June 29, 2018
California Department of Social Services, Specialized Care Incentive
Child Welfare Policy and Program Development Bureau
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Sacramento, CA 95814
SCI@dds.ca.gov

El Dorado County Specialized Care Increment (SCI) Plan

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Placerville, CA 95667

Background
El Dorado County Child Welfare Services (CWS) currently offers a Specialized Care Increment (SCI) to approved Resource Families and Legal Guardians receiving AFDC-FC funds on behalf of children requiring additional care because of medical, developmental, emotional and/or behavioral problems or concerns. There must be documentation of specific behaviors or needs of the child that place a financial demand on the care provider and/or require an increased amount of supervision to maintain the current placement.

El Dorado County CWS proposes adopting the CWDA SCI plan with one modification, the addition of another level. The CWDA SCI matrix and tool to determine SCI funding aligns with the implementation of the Continuum of Care Reform (CCR) Level of Care (LOC) protocol. El Dorado CWS’s proposed county plan regarding implementation of SCI is described below.

Vision Statement:
Transforming Lives and Improving Futures
Approximately 10% of the 293 children/youth currently in care receive a SCI. These 29 children reside in Resource Family Approval Homes (RFA), Non-Related Extended Family Members (NREFM) or Guardianship homes. Either Substitute Care Providers or social workers can request a SCI assessment.

El Dorado County manages 412 AAP cases and of these, 179 have a SCI. The majority of families receiving AAP benefits negotiate a SCI at the time of the adoptive placement. These are children/youth determined to have already met the criteria for a SCI while in foster care.

The County’s current five (5) level, point-value and rate structure for SCI assessments works well and provides resource families with necessary supports to care for our most vulnerable children/youth. It is unknown how the new SCI matrix will affect the number of children/youth eligible for a SCI rate until actual implementation occurs.

El Dorado County’s caregivers eligible to receive a SCI shall not change from our previous practice and includes:

- Licensed County Homes
- RFA Approved Homes
- RFA Emergency & Pending Approval Homes
- Relative/NREFM Approved Homes
- KinGAP Homes
- Guardian Homes
- AAP Homes
- Non-Minor Dependent (NMD) in a paid placement

The SCI is not available for children/youth in these situations:

- Receiving the Intensive Services Foster Care (ISFC) rate
- Therapeutic Foster Care (TFC) placements
- Supervised Independent Living Placements (SILP)
- Foster Family Agency placements (FFA)
- Dual Agency Regional Center clients
- Group Home, or STRTP placements

El Dorado County proposes collapsing the current SCI five (5) level system to four (4) levels: Limited, Mild, Moderate and Exceptional. New rates remain the same for one level and decreases slightly in the other three. The decrease is offset by the increase in the LOC rates. The Agency does not anticipate any current families receiving a SCI will incur a reduction in their rate if, at the time of their child’s reassessment, it is determined the child/youth in their care still warrants a similar SCI.

El Dorado County recognizes the proposed rate structure is designed to ensure that those currently receiving a Specialized Care Rate continue to receive a
similar overall payment for the children in their care, unless the child’s needs warrant a different level of payment at the time of reassessment.

The four (4) level SCI system simplifies the assessment process for both Care Providers and Social Workers alike in that it delineates conditions/behaviors ranging from limited to exceptional. It is the Agency’s expectations that a SCI determination will closely match the LOC determination. If, however, after implementation analysis reveals a different outcome than originally predicted, the Agency will revisit whether a tiered SCI system best supports the needs of the children and youth in care.

<table>
<thead>
<tr>
<th>Old SCI Rate</th>
<th>Under Old Rate, Total Payment to Care Provider Was</th>
<th>New SCI Level at time of Assessment or Reassessment</th>
<th>Total Payment to Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 - $210</td>
<td>$923 + 210 = $1,131</td>
<td>Level 1A - $210</td>
<td>$923 + 210 = $1,131 Basic plus SCI 1A</td>
</tr>
<tr>
<td>Level 2 - $368</td>
<td>$923 + 368 = $1,291</td>
<td>Level 1B - $264</td>
<td>$1,027 + 264 = $1,291 LOC 2 plus SCI 1B</td>
</tr>
<tr>
<td>Level 3 - $551</td>
<td>$923 + 551 = $1,474</td>
<td>Level 2 - $343</td>
<td>$1131 + 343 = 1,474 LOC 3 plus SCI 2</td>
</tr>
<tr>
<td>Level 4 - $831</td>
<td>$923 + 831 = $1,736</td>
<td>Level 3 - $619</td>
<td>$1,235 + 619 = $1,854 LOC 4 plus SCI 3</td>
</tr>
<tr>
<td>Level 5 - $1,050</td>
<td>$923 + 1,050 = $1,973</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

A SCI may only be authorized after an LOC determination is made. However, there may be exceptional circumstances in which a SCI may be approved prior to an initial LOC rate determination to stabilize a placement. In such instances, Program Manager approval is required.

The SCI payment to a Care Provider is in addition to the determined LOC rate.

SCI Triggering Circumstances

Care Providers and Social Workers may ask for a SCI assessment or reassessment based on their perception of the child/youth’s behavior, health or other qualifying factors.

The SCI remains in effect until the payment authorization expires, the child/youth’s condition changes, or placement change occurs. At a minimum, the SCI shall be reviewed at least annually with the exception of children/youth receiving AAP or Kin-GAP benefits. Kin-GAP re-assessments take place every two years.

AAP agreements remain in effect until the terms are met or there is a renegotiation initiated by the parents and they sign an amended agreement to reflect their concurrence of the renegotiated AAP benefit.
Social work staff submit the SCI Matrix and any recommended SCI determination to their supervisor for review with Program Manager approval required for all SCI awards. Approved SCI assessments are given to the clerical unit for completion of the SOC 158 and submission to the Foster Care Eligibility Worker for payment processing.

As is current practice, El Dorado County requires supporting documentation for all SCI authorizations. While documentation varies, it shall address the condition and/or behaviors identified as concerns and can include but is not limited to letters and documentation from therapists and/or medical providers, behavior specialists, Regional Center staff and school staff in addition to the SCI Matrix Worksheet and LOC assessment tools.

Any discrepancies between the Social Work staff and the Care Providers that cannot be resolved by the Social Services Supervisor are brought to the Program Manager. If agreement still cannot be reached, the Care Providers shall be provided notice of the fair hearing process via the State Notice of Action (NOA) should they wish to dispute the decision.

Please note, the NOA notifies care providers of the approval, redetermination or discontinuance of a SCI rate. The NOA form does not inform families of the denial of an SCI upon the conclusion of the assessment. If there are questions or concerns regarding the SCI rate that cannot be resolved through dialogue with the Care Providers, Social Work staff may choose to provide specific information in writing, including the family’s fair hearing rights, using the back of the NOA to the family via a letter or email.

El Dorado County is prepared to implement the new SCI plan upon approval from CDSS and concurrently with LOC implementation.

Families currently receiving a SCI payment shall continue to do so. Rates shall remain the same until such time the SCI expires or a triggering event occurs that sets in motion a LOC assessment. At that time, these children/youth will also be reassessed for additional support using the new SCI matrix.

AAP agreements executed prior to the revised SCI plan will remain the same until the parents initiate a renegotiation of their child’s AAP benefit. Note: AAP eligible children with an AAP basic rate based on the 2007 or 2008 rate structure will not be eligible to receive the LOC rate based on a reassessment but are eligible for the new SCI rates if criteria is met. For AAP cases that use the age-based system, SCI rates will continue to be paid based on the SCI rate structure associated with the case.

Care Providers will be notified of the new SCI rates by way of a Resource Family letter. In addition, time shall be set aside during regular RFA training to announce the change to the SCI assessment process and rate structure. Families receiving AAP benefits will be notified of changes to the SCI rate structure when and if they request a reassessment of their child’s current AAP benefits.
I request that SCF based on the documentation I provided and the concerns, conditions and/or interventions described on the following pages.

1. Resolve the issue immediately. You may request a status hearing.
2. Your request is denied and you disagree with the recommendation. You may ask to speak with a Program Manager and if unable to make a decision, you will receive a copy of the report and obtain an appeal for a status hearing.
3. Your request may be denied due to the requests and program requirements and/or the appeal process.
4. Provide information to the Social Worker to schedule time to review the form together and document any inaccuracies or concerns.
5. Review section A - Medical/Health, B - Developmental Delays and Disabilities, and C - Behavioral and Emotional Concerns and check all applicable.
6. The rate is $67.50 per month.
7. The rate is $34.94 per month.
8. The rate is $24.40 per month.
9. The rate is $210.00 per month.
10. The rate is $124.00 per month.
11. The rate is $24.00 per month.
12. The rate is $34.94 per month.

Informative and Instructional:

<table>
<thead>
<tr>
<th>Care Provider's Name:</th>
<th>Social Worker Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
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</tr>
</tbody>
</table>

Children and Youth System of Care (CYSOC) EL Dorado County Health and Human Services
A MEDICAL/HEALTH: Includes but is not limited to: Drug and/or Alcohol abuse and/or dependence, Chronic mental illness, Diabetes mellitus, Hypertension, Heart Disease, Malignancies, or other medical conditions.

Level 1 - Minor

Level 2 - Moderate

Level 3 - Exceptional

The next higher level:
Condition exists, but only one level up.

The following table is not intended to include every possible condition of situation, but rather act as a guide to make a determination. If a condition exists that is not on the matrix, please contact the assigned social worker and supervisor to determine whether the condition and possible falls under the specified care incident.

El Dorado County SCI Matrix Instructions:

1. Review the matrix to identify conditions that meet the criteria for potential care incidents.
2. For each condition identified, determine if it meets the criteria for a care incident.
3. If a care incident is identified, contact the assigned social worker and supervisor to determine the appropriate response.

