

**RHODE ISLAND CHILD CHARACTERISTICS CHECKLIST  
FOR MENTORING, FOSTER CARE & ADOPTION MATCHING**

**Statement:** This matching form is to be completed by the resource family for the purpose of matching a youth/sibling group with a family and should accompany a comprehensive homestudy or mentor screening. This tool is used for general guidance in matching, with the understanding that the needs, behaviors, and health of a youth may not be fully known during the matching process and/or may change over time.

SECTION 1: RESOURCE FAMILY INFORMATION		
Date of Matching Completion/Update:		
Resource Family Name:		
Address:		
City:	State:	Zip:
Phone 1:	Phone 2:	
Language(s) Spoken:		

SECTION 2: MENTORSHIP/PLACEMENT TYPE CONSIDERATION	
What type of mentorship/placement are you willing to consider?	
<input type="checkbox"/> Foster Care Only <input type="checkbox"/> Concurrent Planning <input type="checkbox"/> Adoption Only* (*homestudy registered w/ARI) <input type="checkbox"/> Both <input type="checkbox"/> Mentor	<input type="checkbox"/> Unsure <input type="checkbox"/> Respite <input type="checkbox"/> Emergency Placement <input type="checkbox"/> Emergency Response <input type="checkbox"/> Child Specific: _____
Would you accept a foster placement on short notice? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, how much notice is needed? _____ days	
<i>For pre-adoptive resource families only:</i> Would you consider placement of a youth/siblings group who is not legally free for adoption? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Would need more information	

**SECTION 3: DEMOGRAPHICS OF YOUTH TO BE CONSIDERED**

**Number of Youth to Consider for Matching**

- Single Child
- Sibling Group – maximum # of children: \_\_\_\_\_

**Sex & Gender**

Youth's Assigned Sex at Birth *(Check all to be considered)*

- Male
- Female

Youth's Gender Identity/Expression *(Check all to be considered)*

- Male
- Female
- Agender
- Non-binary
- Gender fluid
- Trans – Feminine
- Trans – Masculine

**Age**

Age most preferred \_\_\_\_\_ to \_\_\_\_\_

Widest range to be considered \_\_\_\_\_ to \_\_\_\_\_

Would you consider youth who do not present their chronological age? *(i.e. a 12 year-old who presents as 8)*

- Yes
- No

**Race**

- |   |   |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Multiple races     |
| <input type="checkbox"/> Asian                            | <input type="checkbox"/> White or Caucasian |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Unknown            |
| <input type="checkbox"/> Hawaiian / Pacific Islander      |   |

**Ethnicity**

- |                                   |                                       |                                  |
|-----------------------------------|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Non-Hispanic | <input type="checkbox"/> Unknown |
|-----------------------------------|---------------------------------------|----------------------------------|

**SECTION 4 – CHARACTERISTICS OF YOUTH**

Listed below are experiences, needs, and other characteristics of youth in the RI child welfare system. Please indicate your willingness to consider a match with a youth who may have had one or more of the noted life experiences and needs in the domains below.

<b>Life Experiences &amp; Trauma</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a child who may have experienced:</i>			
Emotional abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exposed to domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exposed to illegal activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple placements in child welfare system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parenting teen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Placement in residential care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy and/or child birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous adoption disruption or dissolution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Abuse – Direct/Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Abuse – Indirect/Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Abuse - Unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Birth History of Youth</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a child whose birth history may include:</i>			
Low birth weight / premature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnosis of Fetal Alcohol Syndrome (FAS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fetal Alcohol effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Positive toxicology screen at birth for substances (i.e. Cocaine, Amphetamines, Heroin, Morphine, PCP, Alcohol, Benzodazepines, Marijuana, Propoxyphene, Methadone, Codeine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prenatal Drug Exposure (i.e. Cocaine, Amphetamines, Heroin, Morphine, PCP, Alcohol, Benzodazepines, Marijuana, Propoxyphene, Methadone, Codeine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction at Birth (i.e. heroin, methadone, morphine, other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Developmental</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a child who may have one or more of the following challenges and/or diagnoses:</i>			
Failure to Thrive - Environmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failure to Thrive - Organic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment/Not Deaf: Mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment/Not Deaf: Moderate/Severe & requires intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment: Legally deaf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic Impairment: Requires other treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic Impairment: Requires prescribed footwear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Challenges: Mild & may require intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Challenges: Moderate/Severe & requires intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual Impairment/Not Blind: Mild & may require intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual Impairment/Not Blind: Moderate/Severe & requires intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual Impairment: Legally blind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Education</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a child who may have one or more of the following challenges/needs related to school and learning:</i>			
Requires Early Intervention services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attends Early Head Start programming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attends Head Start programming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is a high achiever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Achieves at-grade level in regular classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Achieves at-below grade level in regular classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has challenges with school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has repeated grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Functioning: Above average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Functioning: Average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Functioning: Below average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has behavior challenges in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has academic challenges in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benefits from tutoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

