

Ohio Department of Job and Family Services
CHILD CHARACTERISTICS CHECKLIST FOR FOSTER CARE AND/OR ADOPTION
 Required for use with the JFS 01673

Name of Applicant # 1	Name of Applicant # 2	Date completed or updated
Address of Applicant(s)		Applicant's Phone: () -
Name of Representing Agency and/or Agent:		Phone: () -
Address of Representative and/or Agent:		FAX: () -

Instructions: Please print. Use the list below to let us know the type of child(ren) you would like to foster and/or adopt. Place an X in the appropriate box. If characteristics would be different for foster care than adoption, place an "A" for adoption and an "F" for foster care.

	Will consider	Will not consider
Gender/Sex of Child		
Female	<input type="checkbox"/>	<input type="checkbox"/>
Male	<input type="checkbox"/>	<input type="checkbox"/>
Age of Child		
Newborn/under 1	<input type="checkbox"/>	<input type="checkbox"/>
1	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	<input type="checkbox"/>
5	<input type="checkbox"/>	<input type="checkbox"/>
6	<input type="checkbox"/>	<input type="checkbox"/>
7	<input type="checkbox"/>	<input type="checkbox"/>
8	<input type="checkbox"/>	<input type="checkbox"/>
9	<input type="checkbox"/>	<input type="checkbox"/>
10	<input type="checkbox"/>	<input type="checkbox"/>
11	<input type="checkbox"/>	<input type="checkbox"/>
12	<input type="checkbox"/>	<input type="checkbox"/>
13	<input type="checkbox"/>	<input type="checkbox"/>
14	<input type="checkbox"/>	<input type="checkbox"/>
15	<input type="checkbox"/>	<input type="checkbox"/>
16	<input type="checkbox"/>	<input type="checkbox"/>
17	<input type="checkbox"/>	<input type="checkbox"/>
Over age 17	<input type="checkbox"/>	<input type="checkbox"/>
Number of Children/Siblings		
1	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	<input type="checkbox"/>
5 or more	<input type="checkbox"/>	<input type="checkbox"/>
Teen Parent with Child	<input type="checkbox"/>	<input type="checkbox"/>

	Will consider	Will not consider
Race/Ethnicity/Language of Child		
American Indian or Alaskan Native	<input type="checkbox"/>	<input type="checkbox"/>
Black or African American	<input type="checkbox"/>	<input type="checkbox"/>
White	<input type="checkbox"/>	<input type="checkbox"/>
Asian	<input type="checkbox"/>	<input type="checkbox"/>
Native Hawaiian or Other Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>
Biracial (2 of the races above must be selected)	<input type="checkbox"/>	<input type="checkbox"/>
Multiracial (3 or more of the races above must be selected)	<input type="checkbox"/>	<input type="checkbox"/>
Unable to determine (applies to deserted child or safe haven baby only)	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic or Latino Ethnicity	<input type="checkbox"/>	<input type="checkbox"/>
Non-English Speaking/specify language:	<input type="checkbox"/>	<input type="checkbox"/>
Placement History		
Child's first placement: no known behavior problems	<input type="checkbox"/>	<input type="checkbox"/>
Child's first placement: agency has no information on child	<input type="checkbox"/>	<input type="checkbox"/>
Child now in residential treatment	<input type="checkbox"/>	<input type="checkbox"/>
Child has had previous foster placement(s)	<input type="checkbox"/>	<input type="checkbox"/>
Child has had previous adoptive placement(s)	<input type="checkbox"/>	<input type="checkbox"/>
Birth History		
Low birth weight or premature	<input type="checkbox"/>	<input type="checkbox"/>
Fetal Alcohol Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Fetal Alcohol Effects	<input type="checkbox"/>	<input type="checkbox"/>
Positive toxicology screen at birth (one or more of the following: Cocaine, Amphetamines, Heroin, Morphine, Phencyclidine (PCP), Alcohol, Benzodiazepines, Hydromorphone, Marijuana, Propoxyphene, Methadone, Codeine)	<input type="checkbox"/>	<input type="checkbox"/>
Prenatal Drug Exposure (one or more of the following: Cocaine, Amphetamines, Heroin, Morphine, Phencyclidine (PCP), Alcohol, Benzodiazepines, Hydromorphone, Marijuana, Propoxyphene, Methadone, Codeine)	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction at Birth (heroin, methadone, morphine, or other)	<input type="checkbox"/>	<input type="checkbox"/>

