Glenn County Specialized Care Rate (SCR) Program

SCR Point of Contact:
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Overview:
Per ACL 17-11, counties have the discretion to apply a Specialized Care Rate (SCR) in conjunction with a Level of Care (LOC) rate. If a child is receiving a LOC rate for a certain condition and/or care and supervision needs, this does not prevent counties, at their discretion, from providing a SCR in addition to the LOC rate for the same condition and/or care and supervision needs, including the ISFC rate. In order for claims for the SCR to be eligible for federal financial participation, the SCR must be paid only to address the behavioral, emotional physical requirements of children/youth in care above and beyond those already cover in the LOC rate structure. See ACL 18-48 for further information on Federal and State Criteria.

Purpose:
Specialized care provides a supplemental payment to the family home provider, in addition to the LOC rate where a LOC rate is applicable (reference ACL 18-06, 18-06E). The purpose of the SCR is to support the cost of the child’s supervision and to meet the additional daily care needs of a child who has behavioral, emotional and/or physical (including health) challenges.

Population Served:
Glenn County has 78 children and Nonminor Dependent (NMD) youth in out of home placement as of June 12, 2018. Of the 78 children/youth, 57 children/youth are placed in a Resource Family Approval (RFA) home (relative or non-relative), licensed foster home pending conversion to RFA, or Non-Related Legal Guardian (NRLG) home. There are also currently Eight (8) children/youth in the KinGap program. The county also has 154 AAP cases. Therefore, Glenn County currently has 219 children/youth whom are eligible for a SCR Needs Assessment and potentially a SCR paid to the caregiver(s) on the child’s behalf.

Implementation Date:
The implementation date will be August 1, 2018. The rates set forth below do not include a change to the existing rate/level system or assessment process and therefore will not affect the families currently receiving a SCR.

Revised July 24, 2018

Equal opportunity employer/program. Auxiliary aids and services available upon request to individuals with disabilities
Process for Determining the Specialized Care Rate (SCR):

1.) SCR Needs Assessments should be initiated after the use of the Level of Care (LOC) Protocol by the social worker whenever there are indications that the LOC rate is insufficient in supporting the needs of the child in placement and/or where a LOC rate is inapplicable (per ACL 17-11, Kin-Gap, NRLG and probate NRLG cases where guardianship was established prior to December 31, 2016). Indications for a SCR may come from the caregiver’s request, social worker, or other members of the Child and Family Team (CFT).

2.) The social worker completes the Glenn County Child’s SCR Needs Assessment (Attachment A) or if placed out of county will use that county’s SCR needs assessment to determine if an SCR is appropriate. If the county where the child is placed does not have a SCR Program than the social worker will use Glenn County Child’s SCR Needs Assessment. The assessment should consider the severity and frequency of the child’s behavioral, emotional and physical needs or other additional needs or concerns (developmental, psychological, social and medical) of the child and the caregiver’s role and commitment in meeting these extraordinary needs.

3.) The social worker will complete the SCR Needs Assessment summarizing the child’s needs, sign and submit to a supervisor for approval. The start date of payment should be the date of assessment by the social worker or date caregiver identified the special need(s) and/or requested an assessment. The SCR should be re-assessed at least annually with every AFDC-FC Reinvestigation (RV).

4.) The social worker will input the additional rate in CWS/CMS placement section as an additional payment and generate a new SOC 158 submitting this and Child’s SCR Needs Assessment to a supervisor for approval.

5.) Any rate change lowered or increased will need a SOC 158 generated in CWS/CMS and forwarded to the Foster Care Eligibility Worker (EW) along with a copy of the needs assessment. The EW will generate a Notice of Action (NOA) and send to the caregiver(s). The caregiver(s) or the child/youth shall have a right to copies of the LOC rate and SCR assessments, which shall be maintained in the child’s file, should a fair hearing be conducted.

Specialized Care Rate (SCR) Levels & Payments
(eligible to RFA, FFH, NRLG, KinGap, AAP)

<table>
<thead>
<tr>
<th>Level</th>
<th>Rate</th>
<th>Brief Description of SCR Rating System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>$120</td>
<td>Concerns can generally be readily controlled with specialized intervention and moderate supervision.</td>
</tr>
<tr>
<td>Level 2</td>
<td>$240</td>
<td>Concerns are more difficult to control but child will respond to sustained specialized intervention and increased supervision and care.</td>
</tr>
<tr>
<td>Level 3</td>
<td>$360</td>
<td>Concerns requires almost continuous specialized intervention, supervision by caregiver and regular and consistent professional treatment of health and behavioral issues.</td>
</tr>
</tbody>
</table>
Attachment A

Child's Specialized Care Rate (SCR) Needs Assessment

Please rank and circle the level of care needed based on Severity and Frequency of the concerns.

Circle 1 for Mild: Concerns can generally be readily controlled with specialized intervention and moderate supervision.

Circle 2 for Moderate: Concerns are more difficult to control but child will respond to sustained specialized intervention and increased supervision and care.

Circle 3 for Severe: Concerns require almost continuous specialized intervention, supervision by caregiver and regular and consistent professional treatment of health and behavioral issues.

If the specific concern does not apply, please circle 0.

Child: ______________________  DOB ______________________

PART 1: MEDICAL, PHYSICAL, DEVELOPMENTAL CONCERNS

1. Overall Health Condition (How is the child's health? Do they get colds and/or flues frequently? Do they miss a lot of school because of their health? Does the child's health prevent them from doing age appropriate activities often?)

Description: ______________________

Level of Care 0 1 2 3

2. Diagnosis (Has the child been officially diagnosed by a doctor with a disease, disorder, etc.?)

Description: ______________________

Level of Care 0 1 2 3

3. Problems with feeding (Is the child able to feed him/herself as appropriate to his/her age? Does the child require tube feeding? Does the child need to be reminded or prodded to eat appropriately? Does the child overeat/under eat/hoard food?)

Description: ______________________

Level of Care 0 1 2 3
4. **Bedwetting or “Accidents”** (Does the child wet the bed at night? Does the child have accidents? Is the child potty trained? Is the child unable to be potty trained? If an older child, has this issue been addressed by a doctor?)

**Description:**


**Level of Care**  0  1  2  3

5. **Breathing Difficulties** (Does the child use a nebulizer? An inhaler?)

**Description:**


**Level of Care**  0  1  2  3

6. **Allergies** (What are the child’s allergies? How severe are they? Is there a special diet needed to prevent the child from consuming what he/she is allergic to? Does the child take medication for allergies?Does the child use an Epi Pen?)

**Description:**


**Level of Care**  0  1  2  3

7. **Birth Defects** (Does the child have any birth defects that limit his/her abilities? Were there any problems with the delivery? Was there oxygen deprivation during the delivery?)

**Description:**


**Level of Care**  0  1  2  3

8. **Physical Disabilities** (Does the child have any physical limitations? If so how do these limitations affect daily living activities? What kind of assistance does the child need?)

**Description:**


**Level of Care**  0  1  2  3
9. Physical Developmental Delays (Is the child growing and developing normally? Is the delay temporary or permanent? Does the child need assistance performing daily living activities?)

Description: 


Level of Care  

0 1 2 3

10. Prenatal Exposure to Drugs/Alcohol (Does the child have Fetal Alcohol Syndrome? Was the mother using drugs/alcohol while pregnant? If so, during what trimester? How much and how frequent? Was the child born tox-positive? How has this exposure affected the child’s development?)

Description: 


Level of Care  

0 1 2 3

11. Medication Monitoring (Is the child on medication? How often do they have to take the medication? Can the child self administer the medication or does the child need assistance?)

Description: 


Level of Care  

0 1 2 3

12. Medical Equipment Needed (Does the child use prescribed medical equipment that needs to be set-up, cleaned, administered, or taken apart?)

Description: 


Level of Care  

0 1 2 3

13. Medical Supervision (Does the child have a life threatening condition or diagnosis that requires constant supervision or immediate medical attention? i.e. Epilepsy, Seizures, etc.)

Description: 


Level of Care  

0 1 2 3
14. **Paramedical Services** (Does the child require someone to be trained in administering a medical service? i.e. injections)

**Description:**

Level of Care  
0 1 2 3

15. **Doctor Visits** (How frequent does the child need to see the doctor? How many different doctors? Are there any specialists necessary for the child to see? Where are the doctor visits? How far does the child have to travel to see the appropriate doctors?)

**Description:**

Level of Care  
0 1 2 3

16. **Other** (Additional concerns noted here)

**Description:**

Level of Care  
0 1 2 3

**PART 2: BEHAVIOR, PSYCHOLOGICAL, EMOTIONAL, SOCIAL CONCERNS**

1. **Diagnosis** (Has the child been officially diagnosed by a doctor with a behavioral or mental disease, disorder, etc.?)

**Description:**

Level of Care  
0 1 2 3

2. **Therapy** (Is the child currently going to therapy? Does the child need therapy? Has the child had therapy in the past?)

**Description:**

Level of Care  
0 1 2 3
3. **Aggression** (Has the child had any violent episodes resulting in physical injury? Does the child exhibit aggressive behavior or bullying to others? i.e. hitting, biting, shoving)

**Description:**

__________________________

**Level of Care**

0 1 2 3

4. **Destructive Behavior** (Has the child caused serious property damage? i.e. breaks toys, hits the wall, destroys clothing, etc.)

**Description:**

__________________________

**Level of Care**

0 1 2 3

5. **Self Injury** (Does the child hurt him/herself on purpose? i.e. biting, scratching, banging head, etc. Does the child engage in risky or dangerous behaviors?)

**Description:**

__________________________

**Level of Care**

0 1 2 3

6. **Depression** (Does the child suffer extensive periods of depression? Does the child exhibit a lack of motivation or energy?)

