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## Vermont Permanency Survey

Learning from families formed through  
adoption and guardianship



## SECTION A. About Your Family

To begin, we would like to ask you a few questions about your family.

<b>A1. How many adult caregivers, including yourself, live in your household?</b>	<input type="text"/>	Number of adult caregivers
<b>A2. How many children under the age of 21 do you currently have?</b> (Please include biological, adoptive, foster, and step children, or any other child that depends on you for support)	<input type="text"/>	Total number of children under 21 years old
<b>A3. How many of your children under the age of 21 live in your household?</b>	<input type="text"/>	Total number of children in household
<b>A4. How many of your children under the age of 21 are...?</b>	<input type="text"/>	Biological children
	<input type="text"/>	Adopted children from a public child welfare agency/ foster care
	<input type="text"/>	Adopted children through a private domestic agency
	<input type="text"/>	Adopted children through a private agency that facilitated an intercountry/international adoption
	<input type="text"/>	Adopted children who are step children
	<input type="text"/>	Adopted children who were adopted from another state's child welfare system/foster care
		-> List state <input type="text"/>
	<input type="text"/>	Children in your legal guardianship
	<input type="text"/>	Children in foster care
	<input type="text"/>	Children in kinship care
	<input type="text"/>	Step Children who are not adopted but in your home through marriage, civil union, or a domestic partnership with your partner or spouse
	<input type="text"/>	Other <input type="text"/>

## SECTION B. Relationship to Child



Included in the packet is a cover sheet that contains the name of one child for whom you receive an Adoption Assistance Agreement or Guardianship Agreement (also called a Subsidy Agreement) from the State of Vermont. We will refer to this child as **Identified Child**. If you do not have this sheet, please contact Christina Shuma, Site Implementation Manager at (802) 764-7467 X2011 or by email at [christinas@lundvt.org](mailto:christinas@lundvt.org).

Please answer the following questions about your **Identified Child** listed on the cover sheet.

<b>B1. In what month and year was your child born?</b>	<input style="width: 50px; height: 20px;" type="text"/> / <input style="width: 50px; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MM</span> <span>YYYY</span> </div>
<b>B2. What is your child's gender?</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
<b>B3. Did you adopt your child or assume guardianship?</b>	<input type="checkbox"/> Adopted <input type="checkbox"/> Guardianship
<b>B4. Is your child of Hispanic/Latino origin, or is your child not of Hispanic/Latino origin?</b>	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino
<b>B5. What is your child's race? (Check all that apply)</b>	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American/African <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White/Caucasian
<b>B6. What is your child's nationality?</b>	<input style="width: 100%; height: 20px;" type="text"/>
<b>B7. Does your child consider him or herself to be:</b>	<input type="checkbox"/> Heterosexual or straight <input type="checkbox"/> Gay or lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> I am unsure
<b>B8. In what year was the adoption finalized?</b>	<input style="width: 50px; height: 20px;" type="text"/> YYYY
<b>B9. What agency assisted you with your adoption?</b>	<input style="width: 100%; height: 20px;" type="text"/>
<b>B10. Are you biologically related to your child, or are you not biologically related to your child?</b>	<input type="checkbox"/> Biologically related <input type="checkbox"/> Not biologically related- <b>Go to B10</b>

Complete if you are biologically related:	B10a. What is your biological relationship to your child?	<input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Sibling <input type="checkbox"/> Cousin <input type="checkbox"/> Other relative: <input type="text"/>
	B10b. Are you biologically related to your child through his or her birth mother or birth father?	<input type="checkbox"/> Through birth mother <input type="checkbox"/> Through birth father
B11. Did you have a significant relationship with your child prior to when this child was removed from his/her birth parent's home?		<input type="checkbox"/> Had prior relationship <input type="checkbox"/> Did not have prior relationship
B12. Did you foster your child prior to adoption or guardianship?		<input type="checkbox"/> Yes <input type="checkbox"/> No
B13. Prior to adoption or guardianship, how long did your child live with you in your home?		<input type="text"/> Years (Enter 0 if less than 1)
B14. How old was your child when you finalized the adoption or guardianship?		<input type="text"/> Years (Enter 0 if less than 1)
B15. Do your child's biological siblings live with you?		<input type="checkbox"/> Yes <input type="checkbox"/> No, there are no biological siblings →Go to B16 <input type="checkbox"/> No biological siblings live with us →Go to B16
Complete if your child's biological sibling(s) live with you	B15a. How many biological siblings live with you?	<input type="text"/> Number of siblings
	B15b. Do <u>ALL</u> your child's biological siblings live with you?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
B16. Had your child ever previously been adopted or in legal guardianship?		<input type="checkbox"/> Had previously been adopted or in guardianship <input type="checkbox"/> Had not previously been adopted or in guardianship <input type="checkbox"/> Don't know
B17. If your adoption was approved after July 1, 2015 do you have a Post Adoption Contact Agreement registered with Probate Court?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

## SECTION C. Family Wellbeing

In completing this section, you will help us better understand family wellbeing and the challenges faced by parents and guardians caring for a child in Vermont. You will be asked to answer questions about your family’s strengths, challenges, parenting, and your relationship to your **Identified Child**.

### Family Relationships

**C1. Please check the box that describes how often each statement is true for you or your family.**

	Never	Very rarely	Rarely	Half the time	Frequently	Very frequently	Always
In my family, we talk about problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When we argue, my family listens to “both sides of the story.”	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In my family, we take time to listen to each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My family pulls together when things are stressful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My family is able to solve our problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Parenting

**C2. Please read each statement below. Check the response that best describes how much you disagree or agree with each statement. When answering question about your child, please refer to your Identified Child**

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
There are many times when I don’t know what to do as a parent.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to help my child learn.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child misbehaves just to upset me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C3. Please tell us how often each of the following happens in your family. Think about your Identified Child when answering each question. Check the response that best fits how often each statement occurs.**

	Never	Very rarely	Rarely	Half the time	Frequently	Very frequently	Always
I praise my child when he/she behaves well.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When I discipline my child, I lose control.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am happy being with my child.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child and I are very close to each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am able to soothe my child when he/she is upset.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I spend time with my child doing what he/she likes to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Next, please answer the following questions about parenting your child (**Identified Child**).

