Department of Children and Families
CERTIFICATION OF SPECIAL NEEDS STATUS
DCF-416
1/19 (Rev.)

Child's LAST Name:	Child's FIRST Name:	DOB:	Gender: Please Select One	Date of Commitment

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

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