May require Special Education testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has 504 Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has IEP - Behavioral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has IEP - Academic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has truancy challenges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has history of suspensions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has history of expulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is academically behind due to inconsistent attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is involved in after-school activities (i.e. sports, dance, clubs, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Dental</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a child who may have the following dental needs:</i>			
Dental needs (i.e. tooth decay, missing teeth, crowded or misaligned teeth, overbite, under bite)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontia anticipated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontia required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Allergies &amp; Respiratory Challenges</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a child who may have one or more of the following allergy types and/or respiratory challenges:</i>			
Allergies: Environmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies: Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies: Medication(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies: Intervention required (i.e. medication, diet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma: Intervention required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma: No intervention required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Diagnosed Medical Conditions</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a child who may have one or more of the following medical diagnoses and/or is currently being tested for:</i>			
Autoimmune disease (i.e. Juvenile Arthritis, Scloderma, Lupus, Celiac)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cancer: In remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: Requires on-going treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleft lip/palate: History of intervention/surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleft lip/palate: May require intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: Insulin-dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: Non-insulin dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis: Does not require intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis: Requires intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydrocephaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease: May require intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lead Poisoning: May require intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limb Condition – May require prosthetic (i.e. amputation, improperly formed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease: May require intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macrocephalic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication required for one or more conditions daily/regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Microcephalic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prior Medical Hospitalization(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prior Surgery(ies)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder (other than Epilepsy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Trait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Medical Treatment &amp; Specialized Care of Youth</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a child whose medical needs may require one or more of the following interventions:</i>			
Apnea monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-home medical care required by licensed professional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited life expectancy due to chronic illness or disabling condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Naso-Gastic (NG) tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nebulizer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-ambulatory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy: Long-term	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy: Short-term	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy: Long-term	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy: Short-term	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically Disabled: Requires accommodations to the living environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically Disabled: Requires assistive devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically Disabled: Requires intervention by caregiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires intermittent medical treatment & evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires lifelong medical supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires lifelong medical treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Terminal illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tracheotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Dietary &amp; Eating Challenges</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a child who may have one or more of the following challenges related to diet and/or eating:</i>			
Anorexia: May require intervention/support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia: May require intervention/support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarding food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires special diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Sleeping Challenges &amp; Needs</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a child who may have one or more of the following challenges related to sleep:</i>			
Afraid of sleeping in the dark	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares/Night terrors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep/Wake challenges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soils bed at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Mental Health Diagnosis(es)</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a child who may be diagnosed with one or more of the following mental health diagnoses:</i>			
Adjustment Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Disorder (ADD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum Disorder (ASD): Mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum Disorder (ASD): Moderate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum Disorder (ASD): Severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-Compulsive Disorder (OCD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional Defiant Disorder (ODD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-Traumatic Stress Disorder (PTSD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reactive Attachment Disorder (RAD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia or other Psychotic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Mental &amp; Emotional Health Care</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Children impacted by trauma often need care related to mental and emotional health, currently, on-going, and/or later in development. Please indicate your willingness to consider a youth who:</i>			



Is currently involved in counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Will likely need counseling at various stages of developmental growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Will likely need on-going counseling throughout childhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Currently benefits from psychotropic medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
May benefit from psychotropic medication at various stages of developmental growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
May need psychiatric hospitalization at various stages of developmental growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
May need to reside in residential care outside of the family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Behaviors	Will/May Consider	Cannot Consider	Have experience with
<i>Please indicate your willingness to consider a child who behavior(s) may include:</i>			
Abuse towards animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breaking curfew	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Defiance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Destruction of clothing/toys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Destruction of household property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Destruction of school or other public property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty accepting and following rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty building healthy attachments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty making same-age peers/friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty relating to/connecting with same-age peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disruptiveness in social settings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fascination with matches, lighters, fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty following directions from adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gang Involvement: Past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gang Involvement: Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head banging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homicidal thoughts or attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Instigating physical fights with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Masturbating in private	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Masturbating in public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not affectionate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overly dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically aggressive towards adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically aggressive towards other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor social skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rocking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running away (overnight)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-abusive / Self-harming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soiling self during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts or attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tantrums: Mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tantrums: Moderate/Severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to reject father figures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to reject mother figures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to form superficial relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of foul language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wetting self during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Sexual Behavior</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>With regards to sexual behaviors, both past and present, please indicate your willingness to consider a youth who:</i>			
Is sexually active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acts seductive/provocative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has history of unsafe/unhealthy sexual boundaries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has committed sexual offences towards children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has sexual abusive-reactive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is at-risk for sexual offending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is a victim of trafficking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is at-risk for trafficking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has successfully completed treatment for sexual abuse (victim)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has successfully completed treatment for sexual abuse (offender)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is currently in treatment for sexual abuse (victim)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is currently in treatment for sexual offending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Substance Use &amp; Abuse</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a youth who:</i>			
Abuses alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuses illegal substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chews tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smokes cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vapes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires or has completed treatment programming for substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Juvenile Justice Involvement</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a youth who has historical and/or current criminal charges related to:</i>			
Assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breaking & entering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crime using a weapon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cruelty to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Possession/Distribution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual offense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Please indicate your willingness to a youth whose criminal history may include:</i>			
Current participation in court diversion programming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous incarceration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current probation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current incarceration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Registration as a sexual offender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Temperament &amp; Personality</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a youth whose general temperament and personality is:</i>			
Active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention seeking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bossy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calm / Laid back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Honest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outgoing / Social	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parentified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pleasant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Positive attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quiet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respectful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Responsible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Interests &amp; Hobbies</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a youth whose interests and hobbies may include:</i>			
Arts & crafts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Board games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Building things / Taking things apart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cars / Trains / Planes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking / Baking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Drawing / Coloring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fishing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hiking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performing Arts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pretend play	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outdoor play	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Puzzles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rock climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Singing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swimming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Video games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION 5 – CHARACTERISTICS OF BIRTH FAMILY**

Youth in the child welfare system may have been born to parents who have medical diagnoses, mental health diagnoses, and other life experiences/conditions. Please indicate your willingness to consider a match with a youth whose birth parents may have had one or more of the noted diagnoses and/or life experiences noted below.

<b>Birth Family History</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>Please indicate your willingness to consider a youth for whom the following pertains to birth history:</i>			
Birth mother used alcohol during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth mother used drugs during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DCYF has no information about birth mother/maternal family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DCYF has no information about birth father/paternal family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family history of domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family history of incest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One or both parents currently incarcerated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One or both parents have alcohol addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One or both parents have drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One or both parents previously incarcerated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Youth was conceived as a result of incest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Please indicate your willingness to consider a youth whose birth parent(s) may have one or more of the following medical diagnoses:</i>			
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell trait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Please indicate your willingness to consider a youth whose birth parent(s) may have one or more of the following mental health diagnoses:</i>			
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-Compulsive Disorder (OCD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personality Disorder (i.e. Borderline, Narcissistic, Antisocial)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-Traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION 6 – BIRTH FAMILY CONNECTEDNESS**

Research promotes the importance of fostering healthy connections. It is important that resource families support the child’s relationships with the birth family, including birth mother, birth father, siblings, and kin, when deemed safe and in the best interests of the child. Below please indicate willingness to promote and support safe and positive birth family connections.

<b>Family &amp; Kin Connectedness</b>	<b>Will/May Consider</b>	<b>Cannot Consider</b>	<b>Have experience with</b>
<i>As a Resource Family/Mentor, please indicate your willing to:</i>			
Meet birth parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have contact with birth parents through agency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Send letters to birth parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive letters from birth parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive videos from birth parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Send videos to birth parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have phone contact between adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicate with birth family through social media	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have phone/email/social media contact with biological siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have visits with biological siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have continued contact with extended birth family relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive birth parents' name, address, phone number, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Give birth parents the resource family's first name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Give birth parents the resource family's identifying information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support the youth having pictures of birth family members privately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Place pictures of the youth's birth family openly in the resource family home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support the youth in speaking openly about the birth family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speak openly, positively about the birth family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participate in case planning meetings with the birth family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other			
In the event of reunification, the resource family would make efforts to maintain supportive contact with youth and birth family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the event of adoption, the resource family would be willing to maintain minimal degree of openness with the birth parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the event of adoption, the resource family would be willing to maintain moderate degree of openness with the birth parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RESOURCE FAMILY/MENTOR SIGNATURES:

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

AGENCY SIGNATURE:

\_\_\_\_\_

Signature

\_\_\_\_\_

Date