SUPPLEMENT TO THE RATE QUESTIONNAIRE

NAME OF CHILD/YOUTH:	AGE OF CHILD/YOUTH (SUPPLEMENT FOR CHILDREN THREE (3) YEARS OF AGE AND OLDER):
DATE FORM COMPLETED:	DATE OF REQUEST FOR SUPPLEMENT:

This form must be completed by the county child welfare services worker or the adoption worker and regional center coordinator or other regional center representative by telephone, fax, e-mail or mail, followed by a signature from that individual, and followed by a signature from the individual reviewing the document and returned to the county or adoptions district office within ten (10) business days for processing. The county may collect information from other professionals by telephone, fax, e-mail or mail.

For each item 1. (one) through 10. (ten) below, please indicate your response by placing a check mark inside only one of the three boxes provided. For item 11. below, indicate a YES response by placing a check mark in either box (a) or box (b) or indicate a NO or DO NOT KNOW response. Any item with a DO NOT KNOW response from the regional center should be referred to other professionals *(marriage and family therapist, licensed clinical social worker, or other medical, developmental, educational, or mental health professionals)* who have relevant information regarding the condition and needs of the child. Information may be obtained by telephone, fax, e-mail or mail, followed by a signature by the individual reviewing the document, and returned to the county or adoptions district office within ten (10) business days for processing.

Complete the questionnaire to the best of your ability. When responding, keep in mind that the deficits must be beyond what would be expected for the age of the child or youth.

DEFICITS IN SELF-HELP SKILLS

1. The child/youth requires constant care and supervision for basic and essential daily care; the child/youth does not independently perform such self-care activities *(e.g.: dressing, eating, toileting, bowel or bladder control, bathing, menstrual care and personal care (such as grooming activities)*.

   ☐ YES *(If YES, skip 2)* ☐ NO ☐ DO NOT KNOW

   COMMENTS:

2. The child/youth requires constant care and supervision in at least one aspect of dressing, eating, toileting, bowel or bladder control, bathing, menstrual care or personal care *(such as grooming activities)*.

   ☐ YES ☐ NO ☐ DO NOT KNOW

   COMMENTS:

IMPAIRMENTS IN PHYSICAL COORDINATION AND MOBILITY

3. The child/youth is incapable of movement without assistance which includes any of the following: must be turned, unable to sit in a wheelchair, requires special lifting equipment, or requires 24-hour frequent repositioning to prevent decubitus ulcers.

   ☐ YES *(If YES, skip 4)* ☐ NO ☐ DO NOT KNOW

   COMMENTS:

IMPAIRMENTS IN PHYSICAL COORDINATION AND MOBILITY - CONTINUED

4. The child/youth: a) requires use of orthotic or prosthetic devices, or other adaptive equipment, and has limited ability to walk and move independently; b) is mobile only with the aid of special equipment; c) depends upon the use of walkers or wheelchairs; d) requires assistance in transferring to the car, toilet, bath, or bed; or e) has limited use of upper extremities (such as arms, hands, and digits). (*Check YES if the child/youth has any one of the above)*.

☐ YES ☐ NO ☐ DO NOT KNOW

COMMENTS:

MEDICAL CONDITIONS

5. The child/youth has an illness or condition that requires the provision of daily care *(e.g.: uncontrolled seizures, apnea episodes several times per day, ventilator, trachea, suctioning required by the caregiver, in-home nursing care, continuous oxygen, feeding tube, dialysis treatment, intravenous medication or therapy, and/or total parenteral nutrition)*.

☐ YES *(If YES, skip 6, 7, and 8)* ☐ NO ☐ DO NOT KNOW

COMMENTS:

6. The child/youth has severe or total impairment in two of the following areas: vision, hearing, or speech.

☐ YES *(If YES, skip 7 and 8)* ☐ NO ☐ DO NOT KNOW

COMMENTS:

7. The child/youth has a chronic illness or medical condition(s) that requires frequent caregiver involvement in care and monitoring such as: weekly care on a reoccurring basis, special diet, multiple medications/management, increased medical appointments, monitoring on a daily basis, apnea monitor used as a precautionary measure, frequent turning, weekly in-home nursing care, intermittent use of oxygen or use of other respiratory assistance device.

☐ YES ☐ NO ☐ DO NOT KNOW

COMMENTS:

8. The child/youth has severe or total impairment in one of the following areas: vision, hearing, or speech.

☐ YES ☐ NO ☐ DO NOT KNOW

COMMENTS:

DISRUPTIVE or SELF-INJURIOUS BEHAVIOR

9. The child/youth has severe behavioral outbursts or deficits that have occurred in the last twelve months and presents a significant high-risk of reoccurrence that, due to their severity, require long term intervention *(i.e.: attempted suicide, acts of aggression that result in serious injury or significant property damage, sexually assaultive behavior, and attempted arson)*.

☐ YES *(If YES, skip 10 and 11)* ☐ NO ☐ DO NOT KNOW

COMMENTS:

10. The child/youth has severe behavioral outbursts or deficits that occur regularly *(e.g.: daily or several times a week)* that require behavioral intervention. This includes when caregiver intervention is needed to avoid self-injury or injury to others, resulting from the behavioral outbursts or deficits. This also includes children/youth who have severe disruptive behaviors such as: elopement, *(running away)* feces smearing, public urination, property destruction, severe aggression, maladaptive sexual behavior, eating disorders, habitual lying and/or theft, and/or sleep disorders.

☐ YES *(If YES, skip 11)* ☐ NO ☐ DO NOT KNOW

COMMENTS:

11. The child/youth needs monitoring due to severe behavioral outbursts or deficits that are frequent and occur at least once a week or four times a month and require behavioral intervention. This includes when caregiver intervention is needed to avoid self-injury or injury to others, resulting from the behavioral outbursts or deficits. This also includes children/youth who have severe disruptive behaviors such as: elopement *(running away)*, feces smearing, public urination, property destruction, severe aggression, maladaptive sexual behavior, eating disorders, habitual lying, theft and/or sleep disorders.

a) ☐ YES *(two or more behaviors present)* **b)** ☐ YES *(one behavior present)* ☐ NO ☐ DO NOT KNOW

COMMENTS:

NAME OF PERSON COMPLETING THE FORM:

DATE: PHONE NUMBER:

AGENCY NAME: FAX NUMBER:

Social Services/Adoption/Probation
(circle one)

ADDRESS:

SIGNATURE:

NAME OF PERSON REVIEWING INFORMATION:

DATE: PHONE NUMBER:

AGENCY NAME: FAX NUMBER:

ADDRESS

SIGNATURE: