# APPLICATION FOR PARTICIPATION

## CLASS SCHEDULE

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

<table>
<thead>
<tr>
<th>Session 1 Dates:</th>
<th>September 13-14, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 2 Dates:</td>
<td>October 18-19, 2019</td>
</tr>
<tr>
<td>Session 3 Dates:</td>
<td>November 15-16, 2019</td>
</tr>
<tr>
<td>Session 4 Dates:</td>
<td>January 10-11, 2020</td>
</tr>
<tr>
<td>Session 5 Dates:</td>
<td>February 6-7, 2020 Thursday &amp; Friday</td>
</tr>
<tr>
<td>Session 6 Dates:</td>
<td>March 12-13, 2020 Thursday &amp; Friday</td>
</tr>
<tr>
<td>Session 7 Dates:</td>
<td>April 17-18, 2020 Friday &amp; Saturday</td>
</tr>
<tr>
<td>Session 8 Dates:</td>
<td>May 15-16, 2020 Friday &amp; Saturday</td>
</tr>
</tbody>
</table>

## APPLICATION DEADLINE:

June 1, 2019

Note: This application is for Kentucky applicants only.

**APPLICATION DECISION BY:** June 15, 2019

**TO APPLY BY MAIL:**
656 Chamberlin Ave, Suite 2, Frankfort, KY 40601

**TO SUBMIT ELECTRONICALLY:** CCDD@KY.GOV

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**PLEASE PRINT IN INK**

Name

Street Address

City

County

State

Zip

Email

Home Phone ( )

Work Phone ( )

Cell Phone ( )

Email

Please continue onto the next 3 pages
1. Are you a person with a disability?  ○ yes   ○ no (If no, 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, 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. Check one in each column for each child with a developmental disability:
   
<table>
<thead>
<tr>
<th>CHILD 1</th>
<th>CHILD 2</th>
<th>CHILD 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Disability</td>
<td>Age</td>
</tr>
<tr>
<td>B – 3</td>
<td>Physical</td>
<td>B – 3</td>
</tr>
<tr>
<td>4 – 7</td>
<td>Cognitive</td>
<td>4 – 7</td>
</tr>
<tr>
<td>8 – 10</td>
<td>Emotional/Behavioral</td>
<td>8 – 10</td>
</tr>
<tr>
<td>11 – 14</td>
<td>Sensory</td>
<td>11 – 14</td>
</tr>
<tr>
<td>15+</td>
<td>Other</td>
<td>15+</td>
</tr>
</tbody>
</table>
   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  (If yes, please describe those services)   ○ no
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________

3. Do you, or does your son/daughter, meet the federal definition of a person with a developmental disability?
   ○ 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 ending around 3:00 p.m. on the second day. Sessions are held at [location]: Hampton Inn - Frankfort, KY: 1310 US 127 South, Frankfort, KY
Rooms and all meals are provided.

PLEASE NOTE: The Partners program does not provide on site child care services. Family members are not permitted to stay at the hotel during the weekend training sessions unless a family member is serving as a personal assistant to a class member.

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 CCDD will reimburse for services but does not provide 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?


The Commonwealth Council on Developmental Disabilities (CCDD) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CCDD does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.