**DEPARTMENT OF CHILDREN AND FAMILIES**

Division of Safety and Permanence

**Subsidized Guardianship Amendment Request – Confirmation of Needs**

**Physical / Personal Care Characteristics (Birth to 5)**

**Instructions:** This form is to be used to confirm the special care needs of the child identified below and is to be **completed by an appropriate professional (e.g., physician, therapist, school personnel, etc)**. Check the appropriate box in each category that most closely reflects the child’s current functioning and / or needs. **If the child’s needs or functioning are age appropriate, the first box should be checked.** Sign, date and provide your professional relationship to the child. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

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| Name – Child | | | | Birthdate (mm/dd/yyyy) | |
| Name – Person Completing Form (Print) | Professional Relationship to Child | | Affiliation (e.g. school / medical facility, etc.) | | |
| **SIGNATURE** – Person Completing Form | | Telephone Number | | | Date Signed |

Check ONE box in each category that best describes the child’s current functioning / needs.

**If the child’s needs or functioning are age appropriate, the first box should be checked.**

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| **Overall Development (PAST 30 DAYS)** | | | |
| Child has no developmental problems. Any concerns are age appropriate or this information is unknown to me. | Child has some problems with physical immaturity or there are concerns about possible delays and / or low IQ. | Child has developmental delays or mild cognitive disabilities. | Child has severe and pervasive developmental delays or profound cognitive disabilities. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Cognitive Development (PAST 30 DAYS)** | | | |
| Child shows no evidence of cognitive development problems. Any concerns are age appropriate **or** this information is unknown to me. | Child has some signs that cognitive skills are not appropriate. Child may be unaware of surroundings, challenges in remembering routines and completing tasks such as sorting, recognizing colors. | Child has clear signs that development is not at the expected level. Child may be unable to understand simple routines or tasks. | Child has significant delays in cognitive functioning that are seriously interfering with their functioning. Child is completely reliant on caregiver to function. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Autism Spectrum (PAST 30 DAYS)** | | | |
| Child’s development appears normal in relation to autistic characteristics **or** this information is unknown to me. | Evidence of mild symptoms of an autism spectrum disorder. Child may meet criteria for Aspergers disorder. | Child has been diagnosed by an appropriate professional as having an autism spectrum disorder. | Severe autism. Symptoms are disabling in at least one area of life skills. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Communication (PAST 30 DAYS)** | | | |
| Child’s ability to communicate is age appropriate or this information is unknown to me. | Child is able to understand others but may have limited ability to express him / her self. | Child has limited abilities to understand others **and** express him / her self. | Child is unable to communicate. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Self Care and Daily Living Skills (PAST 30 DAYS)** | | | |
| Child’s self-care / daily living skills appear to be age appropriate or this information is unknown to me. | Child requires excessive verbal prompting on self-care tasks or daily living skills. | Child requires assistance (physical prompting) on multiple self-care tasks or complete assistance on one self-care task. | Child requires complete assistance on more than one self-care task (eating, bathing, dressing, toileting). |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Medical Needs (PAST 30 DAYS)** | | | | |
| Child is healthy **or** this information is unknown to me / does not apply. | Child has some medical problems that require medical treatment. | | Child has chronic illness that requires ongoing medical intervention (diabetes, severe / uncontrolled asthma, life threatening allergies, HIV). | Child has life threatening illness or medical condition. (active cancer, AIDS, etc). |
| List medical condition (within the last 30 days): | |  | | |

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| If the child’s needs / functioning fall within a shaded box, explain why: |
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| **Medical Needs – Life Threatening (PAST 30 DAYS)** | | | |
| Child’s medical condition has no implications for shortening his / her life **or** this information is unknown to me / does not apply. | Child’s medical condition may shorten life, but not until later in adulthood. | Child’s medical condition places him / her at some risk of premature death before he / she reaches adulthood. | Child’s medical condition places him / her at eminent risk of death. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Medical Needs – Chronicity (PAST 30 DAYS)** | | | |
| Child is expected to fully recover from his / her condition within the next 6 months **or** this information is unknown to me **/** does not apply. | Child is expected to fully recover from his / her condition after at least 6 months but less than 2 years. | Child is expected to fully recover from his / her condition but not within the next 2 years. | Child’s medical condition is expected to continue throughout his / her lifetime. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Medical Needs – Diagnostic Complexity (PAST 30 DAYS)** | | | |
| Child’s medical diagnoses are clear and correct **or** this information is unknown to me / does not apply. | Some evidence exists to say that the child’s symptoms are complex and the diagnosis may not be entirely accurate. | There is substantial concern about the accuracy of the child’s medical diagnoses due to the complexity of symptoms. | It is currently not possible to accurately diagnose the child’s medical conditions. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Medical Needs – Emotional Response (PAST 30 DAYS)** | | | |
| Child is coping well with his / her medical condition **or** this information is unknown to me / does not apply. | Child is experiencing some emotions related to the medical condition, but these are not affecting other areas of life. | Child’s emotional response to his / her condition is interfering with treatment and other areas of life. | Child is having severe emotional response to his / her condition that is interfering with treatment and functioning. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Medical Needs – Impairment in Functioning (PAST 30 DAYS)** | | | |
| Child’s medical condition is not interfering with his / her functioning in other life domains **or** this information is unknown to me / does not apply. | Child’s medical condition is having a limited impact on functioning in one other life domain (self-care, social interaction, communication, etc). | Child’s medical condition is interfering with functioning in more than one life domain or is disabling in at least one domain. | Child’s medical condition has disabled him / her in all other life domains. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Medical Needs – Treatment Involvement (PAST 30 DAYS)** | | | |
| Child and family are actively involved in treatment **or** this is not applicable **or** this information is unknown to me / does not apply. | Child and / or family are generally involved in treatment but may struggle to stay consistent. | Child and / or family are generally uninvolved although they are sometimes compliant with recommendations. | Child and / or family are currently resistant to all efforts to provide medical treatment. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Medical Needs – Intensity of Treatment (PAST 30 DAYS)** | | | |
| Child’s medical treatment involves taking daily medications or visiting a medical professional no more than weekly, **or** this information is unknown to me / does not apply. | Child’s medical treatment involves taking multiple medications or visiting a medical professional multiple times per week. | Child’s treatment is daily but non-invasive. Treatment can be administered by a caregiver. | Child’s medical treatment is daily and invasive and requires either a medical professional or trained caregiver to administer. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Medical Needs – Organizational Complexity (PAST 30 DAYS)** | | | |
| All medical care is provided by a single medical professional **or** this information is unknown to me / does not apply. | Child’s medical care is generally provided by a coordinated team medical professionals who work for the same organization. | Child’s medical care requires collaboration of multiple professionals who work for more than one organization. | Child’s medical care requires the collaboration of multiple professionals who work for more than one organization and are not able to communicate effectively. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Physical Needs (PAST 30 DAYS)** | | | |
| Child has no physical limitations. Any concerns are age appropriate or this information is unknown to me. | Child has some physical condition that places mild limitations on activities (hearing, vision impairment). | Child has physical condition that notably impacts activities (blindness, deafness or significant motor difficulties). | Child has severe physical limitations due to multiple physical conditions. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Dental Needs (PAST 30 DAYS)** | | | |
| No evidence of any dental health needs **or** this information is unknown to me. | Child may have some dental health needs but they are not clearly known at this time. | Dental health is interfering with functioning in at least one life domain (eating, social interaction, etc.). | Child has serious dental health needs that require intensive and / or extended treatment / intervention. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Daily Functioning (PAST 30 DAYS)** | | | |
| Child has **age appropriate** self-care skills. No indication of deficits or this information is unknown to me. | Child has minor indications of problems in self-care compared to same age peers, but is generally self-reliant. | Child demonstrates moderate or routine problems in self-care skills and relies on others for help more than is expected for his / her age group. | Child has severe or constant problems in self-care skills and relies on others for help much more than is expected for his / her age group. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Motor (PAST 30 DAYS)** | | | |
| No evidence of fine or gross motor development problems. Any concerns are age appropriate or this information is unknown to me. | Child has some indicators that motor skills are challenging and there may be some concern that there is a delay. | Child has either fine or gross motor skill delays. | Child has significant delays in fine or gross motor development or both. Delay causes impairment in functioning. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Communication (PAST 30 DAYS)** | | | |
| No evidence of communication problems exists. Any concerns are age appropriate or this information is unknown to me. | Child has a history of communication problems but currently is not experiencing problems. | Child has difficulty understanding or expressing self through language / gestures which interfere with functioning, including trouble interpreting facial gestures or initiating gestures to communicate needs. Toddlers may not follow simple 1-step commands. Preschoolers may be unable to understand simple conversations or carry out 2-3 step commands. | Child has serious communication difficulties and is unable to communicate in any way including pointing and grunting. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Failure to Thrive (PAST 30 DAYS)** | | | |
| No evidence of failure to thrive **or** this information is unknown to me. | Child may have experienced past problems with growth and ability to gain weight and is currently not experiencing problems. | Child is experiencing problems in their ability to maintain weight or growth. Child may be below the 5th percentile for age and sex and may weigh less than 80% of their ideal weight for age, have depressed weight for height. | Child may have one or more of the symptoms listed and is currently at serious medical risk. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Labor and Delivery** | | | |
| Child and biological mother had a normal labor and delivery **or** this information is unknown to me. | Child or mother had some mild problems during delivery, but child does not appear affected by problems. | Child or mother had problems during delivery that resulted in temporary functional difficulties for the child or mother. | Child had severe problems during delivery that have resulted in long term implications for development. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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| **Parent / Sibling Exposure** | | | |
| Child’s parents have no developmental disabilities. The child has no siblings or existing siblings are not experiencing any developmental or behavioral problems **or** this information is unknown to me. | Child’s parents have no developmental disabilities. Child has siblings who are experiencing some mild developmental or behavioral problems. | Child’s parents have no developmental disabilities. Child has a sibling who is experiencing a significant developmental or behavioral problem. | One or both of the child’s parents have been diagnosed with a developmental disability, or the child has multiple siblings who are experiencing significant developmental or behavioral problems. |
| If the child’s needs / functioning fall within a shaded box, explain why: | | | |
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Return completed form to: Agency Fillable