

Effective 6/1/2011, Riverside County implemented new Specialized Care Increment (SCI) processes and rates. Some general information is provided below. Contact your social worker if you have questions.

**Placement Types and SCI Eligibility**

Children in the following placement types **are potentially eligible** to receive an SCI:

- licensed foster family home (FFH)
- approved relative home
- approved Non-Related Extended Family Member (NREFM) home
- approved Non-Related Legal Guardian (NRLG) home
- State Licensed Small Family Home

A child in a NRLG home may be eligible for the SCI pilot rates and process regardless of current or prior dependency.

Children in the following placement types **are not eligible** for an SCI because they already receive funds for special needs as part of their facility rate:

- Foster Family Agency (FFA) home
- Regional Center home
- group homes.

**Initial SCI Rate Assessment Process:** The following table provides an overview of the process for determining SCI funding for each potentially eligible child:

Stage	Description
1	The social worker: <ul style="list-style-type: none"> <li>• completes the DPSS 4093 Special Care Increment Social Worker Assessment with the caregiver and</li> <li>• sends it to Riverside County CSD Central Placement Unit (CPU).</li> </ul>
2	The CPU social worker: <ul style="list-style-type: none"> <li>• reviews the DPSS 4093 Special Care Increment Social Worker Assessment</li> <li>• uses the DPSS 4100 Special Care Increment Worksheet to determine the child's eligibility to SCI funding and the appropriate rate.</li> </ul>
4	If the SCI funding is denied, the caregiver receives: <ul style="list-style-type: none"> <li>• a Special Care Increment Denial Letter</li> <li>• a DPSS 4089 Resolving Special Care Increment (SCI) Grievances brochure and State form PUB 13 "Your Rights Under California Welfare Programs."</li> </ul>
5	If the SCI funding is approved: <ul style="list-style-type: none"> <li>▪ the caregiver receives a:                             <ul style="list-style-type: none"> <li>○ Special Care Increment Approval Letter,</li> <li>○ blank DPSS 4095 Special Care Increment Quarterly Progress Report,</li> <li>○ Resolving Special Care Increment (SCI) Grievances brochure and</li> </ul> </li> <li>▪ State form PUB 13 "Your Rights Under California Welfare Programs."</li> <li>▪ Foster Care Eligibility staff receive a:                             <ul style="list-style-type: none"> <li>○ SOC 158A documenting the current SCI funding rate and</li> <li>○ DPSS 477A Special Care Increment Authorization documenting the rate and the primary domain under which the child qualifies.</li> </ul> </li> </ul>
6	Foster Care eligibility: <ul style="list-style-type: none"> <li>• enters the SCI funding rate into C-IV to authorize the payment and track the due date of the caregiver's quarterly progress report</li> <li>• issues a Notice of Action regarding the funding rate to the caregiver and</li> <li>• sends a copy of the Notice of Action to the case-carrying social worker.</li> </ul>



Riverside County Department of Public Social Services – Children’s Services Division  
**Special Care Increment - Social Worker Assessment – DPSS 4093**

<b>Date of SCI Assessment:</b>	
<b>Date of Birth:</b>	
<b>Date Child Was Placed in the Caregiver's Home:</b>	
<b>Caregiver's Address (street address, apt no., city, state, and zip code):</b>	
<b>Caregiver's Birth Number:</b>	

PLEASE CHECK ONE:       INITIAL SCI ASSESSMENT       REASSESSMENT

After completing the SCI Social Worker Assessment, please forward the completed form via email to [SCIUnit@riversidedpss.org](mailto:SCIUnit@riversidedpss.org) or via fax to 951-358-7360.

**PHYSICAL/HEALTH DISABILITY**

<b>Name of Child/Youth/Youth:</b>	<b>Date of Birth</b>
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<b>Qualifying Condition - Non-EMS:</b> (Check all that apply, regardless of steps).			
<input type="checkbox"/> Feeding Issues	<input type="checkbox"/> Artificial Openings	<input type="checkbox"/> Self-Care Deficits	<input type="checkbox"/> Blood or Genetic Disorders
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Terminal Illness	<input type="checkbox"/> Drug Exposed Infant	<input type="checkbox"/> Neurological Issues
<input type="checkbox"/> Cardiac Issues	<input type="checkbox"/> Infectious Disease(s)	<input type="checkbox"/> Respiratory Issues	<input type="checkbox"/> Surgical/Fractures/Burns Wound Care
<input type="checkbox"/> Other physical/health disability issues not otherwise specified--explain:			(Requires SCI Supervisor approval): _____

**CHILD/YOUTH REQUIREMENTS**

<input type="checkbox"/> Child/youth requires additional care and supervision due to a medical condition of obesity as diagnosed by a medical professional, whose treatment plan includes one or more of the following: regular monitoring by a medical professional over and above age-appropriate check-ups, completion of specific goals identified by professionals (i.e. medical professional, nutritionist, staff of weight management program appropriate to child's/youth's age), <b>adhering to at least the minimum doctor recommended minutes a day of extra-curricular physical activity</b> , and family-oriented education regarding the benefits of regular physical activity.
<input type="checkbox"/> Child/youth requires specialized feeding techniques as recommended by a medical professional (such as for a cleft lip/palate, poor suck/swallow coordination, etc.)
<input type="checkbox"/> Child/youth has visual deficits and requires a sighted guide outside the home
<input type="checkbox"/> Child/youth requires postural supports and frequent repositioning
<input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____

<input type="checkbox"/> Child/youth requires frequent feedings (more than 6 times per day or more than 30 minutes each)
<input type="checkbox"/> Child/youth uses a recognized sign language (such as ASL, SEE, PSE, etc.) or relies the use of a communication board
<input type="checkbox"/> Child/youth requires a sighted guide at all times (inside and outside home)
<input type="checkbox"/> Child/youth requires intermittent use of an apnea monitor, nebulizer, or asthma inhaler
<input type="checkbox"/> Child/youth requires post surgical care and treatment as ordered by a physician
<input type="checkbox"/> Child/youth requires daily adaptive therapy exercises or the use of adaptive equipment in the home
<input type="checkbox"/> Child/youth has a history of terminal illness that is in remission - follow-up for this condition to be no more than 3 times a year, as recommended by a physician.
<input type="checkbox"/> Child/youth requires additional care and supervision due to a medical condition of pregnancy as diagnosed by a medical professional, requiring supervision by the caregiver to ensure the child/youth attends monthly check-ups/other scheduled medical appointments and parenting/childbirth classes, as well as providing for increased nutritional needs <b>as prescribed by a medical professional for the duration of the pregnancy.</b>
<input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____

<input type="checkbox"/> Child/youth is incontinent and over the age of 4, necessitating purchase of diapers and supplies, frequent washing of linens, extra linens, etc.
<input type="checkbox"/> Child/youth requires increased care and supervision due to severe self-care deficits in the areas of grooming, bathing, hygiene, and dressing - but child/youth can provide some assistance such as raising arms to dress
<input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____

<input type="checkbox"/> Child/youth relies on Braille or Tactile Sign Language to communicate
<input type="checkbox"/> Child/youth requires the use of an apnea monitor, nebulizer, or asthma inhaler more than 4 times daily
<input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____

**PHYSICAL/HEALTH DISABILITY**, continued

**\*NOTE:** The rates on this page require Placement Regional Manager, or Deputy Director approval.

**Qualifying Condition - Severe Medical Problems or EMS/Medically Fragile:** These rates apply to a child/youth who has been screened through the Interagency Placement Screening Committee (IPSC) and found to meet the criteria for the Enhanced Medical Services (EMS)/Medically Fragile Program, OR to a child or youth with severe medical problems but deemed by the IPSC or EMS PHN as not appropriate for EMS. Please attach documentation to support level of care. (Check all that apply, regardless of steps).

<input type="checkbox"/> Feeding Issues	<input type="checkbox"/> Artificial Openings	<input type="checkbox"/> Self-Care Deficits	<input type="checkbox"/> Blood or Genetic Disorders
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Terminal Illness	<input type="checkbox"/> Drug Exposed Infant	<input type="checkbox"/> Neurological Issues
<input type="checkbox"/> Cardiac Issues	<input type="checkbox"/> Infectious Disease(s)	<input type="checkbox"/> Respiratory Issues	<input type="checkbox"/> Surgical/Fractures/Burns Wound Care
<input type="checkbox"/> Other serious physical/health disability issues not otherwise specified - <b>provide a detailed description:</b> (Requires SCI Supervisor approval): _____			

**CHILD/YOUTH REQUIREMENTS**

<input type="checkbox"/> Child/youth requires an accessible environment due to the use of a wheelchair at all times (home must be WC accessible) <input type="checkbox"/> Child/youth requires weekly wound care or post-surgical care, as ordered by a physician <input type="checkbox"/> Child requires <b>constant</b> swaddling and comfort due to a specific medical condition such as prematurity, drug withdrawal, failure to thrive, etc. <input type="checkbox"/> Child/youth on medication requires daily monitoring of vital signs in accordance with physicians' orders <input type="checkbox"/> Child/youth with diabetes requires daily blood sugar monitoring and corresponding treatment/interventions, including insulin injections, oral medication, etc. <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
<input type="checkbox"/> Child/youth has exceptional medical feeding needs (such as NG tube, TPN, high frequency) <input type="checkbox"/> Child/youth requires a modified home environment to accommodate his/her needs (severe food allergies, etc.) <input type="checkbox"/> Child/youth has physical/health disability needs that limit/prevent the SCP from utilizing respite services <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
<input type="checkbox"/> Child/youth with a severely compromised immune system requires a safe and sterile environment <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
<input type="checkbox"/> Child/youth has a terminal illness or is on hospice, and requires frequent medical treatments (such as radiation, IV chemotherapy, or palliative care) for end of life issues <input type="checkbox"/> Child/youth is ventilator dependent or requires constant suctioning to maintain an open airway, necessitating constant supervision and care <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____

**APPROVALS:** Original signatures are not required on the DPSS 4093 if a supervisor, manager or a deputy director is forwarding an approved request via CWS/CMS email and indicates electronic approval on the form and in the email.

<b>Placement RM Approval:</b>	<b>By:</b>	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	<b>Date:</b>
<b>Deputy Director Approval:</b>	<b>By:</b>	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	<b>Date:</b>

**EMOTIONAL/BEHAVIORAL**

<b>Name of Child/Youth:</b>	<b>Date of Birth:</b>
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<b>Qualifying Condition:</b> (Check all that apply, regardless of steps). Emotional or behavioral concerns including but not limited to:			
<input type="checkbox"/> extreme level of attention deficit and/or hyperactivity	<input type="checkbox"/> truancy, gang involvement, AWOL's	<input type="checkbox"/> assault, destructive, aggressive behaviors	<input type="checkbox"/> self-mutilation and/or attempted self injury; and/or suicidal ideation
<input type="checkbox"/> fire-starter or cruelty/harm to animals	<input type="checkbox"/> defiance issues, anger challenges	<input type="checkbox"/> extreme tantrums (not development-ally appropriate for age)	<input type="checkbox"/> sexual acting out behaviors, sexual perpetrator
<input type="checkbox"/> nightmares, attachment issues or separation anxiety	<input type="checkbox"/> drug or alcohol use/abuse	<input type="checkbox"/> history of hospitalization (last 2 yrs.) due to mental health condition	<input type="checkbox"/> resistant to taking medications and/or attending treatment
<input type="checkbox"/> debilitating behavioral disorder diagnosed by a medical or mental health professional--for example: bi-polar disorder, schizophrenia, autism, Asperger's Syndrome, Reactive Attachment Disorder (RAD), Conduct Disorder, Oppositional Defiant Disorder (ODD), Obsessive Compulsive Disorder (OCD)			
<input type="checkbox"/> Other serious emotional/ behavioral issues not otherwise specified - explain: _____ (Requires SCI Supervisor approval): _____			

**CHILD/YOUTH REQUIREMENTS**

<input type="checkbox"/> Child/youth with mild or transient episodes of emotional challenges may require extra care
<input type="checkbox"/> Child/youth age 7 or older has night-time enuresis necessitating purchase of diapers and supplies, frequent washing of linens, extra linens, etc.
<input type="checkbox"/> Child/youth has increased needs in regard to bonding activities / holding / soothing.
<input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
<input type="checkbox"/> Child/youth has moderate episodes of emotional/behavioral/physical challenges (challenges that are not transient in nature)
<input type="checkbox"/> Child/youth has emotional or behavioral needs require direct care and supervision, additional structure, and monitoring
<input type="checkbox"/> Child/youth (age 4 or older) has encopresis necessitating purchase of diapers and supplies, frequent washing of linens, extra linens, etc. (This excludes an older child/youth with a DD-score in physical/disability domain)
<input type="checkbox"/> Child/youth requires therapy, and implementation of routine, structured activities
<input type="checkbox"/> Child/youth requires mental health or behavioral therapeutic interventions for his/her safety and well-being-such as the posting of rules and behavior charts in home
<input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
<input type="checkbox"/> Child/youth has emotional/behavioral challenges that requires SCP's participation in therapy, medical sessions or other therapeutic processes
<input type="checkbox"/> Child/youth in an outpatient drug or alcohol treatment program requires additional SCP support
<input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
<input type="checkbox"/> Child/youth requires highly structured supervision due to a severe emotional/behavioral disorder/condition.
<input type="checkbox"/> Child/youth cannot sit still, eats with hands (not utensils), and/or is extremely under socialized (feral); requiring one-on-one attention and teaching by the SCP.
<input type="checkbox"/> Child/youth (over 5) smears feces necessitating purchase of additional supplies, frequent washing of linens and clothes, etc.
<input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____

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\* **NOTE:** The rates below on this page require Placement Regional Manager or Deputy Director approval.

**Qualifying Condition -The emotional/behavioral rates below apply only to a child/youth who has been screened through the Interagency Placement Screening Committee (IPSC) and found to meet the criteria for this level of SCI.** (Check all that apply, regardless of steps).

**CHILD/YOUTH REQUIREMENTS, continued**

- Child/youth with severe emotional/behavioral issues, requires constant direct care and supervision during waking hours to keep the child/youth or others safe
  - Child/youth has severe emotional/behavioral problems which prevents the SCP from obtaining respite care
  - Child/youth has severe emotional/behavioral problems and requires regular intervention through ETS, Therapeutic Behavioral Service (TBS) or Wraparound Services
  - Other - explain: \_\_\_\_\_ (Requires SCI Supervisor approval): \_\_\_\_\_
- 
- Child/youth requires constant and direct care and supervision (24 hours per day) due to Mental Health challenges-these include severe and chronic illnesses that are expected to result in mental/emotional impairment that cannot improve through medication, support or behavioral modification; and/or requires continuous supervision beyond what would be considered age appropriate
  - Child/youth has escalated acting out behaviors and may qualify for group home placement if a lower level of care (least restrictive placement) cannot be located.
  - Other - explain: \_\_\_\_\_ (Requires SCI Supervisor approval): \_\_\_\_\_

**APPROVALS:** Original signatures are not required on the DPSS 4093 if a supervisor, manager or a deputy director is forwarding an approved request via CWS/CMS email and indicates electronic approval on the form and in the email.

<b>Placement RM Approval:</b>	<b>By:</b>	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	<b>Date:</b>
<b>Deputy Director Approval:</b>	<b>By:</b>	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	<b>Date:</b>

**SCI Rate Reassessment Process for Dependent/Delinquent Children:** Each child will receive a semi-annual reassessment of her/his individual needs and SCI funding rate, as described in the following table.