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	Will consider	Will not consider
Developmental		
Mental Retardation: Mild	<input type="checkbox"/>	<input type="checkbox"/>
Mental Retardation: Moderate	<input type="checkbox"/>	<input type="checkbox"/>
Mental Retardation: Severe/Profound	<input type="checkbox"/>	<input type="checkbox"/>
Failure to Thrive (organic or environmental)	<input type="checkbox"/>	<input type="checkbox"/>
Speech Problems: Mild/may require therapy	<input type="checkbox"/>	<input type="checkbox"/>
Speech Problems: Moderate/requires therapy	<input type="checkbox"/>	<input type="checkbox"/>
Speech Problems: Severe/requires therapy	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment/Not Deaf: Mild	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment/Not Deaf: Moderate/Requires treatment	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment/Not Deaf: Severe/Requires treatment	<input type="checkbox"/>	<input type="checkbox"/>
Deaf	<input type="checkbox"/>	<input type="checkbox"/>
Visually Impaired/Not Blind: Mild/requires treatment	<input type="checkbox"/>	<input type="checkbox"/>
Visually Impaired/Not Blind: Moderate/requires treatment	<input type="checkbox"/>	<input type="checkbox"/>
Visually Impaired/Not Blind: Severe/requires treatment	<input type="checkbox"/>	<input type="checkbox"/>
Blind	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic Impairment: Requires special shoes	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic Impairment: Requires leg brace	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic Impairment: Requires other treatment	<input type="checkbox"/>	<input type="checkbox"/>
Dental		
Dental Problems (may include tooth decay, missing teeth, crowded or misaligned teeth, overbite, under bite)	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontia required	<input type="checkbox"/>	<input type="checkbox"/>
Allergies and Respiratory Problems		
Allergies: Food	<input type="checkbox"/>	<input type="checkbox"/>
Allergies: Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Allergies: Environmental	<input type="checkbox"/>	<input type="checkbox"/>
Asthma: No treatment required	<input type="checkbox"/>	<input type="checkbox"/>
Asthma: Treatment required	<input type="checkbox"/>	<input type="checkbox"/>
Other Medical Conditions		
Attention Deficit Hyperactivity Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Disorder (ADD)	<input type="checkbox"/>	<input type="checkbox"/>
Juvenile Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: In remission	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: Requires treatment	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy: Mild	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy: Moderate	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy: Severe	<input type="checkbox"/>	<input type="checkbox"/>
Cleft lip/palate (may require surgery)	<input type="checkbox"/>	<input type="checkbox"/>
Cleft lip/palate (already corrected)	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis: Mild	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis: Moderate	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis: Severe	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: Insulin-dependent	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: Non-insulin dependent	<input type="checkbox"/>	<input type="checkbox"/>
Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disorder: Minor (may need surgery)	<input type="checkbox"/>	<input type="checkbox"/>

	Will consider	Will not consider
Other Medical Conditions (continued)		
Heart Disorder: Major (may need surgery)	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (may require treatment)	<input type="checkbox"/>	<input type="checkbox"/>
Family history of Huntington's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hydrocephaly	<input type="checkbox"/>	<input type="checkbox"/>
Lead Poisoning (may require treatment)	<input type="checkbox"/>	<input type="checkbox"/>
Lice (may require treatment)	<input type="checkbox"/>	<input type="checkbox"/>
Chronic liver disease (may require	<input type="checkbox"/>	<input type="checkbox"/>
Macrocephalic	<input type="checkbox"/>	<input type="checkbox"/>
Microcephalic	<input type="checkbox"/>	<input type="checkbox"/>
Missing limb(s) (may require prosthesis)	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>
Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Previous Pregnancy(ies)	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder (other than Epilepsy)	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
History of sexually transmitted disease (syphilis, gonorrhea, herpes simplex II, chlamydia, other)	<input type="checkbox"/>	<input type="checkbox"/>
Currently has sexually transmitted disease (syphilis, gonorrhea, herpes simplex II, chlamydia, other)	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Trait	<input type="checkbox"/>	<input type="checkbox"/>
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Tuberous Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Previous Medical Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>
Previous Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Medication		
Requires daily medication for one or more conditions	<input type="checkbox"/>	<input type="checkbox"/>
Requires Specialized Care		
Non-Ambulatory	<input type="checkbox"/>	<input type="checkbox"/>
Physically Disabled	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy: Short-term	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy: Long-term	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy: Short-term	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy: Long-term	<input type="checkbox"/>	<input type="checkbox"/>
Requires Intermittent Medical Treatment & Evaluation	<input type="checkbox"/>	<input type="checkbox"/>
Requires Specialized In-Home Care		
Tracheotomy	<input type="checkbox"/>	<input type="checkbox"/>
Naso-gastric tube	<input type="checkbox"/>	<input type="checkbox"/>
Gastric tube	<input type="checkbox"/>	<input type="checkbox"/>
Apnea monitor	<input type="checkbox"/>	<input type="checkbox"/>
Nebulizer	<input type="checkbox"/>	<input type="checkbox"/>
Requires Lifelong Medical Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Requires Lifelong Supervision	<input type="checkbox"/>	<input type="checkbox"/>
Limited Life Expectancy		
Terminally Ill (life expectancy less than 1 yr.)	<input type="checkbox"/>	<input type="checkbox"/>
Limited life expectancy due to chronic illness or disabling condition	<input type="checkbox"/>	<input type="checkbox"/>

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Sleeping Problems		
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>
Afraid of sleeping in the dark	<input type="checkbox"/>	<input type="checkbox"/>
Afraid of the dark	<input type="checkbox"/>	<input type="checkbox"/>
Sleep walking	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting (Enuresis – over 5 years of age, at night)	<input type="checkbox"/>	<input type="checkbox"/>
Soils bed at night (Encopresis)	<input type="checkbox"/>	<input type="checkbox"/>
Dietary or Eating Problems		
Requires special diet	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia (may require treatment)	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia (may require treatment)	<input type="checkbox"/>	<input type="checkbox"/>
Pica	<input type="checkbox"/>	<input type="checkbox"/>
Hoarding food	<input type="checkbox"/>	<input type="checkbox"/>
Overeating	<input type="checkbox"/>	<input type="checkbox"/>
MENTAL / EMOTIONAL HEALTH		
Requires or is currently in counseling/therapy	<input type="checkbox"/>	<input type="checkbox"/>
Refuses counseling/therapy or medication	<input type="checkbox"/>	<input type="checkbox"/>
Previous psychiatric hospitalization	<input type="checkbox"/>	<input type="checkbox"/>
Has Mental Health Diagnosis		
Adjustment disorder	<input type="checkbox"/>	<input type="checkbox"/>
Autism or Asperger's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Bi-polar disorder	<input type="checkbox"/>	<input type="checkbox"/>
Conduct disorder	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Intermittent explosive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional Defiant Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia or other psychotic disorder	<input type="checkbox"/>	<input type="checkbox"/>
Reactive Attachment Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Post-Traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Requires medication for psychiatric disorder / mental health problem	<input type="checkbox"/>	<input type="checkbox"/>
Education / Preschool Child		
Requires Early Intervention Services for developmental delay	<input type="checkbox"/>	<input type="checkbox"/>
Attends Head Start	<input type="checkbox"/>	<input type="checkbox"/>
Attends Therapeutic Head Start	<input type="checkbox"/>	<input type="checkbox"/>
Education / School Age Child		
High Achiever	<input type="checkbox"/>	<input type="checkbox"/>
Achieves at grade level in regular classes	<input type="checkbox"/>	<input type="checkbox"/>
Achieves at below grade level in regular classes	<input type="checkbox"/>	<input type="checkbox"/>
Child struggles with school	<input type="checkbox"/>	<input type="checkbox"/>
Child has repeated grade	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Functioning: Above Average	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Functioning: Average	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Functioning: Below Average	<input type="checkbox"/>	<input type="checkbox"/>
Has Behavior Problems in School: Occasionally	<input type="checkbox"/>	<input type="checkbox"/>
Has Behavior Problems in School: Frequently	<input type="checkbox"/>	<input type="checkbox"/>
Academic Problems: Occasionally	<input type="checkbox"/>	<input type="checkbox"/>
Academic Problems: Frequently	<input type="checkbox"/>	<input type="checkbox"/>
Needs Tutoring in One or More Subjects	<input type="checkbox"/>	<input type="checkbox"/>
Child May Require Educational Testing	<input type="checkbox"/>	<input type="checkbox"/>

