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| **RESOURCE FAMILY (RF) REPORTING TOOL: ACTIVITIES IN SUPPORT OF CHILD/NMD** | | | | | | | | | | 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: | | | | | |

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

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| **1a. The child/NMD may need assistance with basic self-care tasks. Please check the boxes below if you are helping the child/NMD with any of these independence, physical or life skills. (check ALL boxes that apply)**  Eating  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/NMD with these skills? (check ALL boxes that apply)**  Supervision of activities  Verbal cueing as needed  Child/NMD needs some assistance  Child/NMD is not able to complete without help from an adult  **1c. How many skills do you assist the child/NMD with daily?**  At least 1  At least 2  At least 3  At least 4 |
| **2a. Do you arrange and/or facilitate the child/NMD attending speech therapy, physical therapy and/or occupational therapy?**  Yes  No  **2b. How often do you arrange/facilitate the child/NMD 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 youth with any of the listed life skills. (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 youth with these skills? (check ALL boxes that apply)**  Supervision of activities  Verbal cueing as needed  Youth needs some assistance)  Youth is not able to complete the activities without help from an adult  **2e. How many skills do you assist the youth 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/NMD so they can participate in community and/or extra-curricular activities. (check ALL boxes that apply)**  Check-in to make sure child/NMD receives needed assistance/support with skills while participating in community/extra-curricular activities  Go with the child/NMD to community/extra-curricular activities to provide direct support to the child  Participate in community/extra-curricular activities due to the child/NMDs need for constant support or supervision to participate.  **FOR YOUTH 14 & OLDER:** youth receives needed assistance/support with skills in community/extra-curricular activities |

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| **4a. Does the child/NMD 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/NMD and family participates in. (check ALL boxes that apply)**  Child/NMD attends therapy  Family therapy  Group therapy for child/NMD  Support group for RF  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/NMD in addressing behavioral/emotional challenges. (check ALL boxes that apply)**  Taking/facilitating transportation of child/NMD to therapy appointments  1  2  3  4  per month  Talking to therapist, clinicians, social workers or other professionals  1  2  3  4  per month  Monitoring, observing, documenting child/NMDs behaviors 1  2  3  4  per week  Implementing therapeutic intervention/behavior plan  1  2  3  4  per week  Redirecting, prompting child/NMD and/or defusing behaviors  1  2  3  4  per week  Supporting the child/NMD through emotional outbursts/tantrums  1  2  3  4  per week  Supervising/observing child/NMD, including line of sight  Occasional  Frequent  All day  24 hours |
| **5a. For a SCHOOL-AGE CHILD*,* 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 hours per week  3-4 hours per week  5-6 hours per week  7+ hours per week  **5b. For a NON SCHOOL-AGE CHILD, 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  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.  **0-**1  2  3-4  5-6  7 or more hours per week  Maintaining equipment, tools or devices for child to access education  Respond to complaints from child care/preschool 1  2  Other \_\_\_\_ times 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  2  3-4  5-6  7 or more hours per week |
| **6a. Please check the boxes below to show the doctors or other healthcare specialists the child/NMD 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  3-11  7-11  12 times a year  If your pediatrician/dentist provides specialty care for the child/NMD (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/NMD who uses equipment and/or a medical device, check the box to show the care you provide.**  Monitor the child/NMD using medical device and/or testing equipment  Operate and monitor the equipment and/or medical device  **6d. For a child/NMD who has a severe medical and/or developmental health concern check the boxes to show the care needed. (check ALL boxes that apply):**  Child/NMD requires in-home monitoring by medical professional  Child/NMD requires use of medical equipment or devices multiple times per week  Child/NMD 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/NMDs visits and/or participation in community and cultural activities important to their cultural and communal identity? This includes transporting and staying at the visits/activities. (Check ALL boxes that apply)**  Supporting the child/NMDs visits with his/her family, siblings and others  3  4  5  6  7 times per month  Supporting child/NMDs attending community and/or cultural activities  1  2  3  4  5 times per month  Mentoring/coaching birth parents implementing family visitation plans  2  4  6  8 10 hours per week  Participating in permanency related services with birth/ADOPTIVE/OTHER -  **1  2  3** |
| **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: \_\_\_\_\_\_\_\_\_ |