June 28, 2018

California Department of Social Services
Children and Family Services Division
744 P Street
Sacramento, CA 95814
SCI@dss.ca.gov

RE: All County Letter #18-48
San Bernardino County’s Specialized Care Increment (SCI) Plan

Currently San Bernardino County utilizes a six-tier rate structure to administer the Specialized Care Rate (SCR). SB County Children and Family Services (CFS) is proposing a new 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 rate structure. Attached please find SB 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		Jeany Glasgow, CFS Deputy Director at 909-891-3568 Jeany.Glasgow@hss.sbccounty.gov

Marlene Hagen, CFS Director

CC: CaSonya Thomas, Assistant Executive Officer
    Jonathan Byers, CFS Assistant Director
    Jeany Glasgow, CFS Deputy Director
    Karen Hill, CFS Child Welfare Services Manager
San Bernardino County Specialized Care Increment (SCI) Plan

<table>
<thead>
<tr>
<th>Name of County:</th>
<th>San Bernardino</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCI Point of Contact:</td>
<td>Jeany Glasgow (<a href="mailto:Jeany.Glasgow@hss.sbcounty.gov">Jeany.Glasgow@hss.sbcounty.gov</a>)</td>
</tr>
<tr>
<td>Date:</td>
<td>6/28/2018</td>
</tr>
</tbody>
</table>

Counties with Specialized Care Rate (SCR) programs will submit an updated Specialized Care Increment (SCI) plan no later than **June 30, 2018**. Counties will continue with their current SCR program if one applies and pay the Basic Level Rate plus the SCI rates to new and existing cases. The updated plans will not take effect until the Level of Care (LOC) Protocol is implemented based on forthcoming guidance.

Any updated plan or new county SCI plan will include the following:

1. The populations of who will be served. Please include available data that includes the caseload of the current specialized care population and estimate of any potential expanded populations to be served; list the types of behavior and/or health conditions or qualifying factors for which a specialized care rate is currently paid and/or would be paid under the updated plan. This data will be used to inform the fiscal adjustments that will be outlined in the forthcoming County Fiscal Letter.
2. Payment amounts and whether or not the payments are tiered.
3. The criteria and/or the qualifying factors and conditions used to determine the SCI rate in each level and must be clearly described; if the county is using the County Welfare Directors Association (CWDA) SCI plan, the county should reference what criteria of the CWDA SCI plan is applying to the county SCI plan.
4. The County review process and secondary review/approval, including how often the county will conduct a SCI reassessment.
5. Provide description of what circumstances trigger an SCI assessment i.e., additional conditions or the additional care and supervision needs of the child/youth.
6. Proposed implementation dates and a description of how existing families receiving SCI rates will be treated under the new SCI plan; identifying any plans for how existing SCI rates might be reduced or increased under the proposed plan.
7. How families will be notified about the new SCI rates.
8. A copy of the Notice of Action (NOA) form used for SCI approval, denial, redetermination and discontinuance which must note the SCI level authorized.
9. An SCI point of county contact with email, phone number and written address information.

Counties will submit their SCI plans for review and approval to the California Department of Social Services (CDSS) via email to: SCI@dss.ca.gov.
### San Bernardino County Specialized Care Increment (SCI) Plan

