiving special education services? ○ yes ○ no
If yes, please describe those services:

3. Do you, or does your son/daughter, meet the federal definition of a person with a developmental disability? (See definition on last page of this application.) ○ yes ○ no

4. Identify one or two specific problems or issues that are of greatest concern to you.

5. Weekend sessions begin with check-in and lunch at 11:00 a.m. on the first day and end at 3:00 p.m. on the second day. Double occupancy rooms (you will be roomed with another class member) and meals will be provided. Sessions are held at (location)**:**

a. Attendance is required at each weekend session. Will you make a time commitment of two days, one weekend a month (September through May with no session in December), for eight months? ○ yes ○ no ***Please place the session dates on your calendar at this time.***

b. If you are employed, have you talked with your employer about session attendance and made necessary arrangements so you can attend all weekend sessions? ○ yes ○ no

6. If you have a disability, what accommodations do you need to help you actively participate in the weekend sessions (such as wheelchair access or larger print)?

7. Do you require interpreter services (such as American Sign Language (ASL), or other language translation)? ○ yes ○ no If yes, please specify:

8. If you are a parent, will you be using respite/child care services so you can participate in the Partners program? ○ yes ○ no

9. If you are a person with a disability, will you be using personal care assistant (PCA) services during the weekend sessions? ○ yes ○ no
Please note: the Partners program does not provide these services.

10. Are you currently a member of, volunteer for, or involved with, an advocacy organization?

○ **yes** ○ **no**

If yes, what is the name of the organization(s) and what role(s) do you play?

11. Please tell us about yourself/your family.

a. If you are working, tell us about your job and the kind of work you do:

b. If you are in school, tell us about the types of classes you are taking:

c. In what type of community/volunteer activities are you involved?

d. What are some of your personal interests?

12. Tell us why you want to participate in the Partners in Policymaking program.

13. How did you learn about the Partners in Policymaking Program?

FEDERAL DEFINITION OF A PERSON WITH A DEVELOPMENTAL DISABILITY:

The term "developmental disability" is defined in the DD Act as a severe, chronic disability of an individual from birth that:

1. Is attributable to a mental or physical impairment or a combination of mental and physical impairments;
2. Is manifested before the individual attains age 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: self care, receptive and expressive language, learning, mobility, self direction, capacity for independent living, and economic self sufficiency; and
5. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care services, supports or other assistance that is of lifelong or extended duration and is individually planned and coordinated;
6. When applied to infants and young children, individuals from birth to age nine, inclusive, with a substantial developmental delay or specific congenital or acquired conditions may be considered to have a developmental disability if the individual, without services and supports, has a high probability of meeting those criteria later in life.