Inyo County Specialized Care Increment (SCI) Plan

Contact

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Bishop, CA 93514

Overview

Specialized Care Increment (SCI) provides a supplemental payment to the family home provider, in addition to the Level of Care (LOC) rate, for the cost of supervision (and the cost of providing that supervision) to meet the additional daily care needs of a child who has a health and/or behavior problem. Placement of children who need specialized care in family homes complies with State and Federal requirements that a child is entitled to placement in a family environment, in close proximity to the parent's home, and consistent with the best interest and special needs of the child. California's specialized care rate setting system promotes these concepts. The SCI is the supplemental payment added to the LOC rate for children with medical, developmental delays/disabilities and/or behavioral issues.

Qualifying factors may range from moderate level specialized medical care or behaviorally based needs to more intensive or exceptional care needs. Children requiring intensive, therapeutic level of care may require placement in a therapeutic foster home setting. For the purpose of meeting the specialized needs of children who are determined to have moderate to exceptional care needs, Inyo County will provide an SCI. The SCI is intended to assist in offsetting costs related to the provision of care (e.g. increased transportation costs for out of area medical appointments). Caregivers, who do not meet the needs directly and instead rely on the agency to provide support to meet these needs, are not eligible for the SCI.

Methodology

Inyo County will assess the child's medical and/or behavioral issues to
determine the level of SCI. The assessment will include a consultation with the Foster Care Nurse as appropriate. The social worker will use the Statewide SCI Matrix a guideline to determine if the child's needs are at a moderate (Tier 1), intensive (Tier 2) or exceptional (Tier 3) level. The increment dollar amounts paid in addition to the LOC rate, as determined by the LOC assessment tool, will be based on the level assessed and are as follows:

- Moderate (Tier 1): $240.00 increment
- Intensive (Tier 2): $340.00 increment
- Exceptional (Tier 3): $440.00 increment

Currently, the County is not using the LOC assessment tool. Until the implementation of the LOC assessment tool, the County shall continue to use the old rate structure.

### Populations Served and Data

Currently, Inyo County does not have any children/youth receiving an SCI. The County’s current three (3) tier rate structure for SCI assessment 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 an SCI rate until actual implementation occurs.

Inyo County’s caregivers eligible to receive an SCI include:

- Licensed County Homes
- RFA Approved Homes
- RFA Emergency & Pending Approval Homes
- Relative/NREFM Approved 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 Placement (SILP)
- Foster Family agency placement (FFA)
- KinGAP Homes
- Guardian Homes
- AAP Homes
- Dual Agency Regional Center clients
- Group Home or STRTP placements

### SCI Triggering Circumstances

Caregivers may ask for an SCI assessment or reassessment based on their perception of the child/youth’s behavior, health or other qualifying factor.
The Social Worker will assess the need for an SCI at the initial placement and reassess the need for and level of SCI on an annual basis or should the specialized needs of the child change. Examples of a change that should initiate a reassessment include but are not limited to: a change in placement, request from a caregiver, additional conditions identified or additional care and supervision needs of the child/youth.

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.

Upon assessing the level of need and the recommended level of SCI, the Social Worker will submit the SCI Matrix and the Request for Specialized Care Increment (SCI) Form, to the Social Worker Supervisor. The Social Worker Supervisor will review, approve and submit to the Deputy Director of Aging and Social Services or the HHS Assistant Director for final approval. Approved SCI requests and eligibility documents will be forwarded to the Foster Care Integrated Case Worker or Integrated Case Worker Supervisor, in our Eligibility Division, for payment processing.

Inyo County requires supporting documentation for all SCI authorizations. Documentation that is received will vary, however, 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 Level of Care (LOC) assessment tool.

If a caregiver requests and SCI and after an assessment it is determined that an SCI is not appropriate, the Social Worker Supervisor will contact the caregiver by phone to discuss the decision and follow up with a letter outlining the decision of the County. The letter shall provide notice of the fair hearing process should they wish to dispute the decision of the County.

A Notice of Action (NOA) shall be sent to caregivers notifying them of the approval, redetermination or discontinuance of an SCI rate.

Inyo County is prepared to implement the new SCI plan upon approval from CDSS. The LOC will be utilized and implements as required.

Inyo County's SCI rates did not change and as such, notification to caregivers is not needed. However, for new Resource Families, training during the approval process will include information on the SCI assessment process and rate structure.

Promoting Healthy, Self-Reliant And Productive Communities
**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</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Conditions</td>
<td><strong>If three (3) or more of the Tier 1 conditions listed exist, rate will be increased to the next higher level.</strong></td>
<td><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 exist and six (6) Tier 1 conditions exist, rate will be increased to the next higher level.</strong></td>
<td><strong>More than 6 appointments per month not including routine dental or physical examinations.</strong></td>
</tr>
<tr>
<td>Drug exposed history or positive toxicology screen.</td>
<td>□ 1-3 appointments per month not including routine dental or physical examinations.</td>
<td>□ 4-6 appointments per month not including routine dental or physical examinations.</td>
<td>□ FAS/FASD with moderate to severe complications (verifiable medical diagnosis)</td>
</tr>
<tr>
<td>Alcohol exposure (FAS, FASD or FAE)</td>
<td>□ 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.</td>
<td>□ Positive toxicology screen at birth (level should be reduced at 6 month review if baby is not exhibiting any symptoms or difficulties)</td>
<td>□ Conditions requiring daily at home Physical Therapy (PT), Occupational Therapy (OT), in addition to weekly or biweekly therapy sessions.</td>
</tr>
<tr>
<td>Respiratory Difficulties and Diseases</td>
<td>□ Mild breathing difficulties requiring prescription medications with close supervision.</td>
<td>□ 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)</td>
<td>□ Severe feeding problems, excessive crying, sleep disruptions, etc. due to alcohol/drug exposure</td>
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<tr>
<td>Failure to Thrive</td>
<td>□ Sickle Cell SF (Sickle hemoglobin FS, HPPH, Asymptomatic)</td>
<td>□ Apnea or heart monitor required (when discontinued, rate to be reduced to appropriate level)</td>
<td>□ Continuous oxygen. Diabetes with special diet, close monitoring of daily blood sugars levels, insulin injections, etc., Minor is compliant with program.</td>
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<tr>
<td>Diabetes &amp; Heart Disease</td>
<td>□ Symptomatic respiratory difficulties requiring the use of nebulizer breathing treatments.</td>
<td>□ Moderate feeding difficulties requiring therapy or special feeding techniques.</td>
<td>□ Hemophiliac requiring close monitoring to prevent injury.</td>
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<tr>
<td>Hemophilia</td>
<td>□ Diabetes with special diet – no insulin or medication needed.</td>
<td>□ Seizures requiring intermittent monitoring, medications and other interventions to control.</td>
<td>□ Minor requires 4 or more injections per week (i.e. growth hormone, asthma, etc)</td>
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<tr>
<td>Seizures</td>
<td>□ Failure to thrive due to mild feeding difficulties</td>
<td>□ Severe respiratory difficulties requiring medications, breathing treatments (not including the use of inhalers) and/or CPT (Chest Physical Therapy) on a daily basis.</td>
<td>□ Sickle Cell SC, Severe Symptoms.</td>
</tr>
<tr>
<td>Physical</td>
<td>□ Seizure disorder (Abnormal EEG, medication required for seizure activity)</td>
<td>□ Intermittent oxygen.</td>
<td>□ Child requires continuous care and supervision on a daily basis in accordance with a prescribed treatment plan that would otherwise require placement in an</td>
</tr>
<tr>
<td>Disabilities/Impairments</td>
<td>□ Heart disease requiring close monitoring no intervention special treatments or diet.</td>
<td>□ Diabetes with special diet and oral medications. Stable condition, child compliant with prescribed program.</td>
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<tr>
<td>Brain Injury (abuse or accidental)</td>
<td>□ HIV positive clinically well</td>
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<tr>
<td>Visually impaired (birth, abuse, or accidental)</td>
<td>□ Fetal Alcohol Effect or Exposure (FAE) Attention deficits, Memory deficits.</td>
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<tr>
<td>Hearing impaired (birth, abuse, or accidental)</td>
<td>□ Sickle Cell – SB + Thal, Mild Symptoms.</td>
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<tr>
<td>Immune Disorders</td>
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<tr>
<td>Surgical intervention</td>
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<tr>
<td>Orthopedic abnormalities</td>
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<tr>
<td>(birth or abuse) (i.e. scoliosis)</td>
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<tr>
<td>Severe burns</td>
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<thead>
<tr>
<th>Area</th>
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<th>Tier 3</th>
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<tbody>
<tr>
<td>Medical Conditions (continued)</td>
<td>□ Mild/moderate Cerebral Palsy requiring minimal additional assistance with feeding, dressing, bathing, etc.</td>
<td>□ Medical diagnosis of Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Spectrum Disorder (FASD). Not the same as prenatal alcohol exposure Fetal Alcohol Effect (FAE).</td>
<td>□ Visual or hearing impaired requiring constant care provider assistance with daily living activities and/or adaptive home environment.</td>
</tr>
<tr>
<td></td>
