

Adoption Assistance Amendment Request – Confirmation of Needs Physical / Personal Care Characteristics (Ages 5 to 21)

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).** If the child's needs or functioning are age appropriate, the first box should be checked. Check the appropriate box in each category that most closely reflects the child's current functioning and / or needs. 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].

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.

Child's Overall Development (PAST 30 DAYS)

<input type="checkbox"/> Child has no developmental problems. Any concerns are age appropriate or this information is unknown to me.	<input type="checkbox"/> Child has some problems with physical immaturity or there are concerns about possible delays and / or low IQ.	<input type="checkbox"/> Child has developmental delays or mild cognitive disabilities.	<input type="checkbox"/> Child has severe and pervasive developmental delays or profound cognitive disabilities.
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If the child's needs / functioning fall within a shaded box, explain why:

Child's Cognitive Development (PAST 30 DAYS)

<input type="checkbox"/> Child's IQ appears within normal range or this information is unknown to me.	<input type="checkbox"/> Child has low IQ (70 to 85) or has identified learning challenges.	<input type="checkbox"/> Child has moderate cognitive disability. IQ is between 55 and 70.	<input type="checkbox"/> Child has moderate to profound cognitive disability. IQ is less than 55.
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If the child's needs / functioning fall within a shaded box, explain why:

Autism Spectrum (PAST 30 DAYS)

<input type="checkbox"/> Child's development appears normal in relation to autistic characteristics or this information is unknown to me.	<input type="checkbox"/> Evidence of mild symptoms of an autism spectrum disorder. Child / youth may meet criteria for Aspergers disorder.	<input type="checkbox"/> Child has been diagnosed by an appropriate professional as having an autism spectrum disorder.	<input type="checkbox"/> Severe autism. Symptoms are disabling in at least one area of life skills.
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If the child's needs / functioning fall within a shaded box, explain why:

PHYSICAL / PERSONAL CARE CHARACTERISTICS (Ages 5 to 21)

Communication (PAST 30 DAYS)

<input type="checkbox"/> Child's ability to communicate is age appropriate or this information is unknown to me.	<input type="checkbox"/> Child is able to understand others but may have limited ability to express him / her self.	<input type="checkbox"/> Child has limited abilities to understand others and express him / her self.	<input type="checkbox"/> Child is unable to communicate.
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If the child's needs / functioning fall within a shaded box, explain why:

Self Care and Daily Living Skills – Eating, Bathing, Dressing, Toileting (PAST 30 DAYS)

<input type="checkbox"/> Child's self care / daily living skills appear to be age appropriate or this information is unknown to me.	<input type="checkbox"/> Child requires excessive verbal prompting on self-care tasks or daily living skills.	<input type="checkbox"/> Child requires assistance (physical prompting) on multiple self care tasks or complete assistance on one self care task.	<input type="checkbox"/> Child requires complete assistance on more than one self care task (eating, bathing, dressing, toileting).
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If the child's needs / functioning fall within a shaded box, explain why:

Medical Needs (PAST 30 DAYS)

<input type="checkbox"/> Child is healthy or this information is unknown to me / does not apply.	<input type="checkbox"/> Child has some medical problems that require medical treatment (includes controlled asthma).	<input type="checkbox"/> Child has chronic illness that requires ongoing medical intervention (diabetes, severe / uncontrolled asthma, life threatening allergies, HIV).	<input type="checkbox"/> Child has life threatening illness or medical condition (active cancer, AIDS, etc.).
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List medical condition (within the last 30 days): _____

If the child's needs / functioning fall within a shaded box, explain why:

Medical Needs – Life Threatening (PAST 30 DAYS)

<input type="checkbox"/> Child's medical condition has no implications for shortening his / her life or this information is unknown to me / does not apply.	<input type="checkbox"/> Child's medical condition may shorten life, but not until later in adulthood.	<input type="checkbox"/> Child's medical condition places him / her at some risk of premature death before he / she reaches adulthood.	<input type="checkbox"/> Child's medical condition places him / her at eminent risk of death.
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If the child's needs / functioning fall within a shaded box, explain why:

PHYSICAL / PERSONAL CARE CHARACTERISTICS (Ages 5 to 21)

Medical Needs – Chronicity (PAST 30 DAYS)

<input type="checkbox"/> 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.	<input type="checkbox"/> Child is expected to fully recover from his / her condition after at least 6 months but less than 2 years.	<input type="checkbox"/> Child is expected to fully recover from his / her condition but not within the next 2 years.	<input type="checkbox"/> Child's medical condition is expected to continue throughout his / her lifetime.
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If the child's needs / functioning fall within a shaded box, explain why:

Medical Needs – Diagnostic Complexity (PAST 30 DAYS)

<input type="checkbox"/> Child's medical diagnoses are clear and correct or this information is unknown to me / does not apply.	<input type="checkbox"/> Some evidence exists to say that the child's symptoms are complex and the diagnosis may not be entirely accurate.	<input type="checkbox"/> There is substantial concern about the accuracy of the child's medical diagnoses due to the complexity of symptoms.	<input type="checkbox"/> It is currently not possible to accurately diagnose the child's medical conditions.
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If the child's needs / functioning fall within a shaded box, explain why:

Medical Needs – Emotional Response (PAST 30 DAYS)

<input type="checkbox"/> Child is coping well with his / her medical condition or this information is unknown to me / does not apply.	<input type="checkbox"/> Child is experiencing some emotions related to the medical condition, but these are not affecting other areas of life.	<input type="checkbox"/> Child's emotional response to his / her condition is interfering with treatment and other areas of life.	<input type="checkbox"/> Child is having severe emotional response to his / her condition that is interfering with treatment and functioning.
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If the child's needs / functioning fall within a shaded box, explain why:

Medical Needs – Impairment in Functioning (PAST 30 DAYS)

<input type="checkbox"/> Child's medical condition is not interfering with his / her functioning in other areas of life or this information is unknown to me / does not apply.	<input type="checkbox"/> Child's medical condition is having a limited impact on functioning in one area of life (self care, social interaction, communication, etc).	<input type="checkbox"/> Child's medical condition is interfering with functioning in more than one area of life or is disabling in at least one domain.	<input type="checkbox"/> Child's medical condition has disabled him / her in all other areas of life.
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If the child's needs / functioning fall within a shaded box, explain why:

Medical Needs – Treatment Involvement (PAST 30 DAYS)

<input type="checkbox"/> Child is actively involved in treatment or this is not applicable or this information is unknown to me.	<input type="checkbox"/> Child is generally involved in treatment but may struggle to stay consistent.	<input type="checkbox"/> Child is generally uninvolved although they are sometimes compliant with recommendations.	<input type="checkbox"/> Child is currently resistant to all efforts to provide medical treatment.
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If the child's needs / functioning fall within a shaded box, explain why:

PHYSICAL / PERSONAL CARE CHARACTERISTICS (Ages 5 to 21)

Medical Needs – Intensity of Treatment (PAST 30 DAYS)

<input type="checkbox"/> 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.	<input type="checkbox"/> Child's medical treatment involves taking multiple medications or visiting a medical professional multiple times per week.	<input type="checkbox"/> Child's treatment is daily but non-invasive. Treatment can be administered by a caregiver.	<input type="checkbox"/> Child's medical treatment is daily and invasive and requires either a medical professional or trained caregiver to administer.
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If the child's needs / functioning fall within a shaded box, explain why:

Medical Needs – Organizational Complexity (PAST 30 DAYS)

<input type="checkbox"/> All medical care is provided by a single medical professional or this information is unknown to me / does not apply.	<input type="checkbox"/> Child's medical care is generally provided by a coordinated team of medical professionals who work for the same organization.	<input type="checkbox"/> Child's medical care requires collaboration of multiple professionals who work for more than one organization.	<input type="checkbox"/> Child's medical care requires the collaboration of multiple professionals who work for more than one organization and are not able to communicate effectively.
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If the child's needs / functioning fall within a shaded box, explain why:

Physical Needs (PAST 30 DAYS)

<input type="checkbox"/> Child has no physical limitations, any concerns are age appropriate or this information is unknown to me.	<input type="checkbox"/> Child has some physical condition that places mild limitations on activities (hearing, vision impairment).	<input type="checkbox"/> Child has physical condition that notably impacts activities (blindness, deafness or significant motor difficulties).	<input type="checkbox"/> Child has severe physical limitations due to multiple physical conditions.
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If the child's needs / functioning fall within a shaded box, explain why:

Dental Needs (PAST 30 DAYS)

<input type="checkbox"/> No evidence of any dental health needs or this information is unknown to me.	<input type="checkbox"/> Child may have some dental health needs but they are not clearly known at this time.	<input type="checkbox"/> Child has dental needs that require attention. Dental health is interfering with functioning in at least one life domain (eating, social interaction, etc.).	<input type="checkbox"/> Child has serious dental health needs that require intensive and / or extended treatment / intervention.
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If the child's needs / functioning fall within a shaded box, explain why:

PHYSICAL / PERSONAL CARE CHARACTERISTICS (Ages 5 to 21)

Daily Functioning (PAST 30 DAYS)

<input type="checkbox"/> Child has age appropriate self care skills. No indication of deficits or this information is unknown to me.	<input type="checkbox"/> Child has minor indications of problems in self care (dressing, bathrooming, bathing) compared to same age children.	<input type="checkbox"/> Child has notable problems with completing tasks necessary for self care compared to same age children.	<input type="checkbox"/> Child has profound impairment of self care skills compared to same age children.
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If the child's needs / functioning fall within a shaded box, explain why:

Life Skills (PAST 30 DAYS)

<input type="checkbox"/> Child has age appropriate independent living skills. No indication of problems or this information is unknown to me.	<input type="checkbox"/> Child has minor indications of problems in independent living skills compared to same age children (cleanliness, diet, organization).	<input type="checkbox"/> Child has notable problems with completing tasks necessary for independent living compared to same age children (self management, cleaning).	<input type="checkbox"/> Child has profound problems of independent living skills compared to same age children. If not addressed, child will be unable to live independently in the future.
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If the child's needs / functioning fall within a shaded box, explain why:

Return completed form to: DCF/DSP/BPOHC
 Adoption Assistance Amendment Program
 212 East Washington Avenue, Suite 101
 P.O. Box 8916
 Madison, WI 53708-8916

Or fax to: 608-264-6750