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| **DEPARTMENT OF CHILDREN AND FAMILIES**  Division of Safety and Permanence |

**Subsidized Guardianship 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.). Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

**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 | | Telephone Number | | | Date Signed (mm/dd/yyyy) |

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

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

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|  | Requires special diet preparation / supervision – | | |  |  | Tourette’s syndrome – Indicate severity: | | |
|  | Explain: |  | |  |  |  | | |
|  |  | | |  |  |  | | |
|  |  | | |  |  |  | | |
|  | Prescribed physical therapies such as those | | |  |  | Blood disorder / disease – Explain: | |  |
|  | for vision, hearing, speech or gross or fine | | |  |  |  | | |
|  | motor skills require 1 – 2 hours a day. | | |  |  |  | | |
|  |  | | |  |  | Scoliosis – Indicate severity: |  | |
|  | Requires prescribed physical therapies taking | | |  |  |  | | |
|  | 2 – 3 hours a day | | |  |  |  | | |
|  |  | | |  |  |  | | |
|  |  | | |  |  |  | | |
|  |  | | |  |  |  | | |
|  | Other characteristic(s) – Specify: | |  | | | | | |
|  |  | | | | | | | |
|  |  | | | | | | | |
|  |  | | | | | | | |

Return completed form to: Agency Fillable

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