Additional notes:
- The matrix is not exhaustive and may require additional considerations.
- Conditions are prioritized based on the level of need and potential impact.
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickle Cell - 5% to 25% Mild</td>
<td>Medical intervention needed</td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
</tr>
<tr>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Chronic illness (e.g., asthma, diabetes, high blood pressure)</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>Ambulation (non-ambulatory patients)</td>
<td>Physical disability (e.g., amputation, spina bifida)</td>
</tr>
<tr>
<td>Severe Cerebral Palsy</td>
<td>Severe Home Environment</td>
</tr>
<tr>
<td>Moderate hearing impairment</td>
<td>Total assistance with daily living activities and/or provider assistance with daily routines consistent care</td>
</tr>
<tr>
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<td></td>
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</tbody>
</table>

The next higher level, if three (3) or more of the listed conditions exist, the level will be increased to two conditions that exist. If one (1) level of three (3) or two (2) conditions and three (3) of the listed conditions exist, the level will be increased to two conditions that exist. If one (1) level of three (3) or more of the listed conditions exist, the level will be increased to two conditions that exist. If one (1) level of three (3) or more of the listed conditions exist, the level will be increased to two conditions that exist.
<table>
<thead>
<tr>
<th>Level 3 - Exceptional</th>
<th>Level 2 - Moderate</th>
<th>Level 1 - Mild</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism Spectrum Disorder (ASD)</td>
<td>ADHD, Moderate Behavioral Modification</td>
<td>Mild Intellectual Disability with Intellectual Assistance from a Regional Center</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td>Other</td>
</tr>
<tr>
<td>Provider</td>
<td>Provider</td>
<td>Provider</td>
</tr>
<tr>
<td>Social/Health Services</td>
<td>Social/Health Services</td>
<td>Social/Health Services</td>
</tr>
<tr>
<td>Regional Centers</td>
<td>Regional Centers</td>
<td>Regional Centers</td>
</tr>
<tr>
<td>In-Home Assistance</td>
<td>In-Home Assistance</td>
<td>In-Home Assistance</td>
</tr>
<tr>
<td>Daily Medication</td>
<td>Daily Medication</td>
<td>Daily Medication</td>
</tr>
<tr>
<td>Severe Learning Disabilities</td>
<td>Severe Learning Disabilities</td>
<td>Severe Learning Disabilities</td>
</tr>
<tr>
<td>Level 3 / Exceptional</td>
<td>Level 2 / Moderate</td>
<td>Level 1 / Mild</td>
</tr>
</tbody>
</table>

Other:

- Medicaid
- Medicaid
- Medicaid
- Medicaid
- Medicaid
- Medicaid
- Medicaid
- Medicaid
- Medicaid
- Medicaid
- Medicaid
<table>
<thead>
<tr>
<th>Date</th>
<th>Program Manager Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Supervisor Signature</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level Requested:</th>
<th>Level 1A - Limited</th>
<th>Level 1B - Mild</th>
<th>Level 2 - Moderate</th>
<th>Level 3 - Exceptional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End:</td>
<td></td>
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</tbody>
</table>

Supporting documentation attached

Kingsp (2 year renewal). The start date must match the Kingsp Redetermination date.

Completed/Reviewed with care providers/adoptive parents

AAP, NMD homes

Meets placement criteria (licensed county homes, RA, emergency & pending approved homes, NREFM approved, guardian)

**Foster Care Payment Type and SCI Parameters**

<table>
<thead>
<tr>
<th>State</th>
<th>City</th>
<th>Zip</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Provider Names</th>
<th>Street Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Placement Type</th>
<th>DOB</th>
<th>First Name</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Child/NMD Last Name</th>
<th>State</th>
<th>First Name</th>
<th>DOB</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Case Last Name</th>
<th>SW Name</th>
<th>DOB</th>
<th>First Name</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Authorization Form

Special Care Increment
<table>
<thead>
<tr>
<th>Program Manager Signature</th>
<th>Program Manager Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Services Supervisor Signature</td>
<td>Social Services Supervisor Date</td>
</tr>
<tr>
<td>Social Worker’s Signature</td>
<td>Social Worker’s Date</td>
</tr>
<tr>
<td>Care Provider’s Signature</td>
<td>Care Provider’s Date</td>
</tr>
</tbody>
</table>

I hereby attest that the above information regarding this child/young person and its impact on the Care Providers is true to the best of my Knowledge.

REQUIRED SIGNATURES (Signatures may be faxed or scanned)

The statement can be attached to subsequent SCI Requests.

- If the child has a permanent and unchanging condition, the medical/mental health professional can document this once and
- Documentation shall be provided by a third party professional familiar with the child’s condition.
- Documentation must describe the child/young person’s current condition and highlight historical information.
- Records shall be no more than six (6) months older than the SCI Request date.
- Supporting documentation for each concern / condition claimed on the SCI Request.

REQUIRED ATTACHMENTS:
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.

________________________ for __________________________
(Income Type) (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.
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 give 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) ____________________

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