STATE OF CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

**RESOURCE PARENTS REPORT: ACTIVES IN SUPPORT OF CHILD** DATE OF REPORT: 09-Apr-20

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| CHILD’S NAME:  Connor Mahoney | CURRENT AGE:  13 | | GENDER IDENTITY:  Male | CASE#:  94325677E59143 | DATE OF PLACEMENT IN THIS HOME:  11/20/2019 | |
| RESOURCE PARENTS NAME:  Mia Hutchins | | | | EMAIL ADDRESS: | | |
| ADDRESS:  23818 Hutton Court | | CITY:  Moreno Valley | | STATE:  CA | | ZIP:  92551 |
| HOME PHONE:  (951)563-0437 | | CELL PHONE: | | CASE CARRYING WORKER:  Fernando Casas | | |

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| **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. 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 the questionnaire in the manner that best describes the care you are currently providing to the child. We appreciate your input. |

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| **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 daily living skills. (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 (hands, arms, fingers)  **1b. How are you helping the child with these daily living skills? (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 often do you assist the child with these daily living skills?**  0-1 times a week 2-6 times a week Every day |
| **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?** 0-1 times a month 3 times a month 4 or more times a month  **If CHILD IS 14 OR OLDER, COMPLETE QUESTIONS 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). (check ALL boxes that apply)**  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 classes Supporting youth in job searches  **2d. How are you helping the child with these Instrumental Activities of Daily Living (IADLs)? 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  **2e. How often do you assist the child with these Instrumental Activities of Daily Living (IADLS)**  0-1 times a week 2-6 times a week Every day |
| **3. Check the boxes below if you provide support and/or assistance to the child so they can  participate in community activities and/or extra-curricular activities. (check ALL boxes that  apply)**  Check-in to make sure child receives needed assistance/support with Activities of Daily Living wile participating in community/extra-curricular activities  Go with the child to community/extra-curricular activities to provide direct support to the child  To participate in community/extra-curricular activities the child needs my constant support or supervision to participate  **FOR CHILD 14 & OLDER** youth receives needed assistance/support with Instrumental Activities of Daily Living in community/extra-Curricular activities |
| **4a. Does the child have emotional/behavioral challenges as diagnosed by a Licensed therapist or  MD**  YES NO  **4b. Check boxes below with the type of emotional/behavioral supports the child/family  participates in (check ALL boxes that apply)** Child attends therapy Family Therapy  Group therapy for child Support group for caregiver Wraparound (WRAP), TBS or other home based therapeutic services APSS (Adoption Promotion and Supportive Services) Parent Child Interactive Therapy (PCIT) Other (please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **4c. Check boxes below for any activities that you do to support the child in addressing  emotional/behavioral challenges. (check ALL boxes that apply:**  Taking/facilitating transportation of child to therapy appointments 1 2 3 4 5 6+ time/week  Talking to therapist, clinicians, social workers or other professionals 1 2 3 4 5 6+ time/week  Monitoring, observing, documenting child’s behaviors 1 2 3 4 5 6+ time per week  Implementing therapeutic intervention/behavior plan 1 2 3 4 5 6+ time per week  Redirecting, prompting child and/or defusing behaviors 1 2 3 4 5 6+ time per week  Supporting the child through emotional outbursts/tantrums 1 2 3 4 5  6+ time per week  Cleaning due to bed-wetting and/or preparing damage to home 1 2 3 4 5 6+ time per week  Supervising/observing child, including line of sight occasional frequent all day 24 hours |
| **5a. For a SCHOOL-AGE CHILD, how much time are you spending supporting and supervising the  child for homework and/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 devises so child can access  education. Also included assisting with college/financial-aid applications.  **1-2 hours per week** **3-4 hours per week** **5-6 hours per week** **7-8 hours per week**  **9+ hours per week**  **5b. For 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+ times a week**  Provide additional support in coordination with child care/preschool including any issues regarding child’s behavior that might put he/she 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 (circle # that applies) **1** **2** **3** **4** **5+ times a month**  **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, and assisting in school enrollment and partial credit restoration.  **1-2 hours per week** **3-4 hours per week** **5-6 hours per week** **7-8 hours per week**  **9+ hours per week** |
| **6a. Please check the boxes below to show the doctors or other healthcare specialist the child sees.   (check ALL boxes that apply)** Pediatrician for routine well-child care Dentist for routine  well-child care Specialist (ex. Neurologist, allergist, psychiatrist, orthodontist, etc.) **1-3**   **4-5** **6-8** **9-11** **12-14+ 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. Please check the boxes below that apply reading medications prescribed by a doctor. This**  **includes psychotropic medication for emotional/behavioral health.**  Observe, record, and/or report medication effects to doctor and administer:  1 medication as needed 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 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 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 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 the body. |
| **7a. How often are you supporting the child’s visits and/or participating in community or 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 and CHECK the  number that shows the frequency of these activities.)**  Supporting the child’s visits with his/her family, siblings and others 1 2 3 4  5 6+ times per week  Supporting the child in attending community and/or cultural activities 1 2 3 4 5 6+ times per week  Mentoring/coaching birth parents implementing family visitations plans 1 2 3 4 5 6+ times per week |
| **ADDITIONAL COMMENTS, CONCERNS AND/OR SUPPORTS:** |
| **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 Workers Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_ |