<table>
<thead>
<tr>
<th>Population Served and Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Family Services (CFS) will focus on serving Special Health Care Needs (SHCN) children, children with severe mental health/behavioral issues and commercially sexually exploited children (CSEC). This represents 7% of the overall San Bernardino County foster care population. The SCI is available for the following types of placements:</td>
</tr>
<tr>
<td>• Resource Family Homes (RFHs),</td>
</tr>
<tr>
<td>• Approved Relative Caregiver (ARC) homes,</td>
</tr>
<tr>
<td>• Certified Foster Family Homes (FFHs),</td>
</tr>
<tr>
<td>• Approved Non-Relative homes,</td>
</tr>
<tr>
<td>• Non-Related Extended Family Members (NREFMs),</td>
</tr>
<tr>
<td>• Kinship Guardianship Assistance Program (Kin-GAP),</td>
</tr>
<tr>
<td>• Adoption Assistance Program (AAP) homes,</td>
</tr>
<tr>
<td>• Resource Families (RFs), and</td>
</tr>
<tr>
<td>• Certified family homes of Foster Family Agencies (FFAs) who care for SHCN, CSEC, and children with severe mental health/behavioral issues.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Review Process/Triggering Circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Tier Level I is reviewed by the regional social worker (SW) and approved by the Supervising Social Services Practitioner (SSSP), and does not require Child Welfare Services Manager (CWSM) approval.</td>
</tr>
<tr>
<td>• The SSSP and CWSM will review and approve the SCI rate at Tier Levels II and III.</td>
</tr>
<tr>
<td>• An SCI reassessment will be conducted every six months.</td>
</tr>
<tr>
<td>• Whenever possible, raising the LOC rate should be considered prior to SCI; therefore, the regional CWSM will approve SCI’s when the LOC rate is lower than LOC 4.</td>
</tr>
<tr>
<td>• The role of the regional SW is to:</td>
</tr>
<tr>
<td>− Assess a child for SCI prior to placement,</td>
</tr>
<tr>
<td>− At the time of reassessment, or</td>
</tr>
<tr>
<td>− When there is a change in the child’s condition/need.</td>
</tr>
<tr>
<td>• An expired payment authorization or a change in the child’s condition/need trigger an SCI assessment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implementation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The proposed implementation date will be the 1st of the month after the California Department of Social Services (CDSS) approves the plan.</td>
</tr>
<tr>
<td>• The SCI Coordinator will be responsible for conducting training for social workers once the plan is approved.</td>
</tr>
<tr>
<td>• The new SCI rates will not be retroactive to the implementation date.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Existing Families and the new SCI Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• SCI rates utilized before the new SCI plan is approved will not change.</td>
</tr>
<tr>
<td>• The current SCI rate will continue to be paid for existing families receiving SCI payments until the next scheduled SCI reassessment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families will be notified about the new SCI rates by the regional SWs and will receive a Notice of Action (NOA) regarding SCI approval, denial, redetermination and discontinuance. The NOA’s has been attached for reference.</td>
</tr>
</tbody>
</table>
San Bernardino County Specialized Care Increment (SCI) Plan

### SCI Plan Updates
SB County has decided to combine the current six-tier SCR payment structure below into a three-tier SCI payment structure as follows:

<table>
<thead>
<tr>
<th>SCR Tiers and Amounts</th>
<th>New SCI Tiers and Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 $79</td>
<td>1 $184</td>
</tr>
<tr>
<td>2 $184</td>
<td>2 $525</td>
</tr>
<tr>
<td>3 $399</td>
<td></td>
</tr>
<tr>
<td>4 $525</td>
<td>3 $840</td>
</tr>
<tr>
<td>5 $683</td>
<td></td>
</tr>
<tr>
<td>6 $840</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** SCR tiers one, three, four and five were eliminated, the change will result in a rate increase for existing families receiving those tiers.

### SCI Table Information
The Specialized Care Increment (SCI) table below includes the following:
- Behaviors, health conditions and/or qualifying factors for which a SCR will be paid under the updated plan,
- Payment amount and tiers, and
- The criteria used to determine the SCI rate in each level.
SB County Proposes the following three-tier SCI payment structure:

<table>
<thead>
<tr>
<th>TIER I</th>
<th>TIER II</th>
<th>TIER III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild Need(s)</td>
<td>Moderate Need(s)</td>
<td>Intensive Need(s)</td>
</tr>
<tr>
<td>Rate: $184.00</td>
<td>Rate: $525.00</td>
<td>Rate: $840.00</td>
</tr>
<tr>
<td>SSSP Approval Required</td>
<td>SSSP/CWSM Approval Required</td>
<td>SSSP/CWSM Approval Required</td>
</tr>
</tbody>
</table>

### Criteria

- **TIER I**
  - Child/youth has:
    - An educational impairment (below grade or age-appropriate developmental level). *
    - Impaired psychological functioning. *
    - Mild conduct or behavior problems. *
    - Behavior including biting, hitting, and nighttime bedwetting for children ages 3-5.
    - Lice or scabies requiring disinfecting of the home.
    - A prescribed special diet due to medical issues, requiring the purchase of special food items.

