

## Sacramento County Foster Care Rates Effective 7/1/2011

<b>Specialized Care Rates - High Risk Infants (ages 0 to 4)</b>			
Points	Care Level	Dollar Amount	
		Total	Increment (to add)
-----	Standard	\$621	0
1-3	Basic I	765	144
4-6	Basic II	910	289
7-9	Basic III	1053	432
10-12	Minimum I	1111	490
13-15	Minimum II	1169	548
16-18	Minimum III	1229	608
19-21	Moderate I	1316	695
22-24	Moderate II	1405	784
25-27	Moderate III	1494	873
28-30	Intensive I	1552	931
31-33	Intensive II	1613	992
34+	Intensive III	1672	1051

<b>Specialized Care Rates - Children in Foster Care (Ages 0-18)</b>											
Care Levels	Points	Age Ranges									
		0-4		5-8		9-11		12-14		15-18	
		Total	<i>add</i>	Total	<i>add</i>	Total	<i>add</i>	Total	<i>add</i>	Total	<i>add</i>
Standard	-----	\$621	\$0	\$673	\$0	\$708	\$0	\$741	\$0	\$776	\$0
Basic I	1-2	764	143	808	135	845	137	862	121	883	107
Basic II	3-4	906	285	945	272	980	272	984	243	990	214
Basic III	5-6	1048	427	1083	410	1118	410	1105	364	1097	321
Minimum I	7-8	1073	452	1106	433	1141	433	1128	387	1121	345
Minimum II	9-10	1096	475	1131	458	1165	457	1153	412	1147	371
Minimum III	11-12	1120	499	1156	483	1191	483	1176	435	1170	394
Moderate I	13-14	1191	570	1225	552	1260	552	1247	506	1242	466
Moderate II	15-16	1263	642	1298	625	1334	626	1319	578	1313	537
Moderate III	17-18	1334	713	1368	695	1404	696	1391	650	1384	608
Intensive I	19-20	1380	759	1416	743	1451	743	1438	697	1431	655
Intensive II	21-22	1428	807	1465	792	1500	792	1485	744	1478	702
Intensive III	23+	1476	855	1512	839	1546	838	1534	793	1527	751

Countywide Services Agency

Department of  
Health and Human Services

Child Protective Services

Adoptions/Foster Home  
Licensing/Family Child Care  
Home Licensing/Kinship/ICPC  
and Team Decision Making

Stephanie Lynch, Program Manager



## County of Sacramento

Steven C. Szalay,  
Interim County Executive

Bruce Wagstaff,  
Agency Administrator

Ann Edwards-Buckley,  
Department Director

Laura Coulthard,  
Deputy Director

Luis Villa,  
Division Manager

Specialized care is for services and behaviors that are above and beyond basic foster care. These exceptional needs present as current medical, developmental, emotional and/or behavioral issues and specific measures being taken by the caregiver. A child's diagnosis does not necessarily warrant a Special Needs Rate.

### **Special Care Increment (SCI) – Rate Criteria**

Sacramento County Foster Care Rates (SCFCR) sheet effective January 1, 2008 has two Specialized Care Rate boxes, one for High Risk Infants age 0-4, and one for Children in Foster Care ages 0-18. Special Needs are determined by age category (0-4, 5-8, 9-11, 12-14 and 15-18); Care Level (Standard, Minimum, Moderate, and Intensive).

If the child is 0-4, use the High Risk Child Rate Assessment Form (CS 838) packet to assess the child. The caregiver completes the packet and the social worker approves it. The packet is reviewed; points are assigned and totaled on the High Risk Point Scale. Using the Total Points, refer to the (SCFCR) sheet, Specialized Care Rates—High Risk Infants to determine the corresponding Care Level.

A child is eligible for the High Risk Infants rates at the top of the (SCFCR) sheet when the child is age 0-4 and currently presents with medical, emotional or behavioral problems and meets one of these criteria: born with a positive toxicology screen, clinically diagnoses with symptoms associated with prenatal drug exposure or consistent with fetal alcohol syndrome, suffers from a communicable disease that may be life threatening and places the child and those around the child at risk, parent suffers from or may have suffered from a communicable disease that may be life threatening, born to a mother or father who has a history of intravenous drug usage, or medically fragile.

If the child is 0-4 and does not meet the High Risk Infant criteria above, determine the Care Level, and use the Care Level to find the corresponding rate for Children in Foster Care ages 0-18 at the bottom of the (SCFCR) sheet. The Total Special Needs Rate (SCI) is the Foster Care Basic Rate plus the supplemental payment.

For foster care children ages 5-18, the caregiver completes the Special Needs Assessment Form (CS 861) packet and the Medical Problem packet (SC 861 B) (if applicable). The social worker approves the packet; the packet is reviewed, points are assigned and totaled then documented on the Point Scale for Children Ages 5-18. Using Total Points and age of the child find the corresponding row and column at the bottom of the (SCFCR) sheet. The Total Special Needs Rate (SCI) is the Foster Care Basic Rate plus the supplemental payment.

Out of county (OTC), supplemental rates are determined using the specific county's criteria and methodology. The foster care Basic Rate plus the supplemental payment is the SCI.

**DHHS – CPS**

**Probation**

**INSTRUCTIONS: Please check appropriate box for different departments**

## Specialized Foster Care Rate Request

To: \_\_\_\_\_ (Supervisor)      Date: \_\_\_\_\_

From: \_\_\_\_\_      Minor's Name (Print): \_\_\_\_\_

HHS Worker Code & Phone No. \_\_\_\_\_/\_\_\_\_\_      Minor's SSN #: \_\_\_\_\_

DHA EW Code & Phone No. \_\_\_\_\_/\_\_\_\_\_      Birth Date: \_\_\_\_\_ Sex: M  F

Payee Name (Print): \_\_\_\_\_      HHS Case Number: \_\_\_\_\_

Payee SSN/Tax ID #: \_\_\_\_\_      DHA Eligibility Case No. \_\_\_\_\_

Payee Address: \_\_\_\_\_      Foster Child:      Yes  No

\_\_\_\_\_      Sacramento County Home:      Yes  No

Payee Phone No. \_\_\_\_\_      Other County Home (Specify): \_\_\_\_\_

Special Clothing Allowance  Rate Exception  Respite (HHS, 62-210Z)  Other (Specify) \_\_\_\_\_

Brief summary of facts and description of minor's problem. Attach original invoices and any pertinent medical or psychiatric reports and assessments tools, per CSS #49 and #58.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Payment exception dates: FROM \_\_\_\_\_ TO \_\_\_\_\_      POINT TOTAL: \_\_\_\_\_

Calif. Basic Rate: \$ \_\_\_\_\_      County Only Amount \$ \_\_\_\_\_

Single Payment  or Monthly Payments  for \_\_\_\_\_ months      Specialized Care Amount \$ \_\_\_\_\_

Funding Source: FC  CWS  County  SCIAP (HHS, 62-210Z)       Other (Specify): \_\_\_\_\_

Cost Center Code \_\_\_\_\_

GL Account Code \_\_\_\_\_

**DHA Financial Management Approval**      **Date**      Order Number \_\_\_\_\_

**Supervisor Recommendation**

Yes  No  Comments \_\_\_\_\_

\_\_\_\_\_

**Supervisor Signature**      **Date**

**Program Manager Recommendation**

Yes  No  Comments \_\_\_\_\_

\_\_\_\_\_

**Program Manager Signature**      **Date**

### ADDITIONAL APPROVAL FOR EXPENDING COUNTY ONLY MONEY

Yes  No  Comments \_\_\_\_\_

\_\_\_\_\_

**Division Chief Signature**      **Date**

Yes  No  Comments \_\_\_\_\_

\_\_\_\_\_

**Deputy Director Signature**      **Date**



# COUNTY OF SACRAMENTO

## CHILD PROTECTIVE SERVICES DIVISION

P.O. BOX 269057  
3701 BRANCH CENTER ROAD  
SACRAMENTO, CALIFORNIA 95826-9057  
916-875-6330 / FAX 875-6358

JM HUNT, DIRECTOR

LELAND TOM, DIVISION MANAGER

### High Risk Child Rate Assessment Form

This form will be used to determine if this child has special needs that require a special foster care rate.

Please complete it to the best of your ability. If you have questions or problems with this form, please call:

(916) 875-6313 or (916) 875-6378

	<p>Please line out any information that is incorrect in the label at the left and enter correct information below.</p>
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\*\*\* Date of placement with current caretaker: \_\_\_\_\_

- This is an initial application for an assessment to determine eligibility for a Special Needs Rate Increment.
- This is a re-evaluation based on significant change in child's condition and service being provided.
- This is a scheduled renewal of special needs.

This High-Risk Infant rate is available to children from birth through age four who meet one or more of the criteria listed below and who currently present medical, emotional, or behavioral problems.

- \* Born with a positive toxicology screen.
- \* Clinically diagnosed with symptoms associated with prenatal drug exposure.
- \* Clinically diagnosed as having symptoms consistent with fetal alcohol syndrome.
- \* Child may suffer from a communicable disease that may be life threatening and may place the child and those around the child at risk.
- \* Parent suffers from or may have suffered a communicable disease that may be life threatening.
- \* Born to a mother and/or father who has a history of intravenous (I.V.) drug usage.
- \* Medically fragile.

The rates paid under the High-Risk Infant program are determined by the needs of the child, and services provided by the caretaker. A child's special needs may be based on a combination of emotional, medical and behavior problems. The purpose of the Special Needs Increment is to provide the caretaker with resources to meet the demands of a child with exceptional needs, above and beyond what is normal for foster children. The actions employed by the foster parent(s) to guide the child, and the services that are different or higher intensity than those provided for foster children in general, are major factors in the determination.

Caretakers should be continuously monitoring foster children as normal procedure. Foster parents are expected to deal with some behaviors based on a child's age and the fact that the child is a foster child.

Try to look at the child as a whole. Including age, behaviors, and all the other factors. Rates are not based on individual items. But rather on the total picture. This includes all services being provided.

All efforts and services should be designed for the betterment, growth and normalization of the child.

If this is a renewal or re-evaluation of special needs:

Explain how the child's condition or behavior has changed. Degree of change must be significant and result in a notable increase in services being provided.

Four horizontal lines for text entry.

Child's Weight (for children who are under 2 years old or who have eating/feeding problems):

Child's current weight \_\_\_\_\_

Child's birth weight or child's weight at last assessment (if previously assessed) \_\_\_\_\_

Child's weight change (current weight minus birth weight/last assessment weight) \_\_\_\_\_

Part I - Medical Data

A. Medical/physical conditions that place this child at a higher risk of health problems:

List all the medical or physical problems of this child. And whether this is based on caretaker observations and or medical documentation. (Attach all documentation referred to).

1. Caretaker(s) observation: \_\_\_\_\_

Three horizontal lines for text entry.

2. Medical documentation: \_\_\_\_\_

Three horizontal lines for text entry.

Check all that apply:

- |                          |                                 |                          |                        |
|--------------------------|---------------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | Apnea Monitor*                  | <input type="checkbox"/> | Oxygen                 |
| <input type="checkbox"/> | