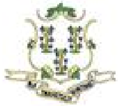
Connecticut Department of Children and Families

CHECKLIST FOR ADOPTION SUBSIDY APPROVAL

DCF-415
10/19 (Rev.)



SW LAST Name:	SW FIRST Name:	Is Child DDS Eligible?: ☐ Yes ☐ No	Is Child part of a sibling group placed together?: ☐ Yes ☐ No	Is Child Identified as an Indian Child/Youth?: ☐ Yes ☐ No
Child's Biological LAST Name:	Child's FIRST Name:	Gender:	LINK #:	Date Of Birth:
Child LAST Name (AFTER Adoption-*Required*):	Child FIRST Name (AFTER Adoption, if applicable):	DCF Office:		
Adoptive Parent #1 LAST Name:	Adoptive Parent #1 FIRST Name:	Adoptive Parent #2 LAST Name:	Adoptive Parent #2 FIRST Name:	

CHECK ALL THAT APPLY:

☐ IV-E | ☐ SSA – Monthly Benefit of: | ☐ SSI - Monthly Benefit of:

OUT-OF-STATE ADOPTIVE FAMILY:

☐ Approved ICPC-100A for Adoption | ☐ Pre-Adoptive family's approved adoption home-study

TYPE OF SUBSIDY:

- ☐ **Basic Financial / Medical**
- ☐ **Medical Only**
- ☐ **Medically Complex**: packet must include DCF-2101 dated within the last six (6) months and signed by all parties
- ☐ **TFC Rate**: packet must include letter from agency stating per diem rate and attach the family's home-study
- ☐ **Other**: Any adoption subsidy rate higher than the above rates must include a memo supporting the higher rate post-adoption: signed by Office Director AND Assistant Bureau Chief.

FORMS AND DOCUMENTS TO BE INCLUDED IN PACKET:

- ☐ **VERIFY THAT ALL LICENSING AND BACKGROUND CHECKS ARE IN THE PROVIDER FILE** (Verified by Licensing Worker)
- ☐ **DCF-416** (one in the child's biological name and one in the child's adoptive name) signed by AOSW & subsidy program supervisor
- ☐ **DCF-418-I** (in child's adoptive name) signed by adoptive parents and subsidy program supervisor. *If there is an addendum for services please submit proposal outlining additional services, signed by all parties.
- ☐ **DCF-738** (in child's adoptive name) signed by adoptive parent(s) and subsidy program supervisor
- ☐ **DCF-739** (in child's adoptive name) signed by adoptive parent(s)
- ☐ **DCF-337** Genetic Parent(s) Information form - signed and initialed by DCF SW and adoptive parent(s)
- ☐ **DCF-338** Genetic Parent(s) Medical Information form signed by AOSW and signed & initialed by adoptive parent(s)
- ☐ **Immunization Record**
- ☐ **DCF-2248** Child Information Disclosure Form, signed by pre-adoptive family, AOSW and FASU support worker or supervisor
- ☐ **VS-51** - COPY of Record of Adoption, signed by adoptive parent(s). **IF** paternity was established or acknowledged after original birth certificate was created **THEN** documentation of legal acknowledgement must be included in subsidy packet. The VS-51 would then reflect **BOTH** mother and father's names.
- ☐ Revenue Enhancement Unit (REU) e-mails regarding IV-E status and social security benefits, as applicable.
- ☐ Copy of Child's Birth Certificate
- ☐ Copy of Child's Social Security Card
- ☐ **JD-JM-58** - Copy of OTC order
- ☐ **JD-JM-65** - Copy of Adjudicatory/Dispositional Orders (Commitment and Extension of Commitment, etc.)
- ☐ **JD-JM-31** - Copy of TPR order
- ☐ Copy of citizenship papers/green card, if the child was born outside of the United States.

Reviewed by:		Approved by:	
Area Office Social Work Supervisor	Date:	CO Fiscal Representative:	Date:
Subsidy Permanency Specialist CSC:	Date:	Subsidy Unit Program Supervisor:	Date:

Department of Children and Families

CERTIFICATION OF SPECIAL NEEDS STATUS

DCF-416
1/19 (Rev.)

Child's Bio LAST Name:	Child's Bio FIRST Name:	DOB:	Gender:	Date of Commitment

Name of Private Agency (*If Applicable*)	Race:	Ethnicity:

Address: (No. and Street)	City	State	Zip

Check All that Apply and Explain Below *(please attach documentation where indicated):*

- ☐ Physical disability (or high risk of such disability) which presents a barrier to adoption. A written diagnosis and recommendation for treatment must be made by a licensed physician.
- ☐ Mental disability (or high risk of such disability) which presents a barrier to adoption. A written diagnosis and recommendation for treatment must be made by a licensed psychiatrist or psychologist.
- ☐ Serious emotional maladjustment (or high risk of such maladjustment) as indicated by a written diagnosis made by a licensed psychiatrist or psychologist. The written statement must include recommendation for treatment and prognosis.
- ☐ Age, when considered with other factors in the child's functioning and circumstances, presents a barrier to adoption.
- ☐ Racial or ethnic factors, when considered with other factors in the child's functioning and circumstances, that present a barrier to adoption.
- ☐ Member of a sibling group which should be placed together.
- ☐ The child has established significant emotional ties with prospective adoptive parents.