	Will consider	Will not consider
Education / School Age Child (cont'd.)		
Truancy	<input type="checkbox"/>	<input type="checkbox"/>
Suspension(s)	<input type="checkbox"/>	<input type="checkbox"/>
Expulsion(s)	<input type="checkbox"/>	<input type="checkbox"/>
Academically Behind Due to Poor Attendance	<input type="checkbox"/>	<input type="checkbox"/>
Child is involved in after school activities (sports, dance, clubs, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Child is in alternative school for emotional, developmental, psychological, or behavior problems	<input type="checkbox"/>	<input type="checkbox"/>
Special Education		
Child is in or requires special education classes for:		
Cognitive disability (Developmental Handicap/DH)	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Disturbance (Severe Emotional Disability, SBH)	<input type="checkbox"/>	<input type="checkbox"/>
Specific Learning Disability (Dyslexia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment/deafness	<input type="checkbox"/>	<input type="checkbox"/>
Speech or Language Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Visual Impairment/blindness	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>
Deaf-blind	<input type="checkbox"/>	<input type="checkbox"/>
Other Health Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Disabilities (2 or more of above disabilities)	<input type="checkbox"/>	<input type="checkbox"/>
Temperament and Personality		
Shy	<input type="checkbox"/>	<input type="checkbox"/>
Energetic	<input type="checkbox"/>	<input type="checkbox"/>
Sweet	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawn, tunes out	<input type="checkbox"/>	<input type="checkbox"/>
Quiet	<input type="checkbox"/>	<input type="checkbox"/>
Responsible	<input type="checkbox"/>	<input type="checkbox"/>
Bold	<input type="checkbox"/>	<input type="checkbox"/>
Respectful/courteous	<input type="checkbox"/>	<input type="checkbox"/>
Timid	<input type="checkbox"/>	<input type="checkbox"/>
Anxious	<input type="checkbox"/>	<input type="checkbox"/>
Honest	<input type="checkbox"/>	<input type="checkbox"/>
Positive Attitude	<input type="checkbox"/>	<input type="checkbox"/>
Resourceful	<input type="checkbox"/>	<input type="checkbox"/>
Outgoing and Social	<input type="checkbox"/>	<input type="checkbox"/>
Pleasant	<input type="checkbox"/>	<input type="checkbox"/>
Calm/laid back	<input type="checkbox"/>	<input type="checkbox"/>
Eager to Please	<input type="checkbox"/>	<input type="checkbox"/>
Reserved	<input type="checkbox"/>	<input type="checkbox"/>
Active	<input type="checkbox"/>	<input type="checkbox"/>
Overactive	<input type="checkbox"/>	<input type="checkbox"/>
Boisterous	<input type="checkbox"/>	<input type="checkbox"/>
Bossy	<input type="checkbox"/>	<input type="checkbox"/>
Attention Seeking	<input type="checkbox"/>	<input type="checkbox"/>
Compulsive	<input type="checkbox"/>	<input type="checkbox"/>