**Description:**

__________________________

**Level of Care**

0 1 2 3

7. **Resistance to authority** (Is the child frequently uncooperative, stubborn, and hard to direct? Are there certain situations when the child is more likely to show resistance?)

**Description:**

__________________________

**Level of Care**

0 1 2 3
8. **Unacceptable Social Behavior** (Does the child lie, steal, scream, curse, tease, defecate in places other than the toilet, etc.?)

   **Description:**

   __________________________

   **Level of Care**

   0 1 2 3

9. **Temper Tantrums** (How frequently does the child have a temper tantrum? How long do the tantrums last? How does the child finally calm down?)

   **Description:**

   __________________________

   **Level of Care**

   0 1 2 3

10. **Ability to Adapt** (How does the child respond to change? Does the child’s functioning get disrupted when change occurs? How long does it take for the child to adjust to change?)

   **Description:**

   __________________________

   **Level of Care**

   0 1 2 3

11. **Coping Mechanisms** (Does the child display unhealthy coping mechanisms? i.e. withdraw, act out, etc.)

   **Description:**

   __________________________

   **Level of Care**

   0 1 2 3

12. **Level of Activity** (Is the child hyperactive? Does the hyperactivity only happen during specific situations or circumstances? Does the hyperactivity only happen during specific times of the day?)

   **Description:**

   __________________________

   **Level of Care**

   0 1 2 3
13. Running or Wandering Away (Has the child ever run away from home? If so, how often? Does the child wander off if not supervised?)

**Description:**

---

**Level of Care**

0 1 2 3

14. Affection (Does the child respond to affection? Is the child resistant toward affection? Does the child reciprocate affection? Does the child give affection in an appropriate manner?)

**Description:**

---

**Level of Care**

0 1 2 3

15. Sexual Issues (Does the child exhibit inappropriate sexual behavior? Does the child lack appropriate boundaries for private and personal space?)

**Description:**

---

**Level of Care**

0 1 2 3

16. Social Relationships (Does the child make friends easily? Does the child keep and maintain relationships with friends? Is the child able to carry on a conversation and interact with fellow peers? Non-peers? Does the child participate in group activities? Does the child like spending a lot of time alone?)

**Description:**

---

**Level of Care**

0 1 2 3

17. School Behavior (How is the child doing in school? Does the child obey the teachers? Does the child display appropriate behavior in the classroom? Does the child have a learning disability which affects school work? Does the child have an I.E.P.?)

**Description:**

---

**Level of Care**

0 1 2 3
18. Behavioral/ Mental Health Appointments (How frequent does the child need to see the doctor/ therapist? How many different doctors? Are there any specialists necessary for the child to see? Where are the doctor visits? How far does the child have to travel to see the appropriate doctors?)

Description:

______________________________________________________________

Level of Care  0 1 2 3

19. Other (Additional concerns noted here)

Description:

______________________________________________________________

Level of Care  0 1 2 3

Summary of Concerns/Needs of Child:

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Recommended SCR (Circle appropriate overall level):

SCR Level of Care  0 1 2 3

LOC Rate: $______

SCR Rate: $______

Total Payment: $______

______________________________________________________________  
Social Worker Signature  Date

______________________________________________________________  
Supervisor Approval/Signature  Date
NOTICE OF ACTION SUPPLEMENT

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

Your Foster Care was underpaid in the amount of $360.00 for June 2018.

This aid is for:

Name
Cash Aid/Medi-Cal

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

Your case has been issued a Special Care Increment.

The County will pay Foster Care benefits for

In the amount of $360.00 for the period:

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 01, 2018</td>
<td>June 30, 2018</td>
<td>$1,263.00</td>
</tr>
</tbody>
</table>

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 monthly payment was computed as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate Payment</td>
<td>$923.00</td>
</tr>
<tr>
<td>Unearned Income</td>
<td>-$0.00</td>
</tr>
<tr>
<td>Earned Income</td>
<td>-$0.00</td>
</tr>
<tr>
<td>Earned Income Disregard</td>
<td>+$0.00</td>
</tr>
<tr>
<td>Special Care Increment</td>
<td>+$360.00</td>
</tr>
<tr>
<td>Infant Supplemental Payment</td>
<td>+$0.00</td>
</tr>
<tr>
<td>Eligible Amount</td>
<td>=$1,263.00</td>
</tr>
<tr>
<td>Amount Already Paid</td>
<td>-$923.00</td>
</tr>
<tr>
<td>Supplemental Payment</td>
<td>$360.00</td>
</tr>
</tbody>
</table>

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

Sincerely, this is an example of a hybrid C-IV generator. This set was added after the month's payment had already issued. The system will not allow me to print just a plan for a hybrid member. 

NA 403 (4/17) REQUIRED FORM - SUBSTITUTES PERMITTED
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

(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

(ADDRESSEE)

☐

☐

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: __________________________

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.
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 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) ________________________

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 ________________________