Explanation:

Recommended by LAST Name:	FIRST Name:	Signature:	Date
Approved by PS LAST Name:	PS FIRST Name:	PS Signature:	Date

Department of Children and Families

CERTIFICATION OF SPECIAL NEEDS STATUS

DCF-416
1/19 (Rev.)

Child's Adopted LAST Name:	Child's Adopted FIRST Name:	DOB:	Gender:	Date of Commitment

Name of Private Agency (*If Applicable*)	Race:	Ethnicity:

Address: (No. and Street)	City	State	Zip

Check All that Apply and Explain Below *(please attach documentation where indicated):*

- ☐ Physical disability (or high risk of such disability) which presents a barrier to adoption. A written diagnosis and recommendation for treatment must be made by a licensed physician.
- ☐ Mental disability (or high risk of such disability) which presents a barrier to adoption. A written diagnosis and recommendation for treatment must be made by a licensed psychiatrist or psychologist.
- ☐ Serious emotional maladjustment (or high risk of such maladjustment) as indicated by a written diagnosis made by a licensed psychiatrist or psychologist. The written statement must include recommendation for treatment and prognosis.
- ☐ Age, when considered with other factors in the child's functioning and circumstances, presents a barrier to adoption.
- ☐ Racial or ethnic factors, when considered with other factors in the child's functioning and circumstances, that present a barrier to adoption.
- ☐ Member of a sibling group which should be placed together.
- ☐ The child has established significant emotional ties with prospective adoptive parents.

Explanation:

Recommended by LAST Name:	FIRST Name:	Signature:	Date
Approved by PS LAST Name:	PS FIRST Name:	PS Signature:	Date

Connecticut Department of Children and Families

SPECIAL NEEDS ADOPTION SUBSIDY - INITIAL AGREEMENT

DCF-418-I

1/19 (Rev.)

The following is an initial agreement entered into by and between the Department of Children and Families and the adoptive parent(s) named below for the purpose of facilitating the legal adoption of the child named below and to assist the adoptive family in providing proper care for the child.

LAST Name of Adoptive Parent #1:	FIRST Name of Adoptive Parent #1:	LAST Name of Adoptive Parent #2:	FIRST Name of Adoptive Parent #2:

Address: (No. and Street):	City:	State :	Zip:

Name of Adopted Child (LAST): First Name:	Child's DOB:	Parent's Telephone:	Parent's e-mail Address:

I. It is agreed that when I/we sign this Adoption Subsidy Agreement and the child's adoption is finalized, I/we am/are eligible to receive (check all applicable item(s):

☐ Adoption Subsidy payment in the negotiated amount of $ per Diem and Title XIX/State Medicaid.

☐ Adoption Subsidy payment in the negotiated amount of $ per Diem.

☐ Connecticut Medical Subsidy in accordance with C.G.S. §17a-117(a) or 17a-120.

☐ If applicable, child's Social Security Benefit (SSA) in the amount of $ per month. (Parent must apply after finalization).

II. I/We understand that if Adoption Subsidy payments under Title IV-E are received, the child is also eligible for medical services under Title XIX and social services under Title XX in accordance with the procedures of the State in which the child resides.

III. /We understand that if needed medical services specified in this agreement are not available in the State in which the child resides, payment for these services will be provided by the Connecticut Department of Children and Families until age EIGHTEEN (18).

I/We understand that if needed social services specified in this agreement are not available in the State in which the child resides, payment for these services will be provided by the Connecticut Department of Children and Families.

Social Services to be Provided **	Medical Services to be Provided
College Tuition Benefit per DCF Policy 25-2	

**Attach service specific addendum for any payments to be made by DCF after the adoption.

III. I/We understand that the child is certified as special needs and I/we are eligible to apply for reimbursement of non-recurring adoption expenses defined as reasonable and necessary adoption fees, court costs, attorney fees, and other expenses related to the legal adoption of the child, not to exceed $750.00. Please refer to the Application for Reimbursement for Non-Recurring Adoption Expenses form (DCF-739).

IV. I/We, as adoptive parents of the child, understand that:

A. Should I/we move, and should we receive adoption assistance for our child(ren) under Title IV-E, the Interstate Compact on Adoption & Medical Assistance representative of Connecticut will refer the child to the state agency administering ICAMA in the new state of residence. This is for the protection of the interests of the child and to assure that the needed medical service(s) specified in the Adoption Subsidy Agreement are provided.

B. The State of Connecticut, Department of Children and Families, will be responsible for the periodic (monthly) Adoption Subsidy payments for the duration of this agreement.

C. Should I/we move this agreement remains in effect regardless of the state of my/our residence.

D. In accordance with this agreement, the monthly payment and/or services for the child under Titles XIX and XX shall begin at the time of the finalization of adoption.

