

Nevada County Foster Care Rates Effective January 2008

Foster Family Home Basic Rates

Special Needs Rates

\$35.00 per check mark from Appraisal/Needs and Services Plan added to Base Rate. Max payable for SCI is \$798 (22.8 checks).

Maximum Payable (Base Rate + Special Care Increment)

Age 0-4	\$1,244.00
Age 5-8	\$1,283.00
Age 9-11	\$1,317.00
Age 12-14	\$1,371.00
Age 15-18	\$1,425.00

Foster Care Specialized Rates *Policy and Procedural Guide*

Issue Date: March 24th, 2009
Effective Date: March 24th, 2009

New Policy
Revision

Overview

Specialized care is a system that allows a county to pay a rate greater than the family home basic rate on behalf of children who receive Aid to Families with Dependent Children-Foster Care (AFDC-FC) who are placed in family homes and require specialized care and supervision. Children requiring specialized care are those children with documented health, and/or behavioral problems that require more than basic foster care supervision. Children who are placed under the authority of a court order, either as a dependent or ward of the Juvenile Court, relinquishment, voluntary placement agreement or guardianship may be eligible to receive a special care rate (SCR). FFAs and group homes are not eligible to receive specialized care rates. Small family homes and relative caregivers, including non-relative extended family members and legal guardians, may be eligible for SCRs. 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 parents home and consistent with the best interest and special needs of the child. All foster parents receiving specialized care rates must:

- Assist social worker with necessary documentation for specialized rates
- Complete and comply with specialized service plan agreement
- Cope with disruptive behavior
- Provide close supervision for the child
- Provide all in-county transportation and reasonable out-of-county transportation (to be negotiated)
- Participate in counseling with foster child, if seemed necessary by therapist
- Maintain and complete necessary paperwork, a journal, incident reports, and any other necessary documentation
- Arrange medical and dental check-ups within 30 days of placement (if necessary)

Special Care Rates are determined by CDSS. The State must approve all county proposals to modify or adopt a system. The county also maintains a matrix whereby the appropriate rate level for each child can be determined.

This Procedural Guide is applicable to all new and existing referrals and cases.

Procedures

A. WHEN: REQUESTING A SPECIAL CARE RATE

When a foster caregiver or social worker feels that a child qualifies for a special rate, the worker and caregiver will work together to review the child's requirements. If there is sufficient need, the worker will request a special care rate.

Process: Social Worker

1. Gather information and documentation from health providers, mental health professionals, foster parents, extended family, the school, daycare providers, and other have knowledge of the child's needs.
 - a. If requesting a level III or IV special rate, prepare the following for inclusion in the application:
 - i. Proof, duration, and frequency of child's counseling
 - ii. Summary of counselor's progress reports
 - iii. Documented history of violence (describe incidents)
 - iv. Documentation of medical visits and physicians' prognosis
 - v. Documentation of special actions that the caregiver has to perform to keep this child viable
2. Using the **Nevada County Special Rate Matrix**, determine the child's classification level.
3. Complete a Specialized Care Rate application.
 - a. NOTE: If the child is placed out of state, or in a California county other than Nevada, the social worker must obtain that county's matrix, rates and application, and use that information for the application.
 - b. Be as specific as possible on the application; complete information expedites the approval process. Include information like:
 - i. What is the foster care parent doing to warrant the SCR?
 - ii. Indicate specific behavior problems that warrant special care
 - iii. Specify medications and frequency of administration.
 - iv. Indicate specifics of hygiene, bed-wetting, physical impairments and their care.
 - c. On the SCR application, indicate whether it is an Initial Placement, Change Request or Annual Review, or a Six Month Renewal with no changes.
 - d. Obtain Ongoing Supervisor's signature.
 - e. Bring all information to Program Manager to request written authorization.

Note: When a child is placed in a foster family home located in a county other than the county with payment responsibility, pursuant to MPP section 11-401.421, the county with payment

responsibility shall pay the host county SCR, or if the host county has no SCR plan, then the county with payment responsibility will pay using its own SCR. If the SCR determination criteria are different between the host and placing counties, the host county's methodology, criteria and rates will apply (pursuant to MPP section 11-401.421).

B: WHEN: RENEWING A SPECIAL CARE RATE

SCR Renewals should stay in the same time frame as Annual Case Renewals, so best practice is to do an additional renewal in a shorter timeframe than 6 months to synchronize the renewal schedules.

Process: Social Worker

1. Review feedback from foster parent, medical provider, or counselor, school, child, or other agencies.
2. Complete steps 1-3, above. Written approval or denial is again necessary from Program Manager.
3. Include in the Court Report the need for, changes to, or discontinuance of the SCR.
4. Include SCR stats in appropriate CWS/CMS sections.

Statues, Regulations, and Related Resources

WIC 11461(e), 11-400(s) (6-8), 11-401.2
AB 2695 (Chapter 977, Statutes of 1982)

FORM(S): Supportive or Required, location

Nevada County Specialized Care Rate Matrix
Specialized Care Rate Request

H Drive
H Drive

APPRAISAL/NEEDS AND SERVICES PLAN

CLIENT'S/RESIDENT'S NAME	DATE OF BIRTH	AGE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE
FACILITY NAME	ADDRESS			CHECK TYPE OF NEEDS AND SERVICES PLAN: <input type="checkbox"/> ADMISSION <input type="checkbox"/> UPDATE
PERSON(S) OR AGENCY(IES) REFERRING CLIENT/RESIDENT FOR PLACEMENT			FACILITY LICENSEE NUMBER	TELEPHONE NUMBER ()

Licensing regulations require that an appraisal of needs be completed for specific clients/residents to identify individual needs and develop a service plan for meeting those needs. If the client/resident is accepted for placement the staff person responsible for admission shall jointly develop a needs and services plan with the client/resident and/or client's/resident's authorized representative referral agency/person, physician, social worker or other appropriate consultant. Additionally, the law requires that the referral agency/person inform the licensee of any dangerous tendencies of the client/resident.

NOTE: For Residential Care Facilities for the Elderly, this form is not required at the time of admission but must be completed if it is determined that an elderly resident's needs have not been met.

BACKGROUND INFORMATION: Brief description of client's/resident's medical history/ emotional, behavioral, and physical problems; functional limitations; physical and mental; functional capabilities; ability to handle personal cash resources and perform simple homemaking tasks; client's/resident's likes and dislikes.

NEEDS	TIME FRAME					OBJECTIVE/PLAN	PERSON(S) RESPONSIBLE FOR IMPLEMENTATION	METHOD OF EVALUATING PROGRESS DOCUMENTATION BY
	Yes	No	Reduce	Increase	Months			
SOCIALIZATION — Difficulty in adjusting socially and unable to maintain reasonable personal relationships								
Concerns								
Peer Relationship Skills								
Parent-Child Relationship Skills								
Adult-Child Relationship Skills								
Authority Relationship Issues								
Interaction/Social Exchange Issues								
Other								
EMOTIONAL — Difficulty in adjusting emotionally								
Behavioral Problems								
Lying — Stealing —								
Aggressiveness								
Sexual Acting Out								
Emotional Disturbance								
Mood Variations								
Withdrawal — Depression —								
Frequent Emotional Outbursts								
Age Appropriateness								
Drug-Alcohol Abuse								
Other								

NEEDS					TIME FRAME	OBJECTIVE/PLAN	PERSON(S) RESPONSIBLE FOR IMPLEMENTATION	METHOD OF EVALUATING PROGRESS OBSERVATION/DOCUMENTATION BY
MENTAL — Difficulty with intellectual functioning including inability to make decisions regarding daily living.								
Concerns	Yes	No	Reduce	Increase	Months			
Intellectual Functioning								
High — Average —								
Borderline — Low —								
Academic Functioning								
Reg. Sch. — Spec. Educ. —								
Vocational								
Decision Making Ability								
0 1 2 3 4 5 6								
Judgement								
0 1 2 3 4 5 6								
Other								
PHYSICAL/HEALTH — Difficulties with physical development and poor health habits regarding body functions.								
Personal Hygiene								
On-Going Health Concerns								
Medication Needs								
Physical Impairments								
Vision — Hearing —								
Other								
Coordination Skills								
Appetite/Weight Issues								
Elimination Difficulties								
Sleep Difficulties								
Other								
FUNCTIONING SKILLS — Difficulty in developing and/or using independent functioning skills.								
Personal Care Skills								
Budgeting Skills								
Homemaking Skills								
Use of Community Resource Skills								
Other								

We believe this person is compatible with the facility program and with other clients/residents in the facility, and that I/we can provide the care as specified in the above objective(s) and plan(s).

TO THE BEST OF MY KNOWLEDGE THIS CLIENT/RESIDENT DOES NOT NEED SKILLED NURSING CARE.

LICENSEE(S) SIGNATURE

DATE

I have reviewed and agree with the above assessment and believe the licensee(s) other person(s)/agency can provide the needed services for this client/resident

CLIENT'S/RESIDENT'S AUTHORIZED REPRESENTATIVE(S)/FACILITY SOCIAL WORKER/PHYSICIAN/OTHER APPROPRIATE CONSULTANT SIGNATURE

DATE

I/We have participated in and agree to release this assessment to the licensee(s) with the condition that it will be held confidential.

CLIENT'S/RESIDENT'S OR CLIENT'S/RESIDENT'S AUTHORIZED REPRESENTATIVE(S) SIGNATURE

DATE



NEVADA COUNTY HUMAN SERVICES AGENCY

Jeff Brown
Director

Alison A. Lehman
Social Services Director
Public Guardian

Department of Social Services

950 MAIDU AVE., PO BOX 1210

NEVADA CITY CALIFORNIA 95959

TELEPHONE (530) 265-1340
FAX (530) 265-9860

Nevada County Specialized Care Rate Request

Child's Name: _____ AKA: _____

Child DOB: ____/____/____ Child Age: _____

Case Number: 17-42/40 - _____ Social Security Number: _____

Sex: [] M [] F Ethnicity: _____ New Request [] 12 Month Renewal [] Placement Change [] *(If this request is a renewal state what problems still exist that were not alleviated during the last 12 months and why, as well as why the placement remains appropriate).*

Requested by: _____ (SW) Rate Effective Date: _____

Reason for need: _____

(If more space is needed use an additional sheet. SCI does not apply to FFAs or Residential/Group-home Care)

Appraisal needs and services plan is attached. Monetarily, each "check" indicating difficulty on the appraisal = \$35.00, to a maximum of \$798.00 (22.8 checks) added to the base rate.

Reviewed by Supervisor (signature): _____ Date: _____

Comments: _____

Rate: \$ _____

Approved by Program Manager: _____ Date: _____