**RESOURCE FAMILY REPORTING TOOL: ACTIVITIES IN SUPPORT OF CHILD** DATE OF REPORT:

| CHILD'S NAME: | CURRENT AGE: | GENDER IDENTITY: | CASE #: | DATE OF PLACEMENT IN THIS HOME: |
|---|---|---|---|---|
| | | | | |

| RESOURCE PARENT NAME: | EMAIL ADDRESS: | |
|---|---|---|
| ADDRESS: | CITY: | STATE: ZIP: |
| HOME PHONE: | CELL PHONE: | CASE CARRYING WORKER: |

**Resource Parent** - Thank you for taking the time to help us understand the needs of the child placed in your home. The information you share about the child's needs is an important factor in the assessment of services and supports for the child. If there are two Resource Parents caring for the child, please include the activities you both do in support of the child. The questions below reflect activities consistent with parental expectations and skills, and may account for efforts applied to meet any needs beyond what is appropriate for the child's age. Please complete this questionnaire in the manner that best describes the care you are currently providing to the child. We appreciate your input.

**1a. The child may need assistance with basic self-care tasks. Please check the boxes below if you are helping the child with any of these Activities of Daily Living (ADLs). (check ALL boxes that apply)**

☐ Feeding ☐ Toileting ☐ Putting on clothes ☐ Bathing ☐ Grooming ☐ Menstrual care
☐ Mobility (walking, standing, transferring to/from wheelchair) ☐ Use of upper extremities (hands, arms, fingers)

**1b. How are you helping the child with these ADLs? (check ALL boxes that apply)**

☐ Supervision of activities ☐ Verbal cueing as needed ☐ Child needs some assistance ☐ Child is not able to complete without help from an adult

**1c. How many ADLs do you assist the child with daily?**

☐ At least 1 ☐ At least 2 ☐ At least 3 ☐ At least 6

**2a. Do you arrange and/or facilitate the child attending speech therapy, physical therapy and/or occupational therapy?** ☐ Yes ☐ No

**2b. How often do you arrange/facilitate the child attending speech therapy, physical therapy and/or occupational therapy?** ☐ 1-2 times a month ☐ 3 times a month ☐ 4 or more times a month ☐ 6 or more times a month

**IF YOUTH IS 14 OR OLDER, COMPLETE, QUESTIONS 2C, 2D, 2E.**

**2c. Please check the boxes below if you are assisting the child with any of the listed Instrumental Activities of Daily Living (IADLs). (check ALL boxes that apply)**

☐ Managing finances ☐ Accessing transportation ☐ Shopping ☐ Preparing meals ☐ Using communication devices such as a phone, TTY etc. ☐ Managing medication ☐ Completing basic homework ☐ Transporting or facilitating attendance at ILP classes ☐ Supporting youth in job searches

**2d. How are you helping the child with these IADLs? (check ALL boxes that apply)**

☐ Supervision of activities ☐ Verbal cueing as needed ☐ Child needs some assistance) ☐ Child is not able to complete the activities without help from an adult

**2e. How many IADLs do you assist the child with daily?** ☐ At least 1 ☐ At least 2 ☐ At least 3 ☐ At least 6

**3. Check the boxes below if you provide support and/or assistance to the child so they can participate in community and/or extra-curricular activities. (check ALL boxes that apply)**

☐ Check-in to make sure child receives needed assistance/support with ADLs while participating in community/extra-curricular activities
☐ Go with the child to community/extra-curricular activities to provide direct support to the child
☐ Participate in community/extra-curricular activities due to the child's need for constant support or supervision to participate.
☐ **FOR YOUTH 14 & OLDER:** youth receives needed assistance/support with IADLs in community/extra-curricular activities

**4a. Does the child have behavioral/emotional challenges as diagnosed by a Licensed Therapist or MD?**
☐ Yes ☐ No

**4b. Check boxes below with the type of behavioral/emotional supports the child/family participates in. (check ALL boxes that apply)** ☐ Child attends therapy ☐ Family therapy ☐ Group therapy for child
☐ Support group for Resource Family ☐ Wraparound (WRAP), TBS or other home-based therapeutic services
☐ APSS (Adoption Promotion and Supportive Services) ☐ Parent Child Interactive Therapy (PCIT)
☐ Other (please describe) _____

**4c. Check boxes below for any activities you do to support the child in addressing behavioral/emotional challenges. (check ALL boxes that apply)**

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ Taking/facilitating transportation of child to therapy appointments | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ ____ | per week |
| ☐ Talking to therapist, clinicians, social workers or other professionals | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ ____ | per week |
| ☐ Monitoring, observing, documenting child's behaviors | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ ____ | per week |
| ☐ Implementing therapeutic intervention/behavior plan | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ ____ | per week |
| ☐ Redirecting, prompting child and/or defusing behaviors | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ ____ | per week |
| ☐ Supporting the child through emotional outbursts/tantrums | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ ____ | per week |
| ☐ Cleaning due to bed-wetting and/or repairing damage to home | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ ____ | per week |
| ☐ Supervising/observing child, including line of sight | ☐ Occasional | ☐ Frequent | ☐ All day | ☐ 24 hours | | |

**5a. For a <u>SCHOOL-AGE CHILD</u>, how much time are you spending supporting and supervising the child for homework and/or other learning activities, beyond what is usually required for a child of the same age?** Include time spent supporting the child in school-based activities, volunteering in the classroom, arranging tutoring, maintaining equipment, tools or devices so the child can access education. Also includes assisting with college/financial-aid applications.
☐ 0-1 hours per week ☐ 2-3 hours per week ☐ 5-6 hours per week ☐ 7-8 hours per week ☐ 9+ hours per week

**5b. For a <u>NON SCHOOL-AGE</u> <u>CHILD</u>, check the boxes below for any support you are providing for the child to participate in/benefit from child care and/or preschool programs. (Check ALL boxes that apply).**
☐ Enrolled child in Early Head Start/Head Start, Transitional Kindergarten program or other child development program.
☐ Read out loud to child ☐ 1 ☐ 2 ☐ 3-4 ☐ 5-6 ☐ 7-8 or more times per week
☐ Spend time to support the child's participation in or benefiting from child care/preschool programs. Includes efforts in coordination with the child care/preschool to ensure the child's continued attendance and/or address behaviors that might put the child at risk of being denied services at daycare or educational facility.
☐ Maintaining equipment, tools or devices for child to access education
☐ Respond to complaints from child care/preschool ☐ 1 ☐ 2 ☐ Other ____ time per week

**5c. How much time are you spending to advocate on behalf of the child with teachers or child care/preschool staff.** This includes activities such as planning/participating in special education development and reviews, picking up child from school due to disciplinary issues, being present at school or speaking on the phone to school personnel, coordinating services (such as TBS) with school, and assisting in school enrollment and partial credit restoration.
☐ 0-1 hours per week ☐ 2-3 hours per week ☐ 4-5 hours per week ☐ 6-7 hours per week ☐ 8+ hours per week

**6a. Please check the boxes below to show the doctors or other healthcare specialists the child sees. (check ALL boxes that apply)** ☐ Pediatrician for routine well-child care ☐ Dentist for routine well-child care
☐ Specialist (i.e., neurologist, allergist, psychiatrist, orthodontist, etc.) ☐ 1 ☐ 2 ☐ 3-6 ☐ 7-11 ☐ 12 times a year
☐ If your pediatrician/dentist provides specialty care for the child (beyond routine well-child appointments) please describe below, and indicate how many appointments a year you arrange with the pediatrician/dentist:
_____
_____

**6b. Check the boxes below that apply regarding medications prescribed by a doctor. This includes psychotropic medication for behavioral/emotional health.**

☐ Observe, record, and/or report medication effects to doctor and administer:
☐ 1 medication as needed (PRN) ☐ 1 medication daily ☐ 2 or more medications daily ☐ 2 or more medications more than once a day ☐ Monitor the child who takes the medication themselves

**6c. For a child who uses equipment and/or a medical device, check the box to show the care you provide.**

☐ Monitor the child using medical device and/or testing equipment ☐ Operate and monitor the equipment and/or medical device

**6d. For a child who has a severe medical and/or developmental health concern check the boxes to show the care needed. (check ALL boxes that apply):**

☐ Child requires in-home monitoring by medical professional
☐ Child requires use of medical equipment or devices multiple times per week
☐ Child with severe condition, including but not limited to: aspiration, suctioning, mist tent, ventilator, tube feeding, tracheotomy, symptomatic AIDS, hepatitis, chemotherapy, indwelling lines, colostomy/ileostomy, burns on more than 10% of body.

**7a. How often are you supporting the child's visits and/or participation in community and cultural activities important to his/her cultural and communal identity? This includes transporting and staying at the visits/activities. (Check ALL boxes that apply)**

☐ Supporting the child's visits with his/her family, siblings and others ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 times per week
☐ Supporting child's attending community and/or cultural activities ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 times per week
☐ Mentoring/coaching birth parents implementing family visitation plans ☐ 2 ☐ 4 ☐ 6 ☐ 8 ☐10 hours per week

**ADDTIONAL COMMENTS, CONCERNS AND/OR SUPPORTS YOU PROVIDE:**

**WOULD YOU LIKE TRAINING OR OTHER SUPPORT IN ANY OF THE AREAS NOTED ABOVE?** ☐ **YES** ☐ **NO**
**Please list those topic(s):**

Resource Parent Signature: _____
Printed Name: _____Date: _____
Social Worker/Probation Officer Signature: _____
Printed Name: _____Date: _____