E. The amount of the monthly subsidy payment is a negotiated amount and is based upon the need of the child at the time of placement and the circumstances of the adoptive family.

F. 1) **The financial subsidy will continue only until the child's EIGHTEENTH (18) birthday, if the child was adopted prior to October 1, 2013.**

2) **The financial subsidy will continue to age 21 for a child whose adoption was finalized after October 1, 2013, if the following conditions are met:**

a. Child was at least 16 years of age or older at the time the adoption agreement was signed.
b. The child is enrolled full-time in an approved secondary education program or a program leading to an equivalent credential or
c. Is enrolled full time in an institution which provides post-secondary or vocational education or
d. Is participating in a program or activity approved by the commissioner that is designed to promote or remove barriers to employment

The commissioner, in the commissioner's discretion, may waive the provision of full time enrollment or participation based on compelling circumstances.

3) The medical subsidy will continue until the child's twenty-first (21) birthday if a Connecticut resident.

G. At the time of this contract my/our family health insurance may be considered in meeting the medical costs of the child.

H. A review will be conducted by the Department of Children and Families to assess the need to continue or modify the amount and/or duration of the financial subsidy/medical subsidy. This Agreement must be renewed by the adoptive parent(s) and the Department of Children and Families. Frequency of Review are as follows:

1. Biennial review for a child adopted prior to October 1, 2013
2. Annual review for a child adopted after October 1, 2013, who reached age 18, who has not reached age 21 and who was at least 16 at the time the adoption agreement was signed and who meets conditions outlined in Section IV F-2.

I. Termination of this agreement will occur:

1. If I/we are no longer responsible for the support of the child.
2. If the Department determines the child is no longer receiving support from the adoptive family.
3. **The child reaches age EIGHTEEN (18) for children adopted prior to October, 1, 2013.** [Medical Subsidy will continue until the child reaches age twenty-one (21) for Connecticut residents].
4. **For the child who meets conditions outlined in Section IV F - 2 and who turns age 21..** [Medical Subsidy will continue until the child reaches age twenty-one (21) for Connecticut residents].
5. In the event of my/our deaths.
6. In the event of the child's death.
7. If I/we request termination of this agreement.

J. The payment may be modified with our concurrence if there are changes:

1. In the needs of the child.
2. In the living arrangements or residence of the child.

K. The child is fully my/our responsibility and my/our family is independent of the Department except for my/our obligation to notify the Department of significant changes and to cooperate with review requirements.

V. A. I/We agree to notify the Department of Children and Families in writing within thirty (30) days in the event I/we are no longer responsible for the support of the child, or are no longer providing any support to the child.

B. I/We agree that the Adoption Subsidy payment may never exceed the maximum foster care maintenance payment in the State of Connecticut.

C. The Department of Children and Families agrees to notify me/us in writing of the intent to reduce or terminate the amount of the Subsidized Adoption payments fifteen (15) days prior to taking such action.

D. The Department of Children and Families agrees to notify me/us in writing forty-five (45) days before the need for renewal and to include the appropriate forms with the renewal notice.

VI. I/We have been advised by the Department of Children and Families of my/our right to appeal to the Adoption Subsidy Review Board if I/we disagree with the Department of Children and Families' decision regarding service and financial issues. I/We have the right to be represented at the hearing by legal counsel at my/our own expense and to receive a timely notice of the date, place, and time of the hearing (C.G.S. §17a-118).

VII. **This agreement shall remain in effect until the child reaches age EIGHTEEN (18) for financial subsidy for a child adopted prior to October 1, 2013 OR age TWENTY ONE (21) for a child adopted after October 1, 2013 who was at least 16 years of age at the time the adoption agreement was signed and who met all conditions outlined in Section IV F-2.** The medical subsidy will remain in effect until child reaches age twenty-one (21) if child is a Connecticut resident. The effective date of agreement is the date of finalization or completion of an application under C.G.S. §17a-117 or §17a-120.

Anticipated Date of Finalization:

Adoptive Parent #1 Signature	Date
Adoptive Parent #2 Signature	Date
Signature of Authorized Representative of the Department of Children and Families	Date

Connecticut Department of Children and Families

AGREEMENT FOR REIMBURSEMENT OF NON-RECURRING ADOPTION EXPENSES

DCF-738
11/07 (Rev.)

Adoptive Parent #1 Name (LAST, First):	Adoptive Parent #2 Name (LAST, First):
Child's Adopted Name (LAST):	Child's Adopted Name (First):
Date of Birth:	Place of Birth:

I/We, affirm that I/We will be adopting the above named special needs child and agree to receive payments for reimbursement of non-recurring adoption expenses incurred prior to the finalization of the adoption.

The Department will reimburse the following non-recurring adoption expenses:

Type of Expense	Estimated Cost
TOTAL ESTIMATED COSTS	

Adoptive Parent #1 Signature:	Date:
Adoptive Parent #2 Signature:	Date:

Approved by Authorized Agent for the Department of Children and Families:	Date:

Date:

Signed copy of this agreement was ☐ given or ☐ sent to adoptive parents on:

Connecticut Department of Children and Families

AGREEMENT FOR REIMBURSEMENT OF NON-RECURRING ADOPTION EXPENSES

DCF-739

1/19 (Rev.)

I. Adoptive Parent(s)					
Parent 1		Parent 2			
Last Name:	First Name:	Last Name:		First Name:	
E-mail:	Phone:	E-mail:		Phone:	
Address: (No. and Street):		City:	State:	Zip:	

II. Adoptive Child			
Adopted Child's LAST Name:	Child's FIRST Name:	Child's DOB:	Child's Place of Birth:

What agency was named statutory parent for the purpose of placing this child into adoption? CT Department of Children and Families

What date did you or do you expect to adopt this child?:

Are you receiving or applying for adoption assistance for this child from any other state?: ☐ Yes ☐ No. If yes, please explain:

Have you applied for or received reimbursement for adoption related expenses from any other source?: ☐ Yes ☐ No. If yes, please explain:

III. Child's Status

(NOTE: *If DCF adoption, attached DCF-416 and required documentation. If a private agency adoption, please check below.)*

☐ The child cannot be placed without assistance due to:

- ☐ Age
- ☐ Membership in an ethnic or racial minority: Which Minority group?:
- ☐ Placed in your home with biological siblings
- ☐ Medical condition or physical handicap ⋆
- ☐ Mental or emotional handicap ⋆

⋆ Documentation is attached substantiating the child's medical or handicapping condition from a physician or psychiatrist.

- ☐ The child cannot or should not return home to biological parents because parental rights have been terminated. A copy of the order terminating parental rights is attached as verification.
- ☐ Documentation is attached that attempts were made to place him/her without adoption assistance, unless contrary to the child's best interest.

(NOTE: without proper documentation on the condition(s) outlined above, eligibility for this program cannot be granted.)

IV. Request for Reimbursement

I/We request reimbursement for the following non-recurring adoption expenses. I/We certify that these expenses are expenses that I/We are required to pay. *(Please attach copies of bill.)*

List Expense(s):	Cost:
TOTAL REIMBURSEMENT REQUESTED	

V. Release of Information

I/We give permission to the Department of Children and Families to obtain information from the following persons or agencies in order to verify information needed to determine eligibility for this reimbursement for non-recurring expenses related to the adoption. Please list any person or agency that can verify information provided in Section III.

1. Name / Agency:		Phone:	
Address: (No. and Street):	City:	State:	Zip:
2. Name / Agency:		Phone:	
Address: (No. and Street):	City:	State:	Zip:
3. Name / Agency:		Phone:	
Address: (No. and Street):	City:	State:	Zip:

VI. Certification

I/We certify that the information provided above is true to the best of my/our knowledge.

Adoptive Parent #1 Signature:	Parent #1 Social Security Number:	Date:
Adoptive Parent #2 Signature:	Parent #2 Social Security Number:	Date:

Please return this application, with the required documentation to:	LAST Name of SW:	FIRST Name of SW:
DCF Office:		

Connecticut Department of Children and Families

GENETIC PARENT(S) INFORMATION *(Use When Submitting to Superior Court)*

DCF-337
6/19 (Rev.)

All information given is current at the time of child's birth

BIO-MOTHER			BIO-FATHER		
DOB:	Age:	# of Years of School completed:	DOB:	Age:	# of Years of School completed:
Race:		Ethnicity:	Race:		Ethnicity:
Nationality (Citizenship):		Religion: (if any):	Nationality (Citizenship):		Religion (if any):

GENERAL PHYSICAL APPEARANCE OF BIO-PARENTS			
Height: Feet Inches	Weight:	Height: Feet Inches	Weight:
Eyes:	Hair:	Eyes:	Hair:
Description of Appearance:		Description of Appearance:	
Talents, Hobbies, Special Interests:		Talents, Hobbies, Special Interests:	

INFORMATION CONCERNING OTHER BIO-CHILDREN							
Name	Adopted?:	Gender:	Age:	Name:	Adopted?:	Gender:	Age:
	☐ Y ☐ N				☐ Y ☐ N		
	☐ Y ☐ N				☐ Y ☐ N		
	☐ Y ☐ N				☐ Y ☐ N		
	☐ Y ☐ N				☐ Y ☐ N		
	☐ Y ☐ N				☐ Y ☐ N		
	☐ Y ☐ N				☐ Y ☐ N		

ADDITIONAL INFORMATION ABOUT BIO-PARENTS	
General Field of Occupation	General Field of Occupation:
Future Aspirations (Including Educational):	Future Aspirations (Including Educational):
Relationship Between Parents (Attach additional Sheets, if necessary):	

Submitted by:	Signature:	Date:

Manner in which plans for the child's future were made by the parents. Reasons for child being placed for adoption and parental rights being terminated.

