The specialized care program provides a supplemental payment to the foster family provider for the cost of providing care and supervision to meet the additional daily needs of a child with health and/or behavioral concerns. The specialized care increment (SCI) is the supplemental payment added to the Level of Care (LOC) rate for children who are determined to have moderate to exceptional care needs due to qualifying factors, such as specialized medical care, developmental delay issues, or behavioral needs.

San Mateo County's current specialized care program structure is based on Difficulty of Care, Adolescent Care and Medically Fragile Home, and is available to foster family homes, including relatives, non-related extended family members (NREFM), county licensed, non-related legal guardians, and, per guidelines of ACL 07-13, KinGap homes.

On average, the current San Mateo County SCI population is as follows:

<table>
<thead>
<tr>
<th>Program</th>
<th>Average number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Care</td>
<td>8</td>
</tr>
<tr>
<td>Kin-GAP</td>
<td>0</td>
</tr>
<tr>
<td>AAP</td>
<td>180</td>
</tr>
</tbody>
</table>

San Mateo County's new SCI rate will still be available to foster family homes, including relatives; NREFM; county licensed foster; resource family approved; Adoption Assistance Program (AAP); and KinGap homes. In addition, children/youth receiving payment through the Approved Relative Caregiver (ARC) program will also be eligible for SCI; there are approximately 10 children currently. Foster family homes receiving dual agency or Intensive Services Foster Care rates will not be eligible for SCI.

The new SCI assessment tool (See Request for Specialized Care Increment) provides staff with the guidelines of the health/medical conditions, developmental delays or disabilities, and/or behavioral issues that would qualify for the SCI rate. Caregivers who do not meet the needs directly and instead rely on the agency to provide support to meet these needs will not be eligible for the SCI.

**New SCI Payment Amount**

The new flat SCI rate of $100 will be added to the determined LOC rate when SCI criteria is met.

**County Review and Reassessment Process**

Social workers will complete both the Level of Care (LOC) and SCI assessment tools following a Child and Family Team (CFT) meeting unless a SCI assessment is needed imminently in order to stabilize a placement. Social workers will submit initial SCI assessments to their supervisors for review. If the supervisor is in agreement, the SCI assessment, including any supporting documentation, will be forwarded to Placement Review Board (PRB) for review and final approval to ensure all claims are documented as required. Supporting documentation will be required and must be included for all SCI requests. Acceptable forms of documentation include, but are not limited to, SCI assessment tools; Level of Care (LOC) assessment tools; Case Plans; Child Assessment of Needs and Strengths (CANS) assessment tools; Resource Parent LOC assessment tools; and/or letters and reports from clinicians, behavior specialists, medical professionals, Regional Center staff, and school staff.
SAN MATEO COUNTY – SCI PLAN

SCI assessments, along with required eligibility documents, are then forwarded to the Foster Care Eligibility unit for payment processing.

SCI reassessments are to occur annually from the date of the last approved SCI assessment or at any time a LOC assessment is triggered. For SCI reassessments, supervisor and manager signatory approval will be required.

SCI Assessments

Each LOC assessment will trigger a SCI assessment, and the information from each tool will be utilized to help inform the assessment of each tool. Both the LOC and SCI assessments will be conducted together in order to simplify the social worker’s workload and to ensure the SCI assessment is being conducted consistently and in a timely manner. The SCI assessment tool will be conducted following:

- An initial out-of-home placement with a foster family;
- Change of placement to another foster family home;
- Step down from a Short Term Residential Therapeutic Program (STRTP) or group home placement to a foster family home;
- An assessment that the youth’s behavior, health, or other qualifying factors that did not previously meet SCI determination is now met;
- The foster family caregiver requests a reassessment to determine eligibility; and/or
- When the current SCI assessment is expiring.

Proposed Implementation Dates

San Mateo County intends to implement the new SCI plan along with the implementation of LOC by August 1, 2018 following the training of all staff on the new policy and procedures.

Families currently receiving SCI will continue to receive the approved SCI until the SCI expires or the placement undergoes a LOC assessment. In the event a LOC and the new SCI assessment is completed and if the determination results in a lower payment, the rate will not be decreased. Current SCI approvals expire in six months from the approved start date. All current SCI approvals will end no later than December 31, 2018.

Notifying Families

San Mateo County plans on issuing a letter to foster families notifying them of LOC and SCI.

NOA Forms

The State Notice of Action (NOA) form (See Notice of Action – Approval, Change or Discontinued (NA 403)) will be used to notify the foster family caregivers of the approval, redetermination or discontinuance of a SCI rate. The social worker will work with the family when assessing the LOC and SCI rates.

