

Milestone Packet Evaluation

Your evaluation is important for providing relevant services to you. Please take a moment to complete this form. Thank you for your participation.

The age of my child is: _____.

Using the scale below, please indicate the extent to which you agree or disagree with each statement.

Strongly Agree	Agree	Disagree	Strongly Disagree
4	3	2	1

- | | | | | |
|--|---|---|---|---|
| 1. This packet has improved my awareness of the need for specialized services to address my child’s deafblindness. (F.01.c) | 4 | 3 | 2 | 1 |
| 2. This packet has helped me become more knowledgeable of local, state, and federal resources that can help my child. (F.02.f) | 4 | 3 | 2 | 1 |
| 3. This packet informed me of how to access other services that are available for my child. (F.02.m) | 4 | 3 | 2 | 1 |
| 4. The information provided in this packet will help me to participate in the planning of goals, objectives, services, and accommodations for my child. (F.03.b) | 4 | 3 | 2 | 1 |
| 5. I will be able to advocate for my child better because of information that was provided in this packet. (F.02.c) | 4 | 3 | 2 | 1 |
| 6. My overall satisfaction with the Milestone Packet was high. (BS.01.e) | 4 | 3 | 2 | 1 |

Comments/Suggestions: _____
