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?

- ☐ Foster Care Only
- ☐ Concurrent Planning
- ☐ Adoption Only* (*homestudy registered w/ARI)
- ☐ Both
- ☐ Mentor
- ☐ Unsure
- ☐ Respite
- ☐ Emergency Placement
- ☐ Emergency Response
- ☐ Child Specific: _____

Would you accept a foster placement on short notice? ☐ Yes ☐ No

If yes, how much notice is needed? _____ days

For pre-adoptive resource families only:
Would you consider placement of a youth/siblings group who is not legally free for adoption?

☐ Yes ☐ No ☐ 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

☐ American Indian or Alaska Native	☐ Multiple races
☐ Asian	☐ White or Caucasian
☐ Black or African American	☐ Unknown
☐ Hawaiian / Pacific Islander	

Ethnicity

☐ Hispanic	☐ Non-Hispanic	☐ 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.

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

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

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

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

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

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

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

Diagnosed Medical Conditions	**Will/May Consider**	**Cannot Consider**	**Have experience with**
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:			
Autoimmune disease (i.e. Juvenile Arthritis, Scloderma, Lupus, Celiac)	☐	☐	☐

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

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

Dietary & Eating Challenges	Will/May Consider	Cannot Consider	Have experience with
Please indicate your willingness to consider a child who may have one or more of the following challenges related to diet and/or eating:			
Anorexia: May require intervention/support	☐	☐	☐
Bulimia: May require intervention/support	☐	☐	☐
Hoarding food	☐	☐	☐
Overeating	☐	☐	☐
Pica	☐	☐	☐
Requires special diet	☐	☐	☐
Other:	☐	☐	☐

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

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

Mental & Emotional Health Care	Will/May Consider	Cannot Consider	Have experience with
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:			

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

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

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

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

Is currently in treatment for sexual abuse (victim)	☐	☐	☐
Is currently in treatment for sexual offending	☐	☐	☐
Other:	☐	☐	☐

Substance Use & Abuse	**Will/May Consider**	**Cannot Consider**	**Have experience with**
Please indicate your willingness to consider a youth who:			
Abuses alcohol	☐	☐	☐
Abuses illegal substances	☐	☐	☐
Chews tobacco	☐	☐	☐
Smokes cigarettes	☐	☐	☐
Vapes	☐	☐	☐
Requires or has completed treatment programming for substance abuse	☐	☐	☐
Other:	☐	☐	☐

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

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

Interests & Hobbies	**Will/May Consider**	**Cannot Consider**	**Have experience with**
Please indicate your willingness to consider a youth whose interests and hobbies may include:			
Arts & crafts	☐	☐	☐
Board games	☐	☐	☐
Building things / Taking things apart	☐	☐	☐
Cars / Trains / Planes	☐	☐	☐
Cooking / Baking	☐	☐	☐
Dancing	☐	☐	☐

Drawing / Coloring	☐	☐	☐
Fishing	☐	☐	☐
Hiking	☐	☐	☐
Music	☐	☐	☐
Painting	☐	☐	☐
Performing Arts	☐	☐	☐
Pretend play	☐	☐	☐
Outdoor play	☐	☐	☐
Puzzles	☐	☐	☐
Rock climbing	☐	☐	☐
Sewing	☐	☐	☐
Singing	☐	☐	☐
Sports	☐	☐	☐
Swimming	☐	☐	☐
Video games	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐

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.

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

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

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.

Family & Kin Connectedness	**Will/May Consider**	**Cannot Consider**	**Have experience with**
As a Resource Family/Mentor, please indicate your willing to:			
Meet birth parents	☐	☐	☐
Have contact with birth parents through agency	☐	☐	☐
Send letters to birth parents	☐	☐	☐
Receive letters from birth parents	☐	☐	☐
Receive videos from birth parents	☐	☐	☐

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

RESOURCE FAMILY/MENTOR SIGNATURES:

_____ _____

Signature Date

_____ _____

Signature Date

AGENCY SIGNATURE:

_____ _____

Signature Date