  *A condition that is not accounted for in LOC rate that requires additional daily care and supervision provided by the resource parent may qualify for SCI.

- **TIER II**
  - Child/youth has:
    - Moderate conduct or behavior problems. *
    - A medically fragile diagnosis.
    - *A cognitive impairment.
    - Enuresis (children ages 5-8), requiring the purchase of additional supplies, and frequent linen washing.
    - The need for a modified home environment to accommodate specialized needs
      - (E.G. removal of asthma triggers).
    - A severely compromised immune system, requiring a safe and sterile environment.

- **TIER III**
  - Child/youth has severe behavioral issues, and require intensive care services, and enhanced supervision:
    - To prevent placement into a Short-Term Residential Therapeutic Program (STRTP), and after transitioning out of the STRTP.
    - Due to being at-risk of or identified as a commercially sexually exploited child (CSEC).
  - Child/youth has a terminal/progressive illness or is on hospice, and requires frequent medical treatment for end of life care.
  - Child/youth requires enhanced supervision due to the need of durable medical equipment, such as a gastrostomy tube (G-tube), peripherally inserted central catheter (PIC line), or tracheostomy (trach) tube.
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

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.

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: ___________________________________________________________________

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.
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

(Addresssee)

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.

The child has ______________________ income.

__________________________ for __________________________ (Countable)

__________________________ (Income Type) for __________________________ (Name of Child)

of $________________________ is effective __________________________. (Date)

This is counted as __________________________ income in the

__________________________ (Earned/Unearned) Foster Care budget calculation.

Other: __________________________

Your case has been discontinued.

As of __________________________, the county is Discontinuing your

__________________________ (Date) Foster Care aid.

Here's why:

You are no longer providing foster care for: __________________________

__________________________ (Name of Child)

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 child has too much income.

The child has too much property. See attached page.
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

(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.

If the County figured that the child’s car or other vehicle 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: _______________________________

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.

Rules: These rules apply. You may review WIC sections: 11460, 11461, 11463, 11463.23, and 16519.
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

STREET ADDRESS

CITY  STATE  ZIP CODE

SIGNATURE  DATE

NAME OF PERSON COMPLETING THIS FORM  PHONE NUMBER

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

NAME  PHONE NUMBER

STREET ADDRESS

CITY  STATE  ZIP CODE
NOTICE OF ACTION - CHANGE
For Kinship - Guardians Only

The County has approved your Kin-GAP aid.

As of__________, the county is Approving your Kin-GAP aid of
(Date)
$__________ per month.

This aid is for: ____________________________ (Name of Child)

As of__________, the county is Changing your Kin-GAP aid
(Date)
from $__________, $__________.

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___________.
(Date)

This is counted as__________ income in the
(Earned/Unearned)

Kin-GAP budget calculation.
NOTICE OF ACTION - CHANGE
For Kinship - Guardians Only

Notice Date: ________________________________
Case Name: __________________________________
Number: ____________________________________
Worker Name: ________________________________
Number: ____________________________________
Telephone: __________________________________
Address: ____________________________________

Questions? Ask your Worker.

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

Other: ________________________________

Your case has been discontinued.

As of ____________, the county is Discontinuing your Kin-GAP aid.

Here’s why:

You are no longer providing foster care for ________________________________.

(Name of Child)

He/she is no longer living in your home/facility. The County will stop paying for Kin-GAP from the day the child leaves your home/facility.

He/she no longer meets the age rules.

The child has too much income.

The child has too much property. See attached page.
NOTICE OF ACTION - CHANGE
For Kinship - Guardians Only

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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.

If the County figured that the child’s car or other vehicle was worth more than you think its 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: __________________________________

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.

Rules: These rules apply. You may review WIC section: 11364.
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.

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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

NA BACK 9 (REPLACES NA BACK 8 AND EP 5) (REVISED 4/2013) - REQUIRED FORM - NO SUBSTITUTE PERMITTED