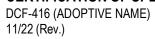
Department of Children and Families CERTIFICATION OF SPECIAL NEEDS STATUS

DCF-416 (BIO NAME) 11/22 (Rev.)



Child's BIO LAST Name:		Child's BIO FIRST Name:	DOB:	B: Gender:			Date of Commitment				
	(D: (A //(A // //)		-			l = a · · ·					
Name of	f Private Agency (If Applicable)		Race:			Ethnicity:					
Address: (No. and Street)			City		State		Zip				
Chack	α All that Annly and Evnlain	Relow (nlease attach docum	entation where indicated):								
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:											
	-		T				T-				
Recomm	mended by LAST :Name:	FIRST Name:	Signature:				Date				
	II. BOLLAGEN	DO FIDOT N					D (
Approve	ed by PS LAST Name:	PS FIRST Name:	PS Signature:				Date				

Department of Children and Families CERTIFICATION OF SPECIAL NEEDS STATUS





Child's ADOPTIVE LAST Name:		Child's ADOPT. FIRST Name:	DOB:	Gender:			Date of Commitment			
Name of Private Agency (If Applicable)			Race: Ethnic			Ethnicity:				
Address: (No. and Street)			City		State		Zip			
Check A	II that Apply and Explain	Below (please attach docum	entation where	indicated):						
	Physical disability (or high risk of nade by a licensed physician.	such disability) which presents a bar	rier to adoption. A	written diagno	sis and recon	nmendation	for treatment must be			
M	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.									
☐ S	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.									
R	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.									
Т	he child has established significa	ant emotional ties with prospective ac	doptive parents.							
Explanation:										
Recommer	nded by LAST :Name:	FIRST Name:	Signature:				Date			
Approved b	by PS LAST Name:	PS FIRST Name:	PS Signature:				Date			