Additional comments such as pertinent social information, personality description, information about other family members, placements of child prior to adoption, etc.

I hereby acknowledge receipt of a copy of this form.	Signature of Adoptive Parent 1:	Date:
	Signature of Adoptive Parent 2:	Date:

Name of Agency:			
Address: (No. and Street):	City:	State:	Zip:

Agency Representative Name:	Agency Representative Signature:	Date:

Additional information obtained after submission of this form to the court may be included in a supplemental report.

Connecticut Department of Children and Families

MEDICAL INFORMATION ON GENETIC PARENT

DCF-338
1/19 (Rev.)

☐ Mother *(Use a separate form for each parent)* ☐ Father

Indicate by checking "Yes" or "No" if you or any genetic relatives (i.e. your mother, father, sisters, brothers, grandparents, aunts, uncles, or any other children you have had) ever had, or now have, the medical items listed. Also complete the "Comment" section.

Medical Condition	Self	Yes – Relative *(Specify which relative)*	Comments: *(Provide details including, cause, age at onset, treatment and any hospitalizations)*
1. Club Foot	☐ No ☐ Yes ☐ Don't Know		
2. Harelip (Cleft Lip) or cleft palate	☐ No ☐ Yes ☐ Don't Know		
3. Congenital heart defect	☐ No ☐ Yes ☐ Don't Know		
4. Any other malformations	☐ No ☐ Yes ☐ Don't Know		
5. Muscular dystrophy	☐ No ☐ Yes ☐ Don't Know		
6. Multiple sclerosis	☐ No ☐ Yes ☐ Don't Know		
7. Cerebral palsy	☐ No ☐ Yes ☐ Don't Know		
8. Other paralysis or crippling disorder	☐ No ☐ Yes ☐ Don't Know		
9. Seizures, convulsions or epilepsy	☐ No ☐ Yes ☐ Don't Know		
10. Blindness, glaucoma or other visual problems	☐ No ☐ Yes ☐ Don't Know		
11. Deafness or other ear problems	☐ No ☐ Yes ☐ Don't Know		
12. Speech problem	☐ No ☐ Yes ☐ Don't Know		
13. Learning disability	☐ No ☐ Yes ☐ Don't Know		
14. Developmental disability: mental or physical	☐ No ☐ Yes ☐ Don't Know		
15. Diabetes	☐ No ☐ Yes ☐ Don't Know		
16. Thyroid disorder	☐ No ☐ Yes ☐ Don't Know		
17. Other hormone disorder	☐ No ☐ Yes ☐ Don't Know		
18. Eczema or other skin conditions	☐ No ☐ Yes ☐ Don't Know		
19. Asthma	☐ No ☐ Yes ☐ Don't Know		
20. Hay fever or other allergy	☐ No ☐ Yes ☐ Don't Know		
21. Hemophilia	☐ No ☐ Yes ☐ Don't Know		
22. Sickle cell anemia	☐ No ☐ Yes ☐ Don't Know		
23. Other blood disease, including anemia	☐ No ☐ Yes ☐ Don't Know		
24. Schizophrenia	☐ No ☐ Yes ☐ Don't Know		
25. Manic depressive	☐ No ☐ Yes ☐ Don't Know		
26. Other mental or emotional illness	☐ No ☐ Yes ☐ Don't Know		
27. Hypertension (high blood pressure)	☐ No ☐ Yes ☐ Don't Know		
28. Stroke	☐ No ☐ Yes ☐ Don't Know		
29. Heart attack (Coronary)	☐ No ☐ Yes ☐ Don't Know		
30. Other Cardiovascular Problems	☐ No ☐ Yes ☐ Don't Know		
31. Cancer	☐ No ☐ Yes ☐ Don't Know		
32. Tumors	☐ No ☐ Yes ☐ Don't Know		
33. Cystic fibrosis	☐ No ☐ Yes ☐ Don't Know		
34. Huntington's disease	☐ No ☐ Yes ☐ Don't Know		
35. Tuberculosis	☐ No ☐ Yes ☐ Don't Know		
36. Kidney disease	☐ No ☐ Yes ☐ Don't Know		
37. Alcoholism or heavy drinking	☐ No ☐ Yes ☐ Don't Know		
38. Drug usage	☐ No ☐ Yes ☐ Don't Know		
39. Hospitalization, operation, or injury	☐ No ☐ Yes ☐ Don't Know		
40. Any other condition you or others in your family might have	☐ No ☐ Yes ☐ Don't Know		

If "yes", please describe:

Initial: Adoptive Parent 1:	Initial: Adoptive Parent 2:

THIS SECTION FOR GENETIC MOTHER ONLY		MENSTRUAL AND PREGNANCY HISTORY	
Age at onset of menses:	Usual Length of Period:	Regular? ☐ Yes ☐ No	Number of Days between:

Please list all your pregnancies in order. (Use one line for each child or for each miscarriage, abortion, or still birth.)

Children: (write: boy, girl, abortion, miscarriage, or still-birth)	How Many Months Did You Carry This Pregnancy?	Year in Which Pregnancy Ended	If Miscarriage or Abortion, Was it Natural or Induced?

