

## Chapter HFS 37

### INFORMATION TO BE PROVIDED TO FOSTER PARENTS

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**Note:** Chapter HSS 37 was renumbered chapter HFS 37 under s. 13.93 (2m) (b) 1., Stats., Register, September, 1996, No. 489.

**HFS 37.01 Authority and purpose.** This chapter is promulgated under the authority of s. 895.485 (4) (a), Stats., to specify the kinds of information about all foster children that the child's placing agency is to provide to the child's foster parent, treatment foster parent or family-operated group home parent, in order to maintain and promote the health, safety and welfare of the foster child and of the foster parent, treatment foster parent or family-operated group home parent and their other family members and to ensure that foster parents can be as effective as possible in providing appropriate care for the foster child because they have received full information about the child from the placing agency.

**History:** Cr. Register, February, 1995, No. 470, eff. 3-1-95.

**HFS 37.02 Applicability. (1) SCOPE.** Except as provided in sub. (2), all requirements contained in this chapter shall be met by all agencies authorized under s. 48.57 or 48.61, Stats., to place children in foster care.

**(2) EXCEPTION.** (a) A placing agency may make an exception to the provision of any kind of information required under this chapter provided that:

1. The information is confidential, the agency does not have access to the information and the agency has made a reasonable effort to obtain the information through appropriate releases of information; or

2. a. The exception does not jeopardize the health, safety or welfare of the foster child, the foster parent, the treatment foster parent or the family-operated group home parent or the community; and

b. The information is not critical to the success of the placement and related treatment or services or the purposes described in s. HFS 37.01.

(b) Any exception made by a placing agency to a requirement under this chapter shall be documented in detail and included in the narrative section of the child's case record. The documentation shall include the specific information that was not provided to the foster parents, the reasons for not providing the information, the name of the agency representative who made the decision to not provide that information, the date the decision was made and written approval by that person's supervisor.

**History:** Cr. Register, February, 1995, No. 470, eff. 3-1-95.

**HFS 37.03 Definitions.** In this chapter:

**(1) "Allegation"** means a charge or statement made by any party regarding a foster child or the child's family which is known to the agency and which has not been proven or for which there is no known substantiating evidence or support, but does not include:

(a) An interpretation of information made by a professional individual involved in the child's treatment;

(b) Any charge or statement which, in whole or in part, formed the basis for the child's removal from his or her home; or

(c) In the case of a delinquent, any additional charges read into the record at the time of adjudication.

**(2) "AODA"** means alcohol or other drug abuse.

**(3) "CAN"** means child abuse or neglect.

**(4) "Child's family"** means, unless otherwise indicated, the child's biological or adoptive family.

**(5) "CHIPS"** means a child in need of protection or services as defined in s. 48.13, Stats.

**(6) "Department"** means the Wisconsin department of health and family services.

**(7) "Family-operated group home"** means a facility which is providing care and maintenance for 5 to 8 children and is operated by one or more persons required to be licensed under s. 48.625, Stats., who do not operate another group home and do not operate the home for a corporation or agency.

**(8) "Foster child"** means a child placed for care and maintenance in a foster home by the department, a placing agency or a court.

**(9) "Foster home"** means any facility operated by a person required to be licensed under s. 48.62 (1) (a) or (b), Stats., that provides care and maintenance for no more than 4 foster children unless all of the children are siblings, or any family-operated group home licensed under s. 48.625, Stats.

**(10) "Foster parent"** means a person licensed under s. 48.62 (1) (a) or (b), Stats., with primary responsibility for the care and supervision of foster children placed in his or her home, or a parent in a family-operated group home licensed under s. 48.625, Stats.

**(11) "Information"** means data relating to the medical, physical, mental or emotional condition of a child or the child's family that has been gathered for the purposes of assessing, adjudicating, placing, treating or providing services to the child. "Information" does not include allegations, except as provided in s. HFS 37.04 (3).

**(12) "Placing agency"** means the public or private agency authorized under s. 48.57 or 48.61, Stats., to place children in foster care.

**History:** Cr. Register, February, 1995, No. 470, eff. 3-1-95; correction made under s. 13.93 (2m) (b) 6., Stats., Register, May, 2001, No. 545.

**HFS 37.04 Information to be provided to foster parents. (1)** (a) A placing agency shall enter on a face sheet and checklist included as appendices A and B to this chapter all available information about a foster child that is called for by the face sheet and checklist or indicate on the face sheet or checklist that specific information was provided in some other form, such as in another document or verbally.

(b) A placing agency shall make a reasonable attempt to gather any information required on appendices A and B that the agency does not possess.

**(2)** Unless an exception has been made and documented under s. HFS 37.02 (2), a placing agency shall provide to a foster child's prospective or actual foster parents all available information included on the face sheet and checklist included as appendices A and B to this chapter.

**(3)** An allegation regarding the foster child or the child's family shall not be provided to the foster parents unless the placing agency determines that, if substantiated, the allegation would have a significant impact on the health, safety or welfare of the foster child or the foster parents or the foster child's or foster par-

ents' family or on the success of the placement and related services.

**(4)** Any allegation provided by the placing agency to the foster parents as information regarding a foster child shall be recorded in the child's case record along with justification for providing that information.

**History:** Cr. Register, February, 1995, No. 470, eff. 3-1-95.

**HFS 37.05 Timing of providing information.** When information about a child that is included in appendices A and B to this chapter becomes known to the placing agency, the placing agency shall provide that information to the foster parents. If the information is known prior to the foster parents' agreement to the placement of the child or the actual placement of the child, the information shall be provided prior to the agreement or actual placement. Information not available to the placing agency prior to the foster parents' agreement to the placement or the actual placement shall be provided to the foster parents within 7 working days after the placing agency's receipt of the information or, if the placing agency determines that the information obtained is of critical importance to the health, safety or welfare of the foster child

or the foster parents, within 3 working days after receipt of the information.

**History:** Cr. Register, February, 1995, No. 470, eff. 3-1-95.

**HFS 37.06 Confidentiality. (1)** At the time that any information regarding a foster child is first provided to the foster parents by the placing agency, the placing agency shall inform the foster parents of all confidentiality requirements mandated under state or federal law, including the requirements under ss. 48.396, 48.78, 48.981 (7), 51.30, 118.125, 146.82, and 252.15, Stats., and any placing agency policy, and penalties which may be imposed for violating the rights to confidentiality of the foster child and the foster child's family.

**(2)** The placing agency providing information about a foster child may require that the information and any related documents be maintained by the foster parent in a manner which would prohibit access to the information by the foster child, any other foster children or any other party whose access to the information is prohibited.

**History:** Cr. Register, February, 1995, No. 470, eff. 3-1-95; **correction in (1) made under s. 13.93 (2m) (b) 7., Stats., Register, May, 2001, No. 545.**

**CHAPTER HFS 37 APPENDIX A  
 INFORMATION FOR FOSTER PARENTS  
 FACE SHEET**

Date of Placement: \_\_\_ / \_\_\_ / \_\_\_

|  |
|--|
| Child's Name: _____ Nickname(s): _____<br>DOB: ___ / ___ / ___ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female SS#: ___ - ___ - ___<br><br>Cultural Identification (as indicated by child if old enough):<br>Height: _____ Weight: _____ lbs.<br>Religious Preference (of child or family):<br>Physical Characteristics (e.g., scars, tattoos, birthmarks, discolorations): |
|--|

|  |
|--|
| Child's Social Worker With Whom Foster Parent Will Have Contact:<br>Name: _____ Title: _____<br><br>Agency:<br><br>Agency Secondary Contact (if social worker not available):<br>Telephone: Regular Hours: (____) _____<br>After Hours: (____) _____ |
|--|

| Reason(s) for Placement   |  |
|---|--|
| <input type="checkbox"/> Delinquent Act(s)<br><input type="checkbox"/> Assaultive<br><input type="checkbox"/> Non-Assaultive  | Nature of Offense(s):  |
| <input type="checkbox"/> CHIPS, other than CAN  | Type of CHIPS:   |
| <input type="checkbox"/> CAN<br><br><input type="checkbox"/> Physical Abuse<br><input type="checkbox"/> Sexual Abuse<br><input type="checkbox"/> Emotional Abuse<br><input type="checkbox"/> Neglect  | Relationship of Alleged Perpetrator(s)<br><br>Does the child exhibit any inappropriate sexual behaviors? |
| <input type="checkbox"/> Developmental Disability<br><input type="checkbox"/> Physical Handicap<br><input type="checkbox"/> AODA<br><input type="checkbox"/> Emotional Disturbance (note related behaviors, e.g., fire starter)<br><input type="checkbox"/> Learning Disability |  |

|  |
|--|
| This is a:<br><br><input type="checkbox"/> Voluntary Placement<br><br><input type="checkbox"/> Court-ordered Placement |
|--|

|  |
|--|
| Medical Assistance #:  |
| Insurance Company (if any): Name _____<br>Telephone: ( ) _____                                 |
| Policy #: _____ Group #: _____   |
| Physician: _____ Type: _____   |
| Address: _____   |
| Telephone: ( ) _____   |
| Dentist: _____   |
| Address: _____   |
| Telephone: ( ) _____   |
| Other Health Specialists/Therapists  |
| Name: _____ Telephone: ( ) _____<br>Specialty: _____   |
| Name: _____ Telephone: ( ) _____<br>Specialty: _____   |
| Preferred Hospital: _____<br>(Note: Use of hospital may be dictated by insurance company/plan) |

|  |
|--|
| Is foster parent expected to participate in therapy with the child? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|

Name of  Birth Mother:  
 Child's  Stepmother:  
 (Check most appropriate one)  Adoptive mother:  
 Address: \_\_\_\_\_  
 Telephone: ( ) \_\_\_\_\_

Name of  Birth Father:  
 Child's  Stepfather:  
 (Check most appropriate one)  Adoptive father:  
 Address: \_\_\_\_\_  
 Telephone: ( ) \_\_\_\_\_

Child's  
 Siblings:

Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_ Phone: ( ) \_\_\_\_\_  
 At home  Out of home (where: \_\_\_\_\_)

Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_ Phone: ( ) \_\_\_\_\_  
 At home  Out of home (where: \_\_\_\_\_)

Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_ Phone: ( ) \_\_\_\_\_  
 At home  Out of home (where: \_\_\_\_\_)

Significant Extended Family Members (Name, Phone and Relationship):

Legal Custodian: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

GAL\*/Legal Counsel: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: ( ) \_\_\_\_\_

\*Guardian ad litem

Significant individuals who may be having contact with the child:

| <u>Name</u> | <u>Phone</u> | <u>Relationship</u> |
|-------------|--------------|---------------------|
| _____       | _____        |                     |
| _____       | _____        |                     |
| _____       | _____        |                     |
| _____       | _____        |                     |

Individuals whose contact with the child is forbidden or restricted (e.g., supervised visitation)

| <u>Name</u> | <u>Relationship</u> | <u>Type of Restriction</u> | <u>Rationale (e.g., court order, parents' wishes)</u> |
|-------------|---------------------|----------------------------|---|
| _____       | _____               | _____                      |   |
| _____       | _____               | _____                      |   |
| _____       | _____               | _____                      |   |
| _____       | _____               | _____                      |   |

(Should you have any questions about contacts, please call the child's social worker.)

Previous Placements (If no court order prohibiting release of name of previous foster home placement(s))

| <u>Type (FH, GH, RCC/CCI, hospital, etc.)</u> | <u>Name</u> | <u>Dates</u> |
|---|-------------|--------------|
| _____   | _____       | _____        |
| _____   | _____       | _____        |
| _____   | _____       | _____        |
| _____   | _____       | _____        |
| _____   | _____       | _____        |
| _____   | _____       | _____        |

School Attending or Will Attend: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Grade: \_\_\_\_\_

Is child enrolled in a special education program? \_\_\_\_ Yes \_\_\_\_ No

If yes, what type: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Day Care or Respite Provider(s)

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Does the child have specific hobbies or interests? Does the child have special abilities/talents (e.g., music, art, athletics)?  
Does the child prefer group or solitary activities?

Does the child have preferences that the foster parent may want to know about (e.g., favorite foods, clothing, toys, music)?

