

## Adoption Assistance 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].

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 <b>age appropriate</b> or this information is unknown to me.	<input type="checkbox"/> Child has some problems with physical immaturity or there are concerns about <b>possible</b> 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:

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### Child's Cognitive Development (PAST 30 DAYS)

<input type="checkbox"/> Child shows no evidence of cognitive development problems. Any concerns are <b>age appropriate</b> or this information is unknown to me.	<input type="checkbox"/> 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.	<input type="checkbox"/> Child has clear signs that development is not at the expected level. Child may be unable to understand simple routines or tasks.	<input type="checkbox"/> Child has significant delays in cognitive functioning that are seriously interfering with their functioning. Child is completely reliant on caregiver to function.
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If the child's needs / functioning fall within a shaded box, explain why:

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### Autism Spectrum (PAST 30 DAYS)

<input type="checkbox"/> Child's development appears normal in relation to autistic characteristics <b>or</b> this information is unknown to me.	<input type="checkbox"/> Evidence of mild symptoms of an autism spectrum disorder. Child 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:

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**PHYSICAL / PERSONAL CARE CHARACTERISTICS (Birth to 5)**

**Communication (PAST 30 DAYS)**

<input type="checkbox"/> Child's ability to communicate is <b>age appropriate</b> 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 <b>and</b> 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 (PAST 30 DAYS)**

<input type="checkbox"/> Child's self care / daily living skills appear to be <b>age appropriate</b> 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 <b>or</b> this information is unknown to me / does not apply.	<input type="checkbox"/> Child has some medical problems that require medical treatment.	<input type="checkbox"/> Child has chronic illness that requires ongoing medical intervention ( <b>diabetes, severe / uncontrolled asthma, life threatening allergies, HIV</b> ).	<input type="checkbox"/> Child has life threatening illness or medical condition. ( <b>active cancer, AIDS, etc</b> ).
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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 <b>or</b> 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 (Birth to 5)**

**Medical Needs – Chronicity (PAST 30 DAYS)**

<input type="checkbox"/> Child is expected to fully recover from his / her condition within the next 6 months <b>or</b> 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 <b>or</b> 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 <b>or</b> 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 life domains <b>or</b> 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 other life domain (self care, social interaction, communication, etc).	<input type="checkbox"/> Child's medical condition is interfering with functioning in more than one life domain or is disabling in at least one domain.	<input type="checkbox"/> Child's medical condition has disabled him / her in all other life domains.
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If the child's needs / functioning fall within a shaded box, explain why:

**PHYSICAL / PERSONAL CARE CHARACTERISTICS (Birth to 5)**

**Medical Needs – Treatment Involvement (PAST 30 DAYS)**

<input type="checkbox"/> Child and family are actively involved in treatment <b>or</b> this is not applicable <b>or</b> this information is unknown to me / does not apply.	<input type="checkbox"/> Child and / or family are generally involved in treatment but may struggle to stay consistent.	<input type="checkbox"/> Child and / or family are generally uninvolved although they are sometimes compliant with recommendations.	<input type="checkbox"/> Child and / or family are 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:

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**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, <b>or</b> 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:

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**Medical Needs – Organizational Complexity (PAST 30 DAYS)**

<input type="checkbox"/> All medical care is provided by a single medical professional <b>or</b> this information is unknown to me / does not apply.	<input type="checkbox"/> Child's medical care is generally provided by a coordinated team 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:

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**Physical Needs (PAST 30 DAYS)**

<input type="checkbox"/> Child has no physical limitations. Any concerns are <b>age appropriate</b> <b>or</b> 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:

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**PHYSICAL / PERSONAL CARE CHARACTERISTICS (Birth to 5)**

**Dental Needs (PAST 30 DAYS)**

<input type="checkbox"/> No evidence of any dental health needs <b>or</b> 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"/> 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:

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**Daily Functioning (PAST 30 DAYS)**

<input type="checkbox"/> Child has <b>age appropriate</b> 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 compared to same age peers, but is generally self reliant.	<input type="checkbox"/> 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.	<input type="checkbox"/> 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.
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If the child's needs / functioning fall within a shaded box, explain why:

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**Motor (PAST 30 DAYS)**

<input type="checkbox"/> No evidence of fine or gross motor development problems. Any concerns are <b>age appropriate</b> or this information is unknown to me.	<input type="checkbox"/> Child has some indicators that motor skills are challenging and there may be some concern that there is a delay.	<input type="checkbox"/> Child has either fine or gross motor skill delays.	<input type="checkbox"/> Child has significant delays in fine or gross motor development or both. Delay causes impairment in functioning.
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If the child's needs / functioning fall within a shaded box, explain why:

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**Communication (PAST 30 DAYS)**

<input type="checkbox"/> No evidence of communication problems exists. Any concerns are <b>age appropriate</b> or this information is unknown to me.	<input type="checkbox"/> Child has a history of communication problems but currently is not experiencing problems.	<input type="checkbox"/> 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.	<input type="checkbox"/> Child has serious communication difficulties and is unable to communicate in any way including pointing and grunting.
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If the child's needs / functioning fall within a shaded box, explain why:

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**PHYSICAL / PERSONAL CARE CHARACTERISTICS (Birth to 5)**

**Failure to Thrive (PAST 30 DAYS)**

<input type="checkbox"/> No evidence of failure to thrive <b>or</b> this information is unknown to me.	<input type="checkbox"/> Child may have experienced past problems with growth and ability to gain weight and is currently not experiencing problems.	<input type="checkbox"/> Child is experiencing problems in their ability to maintain weight or growth. Child may be below the 5 <sup>th</sup> percentile for age and sex and may weigh less than 80% of their ideal weight for age, have depressed weight for height.	<input type="checkbox"/> Child may have one or more of the symptoms listed and is currently at serious medical risk.
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If the child's needs / functioning fall within a shaded box, explain why:

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**Labor and Delivery**

<input type="checkbox"/> Child and biological mother had a normal labor and delivery <b>or</b> this information is unknown to me.	<input type="checkbox"/> Child or mother had some mild problems during delivery, but child does not appear affected by problems.	<input type="checkbox"/> Child or mother had problems during delivery that resulted in temporary functional difficulties for the child or mother.	<input type="checkbox"/> Child had severe problems during delivery that have resulted in long term implications for development.
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If the child's needs / functioning fall within a shaded box, explain why:

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**Parent / Sibling Exposure**

<input type="checkbox"/> Child's parents have no developmental disabilities. The child has no siblings or existing siblings are not experiencing any developmental or behavioral problems <b>or</b> this information is unknown to me.	<input type="checkbox"/> Child's parents have no developmental disabilities. Child has siblings who are experiencing some mild developmental or behavioral problems.	<input type="checkbox"/> Child's parents have no developmental disabilities. Child has a sibling who is experiencing a significant developmental or behavioral problem.	<input type="checkbox"/> 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.
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If the child's needs / functioning fall within a shaded box, explain why:

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Return completed form to: Adoption Assistance  
DCF/DSP - Suite 101  
P.O. Box 8916  
Madison, WI 53708-8916  
  
Or fax to: 608-264-6750