**Information for Out-Of-Home Care Providers – Part B**

**Use of form:** The information contained in this form must be provided to the out-of-home care provider before the prospective out-of-home care provider agrees to placement of the child or no later than seven days after the child is placed with the out-of-home care provider. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes]. If additional space is needed when completing this form, attach additional sheet(s).

|  |
| --- |
| **I. GENERAL INFORMATION** |
| Date Form Filled Out (mm/dd/yyyy)      | Out-of-Home Care Provider:      |
| **A. Child Information** |
| Full Name – Child (Legal)      | Birthdate (mm/dd/yyyy)      | Social Security Number      |
| Race      | Ethnicity      | Gender[ ]  Male [ ]  Female [ ]  Other |
| **II. PLACEMENT REASON(S)** |
| [ ]  Child abuse or neglect (CAN) [ ]  Physical [ ]  Sexual abuse [ ]  Emotional abuse [ ]  Neglect[ ]  Delinquent act(s) [ ]  Assaultive  [ ]  Non-assaultive[ ]  Developmental needs[ ]  Medical needs[ ]  Substance use[ ]  Emotional needs[ ]  Behavioral needs[ ]  Life functioning needs[ ]  Death, illness, or incarceration of primary caregiver | [ ]  Yes [ ]  No CHIPS, other than CAN |
|  | Type of CHIPS / JIPS / Delinquency      |
|  | Nature of Offense(s)[ ]  Property[ ]  Assaultive |
|  | Placement is:[ ]  Voluntary[ ]  Court ordered |
|  |  |
| Other Placement Reasons – Specify.      |
| **III. SIGNIFICANT CONTACTS** |
| **A. Legal Custodian / Guardian**  |
| Full Name      | Relationship (Legal Custodian / Guardian)      |
| Address (Street, City, State, Zip Code)      | Telephone Number      |
| **B. Guardian ad litem (GAL) and Legal Counsel** |
| Full Name      | Relationship[ ]  GAL [ ]  Legal Counsel |
| Address (Street, City, State, Zip Code)      | Telephone Number      |
| Full Name      | Relationship[ ]  GAL [ ]  Legal Counsel |
| Address (Street, City, State, Zip Code)      | Telephone Number      |
| **C. Other Individuals / Contacts** |
| Full Name      | Relationship      |
| Type of Contact      | Telephone Number      |
| Full Name      | Relationship      |
| Type of Contact      | Telephone Number      |
| **IV. PLACEMENT HISTORY AND PERMANENCE GOAL(S)** |
| **A. Previous Placement** (If there is no court order prohibiting release of name of previous out-of-home care provider(s)) |
| Placement Type(FH, GH, RCC, hospital, etc.) | Full Name | Placement Dates |
|  |  | From(mm/dd/yyyy) | To(mm/dd/yyyy) |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|  **B. Permanence Goal** |
| Permanence Goal |
| [ ]  Reunification [ ]  Guardianship |
| [ ]  Adoption [ ]  Placement with a fit and willing relative[ ]  Other Permanent Planned Living Arrangement |
| What is the anticipated date the permanence goal will be achieved?       (mm/dd/yyyy) |
| Concurrent Goal |
| [ ]  Reunification [ ]  Guardianship |
| [ ]  Adoption [ ]  Placement with a fit and willing relative[ ]  Other Permanent Planned Living Arrangement |
| What is the anticipated date the permanence goal will be achieved?       (mm/dd/yyyy) |
| **V. TRAUMA HISTORY** |
|  **A. Sexual Abuse History** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | History of sexual abuse | Specify:       |
| [ ]  | [ ]  | [ ]  | Any involvement of the child as a **victim** in sexual intercourse, sexual contact, prostitution (s. 944.30), sexual exploitation of a child, causing a child to view or listen to sexual activity (s. 948.055) | Specify:       |
| [ ]  | [ ]  | [ ]  | Perpetrator was known to the child (e.g., close relationship, family, etc.) | Specify:       |
| [ ]  | [ ]  | [ ]  | Abuse occurred multiple times | Specify:       |
