October 1, 2018

California Department of Social Services
Children and Family Services Division
744 P Street Sacramento, CA 95814

RE: Lake County's Specialized Care Increment (SCI) Plan

Lake County Department of Social Services, Child Welfare Services, is proposing a revised three-tier Specialized Care Increment (SCI) rate structure that will comply with the implementation of the Continuum of Care Reform (CCR) Level of Care (LOC) Protocol and is consistent with the recommended CWDA SCI Matrix.

Attached please find Lake County's SCI Plan based on the information requested in ACL #18-48. Should you have further questions regarding this plan, please feel free to contact Amber Davis, Deputy Director at 707-262-4545 amber.davis@lakecountyca.gov.

Crystal Markytan
Department of Social Services Director
Lake County Specialized Care Increment Plan

Lake County’s Specialized Care Increment (SCI) rates provide a supplemental payment to assist resource families caring for a child/youth with additional daily needs with behavioral, emotional, physical, and/or health challenges beyond those provided for through the Level of Care (LOC) rate. The SCI rate is intended to meet any needs that are not met by the LOC rate.

**Population Served**
Children/youth in foster care, including Non-Minor Dependents (NMD), will be eligible for SCI rate consideration, including children receiving foster care benefits in a licensed Foster Family Home (FFH), Resource Family Approval (RFA), Non-Related Legal Guardianship, Kin-GAP, or AAP. The SCI rate is not available for child/youth placed in Foster Family Agency (FFA) placements, Short-term Residential Therapeutic Program (STRTP), receiving Intensive Services Foster Care (ISFC), placed in Therapeutic Foster Care (TFC), residing in a Supervised Independent Living Program (SILP), or receiving a dual agency rate as a regional center client. Lake County currently has 12 youth receiving SCI rates in resource and/or foster home placements and 57 youth receiving SCI rates in AAP placements.

**Payment Amounts**
Lake County has established a three-tiered SCI rate. Any of the SCI tiers can be added to any LOC rate with the exception of the ISFC level.

| Lake County Specialized Care Increment (SCI) Rates |
|-----------------|-----------------|-----------------|
| SCI Rate Tier 1  | SCI Rate Tier 2  | SCI Rate Tier 3  |
| $200             | $300             | $400             |

**Qualifying Criteria**
Lake County is adopting the County Welfare Directors Association (CWDA) SCI Matrix (Attachment A). Each tier can be applied to any LOC rate.

Within the mandated timeframes, the social worker assigned to the child’s case will gather information from the resource parent, biological parents, and members of the child and family team in order to compute the LOC rate. If during this process it is determined that the youth has needs that are not met by the LOC rate, the social worker will complete the SCI matrix to determine if an SCI rate should be requested. If a SCI rate should be requested, the social worker will complete the Request for Special Care Increment form and give it to their supervisor along with the copy of the completed SCI Matrix. Once the supervisor and program manager have approved the Special Care Increment rate, the social worker will notify foster care eligibility. The deputy director will give final approval on all Tier 3 SCI rate requests.

In addition to initial placement there are triggering events such as but not limited to the following: change in placement, new mental or physical medical diagnosis, step down from STRTP placement or psychiatric hospital, severe medical injury, death of a family member and or a traumatic event that results in a change in emotional or physical abilities of the youth. If a social worker believes
there has been a triggering event, they will complete the SCI Matrix and Request for Special Care Increment form and submit it to their supervisor and program manager for approval.

The SCI Matrix will be reviewed annually to determine whether the SCI rate remains the same, increases, or is no longer needed. It is important that these possible outcomes are discussed each year with caregivers.

**Proposed Implementation Date**

It is the intention of Lake County to implement the new SCI plan simultaneously with implementation of the approved LOC protocol is set by CDSS. Existing families receiving SCI rates will continue to receive SCI rates from the previous plan until there is either a triggering event or their annual SCI reassessment is completed.

**Notifying Families**

Lake County will notify the families currently receiving SCI rates with a letter with information regarding the new SCI plan. Following a rate change the Foster Care Eligibility Unit will send the Notice of Action: NA-403 (Attachment B) to caregivers along with their fair hearing rights.

