

## ADOPTION ASSISTANCE AMENDMENT REQUEST – CONFIRMATION OF NEEDS PHYSICAL / PERSONAL CARE CHARACTERISTICS

**Use of form:** This confirms the special care needs of the child identified below. The Confirmation of Needs form is to be completed by an appropriate professional (e.g., physician, therapist, psychologist, school personnel, etc.)

**Instructions:** Indicate the characteristic(s) listed below that reflect the special care needs **that are not age appropriate**. Sign, date and provide your professional relationship to the child.

Name – Child		Birthdate (mm/dd/yyyy)
Name – Person Completing Form (print)	Professional Relationship to Child	Affiliation – (e.g., School / Day Care / Medical Facility) Name:
SIGNATURE – Person Completing Form		Date Signed (mm/dd/yyyy)
Telephone Number		

**(Check all that are not age appropriate that the above-named child exhibits)**

- |   |   |
|---|---|
| <p><input type="checkbox"/> Needs some help putting on braces or prosthetic devices and help with buttons or laces, but is basically self-caring and able to maintain own physical assisting devices – Explain: _____</p> <p>_____</p> <p><input type="checkbox"/> Needs assistance to care and maintain physical assistance devices – Explain: _____</p> <p>_____</p> <p><input type="checkbox"/> Requires help with dressing, bathing and general toilet needs, including maintenance procedures (e.g., diapering and applying catheters) – Explain: _____</p> <p>_____</p> <p><input type="checkbox"/> Requires frequent special care to prevent or remedy serious skin conditions (e.g., bedsores, severe eczema). Indicate severity and parental care needed – Explain: _____</p> <p>_____</p> <p><input type="checkbox"/> Requires help of a person or a device to walk or get around</p> <p><input type="checkbox"/> Non-ambulatory</p> <p><input type="checkbox"/> Seizures, motor dysfunctions, controlled by medication</p> <p><input type="checkbox"/> Uncontrollable seizures</p> <p><input type="checkbox"/> Requires therapy for gross or fine motor skills</p> <p><input type="checkbox"/> Requires special diet preparation / supervision – Explain: _____</p> <p>_____</p> | <p><input type="checkbox"/> Exhibits feeding problems (e.g., excessive intake, extreme messiness, extremely slow eating – requires help, supervision or both</p> <p><input type="checkbox"/> Requires tube or gavage feeding</p> <p><input type="checkbox"/> The administration of medications and preparation of special diets are demanding, requiring one to two hours a day</p> <p><input type="checkbox"/> Asthma – indicate severity and method of control (e.g., nebulizer, inhaler, etc., and usage): _____</p> <p>_____</p> <p><input type="checkbox"/> Diabetic</p> <p><input type="checkbox"/> Requires appliances for drainage, colostomy, aspiration, suctioning, mist tent, etc.</p> <p><input type="checkbox"/> Requires prevention procedures such as daily irrigation</p> <p><input type="checkbox"/> Requires extra cleaning and laundry to maintain body hygiene and control of the child’s body waste.</p> <p><input type="checkbox"/> Requires orthotics care that demands excessive amount of time, care and responsibility</p> <p><input type="checkbox"/> Even with proper medical attention, vision speech or hearing functions are impaired and may require parent training.</p> <p><input type="checkbox"/> Requires daily prescribed exercise routines to improve or maintain gross or fine motor skills that require home administration</p> <p><input type="checkbox"/> Tourette’s syndrome – Indicate severity: _____</p> <p>_____</p> |
|---|---|

Requires special diet preparation / supervision  
– Explain: \_\_\_\_\_  
\_\_\_\_\_

Prescribed physical therapies such as those  
for vision, hearing, speech or gross or fine  
motor skills require 1 – 2 hours a day.

Requires prescribed physical therapies taking  
2 – 3 hours a day

Other characteristic(s) – Specify: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tourette's syndrome – Indicate severity:  
\_\_\_\_\_  
\_\_\_\_\_

Blood disorder / disease – Explain:  
\_\_\_\_\_

Scoliosis – Indicate severity: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Return completed form to: Adoption Assistance Program Specialist  
DHFS/DCFS/BPP  
P.O. Box 8916  
Madison, WI 53708-8916  
OR  
Fax to: (608) 264-6750