CSO-1709B
(08/18)

ARIZONA DEPARTMENT OF CHILD SAFETY

# ADOPTION SUBSIDY RATE EVALUATION

*CHILD'S NAME (Last, First, M.I.)* _____ *Birth Date* _____

*AGE AT ADOPTION* _____ Sibling Adoption: ☐ Yes ☐ No *Current Maintenance Amount* _____

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? ☐ Yes ☐ No
   Specify the condition: _____
   Explain how the daily living skills and self care are impaired:

2. Does your child have a cognitive disability? ☐ Yes ☐ No
   Specify the diagnosis:
   - ☐ Autism
   - ☐ Mild Mental Retardation
   - ☐ Moderate Mental Retardation
   - ☐ Severe Mental Retardation
   - ☐ Other: _____

3. Does your child have a significant mobility impairment which requires the use of a mechanical device (e.g., a wheelchair)? ☐ Yes ☐ No
   Specify the device: _____
   3.1 Does your child require assistance to transfer from one surface to another? ☐ Yes ☐ No
   Describe the assistance the child requires:

4. Does your child have a chronic illness requiring unusual or prolonged medical appointments? ☐ Yes ☐ No
   Specify the condition: _____
   Number of appointments per month: _____

5. Does your child have a major medical condition which requires frequent medical care, monitoring, hospitalizations and medically necessary equipment/supplies? ☐ Yes ☐ No
   Specify the condition: _____
   Frequency of care: _____
   By whom: _____

6. Does your child take medication? ☐ Yes ☐ No
   For what condition(s): _____
   How often? _____

7. Does your child require a special diet? ☐ Yes ☐ No
   For what condition: _____
   Explain: _____

8. Does your child require Special Education or have problems in school? ☐ Yes ☐ No
   8.1 Does your child have an Individual Education Plan (IEP) or 504 Plan? ☐ Yes ☐ No
   Explain: _____

*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 PAREN'TS SIGNATURE | DATE |
| DCS REPRESENTATIVE'S NAME (Print) | DCS REPRESENTATIVE'S SIGNATURE | DATE |

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STATE OF ARIZONA