

Pursuant to SB 84 and according to ACL 08-01, dated January 17, 2008, this letter is to inform you of Tehama County's Foster Care Rate and Specialized Care Rates. Effective January 1, 2008 the rates are shown below:

TEHAMA COUNTY FOSTER CARE RATE

| <u>AGE</u> | <u>RATE</u> |
|------------|-------------|
| 0-4 | \$446 |
| 5-8 | \$485 |
| 9-11 | \$519 |
| 12-14 | \$573 |
| 15-19 | \$627 |

SPECIALIZED CARE RATES:

| | |
|-----------|-------|
| Level I | \$253 |
| Level II | \$423 |
| Level III | \$719 |

Sincerely,

Christine C. Applegate, Director

TEHAMA COUNTY DEPARTMENT OF SOCIAL SERVICES
ASSESSMENT FORM FOR CHILDREN WITH SPECIAL NEEDS
INFANTS

The increased level of payment may be used for licensed foster home, relative and non-relative placements. Training requirements established by the Tehama County Department of Social Services must be met prior to payment. Reassessments are to be completed quarterly.

IDENTIFICATION

Child's name: _____ Date of birth: _____

Caregiver's name: _____

Medical/Psychiatric diagnosis: _____

Supervision level: _____ SW _____

Approved: _____ (Re) Assessment date: _____
(Supervisor)

SUPERVISION LEVELS

| | | | |
|--------------|----------------------------|------------------------------|------------------------------|
| BASIC | LEVEL I MINIMAL | LEVEL II MODERATE | LEVEL III MAXIMUM |
|--------------|----------------------------|------------------------------|------------------------------|

Place an "X" in the boxes for the descriptions that are most applicable
(Explain when requested)

MEDICAL AND SPECIAL NEEDS

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|--|--|--|--|
| Visits 3-5 X's weekly; Foster Parent transports |
| No seizures | Occasional seizures; mostly controlled | Frequent seizures; mostly controlled | Uncontrolled seizures <hr/> Other conditions requiring extensive home care Explain: _____ _____ |

MEDICAL AND SPECIAL NEEDS CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|---|---|---|--|
| <p>No drug exposure</p> | <p>Prenatal drug exposure; Fetal Alcohol effects/Syndrome diagnosed; no obvious concerns</p> | <p>Prenatal drug exposure; Fetal Alcohol effects/Syndrome diagnosed; moderate concerns Explain: _____ _____</p> | <p>Prenatal drug exposure; Fetal Alcohol effects/Syndrome diagnosed; serious concerns Explain: _____ _____ _____</p> |
| <p>Medical appts. at 1/month average; Foster Parent transports & participate</p> | <p>Medical appts. at 2-4/month average; Foster Parent transports & participates</p> | <p>Medical appts. > 4/month; Foster Parent transports & participates</p> | <p>Medical appts. > 4/month; Foster Parent transport & participates out of area Explain: _____ _____ _____</p> |

Comments:

ADDITIONAL FACTORS TO CONSIDER:

Caregiver's willingness to deal with difficult parents.

TEHAMA COUNTY DEPARTMENT OF SOCIAL SERVICES
ASSESSMENT FORM FOR CHILDREN WITH SPECIAL NEEDS
PRE-SCHOOL

The increased level of payment may be used for licensed foster home, relative and non-relative placements. Training requirements established by the Tehama County Department of Social Services must be met prior to payment. Reassessments are to be completed quarterly.

IDENTIFICATION

Child's name: _____ Date of birth: _____

Caregiver's name: _____

Medical/Psychiatric diagnosis: _____

Supervision level: _____ SW: _____

Approved: _____ (Re) Assessment date: _____
(Supervisor)

SUPERVISION LEVELS

| | | | |
|--------------|----------------------------|------------------------------|------------------------------|
| BASIC | LEVEL I MINIMAL | LEVEL II MODERATE | LEVEL III MAXIMUM |
|--------------|----------------------------|------------------------------|------------------------------|

Place an "X" in the boxes for the descriptions that are most applicable
(Explain when requested)

MOBILITY

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|-------------------------|---|--|--|
| Walks unassisted | Walks unassisted with use of prosthetic device | Mobile with assistance and/or special equipment | Immobile, incapable of independent movement; non-ambulatory |

SELF-HELP

| | | | |
|--|---|---|------------------------------------|
| Uses toilet with no supervision | Uses toilet with minimum supervision; occasional bowel and bladder accidents Explain: _____ _____ | Partial control; frequent bowel and bladder accidents Explain: _____ _____ _____ | No bowel or bladder control |
|--|---|---|------------------------------------|

SELF HELP CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|--|---|---|---|
| Dresses self | Dresses self with minimal assistance; is cooperative | Dresses self with moderate assistance; is resistant | Cannot dress self; unable to assist |
| Age appropriate reminder of hygiene needs | Needs assistance with hygiene; is cooperative | Unable to care for own hygiene needs; is cooperative Explain: _____ _____ _____ | Unable to care for own hygiene needs; is resistant Explain: _____ _____ _____ |

COMMUNICATION

| | | | |
|---|---|---|--|
| Understands and follows verbal instruction | Understands and follows verbal instruction with some misunderstanding Explain: _____ _____ | Understands only a few words Explain: _____ _____ _____ | No receptive language; deaf or aphasia |
| Able to answer questions; can converse | Verbal skills limited to two-word sentences | Limited verbal skills; requiring speech intervention | No expressive language; unintelligible speech |
| Can follow directions | Can follow directions; needs occasional reminding | Can follow directions; needs constant reminding | Cannot follow directions |

BEHAVIOR

| | | | |
|--|--|---|---|
| Appropriate interaction with others | Moderate social interaction; some threats, manipulative, disruptive Explain: _____ _____ _____ | Minimal social interaction; some threats, manipulative, disruptive Explain: _____ _____ _____ | Severely inappropriate or no social interaction; threats, severely manipulative; disruptive Explain: _____ _____ |
|--|--|---|---|

BEHAVIOR CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|--|---|---|---|
| Seldom or never aggressive towards others and/or animals | Minimal aggression towards others and/or animals; does no harm Explain: _____ _____ | Moderate aggression towards others and/or animals; does no harm Explain: _____ _____ | Frequent aggression towards others and/or animals; does harm Explain: _____ _____ |
| Not destructive to property; not self abusive | Occasionally destructive to property and/or self abusive | Occasionally destructive to property and/or self abusive; difficult to redirect Explain: _____ _____ _____ | Very destructive to property and/or self abusive; constant vigilance required Explain: _____ _____ _____ |
| No smearing of feces | Occasional smearing of feces | Frequent smearing of feces | Constant smearing of feces |
| Sexual behavior age appropriate; inoffensive | Some inappropriate sexual behavior requiring correction | Frequent inappropriate sexual behavior requiring correction | Frequent inappropriate sexual behavior requiring constant diligence |
| Adaptable, accepts changes readily | Change presents minimal difficulty; needs help | Change presents moderate difficulty; needs help | Cannot handle change; rigid |

MEDICAL AND SPECIAL NEEDS

| | | | |
|------------|-----------------------------|---|---------------------|
| Feeds self | Feeds self with supervision | Feeds self with supervision and special equipment | Unable to feed self |
|------------|-----------------------------|---|---------------------|

MEDICAL AND SPECIAL NEEDS CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|---|--|---|---|
| No seizures | Occasional seizures; mostly controlled | Frequent seizures; mostly controlled | Uncontrolled seizures <hr/> Colostomy, ileostomy, catheterization, ventilator-dependent, and other conditions requiring extensive home care Explain: _____ _____ _____ |
| No prenatal drug exposure | Prenatal drug exposure; Fetal Alcohol effects/Syndrome diagnosed; no obvious concerns | Prenatal drug exposure; Fetal Alcohol effects/Syndrome diagnosed; moderate concerns Explain: _____ _____ _____ | Prenatal drug exposure; Fetal Alcohol effects/Syndrome diagnosed; serious concerns Explain: _____ _____ _____ |
| Medical appts. at 1/month average; Foster Parent transports & participates | Medical appts. at 2-4/month average; Foster Parent transports & participates | Medical appts. > 4/month; Foster Parent transports & participates | Medical appts. >4/month; Foster Parent transports & participates out of area Explain: _____ _____ _____ |
| No counseling required | Routine frequency of counseling appts.;4/month; Foster Parent transports and participates | Routine frequency of counseling appts.; 5- 7/month; Foster Parent transports and participates | Routine frequency of counseling appts.; 8+/month; Foster Parent transports and participates |

MEDICAL AND SPECIAL NEEDS CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|--|---|---|---|
| No chronic and/or contagious life threatening illness | Chronic and/or contagious life threatening illness; no or mild complications | Chronic and/or contagious life threatening illness; moderate complications | Chronic and/or contagious life threatening illness; severe complications |
| Does not wet/soils clothing/bed | Wets or soils clothing/bed 1-2/week | Wets or soils clothing/bed 3-4/week | Wets or soils clothing several times per week; wets bed daily, hides wet clothing |
| No food restriction | Restriction of certain foods, i.e., strawberries, seafood, etc.; severity of reaction mild | Restriction of 1 food category i.e., dairy products, sugars, etc.; requires special foods, food supplements; severity of reaction moderate | Restriction of more than 1 food category i.e., dairy products, sugars etc.; requires special diet or food supplements, or severe reaction to certain foods |
| No psychotropic medications | Stabilized; no or minimal psychotropic medications | Stabilized; moderate psychotropic medications | Unstable; frequent changes in psychotropic medications |

COMMENTS:**ADDITIONAL FACTORS TO CONSIDER:**

Caregiver's willingness to deal with difficult parents.

TEHAMA COUNTY DEPARTMENT OF SOCIAL SERVICES
ASSESSMENT FORM FOR CHILDREN WITH SPECIAL NEEDS
TODDLERS

The increased level of payment may be used for licensed foster home, relative and non-relative placements. Training requirements established by the Tehama County Department of Social Services must be met prior to payment. Reassessments are to be completed quarterly.

IDENTIFICATION

Child's name: _____ Date of birth: _____

Caregiver's name: _____

Medical/Psychiatric diagnosis: _____

Supervision level: _____ SW: _____

Approved: _____ (Re) Assessment date: _____
(Supervisor)

SUPERVISION LEVELS

| | | | |
|--------------|----------------------------|------------------------------|------------------------------|
| BASIC | LEVEL I MINIMAL | LEVEL II MODERATE | LEVEL III MAXIMUM |
|--------------|----------------------------|------------------------------|------------------------------|

Place an "X" in the boxes for the descriptions that are most applicable
(Explain when requested)

MOBILITY

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|-------------------------|---|--|--|
| Walks unassisted | Walks unassisted with use of prosthetic device | Mobile with assistance and/or special equipment | Immobile, incapable of independent movement; non-ambulatory |

BEHAVIOR

| | | | |
|---|--|---|---|
| Age appropriate aggression towards others and/or animals | Frequent aggression towards others and/or animals; easy to redirect; does no harm Explain: _____ _____ _____ | Frequent aggression towards others and/or animals; difficult to redirect; does no harm Explain: _____ _____ _____ | Frequent aggression towards others and/or animals; does harm Explain: _____ _____ _____ |
|---|--|---|---|

BEHAVIOR CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|---|--|--|--|
| Not destructive to property; not self abusive | Occasionally destructive to property and/or self abusive | Occasionally destructive to property and/or self abusive; difficult to redirect Explain: _____ _____ _____ | Very destructive to property and/or self abusive; constant vigilance required Explain: _____ _____ _____ |
| No or occasional smearing of feces; toilet trained | Occasional smearing of feces; not toilet trained | Frequent smearing of feces; not toilet trained | Constant smearing of feces; not toilet trained |
| Age appropriate inquisitiveness towards human sexual anatomy | Some inappropriate sexual behavior with others and/or animals, requiring correction | Frequent inappropriate sexual behavior with others and/or animals requiring correction | Excessive inappropriate sexual behavior with others and/or animals; constant vigilance required |

MEDICAL AND SPECIAL NEEDS

| | | | |
|----------------------------------|--|---|--|
| No seizures | Occasional seizures; mostly controlled | Frequent seizures; mostly controlled | Uncontrolled seizures _____ Colostomy, ileostomy, catheterization, ventilator-dependent, and other conditions requiring extensive home care Explain: _____ _____ |
| No prenatal drug exposure | Prenatal drug exposure; Fetal alcohol effects/Syndrome diagnosed; no obvious concerns | Prenatal drug exposure; Fetal alcohol effects/Syndrome diagnosed; moderate concerns Explain _____ _____ _____ | Prenatal drug exposure; Fetal alcohol effects/Syndrome diagnosed; serious concerns Explain: _____ _____ |

MEDICAL AND SPECIAL NEEDS CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|---|---|---|---|
| Medical appts. at 1/month average; Foster Parent transports & participates | Medical appts. at 2-4/month average; Foster Parent transports & participates | Medical appts. > 4/month; Foster Parent transports & participates | Medical appts. > 4/month; Foster Parent transports & participates out of area. Explain:_____ _____ _____ |
| No food restrictions | Restriction of certain foods, i.e., strawberries, seafood, etc.; severity of reaction mild | Restriction of 1 food category i.e., dairy products, sugars, etc.; requires special foods, food supplements; severity of reaction moderate | Restriction of more than 1 food category i.e., dairy products and sugar, etc.; requires special diet or food supplement, or severe reaction to certain foods |

COMMENTS:**ADDITIONAL FACTORS TO CONSIDER:**

Caregiver's willingness to deal with difficult parents.

TEHAMA COUNTY DEPARTMENT OF SOCIAL SERVICES
ASSESSMENT FORM FOR CHILDREN WITH SPECIAL NEEDS
SCHOOL-AGED

The increased level of payment may be used for licensed foster home, relative and non-relative placements. Training requirements established by the Tehama County Department of Social Services must be met prior to payment. Reassessments are to be completed quarterly.

IDENTIFICATION

Child's name: _____ Date of birth: _____

Caregiver's name: _____

Medical/Psychiatric diagnosis: _____

Supervision level: _____ SW/PO: _____

Approved: _____ (Re) Assessment date: _____
(Supervisor)

SUPERVISION LEVELS

| | | | |
|--------------|----------------------------|------------------------------|------------------------------|
| BASIC | LEVEL I MINIMAL | LEVEL II MODERATE | LEVEL III MAXIMUM |
|--------------|----------------------------|------------------------------|------------------------------|

Place an "X" in the boxes for the descriptions that are most applicable
(Explain when requested)

MOBILITY

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|-------------------------|---|--|--|
| Walks unassisted | Walks unassisted with use of prosthetic device | Mobile with assistance and/or special equipment | Immobile, incapable of independent movement; non-ambulatory |

SELF-HELP

| | | | |
|--|--|--|------------------------------------|
| Uses toilet with no supervision | Uses toilet with minimum supervision; occasional bowel and bladder accidents Explain: _____ _____ | Partial control; frequent bowel and bladder accidents Explain: _____ _____ _____ | No bowel or bladder control |
|--|--|--|------------------------------------|

SELF-HELP CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|---|--|---|---|
| <p>Dresses self</p> | <p>Dresses self with minimal assistance; is cooperative</p> | <p>Dresses self with moderate assistance; is resistant</p> | <p>Cannot dress self; unable to assist</p> |
| <p>Age appropriate reminder of hygiene needs</p> | <p>Needs assistance with hygiene; is cooperative</p> | <p>Unable to care for own hygiene needs; is cooperative Explain: _____ _____ _____</p> | <p>Unable to care for own hygiene needs; is resistant Explain: _____ _____ _____</p> |

COMMUNICATION

| | | | |
|--|---|---|--|
| <p>Understands and follows verbal instruction</p> | <p>Understands and follows verbal instruction with some misunderstanding Explain: _____ _____</p> | <p>Understands only a few words Explain: _____ _____ _____</p> | <p>No receptive language; deaf or aphasia</p> |
|--|---|---|--|

BEHAVIOR

| | | | |
|--|---|--|--|
| <p>Appropriate interaction with others</p> | <p>Moderate social interaction; some threats, manipulative, disruptive Explain: _____ _____</p> | <p>Minimal social interaction; some threats, manipulative, disruptive Explain: _____ _____</p> | <p>Severely inappropriate or no social interaction; threats, severely manipulative, disruptive Explain: _____ _____ _____</p> |
| <p>Seldom or never aggressive towards others and/or animals</p> | <p>Minimal aggression towards others and/or animals; does no harm Explain: _____ _____</p> | <p>Frequent aggression towards others and/or animals; does no harm Explain: _____ _____</p> | <p>Frequent aggression towards others and/or animals; does harm Explain: _____ _____</p> |

BEHAVIOR CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|--|---|---|---|
| Not destructive to property; not self abusive | Occasionally destructive to property and/or self abusive | Occasionally destructive to property and/or self abusive; difficult to redirect Explain: _____ _____ | Very destructive to property and/or self abusive; constant vigilance required Explain: _____ _____ |
| No smearing of feces | Occasional smearing of feces | Frequent smearing of feces | Constant smearing of feces |
| Sexual behavior age appropriate; inoffensive | Some inappropriate sexual behavior requiring correction | Frequent inappropriate sexual behavior requiring correction | Frequent inappropriate sexual behavior requiring constant diligence |
| Does not wander away | Tendency to wander on occasion; comes back on own motivation | Frequent tendency to wander; comes back on own motivation | Frequent tendency to wander; must be brought back; requires constant supervision |
| Adaptable, accepts changes readily | Change presents minimal difficulty; needs help | Change presents moderate difficulty; needs help | Cannot handle change; rigid |

MEDICAL AND SPECIAL NEEDS

| | | | |
|-----------------------------------|--|--|---|
| Does not use drugs/alcohol | Has experimented on occasion with drugs/alcohol | Frequent experimentation with drugs/alcohol | Chronic use of drugs/alcohol; established pattern of abuse |
| Feeds self | Feeds self with supervision | Feeds self with supervision and special equipment | Unable to feed self |

MEDICAL AND SPECIAL NEEDS CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|--|--|--|--|
| <p>No seizures</p> | <p>Occasional seizures; mostly controlled</p> | <p>Frequent seizures; mostly controlled</p> | <p>Uncontrolled seizures</p> <hr/> <p>Colostomy, ileostomy, catheterization, ventilator-dependent, and other conditions requiring extensive home care Explain: _____ _____ _____</p> |
| <p>No prenatal drug exposure</p> | <p>Prenatal drug exposure; Fetal Alcohol effects/Syndrome diagnosed; no obvious concerns</p> | <p>Prenatal drug exposure; Fetal Alcohol effects/Syndrome diagnosed; moderate concerns Explain: _____ _____ _____</p> | <p>Prenatal drug exposure; Fetal Alcohol effects/Syndrome diagnosed; serious concerns Explain: _____ _____ _____</p> |
| <p>Medical appts. at 1/month average; Foster Parent transports & participates</p> | <p>Medical appts. at 2-4/month average; Foster Parent transports & participates</p> | <p>Medical appts. > 4/month; Foster Parent transports & participates</p> | <p>Medical appts. >4/month; Foster Parent transports & participates out of area. Explain: _____ _____</p> |
| <p>No counseling required</p> | <p>Routine frequency of counseling appts.; 4/month; Foster Parent transports and participates</p> | <p>Routine frequency of counseling appts.; 5-7/month; Foster Parent transports and participates</p> | <p>Routine frequency of counseling appts.; 8+/month; Foster Parent transports and participates</p> |

MEDICAL AND SPECIAL NEEDS CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|--|---|---|--|
| No chronic and/or contagious life threatening illness | Chronic and/or contagious life threatening illness; no or mild complications | Chronic and/or contagious life threatening illness; moderate complications | Chronic and/or contagious life threatening illness; severe complications |
| Does not wet/soils clothing/bed | Wets or soils clothing/bed 1-2/week | Wets or soils clothing/bed 3-4/week | Wets or soils clothing several times per week; wets bed daily, hides wet clothing |
| No food restriction | Restriction of certain foods, i.e., strawberries, seafood, etc.; severity of reaction mild | Restriction of 1 food category i.e., dairy products, sugars, etc.; requires special foods, food supplements; severity of reaction moderate | Restriction of more than 1 food category i.e., dairy products, sugars, etc.; requires special diet or food supplements, or severe reaction to certain foods |
| No psychotropic medications | Stabilized; no or minimal psychotropic medications | Stabilized; moderate psychotropic medications | Unstable; frequent changes in psychotropic medications |
| Usually attends school regularly and willingly | Resists attending school and/or cuts school occasionally | Refuses attending school and/or cuts school monthly | Refuses attending school and/or cuts school weekly |
| Parent/Teacher conference 2X's/year | Foster Parent attendance at school related meetings approximately 1X/month | Foster Parent attendance at school related meetings approximately 1X/week | Foster Parent attendance at school related meetings several times weekly |

MEDICAL AND SPECIAL NEEDS CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|---|---|---|--|
| Not suicidal | Threatened suicide once | Frequently threatening of suicide | Attempted suicide or has previous crisis unit hospitalization |
| Able to take bus/bike/walk to school | Restricted from bus by school once or twice for short period | Restricted from bus by school more than twice for short period | On-going restricted from bus by school for short period or longer |

COMMENTS:**ADDITIONAL FACTORS TO CONSIDER:**

Caregiver's willingness to deal with difficult parents.

TEHAMA COUNTY DEPARTMENT OF SOCIAL SERVICES
ASSESSMENT FORM FOR CHILDREN WITH SPECIAL NEEDS
TEENS

The increased level of payment may be used for licensed foster home, relative and non-relative placements. Training requirements established by the Tehama County Department of Social Services must be met prior to payment. Reassessments are to be completed quarterly.

IDENTIFICATION

Child's name: _____ Date of birth: _____

Caregiver's name: _____

Medical/Psychiatric diagnosis: _____

Supervision level: _____ SW/PO: _____

Approved: _____ (Re) Assessment date: _____
(Supervisor)

SUPERVISION LEVELS

| | | | |
|-------|--------------------|----------------------|----------------------|
| BASIC | LEVEL I MINIMAL | LEVEL II MODERATE | LEVEL III MAXIMUM |
|-------|--------------------|----------------------|----------------------|

Place an "X" in the boxes for the descriptions that are most applicable
(Explain when requested)

MOBILITY

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|------------------|--|---|---|
| Walks unassisted | Walks unassisted with use of prosthetic device | Mobile with assistance and/or special equipment | Immobile, incapable of independent movement; non-ambulatory |

SELF-HELP

| | | | |
|--------------|--|---|-------------------------------------|
| Dresses self | Dresses self with minimal assistance; is cooperative | Dresses self with moderate assistance; is resistant | Cannot dress self; unable to assist |
|--------------|--|---|-------------------------------------|

SELF HELP CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|--|--|---|---|
| <p>Able and routinely cares for own hygiene needs</p> | <p>Able, but does not maintain hygiene needs on a regular basis</p> | <p>Able, but rarely maintains hygiene needs Explain: _____ _____</p> | <p>Unable to care for own hygiene needs Explain: _____ _____</p> |

COMMUNICATION

| | | | |
|---|---|---|--|
| <p>Understands and follows verbal instructions</p> | <p>Understands and follows verbal instructions with some misunderstanding Explain: _____ _____</p> | <p>Understands only a few words Explain: _____ _____</p> | <p>No receptive language; deaf or aphasia</p> |
|---|---|---|--|

BEHAVIOR

| | | | |
|--|--|--|---|
| <p>Appropriate interaction with others</p> | <p>Moderate social interaction; some threats, manipulative, disruptive Explain: _____ _____</p> | <p>Minimal social interaction; some threats, manipulative, disruptive Explain: _____ _____</p> | <p>Severely inappropriate or no social interactions; threats, severely manipulative, disruptive Explain: _____ _____</p> |
| <p>Seldom or never aggressive towards others and/or animals</p> | <p>Minimal aggression towards others and/or animals; does no harm Explain: _____ _____</p> | <p>Frequent aggression towards others and/or animals; does no harm Explain: _____ _____</p> | <p>Frequent aggression towards others and/or animals; does harm Explain: _____ _____</p> |
| <p>Not destructive to property; not self abusive</p> | <p>Occasionally destructive to property and/or self abusive</p> | <p>Occasionally destructive to property and/or self abusive; difficult to redirect Explain: _____ _____</p> | <p>Very destructive to property and/or self abusive; constant vigilance required Explain: _____ _____</p> |

BEHAVIOR CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|---|--|--|--|
| No smearing of feces | No smearing of feces | No smearing of feces | Some smearing of feces |
| Sexual behavior age appropriate; inoffensive | Some inappropriate sexual behavior requiring correction | Frequent inappropriate sexual behavior requiring correction | Alarming Inappropriate sexual behavior with others and/or animals |
| Does not run away | Has run away or attempted to run away 1-2 X's | Chronic run-a-way | Chronic run-a-way; involves others |
| Adaptable; accepts changes readily | Change presents minimal difficulty; needs help | Change presents moderate difficulty; needs help | Cannot handle change; rigid |

MEDICAL AND SPECIAL NEEDS

| | | | |
|--|--|---|---|
| Feeds self | Feeds self with supervision | Feeds self with supervision and special equipment | Unable to feed self |
| Uses toilet with no supervision | Uses toilet with minimum supervision; occasional bowel and bladder accidents Explain: _____ _____ _____ | Partial control; frequent bowel and bladder accidents Explain: _____ _____ _____ | No bowel or bladder control |
| Does not use drugs/ alcohol | Has experimented on occasion with drugs/alcohol | Frequent experimentation with drugs/alcohol; requires treatment | Chronic use of drugs/alcohol; established pattern of abuse; requires treatment |

MEDICAL AND SPECIAL NEEDS CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|--|---|--|--|
| <p>No seizures</p> | <p>Occasional seizures; mostly controlled</p> | <p>Frequent seizures; mostly controlled</p> | <p>Uncontrolled seizures</p> <hr/> <p>Colostomy, ileostomy, catheterization, ventilator-dependent, and other conditions requiring extensive home care Explain: _____ _____ _____</p> |
| <p>No prenatal drug exposure</p> | <p>Prenatal drug exposure; Fetal Alcohol effects/Syndrome diagnosed; no obvious concerns</p> | <p>Prenatal drug exposure; Fetal Alcohol/effects Syndrome diagnosed; moderate concerns Explain: _____ _____ _____</p> | <p>Prenatal drug exposure; Fetal Alcohol effects/Syndrome diagnosed; serious concerns Explain: _____ _____</p> |
| <p>Medical appts. at 1/month average; Foster Parent transports & participates</p> | <p>Medical appts. at 2-4/month average; Foster Parent transports & participates</p> | <p>Medical appts.> 4/month; Foster Parent transports & participates</p> | <p>Medical appts. >4/month; Foster parent transports & participates out of area Explain: _____ _____ _____</p> |
| <p>No counseling required</p> | <p>Routine frequency of counseling appts; 4/month; Foster Parent transports and participates</p> | <p>Routine frequency of counseling appts.; 5-7/month; Foster Parent transports and participates</p> | <p>Routine frequency of counseling appts.; 8+/month; Foster Parent transports and participates</p> |

MEDICAL AND SPECIAL NEEDS CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|--|--|---|--|
| No chronic and/or contagious life threatening illness | Chronic and/or contagious life threatening illness; no or mild complications | Chronic and/or contagious life threatening illness; moderate complications | Chronic and/or contagious life threatening illness; severe complications |
| Does not wet/soils clothing/bed | Wets or soils clothing/bed 1-2/week | Wets or soils clothing/bed 3-4/week | Wets or soils clothing several times per week; wets bed daily, hides wet clothing |
| No food restriction | Restriction of certain foods i.e., strawberries, seafood, etc.; severity of reaction mild | Restriction of 1 food category i.e., dairy products, sugars, etc.; requires special foods, food supplements; severity of reaction moderate | Restriction of more than 1 food category i.e., dairy products, sugars, etc.; requires special diet or food supplements; or severe reaction to certain foods |
| No psychotropic medications | Stabilized; no or minimal psychotropic medications | Stabilized; moderate psychotropic medications | Unstable; frequent changes in psychotropic medications |
| Usually attends school regularly and willingly | Resists attending school and/or cuts school occasionally | Refuses attending school and/or cuts school monthly | Refuses attending school and/or cuts school weekly |
| Parent/Teacher conference 2X's/year | Foster Parent attendance at school related meetings approximately 1X/month | Foster Parent attendance at school related meetings approximately 1X/week | Foster Parent attendance at school related meetings several times weekly |
| Not suicidal | Threatened suicide once | Frequently threatening suicide | Attempted suicide or has previous crisis unit hospitalization |

MEDICAL AND SPECIAL NEEDS CONT'D

| BASIC | LEVEL I | LEVEL II | LEVEL III |
|--------------------------------------|--|--|---|
| Able to take bus/bike/walk to school | Restricted from bus by school once or twice for short period | Restricted from bus by school more than twice for short period | On-going restricted from bus by school for short period or longer |

COMMENTS:

ADDITIONAL FACTORS TO CONSIDER:

Caregiver's willingness to deal with difficult parents.

Tehama County Department of Social Services – Child Welfare Services (CWS) Policies & Procedures

Original Effective Date: DATE

Revised: DATE

Title: **Specialized Care Rate (SCR) Program**

POLICY

The Specialized Care Rate (SCR) Programs is designed by the county and approved by the State. Specialized Care Rate Programs vary widely throughout the State. Systems can vary significantly on rate amounts, duration, process, time frames, and required documentation.

Specialized Care Rate increments are authorized for the purpose of providing additional financial support for the care and supervision of youth in foster care who have a medical, health or behavioral challenge that is beyond what would be normally expected for the child's age and developmental stage requiring extraordinary care and supervision for extended periods of time.

Specialized Care Rate increments, once approved, are added to the monthly basic rate. SCR increments are reviewed quarterly, and can increase, decrease, or end as medical, mental health, or behavioral challenges arise or change.

Information including the following will be used in the quarterly review of the Specialized Care Rate:

- Transportation and attendance at all medical, mental health and dental appointments.
- Care provider supervision and transportation to visitation.
- Care provider participation in school meetings, Team Decisionmaking (TDM) meetings and other family meetings.
- Care provider participation in additional training.
- Care provider participation and engagement in placement transitions and permanency outcomes.

To participate in the Specialized Care Program, caregiver must team with the county in creating detailed documentation of interventions, treatment, support, and services provided.

Not all medical conditions, mental health challenges, and/or troubling behaviors qualify for a specialized care rate.

| Age Group | | Basic Rate (B) | |
|---------------------------|-------------------------------|-----------------------------|--|
| 0-4 | | \$446 | |
| 5-8 | | \$485 | |
| 9-11 | | \$519 | |
| 12-14 | | \$573 | |
| 15-19 | | \$627 | |
| Level 1 (Mild) | Level 2 (Moderate) | Level 3 (Severe) | |
| B + \$253 | B + \$423 | B + \$719 | |

| |
|---|
| Title: Specialized Care Rate (SCR) Program |
|---|

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|------------------------------|
| <i>CONTINUED page 2 of 4</i> |
|------------------------------|

PROCEDURE

If a caregiver believes the minor in their care may be eligible for a specialized care rate based upon their medical, mental health or behavioral challenges the caregiver and the child's social worker should discuss the specific challenges and determine if it may be appropriate for the caregiver to request a specialized care rate assessment.

If it is determined that such a request would be appropriate the caregiver should be provided/complete the following forms:

- Specialized Care Rate Program Policy & Procedure
- Specialized Care Rate Assessment Form, including the Specialized Care Rate Training Requirements/Agreement (see also outline of these requirements below)
- Specialized Care Rate Caregiver Contract
- Specialized Care Rate Quarterly Report
- Specialized Care Rate Letter

Assessment forms should be submitted to the Placement Support Team. The PST will verify the information contained therein, seek any additional information that may be necessary to process the request for an SCR increment payment, and determine if a specialized care increment will be issued.

The process of establishing an SCR increment payment may take up to 30 days. The PST will notify the caregiver of the approval or denial of their request. Payments may be prorated back to date of the request, and in certain situations back to the date of placement. It is important to make the request as soon as a need for consistent extraordinary care is identified.

If approved for an SCR increment payment the caregiver will be asked to sign the SCR Caregiver Contract to be kept on file with the county. A copy will be provided to the caregiver along with a completed copy of the Specialized Care Rate Training Requirements/Agreement. Each quarter thereafter, following the schedule outlined on the SCR Caregiver Contract, the caregiver will be required to submit the SCR Quarterly Report as well as certificates of training attended during that period. The SCR Quarterly Report form also asks the caregiver to verify, as applicable to the SCR increment they are receiving, the following:

- Transportation was provided to appointments during review period
- Caregiver is current with all licensing or home approval requirements and training hours
- Caregiver participation in monthly social worker contacts and teacher conferences.

The SCR Quarterly Report will be part of the PST's quarterly reassessment of the specialized care increment and determination if it will continue, change, or end. If the conditions/behaviors improve, the specialized care increment may be either decreased or discontinued.

Classification of Specialized Care Rate

LEVEL A: MILD

| |
|---|
| Title: Specialized Care Rate (SCR) Program |
| <i>CONTINUED page 3 of 4</i> |

Specialized care needed because of child's physical or emotional behavior is such that requires more than normal care and supervision due to 3 or more of the following indicators alone and/or in combination with any indicators from the moderate and/or severe categories:

1. Medical conditions including but not limited to asthma, epilepsy, food allergies, or chronic illness.
2. Enuresis, encopresis, hyper-kinetic behavior, moderate or occasional emotional/behavioral problems.
3. Moderate education problems/challenges.
4. Frequent trips to doctor or therapist.

LEVEL B: MODERATE

Specialized care needed because of child's physical or emotional behavior is such that requires more than normal care and supervision due to 2 or more of the following indicators alone and/or in combination with any indicators from the mild and/or severe categories:

1. Severe physical or medical problems requiring frequent trips to doctor or therapist.
2. Recurrent out-of-county trips to doctor or therapists.
3. Severe educational problems.

LEVEL C: SEVERE

Specialized care needed because of child's physical or emotional behavior is such that requires more than normal care and supervision due to 1 or more of the following indicators alone and/or in combination with any indicators from the mild and/or moderate categories:

1. Severe emotional or behavioral challenges, destructive behavior, stealing, abnormal sexual behavior, sexual acting out, frequent running away, assaultive behavior, fire setting, etc.
2. Severe challenges in school requiring foster parent to have daily interaction with education personal.

The above criteria will be used as a guideline for the Placement Support Team to utilize when assessing or considering Specialized Care Rate requests in concert with the narrative explanations/other information provided during the SCR assessment process, including but not limited to consultation with service providers or the child's social worker.

Specialized Care Rate Training and Service Requirements

- The caregiver will ensure the availability of at least one parent in the home on a full-time basis when child(ren) is/are home.
- The caregiver(s) will attend ongoing foster training as outlined below;
 - 24 hours each year for Level I
 - 36 hours for Level II
 - 48 hours for Level III.****Training hours are in addition to valid First Aid/CPR certification.*
- The caregiver(s) agree to work as a parent role model for families participating in Reunification services.
- The caregiver(s) agree to supervise relative visits upon request.

Title: **Specialized Care Rate (SCR) Program**

CONTINUED page 4 of 4

- The caregiver(s) agree to transport the child(ren) to services.
- The caregiver(s) agree to participate in services, such as counseling and medical appointments, when deemed necessary and appropriate.
- The caregiver(s) agree to provide a special diet, including a bag lunch for school, if necessary.
- The caregiver(s) agree to provide other services as specified on the Service Plan, to include but not limited to, Independent Living Skills Program (ILSP), WRAP, Multi-Agency Team (MATT), and Therapeutic Behavioral Services (TBS).

REFERENCES

Regulations

To be inserted

Related/Referenced Policies & Procedures

FORMS

Specialized Care Rate Program Brochure



SCR Brochure.pub

Specialized Care Rate Assessment Form, including the Specialized Care Rate Training Requirements/Agreement



Tehama SCR
Assessment.doc

Specialized Care Rate Caregiver Contract



Tehama SCR
Caregiver Contract.d

Specialized Care Rate Quarterly Report



Tehama SCR
Quarterly Report.doc

Specialized Care Rate Letter



Tehama Co SCR
Rate Letter.doc

Other



Charlene Reid, MSW, Director

t: (530) 527-1911 • f: (530) 527-5410 • P.O. Box 1515 • 310 South Main Street • Red Bluff, CA 96080

www.tcdss.org

Date

REQUEST FOR SPECIALIZED CARE RATE

From: _____ Approved: _____
Social Worker Supervisor

Minor's name: _____

Date of birth: _____

Case no.: _____

The above-named minor was placed at:

facility name

The level of supervision was determined to be: (circle one) **Basic** I II III

Eligibility Date: _____

See attached assessment and foster parent specialized care qualification.

lkc: SAVE/Specialized Care Rate Request (09/2006)



Specialized Care Rate (SCR) Assessment Form

The increased level of payment may be used for licensed foster care homes, and non-relative placements. Training requirements established by the Tehama County Department of Social services must be met prior to payment. Reassessments are to be completed quarterly.

Identification

Minor's name: _____ Date of birth: _____

Caregiver's name: _____ Placement Date: _____

Any known Medical/Psychiatric diagnosis: _____

Is the minor a Regional Center Client: ____ Yes ____ No ____ Unknown

Current Visitation Schedule (include location): _____

Social Worker: _____

Health Needs and Concerns: *Please indicate if each section is applicable to youth, by indicating N/A, Yes or No.*

| Concern | Mild | Moderate | Severe |
|--|---|--|--|
| Food Allergies- | Restriction of certain foods, i.e., strawberries, seafood, etc., severity of reaction is mild. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Restriction of 1 food category, i.e., dairy products, gluten, etc., requires special foods/supplements; severity of reaction is moderate. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Restriction of more than 1 category, i.e., dairy products and sugar, etc.; requires special diet, severe reaction to certain foods. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Feeding (children two years of age and above)- | Feeds self with supervision. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Feeds self with supervision and special equipment. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Unable to feed self. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Self-help skills (children 5 years of age and older)- <i>(continued to next page)</i> | Moderate Age appropriate self-help skills; Feeds and dresses self with minimal assistance, walks unassisted, | Minimal self-help skills; Mobile with assistance and/or special equipment, frequent bowel and bladder accidents, dresses self | Non-ambulatory, and incapable of independent movement, cannot dress self and unable to assist, unable to care for own hygiene needs, no bowel |

| | | | |
|--|--|---|--|
| | requires some supervision with toileting; occasional soiling accidents, needs assistance with hygiene <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | with assistance but is resistant <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | or bladder control. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|---|--|

Please explain any of the above observed behaviors or concerns in detail below. In addition, please describe what you do on a daily basis to meet the child’s needs which requires a higher level of care that you believe to be above basic parenting responsibilities:

Medical and Special Needs: *Please indicate if each section is applicable to youth, by indicating N/A, Yes or No.*

| Concern | Mild | Moderate | Severe |
|---|--|---|---|
| Pre-natal Drug/Alcohol Exposure- (Please describe in complete detail below) | Prenatal drug exposure; Fetal Alcohol Effects/Syndrome diagnosed: minimal effects. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Prenatal drug exposure; Fetal Alcohol Effects/Syndrome diagnosed: moderate concerns or effects. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Prenatal drug exposure; Fetal Alcohol effects/syndrome diagnosed: severe effects. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical Appointments- | Medical appointments. 2-4 per month, caregiver participates and transports. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Medical appointments. 4+ per month, caregiver participates and transports. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Medical appointments. 4+ per month, caregiver participates and transports out of the area. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic or Life Threatening Illness- | Chronic and/or contagious life threatening illness; little to mild complications. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic and/or contagious life threatening illness; moderate complications. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic and/or contagious life threatening illness; moderate to severe complications. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Counseling and Mental Health- ___/___/___ Date of Mental Health Assessment or check box below if non-applicable. | Routine frequency of counseling appointments; 4 per month. Caregiver transports and participates. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Routine frequency of counseling appointments; 5 to 7 per month. Caregiver transports and participates. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Routine frequency of counseling appointments; 8+ per month. Caregiver transports and participates. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Psychotropic Medications- <i>(continued to next page)</i> | Stabilized; minor takes psychotropic medication as administered with little to no resistance. | Stabilized; moderate compliance with psychotropic medication. Minor has to be encouraged to | Unstable; frequent changes in medications and/or refusal to take prescribed medications. |

| | | | |
|---|--|---|---|
| | <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | comply. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Suicide- | Threatened or discussed suicide on one occasion. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequently threatening and discussing suicide. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Attempted suicide or has current or previous crisis unit hospitalization. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Enuresis/Encopresis (children over 4 years of age)- | Wets or soils clothing or bed 1 to 2 times per week. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Wets or soils clothing or bed 3 to 4 times per week. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Wets or soils clothing several times per week and wets bed daily, hides wet clothing and/or sheets, pattern of smearing feces. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Substance Abuse- | Has experimented on occasion with drugs and/or alcohol. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent experimentation with drugs and/or alcohol. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic use of drugs and or alcohol; 2 to 3 times a week. (Social worker to refer minor to Drug and Alcohol Services). <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain any of the above observed behaviors or concerns in detail below. In addition, please describe what you do on a daily basis to meet the child's needs which requires a higher level of care that you believe to be above basic parenting responsibilities:

Behavior Needs and Concerns: Please indicate if each section is applicable to youth, by indicating N/A, Yes or No.

| Concern | Mild | Moderate | Severe |
|---|---|---|---|
| Interaction with others and/or animals- | Moderate social interaction; some threats, manipulative, disruptive, occasional aggression toward others and/or animals. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Poor social interactions, verbal threats, manipulative, disruptive, frequent aggression toward others and/or animals, difficult to redirect. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Severely inappropriate or no social interaction; verbal and physical threats, severely manipulative, disruptive, frequent aggression toward others and/or animals with harmful intent. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Property Destruction- | Occasionally destructive to property and/or self abusive. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Destructive to property and/or abusive one to three times a week; very difficult to redirect. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Destructive to property on a daily basis and/or self abusive; Constant vigilance required. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | | | |
|-------------------------------------|--|---|---|
| Sexualized Behavior- | Some inappropriate sexual behavior with others and/or animals, requires correction. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent inappropriate sexual behavior with others and/or animals requires correction. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive inappropriate sexual behavior with others and/or animals; constant vigilance required. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Listening and Following Directions- | Understands and follows verbal instructions and directions with minimal misunderstanding and reminding. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Follows directions but requires constant reminding and supervision. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | No receptive and/or expressive language; cannot follow directions. (3 to 18 years of age) <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Routine Disruptions- | Change presents minimal difficulty; needs frequent assistance and reminding. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Change presents moderate difficulty; needs frequent assistance and reminding. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Intolerant of change. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Running Away- | Tendency to wander on occasion, comes back on own. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent tendency to wander or runaway. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent tendency to wander, runaway, involves others or threatens to leave; must be brought back, requires constant supervision <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| School Attendance- | Resistant to attend school and/or cuts school occasionally. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Refuses to attend school and/or cuts school weekly. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Refuses to attend school and/or cuts school weekly. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| School Meetings/IEP- | Caregiver required to attend school related meetings approximately once per month. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Caregiver required to attend school related meetings approximately once per week. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | Caregiver required to attend school related meetings multiple times per week. <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain any of the above observed behaviors or concerns in detail below. In addition, please describe what you do on a daily basis, including transportation to meet the child's needs which requires a higher level of care that you believe to be above basic parenting responsibilities:

Tehama County Department of Social Services Specialized Care Rate Training Requirements

I/We will ensure the availability of at least one parent in the home on a full-time basis when child(ren) is/are home.

I/We will attend ongoing foster training as outlined below;

- 24 hours each year for Level I
- 36 hours for Level II
- 48 hours for Level III.

****Training hours are in addition to valid First Aid/CPR certification.*

Services Required for Specialized Rate Reimbursement

- I/We agree to work as a parent role model for families participating in Reunification services.
- I/We agree to supervise relative visits upon request.
- I/We agree to transport the child(ren) to services.
- I/We agree to participate in services, such as counseling and medical appointments, when deemed necessary and appropriate.
- I/We agree to provide a special diet, including a bag lunch for school, if necessary.
- I/We agree to provide other services as specified on the Service Plan, to include but not limited to, Independent Living Skills Program (ILSP), WRAP, Multi-Agency Team (MATT), and Therapeutic Behavioral Services (TBS).

I/We understand that the Department policy requires on-going documentation by the caregiver of the minor's behaviors and appointments. Re-assessment of the minor's needs will be required on a quarterly basis, and the Specialized Care Rate may be increased, decreased, or discontinued following each review.

I/We have completed the training requirements and agree to provide the services noted above.

Caregiver Signature

Date

PST Supervisor Signature

Date

For Department use only

SCR Approval/Assessment Date: _____ **Approved Level** _____

Suggested Training Topics and PST comments:

Information contained in this report is confidential and to be used only for the purpose of establishing the appropriate Specialized Care Rate and documenting care in the minor's file for Tehama County Child Welfare Services Division. Information contained in this report may become a part of Court records, if applicable to social worker findings or case plan approval.

Information contained in this report may be subject to additional verification.

By completing and signing this report, the caregiver is verifying the information to be true and correct to the best of his/her knowledge.

INSTRUCTIONS:

- Complete report quarterly and return no later than the 10th of the month following the report period.

| Quarterly Period | Quarterly Report Due Date |
|--------------------------|---------------------------|
| January through March | April 10th |
| April through June | July 10th |
| July through September | October 10th |
| October through December | January 10th |

- Reports should be legible and in ink. Reports may be typed.
- Completed reports will be date stamped upon receipt.
- The agency will send a courtesy reminder regarding reports; however, it is the care provider's responsibility to submit the reports quarterly and timely regardless of reminders.
- Copies of receipts, attendance logs, records of extra-curricular activities or any other form of verification regarding information provided within the quarterly report should be attached to the report. Verifications must be submitted for a report to be considered complete.
- Caregivers are encouraged to include pictures of the youth or copies of awards or certificates during the month of review.

Quarterly progress reports cannot be substituted for the required CHDP records submission requirement. If you have already submitted information on a CHDP report, it is not necessary to repeat the same information on the quarterly report.

What happens if my quarterly progress report is not submitted timely?

- If not received by the last date of the month following the report period, the SCR will be reduced to the basic rate regardless of the current level.
- In October each year the Placement Support Team will notify you if you have not completed your required training hours. If hours are not completed by January 10th your SCR will be reduced to the basic rate regardless of the current level.

If you need any assistance in completing the quarterly reports, please do not hesitate to contact the Placement Support Team or your Social Worker.

| | | | |
|--------------------------------------|--|------|--|
| Caregiver Signature | | | |
| Caregiver Name <i>(Please Print)</i> | | Date | |
| Date Received by PST | | | |

| Date | Health/Service Provider or Activity | Reason for Visit | Type of Appointment |
|------|-------------------------------------|------------------|--|
| | | | <input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services |
| | | | <input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services |
| | | | <input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services |
| | | | <input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services |
| | | | <input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services |
| | | | <input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services |
| | | | <input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services |
| | | | <input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services |
| | | | <input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services |
| | | | <input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services |
| | | | <input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services |

****If additional space is necessary please attach additional sheets**

BEHAVIOR CHALLENGES No significant behavior challenges in this reporting period

| Date(s) | Description of Behavior **Attach Incident Report** |
|---------|---|
| | |
| | |
| | |

EXTRACURRICULAR/SPORTING ACTIVITIES: Check all that apply No extracurricular or sports

| | | | |
|----------------------|----------------------|-------------------|----------------|
| After school program | Soccer | Baseball/softball | Football |
| Track/field | Dance | Gymnastics | Basketball |
| Music/choir | Art | Tutoring | School club |
| Play group | Religious activities | ILSP activities | Scouts or YMCA |
| Other: | Other: | | |

FOSTER PARENT TRAININGS COMPLETED THIS QUARTER No Trainings

| Date(s) | Description of Training and/or Topics **Attach Certificates** |
|---------|--|
| | |
| | |
| | |

The following is a list of requirements based upon SCR Levels. Please mark all that apply.

- I have provided transportation to appointments during review period.
- I am current with all licensing or home approval requirements and training hours.
- I participate in monthly social worker contacts and teacher conferences.

Foster Parent Signature

Date

Please make sure that you have accurately completed this report. Your answers are used to validate continued eligibility for the SCR program. When completed, return to the following address:

**Tehama County Department of Social Services
PO BOX 1515, Red Bluff, CA 96080
ATTN: PST**

For Department Use Only

- MATT Referral/Child's needs appear to exceed Level 3
- Verified that Caregiver is current with all licensing or home approval requirements and training hours.

SCR Approval/Assessment Date: _____ **Approved Level** _____

Suggested Training Topics and PST comments:
