6/27/2018

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
Ventura County’s Specialized Care Rate Plan

Attached please find Ventura County's Specialized Care Rate Plan per the instructions provided in ACL 18-48. Ventura is proposing a three-tier rate structure that utilizes the framework provided by CWDA. Ventura County will continue to use the existing SCI plan for cases that do not qualify for the Level of Care rates.

The Ventura County Board of Supervisors has approved this SCR Plan. If you have any questions, please contact Joanna Genet at 805-477-5328 joanna.genet@ventura.org.

Judy Webber, CFS Deputy Director

6/27/18
Date
Ventura County Specialized Care Rate Plan
Effective with the implementation of Level of Care

OVERVIEW:
Specialized care provides a supplemental payment to the family home provider, in addition to the Level of Care 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 behavioral, emotional and/or physical (including health) challenges. 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.

POPULATION:
Specialized Care Rates are available for Foster Care, Non-Related Legal Guardian (NRLG), Kin-GAP and Adoption Assistance Program (AAP) case. Placement types include, Approved Relative, Non-Related Extended Family Members, Guardians and Foster Family Agency homes. A Specialized Care Increment (SCI) is available in addition to the ISFC rate with Senior Management approval.

<table>
<thead>
<tr>
<th>Home Based Placements</th>
<th>No SCI</th>
<th>TIER I</th>
<th>TIER II</th>
<th>TIER III</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td>635</td>
<td>519</td>
<td>13</td>
<td>21</td>
<td>82</td>
</tr>
<tr>
<td>Projected</td>
<td>736</td>
<td>598</td>
<td>128</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Averages based on data received between March 2017 and Feb 2018.

PROCEDURES:
The Child Welfare Social Worker (CWSW) will assess the child's behavioral, emotional and/or physical (including health) challenges to determine the level of SCI needed above and beyond what is already covered in the LOC rate structure. As appropriate the assessment should include, but is not limited to, a consultation with a Public Health Nurse, child's mental health clinician or others who have expertise in a child's needs.

It is recommended that an SCI assessment should be completed after a Child and Family Team (CFT) meeting and after use of the LOC Protocol and any other relevant assessments. However, there may be circumstances in which an SCI is needed more immediately in order to stabilize a placement. In either case, the SCI can be paid retroactively to the initial date of the request. Upon assessing the level of need and the recommended level of SCI, the social worker or other child welfare staff will complete the SCI Matrix and Dependent/Ward Payment Plan.
The following information must be included in the request:

- A specific description of the child’s special care needs which were not adequately addressed in the Level of Care rate determination.

- A description of the additional time or expense to the caregiver that goes above and beyond the Level of Care rate already being provided.

- If transportation is included in the SCI, it must be clearly linked to the physical, behavioral/ emotional, or health needs of the child. School Transportation may be requested as an Educational Travel Reimbursement (ETR).

- Identify on the payment plan what level of SCI is being requested.

- Identify if the request is due to the behavioral health needs of the child.

The CWSW, CWSW Supervisor, and Program Manager must all sign the Dependent/Ward Payment Plan (56-04-004) prior to submitting the request to eligibility. A request for an SCI at Tier III will require Senior Management approval.

Specialized Care Increments will be re-assessed every six months or whenever a new LOC determination is completed. SCI’s should be re-assessed whenever a change in placement or a change in the child’s needs occur.

At the six-month reassessment, the CWSW will reevaluate the needs of the child. The CWSW will submit a new Dependent Ward/Payment Plan (56-04-004) to request that the Special Care Increment to continue or change if appropriate. The SCI will automatically end if a new payment plan is not received.

In addition to the above, the CWSW must provide the following information when requesting that the Special Care Increment to continue or change:

- A brief description of the progress of the child in that home.

- A brief prognosis of the child’s future needs.

Payment plans without the above information will not be approved by management.

For children placed out of county, the host county’s SCI will be used. If the host county does not have an SCR Plan, the placing county’s SCR rates will be used.

**IMPLEMENTATION PLAN:**
After LOC implementation, Ventura County will maintain two SCI plans, Table A for cases that continue to receive age based rates and Table B for case that have received an LOC determination. Cases that have received an LOC determination that required an SCI will be required to use the appropriate SCI from Table B.
INFORMING FAMILIES:
Ventura County provides Rate and SCI information to caregivers at orientation. This information is also posted on our Foster VC Kids web site. In addition, Ventura County will utilize mass mailings and caregiver mentors to inform families of the new SCI structure. Upon approval of an SCI, the caregiver will receive a system generated Notice of Action indicating an SCI has been approved, changed or discontinued.
<table>
<thead>
<tr>
<th>Moderate</th>
<th>Severe</th>
<th>Intensive</th>
<th>Enriched Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50</td>
<td>$164</td>
<td>$263</td>
<td>$890 total rate</td>
</tr>
<tr>
<td>- Behavior problems</td>
<td>- Behavioral problems requiring considerable structure</td>
<td>- Numerous medical appointments</td>
<td>-Non-organic failure to thrive due to severe physical/emotional neglect</td>
</tr>
<tr>
<td>- Twice monthly medical therapy or other appointments</td>
<td>- More than occasional bedwetting</td>
<td>- Physically destructive, unsocialized behavior</td>
<td>-Neo-natal withdrawal syndrome</td>
</tr>
<tr>
<td>- Occasional bedwetting or soiling</td>
<td>- Special diet or formula</td>
<td>- Emotional problems requiring therapeutic intervention</td>
<td>-Severe cerebral palsy</td>
</tr>
<tr>
<td>- Minor physical problems, requiring special soap</td>
<td>- Physical problems requiring special care</td>
<td>- Requires constant supervision and control to ensure safety of self and others</td>
<td>-Very low birth weight babies needing multiple specialist appointments</td>
</tr>
<tr>
<td>- Child in cast, or simple injury</td>
<td>- Supervision with prescribed medication, or diabetic child that self injects</td>
<td>- Child is diabetic, needs foster parent to inject, and/or has frequent emergencies</td>
<td>-Gastric-intestinal tube feeding</td>
</tr>
<tr>
<td>- Problems in school requiring some tutoring</td>
<td>- Emotional needs of the child requires more than 20 miles but less than 40 miles daily total transportation</td>
<td>- Child has serious communicable disease, requires extensive observation</td>
<td>-Chronic significant depression, displaying behavior such as suicide ideation, or self-mutilation</td>
</tr>
<tr>
<td>- Emotional needs of the child require less than 20 miles daily total transportation</td>
<td></td>
<td>- Premature infant requires close observation</td>
<td>-A child diagnosed with chronic mental disorder that requires ongoing therapeutic intervention</td>
</tr>
</tbody>
</table>
# Specialized Care Increment – Table B

Effective with the implementation of Level of Care  
The Specialized Care Increment provides a supplemental payment in addition to a basic rate that pays for the cost of supervision to meet the additional daily care needs of a child/youth.

<table>
<thead>
<tr>
<th>Tier</th>
<th>I</th>
<th>II</th>
<th>III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>$300</td>
<td>$475</td>
<td>$650</td>
</tr>
</tbody>
</table>

## Criteria

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>If three (3) or more of the Tier 1 conditions listed exist, rate will be increased to the next higher level.</td>
<td>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.</td>
<td>More than six appointments per month not including routine dental or physical examinations.</td>
</tr>
<tr>
<td>Drug exposed history or positive toxicology screen.</td>
<td></td>
<td></td>
<td>FAS/FASD with moderate to severe complications (verifiable medical diagnosis)</td>
</tr>
<tr>
<td>Alcohol exposure (FAS, FASD or FAE)</td>
<td></td>
<td></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></td>
<td></td>
<td>Severe feeding problems, excessive crying, sleep disruptions, etc. due to alcohol/drug exposure</td>
</tr>
<tr>
<td>Failure to Thrive</td>
<td></td>
<td></td>
<td>Continuous oxygen.</td>
</tr>
<tr>
<td>Diabetes &amp; Heart Disease</td>
<td></td>
<td></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></td>
<td></td>
<td>Hemophiliac requiring close monitoring to prevent injury.</td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
<td>Minor requires 4 or more injections per week (i.e. growth hormone, asthma, etc.)</td>
</tr>
<tr>
<td>Physical Disabilities/Impairments</td>
<td></td>
<td></td>
<td>Sickle Cell SC, Severe Symptoms.</td>
</tr>
<tr>
<td>Brain Injury (abuse or accidental)</td>
<td></td>
<td></td>
<td>Child requires continuous care and supervision on a daily basis in accordance with a prescribed treatment plan.</td>
</tr>
<tr>
<td>Visually impaired (birth, abuse, or accidental)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing impaired (birth, abuse, or accidental)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immune Disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Intervention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic abnormalities (birth or abuse) (i.e. scoliosis)</td>
<td></td>
<td></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. Regular in-home assistance from a</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>Developmental Delay Disabilty (e.g., Intellectual Disability, Autism Spectrum etc.) Learning Delays or Disabilities</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></td>
<td></td>
</tr>
<tr>
<td>Sensory Integration Disorder</td>
<td>Intermittent assistance from a behaviorist or social/health services provider.</td>
<td>behaviorist or social/health services provider.</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td>Multiple impairments, less than 18 months developmentally, nonambulatory. Regional Center client documentation required from RC SW.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other:</td>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavioral Issues</th>
<th>Behavior modification required but no medication prescribed.</th>
<th>Behavior modification needed in conjunction with prescribed daily medication.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWOL</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.</td>
</tr>
<tr>
<td>Aggressive and Assaultive</td>
<td>Close supervision is sometimes necessary to minimize risk and/or reduce potential for disruption.</td>
<td>Behaviors frequently are disruptive to household, school and in other social interactions.</td>
</tr>
<tr>
<td>Animal Cruelty</td>
<td>Psychotropic medication may be required with close supervision by care provider and increased follow up by therapeutic provider.</td>
<td>Stabilization of disruptive behaviors requires special intervention and discipline strategies.</td>
</tr>
<tr>
<td>CSEC</td>
<td>Other:</td>
<td>Care provider needs special training and participates in counseling with the minor to accomplish this.</td>
</tr>
<tr>
<td>Substance Use/Abuse</td>
<td></td>
<td>601 behaviors (truant, beyond control of caregiver) exhibited at this level.</td>
</tr>
<tr>
<td>Gang Activity</td>
<td></td>
<td>Chronic resistance to behavior modification strategies.</td>
</tr>
<tr>
<td>Fire Setting</td>
<td></td>
<td>Personal property of others in the home at high risk.</td>
</tr>
<tr>
<td>Severe mental health issues—including suicidal ideation and/or Self Harm Psychiatric hospitalization(s)</td>
<td></td>
<td>Excessive anti-social behaviors which strictly limits unsupervised social interaction.</td>
</tr>
<tr>
<td>Adjudicated violent offenses, significant property damage, and/or sex offenders/perpetrators Habitual Truancy</td>
<td></td>
<td>Other:</td>
</tr>
<tr>
<td>Three or more placements due to the child’s behavior</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Children and Family Services  
4651 Telephone Rd, Suite 300  
Ventura, CA 93003  
(805) 654-3444

Revised 05/18
# Children and Family Services
## Dependent/Ward Payment Plan

To be completed on ALL payment plans where anything other than the Basic Foster Care rate is requested.

<table>
<thead>
<tr>
<th>Regional Center Client (please check if child is receiving regional center services)</th>
<th>Eligibility Use: CalWIN Case Name: CalWIN Case Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Name</td>
<td>DOB</td>
</tr>
<tr>
<td>Address of Placement</td>
<td>Vendor Address</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

**REQUEST TYPE:**
- [ ] Special Need (SCI)  
- [ ] Clothing  
- [ ] Out of State  
- [ ] Out of County  
- [ ] Dual Agency  
- [ ] Trust Fund  
- [ ] Kinship Emergency  
- [ ] SCIAP  
- [ ] All County Funds  
- [ ] Static Criteria (limited to 60 days)

**EDUCATIONAL TRAVEL REIMBURSEMENT (ETR):**
- [ ] YES or [ ] NO

Mode of Transportation:
- [ ] Car,  
- [ ] Public Transportation;  
- [ ] Other: Description required below

Name of School:  
Address of School:  
Reimbursement

**DESCRIBE NEED:** Is rate due to behavioral health needs? [ ] YES or [ ] NO

Effective Date:  
Amount:  
Social Worker/Probation Officer  
Date  
Child Welfare/Probation Supervisor  
Date  
Program Manager  
Date  
[ ] Approved  
[ ] Denied

Termination Date:  
[ ] Rate added to CWS/CMS

Eligibility Officer  
Date  
Eligibility Supervisor  
Date  
Additional Approval  
Date  
[ ] Approved  
[ ] Denied

Additional Approval is Required for:  
All County Funds, Kinship, Static Criteria and SCIAP

56-04-004 (02/18)
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)

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 ________________________________
(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)

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.

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: ________________________________
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