Placing agency has given the foster parent:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Birth certificate (copy),<br>if available                         | <input type="checkbox"/> Medical records/summary                                | * <input type="checkbox"/> Social history/summary                        |
| * <input type="checkbox"/> Court order   | <input type="checkbox"/> Permission to operate<br>hazardous machines            | <input type="checkbox"/> Social Security Card                            |
| * <input type="checkbox"/> Court report/summary  | <input type="checkbox"/> Placement Agreement                                    | * <input type="checkbox"/> Summary of social/<br>psychiatric evaluations |
| * <input type="checkbox"/> Dental records/summary  | * <input type="checkbox"/> School academic<br>records/summary                   |  |
| <input type="checkbox"/> Information on child's<br>specific diagnosis and/or<br>disability | <input type="checkbox"/> School and community<br>activity permissions           | <input type="checkbox"/> Summary of mental<br>health treatment           |
| <input type="checkbox"/> MA card   | <input type="checkbox"/> Signed medical release<br>for emergency health<br>care |  |

\* Summary is requested to ensure that materials (e.g., psychological assessments) can be interpreted by foster parents. Primary source documents can be provided if useful for clarification.

**CHAPTER HFS 37 APPENDIX B  
INFORMATION FOR FOSTER PARENTS  
CHECKLIST**

|     |   | Yes | No | NK<br>* | If "Yes", please<br>comment |
|-----|---|-----|----|---------|-----------------------------|
| 1.  | Previous hospitalizations   |     |    |         |                             |
|     | a. Was anesthesia used?   |     |    |         |                             |
|     | b. Problems with anesthesia?  |     |    |         |                             |
| 2.  | Previous serious illnesses or injuries  |     |    |         |                             |
| 3.  | Has child had any other medical tests (e.g., CAT Scan, EEG, MRI)?   |     |    |         |                             |
| 4.  | Taking any medication including birth control pills or the use of birth control devices which require a prescription or other involvement of a physician? (If "Yes", name of medication, dosage, reason, prescription or over the counter, how given, by whom, who prescribed). |     |    |         |                             |
| 5.  | Immunizations (Indicate date(s))  |     |    |         | <b>Date(s)</b>              |
|     | DPT (infants)(Diphtheria, Pertussis, Tetanus)   |     |    |         |                             |
|     | Polio (type: TOPV-Oral or IPV-Injectable)   |     |    |         |                             |
|     | MMR (Measles, Mumps, Rubella)   |     |    |         |                             |
|     | Flu   |     |    |         |                             |
|     | Pneumonia   |     |    |         |                             |
|     | Hepatitis B   |     |    |         |                             |
| 6.  | Significant biological family medical history: (e.g., cancer, heart problems)   |     |    |         |                             |
| 7.  | Medical needs   |     |    |         |                             |
|     | Apnea monitor   |     |    |         |                             |
|     | Gastrostomy   |     |    |         |                             |
|     | Tracheotomy   |     |    |         |                             |
|     | Ventilator  |     |    |         |                             |
|     | Heart monitor   |     |    |         |                             |
|     | Other (specify)   |     |    |         |                             |
| 8.  | Degenerative disorder   |     |    |         |                             |
| 9.  | Allergies, including animals, insect bites/stings, soap, wool, food, drugs, milk. (If "Yes", to what, symptoms, treatment)  |     |    |         |                             |
| 10. | Child has or ever had the following:<br>(If yes, date child had it)   |     |    |         | <b>Date(s)</b>              |
|     | 7-day Measles   |     |    |         |                             |
|     | 3-day German Measles  |     |    |         |                             |
|     | Chicken Pox   |     |    |         |                             |
|     | Rubella   |     |    |         |                             |
|     | Mumps   |     |    |         |                             |
|     | Whooping Cough  |     |    |         |                             |
|     | Scarlet Fever   |     |    |         |                             |

\*NK=Not Known At This Time



|     |   | Yes | No | NK<br>* | If "Yes", please<br>comment |
|-----|---|-----|----|---------|-----------------------------|
|     | Strep Throat  |     |    |         |                             |
|     | Impetigo  |     |    |         |                             |
|     | Lice  |     |    |         |                             |
|     | Worms   |     |    |         |                             |
|     | Sexually Transmitted Disease  |     |    |         |                             |
|     | Hepatitis B   |     |    |         |                             |
|     | Polio   |     |    |         |                             |
|     | Pneumonia   |     |    |         |                             |
|     | Mononucleosis   |     |    |         |                             |
|     | Scabies   |     |    |         |                             |
|     | Other   |     |    |         |                             |
| 11. | Current dental problems   |     |    |         |                             |
|     | Braces or retainers?  |     |    |         |                             |
|     | Bridges or dentures?  |     |    |         |                             |
|     | Last dental exam date? _____  |     |    |         |                             |
| 12. | Appetite above or below normal  |     |    |         |                             |
|     | Balanced diet   |     |    |         |                             |
|     | Unusual eating patterns/habits (e.g., large sugar intake, no vegetables)                  |     |    |         |                             |
| 13. | Abdominal Concerns  |     |    |         |                             |
|     | Has had an ulcer or heartburn   |     |    |         |                             |
|     | Child regularly uses Tums or other antacid  |     |    |         |                             |
|     | Frequent nausea or vomiting   |     |    |         |                             |
|     | Child drinks caffeinated coffee or cola.      How much per day?                           |     |    |         |                             |
|     | Has had "yellow jaundice" or liver disease  |     |    |         |                             |
|     | Gets abdominal pain   |     |    |         |                             |
|     | Child uses laxatives. How often?  |     |    |         |                             |
|     | Becomes constipated or gets diarrhea  |     |    |         |                             |
|     | Has had blood in stool recently   |     |    |         |                             |
|     | Special diet needs (religious, medical, philosophical, vitamin/mineral supplements, etc.) |     |    |         |                             |
| 14. | Anorexia/bulimia/other eating disorders. Ever had treatment?                              |     |    |         |                             |
| 15. | Headaches   |     |    |         |                             |
|     | Migraine  |     |    |         |                             |
| 16. | Coordination or balance problems/dizziness  |     |    |         |                             |
|     | Has had serious head injury or loss of consciousness                                      |     |    |         |                             |

\*NK=Not Known At This Time

|     |  | Yes | No | NK<br>* | If "Yes", please<br>comment |
|-----|--|-----|----|---------|-----------------------------|
|     | Numbness or loss of strength in hand, arm or leg                 |     |    |         |                             |
|     | Any trouble with swallowing or speaking                          |     |    |         |                             |
| 17. | Has had a seizure  |     |    |         |                             |
|     | Has had epilepsy   |     |    |         |                             |
|     | Type and frequency of seizures                                   |     |    |         |                             |
|     | How to respond   |     |    |         |                             |
|     | Controlled or uncontrolled                                       |     |    |         |                             |
|     | Ever hospitalized for seizures                                   |     |    |         |                             |
|     | Ongoing medicines for seizures                                   |     |    |         |                             |
| 18. | Does child wear glasses? If yes, for how long?                   |     |    |         |                             |
|     | Last eye exam (date, Dr.'s name)                                 |     |    |         |                             |
|     | Blurred or double vision   |     |    |         |                             |
|     | Contact lenses   |     |    |         |                             |
| 19. | Has hearing problem  |     |    |         |                             |
|     | Ringing in ears  |     |    |         |                             |
|     | Discharge or infection in ears                                   |     |    |         |                             |
|     | Tube(s) in ears  |     |    |         |                             |
| 20. | Blocking of nose, discharge, post-nasal drip                     |     |    |         |                             |
|     | Nose bleeds  |     |    |         |                             |
|     | Persistent hoarseness  |     |    |         |                             |
| 21. | Treatment for skin trouble, rashes, hives, acne, or breaking out |     |    |         |                             |
| 22. | Has had bursitis, sprain or dislocation of bone or joint         |     |    |         |                             |
|     | Cramps or pain in legs   |     |    |         |                             |
|     | Backaches  |     |    |         |                             |
|     | Arthritis  |     |    |         |                             |
| 23. | Thyroid problems   |     |    |         |                             |
| 24. | Child has had test for AIDS/HIV (If yes, date: _____)            |     |    |         | Results:                    |
| 25. | Child has had test for Hepatitis (If yes, (date: _____)          |     |    |         | Results:                    |
| 26. | Chest pain or discomfort/heart concerns                          |     |    |         |                             |
|     | Asthma or wheezing   |     |    |         |                             |
|     | Cough, phlegm, bronchitis  |     |    |         |                             |
|     | Has coughed up blood   |     |    |         |                             |
|     | Smoke? If yes, how long? How much?                               |     |    |         |                             |
|     | TB skin test. If yes, when? Results?                             |     |    |         |                             |
|     | Heart trouble  |     |    |         |                             |

\*NK=Not Known At This Time

|   | Yes | No | NK<br>* | If "Yes", please<br>comment |
|---|-----|----|---------|-----------------------------|
| Rheumatic Fever   |     |    |         |                             |
| Has had electrocardiogram (EKG)                             |     |    |         |                             |
| Has had chest X-ray. If yes, when was last one?             |     |    |         |                             |
| Heart murmur  |     |    |         |                             |
| High or low blood pressure. Last check up?                  |     |    |         |                             |
| Irregular heart beat  |     |    |         |                             |
| Shortage of breath  |     |    |         |                             |
| Swollen ankles  |     |    |         |                             |
| How many pillows does child sleep on?                       |     |    |         |                             |
| 27. Urinary or prostate problems/Gall bladder               |     |    |         |                             |
| Incontinence, urine or fecal                                |     |    |         |                             |
| Bleeding or burning when urinating                          |     |    |         |                             |
| Abnormally frequent urination                               |     |    |         |                             |
| Has had kidney or gall bladder stone                        |     |    |         |                             |
| 28. Anemia  |     |    |         |                             |
| 29. Blood problems  |     |    |         |                             |
| 30. Cancer, leukemia, or other malignancy                   |     |    |         |                             |
| 31. History of abusing or not taking prescribed medications |     |    |         |                             |
| 32. Alcohol use or abuse                                    |     |    |         |                             |
| 33. Other drug use or abuse                                 |     |    |         |                             |
| AODA treatment  |     |    |         |                             |
| 34. Is child menstruating?                                  |     |    |         |                             |
| Child understands menstruation                              |     |    |         |                             |
| Child's periods are normal                                  |     |    |         |                             |
| Excessive cramping or pain                                  |     |    |         |                             |
| PMS symptoms  |     |    |         |                             |
| Medication for cramps. If yes, what medication?             |     |    |         |                             |
| Bleeding or discharge other than when menstruating          |     |    |         |                             |
| Has had a "yeast" infection                                 |     |    |         |                             |
| Has had a "Pap" test. If yes, when? Why?                    |     |    |         |                             |
| Abnormal results?   |     |    |         |                             |
| 35. Child has physical or developmental disabilities        |     |    |         |                             |
| If yes, what type of disability?                            |     |    |         |                             |
| Autism  |     |    |         |                             |
| Blindness   |     |    |         |                             |
| Cerebral Palsy  |     |    |         |                             |

\*NK=Not Known At This Time

|  | Yes | No | NK<br>* | If "Yes", please<br>comment |
|--|-----|----|---------|-----------------------------|
| Deafness   |     |    |         |                             |
| Dyslexia   |     |    |         |                             |
| Emotional Disturbance  |     |    |         |                             |
| Epilepsy   |     |    |         |                             |
| Fetal Alcohol Effect   |     |    |         |                             |
| Fetal Alcohol Syndrome   |     |    |         |                             |
| Mental Retardation   |     |    |         |                             |
| Muscular Dystrophy   |     |    |         |                             |
| Neurological Impairment  |     |    |         |                             |
| Physical Impairment  |     |    |         |                             |
| Other (specify):   |     |    |         |                             |
| Restrictions on Activities (e.g., lifting, driving, riding bikes)  |     |    |         |                             |
| Special equipment (e.g., cane, walker, wheelchair)   |     |    |         |                             |
| 36. Considering the age of the child, his/her abilities are not appropriate for:   |     |    |         |                             |
| Bathing  |     |    |         |                             |
| Feeding  |     |    |         |                             |
| Toileting  |     |    |         |                             |
| Dressing   |     |    |         |                             |
| Learning   |     |    |         |                             |
| Receptive Language   |     |    |         |                             |
| Mobility   |     |    |         |                             |
| Danger Awareness   |     |    |         |                             |
| Social/Emotional Functioning   |     |    |         |                             |
| Capacity for Independent Living  |     |    |         |                             |
| Other (specify):   |     |    |         |                             |
| 37. Limitations in verbal skills. (If yes, also check a or b below)  |     |    |         |                             |
| a. Child is non-verbal   |     |    |         |                             |
| b. Child has very limited verbal skills  |     |    |         |                             |
| 38. History of behavioral or emotional problems  |     |    |         |                             |
| 39. History of treatment for behavioral or emotional problems at a clinic or hospital  |     |    |         |                             |
| 40. Someone in child's immediate family has been treated or hospitalized for emotional or mental health problems. (If yes, also check below) |     |    |         |                             |
| Depression   |     |    |         |                             |
| Anxiety  |     |    |         |                             |
| Mood swings  |     |    |         |                             |

