

Adoption Assistance Amendment Request – Confirmation of Needs Emotional Characteristics (Ages 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].

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.

Adjustment / Emotional Response to Past Trauma – Affect Regulation (PAST 30 DAYS)

<input type="checkbox"/> Infant / child has no problems with emotional response. Concerns are age / developmentally appropriate or this information is unknown to me.	<input type="checkbox"/> Infant / child has mild to moderate problems with emotional response regulation.	<input type="checkbox"/> Infant / child has significant problems with emotional response regulation but is able to control affect at times. Problems are interfering with child's functioning.	<input type="checkbox"/> Infant / child has severe problems regulating affect / emotional response even with caregiver's support.
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------

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

Adjustment to Past Trauma – Re-experiencing the Trauma (PAST 30 DAYS)

<input type="checkbox"/> There is no evidence that infant / child re-experiences the trauma. Concerns are age / developmentally appropriate or this information is unknown to me.	<input type="checkbox"/> Child experienced some indications that the trauma was being re-experienced in the form of sleep disruption or play after the trauma but is no longer present. Subtle changes in child's functioning.	<input type="checkbox"/> Child experiences consistent indications that the trauma is being re-experienced: sleep disturbance, nightmares. Play mimicking trauma experienced.	<input type="checkbox"/> Child experiences repeated and severe incidents of re-experiencing trauma that significantly interferes with functioning and can not be managed by caregivers.
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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

EMOTIONAL CHARACTERISTICS (Ages Birth to 5)

Adjustment to Past Trauma – Avoidance (PAST 30 DAYS)

<input type="checkbox"/> No evidence of avoidant behavior. Concerns are age / developmentally appropriate or this information is unknown to me.	<input type="checkbox"/> Mild problems with avoiding some situations either after the trauma or presently on an infrequent basis. Infants due to limited mobility rarely exhibit this symptom.	<input type="checkbox"/> Moderate problems with avoidant behavior that occurs on a consistent basis when child is exposed to triggers related to the trauma. Caregiver can support the child.	<input type="checkbox"/> Severe problems with avoidant behavior that occurs consistently but cannot be mediated by caregivers and causes significant distress.
--------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------

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

Adjustment to Past Trauma – Increased Arousal (PAST 30 DAYS)

<input type="checkbox"/> No evidence of increased arousal. Concerns are age or developmentally appropriate or this information is unknown to me.	<input type="checkbox"/> Infant / child may have a history of increased arousal or currently shows this behavior on an infrequent basis.	<input type="checkbox"/> Infant / child demonstrates increased arousal most of the time. Infants appear wide eyed, over reactive to stimuli, and have exaggerated startle response. Older children may have all of the above with behavioral reactions such as tantrums.	<input type="checkbox"/> Severe problems with attachment. A child who is unable to separate or a child who appears to have severe problems with forming or maintaining relationships with caregivers.
---------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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

Adjustment to Past Trauma – Numbing Response (PAST 30 DAYS)

<input type="checkbox"/> No evidence of numbing response. Concerns are age or developmentally appropriate or this information is unknown to me.	<input type="checkbox"/> Child exhibits some problems with numbing. Child may have a restricted range of affect or an inability to express or experience certain emotions (e.g., anger or sadness).	<input type="checkbox"/> Child has moderate difficulties with numbing responses. Child may have blunted or flat emotional state or have difficulty experiencing intense emotion or feel consistently detached or estranged from others.	<input type="checkbox"/> Child has significant numbing responses or multiple symptoms of numbing. Diminished interest or participation in activities.
--------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------

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

Regulatory (PAST 30 DAYS)

<input type="checkbox"/> Child has no evidence of regulatory problems including ability to control bodily functions such as eating, sleeping, eliminating, sensitivity to external stimulation, etc. or this information is unknown to me.	<input type="checkbox"/> Some problems with regulation. Infants may have unpredictable patterns and be difficult to console. Older children may require a great deal of structure and need more support than other children in coping with frustration and difficult emotions.	<input type="checkbox"/> Moderate problems with regulation. Children may have severe reactions to stimuli and emotions that interfere with their functioning and ability to progress developmentally. Unpredictable patterns in eating and sleeping routines that disrupt the rest of the family.	<input type="checkbox"/> Profound problems with regulation are present that place the child's safety, well being and / or development at risk.
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------

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

EMOTIONAL CHARACTERISTICS (Ages Birth to 5)

Eating (PAST 30 DAYS)

<input type="checkbox"/> No evidence of problems relating to eating. Concerns are age or developmentally appropriate or this information is unknown to me.	<input type="checkbox"/> Mild problems with eating that have been present in the past or are currently present some of the time causing mild impairment in functioning.	<input type="checkbox"/> Moderate problems with eating are present and impair the child's functioning. Children may seriously overeat, refuse most foods and not have a clear pattern of when they eat.	<input type="checkbox"/> Severe problems with eating are present putting the infant / child at risk developmentally. The child and family are very distressed and unable to overcome problems in this area.
-------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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