<td>□ Minimal brain injury requiring minimal additional observations and guidelines. No shunt required or with stable shunt requiring no medical intervention.</td>
<td>□ Shunt placement-functioning stable</td>
<td>□ Hearing impaired requiring assistance with daily living including care provider signing abilities for specific child.</td>
</tr>
<tr>
<td></td>
<td>□ Visual condition is stable and infrequent intervention is needed (e.g., eye drops or eye patch).</td>
<td>□ Sickle Cell SB Thal Moderate Symptoms 11. Minor requires 1-3 injections per week (i.e. growth hormones, asthma, etc).</td>
<td>□ Combined cleft lip/palate.</td>
</tr>
<tr>
<td></td>
<td>□ Hearing condition is stable and infrequent intervention is needed or hearing aid is needed.</td>
<td>□ Cleft lip requiring surgical intervention and special feeding assistance.</td>
<td>□ Other:</td>
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<tr>
<td></td>
<td>□ Minimal bracing equipment is needed (i.e. AFO's)</td>
<td>□ Physical abnormalities requiring medical intervention.</td>
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<td></td>
<td>□ Other:</td>
<td>□ Moderate Cerebral Palsy or physical disability requiring assistance with feeding, dressing, etc.</td>
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<td>□ 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.</td>
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<td></td>
<td>□ 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).</td>
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<td>□ Scoliosis requiring assisted daily exercise and/or bracing.</td>
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<td></td>
<td></td>
<td>□ Other:</td>
<td></td>
</tr>
<tr>
<td>Developmental Delays or Disabilities</td>
<td>□ Moderate developmental delays or disabilities requiring weekly care provider assistance.</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.</td>
<td>□ Severe learning delays or disabilities requiring extensive daily assistance several times a day from the care provider.</td>
</tr>
<tr>
<td>Developmental Delay</td>
<td>□ Other:</td>
<td>□ Other:</td>
<td>□ Regular in-home assistance from a</td>
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Promoting Healthy, Self-Reliant And Productive Communities
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<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Delays or Disabilities (continued)</td>
<td>□ Behavior modification required but no medication prescribed.</td>
<td>□ Behavior modification needed in conjunction with prescribed daily medication.</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.</td>
</tr>
<tr>
<td>Developmental Disability (e.g., Intellectual Disability, Autism Spectrum etc.)</td>
<td>□ The child presents some risky behaviors sometimes placing self and/or others at risk.</td>
<td>□ The child is at high risk to self and/or others. Behaviors frequently are disruptive to household, school and in other social interactions.</td>
<td>□ 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.</td>
</tr>
<tr>
<td>Learning Delays or Disabilities</td>
<td>□ Close supervision is sometimes necessary to minimize risk and/or reduce potential for disruption.</td>
<td>□ Stabilization of disruptive behaviors requires special intervention and discipline strategies.</td>
<td>□ 601 and 602 frequently exhibited themselves at this level.</td>
</tr>
<tr>
<td>Sensory Integration Disorder</td>
<td>□ Psychotropic medication may be required with close supervision by care provider and increased follow up by therapeutic provider.</td>
<td>□ Care provider needs special training and participates in counseling with the minor to accomplish this.</td>
<td>□ Monthly evaluations are essential at this level to track the progress of the minor and adjust treatment strategies as needed.</td>
</tr>
<tr>
<td>Behavioral Issues</td>
<td>□ Other:</td>
<td>□ 601 behaviors (truant, beyond control of caregiver) exhibited at this level.</td>
<td>□ 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.</td>
</tr>
<tr>
<td>AWOL</td>
<td></td>
<td>□ Chronic resistance to behavior modification strategies.</td>
<td>□ Other:</td>
</tr>
<tr>
<td>Aggressive and Assaultive</td>
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<td>□ Personal property of others in the home at high risk.</td>
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<tr>
<td>Animal Cruelty</td>
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<td>□ Excessive anti-social behaviors which strictly limits unsupervised social interaction.</td>
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<tr>
<td>CSEC</td>
<td></td>
<td>□ Other:</td>
<td></td>
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<tr>
<td>Substance Use/Abuse</td>
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<tr>
<td>Gang Activity</td>
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<tr>
<td>Fire Setting</td>
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<tr>
<td>Severe mental health issues-including suicidal ideation and/or Self Harm</td>
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<tr>
<td>Psychiatric hospitalization(s)</td>
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<tr>
<td>Adjudicated violent offenses, significant property damage, and/or sex offenders/perpetrators</td>
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<tr>
<td>Habitual Truancy</td>
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<tr>
<td>Three or more placements due to the child's behavior</td>
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Promoting Healthy, Self-Reliant And Productive Communities
### Request for Specialized Care Increment (SCI)

**Date:** __________________________  **Social Worker:** __________________________

**Child’s Name:** __________________________  **Date of Birth:** __________________________

**Name of Resource Family:** __________________________

**Summary of Child’s Special Needs:**

________________________________________

________________________________________

**Please note:** Justification and appropriate documentation must be located in the case file.

Resource Family will assume primary responsibility for meeting the needs of the child, including the provision of transportation to medical appointments.  

- **Yes**  
- **No**  
  If no, please explain the reason for SCI:

________________________________________

Child is assessed as appropriate for the following SCI:

- **Moderate (Tier 1)**  
  - $240.00

- **Intensive (Tier 2)**  
  - $340.00

- **Exceptional (Tier 3)**  
  - $440.00

The SCI will be added to the Level of Care rate of __________________________ beginning on __________________________ and ending on __________________________

**Social Worker Signature** __________________________  **Date** __________________________

**CPS Supervisor** __________________________  **Date** __________________________

- **Approved**  
- **Denied (Reason):** __________________________

**HHS Deputy Director/HHS Assistant Director** __________________________  **Date** __________________________

*Promoting Healthy, Self-Reliant And Productive Communities*
NOTICE OF ACTION
CHANGE
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 Services Foster Care, Group Homes and Short-Term
Residential Therapeutic Programs

As of December 01, 2017, the county is Changing your
Foster Care aid from $923.00 to $1,263.00.

This aid is for:

<table>
<thead>
<tr>
<th>Name</th>
<th>Type Of Aid</th>
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</tbody>
</table>

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 $1,263.00 for the period:

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 01, 2017</td>
<td>December 31, 2017</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:

| Monthly Rate: | $923.00 |
| Facility Rate Frequency | Monthly |
| Prorated (per day) Rate | $28.77 |
| Number of Days | 31 |
| Rate Payment | $923.00 |
| Unearned Income | -$0.00 |
| Earned Income | -$0.00 |
| Earned Income Disregard | +$0.00 |
| Special Care Increment | +$340.00 |
| Infant Supplemental Payment | +$0.00 |

Eligible Amount* = $1,263.00

*This payment is rounded down to the nearest dollar.

Rules: These rules apply. You may review them at your local welfare office: EAS 45-302.431(a)
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 10850.)

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:
  Inyo County Health and Human Services
  220 N MAIN ST
  BISHOP, CA 93514
  (760) 872-1394 / Fax: (760) 872-4950
  OR
- Call toll free: 1-800-952-6253 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.

California Indian Legal Services
873 N MAIN ST SUITE 120
BISHOP, CA 93514
(760) 873-3631

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 Inyo 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

BIRTHDATE

PHONE NUMBER

STREET ADDRESS

CITY  STATE  ZIPCODE

SIGNATURE

DATE

NAME OF PERSON COMPLETING THIS FORM

PRERE WARSHIP

☐ 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  ZIPCODE

NA BACK 6 (REPLACES NA BACK 6 AND EP 5)(REVISED 4/2013) - REQUIRED FORM - NO SUBSTITUTE PERMITTED