Stage	Description
1	The caregiver completes the DPSS 4095 Special Care Increment- Progress Report to: <ul style="list-style-type: none"> <li>• verify the specialized care provided during the report period and</li> <li>• document the child's current needs.</li> </ul>
2	The case carrying social worker: <ul style="list-style-type: none"> <li>• meets with the caregiver and</li> <li>• reassesses the child's needs utilizing the DPSS 4093 Special Care Increment Social Worker Assessment.</li> </ul>
3	Upon receipt of the caregiver and social worker's documentation, the CPU social worker re-determines the child's eligibility and SCI funding rate.
4	If the SCI funding is denied, the caregiver receives a/an: <ul style="list-style-type: none"> <li>• Special Care Increment Denial Letter</li> <li>• DPSS 4089 Resolving Special Care Increment (SCI) Grievances brochure and</li> <li>• State form PUB 13 "Your Rights Under California Welfare Programs."</li> </ul>
5	If the SCI funding is approved: <ul style="list-style-type: none"> <li>• the caregiver receives a: <ul style="list-style-type: none"> <li>○ Special Care Increment Approval Letter,</li> <li>○ blank DPSS 4095 Special Care Increment Quarterly Progress Report</li> <li>○ DPSS 4089 Resolving Special Care Increment (SCI) Grievances brochure and</li> <li>○ State form PUB 13 "Your Rights Under California Welfare Programs."</li> </ul> </li> <li>• Foster Care eligibility staff receive a: <ul style="list-style-type: none"> <li>○ SOC 158A documenting the current rate and</li> <li>○ DPSS 477A Specialized Care Increment Authorization form documenting the SCI funding rate and the primary domain under which the child qualifies.</li> </ul> </li> </ul>
6	Foster Care eligibility: <ul style="list-style-type: none"> <li>• enters the SCI funding rate into the C-IV database to authorize the payment and track the due date of the caregiver quarterly progress report</li> <li>• issues a Notice of Action regarding the SCI funding rate to the caregiver and</li> <li>• sends a copy of the Notice of Action to the case-carrying social worker.</li> </ul>

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**SCI Funding Rate Reassessment for Non-Dependent Children in Non-Related Legal Guardianship:** Each child will receive a semi-annual reassessment of her/his individual needs and SCI funding rate as described in the following table.

Stage	Description
1	The caregiver completes the DPSS 4161 Special Care Increment Semi-annual Progress Report to: <ul style="list-style-type: none"> <li>• verify the specialized care provided during the report period and</li> <li>• document the child's current needs.</li> </ul>
2	The case carrying social worker: <ul style="list-style-type: none"> <li>• meets with the caregiver and</li> <li>• reassesses the child's needs utilizing the DPSS 4093 Special Care Increment Social Worker Assessment.</li> </ul>
3	Upon receipt of the caregiver and social worker's documentation, the CPU social worker re-determines the child's eligibility and SCI funding rate.
4	If the SCI funding is denied, the caregiver receives a/an: <ul style="list-style-type: none"> <li>• Special Care Increment Denial Letter</li> <li>• DPSS 4089 Resolving Special Care Increment (SCI) Grievances brochure and</li> <li>• State form PUB 13 "Your Rights Under California Welfare Programs."</li> </ul>

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Riverside County Department of Public Social Services – Children’s Services  
**Special Care Increment - NRLG Progress Report - DPSS 4161**

	Date:
Child/s/NMD’s Name:	DOB:
CPU/SCI Social Worker’s Name:	CPU/SCI Phone:

If a non-dependent child or non-minor dependent (NMD) placed with a Non-Related Legal Guardian (NRLG) receives a specialized care increment (SCI), the child’s eligibility to an SCI must be reassessed every six months.

Information contained in this report

- is confidential and to be used only for the purpose of reassessing the child’s SCI eligibility and rate.
- may be subject to additional verification.

By completing and signing this report, the non-related legal guardian is certifying the information to be true and correct to the best of his/her knowledge.

**Instructions:**

- Complete this report and return it in the envelope provided.
- Reports should be legible and in ink, or they may be typed. We suggest you keep a copy of the report and supporting documentation for your records.
- In order to qualify for the SCI this report **must** be received by the Placement/SCI unit. Completed reports will be date stamped upon receipt.
- The agency will send a courtesy reminder regarding reports; however, it is the guardian’s responsibility to submit the reports timely regardless of reminders.
- Copies of receipts, attendance logs, records of extra-curricular activities, corroborating documentation from at least two (2) qualified persons, or any other form of documentation regarding information provided within the report **must** be attached for the report to be considered complete.
- Guardians are encouraged to include pictures of the child/youth/NMD or copies of awards or certificates during the month of review.
- Copies of SCI reports should be made available to social workers during home visits.

**What happens if the SCI Report is not submitted timely?**

- If a report is not received within two weeks of your SCI Reassessment due date, you will receive a friendly reminder.
- If a report is not received by the last date of the month in which the SCI Reassessment is due, your rate will be reduced to the basic care rate. In order to qualify for the SCI this report **must** be received by the Placement/SCI unit.

**If funding is reduced to the basic rate because you did not submit the report in a timely manner**, the Special Care Increment payment **will not** be reinstated retroactively. Reinstatement of the Special Care Increment payment will be effective as of the date the required documentation is received by the Placement/SCI unit.

- If you need any assistance in completing the report, please do not hesitate to contact the Placement/SCI unit directly at: (951) 358-7400.

<b>By signing this report I am stating the information is true and correct to the best of my knowledge. I certify that I am in compliance with all Community Care Licensing (CCL) requirements.</b>	
Guardian Name- (please print):	Date:
Guardian Signature: ►	
CPU/SCI Social Worker:	Date Received:

## Special Care Increment (SCI) – NRLG Progress Report

On behalf of: \_\_\_\_\_

NRLG Child/Youth/NMD Name

Age

Monthly medical, mental health or supportive services must be participated in during the review period to remain eligible for an SCI payment. Please list/describe your participation in each area below and attach additional pages as needed. Be sure to make a note in each area listed.

Medical		No Medical Appointments
Dates	Doctor/Other Professional	Reason for Visit

Emotional / Behavioral/ Mental Health		No Mental Health Appointments
Dates	Therapist or Other Professional	Reason for Visit

Other Supportive Services or Appointments		No Supportive Services
Dates	Provider	Reason for Visit

**INSTRUCTIONS:** Copies of receipts, attendance logs, records of extra-curricular activities or any other form of documentation regarding information provided within the report must be attached for the report to be considered complete. Please make sure that you have accurately completed this report. This information will be used to validate continued eligibility for the SCI program. When completed, please return this document and all supporting documentation to:

**Riverside County Department of Public Social Services, ATTN: Placement/SCI Unit  
10281 Kidd St., 2<sup>nd</sup> Floor  
Riverside, CA. 92503**

5	<p>If the SCI funding is approved:</p> <ul style="list-style-type: none"> <li>• the caregiver receives a: <ul style="list-style-type: none"> <li>○ Special Care Increment Approval Letter,</li> <li>○ blank DPSS 4161 Special Care Increment Semi-Annual Progress Report</li> <li>○ DPSS 4089 Resolving Special Care Increment (SCI) Grievances brochure and</li> <li>○ State form PUB 13 “Your Rights Under California Welfare Programs.”</li> </ul> </li> <li>• Foster Care eligibility staff receive a: <ul style="list-style-type: none"> <li>○ SOC 158A documenting the current rate and</li> <li>○ DPSS 477A Specialized Care Increment Authorization form documenting the SCI funding rate and the primary domain under which the child qualifies.</li> </ul> </li> </ul>
6	<p>Foster Care eligibility:</p> <ul style="list-style-type: none"> <li>• enters the SCI funding rate into the C-IV database to authorize the payment and track the due date of the caregiver semi annual progress report</li> <li>• issues a Notice of Action regarding the SCI funding rate to the caregiver and</li> <li>• sends a copy of the Notice of Action to the case-carrying social worker.</li> </ul>

**Note:** The SCI funding rate expires if the caregiver does not submit a fully completed DPSS 4161 semi-annual progress report to CPU.



<b>Social Worker's Name:</b>	<b>Date of the SCI Assessment:</b>
<b>Child/Youth Name:</b>	<b>Date of Birth:</b>
<b>Caregiver's Name:</b>	<b>Date Child/Youth Was Placed in the Caregiver's Home:</b>
<b>Caregiver's Address: (street address, apt no., city, state, and zip code)</b>	
<b>Caregiver's Home Phone Number:</b>	<b>Caregiver's Cell Phone Number:</b>

PLEASE CHECK ONE:     INITIAL SCI ASSESSMENT                       REASSESSMENT

**\*\*\*\*\*THIS FORM IS RESTRICTED FOR USE BY THE CPU/SPECIAL CARE INCREMENT UNIT:**

A Specialized Care Increment (SCI) is an amount authorized *in addition* to the basic foster care rate for the age of the child/youth in an eligible placement type. The SCI is requested by the care provider and authorized by the Placement/SCI Unit, in conjunction with the assigned social worker.

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To qualify for an SCI, a child/youth must require additional care and supervision for reasons specified in **one or both** of the following “**primary domains**”:

- **physical/health disability domain**
- **emotional/behavioral domain**

**Note: Although the child/youth may qualify in both primary domains, the child/youth may receive only one (1) primary SCI--the highest.**

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**PHYSICAL/HEALTH DISABILITY**

**Name of Child/Youth:** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Qualifying Condition - Non-EMS:** (Check all that apply, regardless of steps).

<input type="checkbox"/> Feeding Issues	<input type="checkbox"/> Artificial Openings	<input type="checkbox"/> Self-Care Deficits	<input type="checkbox"/> Blood or Genetic Disorders
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Terminal Illness	<input type="checkbox"/> Drug Exposed Infant	<input type="checkbox"/> Neurological Issues
<input type="checkbox"/> Cardiac Issues	<input type="checkbox"/> Infectious Disease(s)	<input type="checkbox"/> Respiratory Issues	<input type="checkbox"/> Surgical/Fractures/Burns Wound Care
<input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____			

INCREMENT	CHILD/YOUTH REQUIREMENTS
<b>\$100</b>	<input type="checkbox"/> Child/youth requires additional care and supervision due to a medical condition of obesity as diagnosed by a medical professional, whose treatment plan includes one or more of the following: regular monitoring by a medical professional over and above age-appropriate check-ups, completion of specific goals identified by professionals (i.e. medical professional, nutritionist, staff of weight management program appropriate to child's/youth's age), <b>adhering to at least the minimum doctor recommended minutes a day of extra-curricular physical activity</b> , and family-oriented education regarding the benefits of regular physical activity. <input type="checkbox"/> Child/youth requires specialized feeding techniques as recommended by a medical professional (such as for a cleft lip/palate, poor suck/swallow coordination, etc.) <input type="checkbox"/> Child/youth has visual deficits and requires a sighted guide outside the home <input type="checkbox"/> Child/youth requires postural supports and frequent repositioning <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
<b>\$150</b>	<input type="checkbox"/> Child/youth requires frequent feedings (more than 6 times per day or more than 30 minutes each) <input type="checkbox"/> Child/youth uses a recognized sign language (such as ASL, SEE, PSE, etc.) or relies on the use of a communication board <input type="checkbox"/> Child/youth requires a sighted guide at all times (inside and outside home) <input type="checkbox"/> Child/youth requires intermittent use of an apnea monitor, nebulizer, or asthma inhaler <input type="checkbox"/> Child/youth requires post surgical care and treatment as ordered by a physician <input type="checkbox"/> Child/youth requires daily adaptive therapy exercises or the use of adaptive equipment in the home <input type="checkbox"/> Child/youth has a history of terminal illness that is in remission – follow-up for this condition to be no more than 3 times a year, as recommended by a physician <input type="checkbox"/> Child/youth requires additional care and supervision due to a medical condition of pregnancy as diagnosed by a medical professional, requiring supervision by the caregiver to ensure the child/youth attends monthly check-ups/other scheduled medical appointments and parenting/childbirth classes, as well as providing for increased nutritional needs <b>as prescribed by a medical professional for the duration of the pregnancy.</b> <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
<b>\$200</b> <small>(ENTER SCI FFA SPECIAL PROJECT CODE)</small>	<input type="checkbox"/> Child/youth is incontinent and over the age of 4, necessitating purchase of diapers and supplies, frequent washing of linens, extra linens, etc. <input type="checkbox"/> Child/youth requires increased care and supervision due to severe self-care deficits in the areas of grooming, bathing, hygiene, and dressing- but child/youth can provide some assistance such as raising arms to dress <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
<b>\$250</b> <small>(ENTER SCI FFA SPECIAL PROJECT CODE)</small>	<input type="checkbox"/> Child/youth relies on Braille or Tactile Sign Language to communicate <input type="checkbox"/> Child/youth requires the use of an apnea monitor, nebulizer, or asthma inhaler more than 4 times daily <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____

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PHYSICAL/HEALTH DISABILITY, continued

**\*NOTE:** The rates on this page require Placement Regional Manager, or Deputy Director approval.

**Qualifying Condition--Severe Medical Problems or EMS/Medically Fragile:** These rates apply to a child/youth who has been screened through the Interagency Placement Screening Committee (IPSC) and found to meet the criteria for the Enhanced Medical Services (EMS)/Medically Fragile Program, OR to a child/youth with severe medical problems but deemed by the IPSC or EMS PHN as not appropriate for EMS. Please attach documentation to support level of care. (Check all that apply, regardless of steps).

<input type="checkbox"/> Feeding Issues	<input type="checkbox"/> Artificial Openings	<input type="checkbox"/> Self-Care Deficits	<input type="checkbox"/> Blood or Genetic Disorders
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Terminal Illness	<input type="checkbox"/> Drug Exposed Infant	<input type="checkbox"/> Neurological Issues
<input type="checkbox"/> Cardiac Issues	<input type="checkbox"/> Infectious Disease(s)	<input type="checkbox"/> Respiratory Issues	<input type="checkbox"/> Surgical/Fractures/Burns Wound Care
<input type="checkbox"/> Other serious physical/health disability issues not otherwise specified - <b>provide a detailed description:</b> (Requires SCI Supervisor approval): _____			

INCREMENT	CHILD/YOUTH REQUIREMENTS
<p><b>*\$667</b></p> <p>RM APPROVAL REQUIRED</p> <p>(ENTER SCI MED FRAGILE SPECIAL PROJECT CODE)</p>	<input type="checkbox"/> Child/youth requires an accessible environment due to the use of a wheelchair at all times (home must be WC accessible) <input type="checkbox"/> Child/youth requires weekly wound care or post-surgical care, as ordered by a physician <input type="checkbox"/> Child/youth requires <b>constant</b> swaddling and comfort due to a specific medical condition such as prematurity, drug withdrawal, failure to thrive, etc. <input type="checkbox"/> Child/youth on medication requires daily monitoring of vital signs in accordance with physicians' orders <input type="checkbox"/> Child/youth with diabetes requires daily blood sugar monitoring and the corresponding treatment/interventions, including insulin injections, oral medication, etc. <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
<p><b>*\$811</b> ↓</p> <p>RM APPROVAL REQUIRED</p>	<input type="checkbox"/> Child/youth has exceptional medical feeding needs (such as NG tube, TPN, high frequency) <input type="checkbox"/> Child/youth requires a modified home environment to accommodate his/her needs (severe food allergies, etc.) <input type="checkbox"/> Child/youth has physical/health disability needs that limit/prevent the SCP from utilizing respite services <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
<p><b>*\$956</b> ↓</p> <p>RM APPROVAL REQUIRED</p>	<input type="checkbox"/> Child/youth with a severely compromised immune system requires a safe and sterile environment <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
<p><b>*\$1100+</b> ↓</p> <p>DD APPROVAL REQUIRED</p>	<input type="checkbox"/> Child/youth has a terminal illness or is on hospice, and requires frequent medical treatments (such as radiation, IV chemotherapy, or palliative care) for end of life issues <input type="checkbox"/> Child/youth is ventilator dependent or requires constant suctioning to maintain an open airway, necessitating constant supervision and care <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____

**APPROVALS:** Original signatures are not required on the DPSS 4100 if a supervisor, manager or a deputy director is forwarding an approved request via CWS/CMS email and indicates electronic approval on the form and in the email.

Placement RM Approval:	By:	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	Date:
Deputy Director Approval:	By:	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	Date:

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**EMOTIONAL/BEHAVIORAL**

<b>Name of Child/Youth:</b>	<b>Date of Birth</b>
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<b>Qualifying Condition:</b> (Check all that apply, regardless of steps). Emotional or behavioral concerns including but not limited to:			
<input type="checkbox"/> extreme level of attention deficit and/or hyperactivity	<input type="checkbox"/> truancy, gang involvement, AWOL's	<input type="checkbox"/> assault, destructive, aggressive behaviors	<input type="checkbox"/> self-mutilation and/or attempted self injury; and/or suicidal ideation
<input type="checkbox"/> fire-starter or cruelty/harm to animals	<input type="checkbox"/> defiance issues, anger challenges	<input type="checkbox"/> extreme tantrums (not developmentally appropriate for age)	<input type="checkbox"/> sexual acting out behaviors, sexual perpetrator
<input type="checkbox"/> nightmares, attachment issues or separation anxiety	<input type="checkbox"/> drug or alcohol use/abuse	<input type="checkbox"/> history of hospitalization (last 2 yrs.) due to mental health condition	<input type="checkbox"/> resistant to taking medications and/or attending treatment
<input type="checkbox"/> debilitating behavioral disorder diagnosed by a medical or mental health professional - for example: bi-polar disorder, schizophrenia, autism, Asperger's Syndrome, Reactive Attachment Disorder (RAD), Conduct Disorder, Oppositional Defiant Disorder (ODD), Obsessive Compulsive Disorder (OCD)			
<input type="checkbox"/> other serious emotional/ behavioral issues not otherwise specified - explain:			(Requires SCI Supervisor approval): _____

INCREMENT	CHILD/YOUTH REQUIREMENTS
\$100  (ENTER SCI FFA SPECIAL PROJECT CODE)	<input type="checkbox"/> Child/youth with mild or transient episodes of emotional challenges may require extra care <input type="checkbox"/> Child/youth age 7 or older has night-time enuresis necessitating purchase of diapers and supplies, frequent washing of linens, extra linens, etc. <input type="checkbox"/> Child/youth has increased needs in regard to bonding activities / holding / soothing <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
\$250  (ENTER SCI FFA SPECIAL PROJECT CODE)	<input type="checkbox"/> Child/youth has moderate episodes of emotional/behavioral/physical challenges (challenges that are not transient in nature) <input type="checkbox"/> Child/youth has emotional or behavioral needs that require direct care and supervision, additional structure, and monitoring <input type="checkbox"/> Child/youth (age 4 or older) has encopresis necessitating purchase of diapers and supplies, frequent washing of linens, extra linens, etc. (This excludes an older child/youth with a DD-score in physical/disability domain) <input type="checkbox"/> Child/youth requires therapy, and implementation of routine, structured activities <input type="checkbox"/> Child/youth requires mental health or behavioral therapeutic interventions for his/her safety and well-being-such as the posting of rules and behavior charts in home <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
\$400  (ENTER SCI FFA SPECIAL PROJECT CODE)	<input type="checkbox"/> Child/youth has emotional/behavioral challenges that requires SCP's participation in therapy, medical sessions or other therapeutic processes <input type="checkbox"/> Child/youth in an outpatient drug or alcohol treatment program requires additional SCP support <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
\$550  (ENTER SCI FFA SPECIAL PROJECT CODE)	<input type="checkbox"/> Child/youth requires highly structured supervision due to a severe emotional/behavioral disorder/condition <input type="checkbox"/> Child/youth cannot sit still, eats with hands (not utensils), and/or is extremely under socialized (feral); requiring one-on-one attention and teaching by the SCP <input type="checkbox"/> Child/youth (over 5) smears feces necessitating purchase of additional supplies, frequent washing of linens and clothes, etc. <input type="checkbox"/> Other-explain: _____ (Requires SCI Supervisor approval): _____

*Continued on next page*

**\* NOTE:** The rates below on this page require Placement Regional Manager or Deputy Director approval.

**Qualifying Condition--The emotional/behavioral rates below apply only to a child or youth who has been screened through the Interagency Placement Screening Committee (IPSC) and found to meet the criteria for this level of SCI.** (Check all that apply, regardless of steps).

INCREMENT	CHILD/YOUTH REQUIREMENTS, continued
<p><b>*\$800</b>                      RM APPROVAL                      REQUIRED                      (ENTER SCI GH                      SPECIAL PROJECT                      CODE)</p>	<p><input type="checkbox"/> Child/youth with severe emotional/behavioral issues, requires constant direct care and supervision during waking hours to keep the child/youth or others safe</p> <p><input type="checkbox"/> Child/youth has severe emotional/behavioral problems which prevents the SCP from obtaining respite care</p> <p><input type="checkbox"/> Child/youth has severe emotional/behavioral problems and requires regular intervention through ETS, Therapeutic Behavioral Service (TBS) or Wraparound Services</p> <p><input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____</p>
<p><b>*\$1100+</b>                      DD APPROVAL                      REQUIRED                      (ENTER SCI GH                      SPECIAL PROJECT                      CODE)</p>	<p><input type="checkbox"/> Child/youth requires constant and direct care and supervision (24 hours per day) due to Mental Health challenges-these include severe and chronic illnesses that are expected to result in mental/emotional impairment that cannot improve through medication, support or behavioral modification; and/or requires continuous supervision beyond what would be considered age appropriate</p> <p><input type="checkbox"/> Child/youth has escalated acting out behaviors and may qualify for group home placement if a lower level of care (least restrictive placement) cannot be located</p> <p><input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____</p>

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Placement RM Approval:	By: _____	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	Date: _____
Deputy Director Approval:	By: _____	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	Date: _____



Riverside County Department of Public Social Services – Children’s Services  
**Special Care Increment - Progress Report – DPSS 4095**

		Date:
Child’s/NMD’s Name:	DOB:	
CPU/SCI Social Worker’s Name:	CPU/SCI SW Telephone Phone:	

If the dependent child or non-minor dependent (NMD) placed in your home is receiving a special care increment (SCI), the child’s/NMD’s eligibility to an SCI must be reassessed every six (6) months.

Information contained in this report

- is confidential and to be used only for the purpose of maintaining the appropriate Special Care Increment (SCI) rate level and documenting care in the child welfare file.
- may become a part of court records, if applicable to social worker findings or case plan approval.
- may be subject to additional verification.

By completing and signing this report, the caregiver is certifying the information to be true and correct to the best of his/her knowledge.

**Instructions:**

- Complete the progress report and return it to the Placement/SCI Unit.
- The Progress Report is due no later than the 10<sup>th</sup> of the last month for which SCI is currently approved.
- Reports should be legible and in ink, or they may be typed. We suggest you keep a copy of the report and supporting documentation for your records.
- In order to qualify for the SCI this report **must** be received by the Placement/SCI unit. Completed reports will be date stamped upon receipt.
- The agency will send a courtesy reminder regarding reports; however, it is the caregiver’s responsibility to submit the reports and timely regardless of reminders.
- Copies of receipts, attendance logs, records of extra-curricular activities or any other form of documentation regarding information provided within the report **must** be attached for the report to be considered complete.
- Caregivers are encouraged to include pictures of the child/youth/NMD, or copies of awards or certificates during the month of review.
- Copies of progress reports should be made available to social workers during home visits

**What happens if the semi-annual progress report is not submitted timely?**

- If a progress report is not received by 10th of the last month for which SCI is currently approved, your rate will be reduced to the basic care rate. In order to qualify for the SCI this report **must** be received by the Placement/SCI unit.
- **If funding is reduced to the basic rate because you did not submit the progress report in a timely manner, reinstatement of your previous funding will be effective as of the date the required documentation is received by the Placement/SCI unit. Funding WILL NOT be retroactive.**

If you need any assistance in completing the progress report, please do not hesitate to contact the Placement/SCI unit directly at: (951) 358-7400.

<b>By signing this report I am stating the information is true and correct to the best of my knowledge. I certify that I am in compliance with all Community Care Licensing (CCL) or Relative Assessment Unit (RAU) requirements.</b>	
Caregiver Name- (please print):	Date:
Caregiver Signature: ►	
CPU/SCI Social Worker:	Date Received:

# Special Care Increment (SCI) - Progress Report

For the reporting period: \_\_\_\_\_

On behalf of: \_\_\_\_\_

Foster Child/Youth/NMD Name

Age

Monthly medical, mental health or supportive services must be participated in during the review period to remain eligible for an SCI payment. Please list/describe your participation in each area below and attach additional pages as needed. Be sure to make a note in each area listed.

**Reminder:** All CHDP exams must be up to date for SCI payments to continue.

<b>Medical</b>		<input type="checkbox"/> No Medical Appointments
CHDP verifications will be submitted directly to the agency for the following appointment dates:		
Dates	Doctor/Other Professional	Reason for Visit

<b>Emotional / Behavioral/ Mental Health</b>		<input type="checkbox"/> No Mental Health Appointments
Dates	Therapist or Other Professional	Reason for Visit

<b>Other Supportive Services or Appointments</b>		<input type="checkbox"/> No Supportive Services
Dates	Provider	Reason for Visit

**INSTRUCTIONS:** Copies of receipts, attendance logs, records of extra-curricular activities or any other form of documentation regarding information provided within the report must be attached for the report to be considered complete. Please make sure that you have accurately completed this report. This information will be used to validate continued eligibility for the SCI program. When completed, please return this document and all supporting documentation to:

**Riverside County Department of Public Social Services, ATTN: Placement/SCI Unit  
10281 Kidd St., 2<sup>nd</sup> Floor  
Riverside, CA. 92503**