CURRENT PREGNANCY

Is the baby's father aware of this pregnancy? ☐ Yes ☐ No ☐ Not Sure	Is the baby's father a genetic relative of yours? ☐ Yes ☐ No If "Yes", how is he related?
What month did prenatal care begin for this baby?	Any Complications?

Any exposure during this pregnancy? ☐ X-ray ☐ Electrocardiogram ☐ Radiation

DRUGS TAKEN DURING PREGNANCY

List Prescription Drugs, frequency and dosages:

List Non-Prescription Drugs frequency and dosages (including aspirin and/or nose drops) When and frequency during pregnancy

SUBSTANCE:	Yes/No	If "Yes", What kind?:	Amount?:	How Often?:
Alcohol	☐ Yes / ☐ No			
Amphetamines *(Uppers)*	☐ Yes / ☐ No			
Barbiturates *(Downers)*	☐ Yes / ☐ No			
Cigarettes	☐ Yes / ☐ No			
Cocaine	☐ Yes / ☐ No			
Heroin	☐ Yes / ☐ No			
LSD	☐ Yes / ☐ No			
Marijuana	☐ Yes / ☐ No			
Opioids	☐ Yes / ☐ No			
Other:	☐ Yes / ☐ No			

BIRTH HISTORY

Child's Name:	DOB:	Time:	Gender:	Weight: lbs oz

Term: ☐ Premature ☐ Full ☐ Postmature	Pregnancy occurred at (# of Weeks):	Head Circumference	Chest Circumference

Any Abnormalities:

Mother's Blood Type	Rh Factor:	Baby's Blood Type:
Duration of Labor:	Anesthesia Used:	
Type of Delivery:	Apgar score at 1 and 5 minutes:	Condition of Child at Birth:

CHILD's MEDICAL HISTORY			
First Tooth at *(months):*	Sat Alone at *(months):*	Walked at *(months):*	Convulsive Disorder *(month and year noted)*
Toilet Trained at *(months):*	Diagnosed Medical Conditions *(i.e., allergies, asthma, bronchitis, etc.):*		

Attach Medical Passport and Do Not Complete if Immunizations, Diseases and Hospitals Information are Contained on Passport

IMMUNIZATIONS	Original Date:	Booster Date:	Booster Date:	Booster Date:
DPT				
Small Pox				
Polio				
Other:				
Measles				
Mumps				
Rubella				
Chicken Pox				
Whooping Cough				
Other:				
Comments:				

HOSPITALIZATIONS
Any Hospitalizations? (Reason, Date(s) and Place(s):

EVALUATIONS / EXAMINATIONS		
Please complete the following Type of Tests:	Date	Performed by:
Psychological Evaluations		
Psychiatric Evaluation		
Intellectual Assessment		
Developmental Evaluation *(Includes :Speech, Language, Hearing)*		
Physical Examination		
Neurological Evaluation		
OTHER:		

I hereby acknowledge receipt of a copy of this form.	Signature of Adoptive Parent 1:		Date:
	Signature of Adoptive Parent 2:		Date:
Name of Agency:			
Address (No. and Street)	City:	State:	Zip:
Agency Representative Name:	Agency Representative Signature		Date

Connecticut Department of Children and Families

MEDICAL INFORMATION ON GENETIC PARENT

DCF-338

1/19 (Rev.)

☐ Mother *(Use a separate form for each parent)* ☐ Father

Indicate by checking "Yes" or "No" if you or any genetic relatives (i.e. your mother, father, sisters, brothers, grandparents, aunts, uncles, or any other children you have had) ever had, or now have, the medical items listed. Also complete the "Comment" section.

Medical Condition	Self	Yes – Relative *(Specify which relative)*	Comments: *(Provide details including, cause, age at onset, treatment and any hospitalizations)*
1. Club Foot	☐ No ☐ Yes ☐ Don't Know		
2. Harelip (Cleft Lip) or cleft palate	☐ No ☐ Yes ☐ Don't Know		
3. Congenital heart defect	☐ No ☐ Yes ☐ Don't Know		
4. Any other malformations	☐ No ☐ Yes ☐ Don't Know		
5. Muscular dystrophy	☐ No ☐ Yes ☐ Don't Know		
6. Multiple sclerosis	☐ No ☐ Yes ☐ Don't Know		
7. Cerebral palsy	☐ No ☐ Yes ☐ Don't Know		
8. Other paralysis or crippling disorder	☐ No ☐ Yes ☐ Don't Know		
9. Seizures, convulsions or epilepsy	☐ No ☐ Yes ☐ Don't Know		
10. Blindness, glaucoma or other visual problems	☐ No ☐ Yes ☐ Don't Know		
11. Deafness or other ear problems	☐ No ☐ Yes ☐ Don't Know		
12. Speech problem	☐ No ☐ Yes ☐ Don't Know		
13. Learning disability	☐ No ☐ Yes ☐ Don't Know		
14. Developmental disability: mental or physical	☐ No ☐ Yes ☐ Don't Know		
15. Diabetes	☐ No ☐ Yes ☐ Don't Know		
16. Thyroid disorder	☐ No ☐ Yes ☐ Don't Know		
17. Other hormone disorder	☐ No ☐ Yes ☐ Don't Know		
18. Eczema or other skin conditions	☐ No ☐ Yes ☐ Don't Know		
19. Asthma	☐ No ☐ Yes ☐ Don't Know		
20. Hay fever or other allergy	☐ No ☐ Yes ☐ Don't Know		
21. Hemophilia	☐ No ☐ Yes ☐ Don't Know		
22. Sickle cell anemia	☐ No ☐ Yes ☐ Don't Know		
23. Other blood disease, including anemia	☐ No ☐ Yes ☐ Don't Know		
24. Schizophrenia	☐ No ☐ Yes ☐ Don't Know		
25. Manic depressive	☐ No ☐ Yes ☐ Don't Know		
26. Other mental or emotional illness	☐ No ☐ Yes ☐ Don't Know		
27. Hypertension (high blood pressure)	☐ No ☐ Yes ☐ Don't Know		
28. Stroke	☐ No ☐ Yes ☐ Don't Know		
29. Heart attack (Coronary)	☐ No ☐ Yes ☐ Don't Know		
30. Other Cardiovascular Problems	☐ No ☐ Yes ☐ Don't Know		
31. Cancer	☐ No ☐ Yes ☐ Don't Know		
32. Tumors	☐ No ☐ Yes ☐ Don't Know		
33. Cystic fibrosis	☐ No ☐ Yes ☐ Don't Know		
34. Huntington's disease	☐ No ☐ Yes ☐ Don't Know		
35. Tuberculosis	☐ No ☐ Yes ☐ Don't Know		
36. Kidney disease	☐ No ☐ Yes ☐ Don't Know		
37. Alcoholism or heavy drinking	☐ No ☐ Yes ☐ Don't Know		
38. Drug usage	☐ No ☐ Yes ☐ Don't Know		
39. Hospitalization, operation, or injury	☐ No ☐ Yes ☐ Don't Know		
40. Any other condition you or others in your family might have	☐ No ☐ Yes ☐ Don't Know		

If "yes", please describe:

Initial: Adoptive Parent 1:	Initial: Adoptive Parent 2:

THIS SECTION FOR GENETIC MOTHER ONLY		MENSTRUAL AND PREGNANCY HISTORY	
Age at onset of menses:	Usual Length of Period:	Regular? ☐ Yes ☐ No	Number of Days between:

Please list all your pregnancies in order. (Use one line for each child or for each miscarriage, abortion, or still birth.)

Children: (write: boy, girl, abortion, miscarriage, or still-birth)	How Many Months Did You Carry This Pregnancy?	Year in Which Pregnancy Ended	If Miscarriage or Abortion, Was it Natural or Induced?

CURRENT PREGNANCY

Is the baby's father aware of this pregnancy? ☐ Yes ☐ No ☐ Not Sure	Is the baby's father a genetic relative of yours? ☐ Yes ☐ No If "Yes", how is he related?
What month did prenatal care begin for this baby?	Any Complications?

Any exposure during this pregnancy? ☐ X-ray ☐ Electrocardiogram ☐ Radiation

DRUGS TAKEN DURING PREGNANCY

List Prescription Drugs, frequency and dosages:

List Non-Prescription Drugs frequency and dosages (including aspirin and/or nose drops) When and frequency during pregnancy

SUBSTANCE:	Yes/No	If "Yes", What kind?:	Amount?:	How Often?:
Alcohol	☐ Yes / ☐ No			
Amphetamines *(Uppers)*	☐ Yes / ☐ No			
Barbiturates *(Downers)*	☐ Yes / ☐ No			
Cigarettes	☐ Yes / ☐ No			
Cocaine	☐ Yes / ☐ No			
Heroin	☐ Yes / ☐ No			
LSD	☐ Yes / ☐ No			
Marijuana	☐ Yes / ☐ No			
Opioids	☐ Yes / ☐ No			
Other:	☐ Yes / ☐ No			

BIRTH HISTORY

Child's Name:	DOB:	Time:	Gender:	Weight: lbs oz

Term: ☐ Premature ☐ Full ☐ Postmature	Pregnancy occurred at (# of Weeks):	Head Circumference	Chest Circumference

Any Abnormalities:

Mother's Blood Type	Rh Factor:	Baby's Blood Type:
Duration of Labor:	Anesthesia Used:	
Type of Delivery:	Apgar score at 1 and 5 minutes:	Condition of Child at Birth:

CHILD's MEDICAL HISTORY			
First Tooth at *(months):*	Sat Alone at *(months):*	Walked at *(months):*	Convulsive Disorder *(month and year noted)*
Toilet Trained at *(months):*	Diagnosed Medical Conditions *(i.e., allergies, asthma, bronchitis, etc.):*		

Attach Medical Passport and Do Not Complete if Immunizations, Diseases and Hospitals Information are Contained on Passport

IMMUNIZATIONS	Original Date:	Booster Date:	Booster Date:	Booster Date:
DPT				
Small Pox				
Polio				
Other:				
Measles				
Mumps				
Rubella				
Chicken Pox				
Whooping Cough				
Other:				
Comments:				

HOSPITALIZATIONS
Any Hospitalizations? (Reason, Date(s) and Place(s):

EVALUATIONS / EXAMINATIONS		
Please complete the following Type of Tests:	Date	Performed by:
Psychological Evaluations		
Psychiatric Evaluation		
Intellectual Assessment		
Developmental Evaluation *(Includes :Speech, Language, Hearing)*		
Physical Examination		
Neurological Evaluation		
OTHER:		

I hereby acknowledge receipt of a copy of this form.	Signature of Adoptive Parent 1:		Date:
	Signature of Adoptive Parent 2:		Date:
Name of Agency:			
Address (No. and Street)	City:	State:	Zip:
Agency Representative Name:	Agency Representative Signature		Date

Connecticut Department of Children and Families

ADOPTION PLACEMENT - CHILD DISCLOSURE

DCF-2248
1/19 (Rev.)

The information contained in this document shall not include any information that may identify the biological parents or the relatives of the child. Please arrange for a legal consult with your principal or staff attorney if you have any questions concerning the information that you may disclose to prospective adoptive parent.

DCF Office:		Meeting Date:
Child's FIRST Name (*Use ONLY the child's first name when meeting the pre-adoptive family*):	Gender:	Date Of Birth:
Current type of residence:		LINK#

Birth Information: (Any complications, etc.)

Child's Personality: (Give brief description of child's present functioning in his/her environment, child's strengths/weaknesses and behaviors & habits):

List any relevant information regarding the child's cultural, religious, sexual orientation, disability or identity issues:

Medical Information:

Education: (All regular education information should be given OR special education status and why. Include special considerations/programs/needs/testing result.)

Siblings: (Relationships/contact now & for future, visitation, etc. Provide the information in general terms. For example, the child has a sister who resides with the mother. The child enjoys visiting with his sister on a weekly basis):

Extended family/special people in child's life (other than biological parents): identify relatives in general terms. For example, state that there is a grandfather or aunt that the child has a special relationship with. Do not include information that could identify the relative of the child):

Placement History: (do not provide any identifying addresses of the parents or relatives):

CHILD'S TRAUMA / CHILD PROTECTIVE SERVICE HISTORY

Reason child came into DCF care:

Early parenting notes:

LEGAL
Current Legal Status:
Legal Risk discussion, if applicable. (Possible referral to child attorney, may be given):
Open Adoption, if applicable. (Give parameters of any agreement, legal or otherwise, or expectations of, give CAFAF information):
Standing Court Orders, if applicable:
Citizenship and/or Immigration issues pending, if applicable:
Current visitation and transportation arrangements:
SUBSIDY
Medical and why:
Financial / What are the certified special needs criteria:
Other services currently identified (What will be provided and by whom):

PERTINENT GENETIC PARENT INFORMATION

This section shall not include any information that would identify the biological parents. The histories should address the issues without providing identifying information. Discussion of extended family members should be in general terms. (For example, the child has two siblings, one brother and one sister residing with the maternal grandmother).

Discussion of the DCF-337 and DCF-338 (these forms should be completed ahead of the meeting and brought to the meeting. Medical, psychiatric, substance use diagnosis and history):

Family History:

Education History:

Extended family information, if known:

RESOURCE CHECKLIST

Please list resources that are available in the community to help new adoptive parents:

List what trainings might be helpful/available to adoptive parents:

MEETING PARTICIPANTS AND SIGNATURES

Social Worker LAST Name:	Social Worker FIRST Name:	SW Signature	Date
Social Work Supervisor LAST Name:	Social Work Supervisor FIRST Name:	SWS Signature	Date
Pre-Adoptive Parent #1 LAST Name:	Pre-Adoptive Parent #1 FIRST Name:	Pre-Adoptive Parent #1 Signature:	Date
Pre-Adoptive Parent #2 LAST Name:	Pre-Adoptive Parent #2 FIRST Name:	Pre-Adoptive Parent #2 Signature:	Date:
FASU or Private Agency SW LAST Name:	FASU or Private Agency SW FIRST Name:	FASU or Private Agency SW Signature:	Date:
Foster Parent #1 LAST Name:	Foster Parent #1 FIRST Name:	Foster Parent #1 Signature:	Date:
Foster Parent #2 LAST Name:	Foster Parent #2 FIRST Name:	Foster Parent #2 Signature:	Date:
Other LAST Name (if needed):	Other FIRST Name (if needed):	Signature:	Date:
Other LAST Name (if needed):	Other FIRST Name (if needed):	Signature:	Date:
Other LAST Name (if needed):	Other FIRST Name (if needed):	Signature:	Date: