



**ARIZONA DEPARTMENT OF CHILD SAFETY
ADOPTION SUBSIDY RATE EVALUATION**

CHILD'S NAME (Last, First, M.I.)	Birth Date
Sibling Adoption: Yes No	Current Maintenance Amount
AGE AT ADOPTION	

- | | | |
|--|-----|----|
| 1. Does your child have a developmental delay or disability, physical disability, or medical condition which impairs his/her daily living or self care skills?..... | Yes | No |
| 1.1 Does your child receive services from the Division of Developmental Disabilities?.....
Specify the condition:
Explain how the daily living skills and self care are impaired: | Yes | No |
| 2. Does your child have a cognitive disability?
Specify the diagnosis:
Autism
Mild Mental Retardation
Moderate Mental Retardation
Severe Mental Retardation
Other: | Yes | No |
| 3. Does your child have a significant mobility impairment which requires the use of a mechanical device (e.g., a wheelchair)?.....
Specify the device:
3.1 Does your child require assistance to transfer from one surface to another?.....
Describe the assistance the child requires: | Yes | No |
| 4. Does your child have a chronic illness requiring unusual or prolonged medical appointments?
Specify the condition:
Number of appointments per month: | Yes | No |
| 5. Does your child have a major medical condition which requires frequent medical care, monitoring, hospitalizations and medically necessary equipment/supplies?
Specify the condition:
Frequency of care:
By whom: | Yes | No |
| 6. Does your child take medication?
For what condition(s):
How often? | Yes | No |
| 7. Does your child require a special diet?
For what condition:
Explain: | Yes | No |
| 8. Does your child require Special Education or have problems in school?
8.1 Does your child have an Individual Education Plan (IEP) or 504 Plan?
Explain: | Yes | No |

Continued on reverse

9. Does your child have a mental/behavioral health condition which requires treatment? Yes No
Specify the condition:
- 9.1 Does your child exhibit aggressive or destructive behaviors? Yes No
9.2 Does your child exhibit severe oppositional defiant behaviors? Yes No
9.3 Does your child exhibit severe hyperactive behavior? Yes No
9.4 Does your child exhibit sexual acting out behavior? Yes No
9.5 Does your child exhibit sexually deviant or offender behavior? Yes No
Describe your child's behavior:
10. Does your child have delinquency or court involvement? Yes No
10.1 Is your child delinquent or been in detention? Yes No
Explain:
11. Does your child currently participate in therapy? Yes No
Specify the diagnosis:
- | What type? | How often? | Where provided? | Therapist? |
|--------------------------------|------------|-----------------|------------|
| Physical | _____ | _____ | _____ |
| Occupational | _____ | _____ | _____ |
| Speech | _____ | _____ | _____ |
| Behavioral/mental health (1st) | _____ | _____ | _____ |
| Behavioral/mental health (2nd) | _____ | _____ | _____ |
| Intensive in-home | _____ | _____ | _____ |
| Other: _____ | _____ | _____ | _____ |
12. Describe any additional care, supervision, time or expense required to care for your child.

I/we, the undersigned, declare that the information contained on this document is true, correct and complete to the best of my/our knowledge and belief.

PRIMARY PARENT'S NAME (Print)	PRIMARY PARENT'S SIGNATURE	DATE
SECONDARY PARENT'S NAME (Print)	SECONDARY PARENT'S SIGNATURE	DATE
DCS REPRESENTATIVE'S NAME (Print)	DCS REPRESENTATIVE'S SIGNATURE	DATE



Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for Department services is available upon request. • Ayuda gratuita con traducciones relacionadas con los servicios del DCS está disponible a solicitud del cliente.