SCI Point of Contact

Michele Tom, Human Services Manager
San Mateo County, Human Services Agency, Children & Family Services
1487 Huntington Avenue, South San Francisco, CA 94080
(650) 877-5675
MXTom@smegov.org
Request for Specialized Care Increment (SCI)

Child's Name: __________________________ Date of Birth: __________________________ Case Number: __________________________

Current Placement: __________________________ Placement Type: __________________________

Current Rate: __________________________ SCI Request Date: __________________________

SCI Start Date: __________________________ SCI End Date: __________________________

Please check one: □ Initial SCI Assessment □ SCI Reassessment

* PRB Approval required for all initial SCI requests

SCI rate: $100

Note: The following are ineligible for SCI Payments:
- Child/youth in Foster Family Agency (FFA), STRTP, Group Home, SILP, and Transitional Housing Programs (THPP and THP+FC);
- Child/youth receiving Intensive Services Foster Care (ISFC) rate; and
- Child/youth receiving Dual Agency/Regional Center rate.

The following table is not intended to include every possible condition or situation, but rather as some basic guidelines. If a similar condition exists, please write it on the table for review.

To be eligible for SCI, at least one condition must exist.

<table>
<thead>
<tr>
<th>Health/Medical Conditions</th>
<th>Developmental Delays or disabilities</th>
<th>Behavioral Issues</th>
<th>General Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Oncology (Cancer)</td>
<td>□ Developmental Delay</td>
<td>□ AWOL</td>
<td>□ Scores at least 5 in both Behavioral/Emotional and Health Domains. Level-up provisions only considered one of the domains.</td>
</tr>
<tr>
<td>□ HIV-AIDS</td>
<td>□ Developmental Disability (e.g., Intellectual Disability, Autism Spectrum etc.)</td>
<td>□ Aggressive and Assaultive</td>
<td></td>
</tr>
<tr>
<td>□ Seizures</td>
<td>□ Learning Delays or Disabilities</td>
<td>□ Animal Cruelty</td>
<td></td>
</tr>
<tr>
<td>□ Organ Failure Transplant Candidate</td>
<td>□ Sensory Integration Disorder</td>
<td>□ CSEC</td>
<td></td>
</tr>
<tr>
<td>□ Sickle Cell Anemia</td>
<td></td>
<td>□ Substance Use/Abuse</td>
<td></td>
</tr>
<tr>
<td>□ Diagnosis of Cerebral Palsy (CP)</td>
<td></td>
<td>□ Gang Activity</td>
<td></td>
</tr>
<tr>
<td>□ Respiratory Difficulties and Diseases</td>
<td></td>
<td>□ Fire Setting</td>
<td></td>
</tr>
<tr>
<td>□ Failure to Thrive</td>
<td></td>
<td>□ Severe mental health issues-including suicidal ideation and/or Self Harm</td>
<td></td>
</tr>
<tr>
<td>□ Diabetes</td>
<td></td>
<td>□ Psychiatric hospitalization(s)</td>
<td></td>
</tr>
<tr>
<td>□ Heart Disease</td>
<td></td>
<td>□ Adjudicated violent offenses, significant property damage, and/or sex offenders/perpetrators</td>
<td></td>
</tr>
<tr>
<td>□ Hemophilia</td>
<td></td>
<td>□ Habitual Truancy</td>
<td></td>
</tr>
<tr>
<td>□ Physical Disabilities/Impairments</td>
<td></td>
<td>□ Three or more placements in the past 12</td>
<td></td>
</tr>
<tr>
<td>□ Brain Injury (abuse or accidental)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Visually impaired (birth, abuse, or accidental)
- Hearing impaired (birth, abuse, or accidental)
- Immune Disorders
- Surgical intervention
- Orthopedic abnormalities (birth or abuse) (i.e. scoliosis)
- Severe burns

<table>
<thead>
<tr>
<th>months due to the child’s behavior</th>
</tr>
</thead>
</table>

**Resources Used for Assessment:**
- LOC Protocol
- Child and Family Team (CFT)
- Medical Records
- Child and Adolescent Needs and Strengths (CANS)
- Case Plan
- Other

Social Worker Name: _____________________________
Social Worker Signature: _____________________________
Date: ____________

SW Supervisor Name: _____________________________
SW Supervisor Signature: _____________________________
Date: ____________

*PRB Representative Name: _____________________________
PRB Rep Signature: _____________________________
Date: ____________

PRB Decision:  
- ☐ Approved
- ☐ Denied

Comments:

*PRB Approval required for all initial SCI requests.*
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

(ADDRSESEE)

Notice Date: 
Case Name: 
Number: 
Worker Name: 
Number: 
Telephone: 
Address: 

Questions? Ask your Worker.

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

APPROVAL

☐ The County has approved your Foster Care aid. 

As of __________, the county is Approving your Foster Care aid of $__________ per month.

This aid is for: ________________________________.

CHANGE

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

This aid is for: ________________________________.

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

☐ Your case had a rate increase.

☐ Your case had a rate decrease.

☐ Your case has been issued an Infant Supplemental Payment.

☐ Your case has been issued a Supplemental Care Increment.

☐ The child has countable income.

_________________________ for __________________________ for

(income Type) (Child’s Name)

of $__________ is effective ____________.

This is counted as __________________ income in the Foster Care budget calculation.

☐ Other: __________________________

☐ Due to funding requirements, you may receive multiple checks for this benefit month. The sum of these checks will be equal to the amount listed above.
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: ________________________________

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 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: 1-800-952-5283 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 __________