\*NK=Not Known At This Time

|                  |   | Yes | No | NK<br>* | If "Yes", please<br>comment |
|------------------|---|-----|----|---------|-----------------------------|
| Suicide attempts |   |     |    |         |                             |
| AODA             |   |     |    |         |                             |
| Mental Health    |   |     |    |         |                             |
| 41.              | Has the child ever:   |     |    |         |                             |
|                  | Felt hopeless or depressed  |     |    |         |                             |
|                  | Had unexplained crying spells   |     |    |         |                             |
|                  | Planned or attempted suicide  |     |    |         |                             |
|                  | Had peculiar or bizarre thoughts  |     |    |         |                             |
|                  | Had trouble eating or sleeping (either too much or too little)                    |     |    |         |                             |
|                  | Had an excess of energy or activity   |     |    |         |                             |
|                  | Felt like hurting him/her self  |     |    |         |                             |
|                  | Displayed reckless or dangerous behavior  |     |    |         |                             |
|                  | Heard things no one else around him/her heard                                     |     |    |         |                             |
|                  | Shown inappropriate emotions (reactions that didn't make sense in the situation). |     |    |         |                             |
|                  | Assaulted anyone physically (if yes, who, how recently, and how severely).        |     |    |         |                             |
|                  | Assaulted anyone sexually (if yes, who, how recently, and how severely).          |     |    |         |                             |
|                  | Assaulted or abused animals   |     |    |         |                             |
| 42.              | Child has had any of the following problems at home or in the community.          |     |    |         |                             |
|                  | Withdrawing socially (doesn't want to be around other people)                     |     |    |         |                             |
|                  | Lying or stealing   |     |    |         |                             |
|                  | Arguing or fighting with peers or siblings  |     |    |         |                             |
|                  | Clinging excessively to a parent, teacher or other person                         |     |    |         |                             |
|                  | Problems with police  |     |    |         |                             |
|                  | Setting fires   |     |    |         |                             |
|                  | Refusing to follow instructions from parents or obey house rules, etc.            |     |    |         |                             |
| 43.              | Child ran away in past. (If yes, answer below)                                    |     |    |         |                             |
|                  | For how long?   |     |    |         |                             |
|                  | From where did child run?   |     |    |         |                             |
|                  | Where did child go?   |     |    |         |                             |
|                  | How was child returned? (Voluntarily, law enforcement, social worker?)            |     |    |         |                             |
|                  | Why did child run?  |     |    |         |                             |
|                  | Did/does child run alone or with others?  |     |    |         |                             |
| 44.              | Child has had any of the following problems at school                             |     |    |         |                             |
|                  | Poor grades   |     |    |         |                             |

\*NK=Not Known At This Time

|   | Yes | No | NK<br>* | If "Yes", please<br>comment |
|---|-----|----|---------|-----------------------------|
| Difficulty making friends   |     |    |         |                             |
| Suspensions from school   |     |    |         |                             |
| Fighting or arguing with peers or teachers  |     |    |         |                             |
| Frequent lying or stealing  |     |    |         |                             |
| Frequent truancy (including cutting classes)  |     |    |         |                             |
| 45. Child has trouble sleeping. If yes, answer below:   |     |    |         |                             |
| Child takes sleeping pills. If yes, how often?  |     |    |         |                             |
| General sleeping pattern (sleep alone, cold or warm room, lights on or off, door open or closed, usual hours of sleep, naps, sleep with toy, pajamas, sleep walk, wake during night, etc.) (Circle appropriate description or describe: |     |    |         |                             |
| 46. Child has fears/phobias. If yes, answer below:  |     |    |         |                             |
| Darkness  |     |    |         |                             |
| Animals   |     |    |         |                             |
| Cars  |     |    |         |                             |
| Loud noises   |     |    |         |                             |
| Heights   |     |    |         |                             |
| Water (e.g., swimming pools, baths, lakes)  |     |    |         |                             |
| Weather (e.g., wind, thunder, storms)   |     |    |         |                             |
| Other (specify)   |     |    |         |                             |
| 47. Child has a history of making abuse allegations against care providers  |     |    |         |                             |

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