Elimination / Bathrooming (PAST 30 DAYS)

<input type="checkbox"/> There is no evidence of elimination problems. Any concerns are age or developmentally appropriate or this information is unknown to me. (This does not include potty training concerns.)	<input type="checkbox"/> Infant / child may have a history of elimination difficulties but is presently not experiencing this other than on rare occasions.	<input type="checkbox"/> Infant / child demonstrates problems with elimination on a consistent basis that is interfering with the child's functioning. (Lack of routine resulting in constipation, encopresis and enuresis.)	<input type="checkbox"/> Infant / child demonstrates significant difficulty with elimination to the extent that child / parent are in significant distress or interventions have failed.
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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

Sensory Reactivity (PAST 30 DAYS)

<input type="checkbox"/> There is not evidence of sensory reactivity that is under or over reactive. Any concerns are age or developmentally appropriate or this information is unknown to me.	<input type="checkbox"/> Infant / child may have a history of sensory issues or mild issues currently that are controlled by caregiver support.	<input type="checkbox"/> Infant / child demonstrates under / over reactivity to sensory input in one or more area which impairs the child's functioning.	<input type="checkbox"/> Infant / child demonstrates significant reactions to sensory input so that the caregiver is unable to help the child.
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------

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

Emotional Control (PAST 30 DAYS)

<input type="checkbox"/> Infant / child has no problem with emotional control. Any concerns are age or developmentally appropriate or this information is unknown to me.	<input type="checkbox"/> Infant / child has mild problems with emotional control that can be overcome with caregiver support.	<input type="checkbox"/> Child has a moderate level of problems with emotional control that interferes most of the time with functioning (difficult to console, does not respond to caregiver support, becomes physically aggressive out of frustration).	<input type="checkbox"/> Infant / child has significant level of emotional control problems that are interfering with development. Caregivers are not able to help the child.
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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

EMOTIONAL CHARACTERISTICS (Ages Birth to 5)

Sleep – Child Must be 12 Months or Older (PAST 30 DAYS)

<input type="checkbox"/> Child gets a full night's sleep each night. Any concerns are age or developmentally appropriate or this information is unknown to me.	<input type="checkbox"/> Child has some problems sleeping. Toddlers resist sleep and consistently need a great deal of adult support to sleep. Preschoolers may have a history of poor sleep or continued problems 1-2 nights per week.	<input type="checkbox"/> Child is having problems with sleep that might include difficulty falling asleep, night waking, night terrors or nightmares on a regular basis (4 or more times per week).	<input type="checkbox"/> Child is experiencing significant sleep problems that result in sleep deprivation that affects the child's functioning. Parents have exhausted numerous strategies for assisting child.
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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

Attachment (PAST 30 DAYS)

<input type="checkbox"/> No evidence of problems with attachment. Any concerns are age or developmentally appropriate or this information is unknown to me.	<input type="checkbox"/> Mild problems with attachment. Children may be overly reactive to separation or seem preoccupied with parent. Boundaries may seem inappropriate.	<input type="checkbox"/> Moderate problems with attachment and may fail to demonstrate stranger anxiety or have extreme reactions to separation resulting affecting development, may avoid caregivers and have inappropriate boundaries putting them at risk.	<input type="checkbox"/> Severe attachment problems. Children attachment to anyone or no one in an extreme manner. Child meets criteria for Reactive Attachment Disorder.
--------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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

Depression (PAST 30 DAYS)

<input type="checkbox"/> No evidence or concern about depression. Any concerns are age or developmentally appropriate or this information is unknown to me.	<input type="checkbox"/> Child may be depressed or has experienced situations that may lead to depression. Infants may appear withdrawn and slow to engage at times. Older children are irritable or do not demonstrate a range of emotional response / affect.	<input type="checkbox"/> Moderate problems with depression are present. Children may have negative verbalizations, no emotional response, dark / sad play and demonstrate little enjoyment in play and interactions.	<input type="checkbox"/> Clear evidence of a disabling level of depression that makes it virtually impossible for the child to function in any life domain.
--------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------

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

EMOTIONAL CHARACTERISTICS (Ages Birth to 5)

Anxiety (PAST 30 DAYS)

<input type="checkbox"/> No evidence or concern about anxiety. Any concerns are age or developmentally appropriate or this information is unknown to me.	<input type="checkbox"/> History or suspicion of anxiety problems or mild to moderate anxiety. Infant / child may appear anxious in certain situation but has the ability to be soothed / calmed.	<input type="checkbox"/> Anxiety with significant fearfulness that has interfered significantly in child's ability to function. Child may be irritable, over reactive to stimuli, uncontrollable crying and significant separation anxiety.	<input type="checkbox"/> Clear evidence of debilitating level of anxiety that makes it virtually impossible for the child to function in any area of life.
-----------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------

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

Return completed form to: Adoption Assistance
DCF/DSP - Suite 101
P.O. Box 8916
Madison, WI 53708-8916

Or fax to: 608-264-6750