

CHILD SPECIFIC FUNDING TEMPLATE

INSTRUCTIONS: This document shall be completed when requesting funding pursuant to Assembly Bill 153 (Chapter 86, Statutes of 2021; WIC § 16001) for children with exceptional needs. If a qualified individual (QI) assessment has already been completed, it can be submitted with this form and answers can refer to the QI assessment, e.g., refer to the attached QI assessment, Section II. Only complete those sections relevant to this child. Once complete, please submit completed form and any relevant documentation to RatesPolicy@dss.ca.gov.

County:	
Contact Person:	
Phone Number:	
Email Address:	

CHILD/NON-MINOR DEPENDENT	
Name of child/Nonminor dependent (NMD):	
Date of birth:	
CWS/CMS ID # (19-digit Client ID):	
Gender Identification:	
Sexual Orientation, Gender Identity and Expression (SOGIE - how the child/NMD expresses gender/preferred pronouns):	
Ethnicity (specify if more than one):	
Cultural considerations, i.e., language preferences, religious practices, traditions, spirituality, food preferences, etc.:	

ASSESSMENT/RECOMMENDATION BASIS	
<i>(Indicate Yes, No, or N/A to all that apply. Include date of the assessment or meeting)</i>	
Qualified Individual Assessment	
System of Care Technical Assistance	

Clinical recommendation approved by an interagency placement committee that considers the recommendations of a child and family team.	
Other child/NMD-specific assessments or evaluations.	

PERMANENCY AND FAMILY FINDING <i>(Indicate Yes, No, or N/A to all that apply and provide further detail when directed)</i>	
Is there an identified permanent family home that is the permanency goal for the child? If so, please state the permanency goal and the child's relationship to the identified home.	
Does the child/NMD have intensive family finding needs?	
Does the child/NMD and family have family engagement related needs?	
Did the assessment or recommendation indicated above identify specific needs of the child/NMD and family that would support the child's/NMD's placement with the family? If so, please describe.	
What is the current frequency of Child and Family Team (CFT) meetings? What is the date of the last CFT?	
What exceptional services or supports, are needed but unavailable to support the child/NMD in the least restrictive setting?	
Identify the approximate/estimated costs associated with these needs.	
Describe how these funds will be expended, including any third-party service providers.	

PLACEMENT CHALLENGES <i>(Indicate Yes, No, or N/A to all that apply and provide further detail when directed)</i>	
Is there a 14-day notice for a placement change? If so, what was the reason for the 14-day notice?	
Is there an inability to identify placement due to recurring placement denials? If so, what were the reasons given for the placement denials?	
Does the child have any Commercial Sexual Exploitation of Children (CSEC) related needs? If so, please describe.	
Has the County completed a System of Care Technical Assistance (TA) call to mitigate placement challenges?	
What is the child's/NMD's preferred placement? What is the County's preferred placement?	
Provide a list of the requested services or supports that are needed but unavailable to support the child/NMD in the least restrictive setting?	
Identify the approximate/estimated costs associated with these needs.	
Describe how these funds will be expended, and identify any third-party service providers.	

BEHAVIORAL HEALTH (Mental Health and Substance Use Disorder) <i>(Indicate Yes, No, or N/A to all that apply and provide further detail when directed)</i>	
Are all applicable Mental Health Providers (MHP) actively involved in the development of this request?	
Are all applicable MHPs participating in all CFT meetings?	
Is the Substance Use Disorder (SUD) provider, as applicable, actively involved in the development of this request?	
Is the SUD provider, as applicable, participating in all CFTs?	
Are all the Behavioral Health needs identified in the child's/NMD's assessments being addressed?	
Is the child/NMD currently determined to meet medical necessity for a psychiatric hospital or a Psychiatric Health Facility?	
Did a Short Term Residential Therapeutic Program (STRTP) treating clinician recommend a higher level of care for the child/NMD? If so, please describe.	
Is the child/NMD and family actively participating in the services being provided?	
Was responsibility for the child's/NMD's specialty mental health services presumptively transferred?	
Provide a list of the requested services or supports that are needed but unavailable to support the child/NMD in the least restrictive setting?	
Identify the approximate/estimated costs associated with these needs.	
Describe how these funds will be expended, and identify any third-party service providers.	

DEVELOPMENTAL <i>(Indicate Yes, No, or N/A to all that apply and provide further detail when directed)</i>	
Is the child/NMD a regional center consumer? If so, identify the regional center.	
Is the applicable regional center actively involved in the development of this funding request?	
Is the applicable regional center participating in all CFTs?	
Does the child/NMD require a regional center vendorized placement?	
Provide a list of the requested services or supports that are needed but unavailable to support the child/NMD in the least restrictive setting?	
Identify the approximate/estimated costs associated with these needs.	
Describe how these funds will be expended, and identify any third-party service providers.	

MEDICAL <i>(Indicate Yes, No, or N/A to all that apply and provide further detail when directed)</i>	
Are there any physical health concerns, diagnoses, conditions or special health care needs that cannot be addressed under existing rate/placement structures? If so, please describe.	
Is there is an Individualized Health Care Plan (IHCP), and an IHCP Team in place? If so, is the IHCP actively involved in the development of this funding request?	

Are there any costs that Medi-Cal cannot cover? If so, please describe.	
Provide a list of the requested services or supports that are needed but unavailable to support the child/NMD in the least restrictive setting?	
Identify the approximate/estimated costs associated with these needs.	
Describe how these funds will be expended, and identify any third-party service providers.	

TOTAL FUNDING REQUEST	
What is the total dollar amount for the quarter that is requested for funding?	
Will the funding request be a one-time cost or reoccurring costs? If reoccurring, what is the frequency of the reoccurring costs?	
Approximately how long will the funding be needed?	

Signature: _____

Date: _____