| [ ]  | [ ]  | [ ]  | Abuse occurred over a period longer than 6 months | Specify:       |
| [ ]  | [ ]  | [ ]  | Threat of force or physical force was used during the abuse | Specify:       |
| [ ]  | [ ]  | [ ]  | Lack of support from close family members of abuse disclosure | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  **B. Trauma History** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Child is a victim of sex trafficking | Specify:       |
| [ ]  | [ ]  | [ ]  | Physical abuse | Specify:       |
| [ ]  | [ ]  | [ ]  | Neglect | Specify:       |
| [ ]  | [ ]  | [ ]  | Emotional abuse | Specify:       |
| [ ]  | [ ]  | [ ]  | Medical trauma | Specify:       |
| [ ]  | [ ]  | [ ]  | Child has experienced a natural disaster | Specify:       |
| [ ]  | [ ]  | [ ]  | Child has witnessed family violence | Specify:       |
| [ ]  | [ ]  | [ ]  | Child has witnessed community violence | Specify:       |
| [ ]  | [ ]  | [ ]  | Victim of criminal activity or witnessed the victimization of a family or friend | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  **C. Adjustment to Trauma** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Problems with affect regulation (e.g., exaggerated emotional response) | Specify:       |
| [ ]  | [ ]  | [ ]  | Re-experiences the trauma (e.g., sleep disturbance, nightmares) | Specify:       |
| [ ]  | [ ]  | [ ]  | Increased arousal | Specify:       |
| [ ]  | [ ]  | [ ]  | Adjustment problems (e.g., PTSD, flashbacks, nightmares, anxiety) | Specify:       |
| [ ]  | [ ]  | [ ]  | Experiences episodes of dissociation (e.g., avoids thoughts/feelings associated with the trauma, unable to recall a specific event, etc.) | Specify:       |
| [ ]  | [ ]  | [ ]  | Difficulty with a numbing response (e.g., flat emotional state, detached) | Specify:       |
| [ ]  | [ ]  | [ ]  | Traumatic grief due to death or the separation from caregiver | Specify:       |
| [ ]  | [ ]  | [ ]  | Experiences intrusive thoughts | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
| **VI. SCHOOL / CHILD CARE** |
|  **A. Educational Needs** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Difficulty getting along with teachers | Specify:       |
| [ ]  | [ ]  | [ ]  | Difficulty getting along with peers | Specify:       |
| [ ]  | [ ]  | [ ]  | Extra time spent with child on required school activities (e.g., homework) | Specify:       |
| [ ]  | [ ]  | [ ]  | Attendance / Truancy issues, unrelated to school suspensions | Specify:       |
| [ ]  | [ ]  | [ ]  | Disruptions at school or day care | Specify:       |
| [ ]  | [ ]  | [ ]  | Clings excessively to parent, teacher or other | Specify:       |
| [ ]  | [ ]  | [ ]  | Frequent suspensions or expulsions | Specify:       |
| [ ]  | [ ]  | [ ]  | School / childcare does not meet the needs of the child | Specify:       |
| [ ]  | [ ]  | [ ]  | Difficulty with achievement (e.g., low grades, failing some subjects) | Specify:       |
| [ ]  | [ ]  | [ ]  | Child receives services for: | Specify:       |
|  |  |  | [ ]  Autism Spectrum Disorder | [ ]  Significant development delay |  |
|  |  |  | [ ]  Cognitive disabilities | [ ]  Specific learning disabilities |  |
|  |  |  | [ ]  Emotional behavioral disabilities | [ ]  Speech / language impairment |  |
|  |  |  | [ ]  Hearing impairment | [ ]  Traumatic Brain Injury |  |
|  |  |  | [ ]  Orthopedic impairment | [ ]  Visual impairment |  |
|  |  |  | [ ]  Other health impaired | [ ]  Other |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
| **VII. LIFE FUNCTIONING** |
|  **A. Developmental** |
| Y  | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Significant delays in cognitive functioning | Specify:       |
| [ ]  | [ ]  | [ ]  | Reliant on caregiver to function | Specify:       |
| [ ]  | [ ]  | [ ]  | Unable to indicate wants and / or needs | Specify:       |
| [ ]  | [ ]  | [ ]  | Difficulty understanding simple routines or simple tasks | Specify:       |
| [ ]  | [ ]  | [ ]  | Meets diagnostic criteria for autism disorder | Specify:       |
| [ ]  | [ ]  | [ ]  | Limited communication skills or is unable to communicate | Specify:       |
| [ ]  | [ ]  | [ ]  | Requires excessive verbal prompting on self-care tasks or daily living skills | Specify:       |
| [ ]  | [ ]  | [ ]  | Requires assistance on self-care tasks (e.g., eating, bathing, dressing, etc.) | Specify:       |
| [ ]  | [ ]  | [ ]  | Fine or gross motor skill delays | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
| 1. **Medical**
 |
| Y  | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Medical illness which requires medical treatment / intervention | Specify:       |
| [ ]  | [ ]  | [ ]  | Life threatening illness or medical condition | Specify:       |
| [ ]  | [ ]  | [ ]  | Medical condition with risk of premature death (e.g., prior to adulthood) | Specify:       |
| [ ]  | [ ]  | [ ]  | Lifelong medical condition (e.g., no expectation to fully recover) | Specify:       |
| [ ]  | [ ]  | [ ]  | Concern about the accuracy of the medical diagnosis | Specify:       |
| [ ]  | [ ]  | [ ]  | Child has difficulty coping with the medical condition | Specify:       |
| [ ]  | [ ]  | [ ]  | Interferes with functioning in more than one life domain | Specify:       |
| [ ]  | [ ]  | [ ]  | Medical condition requires daily and invasive medical treatment  | Specify:       |
| [ ]  | [ ]  | [ ]  | Medical condition requires taking multiple medications  | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
| 1. **Health Concerns or Symptoms**
 |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
|  |  |  | **Brain or head concerns** |  |
| [ ]  | [ ]  | [ ]  | Serious head injury or loss of consciousness | Specify:       |
| [ ]  | [ ]  | [ ]  | Headaches, migraines, dizziness, coordination or balance challenges | Specify:       |
| [ ]  | [ ]  | [ ]  | Traumatic Brain Injury | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  |  |  | **Heart and lungs** |  |
| [ ]  | [ ]  | [ ]  | Short of breath, swollen ankles | Specify:       |
| [ ]  | [ ]  | [ ]  | High or low blood pressure | Specify:       |
| [ ]  | [ ]  | [ ]  | Heart trouble or murmur, chest pain, irregular heartbeat  | Specify:       |
| [ ]  | [ ]  | [ ]  | Flu, pneumonia | Specify:       |
| [ ]  | [ ]  | [ ]  | Wheezing, bronchitis | Specify:       |
| [ ]  | [ ]  | [ ]  | Asthma | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  | **Skin conditions or allergies** |  |
| [ ]  | [ ]  | [ ]  | Lice, scabies, worms | Specify:       |
| [ ]  | [ ]  | [ ]  | Chronic diaper rash, impetigo | Specify:       |
| [ ]  | [ ]  | [ ]  | Treatment for skin trouble, rashes, hives, breaking out, acne | Specify:       |
| [ ]  | [ ]  | [ ]  | Eczema | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  |  |  | **Eye, ear, nose, throat or dental problems** |
| [ ]  | [ ]  | [ ]  | Trouble swallowing, speaking, persistent hoarseness | Specify:       |
| [ ]  | [ ]  | [ ]  | Chronic or severe ear or sinus infections | Specify:       |
| [ ]  | [ ]  | [ ]  | Blocking of nose, discharge, post-nasal drip | Specify:       |
| [ ]  | [ ]  | [ ]  | Severe or painful dental problems | Specify:       |
| [ ]  | [ ]  | [ ]  | Blindness, blurred, or double vision.Date of last eye exam:       (mm/dd/yyyy) | Specify:       |
| [ ]  | [ ]  | [ ]  | Hearing problems, ringing ears, discharge / infection, tubes | Specify:       |
| [ ]  | [ ]  | [ ]  | Sensory disorder/diagnosis | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  |  |  | **Systemic conditions** |
| [ ]  | [ ]  | [ ]  | Colic | Specify:       |
| [ ]  | [ ]  | [ ]  | Numbness or loss of strength in hand, arm or leg | Specify:       |
| [ ]  | [ ]  | [ ]  | Urinary, prostate, gall bladder, kidney problems | Specify:       |
| [ ]  | [ ]  | [ ]  | Reflux, choking, heartburn, ulcers | Specify:       |
| [ ]  | [ ]  | [ ]  | Constipation, diarrhea, blood in stool, uses laxatives | Specify:       |
| [ ]  | [ ]  | [ ]  | Incontinent, encopretic | Specify:       |
| [ ]  | [ ]  | [ ]  | Sprain or dislocation of bone or joint; e.g., brittle bones or rolling joints | Specify:       |
| [ ]  | [ ]  | [ ]  | Arthritis, backaches, cramps, bursitis, or pain in legs | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  |  |  | **Risk factors** |
| [ ]  | [ ]  | [ ]  | Low birth weight | Specify:       |
| [ ]  | [ ]  | [ ]  | Lack of prenatal care | Specify:       |
| [ ]  | [ ]  | [ ]  | Born premature or overdue | Specify:       |
| [ ]  | [ ]  | [ ]  | Complications at birth | Specify:       |
| [ ]  | [ ]  | [ ]  | In utero exposure to alcohol and /or drugs | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  **D. Medical Illness or Diagnosis** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Check illness child has had, as applicable | Specify:       |
|  | [ ]  7-day measles | [ ]  Rubella |  |  |
|  | [ ]  Chicken pox | [ ]  Scarlet fever |  |  |
|  | [ ]  German measles | [ ]  Strep throat |  |  |
|  | [ ]  Covid 19 | [ ]  Whooping cough |  |  |
|  | [ ]  Mumps | [ ]  Other |  |  |
| [ ]  | [ ]  | [ ]  | Polio | Specify:       |
| [ ]  | [ ]  | [ ]  | Hepatitis BDate of last test:       (mm/dd/yyyy) | Specify:       |
| [ ]  | [ ]  | [ ]  | Tuberculosis (TB) | Specify:       |
| [ ]  | [ ]  | [ ]  | AIDS / HIVDate of last test:       (mm/dd/yyyy) | Specify:       |
| [ ]  | [ ]  | [ ]  | Mononucleosis, thyroid problems | Specify:       |
| [ ]  | [ ]  | [ ]  | Hemophilia, Sickle Cell anemia | Specify:       |
| [ ]  | [ ]  | [ ]  | Lead poisoning | Specify:       |
| [ ]  | [ ]  | [ ]  | Liver disease | Specify:       |
| [ ]  | [ ]  | [ ]  | Diabetes | Specify:       |
| [ ]  | [ ]  | [ ]  | Seizure disorder, epilepsy | Specify:       |
| [ ]  | [ ]  | [ ]  | Cerebral Palsy, Muscular Dystrophy | Specify:       |
| [ ]  | [ ]  | [ ]  | Down’s Syndrome | Specify:       |
| [ ]  | [ ]  | [ ]  | Cancer, leukemia, or other malignancy | Specify:       |
| [ ]  | [ ]  | [ ]  | Failure to Thrive | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  **E. Medical Appointments and Treatment** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Frequent therapeutic exercises done by child with provider’s help | Specify:       |
| [ ]  | [ ]  | [ ]  | Requires care of medical equipment | Specify:       |
| [ ]  | [ ]  | [ ]  | Frequent doctor visits or hospitalizations | Specify:       |
| [ ]  | [ ]  | [ ]  | Medical tests (Check those that apply and when the tests were completed) |  |
|  |  |  | [ ]  | CAT scan |       (mm/dd/yyyy) |  | [ ]  | MRI |       (mm/dd/yyyy) |
|  |  |  | [ ]  | Chest x-ray |       (mm/dd/yyyy) |  | [ ]  | Pap test |       (mm/dd/yyyy) |
|  |  |  | [ ]  | EEG |       (mm/dd/yyyy) |  | [ ]  | TB skin test |       (mm/dd/yyyy) |
|  |  |  | [ ]  | EKG |       (mm/dd/yyyy) |  | [ ]  | Other  |       (mm/dd/yyyy) |
| [ ]  | [ ]  | [ ]  | Recent hospitalization | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  **F. Other Life Functioning Needs** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Difficulty in social relationships with same age peers | Specify:       |
| [ ]  | [ ]  | [ ]  | Difficulty in social relationships with adults | Specify:       |
| [ ]  | [ ]  | [ ]  | No engagement or interest in recreational activities | Specify:       |
| [ ]  | [ ]  | [ ]  | Does not sleep through the night, including nightmares , sleepwalking | Specify:       |
| [ ]  | [ ]  | [ ]  | Wets the bed | Specify:       |
| [ ]  | [ ]  | [ ]  | Concerns with independent living (e.g., difficulty with cooking and / or cleaning, problems with money management) | Specify:       |
| [ ]  | [ ]  | [ ]  | Difficulty in relationships with parents and / or siblings (e.g., arguing, difficulty in maintaining a positive relationship) | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
| **VIII. ACCULTURATION NEEDS** |
|  **A. Cultural Identity** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | English as a second language / needs a translator  | Specify:       |
| [ ]  | [ ]  | [ ]  | Struggles with cultural identity | Specify:       |
| [ ]  | [ ]  | [ ]  | Needs assistance with creating connections to others who share his / her cultural identity  | Specify:       |
| [ ]  | [ ]  | [ ]  | Needs support to practice cultural rituals  | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
| **IX. EMOTIONAL NEEDS** |
|  **A. Attachment** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Lack of concern for others, lack of remorse or conscience | Specify:       |
| [ ]  | [ ]  | [ ]  | Difficulty communicating with others, does not vocalize or maintain eye contact | Specify:       |
| [ ]  | [ ]  | [ ]  | Avoids emotional situations and personal relationships | Specify:       |
| [ ]  | [ ]  | [ ]  | Excessively / inappropriately seeks attention | Specify:       |
| [ ]  | [ ]  | [ ]  | Difficulty establishing and maintaining attachment to caregiver | Specify:       |
| [ ]  | [ ]  | [ ]  | Over or under-reacts to separation from caregiver during transitions | Specify:       |
| [ ]  | [ ]  | [ ]  | Over or under-reacts to family interactions | Specify:       |
| [ ]  | [ ]  | [ ]  | Difficulty making and maintaining friendships | Specify:       |
| [ ]  | [ ]  | [ ]  | Multiple placements | Specify:       |
| [ ]  | [ ]  | [ ]  | Lack of boundaries with strangers; lack of fear | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  **B. Attention or Functioning Level** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Needs close or constant supervision | Specify:       |
| [ ]  | [ ]  | [ ]  | Extreme hyperactive and impulsive behaviors | Specify:       |
| [ ]  | [ ]  | [ ]  | Refuses or is unable to follow instructions or rules (non-academically) | Specify:       |
| [ ]  | [ ]  | [ ]  | Has difficulty focusing or sustaining attention in home environment | Specify:       |
| [ ]  | [ ]  | [ ]  | Needs structured behavior management, fails to respond to limit-setting or discipline | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  **C. Mental Health Needs** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | History of mental health needs or diagnosis in family | Specify:       |
| [ ]  | [ ]  | [ ]  | Suicidal risk | Specify:       |
| [ ]  | [ ]  | [ ]  | Self-injurious (e.g., intentionally harms self) | Specify:       |
| [ ]  | [ ]  | [ ]  | Other self-harm (e.g., reckless, risk-taking behavior) | Specify:       |
| [ ]  | [ ]  | [ ]  | Lethargic, apathetic, withdrawn, unresponsive | Specify:       |
| [ ]  | [ ]  | [ ]  | Psychosis (e.g., hallucinations, delusions, bizarre behavior) | Specify:       |
| [ ]  | [ ]  | [ ]  | Extreme fears or phobias | Specify:       |
| [ ]  | [ ]  | [ ]  | Frequent mental health treatment or hospitalizations | Specify:       |
| [ ]  | [ ]  | [ ]  | Psychiatric diagnosis | Specify:       |
| [ ]  | [ ]  | [ ]  | Anxiety | Specify:       |
| [ ]  | [ ]  | [ ]  | Depression | Specify:       |
| [ ]  | [ ]  | [ ]  | Exploited | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  **D. Other Emotional Needs** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Difficult to soothe or console; unexplained, excessive, or prolonged crying spells | Specify:       |
| [ ]  | [ ]  | [ ]  | Displays emotions that are inappropriate to the situation | Specify:       |
| [ ]  | [ ]  | [ ]  | Is preoccupied with routine, objects, or appearance | Specify:       |
| [ ]  | [ ]  | [ ]  | Frequent or excessive temper tantrums or rage | Specify:       |
| [ ]  | [ ]  | [ ]  | Takes unusual risks with personal safety | Specify:       |
| [ ]  | [ ]  | [ ]  | Involvement in activities that are harmful to the child’s physical, mental or moral well-being | Specify:       |
| [ ]  | [ ]  | [ ]  | Somatization (e.g. persistent physical symptoms without a medical cause, such as headaches) | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
| **X. BEHAVIORAL NEEDS** |
|  **A. Dietary Needs or Concerns** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Persistent or ongoing feeding problems | Specify:       |
| [ ]  | [ ]  | [ ]  | Gorges or hoards food | Specify:       |
| [ ]  | [ ]  | [ ]  | Eats non-food items | Specify:       |
| [ ]  | [ ]  | [ ]  | Eating disorder; excessive preoccupation with food, weight, or body image | Specify:       |
| [ ]  | [ ]  | [ ]  | Dramatic weight gain or loss | Specify:       |
| [ ]  | [ ]  | [ ]  | Special diet needs or limitations | Specify:       |
| [ ]  | [ ]  | [ ]  | Picky eater | Specify:       |
| [ ]  | [ ]  | [ ]  | Binge eats | Specify:       |
| [ ]  | [ ]  | [ ]  | History of hospitalization(s) as a result of an eating disturbance | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  **B. Substance Use or Abuse** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Tobacco use | Specify:       |
| [ ]  | [ ]  | [ ]  | Fetal alcohol effects or syndrome | Specify:       |
| [ ]  | [ ]  | [ ]  | History of drug dependency or AODA issues in family | Specify:       |
| [ ]  | [ ]  | [ ]  | History of abusing over the counter or prescribed medications | Specify:       |
| [ ]  | [ ]  | [ ]  | Alcohol or drug use; use or abuse of household items or chemicals for other than intended purposes | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  **C. Sexual Development and / or Behaviors** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Any involvement of the child as a **perpetrator** in sexual intercourse, sexual contact, prostitution (s.944.30), sexual exploitation of a child, causing a child to view or listen to sexual activity (s. 948.055) | Specify:       |
| [ ]  | [ ]  | [ ]  | Inappropriate sexual behaviors, displays overt sexual gestures, language, or dress | Specify:       |
| [ ]  | [ ]  | [ ]  | Unusual or painful menstruation | Specify:       |
| [ ]  | [ ]  | [ ]  | Sexual activity | Specify:       |
| [ ]  | [ ]  | [ ]  | Use of birth control, medication, or other birth control methods | Specify:       |
| [ ]  | [ ]  | [ ]  | Sexually transmitted disease | Specify:       |
| [ ]  | [ ]  | [ ]  | Expectant parent or parenting | Specify:       |
| [ ]  | [ ]  | [ ]  | Medical complications resulting from an abortion | Specify:       |
| [ ]  | [ ]  | [ ]  | Anxiety associated with sexual identity | Specify:       |
| [ ]  | [ ]  | [ ]  | High-risk sexual behaviors (e.g., multiple partners, older partners, prostitution) | Specify:       |
| [ ]  | [ ]  | [ ]  | Sexual aggression | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
|  |  |  | The child identifies as:       | Specify:       |
|  **D. Violence or Aggression** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Association with a gang or any other group harmful to self or others | Specify:       |
| [ ]  | [ ]  | [ ]  | Extremely destructive to property | Specify:       |
| [ ]  | [ ]  | [ ]  | Threatened or assaulted anyone physically  | Specify:       |
| [ ]  | [ ]  | [ ]  | Abused or acts cruel to animals – physically or sexually | Specify:       |
| [ ]  | [ ]  | [ ]  | Bullies or instigates situations or fights | Specify:       |
| [ ]  | [ ]  | [ ]  | Verbally aggressive | Specify:       |
| [ ]  | [ ]  | [ ]  | Inappropriate use of weapons | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
| 1. **Legal**
 |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Involvement in the legal system | Specify:       |
| [ ]  | [ ]  | [ ]  | Engagement in delinquent behavior | Specify:       |
| [ ]  | [ ]  | [ ]  | History of arrests | Specify:       |
| [ ]  | [ ]  | [ ]  | Plans criminal / delinquent behavior, premeditated behavior | Specify:       |
| [ ]  | [ ]  | [ ]  | Behavior places community residents at risk of harm | Specify:       |
| [ ]  | [ ]  | [ ]  | Does not comply with court sanctions / orders | Specify:       |
| [ ]  | [ ]  | [ ]  | Influenced by parental criminal behavior | Specify:       |
| [ ]  | [ ]  | [ ]  | Influenced by environment to engage in criminal / delinquent behavior | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
| 1. **Runaway**
 |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | History of running away from home | Specify:       |
| [ ]  | [ ]  | [ ]  | Runs frequently, runs at every opportunity, or has run on multiple occasions | Specify:       |
| [ ]  | [ ]  | [ ]  | Consistently runs to the same location, neighborhood, or community | Specify:       |
| [ ]  | [ ]  | [ ]  | Runs to unsafe environments; likelihood of victimization is high | Specify:       |
| [ ]  | [ ]  | [ ]  | Engages in delinquent and / or dangerous activities while on the run | Specify:       |
| [ ]  | [ ]  | [ ]  | Others encourage or help youth to run | Specify:       |
| [ ]  | [ ]  | [ ]  | Unrealistic expectations of the consequence of his / her running behavior | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
| 1. **Other Behavioral Needs**
 |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Sets fires  | Specify:       |
| [ ]  | [ ]  | [ ]  | Self-stimulating behaviors or repetitive body motions | Specify:       |
| [ ]  | [ ]  | [ ]  | Unusually accident prone | Specify:       |
| [ ]  | [ ]  | [ ]  | Extremely sensitive to outside stimuli – fabrics, smells, noise, temperature, or clothing | Specify:       |
| [ ]  | [ ]  | [ ]  | Smears feces | Specify:       |
| [ ]  | [ ]  | [ ]  | Steals | Specify:       |
| [ ]  | [ ]  | [ ]  | Habitually lies | Specify:       |
| [ ]  | [ ]  | [ ]  | Shows bizarre or disturbed thoughts or behaviors (e.g., death, weapons, fire, etc.) | Specify:       |
| [ ]  | [ ]  | [ ]  | Oppositional | Specify:       |
| [ ]  | [ ]  | [ ]  | Antisocial behaviors (e.g., lying, stealing, manipulation, etc.) | Specify:       |
| [ ]  | [ ]  | [ ]  | Behavioral regression | Specify:       |
| [ ]  | [ ]  | [ ]  | Intentional misbehavior | Specify:       |
| [ ]  | [ ]  | [ ]  | Atypical behaviors (e.g., head banging, smelling objects, spinning, twirling, hand flapping, finger-flicking)  | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
| **XI. OUT-OF-HOME CARE PROVIDER QUALIFICATIONS OR NEEDS** |
| Y | N | U | Check Y (Yes), N (No) or U (Unknown) for each category listed below. |
| [ ]  | [ ]  | [ ]  | Frequent and long-distance transportation | Specify:       |
| [ ]  | [ ]  | [ ]  | Frequent family interaction visits | Specify:       |
| [ ]  | [ ]  | [ ]  | Transportation to school of origin | Specify:       |
| [ ]  | [ ]  | [ ]  | Involvement in medical or therapy appointments  | Specify:       |
| [ ]  | [ ]  | [ ]  | Other | Specify:       |
| **XII. IMPORTANT DOCUMENTS** |
| The placing agency has given the out-of-home care provider (s): (Check all that apply.) |
| [ ]  | Birth certificate (copy) | [ ]  | School academic records\*, including IEP |
| [ ]  | Court order\* | [ ]  | Signed medical release for emergency health care |
| [ ]  | Court report\* | [ ]  | Social history\* |
| [ ]  | Dental records\* | [ ]  | Social Security card |
| [ ]  | Information on diagnosis | [ ]  | Summary of mental health treatment\* |
| [ ]  | MA card | [ ]  | Summary of social / psychiatric evaluations\* |
| [ ]  | Medical records – including immunization record\* | [ ]  | Other – Specify: |       |
| [ ]  | Placement agreement | [ ]  | Other – Specify: |       |
| \*Summary is requested to ensure that materials can be interpreted by the out-of-home care provider(s). Primary source documents can be provided if useful for clarification. This form and the information included herein have been shared with the out-of-home care provider(s). |
| **XIII. PLAN FOR MANAGING CHALLENGING BEHAVIORS** |
| Describe any special skills or knowledge the out-of-home care provider will need to acquire to meet the needs of the child and handle the behaviors of the child in a safe manner. |
|       |
| List the child’s behaviors that may lead to health or safety concerns. |
|       |
| Describe warning signs of a developing crisis. Describe actions or situations that may cause the child anxiety or to act out. |
|       |
| Describe steps to take in responding to an emergency or crisis. This should include interventions that have worked in the past and steps that should be taken if the child’s behaviors or emotions begin to escalate or worsen. |
|       |
| Describe the agency’s reporting requirements and debriefing procedures for emergency situations. |
|       |
| If the child has a history of running away, describe the primary factors that have previously contributed to the child’s missing episode.      |
| If the child has a history of running away, describe any plans or interventions that should be put in place to ensure the child’s safety, well-being, and prevention of running in the future.       |
| **XIV. CONSIDERATIONS FOR CONFIRMING SAFE ENVIRONMENTS** |
| [ ]  | Additional or special training for the out-of-home care provider. |
|  |       |
| [ ]  | Additional contact by the agency or other providers. |
|  |       |
| [ ]  | Rearrange the living environment. |
|  |       |
| [ ]  | Closer supervision of children by caregivers. |
|  |       |
| [ ]  | Additional house rules. |
|  |       |
| [ ]  | Install special equipment (e.g., ramp, electrical generator, door alarm, etc.). |
|  |       |
| **XV. SIGNATURES** |
|       |  |       |
|  **SIGNATURE** – Child Welfare Professional  |  | Date Signed |
|       |  |       |
|  **SIGNATURE** – Out-of-Home Care Provider |  | Date Signed |
|       |  |       |
|  **SIGNATURE** – Out-of-Home Care Provider |  | Date Signed |