**SCI Point of Contact(s)**

1. Mary Pagan, Program Manager  
   Phone: 707-262-4505  
   Email: mary.pagan@lakecountyca.gov  
   Address: 926 S Forbes, Lakeport CA 95457
Lake County Special Care Increment Matrix

Child's Name: 

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 **If three (3) or more of the Tier 1 conditions listed exist, rate will be increased to the next higher level.</th>
<th>Tier 2 **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.</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical conditions</strong></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>□ More than 6 appointments per month not including routine dental or physical examinations.</td>
</tr>
<tr>
<td>Drug exposed history or positive toxicology screen.</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>□ FAS/FASD with moderate to severe complications (verifiable medical diagnosis)</td>
</tr>
<tr>
<td>Alcohol exposure (FAS, FASD or FAE)</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>□ 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>□ Sickle Cell SF (Sickle hemoglobin FS, HPFH, Asymptomatic)</td>
<td>□ Apea or heart monitor required (when discontinued, rate to be reduced to appropriate level)</td>
<td>□ Severe feeding problems, excessive crying, sleep disruptions, etc. due to alcohol/drug exposure.</td>
</tr>
<tr>
<td>Failure to Thrive</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>□ Continuous oxygen.</td>
</tr>
<tr>
<td>Diabetes &amp; Heart Disease</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>□ Diabetes with special diet, close monitoring of daily blood sugars levels, insulin injections, etc., Minor is compliant with program.</td>
</tr>
<tr>
<td>Hemophilia</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>□ Hemophiliac requiring close monitoring to prevent injury.</td>
</tr>
<tr>
<td>Seizures</td>
<td>□ Seizure disorder (Abnormal EEG, medication required for seizure activity)</td>
<td>□ Intermittent oxygen.</td>
<td>□ Minor requires 4 or more injections per week (i.e. growth hormone, asthma, etc)</td>
</tr>
<tr>
<td>Brain Injury (abuse or accidental)</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>□ 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>□ Child requires continuous care and supervision on a daily basis in accordance with a prescribed treatment plan that would otherwise require placement in an institutional facility.</td>
</tr>
<tr>
<td>Visually impaired (birth, abuse, or accidental)</td>
<td>□ Shunt placement-functioning stable</td>
<td>□ Shunt placement-functioning stable</td>
<td>□ Shunt placement-functioning stable</td>
</tr>
</tbody>
</table>
### Lake County Special Care Increment Matrix

<table>
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<tr>
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<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Conditions (continued)</strong></td>
<td>□ Heart disease requiring close monitoring no intervention special treatments or diet. □ HIV positive clinically well □ 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>
</tbody>
</table>
## Lake County Special Care Increment Matrix

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<th>Tier 1 **If three (3) or more of the Tier 1 conditions listed exist, rate will be increased to the next higher level.</th>
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<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Developmental delays or disabilities</strong></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. □ Other.</td>
<td>□ Severe learning 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, non-ambulatory. Regional Center client documentation required from RC SW. □ Other:</td>
</tr>
<tr>
<td>Developmental Delay</td>
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<tr>
<td>Intellectual Disability</td>
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<tr>
<td>Autism Spectrum</td>
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<tr>
<td>Learning Delays or Disabilities</td>
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<tr>
<td>Sensory Integration Disorder</td>
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<tr>
<td><strong>Behavioral Issues</strong></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.</td>
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<tr>
<td>AWOL</td>
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<tr>
<td>Aggressive and Assaultive</td>
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<tr>
<td>Animal Cruelty</td>
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<td>CSEC</td>
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<tr>
<td>Substance Use/Abuse</td>
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<td>Gang Activity</td>
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<td>Fire Setting</td>
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<td>Severe mental health issues-</td>
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<td>including suicidal ideation and/or</td>
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<tr>
<td>Self Harm</td>
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<tr>
<td>Psychiatric hospitalization(s)</td>
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<tr>
<td>Adjudicated violent offenses,</td>
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<td>significant property damage, and/or</td>
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<tr>
<td>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</td>
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<tr>
<td>child's behavior</td>
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</tbody>
</table>

*(Tier 1, 2, and 3 conditions are not described in the image)*
## Lake County Special Care Increment Matrix

<table>
<thead>
<tr>
<th>Total # of conditions marked</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>□</td>
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<tr>
<td>at least 2</td>
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<td>3 to 5</td>
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<td>6 or more</td>
<td>□</td>
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<table>
<thead>
<tr>
<th>Eligible</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>no</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>yes</td>
<td></td>
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<table>
<thead>
<tr>
<th>Comments</th>
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</table>

Child's Name [Blank]
NOTICE OF ACTION
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

☐ 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: ____________________________________________ (Name of Child)

As of ____________, the county is Changing your Foster Care aid from $ ____________ to $ ____________.

This aid is for: ____________________________________________ (Name of Child)

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.

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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.
NOTICE OF ACTION - CHANGE
For Kinship - Guardians Only

☐ The County has approved your Kin-GAP aid.

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

This aid is for: ____________________________________________
(Name of Child)

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

This aid is for: ____________________________________________
(Name of Child)

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 __________ income

☐ (Countable)

☐ for __________________________________________
(Income Type) (Name of Child)

of $ __________ is effective ____________.

This is counted as __________ income in the
(Earned/Unearned) Kin-GAP budget calculation.

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 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) ____________________________

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 __________

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 __________

ADDRESS __________

CITY __________ STATE __________ ZIP CODE __________