Alpine County Specialized Care Increment Plan

Alpine County’s Specialized Care Increment (SCI)/Specialized Care Rate (SCR) Program provides a supplemental payment to the resource family provider caring for a child with additional daily needs and with behavioral, emotional, physical and/or health issues beyond those provided by the Level of Care (LOC) rate. The SCI payment is in addition to the LOC rate. The LOC and SCI may be based on the same conditions when the care and supervision needs of the child are not sufficiently provided by the determined LOC rate.

Population Served

Children/youth in foster care, including Non-Minor Dependents, will be eligible for SCI consideration, including children receiving foster care benefits in a Non-Relative Legal Guardianship, Kin-GAP, or AAP. The SCI is not available for a child/youth receiving Intensive Services Foster Care (ISFC), placed in Therapeutic Foster Care (TFC), residing in a Supervised Independent Living Program (SILP), residing in a Short Term Residential Therapeutic Program (STRTP), or receiving a Dual Agency Rate as a regional center client.

Currently, there are no children in Alpine County who are receiving an SCI, however it is anticipated that there could be 1 child at any time who could receive an SCI.

Payment Amounts

Alpine County has three established SCI rate levels and will offer SCI rates to resource families meeting criteria for the completion of the SCI assessment. Any of the SCI levels can be applied to any LOC rate with the exception of the ISFC level. As stated above, any child who qualifies for ISFC LOC will not qualify for an additional SCI payment.

Alpine County Specialized Care Increment (SCI) Rates

<table>
<thead>
<tr>
<th>SCI Rate Level 1</th>
<th>SCI Rate Level 2</th>
<th>SCI Rate Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOC Rate plus $100</td>
<td>LOC Rate plus $150</td>
<td>LOC Rate plus $200</td>
</tr>
</tbody>
</table>

Alpine County will apply the same cost of living increases used for the LOC rates to the SCI rates with the same effective dates.

Qualifying Criteria

Alpine County is adopting the County Welfare Directors Association (CWDA) SCI Matrix (Attachment A). Each tier can be applied to any LOC rate, except for the ISFC rate.
County Review Process

An SCI assessment will occur after the initial and any subsequent Child and Family Team meeting, and after the completion of the LOC protocol. At triggering events, as defined by ACL 17-11, and within mandated timelines, the social worker completes the LOC determination matrix to determine the foster care rate and the SCI worksheet (attachment B). In order to determine the appropriate tier for the child, the social worker will gather information from the resource parents, biological parents, behavioral health providers, the Child and Family Team, and other providers as determined. The social worker will give the SCI worksheet to the Deputy Director or Director for review and approval. The effective date of the SCI will be the date the Deputy Director or Director approves the worksheet. A copy will be provided to the integrated case worker and a copy will be maintained in the child welfare case file. The social worker will enter the SCI rate amount in the placement section of CWS/CMS, the child welfare case management system. The integrated case worker will issue the applicable Notice of Action (NOA) (Attachment C).

In instances where an SCI is needed prior to the initial LOC rater determination to immediately stabilize a foster care placement the same procedure will be followed and the SCI rate will be applied to the basic foster care rate.

Reassessment

The SCI will be reassessed every six months however the SCI may be reevaluated if the social worker determines that the SCI is not meeting the child’s needs (conducted in conjunction with a LOC assessment), there is a change in the child’s needs or a resource family requests a reassessment. The same procedures described above will be followed for reassessments.

Implementation

Alpine County’s SCI Plan will be implemented once the LOC protocol is fully implemented by California Department of Social Services (CDSS). Currently, there are no children in care receiving an SCI to be transitioned to the new SCI plan.

Out of County placement

Out of county SCI rates will be determined using the county of residences SCI criteria and methodology. If the county of residence does not have an SCI plan then Alpine County will use our County plan.
Alpine County SCI Point of Contact

Nichole Williamson, Director
75A Diamond Valley Road
Markleeville, CA 96120

(530)694-2235

nwilliamson@alpinecountyca.gov
## Alpine County SCI Matrix

**SCI Matrix**

The following table is not intended to include every possible condition or situation, but rather as some basic guidelines. In general, the conditions are suggested to be the minimum for a particular Tier, especially for Tier 3.

<table>
<thead>
<tr>
<th>Area</th>
<th>Tier 1 <strong>If three (3) or more of the Tier 1 conditions listed exist, rate will be increased to the next higher level.</strong></th>
<th>Tier 2 <strong>If three (3) or more Tier 2 conditions exist, or two (2) Tier 2 conditions and three (3) Tier 1 conditions exist, or one (1) Tier 2 conditions and six (6) Tier 1 conditions exist, rate will be increased to the next higher level.</strong></th>
<th>Tier 3</th>
</tr>
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</table>
| **Medical conditions** | - Drug exposed history or positive toxicology screen.  
- Alcohol exposure (FAS, FASD or FAE)  
- Respiratory Difficulties and Diseases  
- Failure to Thrive  
- Diabetes & Heart Disease  
- Hemophilia  
- Seizures  
- Physical Disabilities/Impairments  
- Brain Injury (abuse or accidental)  
- Visually impaired (birth, abuse, or accidental)  
- Hearing impaired (birth, abuse, or accidental)  
- Immune Disorders  
- Surgical intervention Orthopedic abnormalities (birth or abuse) (i.e. scoliosis)  
- Severe burns | - 1-3 appointments per month not including routine dental or physical examinations.  
- Long-term prescription medications (medication needed on a daily basis for a period of 1 or more months).  
- One-two medications not including prescription vitamins or short-term antibiotics.  
- Mild breathing difficulties requiring prescription medications with close supervision.  
- Sickle Cell SF (Sickle hemoglobin FS, HPFH, Asymptomatic)  
- Symptomatic respiratory difficulties requiring the use of nebulizer breathing treatments.  
- Diabetes with special diet – no insulin or medication needed.  
- Failure to thrive due to mild feeding difficulties  
- Seizure disorder (Abnormal EEG, medication required for seizure activity)  
- Heart disease requiring close monitoring no intervention special treatments or diet.  
- HIV positive clinically well | - 4-6 appointments per month not including routine dental or physical examinations.  
- Positive toxicology screen at birth (level should be reduced at 6 month review if baby is not exhibiting any symptoms or difficulties)  
- Confirmed by maternal history, drug and/or alcohol exposure prenatal with symptoms. (level should be reduced at 6 month review if infant is not exhibiting any symptoms or difficulties)  
- Apnea or heart monitor required (when discontinued, rate to be reduced to appropriate level)  
- Moderate feeding difficulties requiring therapy or special feeding techniques.  
- Seizures requiring intermittent monitoring, medications and other interventions to control.  
- Severe respiratory difficulties requiring medications, breathing treatments (not including the use of inhalers) and/or CPT (Chest Physical Therapy) on a daily basis.  
- Intermittent oxygen.  
- Diabetes with special diet and oral medications. Stable condition, child compliant with prescribed program.  
- Medical diagnosis of Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Spectrum Disorder (FASD). Not the same as prenatal alcohol exposure Fetal Alcohol Effect (FAE).  
- Shunt placement-functioning stable | - More than 6 appointments per month not including routine dental or physical examinations.  
- FAS/FASD with moderate to severe complications (verifiable medical diagnosis)  
- Conditions requiring daily at home Physical Therapy (PT), Occupational Therapy (OT), in addition to weekly or biweekly therapy sessions.  
- Severe feeding problems, excessive crying, sleep disruptions, etc. due to alcohol/drug exposure  
- Continuous oxygen.  
- Diabetes with special diet, close monitoring of daily blood sugars levels, insulin injections, etc., Minor is compliant with program.  
- Hemophiliac requiring close monitoring to prevent injury.  
- Minor requires 4 or more injections per week (i.e. growth hormone, asthma, etc)  
- Sickle Cell SC, Severe Symptoms.  
- Child requires continuous care and supervision on a daily basis in accordance with a prescribed treatment plan that would |
### Alpine County SCI Matrix

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<th>Tier 3 otherwise require placement in an institutional facility.</th>
</tr>
</thead>
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<tr>
<td></td>
<td>☐ Fetal Alcohol Effect or Exposure (FAE) Attention deficits, Memory deficits, ☐ Sickle Cell – SB + Thal, Mild Symptoms. ☐ Mild/moderate Cerebral Palsy requiring minimal additional assistance with feeding, dressing, bathing, etc. ☐ Minimal brain injury requiring minimal additional observations and guidelines. No shunt required or with stable shunt requiring no medical intervention. ☐ Visual condition is stable and infrequent intervention is needed (e.g., eye drops or eye patch). ☐ Hearing condition is stable and infrequent intervention is needed or hearing aid is needed. ☐ Minimal bracing equipment is needed (i.e. AFO’s) ☐ Other:</td>
<td>☐ Sickle Cell SB Thal Moderate Symptoms 11. Minor requires 1-3 injections per week (i.e. growth hormones, asthma, etc). ☐ Cleft lip requiring surgical intervention and special feeding assistance. ☐ Physical abnormalities requiring medical intervention. ☐ Moderate Cerebral Palsy or physical disability requiring assistance with feeding, dressing, etc. ☐ 2nd degree burns requiring regular, but not daily dressing changes. This generally applies to children 8 or over who can cooperate with the treatment plan. ☐ Visually impaired requiring minimal assistance with daily living (i.e. Mobility, special education, etc.) 17. Hearing-impaired requiring moderate assistance (i.e. specialized communication techniques, speech therapy, and special school program). ☐ Scoliosis requiring assisted daily exercise and/or bracing. ☐ Other:</td>
<td>☐ Visual or hearing impaired requiring constant care provider assistance with daily living activities and/or adaptive home environment. ☐ Hearing impaired requiring assistance with daily living including care provider signing abilities for specific child. ☐ Combined cleft lip/palate. ☐ Other:</td>
</tr>
<tr>
<td></td>
<td>Moderate developmental delays or disabilities requiring weekly care provider assistance. ☐ Other:</td>
<td>Moderate to severe developmental delays or disabilities that require daily assistance from the care provider. Regional Center client documentation required from RC SW. ☐ Intermittent assistance from a behaviorist or social/health services provider. ☐ Regional Center client: 0-3 years of age to be included in Early Intervention Program (EIP) (i.e. Lori Ann Infant Stimulation, Exceptional Parents Unlimited (EPU). Documentation required from either EIP or RC social worker.</td>
<td>Moderate to severe developmental delays or disabilities requiring extensive daily assistance several times a day from the care provider. ☐ Regular in-home assistance from a behaviorist or social/health services provider. ☐ Multiple impairments, less than 18 months developmentally, nonambulatory. Regional Center</td>
</tr>
<tr>
<td></td>
<td>☐ Developmental delays or disabilities (e.g., Intellectual Disability, Autism Spectrum etc.) ☐ Learning Delays or Disabilities ☐ Sensory Integration Disorder</td>
<td>☐ Regional Center: 0-3 years of age to be included in Early Intervention Program (EIP) (i.e. Lori Ann Infant Stimulation, Exceptional Parents Unlimited (EPU). Documentation required from either EIP or RC social worker.</td>
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5/4/2018
## Alpine County SCI Matrix

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</tr>
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<tbody>
<tr>
<td>Behavioral Issues</td>
<td>□ Behavior modification required but no medication prescribed. □ The child presents some risky behaviors sometimes placing self and/or others at risk. □ Close supervision is sometimes necessary to minimize risk and/or reduce potential for disruption. □ Psychotropic medication may be required with close supervision by care provider and increased follow up by therapeutic provider. □ Other:</td>
<td>□ Behavior modification needed in conjunction with prescribed daily medication. □ The child is at high risk to self and/or others. Behaviors frequently are disruptive to household, school and in other social interactions. □ Stabilization of disruptive behaviors requires special intervention and discipline strategies. □ Care provider needs special training and participates in counseling with the minor to accomplish this. □ 601 behaviors (truant, beyond control of caregiver) exhibited at this level. □ Chronic resistance to behavior modification strategies. □ Personal property of others in the home at high risk. □ Excessive anti-social behaviors which strictly limits unsupervised social interaction. □ Other:</td>
<td>□ Child at extreme risk to self and/or others. In addition, therapeutic plan is required to address the minor’s disruptive, dangerous, and high-risk behaviors. □ Behaviors can be stabilized and reduced. Active participation in all areas of counseling and intervention is required by the care provider in order to facilitate therapy and treatment. □ 601 and 602 frequently exhibited themselves at this level. □ Monthly evaluations are essential at this level to track the progress of the minor and adjust treatment strategies as needed. □ Minors at this level are at risk of STRTP placement if professional treatment or behavior management plans do not modify high risk behaviors and/or emotional disturbances. □ Other:</td>
</tr>
</tbody>
</table>

### Behavioral Issues

- **AWOL**
- **Aggressive and Assaultive**
- **Animal Cruelty**
- **CSEC**
- **Substance Use/Abuse**
- **Gang Activity**
- **Fire Setting**
- **Severe mental health issues-including suicidal ideation and/or Self Harm**
- **Psychiatric hospitalization(s)**
- **Adjudicated violent offenses, significant property damage, and/or sex offenders/perpetrators**
- **Habitual Truancy**
- **Three or more placements due to the child’s behavior**
NOTICE OF ACTION - APPROVAL, CHANGE OR DISCONTINUED
For Resource Families, including homes certified by a Foster Family Agency, County Approved Relative Homes, Non-Relative Extended Family Members, Foster Family Homes, Non-Related Legal Guardians, Intensive Treatment Foster Care and/or Intensive Services Foster Care, Group Homes and Short-Term Residential Therapeutic Programs

(ADDRESSEE)

Notice Date: ________________________
Case Name: ________________________
Number: _________________________
Worker Name: ______________________
Number: _________________________
Telephone: _________________________
Address: _________________________

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

APPROVAL
☐ The County has approved your Foster Care aid.
As of ______________, the county is Approving your Foster Care aid of $ ______________ per month.
This aid is for: ____________________________________________.

CHANGE
As of ______________, the county is Changing your Foster Care aid from $ ______________ to $ ______________.
This aid is for: ____________________________________________.
Here’s why: Your rate is based on a level of care determination as defined in AB 403 and WIC section 11461.
☐ Your case had a rate increase.
☐ Your case had a rate decrease.
☐ Your case has been issued an Infant Supplemental Payment.
☐ Your case has been issued a Supplemental Care Increment.
☐ The child has countable income.
___________ (Income Type) for _____________ (Child’s Name)
of $ ______________ is effective ______________.
This is counted as ______________ income in the Foster Care budget calculation.
☐ Other:
☐ Due to funding requirements, you may receive multiple checks for this benefit month. The sum of these checks will be equal to the amount listed above.
NOTICE OF ACTION - APPROVAL, CHANGE OR DISCONTINUED
For Resource Families, including homes certified by a Foster Family Agency, County Approved Relative Homes, Non-Relative Extended Family Members, Foster Family Homes, Non-Related Legal Guardians, Intensive Treatment Foster Care and/or Intensive Services Foster Care, Group Homes and Short-Term Residential Therapeutic Programs

Notice Date: ______________________
Case Name: ______________________
Number: ______________________
Worker Name: ______________________
Number: ______________________
Telephone: ______________________
Address: ______________________

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

DISCONTINUED

☐ Your case has been discontinued.
As of ____________, the county is Discontinuing your Foster Care aid of $___________ per month.

Here's why:

☐ You are no longer providing foster care for: ________________________________

☐ The child's dependency case has been dismissed.

☐ He/she is no longer living in your home/facility. The County will stop paying for Foster Care from the day the child leaves your home/facility. He/she no longer meets the age rules.

☐ The youth is at least 18 years of age and does not qualify for extended foster care.

☐ The youth is at least 21 years of age.

☐ The child has too much income.

☐ The child has too much property. See attached page.
   If the County figured that the child's vehicle or other property was worth more than you think it's worth, you can give the County proof that it is worth less. Ask the County how. If you can prove it is worth less the child may get Foster Care aid.

☐ The legal guardianship was terminated.

☐ You moved out of the State of California.

☐ You did not return your completed redetermination paperwork.

☐ Other: ________________________________
YOUR HEARING RIGHTS
You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing before an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:
• Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
• Your Child Care Services may stay the same while you wait for a hearing.
• Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:
Yes, lower or stop: ☐ Cash Aid ☐ CalFresh ☐ Child Care

While You Wait for a Hearing Decision for:
Welfare to Work:
You do not have to take part in the activities.
You may receive child care payments for employment and for activities approved by the county before this notice.
If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.
If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.
• To get those supportive services, you must go to the activity the county told you to attend.
• If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

Cal-Learn:
• You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
• We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION
Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. (W&I Code Sections 10850 and 10950.)

TO ASK FOR A HEARING:
• Fill out this page.
• Make a copy of the front and back of this page for your records.
• If you ask, your worker will get you a copy of this page.
• Send or take this page to:

OR
• Call toll free: 1-800-952-5253 or for hearing or speech impaired who use TDD, 1-800-952-8349.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST
I want a hearing due to an action by the Welfare Department of County about my:
☐ Cash Aid ☐ CalFresh ☐ Medi-Cal ☐ Other (list)☐ Other (list)

Here's Why:

☐ If you need more space, check here and add a page.
☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is:

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE PHONE NUMBER

STREET ADDRESS

CITY STATE ZIP CODE

SIGNATURE DATE

NAME OF PERSON COMPLETING THIS FORM PHONE NUMBER

☐ I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)

NAME PHONE NUMBER

STREET ADDRESS

CITY STATE ZIP CODE
NOTICE OF ACTION - APPROVAL, CHANGE OR DISCONTINUED
For Kinship - Guardians Only

Notice Date: ____________________________
Case Name: ____________________________________________
Number: __________________________
Worker Name: ____________________________________________
Number: __________________________
Telephone: __________________________
Address: __________________________

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

APPROVAL
☐ The County has approved your Kin-GAP aid.

As of ____________, the county is Approving Kin-GAP aid of $ ____________ per month.

This aid is for: ____________________________

CHANGE
As of ____________, the county is Changing your Kin-GAP aid from $ ____________ to $ ____________.

This aid is for: ____________________________

Here's why: Your rate is based on a level of care determination as defined in AB 403 and WIC section 11461.

☐ Your case had a rate increase.
☐ Your case had a rate decrease.
☐ Your case has been issued an Infant Supplemental Payment.
☐ Your case has been issued a Supplemental Care Increment.
☐ The child has countable income.

__________________________ for ____________________________
(Income Type) (Child's Name)
of $ ____________ is effective ____________.

This is counted as __________________收入 income in the Kin-GAP budget calculation.

☐ Other: ____________________________

☐ Due to funding requirements, you may receive multiple checks for this benefit month. The sum of these checks will be equal to the amount listed above.
NOTICE OF ACTION - APPROVAL, CHANGE OR DISCONTINUED
For Kinship - Guardians Only

(ADDRESS)

Notice Date: __________________________
Case Name: ___________________________
Number: ___________________________
Worker Name: ___________________________
Number: ___________________________
Telephone: ___________________________
Address: ___________________________

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

DISCONTINUED

☐ Your case has been discontinued.
As of ____________, the county is Discontinuing your
Kin-GAP aid of $ ____________ per month.

Here's why:

☐ You are no longer providing support
for: ___________________________
He/she no longer meets the age rules.

☐ The youth is at least 18 years of age and does not qualify for
extended Kin-GAP.

☐ The youth is at least 21 years of age.

☐ The child has too much income.

☐ The child has too much property. See attached page. If the
County figured that the child's vehicle or other property was
worth more than you think it's worth, you can give the County
proof that it is worth less. Ask the County how. If you can prove
it is worth less the child may get Kin-GAP aid.

☐ The legal guardianship was terminated.

☐ You did not return your completed redetermination paperwork.

☐ Other: ___________________________

NA 403A (4/17) REQUIRED FORM - SUBSTITUTES PERMITTED
YOUR HEARING RIGHTS
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If you ask for a hearing before an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:
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- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:
Yes, lower or stop: □ Cash Aid □ CalFresh □ Child Care

While You Wait for a Hearing Decision for:
Welfare to Work:
You do not have to take part in the activities.
You may receive child care payments for employment and for activities approved by the county before this notice.
If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.
If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.
- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

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- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION
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TO ASK FOR A HEARING:
- Fill out this page.
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HEARING REQUEST
I want a hearing due to an action by the Welfare Department of ____________________________________________ County about my:
□ Cash Aid □ CalFresh □ Medi-Cal □ Other (list)

Here’s Why:

If you need more space, check here and add a page.
□ I need the state to provide me with an interpreter at no cost to me.
   (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is:

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED
BIRTH DATE PHONE NUMBER
STREET ADDRESS
CITY STATE ZIP CODE
SIGNATURE DATE

NAME OF PERSON COMPLETING THIS FORM PHONE NUMBER
STREET ADDRESS
CITY STATE ZIP CODE

□ I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)

NAME PHONE NUMBER
STREET ADDRESS
CITY STATE ZIP CODE

NA BACK 9 (REPLACES NA BACK 6 AND EP 5) (REVISED 4/2013) - REQUIRED FORM - NO SUBSTITUTE PERMITTED
SPECIALIZED CARE INCREMENT WORKSHEET

Child’s Name______________________________________   DOB:_______________

Child’s Assessed LOC:_____________  Date of LOC Determination:_______________

This child’s needs for a Specialized Care Increment are based on the following:

( ) MEDICAL CONDITIONS  
( ) Tier 1  
( ) Tier 2  
( ) Tier 3

( ) DEVELOPMENTAL DELAYS or DISABILITIES  
( ) Tier 1  
( ) Tier 2  
( ) Tier 3

( ) BEHAVIORAL ISSUES  
( ) Tier 1  
( ) Tier 2  
( ) Tier 3

Recommended Tier:_______________

Attach completed Specialized Care Increment Matrix.

Comments:

Social Worker Signature:___________________________ Date:_________________

Director Signature:_______________________________ Date:_________________

If approved, effective date:________________________

*Provide this form to the foster care eligibility worker. Place copy in CPS file. If approved, enter SCI in CWS/CMS.*

Reassessment Due Date (every six (6) months):___________________________________