<b>C4. During the past month, how often have you felt that you just did not understand your child?</b>	<input type="checkbox"/> Every day <input type="checkbox"/> A few times a week <input type="checkbox"/> Once a week <input type="checkbox"/> Less than once a week <input type="checkbox"/> Never
<b>C5. How confident are you that your family can meet your child's needs?</b>	<input type="checkbox"/> Extremely confident <input type="checkbox"/> Very confident <input type="checkbox"/> Somewhat confident <input type="checkbox"/> Slightly confident <input type="checkbox"/> Not at all confident <input type="checkbox"/> <i>Don't know</i>
<b>C6. How would you describe your relationship to your child over the past 6 months?</b>	<input type="checkbox"/> Has gotten better <input type="checkbox"/> About the same <input type="checkbox"/> Has gotten worse <input type="checkbox"/> <i>Don't know</i>

The next few questions ask you to think about the overall impact of adoption or guardianship of your child on your family. Please think about your Identified Child as you answer each question.

<b>C7. Overall, how would you rate the impact of your child's adoption or guardianship on your family?</b>							
	<input type="checkbox"/> Extremely positive	<input type="checkbox"/> Moderately positive	<input type="checkbox"/> Slightly positive	<input type="checkbox"/> Neither positive nor negative	<input type="checkbox"/> Slightly negative	<input type="checkbox"/> Moderately negative	<input type="checkbox"/> Extremely negative
<b>C8. Overall, how do you think your spouse, partner, or other adult caring for your child would rate the impact of your child's adoption or guardianship on your family?</b>							
N/A	<input type="checkbox"/> Extremely positive	<input type="checkbox"/> Moderately positive	<input type="checkbox"/> Slightly positive	<input type="checkbox"/> Neither positive nor negative	<input type="checkbox"/> Slightly negative	<input type="checkbox"/> Moderately negative	<input type="checkbox"/> Extremely negative
<b>C9. Overall, would you say the impact of your child's adoption or guardianship on your relationship with your partner, spouse, or other adult caring for this child has been...?</b>							
N/A	<input type="checkbox"/> Extremely positive	<input type="checkbox"/> Moderately positive	<input type="checkbox"/> Slightly positive	<input type="checkbox"/> Neither positive nor negative	<input type="checkbox"/> Slightly negative	<input type="checkbox"/> Moderately negative	<input type="checkbox"/> Extremely negative
<b>C10. Overall, would you say the impact of your child's adoption or guardianship on your other children has been...?</b>							
N/A	<input type="checkbox"/> Extremely positive	<input type="checkbox"/> Moderately positive	<input type="checkbox"/> Slightly positive	<input type="checkbox"/> Neither positive nor negative	<input type="checkbox"/> Slightly negative	<input type="checkbox"/> Moderately negative	<input type="checkbox"/> Extremely negative

## Belonging and Emotional Security Tool (BEST)

**C11.** The following questions ask about the relationships between you, your child, and your family. For each statement, please tell me if you strongly disagree, disagree, feel neutral, agree, or strongly agree based on your relationship with your **Identified Child** over the past 6 months.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
My child belongs to our family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When something important happens to my child, I want to talk with him/her about it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I care deeply about what happens to my child.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It makes me feel happy when we spend time together.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I let my child know he/she is wanted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I expect to exchange holiday cards or gifts with my child just like everyone else in our family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel close to my child.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I love my child.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I trust my child.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would give my child money if he/she ever needed it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I include my child in family photos and portraits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I pay attention to my child when she/he asks for help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child cares deeply about what happens to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I include my child in family vacations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child loves me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I let my child know he/she will be in our family for life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I let my child know he/she will always be able to count on my help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I will do everything to keep my relationship going when my child is no longer living at home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I find a way to stand behind my child even when he/she is wrong.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have done everything I can to make my child feel he/she belongs to our family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am committed to my child for life, no matter what.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## SECTION D. Child Wellbeing

In this section, we will ask you questions about your child’s strengths, challenging behaviors, and school experiences. This information will be used to help provide feedback to the Vermont System of Care about the experiences of families formed through adoption and guardianship.

### Educational Wellbeing

First, we will ask about your **Identified Child’s** experiences in school. Please answer question D1 even if your child is not in school.

<b>D1. What best describes your child’s current educational status?</b>	
<input type="checkbox"/> Enrolled in school (Please enter grade level)	<input type="checkbox"/> Pre-Kindergarten <input type="checkbox"/> 6 <sup>th</sup> grade <input type="checkbox"/> Kindergarten <input type="checkbox"/> 7 <sup>th</sup> grade <input type="checkbox"/> 1 <sup>st</sup> grade <input type="checkbox"/> 8 <sup>th</sup> grade <input type="checkbox"/> 2 <sup>nd</sup> grade <input type="checkbox"/> 9 <sup>th</sup> grade <input type="checkbox"/> 3 <sup>rd</sup> grade <input type="checkbox"/> 10 <sup>th</sup> grade <input type="checkbox"/> 4 <sup>th</sup> grade <input type="checkbox"/> 11 <sup>th</sup> grade <input type="checkbox"/> 5 <sup>th</sup> grade <input type="checkbox"/> 12 <sup>th</sup> grade
If your child is not in school (has not started school, graduated/received GED, dropped out, or not in school for other reasons) SKIP TO question D11 (Child Social and Emotional Wellbeing).	
<b>D2. Does your child have or not have an Educational Support Team?</b>	<input type="checkbox"/> Has an Educational Support Team <input type="checkbox"/> Does not have an Educational Support Team
<b>D3. Does your child currently have a 504 plan, or does your child not have a 504 plan?</b>	<input type="checkbox"/> Has 504 plan <input type="checkbox"/> Does not have 504 plan
<b>D4. Does your child <u>currently</u> have an Individualized Education Program (IEP), or does your child not have an IEP?</b>	<input type="checkbox"/> Has IEP <input type="checkbox"/> Does not have IEP
<b>D5. Does your child have at least one teacher at school who really understand his or her needs?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i>
<b>D6. How would you describe your child’s school performance in reading and language arts?</b>	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Very poor
<b>D7. How would you describe your child’s school performance in math?</b>	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Very poor

<b>D8. Since starting Kindergarten, has your child repeated any grades?</b>	<input type="checkbox"/> Yes, has repeated grade
	<input type="checkbox"/> No, has not repeated a grade
	<input type="checkbox"/> Has not started Kindergarten

**D9. During the past 6 months, please indicate whether your child participated or did not participate in any of these activities after school or on weekends.**

Academic tutoring/support	<input type="checkbox"/> Participated	<input type="checkbox"/> Did not participate
Sports or athletic activities	<input type="checkbox"/> Participated	<input type="checkbox"/> Did not participate
Martial arts	<input type="checkbox"/> Participated	<input type="checkbox"/> Did not participate
Art, dance, or music class	<input type="checkbox"/> Participated	<input type="checkbox"/> Did not participate
Clubs or organizations	<input type="checkbox"/> Participated	<input type="checkbox"/> Did not participate
Religious youth group	<input type="checkbox"/> Participated	<input type="checkbox"/> Did not participate
Religious instruction/Sunday school	<input type="checkbox"/> Participated	<input type="checkbox"/> Did not participate
Volunteer work	<input type="checkbox"/> Participated	<input type="checkbox"/> Did not participate
Part-time job	<input type="checkbox"/> Participated	<input type="checkbox"/> Did not participate
Unpaid internship	<input type="checkbox"/> Participated	<input type="checkbox"/> Did not participate
Other (please describe):	<input type="text"/>	

**D10. During the past 6 months, has your child...**

Changed schools for reasons other than grade promotion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skipped school or cut classes without your permission	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Received an in-school suspension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Received an out-of-school suspension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Been expelled from school	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Received any awards, certificates, or made honor role	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Had a leadership role in a club or organization	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## Child Social and Emotional Wellbeing

This next set of questions will ask you about your child's strengths, social wellbeing and emotional wellbeing. Please think about your **Identified Child** as you answer each question.

<b>D11. In general, how easy or hard is it for your child to make friends?</b>	<input type="checkbox"/> Very easy <input type="checkbox"/> Somewhat easy <input type="checkbox"/> Somewhat hard <input type="checkbox"/> Very hard  <input type="checkbox"/> <i>Don't know/Does not apply</i>
<b>D12. How much is your child liked by other children?</b>	<input type="checkbox"/> A great deal <input type="checkbox"/> A lot <input type="checkbox"/> A moderate amount <input type="checkbox"/> A little <input type="checkbox"/> Not at all  <input type="checkbox"/> <i>Don't know/Does not apply</i>
<b>D13. How much does your child get along with other adults in his/her life?</b>	<input type="checkbox"/> A great deal <input type="checkbox"/> A lot <input type="checkbox"/> A moderate amount <input type="checkbox"/> A little <input type="checkbox"/> Not at all  <input type="checkbox"/> <i>Don't know/Does not apply</i>
<b>D14. Does your child have others outside of your family that is positive influences in his/her life?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> <i>Don't know</i>
<b>D15. Has anyone consistently been in your child's life since birth?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> <i>Don't know</i>
<b>D16. How easy or hard is it for your child to bounce back quickly when things don't go his or her way?</b>	<input type="checkbox"/> Very easy <input type="checkbox"/> Somewhat easy <input type="checkbox"/> Somewhat hard <input type="checkbox"/> Very hard  <input type="checkbox"/> <i>Don't know/Does not apply</i>
<b>D17. How easy or hard is it for your child to find things he/she likes about himself/herself?</b>	<input type="checkbox"/> Very easy <input type="checkbox"/> Somewhat easy <input type="checkbox"/> Somewhat hard <input type="checkbox"/> Very hard  <input type="checkbox"/> <i>Don't know/Does not apply</i>

<p><b>D18. How easy or hard is it for your child to stay calm when faced with a challenge?</b></p>	<input type="checkbox"/> Very easy <input type="checkbox"/> Somewhat easy <input type="checkbox"/> Somewhat hard <input type="checkbox"/> Very hard <input type="checkbox"/> <i>Don't know/Does not apply</i>
<p><b>D19. How easy or hard is it for your child to ask for help?</b></p>	<input type="checkbox"/> Very easy <input type="checkbox"/> Somewhat easy <input type="checkbox"/> Somewhat hard <input type="checkbox"/> Very hard <input type="checkbox"/> <i>Don't know/Does not apply</i>
<p><b>D20. How optimistic is your child about his or her future?</b></p>	<input type="checkbox"/> Extremely <input type="checkbox"/> Very optimistic <input type="checkbox"/> Moderately optimistic <input type="checkbox"/> Slightly optimistic <input type="checkbox"/> Not at all optimistic <input type="checkbox"/> <i>Don't know/Does not apply</i>
<p><b>D21. How often does your child offer to help others?</b></p>	<input type="checkbox"/> Always <input type="checkbox"/> Most of the time <input type="checkbox"/> About half of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Never <input type="checkbox"/> <i>Don't know/Does not apply</i>
<p><b>D22. During the past 6 months, how often did your child show interest and curiosity in learning new things?</b></p>	<input type="checkbox"/> Always <input type="checkbox"/> Most of the time <input type="checkbox"/> About half of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Never

**D23. In your opinion, what are your child's three greatest strengths?**

<p><b>Strength 1:</b></p>	
<p><b>Strength 2:</b></p>	
<p><b>Strength 3:</b></p>	

## Challenging Behavior

**D24.** For this set of questions, we hope to better understand the behavioral challenges that your child may face. Please think about your child's behavior over the past 6 months and indicate whether the behavior is not true, sometimes true, or often true for your child. Please refer to your **Identified Child**.

In the past 6 months, your child....	Not true	Sometimes True	Often True
Has had difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has been impulsive or has acted without thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has cheated or told lies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has argued too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has demanded a lot of attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has sudden changes in mood or feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has been restless or overly active and/or has not been able to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has been stubborn, sullen, or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has had a very strong temper and lost it easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has been rather high strung, tense, or nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has not seemed to feel sorry after (he/she) has misbehaved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has been disobedient at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has had difficulty getting mind off certain thoughts or had obsessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has been disobedient at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has been easily confused or seemed to be in a fog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has been too fearful or anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has had trouble getting along with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has bullied or has been cruel or mean to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has been too dependent on others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has had trouble getting along with teachers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has felt worthless or inferior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has been unhappy, sad, or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has been clinging to adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has broken things on purpose or deliberately destroyed things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is not liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has felt or complained that no one loves (him/her)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has cried too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has been withdrawn or has not gotten involved with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has taken things that do not belong to him or her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past 6 months, has your child....			
Been in trouble with the law or juvenile justice system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Been involved in a gang?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Run away for a period more than 7 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

D25. Does your child have a physical health issue that impacts his or her daily functioning?

<input type="checkbox"/> Has physical health issue→ Explain: <input type="checkbox"/> Does not have physical health issue	
--	--

D26. Does your child have mental health issues that impact his or her daily functioning?

<input type="checkbox"/> Has mental health issue→ Explain: <input type="checkbox"/> Does not have mental health issue	
--	--

D27. Does your child have sibling conflicts that impact his or her daily functioning?

<input type="checkbox"/> Has sibling conflicts issue→ Explain: <input type="checkbox"/> Does not have issue with sibling conflict	
--	--

D28. Does your child have food or eating issues that impact his or her daily functioning?

<input type="checkbox"/> Has food or eating issues→ Explain: <input type="checkbox"/> Does not have food or eating issue	
---	--

D29. Does your child have an physical disability that impacts his or her daily functioning?

<input type="checkbox"/> Has physical disability issues→ Explain: <input type="checkbox"/> Does not have physical disability issue	
---	--

D30. Does your child have language problems that impact his or her functioning?

<input type="checkbox"/> Has language problems→ Explain: <input type="checkbox"/> Does not have language problems	
--	--

D31. What language(s) did your child speak <u>when you adopted</u> him or her?	
D32. What language(s) does your child speak <u>now</u> ?	
D33. Was your child exposed prenatally to alcohol or substance use?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

**D34. Does your child/youth have alcohol or substance use problems that impact his or her daily functioning?**

<input type="checkbox"/> Has alcohol/substance use problems→ Explain: <input type="checkbox"/> Does not have alcohol/substance use problems	
--	--

**D35. Does your child/youth have an intellectual disability that impacts his or her daily functioning?**

<input type="checkbox"/> Has intellectual disability→ Explain: <input type="checkbox"/> Does not have intellectual disability	
--	--

**D36. Please think about this child’s physical and mental health, behavioral issues, and child care. In the past 6 months, did you or did anyone in your family have to quit a job, refuse a job offer, or change a job because of any of these issues with this child, or did they not have to do any of these things?**

<input type="checkbox"/> Yes, had job impact→ Explain: <input type="checkbox"/> No, did not have job impact	
--	--

### Out of Home Care

**D37. Since the adoption or guardianship was finalized, has your child (Identified Child) ever lived outside of your home for two weeks or longer because he or she was...**

Living with a relative or family friend?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Receiving treatment in a residential treatment setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Receiving treatment in a psychiatric hospital setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
At summer camp or on extended vacation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In a juvenile justice setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
At a boarding school or in college?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Homeless or ran away from home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In an emergency assessment bed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other (please describe):	<input type="text"/>	

**D38. Where is your child currently living?**

- With me
- With a relative or family friend
- Residential treatment setting
- Psychiatric hospital setting
- Summer camp/extended vacation
- Juvenile justice setting
- Boarding school or college
- Run away or homeless
- Emergency assessment bed
- Other (please describe):



## SECTION E. Caregiver Wellbeing

In this section, we will ask you questions about your own experiences as a parent or guardian for your child, past experiences you may have had, and the support from those around you. Additionally, we will ask a few more questions specifically around adoption and guardianship.

### Caregiver Resilience

**E1. Please read each statement and indicate whether you strongly disagree, disagree, feel neutral, agree, or strongly agree with the statement.**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
A. I tend to bounce back quickly after hard times.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. I have a hard time making it through stressful events.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. It does not take me long to recover from a stressful event.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. It is hard for me to snap back when something bad happens.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. I usually come through difficult times with little trouble.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. I tend to take a long time to get over setbacks in my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**E2. In your opinion, what are your three greatest strengths as a parent or guardian?**

<b>Strength 1:</b>	
<b>Strength 2:</b>	
<b>Strength 3:</b>	

<p><b>E3. How often do you feel that you make a difference in the life of your child?</b></p>	<input type="checkbox"/> Always <input type="checkbox"/> Most of the time <input type="checkbox"/> About half the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Never <input type="checkbox"/> Don't know
---	--

## Caregiver Experiences over the Past 6 Months

E4. Next, please think back over the past 6 months and try to remember how things have been for YOU as a result of parenting your **Identified Child** who was adopted or is in guardianship.

During the past 6 months, as a result of parenting your Identified Child who was adopted or in guardianship, how much was each of the following a problem for YOU?	Not at all	A little	A moderate amount	A lot	A great deal
A. Interruption of personal time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Missing obligations related to your job or similar responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Disruption of family routines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Financial strain for your family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Less attention paid to other family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Disruption or upset relationships within the family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Disruption of your family's social activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Disruption of friendships or significant relationships within the community?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Poor self-care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Increase in your alcohol consumption or substance use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please think back to how YOU have felt as a result of parenting your Identified Child who was adopted or is in guardianship .	Not at all	A little	A moderate amount	A lot	A great deal
During the past 6 months, as a result of parenting your child,	Not at all	A little	A moderate amount	A lot	A great deal
K. How isolated have you felt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. How sad or unhappy have you felt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. How angry or frustrated have you felt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. How worried have you felt about your child's future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. How worried have you felt about your family's future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P. How resentful have you felt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q. How overwhelmed have you felt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R. How hopeful have you felt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S. How proud have you felt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T. How supported have you felt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
U. How misunderstood have you felt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
V. How judged or criticized have you felt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Caregiver's Adverse Childhood Experiences (ACES)

E5. The following questions ask about events that may have or have not happened to you during your childhood. These questions are more sensitive in nature, so please skip over any question that makes you feel uncomfortable. By asking these questions, we hope to better understand the early experiences of caregivers that may or may not impact how they relate to or parent a child later in life.

When you were growing up, during your first 18 years of life:		
Did you live with anyone who was depressed, mentally ill, or suicidal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <i>Prefer to skip</i>
Did you live with anyone who was a problem drinker or alcoholic, used illegal street drugs or who abused prescription medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <i>Prefer to skip</i>
Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <i>Prefer to skip</i>
Were your parents separated or divorced?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <i>Prefer to skip</i> <input type="checkbox"/> <i>Not applicable</i>
Did you live with a parent or guardian who died?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <i>Prefer to skip</i>
Did anyone at least 5 years older than you or an adult ever touch you sexually or try to make you touch them sexually?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <i>Prefer to skip</i>
Did anyone at least 5 years older than you force you to have sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <i>Prefer to skip</i>

When you were growing up, during your first 18 years of life:		
How often did your parents, guardians or adults in your home ever slap, hit, kick, punch, or beat <b>each other up</b> ?	<input type="checkbox"/> Many times <input type="checkbox"/> A few times <input type="checkbox"/> Once <input type="checkbox"/> Never	<input type="checkbox"/> <i>Prefer to skip</i> <input type="checkbox"/> <i>Not applicable</i>
How often did a parent or adult in your home ever hit, beat, kick, or physically hurt <b>you</b> in any way?	<input type="checkbox"/> Many times <input type="checkbox"/> A few times <input type="checkbox"/> Once <input type="checkbox"/> Never	<input type="checkbox"/> <i>Prefer to skip</i>
How often did a parent or adult in your home ever swear at you, insult you, or put you down?	<input type="checkbox"/> Many times <input type="checkbox"/> A few times <input type="checkbox"/> Once <input type="checkbox"/> Never	<input type="checkbox"/> <i>Prefer to skip</i>
How often were your basic needs unmet (food, shelter, clothing)?	<input type="checkbox"/> Many times <input type="checkbox"/> A few times <input type="checkbox"/> Once <input type="checkbox"/> Never	<input type="checkbox"/> <i>Prefer to skip</i>

E6. How do these early experiences in your life impact the way you parent your child (the identified child) today?

## Caregiver Support

The following questions ask about the support you receive from those around you.

<p><b>E7.</b> During the past 6 months, how often have you felt you could turn to a friend or family member for support?</p>	<input type="checkbox"/> Always <input type="checkbox"/> Most of the time <input type="checkbox"/> About half the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Never <input type="checkbox"/> <i>Don't know</i>
<p><b>E8.</b> In the past 6 months has the support you receive from others increased, stayed about the same, or decreased?</p>	<input type="checkbox"/> Support increased <input type="checkbox"/> Support stayed the same <input type="checkbox"/> Support decreased
<p><b>E9.</b> In the past 6 months, how easy or hard has it been to get child care when needed?</p>	<input type="checkbox"/> Very easy <input type="checkbox"/> Somewhat easy <input type="checkbox"/> Somewhat hard <input type="checkbox"/> Very hard <input type="checkbox"/> <i>Have not needed</i>
<p><b>E10.</b> In the past 6 months, how easy or hard has it been to get respite when needed?</p>	<input type="checkbox"/> Very easy <input type="checkbox"/> Somewhat easy <input type="checkbox"/> Somewhat hard <input type="checkbox"/> Very hard <input type="checkbox"/> <i>Have not needed</i>

## Adoption and Guardianship Experiences

This set of questions asks more specifically about adoption and guardianship. Please think about the **Identified Child** as you answer each question.

<p><b>E11.</b> In the past 6 months, how often did your child bring up adoption or guardianship in conversation?</p>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Less than monthly <input type="checkbox"/> Never
<p><b>E12.</b> In the past 6 months, how often did you bring up adoption or guardianship with your child?</p>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Less than monthly <input type="checkbox"/> Never
<p><b>E13.</b> How comfortable or uncomfortable are you answering questions about his or her birth parent's history?</p>	<input type="checkbox"/> Very comfortable <input type="checkbox"/> Somewhat comfortable <input type="checkbox"/> Somewhat uncomfortable <input type="checkbox"/> Very uncomfortable <input type="checkbox"/> <i>Does not apply (Please explain)</i>

### Contact with Birth Mother

<p><b>E14.</b> In general, how important is it to you that the <b>Identified Child</b> has contact with his or her <b>birth mother</b>?</p>		<input type="checkbox"/> Extremely important <input type="checkbox"/> Very important <input type="checkbox"/> Moderately important <input type="checkbox"/> Slightly important <input type="checkbox"/> Not at all important <input type="checkbox"/> <i>Contact is not possible-(Please explain) Skip to E18</i>
<p><b>E15.</b> In the past 6 months, how often has your <b>child</b> had contact with his or her <b>birth mother</b>?</p>		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Less than monthly <input type="checkbox"/> Never- <b>Skip to E18</b>
<p><b>Skip if no contact in past 6 months</b></p>	<p><b>E16.</b> In the past 6 months, what type of contact has your <b>Identified Child</b> had with his/her <b>birth mother</b>? (Check all that apply).</p>	<input type="checkbox"/> In-person/Visitation <input type="checkbox"/> Phone/Skype/Facetime <input type="checkbox"/> Mail/Email <input type="checkbox"/> Social Media <input type="checkbox"/> Other <input type="text"/>
	<p><b>E17.</b> In the past 6 months, how has your <b>Identified Child's</b> contact with his or her <b>birth mother</b> impacted your family?</p>	<input type="checkbox"/> Very positive impact <input type="checkbox"/> Slightly positive impact <input type="checkbox"/> Neither positive nor negative <input type="checkbox"/> Slightly negative impact <input type="checkbox"/> Very negative impact

### Contact with Birth Father

<p><b>E18.</b> In general, how important is it to you that the <b>Identified Child</b> has contact with his or her <b>birth father</b>?</p>		<input type="checkbox"/> Extremely important <input type="checkbox"/> Very important <input type="checkbox"/> Moderately important <input type="checkbox"/> Slightly important <input type="checkbox"/> Not at all important <input type="checkbox"/> <i>Contact is not possible (Please explain) -Skip to E22</i>
<p><b>E19.</b> In the past 6 months, how often has your <b>child</b> had contact with his or her <b>birth father</b>?</p>		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Less than monthly <input type="checkbox"/> Never- <b>Skip to E22</b>
<p><b>Skip if no contact in past 6 months</b></p>	<p><b>E20.</b> In the past 6 months, what type of contact has your <b>Identified Child</b> had with his/her <b>birth father</b>? (Check all that apply).</p>	<input type="checkbox"/> In-person/Visitation <input type="checkbox"/> Phone/Skype/Facetime <input type="checkbox"/> Mail/Email <input type="checkbox"/> Social Media <input type="checkbox"/> Other <input type="text"/>
	<p><b>E21.</b> In the past 6 months, how has your <b>Identified Child's</b> contact with his or her <b>birth father</b> impacted your family?</p>	<input type="checkbox"/> Very positive impact <input type="checkbox"/> Slightly positive impact <input type="checkbox"/> Neither positive nor negative <input type="checkbox"/> Slightly negative impact <input type="checkbox"/> Very negative impact

## Contact with Birth Siblings

E22. How many birth siblings does your child have?		<input type="checkbox"/> Birth siblings <i>If 0, skip to E28</i>
E23. How many of your child's birth siblings live outside of your home?		<input type="checkbox"/> Birth siblings outside of home- <i>If 0, skip to E28</i>
<b>Complete the following if your child has at least one birth sibling living outside of your home:</b>		
E24. In general, how important is it to you that the <b>Identified Child</b> has contact with his or her <b>birth siblings</b> living outside of your home?		<input type="checkbox"/> Extremely important <input type="checkbox"/> Very important <input type="checkbox"/> Moderately important <input type="checkbox"/> Slightly important <input type="checkbox"/> Not at all important
E25. In the past 6 months, how often has your child had contact with his or her <b>birth sibling</b> living outside of your home? <i>Please refer to the birth sibling living outside of your home who has the most contact with the identified child.</i>		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Less than monthly <input type="checkbox"/> Never- <b>Skip to E28</b>
<b>Skip if no contact in past 6 months</b>	E26. In the past 6 months, what type of contact has your <b>Identified Child</b> had with this <b>birth sibling</b> ? (Check all that apply)	<input type="checkbox"/> In-person/Visitation <input type="checkbox"/> Phone/Skype/Facetime <input type="checkbox"/> Mail/Email <input type="checkbox"/> Social Media <input type="checkbox"/> Other <input style="width: 100px;" type="text"/>
	E27. In the past 6 months, how has your <b>Identified Child's</b> contact with this <b>birth sibling</b> impacted your family?	<input type="checkbox"/> Very positive impact <input type="checkbox"/> Slightly positive impact <input type="checkbox"/> Neither positive nor negative <input type="checkbox"/> Slightly negative impact <input type="checkbox"/> Very negative impact

This set of questions asks you to reflect on your adoption and guardianship experiences with your child over time. Please think about the **Identified Child** as you answer each question.

<b>E28. If you knew then what you know now, do you think you still would have adopted or assumed guardianship of your child?</b>	<input type="checkbox"/> Definitely would have <input type="checkbox"/> Probably would have <input type="checkbox"/> Might or might not have <input type="checkbox"/> Probably would not have <input type="checkbox"/> Definitely would not have
<b>E29. How often do you think of ending this adoption or guardianship? Would you say...?</b>	<input type="checkbox"/> Never- <i>Skip to section F</i> <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Usually <input type="checkbox"/> Always

**If you have thought about ending this adoption :**

What were reasons why you thought about ending this adoption or guardianship?

**E30. Have you or your spouse/partner ever taken any of the following actions to end this adoption or guardianship ?**

Spoke with a caseworker, adoption agency worker or social service agency worker about it	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spoke with an attorney about it	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spoke with a close friend or family member about it	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spoke with clergy or religious leader about it	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reached out online or via social media	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spoke with other (please describe):		

**E31. Is there any additional information you would like to share about these actions?**

## SECTION F. Community Services

### Pre-Permanency Services

**F1.** Please indicate whether your family used any of the following trainings and/or services. If a service was used, please describe how helpful it was in preparing you to parent the **Identified Child**.

Trainings/ Services	Did your family use this training / service?			If used, how helpful was this Training/ service?		
Lund Project Family's permanency counselors	<input type="checkbox"/> Didn't know about	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	How helpful was this service? <input type="checkbox"/> Very helpful <input type="checkbox"/> Somewhat helpful <input type="checkbox"/> Not helpful	
Lund finalization case manager	<input type="checkbox"/> Didn't know about	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	How helpful was this service? <input type="checkbox"/> Very helpful <input type="checkbox"/> Somewhat helpful <input type="checkbox"/> Not helpful	
Fostering to Forever training for caregivers (through DCF)	<input type="checkbox"/> Didn't know about	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	How helpful was this service? <input type="checkbox"/> Very helpful <input type="checkbox"/> Somewhat helpful <input type="checkbox"/> Not helpful	
RPC+: Trauma informed resource parenting curriculum (6-8 weeks)	<input type="checkbox"/> Didn't know about	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	How helpful was this service? <input type="checkbox"/> Very helpful <input type="checkbox"/> Somewhat helpful <input type="checkbox"/> Not helpful	
Adoption Learning Partnership online training	<input type="checkbox"/> Didn't know about	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	How helpful was this service? <input type="checkbox"/> Very helpful <input type="checkbox"/> Somewhat helpful <input type="checkbox"/> Not helpful	
Shared Parenting Meetings	<input type="checkbox"/> Didn't know about	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	How helpful was this service? <input type="checkbox"/> Very helpful <input type="checkbox"/> Somewhat helpful <input type="checkbox"/> Not helpful	
Vermont Foster and Adoptive Family Association Training/conferences	<input type="checkbox"/> Didn't know about	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	How helpful was this service? <input type="checkbox"/> Very helpful <input type="checkbox"/> Somewhat helpful <input type="checkbox"/> Not helpful	
Vermont Kin as Parents	<input type="checkbox"/> Didn't know about	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	How helpful was this service? <input type="checkbox"/> Very helpful <input type="checkbox"/> Somewhat helpful <input type="checkbox"/> Not helpful	
Transracial cross cultural training	<input type="checkbox"/> Didn't know about	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	How helpful was this service? <input type="checkbox"/> Very helpful <input type="checkbox"/> Somewhat helpful <input type="checkbox"/> Not helpful	
<b>F2. Overall, how prepared did you feel to meet the needs of your child at the time of finalization?</b>					<input type="checkbox"/> Extremely prepared <input type="checkbox"/> Very prepared <input type="checkbox"/> Moderately prepared <input type="checkbox"/> Slightly prepared <input type="checkbox"/> Not at all prepared	



**F3. Overall, how would you rate the Vermont Department for Children and Families (DCF) in preparing you to meet the needs of your child?**

- Very good
- Good
- Fair
- Poor
- Very poor

**Service Use in the Past 6 Months**

**F4.** The table below provides a list of services that may be offered in your community. Please check any of the following services that you have used in the past 6 months (Check all that apply):

Family support services	School/Child care services for Identified Child	Medical services for Identified Child	Mental health services	Post permanency services
<input type="checkbox"/> Family counseling through community mental health <input type="checkbox"/> Intensive family based services <input type="checkbox"/> Case management service coordination <input type="checkbox"/> DCF social work services <input type="checkbox"/> Family safety planning <input type="checkbox"/> Agency support services <input type="checkbox"/> LGBTQ support services <input type="checkbox"/> Online support/ Blogs <input type="checkbox"/> Family Counseling through a private provider	<input type="checkbox"/> Regular child care services <input type="checkbox"/> After school program <input type="checkbox"/> Mentoring <input type="checkbox"/> Behavior support services <input type="checkbox"/> School-based clinician <input type="checkbox"/> Alternative school	<input type="checkbox"/> Routine medical care <input type="checkbox"/> Medication management <input type="checkbox"/> Services for children who are blind or visually impaired <input type="checkbox"/> Services for children who are deaf or hard of hearing <input type="checkbox"/> Speech or occupational therapy <input type="checkbox"/> Developmental disability case management services <input type="checkbox"/> Physical disability <input type="checkbox"/> Other developmental disabilities services (including personal care or family managed respite)	<p style="text-align: center;"><b><u>Identified Child</u></b></p> <input type="checkbox"/> Psychological assessment <input type="checkbox"/> Individual counseling or therapy through community mental health <input type="checkbox"/> Group counseling <input type="checkbox"/> Psychiatric medication <input type="checkbox"/> Coordinated service plan/ACT 264 <input type="checkbox"/> Care coordination/Case management <input type="checkbox"/> Individual counseling (private provider) <input type="checkbox"/> Substance abuse treatment <p style="text-align: center;"><b><u>Caregiver</u></b></p> <input type="checkbox"/> Individual counseling or therapy through community mental health <input type="checkbox"/> Group counseling <input type="checkbox"/> Psychiatric medication <input type="checkbox"/> Substance abuse treatment <input type="checkbox"/> Individual counseling private provider	<input type="checkbox"/> Adoption/Guardianship Assistance Program(AKA; Subsidy) <input type="checkbox"/> Post permanency services <input type="checkbox"/> Vermont Adoption Consortium (VAC) resource library <input type="checkbox"/> Vermont Adoption Registry <input type="checkbox"/> Post permanency newsletter <input type="checkbox"/> Parent support group <input type="checkbox"/> Post permanency trainings for adoptive parents and guardians <input type="checkbox"/> Trauma assessment <input type="checkbox"/> Training/Conference for families formed through adoption and guardianship

**The next three questions ask you about services in your community. Please refer to previous table for a list of services as needed.**

**F5. In your opinion, what are the top three most important services or supports for families formed through adoption or guardianship?**

<b>Helpful Service 1:</b>	
<b>Helpful Service 2:</b>	
<b>Helpful Service 3:</b>	

**F6. In your community, what three services are most needed but hard to get or not available for families formed through adoption or guardianship?**

<b>Need Service 1:</b>	
<b>Need Service 2:</b>	
<b>Need Service 3:</b>	

**F7. In your community, what are the three biggest barriers to getting support or services families formed through adoption or guardianship?**

<b>Barrier 1:</b>	
<b>Barrier 2:</b>	
<b>Barrier 3:</b>	

This set of questions asks about how often services in your community meet the needs of your child and family.

F8. In the past 6 months, how often have the following types of services in your community met the needs of your family?	Always	Most of the time	About half of the time	Some of the time	Never	Have not used
Family support services (Family counseling/family-based services)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child care services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child medical services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caregiver mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post permanency support services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse services						
DCF Child Welfare Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical disability services						

F9. Is there anything else about your experience of adoption or guardianship of your child that you would like to share?

F10. Overall, how would you describe your adoption or guardianship experience?

- Easier than I anticipated
- What I anticipated
- Harder than I anticipated

F11. Given your experience of adoption or guardianship with this child, how likely would you be to recommend adoption or guardianship to others?

- Definitely will
- Probably will
- Might or might not
- Probably won't
- Definitely won't

## SECTION G. Transracial Adoption Experiences



In this section, **transracial adoption** means a public or private adoption of an ethnic minority child of color by one or more parents who are not of the same race or ethnicity of the child.

### Family

<b>G1.</b> Does your family see itself as a transracial family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>G2.</b> Has your family talked about being a transracial family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>G3.</b> Has your family chosen childcare providers, teachers, or other role models similar to your child's race and ethnicity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>G4.</b> Does your family have friends that share the same racial or ethnic background of your child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>G5.</b> Has your family prepared foods associated with your child's racial or ethnic background?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>G6.</b> Has your family lived in or moved to racially or culturally diverse neighborhood?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>G7.</b> Do you feel confident that your family can meet your child's needs based on his or her transracial ethnic identity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>G8.</b> Is your child comfortable being in a transracial family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**G9.** Has there been any impact of your child's transracial adoption or guardianship on your immediate family?

<input type="checkbox"/> Yes → Please explain: <input type="checkbox"/> No	
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**G10.** Has there been any impact of your child's transracial adoption or guardianship on your extended family?

<input type="checkbox"/> Yes → Please explain: <input type="checkbox"/> No	
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**G11.** Has your family been involved in religious, social, or recreational groups or activities that reflect your child's race or ethnicity or culture?

<input type="checkbox"/> Yes → Please explain: <input type="checkbox"/> No	
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**G12.** Does your child have problems being in a transracial family?

<input type="checkbox"/> Yes → Please explain: <input type="checkbox"/> No	
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**G13.** Does your child have sources of support in your transracial family?

<input type="checkbox"/> Yes → Please explain: <input type="checkbox"/> No	
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**G14.** Does or did your child have problems with racial discrimination?

<input type="checkbox"/> Yes → Please explain: <input type="checkbox"/> No	
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**G15.** Do you feel you know how to help your child when he or she is being teased or bullied or discriminated against because of race?

<input type="checkbox"/> Yes → Please explain: <input type="checkbox"/> No	
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**G16.** Has the transracial adoption or guardianship had an impact of your well-being?

<input type="checkbox"/> Yes → Please explain: <input type="checkbox"/> No	
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**G17.** Has the transracial adoption or guardianship had an impact on your marriage or significant other relationship?

<input type="checkbox"/> Yes → Please explain: <input type="checkbox"/> No	
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## SECTION H. Demographics

To begin, we would like to ask you a few questions about you.

<b>H1. What is your gender?</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
<b>H2. What is your month and year of birth?</b>	<div style="display: flex; align-items: center; gap: 10px;"> <input style="width: 40px; height: 20px;" type="text"/> / <input style="width: 80px; height: 20px;" type="text"/> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MM</span> <span>YYYY</span> </div>
<b>H3. Are you of Hispanic/Latino origin, or are you not of Hispanic/Latino origin?</b>	<input type="checkbox"/> Hispanic/Latino origin <input type="checkbox"/> Not of Hispanic/Latino origin
<b>H4. What is your race? (Check all that apply)</b>	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White/Caucasian
<b>H5. What is your current relationship status?</b>	<input type="checkbox"/> Single, never married, not living with partner <input type="checkbox"/> Living with a partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
<b>H6. Do you consider yourself to be:</b>	<input type="checkbox"/> Heterosexual or straight <input type="checkbox"/> Gay or lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Other
<b>H7. What is the highest level of education you have completed?</b>	<input type="checkbox"/> Eighth grade or less <input type="checkbox"/> Some high school <input type="checkbox"/> High school diploma <input type="checkbox"/> GED <input type="checkbox"/> Some college <input type="checkbox"/> 2- or 4-year college degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Advanced graduate work or Ph.D.
<b>H8. What is your best estimate of your household income for this past year? Consider income from all sources before taxes. SELECT ONLY ONE.</b>	<input type="checkbox"/> Under \$15,000 <input type="checkbox"/> \$15,001 to \$30,000 <input type="checkbox"/> \$30,001 to 45,000 <input type="checkbox"/> \$45,001 to 60,000 <input type="checkbox"/> \$60,001 to 75,000 <input type="checkbox"/> \$75,001 to 90,000 <input type="checkbox"/> \$90,001 to \$105,000 <input type="checkbox"/> \$105,001 to \$120,000 <input type="checkbox"/> Over \$120,000

Please refer to the **Identified Child** when answering these last few questions.

**H 9.** We would like to request your permission to link your survey answers to data collected by Vermont DCF when your child was in foster care. By linking these data sources, we will be able to better understand how the pre-adoption experiences of your child impact post-adoption experiences. **Do we have permission to link these data sources?**

Yes, I give permission to link data->Initial:

No, I do not give permission to link data->Initial:

**Thank you for taking the time to complete this survey.**

We are grateful for all of your feedback. As a small token of our appreciation, you will receive a **\$20 gift card** upon submitting this survey. Please allow up to four weeks to receive your incentive. If you have not received your gift card after four weeks, please contact Christina Shuma by phone at (802) 864-7467 x 2011 or by email at [christinas@lundvt.org](mailto:christinas@lundvt.org)

**Please return your survey in the self-addressed, stamped envelope enclosed in this packet.**

If you are not already receiving post permanency services and would like to be contacted by a post permanency service coordinator, please contact the Post Permanency Manager at 802 241-0901. You may also mail a request to Post Permanency Manager, Family Services Division, 280 State Drive HC1 North, Waterbury, VT 05671-1030 or contact your Vermont agency.

