

# RESOURCE PARENTS REPORT TOOL: ACTIVITIES IN SUPPORT OF CHILD

DATE OF REPORT: \_\_\_\_\_

Resource Parent

Thank you for taking the time to help us understand the needs of the child placed in your home. The information you share about the child’s needs is an important factor in the assessment of services and supports for the child. If there are two Resource Parents caring for the child, please include the activities you both do in support of the child. The questions below reflect activities consistent with parental expectations and skills and may account for efforts applied to meet any needs beyond what is appropriate for the child’s age. Please complete this questionnaire in the manner that describes the care you are currently providing to the child. **This form should be filled out 4-5 weeks after placement of the child in the home.**

**\*If you need more information on what development looks like for children you can find more**

**resources at:** <https://www.cdc.gov/ncbddd/childdevelopment/index.html>

CHILD’S NAME:	CURRENT AGE:	GENDER IDENTITY:	DATE OF PLACEMENT IN HOME:
RESOURCE PARENT NAME:		EMAIL ADDRESS:	
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE:	CASE CARRYING WORKER:	

**1a. The child may need assistance with basic self-care tasks. Please check the boxes below if you are helping the child with any of these Activities of Daily Living (ADLs). (Check ALL boxes that apply)**

- Feeding      Toileting      Putting on clothes      Bathing      Grooming      Menstrual Care
- Mobility (walking, standing, transferring to/from wheelchair)
- Use of upper extremities (hand, arms, fingers)

**1b. How are you helping the child with these ADLs? (Check ALL boxes that apply)**

- Supervision of activities      Verbal cueing as needed      Child needs some assistance
- Child is not able to complete without help from an adult

**1c. How many ADLs do you assist the child with daily?**

- At least 1      At least 2      At least 3      At least 6

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CAREGIVER COMMENTS:

SOCIAL WORKER COMMENTS:

**2a. Do you arrange and /or facilitate the child attending speech therapy, physical therapy and /or occupational therapy?**      Yes      No

**2b. How often do you arrange /facilitate the child 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, QUESTION 2C, 2D, 2E**

**2c. Please check the boxes below if you are assisting the child with any of the listed Instrumental Activities of Daily Living (IADLs)**

Managing finances      Accessing transportation      Shopping      Preparing meals  
Using communication devices such as phone, TTY etc.      Managing medication  
Completing basic homework      Transporting or facilitating attendance at ILP  
Supporting youth in job searches

**2d. How are you helping the child with these IADLs? (Check ALL boxes that apply)**

Supervision of activities      Verbal Cueing as needed      Child needs some assistance  
Child is not able to complete the activities without help from an adult

**2e. How many IADLs do you assist the child with daily?**

At least 1      At least 2      At least 3      At least 6

CAREGIVER COMMENTS:

SOCIAL WORKER COMMENTS:

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**3. Check the boxes below if you provide support and /or assistance to the child so they can participate in community and /or extra-curricular activities. (Check ALL boxes that apply)**

Check-in to make sure child receives needed assistance/support with ADLs while participating in community/extra-curricular activities.

Go with the child to community/extra-curricular activities to provide direct support to the child.

Participate in community/extra-curricular activities due to the child's need for my constant support or supervision to participate.

**FOR YOUTH 14 & OLDER** youth receives needed assistance/support with IADLs in community/extra-curricular activities.

**CAREGIVER COMMENTS:**

**SOCIAL WORKER COMMENTS:**

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**4a. Does the child 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/family participates in.**

**(check ALL boxes that apply)**

Child attends therapy      Family therapy      Group therapy for child

Support group for Resource Family      Parent Child Interactive Therapy (PCIT)

Wraparound (WRAP), TBS or other home-based therapeutic services

APSS (Adoption Promotion and Supportive Services)

Other (please describe) \_\_\_\_\_

**4c. Check boxes below for any activities you do to support the child in addressing behavioral/emotional challenges. (Check ALL boxes that apply).**

Talking/facilitating transportation of child to therapy appointments      1      2      3      4 per week

Talking to therapist, clinicians, social workers or other professionals      1      2      3      4 per week

Monitoring, observing, documenting child's behaviors      1      2      3      4 per week

Implementing therapeutic intervention/behavior plan      1      2      3      4 per week

Redirecting, prompting child and/or defusing behaviors      1      2      3      4 per week

Supporting the child through emotional outburst/tantrums      1      2      3      4 per week

Cleaning due to bed-wetting and/or repairing damage to home      1      2      3      4 per week

Supervising/observing child, including line of sight      Occasional      Frequent      All day      24

hours

**CAREGIVER COMMENTS:**

**SOCIAL WORKER COMMENTS:**

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**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      2-3 hours per week      5-6 hours per week      7-8 hours per week  
9+ 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      1      2      3-4      5-6      7-8 or more times per week

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.

Maintaining equipment, tools or devices for child to access education

- Respond to complaints from child care/preschool      1      2      3      Other \_\_\_\_ time 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, assisting in school enrollment and partial credit restoration.

- 0-1 hours per week      2-3 hours per week      4-5 hours per week      6-7 hours per week  
8+ hours per week

**CAREGIVER COMMENTS:**

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## SOCIAL WORKER COMMENTS:

### 6a. Please check the boxes below to show the doctors or other healthcare specialists the child 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      3-6      7-11  
12 times a year

If your pediatrician/dentist provides specialty care for the child (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 who uses equipment and/or a medical device, check the box to show the care you provide.

Monitor the child using medical device and/or testing equipment

Operate and monitor the equipment and/or medical device

### 6d. For a child who has a severe medical and/or developmental health concern check the boxes to show the care needed. (Check ALL boxes that apply):

Child requires in-home monitoring by medical professional

Child requires use of medical equipment or devices multiple times per week

Child 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.

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**CAREGIVER COMMENTS:**

**SOCIAL WORKER COMMENTS:**

**7a. How often are you supporting the child’s visits and/or participation in community and cultural activities important to his/her cultural and communal identity? This includes transporting and staying at the visits/activities. (Check ALL boxes that apply)**

Supporting the child’s visits with his/her family, siblings and others	1	2	3	4	5	times per week
Supporting child’s attending community and/or cultural activities	1	2	3	4	5	times per week
Mentoring/coaching birth parents implementing family visitation plans	2	4	6	8	10	hours per week

**CAREGIVER COMMENTS:**

**SOCIAL WORKER COMMENTS:**

**ADDITIONAL COMMENTS, CONCERNS AND/OR SUPPORTS YOU PROVIDE:**

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**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: \_\_\_\_\_