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	Will consider	Will not consider
Behaviors and Characteristics		
Head banging	<input type="checkbox"/>	<input type="checkbox"/>
Rocking	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to reject father figures	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to reject mother figures	<input type="checkbox"/>	<input type="checkbox"/>
Follows adult directions	<input type="checkbox"/>	<input type="checkbox"/>
Tends to form superficial relationships	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in attaching	<input type="checkbox"/>	<input type="checkbox"/>
Not affectionate	<input type="checkbox"/>	<input type="checkbox"/>
Fearful	<input type="checkbox"/>	<input type="checkbox"/>
Overly dependent	<input type="checkbox"/>	<input type="checkbox"/>
Manipulative	<input type="checkbox"/>	<input type="checkbox"/>
Stubborn	<input type="checkbox"/>	<input type="checkbox"/>
Defiant	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty making friends and relating with other children	<input type="checkbox"/>	<input type="checkbox"/>
Wets during the day	<input type="checkbox"/>	<input type="checkbox"/>
Soils him/herself during the day	<input type="checkbox"/>	<input type="checkbox"/>
Temper Tantrums: Mild	<input type="checkbox"/>	<input type="checkbox"/>
Temper Tantrums: Moderate	<input type="checkbox"/>	<input type="checkbox"/>
Temper Tantrums: Severe	<input type="checkbox"/>	<input type="checkbox"/>
Poor social skills	<input type="checkbox"/>	<input type="checkbox"/>
Child can be disruptive in social settings	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty accepting and obeying rules	<input type="checkbox"/>	<input type="checkbox"/>
Masturbation: Occasionally	<input type="checkbox"/>	<input type="checkbox"/>
Masturbation: Frequently	<input type="checkbox"/>	<input type="checkbox"/>
Masturbation: Past	<input type="checkbox"/>	<input type="checkbox"/>
Masturbation: Private	<input type="checkbox"/>	<input type="checkbox"/>
Masturbation: Public	<input type="checkbox"/>	<input type="checkbox"/>
Biting	<input type="checkbox"/>	<input type="checkbox"/>
Lying	<input type="checkbox"/>	<input type="checkbox"/>
Stealing	<input type="checkbox"/>	<input type="checkbox"/>
Frequently starts physical fights with other children	<input type="checkbox"/>	<input type="checkbox"/>
Physically aggressive toward other children	<input type="checkbox"/>	<input type="checkbox"/>
Physically aggressive toward adults	<input type="checkbox"/>	<input type="checkbox"/>
Gang Involvement (past)	<input type="checkbox"/>	<input type="checkbox"/>
Gang Involvement (present)	<input type="checkbox"/>	<input type="checkbox"/>
Self-abusive, self-harming	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts or attempts	<input type="checkbox"/>	<input type="checkbox"/>
Poor anger management	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use and Abuse		
Smokes cigarettes	<input type="checkbox"/>	<input type="checkbox"/>
Chews tobacco	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>
Other substance abuse	<input type="checkbox"/>	<input type="checkbox"/>
Requires or has completed treatment program for substance abuse	<input type="checkbox"/>	<input type="checkbox"/>
Other Behaviors		
Runaway: Occasionally	<input type="checkbox"/>	<input type="checkbox"/>
Runaway: Frequently	<input type="checkbox"/>	<input type="checkbox"/>
Runaway: Past	<input type="checkbox"/>	<input type="checkbox"/>
Breaks curfew	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to abuse animals	<input type="checkbox"/>	<input type="checkbox"/>
Destructive of: Clothing, toys	<input type="checkbox"/>	<input type="checkbox"/>
Destructive of: Household property	<input type="checkbox"/>	<input type="checkbox"/>
Destructive of: School or other public property	<input type="checkbox"/>	<input type="checkbox"/>

	Will consider	Will not consider
Other Behaviors (continued)		
Uses foul language	<input type="checkbox"/>	<input type="checkbox"/>
Child involved in group or activity that physically sets itself apart from the mainstream and focuses on negative or deviant themes	<input type="checkbox"/>	<input type="checkbox"/>
Child obsessed with guns, knives, explosives, or other destructive devices or themes	<input type="checkbox"/>	<input type="checkbox"/>
Currently plays with matches/lighters	<input type="checkbox"/>	<input type="checkbox"/>
Fire setting	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Behavior		
Sexually active	<input type="checkbox"/>	<input type="checkbox"/>
Seductive	<input type="checkbox"/>	<input type="checkbox"/>
History of inappropriate sexual behavior	<input type="checkbox"/>	<input type="checkbox"/>
Child involved in prostitution	<input type="checkbox"/>	<input type="checkbox"/>
Known sexual perpetrator	<input type="checkbox"/>	<input type="checkbox"/>
Sexual offender (juvenile adjudication)	<input type="checkbox"/>	<input type="checkbox"/>
Sexual perpetrator who has successfully completed treatment	<input type="checkbox"/>	<input type="checkbox"/>
Child at risk for offending sexual behaviors	<input type="checkbox"/>	<input type="checkbox"/>
Child has initiated sexual behavior toward other children or adults	<input type="checkbox"/>	<input type="checkbox"/>
Sexually acting out behavior (may include frequent masturbation, exposing or frequent touching of genitals, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Child has an alternative sexual orientation (may include homosexual, bisexual or transgender lifestyles)	<input type="checkbox"/>	<input type="checkbox"/>
Juvenile Court Involvement		
Unruly adjudication	<input type="checkbox"/>	<input type="checkbox"/>
Theft: Past conviction or current charges	<input type="checkbox"/>	<input type="checkbox"/>
Breaking curfew: Past conviction or current charges	<input type="checkbox"/>	<input type="checkbox"/>
Domestic violence: Past conviction or current charges	<input type="checkbox"/>	<input type="checkbox"/>
Cruelty to animals: Past conviction or current charges	<input type="checkbox"/>	<input type="checkbox"/>
Crime using a weapon: Past conviction or current charges	<input type="checkbox"/>	<input type="checkbox"/>
Other delinquency adjudication(s)	<input type="checkbox"/>	<input type="checkbox"/>
Previously Incarcerated	<input type="checkbox"/>	<input type="checkbox"/>
Currently incarcerated	<input type="checkbox"/>	<input type="checkbox"/>
Registered sex offender	<input type="checkbox"/>	<input type="checkbox"/>
Court order for restitution	<input type="checkbox"/>	<input type="checkbox"/>
Court order for child support	<input type="checkbox"/>	<input type="checkbox"/>
Child is on probation	<input type="checkbox"/>	<input type="checkbox"/>
Child is on parole	<input type="checkbox"/>	<input type="checkbox"/>
Child has participated in Court diversion program(s)	<input type="checkbox"/>	<input type="checkbox"/>
Child has had serious on-going involvement with Juvenile Court for delinquent or assaulting behaviors in the past 2 years	<input type="checkbox"/>	<input type="checkbox"/>
Current or Previous Charge or Conviction(s)		
Aggravated murder	<input type="checkbox"/>	<input type="checkbox"/>
Murder	<input type="checkbox"/>	<input type="checkbox"/>
Involuntary manslaughter	<input type="checkbox"/>	<input type="checkbox"/>
Felonious assault	<input type="checkbox"/>	<input type="checkbox"/>
Aggravated assault	<input type="checkbox"/>	<input type="checkbox"/>
Assault	<input type="checkbox"/>	<input type="checkbox"/>

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	Will consider	Will not consider
Current or Previous Charge or Conviction(s)		
Rape	<input type="checkbox"/>	<input type="checkbox"/>
Sexual battery	<input type="checkbox"/>	<input type="checkbox"/>
Gross sexual imposition	<input type="checkbox"/>	<input type="checkbox"/>
Conspiracy to commit aggravated murder or murder	<input type="checkbox"/>	<input type="checkbox"/>
Use or possession of a firearm or body armor in an offense that would be considered a felony if committed by an adult.	<input type="checkbox"/>	<input type="checkbox"/>
Family History		
Child has strong ties to birth family	<input type="checkbox"/>	<input type="checkbox"/>
Child needs continued contact with parents	<input type="checkbox"/>	<input type="checkbox"/>
Child needs continued contact with siblings	<input type="checkbox"/>	<input type="checkbox"/>
Child needs continued contact with other relatives	<input type="checkbox"/>	<input type="checkbox"/>
Child has strong ties to foster family and needs continued contact	<input type="checkbox"/>	<input type="checkbox"/>
Child has strong ties to a non-related significant other and needs continued contact	<input type="checkbox"/>	<input type="checkbox"/>
Sexually abused: Indirect	<input type="checkbox"/>	<input type="checkbox"/>
Sexually abused: Direct	<input type="checkbox"/>	<input type="checkbox"/>
Physically abused	<input type="checkbox"/>	<input type="checkbox"/>
Psychologically or emotionally abused	<input type="checkbox"/>	<input type="checkbox"/>
Child victim of physical neglect	<input type="checkbox"/>	<input type="checkbox"/>
Child victim of emotional neglect	<input type="checkbox"/>	<input type="checkbox"/>
Child exposed to domestic violence	<input type="checkbox"/>	<input type="checkbox"/>
Child conceived as a result of rape	<input type="checkbox"/>	<input type="checkbox"/>
Child conceived as a result of prostitution	<input type="checkbox"/>	<input type="checkbox"/>
Child conceived as a result of incest	<input type="checkbox"/>	<input type="checkbox"/>
Incest family history	<input type="checkbox"/>	<input type="checkbox"/>
Criminal record	<input type="checkbox"/>	<input type="checkbox"/>
History of one or both parents		
Child exposed to mental illness by other than family member	<input type="checkbox"/>	<input type="checkbox"/>
One or both parents have mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
Family history of domestic violence	<input type="checkbox"/>	<input type="checkbox"/>
Child exposed to domestic violence by other than family member	<input type="checkbox"/>	<input type="checkbox"/>

	Will consider	Will not consider
History of one or both parents		
One or both parents have alcohol addiction	<input type="checkbox"/>	<input type="checkbox"/>
One or both parents have drug addiction	<input type="checkbox"/>	<input type="checkbox"/>
Mother used alcohol during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Mother used drugs during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Agency has no information about the birth father	<input type="checkbox"/>	<input type="checkbox"/>
Agency has no information about either parent (i.e. 'safe haven' baby)	<input type="checkbox"/>	<input type="checkbox"/>
One or both parents have criminal record	<input type="checkbox"/>	<input type="checkbox"/>
One or both parents have diagnosed mental illness		
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Bi-polar disorder	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
Borderline personality disorder	<input type="checkbox"/>	<input type="checkbox"/>
Other personality disorder	<input type="checkbox"/>	<input type="checkbox"/>
Intermittent explosive disorder	<input type="checkbox"/>	<input type="checkbox"/>
FOSTER/ADOPTIVE PARENT INVOLVEMENT W/BIRTH FAMILY		
Foster/Adoptive Parent is willing to:		
Meet birth parents	<input type="checkbox"/>	<input type="checkbox"/>
Have contact with birth parents through agency or intermediary	<input type="checkbox"/>	<input type="checkbox"/>
Send letters to birth parent	<input type="checkbox"/>	<input type="checkbox"/>
Receive letters from birth parents	<input type="checkbox"/>	<input type="checkbox"/>
Send videos to birth parents	<input type="checkbox"/>	<input type="checkbox"/>
Receive videos from birth parents	<input type="checkbox"/>	<input type="checkbox"/>
Have phone contact between adults	<input type="checkbox"/>	<input type="checkbox"/>
Have child continue visits with siblings	<input type="checkbox"/>	<input type="checkbox"/>
Have child continue visits with extended relatives in birth family	<input type="checkbox"/>	<input type="checkbox"/>
Receive birth parents' name, address, phone number, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Give birth parents the foster caregiver's or adoptive parent's first name	<input type="checkbox"/>	<input type="checkbox"/>
Give birth parents foster/adoptive family identifying information	<input type="checkbox"/>	<input type="checkbox"/>

Adoptive/Foster Parent Statement of Understanding

I/we understand that I/we will not be considered for matching with any child with a characteristic outside the criteria noted on this checklist. I/we understand that the agency will place children based on characteristics known to the agency at the time of placement. I/we also understand that I/we may revise this checklist at any time by contacting my/our adoption or foster home worker.

Adoptive/Foster Parent's Signature	Date
Adoptive/Foster Parent's Signature	Date

Assessor's Signature	Date
Supervisor's Signature	Date