

Office of Provider Management  
Caregiver Effort Declaration

This form may be submitted in lieu of a written statement from the caregiver to support an application for a Specialized Foster Care Per Diem or CPA Foster Parent Per Diem Waiver. The caregiver must complete the form.

| Date Completed: 7/25/24  |         | Agency Name or County Department: Elks Aidmore, Inc  |  |
|--|---------|--|--|
| Caregiver's Name: Katie Spaulding  |         | Caregiver's Phone or Email Address: (912) 713-7608 katie.spaulding@shps.com  |  |
| Child Information  |         |  |  |
| Child's Name: Breanna Baker  | Age: 12 | Considering the Child's Age, Check The Boxes Which Best Describe The Child:<br><input checked="" type="checkbox"/> Average Weight <input type="checkbox"/> Under Weight <input type="checkbox"/> Over Weight<br><input checked="" type="checkbox"/> Average Height <input type="checkbox"/> Below Average Height <input type="checkbox"/> Above Average Height |  |
| Based on your opinion, check the amount of care giving effort you believe is required to meet the child's needs :<br><input type="checkbox"/> Extremely High Effort <input type="checkbox"/> High Effort <input checked="" type="checkbox"/> Average Effort  |         |  |  |
| Approximate Number of Re-Occurring Monthly Appointments for The Child:<br><input type="checkbox"/> Less Than 2 Per Month <input checked="" type="checkbox"/> 3-5 Per Month <input type="checkbox"/> More Than 5 Per Month  |         |  |  |
| Average # of Miles Driven To Monthly Appointments: 40 miles not sure   |         | if employed outside of the home, please indicate the average number of days missed from work in a month to care for this child: 2  |  |
| Caregiver Assessment of Child's Needs  |         |  |  |
| Please check any boxes that apply. If a box is checked, provide supporting information or details. If the item does not apply, select N/A.   |         |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child is dependent upon medical support equipment including but not limited to a respirator, feeding pump or oxygen.<br>Check All That Apply: <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Feeding Tube <input type="checkbox"/> Tracheotomy <input type="checkbox"/> Oxygen <input type="checkbox"/> Ventilator <input type="checkbox"/> Suctioning <input type="checkbox"/> Respirator<br><input type="checkbox"/> Braces <input type="checkbox"/> Prosthetic <input type="checkbox"/> Crutches <input type="checkbox"/> Other _____<br>Describe: |         |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a life-threatening, acute/chronic <u>infectious</u> disease.<br>Describe:   |         |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a life-threatening, acute/chronic <u>non-infectious</u> disease.<br>Describe:   |         |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a terminal illness.<br>Describe:  |         |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a condition that requires ongoing administration of intravenous medication or nutrition support.<br>Describe:   |         |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a condition that requires intensive rehabilitation and/or developmental disability services.<br>Describe:   |         |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child is in a <input type="checkbox"/> full body cast, <input type="checkbox"/> partial body cast, <input type="checkbox"/> other type cast<br>Describe:  |         |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child requires regular range of motion stretching, atrophy avoidance exercising and/or physical repositioning.<br>Describe:   |         |  |  |
| <input type="checkbox"/> Other:  |         |  |  |
| Caregiver Home   |         |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Caregiver home or auto requires special adaptive equipment directly related to care of the above named child.<br>If so, what is needed and why?   |         |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Caregiver home requires additional electrical outlets or other such modifications directly related to care of the above named child.<br>If so, what is needed and why?  |         |  |  |

**Caregiver Family**

Describe the impact of caring for this child on your family (include any family or personal challenges, changes experienced whether negative or positive):

**Caregiver Assessment of Child's Independent Functioning (if the child is 5 years old or older, please complete this section.)**

**Check All of the Functions That The Child Can Perform**

- Takes Own Bath / Shower
- Puts On Clothes Without Assistance
- Feeds Self
- Washes Hands
- Brushes Teeth
- Performs Expected Hygiene Tasks Appropriate for Age
- Uses Toilet

Briefly Describe Any Age-Appropriate Self-Care Tasks That The Child Can Not Do:

**Caregiver Observation of Behaviors**

**Check All Behaviors Exhibited By The Child**

- Overanxious or Insecure
- Depressed or Extremely Sad
- Disturbed or Constantly Worried
- Nervous or Impulsive
- Failure To Thrive
- Eats Non-Food Items
- Hyperactive
- Sleeps Little
- Has Angry Outbursts
- Difficult to Bond With
- Starves Self
- Over-Eats
- Hits Others
- Self-Harms
- Disrespectful
- Chronically Lies
- Wets Bed
- Wets Self During the Day
- Has Bowel Movements Other than In the Toilet
- Smears Feces
- Cruelty to Animals
- Destroys Property
- Chronically Steals
- Runs Away
- Suicidal Behavior
- Homicidal Behavior
- Engages in Sexually Inappropriate Behavior
- Displays Psychotic Behavior
- Other \_\_\_\_\_

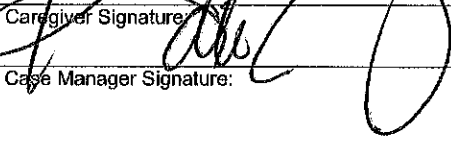
**Comments:**

Child has talked to younger girls at daycare about sexual experiences with brother (older) and brother's best friend or her best friends brother. She said she didn't tell them but how would the girls know this? the second day of daycare.

**Additional Caregiver Comments**

**Signatures**

This section must be signed by the Caregiver and DFCS Case Manager or CPA Case Support Worker.

Caregiver Signature: 

Case Manager Signature: \_\_\_\_\_

- This form is a true and accurate reflection of the child's current needs and my effort required to care for the child.
- I have reviewed and concur with the information provided.
- I have reviewed and do not concur with the information provided. Provide explanation:

Date: 7/25/24

Date: \_\_\_\_\_

\*Submit this form with a Specialized Foster Care or RBWO Program Designation/Walver Application.

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|  |        |  |  |
|--|--------|--|--|
| Date Completed: 7/25/24  |        | Agency Name or County Department: Elk's Admore, Inc  |  |
| Caregiver's Name: Kate Spaulding   |        | Caregiver's Phone or Email Address:  |  |
| <b>Child Information</b>   |        |  |  |
| Child's Name: Marshauna Phillips   | Age: 7 | Considering the Child's Age, Check The Boxes Which Best Describe The Child:<br><input type="checkbox"/> Average Weight <input checked="" type="checkbox"/> Under Weight <input type="checkbox"/> Over Weight (not sure - small frame)<br><input type="checkbox"/> Average Height <input type="checkbox"/> Below Average Height <input type="checkbox"/> Above Average Height |  |
| Based on your opinion, check the amount of care giving effort you believe is required to meet the child's needs :<br><input type="checkbox"/> Extremely High Effort <input checked="" type="checkbox"/> High Effort <input type="checkbox"/> Average Effort  |        |  |  |
| Approximate Number of Re-Occurring Monthly Appointments for The Child:<br><input type="checkbox"/> Less Than 2 Per Month <input checked="" type="checkbox"/> 3-5 Per Month <input type="checkbox"/> More Than 5 Per Month  |        |  |  |
| Average # of Miles Driven To Monthly Appointments: 40 miles - not sure   |        | If employed outside of the home, please indicate the average number of days missed from work in a month to care for this child: 2  |  |
| <b>Caregiver Assessment of Child's Needs</b>   |        |  |  |
| Please check any boxes that apply. If a box is checked, provide supporting information or details. If the item does not apply, select N/A.   |        |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child is dependent upon medical support equipment including but not limited to a respirator, feeding pump or oxygen.<br>Check All That Apply: <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Feeding Tube <input type="checkbox"/> Tracheotomy <input type="checkbox"/> Oxygen <input type="checkbox"/> Ventilator <input type="checkbox"/> Suctioning <input type="checkbox"/> Respirator<br><input type="checkbox"/> Braces <input type="checkbox"/> Prosthetic <input type="checkbox"/> Crutches <input type="checkbox"/> Other _____<br>Describe: |        |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a life-threatening, acute/chronic <u>infectious</u> disease.<br>Describe:   |        |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a life-threatening, acute/chronic <u>non-infectious</u> disease.<br>Describe:   |        |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a terminal illness.<br>Describe:  |        |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a condition that requires ongoing administration of intravenous medication or nutrition support.<br>Describe:   |        |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a condition that requires intensive rehabilitation and/or developmental disability services.<br>Describe:   |        |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child is in a <input type="checkbox"/> full body cast, <input type="checkbox"/> partial body cast, <input type="checkbox"/> other type cast<br>Describe:  |        |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child requires regular range of motion stretching, atrophy avoidance exercising and/or physical repositioning.<br>Describe:   |        |  |  |
| <input checked="" type="checkbox"/> Other: child does take Aderol meds for ADHD (Does NOT work)  |        |  |  |
| <b>Caregiver Home</b>  |        |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Caregiver home or auto requires special adaptive equipment directly related to care of the above named child.<br>If so, what is needed and why?   |        |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Caregiver home requires additional electrical outlets or other such modifications directly related to care of the above named child.<br>If so, what is needed and why?  |        |  |  |

**Caregiver Family**

Describe the impact of caring for this child on your family (Include any family or personal challenges, changes experienced whether negative or positive):

Mardawna is very easily distracted when trying to complete any task. She fights constantly with younger sister. They team up together and tells lies on each other. Never listen and always wants her way.

**Caregiver Assessment of Child's Independent Functioning (If the child is 5 years old or older, please complete this section.)**

Check All of the Functions That The Child Can Perform

- Takes Own Bath / Shower
- Puts On Clothes Without Assistance
- Feeds Self
- Washes Hands
- Brushes Teeth
- Performs Expected Hygiene Tasks Appropriate for Age
- Uses Toilet

Briefly Describe Any Age-Appropriate Self-Care Tasks That The Child Can Not Do:

**Caregiver Observation of Behaviors**

Check All Behaviors Exhibited By The Child

- Overanxious or Insecure
- Depressed or Extremely Sad
- Disturbed or Constantly Worried
- Nervous or Impulsive
- Failure To Thrive
- Eats Non-Food Items
- Hyperactive
- Sleeps Little
- Has Angry Outbursts
- Difficult to Bond With
- Starves Self
- Over-Eats
- Hits Others
- Self-Harms
- Disrespectful
- Chronically Lies
- Wets Bed
- Wets Self During the Day
- Has Bowel Movements Other than In the Toilet
- Smears Faces
- Cruelty to Animals
- Destroys Property
- Chronically Steals
- Runs Away
- Suicidal Behavior
- Homicidal Behavior
- Engages in Sexually Inappropriate Behavior
- Displays Psychotic Behavior
- Other \_\_\_\_\_

Comments:

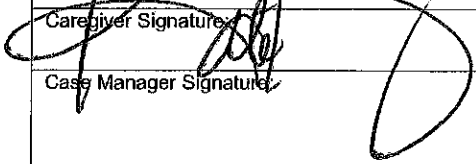

When sent to room alone because of acting out child will destroy items that is not hers and other things that she can destroy. She picks her skin until she bleeds for no apparent reason or have to sit quiet or alone.

**Additional Caregiver Comments**

Child does focus to draw and do word puzzles but will somehow get with younger sister to fight, jump on bed and just be destructive to others property. I think medication needs to be elevated to higher dose.

**Signatures**

This section must be signed by the Caregiver and DFCS Case Manager or CPA Case Support Worker.

|   |  |                 |
|---|--|-----------------|
| Caregiver Signature<br>     | <input checked="" type="checkbox"/> This form is a true and accurate reflection of the child's current needs and my effort required to care for the child.   | Date<br>7/25/24 |
| Case Manager Signature<br> | <input type="checkbox"/> I have reviewed and concur with the information provided.<br><input type="checkbox"/> I have reviewed and do not concur with the information provided. Provide explanation: | Date            |

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|  |           |  |  |
|--|-----------|--|--|
| Date Completed:<br>7/25/14   |           | Agency Name or County Department:<br>EK's Holmore Inc.   |  |
| Caregiver's Name:<br>Katie Spaulding   |           | Caregiver's Phone or Email Address:<br>912-713-7608 Katie.spaulding@ship8.com  |  |
| <b>Child Information</b>   |           |  |  |
| Child's Name:<br>Myana Phillips  | Age:<br>6 | Considering the Child's Age, Check The Boxes Which Best Describe The Child:<br><input type="checkbox"/> Average Weight <input type="checkbox"/> Under Weight <input checked="" type="checkbox"/> Over Weight (Not sure)<br><input type="checkbox"/> Average Height <input type="checkbox"/> Below Average Height <input type="checkbox"/> Above Average Height |  |
| Based on your opinion, check the amount of care giving effort you believe is required to meet the child's needs :<br><input type="checkbox"/> Extremely High Effort <input checked="" type="checkbox"/> High Effort <input type="checkbox"/> Average Effort  |           |  |  |
| Approximate Number of Re-Occurring Monthly Appointments for The Child:<br><input type="checkbox"/> Less Than 2 Per Month <input checked="" type="checkbox"/> 3-5 Per Month <input type="checkbox"/> More Than 5 Per Month  |           |  |  |
| Average # of Miles Driven To Monthly Appointments:<br>40 miles (not sure)  |           | If employed outside of the home, please indicate the average number of days missed from work in a month to care for this child: 2  |  |
| <b>Caregiver Assessment of Child's Needs</b>   |           |  |  |
| Please check any boxes that apply. If a box is checked, provide supporting information or details. If the item does not apply, select N/A.   |           |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child is dependent upon medical support equipment including but not limited to a respirator, feeding pump or oxygen.<br>Check All That Apply: <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Feeding Tube <input type="checkbox"/> Tracheotomy <input type="checkbox"/> Oxygen <input type="checkbox"/> Ventilator <input type="checkbox"/> Suctioning <input type="checkbox"/> Respirator<br><input type="checkbox"/> Braces <input type="checkbox"/> Prosthetic <input type="checkbox"/> Crutches <input type="checkbox"/> Other _____<br>Describe: |           |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a life-threatening, acute/chronic <u>infectious</u> disease.<br>Describe:   |           |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a life-threatening, acute/chronic <u>non-infectious</u> disease.<br>Describe:   |           |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a terminal illness.<br>Describe:  |           |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a condition that requires ongoing administration of Intravenous medication or nutrition support.<br>Describe:   |           |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child has a condition that requires intensive rehabilitation and/or developmental disability services.<br>Describe:   |           |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child is in a <input type="checkbox"/> full body cast, <input type="checkbox"/> partial body cast, <input type="checkbox"/> other type cast<br>Describe:  |           |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Child requires regular range of motion stretching, atrophy avoidance exercising and/or physical repositioning.<br>Describe:   |           |  |  |
| <input checked="" type="checkbox"/> Other: Child needs some type of medication to calm the behavior down   |           |  |  |
| <b>Caregiver Home</b>  |           |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Caregiver home or auto requires special adaptive equipment directly related to care of the above named child.<br>If so, what is needed and why?   |           |  |  |
| <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Caregiver home requires additional electrical outlets or other such modifications directly related to care of the above named child.<br>If so, what is needed and why?  |           |  |  |

Caregiver Family

Describe the impact of caring for this child on your family (include any family or personal challenges, changes experienced whether negative or positive):

Child talks but you can barely understand what is being said. She needs speech therapy. She does not understand to be quiet or sit still and is into everything. Fights constantly with sister. Does bad things and lie on sister. She tends to shut down if she is in trouble.

Caregiver Assessment of Child's Independent Functioning (If the child is 5 years old or older, please complete this section.)

Check All of the Functions That The Child Can Perform

- Takes Own Bath / Shower
- Puts On Clothes Without Assistance
- Feeds Self
- Washes Hands
- Brushes Teeth
- Performs Expected Hygiene Tasks Appropriate for Age
- Uses Toilet

Briefly Describe Any Age-Appropriate Self-Care Tasks That The Child Can Not Do:

Can take bath by self but needs to be assisted. Does not wash body appropriately. Will go in water and come right out. When eating food will go all over table, chair and floor. Food all over face and hand, she will not wipe off unless told to.

Caregiver Observation of Behaviors

Check All Behaviors Exhibited By The Child

- Overanxious or Insecure
- Depressed or Extremely Sad
- Disturbed or Constantly Worried
- Nervous or Impulsive
- Failure To Thrive
- Eats Non-Food Items
- Hyperactive
- Sleeps Little
- Has Angry Outbursts
- Difficult to Bond With
- Starves Self
- Over-Eats
- Hits Others
- Self-Harms
- Disrespectful
- Chronically Lies
- Wets Bed
- Wets Self During the Day
- Has Bowel Movements Other than In the Toilet
- Smears Feces
- Cruelty to Animals
- Destroys Property
- Chronically Steals
- Runs Away
- Suicidal Behavior
- Homicidal Behavior
- Engages in Sexually Inappropriate Behavior
- Displays Psychotic Behavior
- Other \_\_\_\_\_

Comments:

Child will pick skin when is told to sit in corner. She told older sister to call DFCS on me because she don't like rules. Very scary at night and wants night light.

Additional Caregiver Comments

Child can be very loud when sitting with siblings and always must have things her way. Daycare have to always stay on her because of acting out.

Signatures

This section must be signed by the Caregiver and DFCS Case Manager or CPA Case Support Worker.

Caregiver Signature:

*[Handwritten signature]*

This form is a true and accurate reflection of the child's current needs and my effort required to care for the child.

Date: 7/25/2011

Case Manager Signature:

I have reviewed and concur with the information provided.  
 I have reviewed and do not concur with the information provided. Provide explanation:

Date:

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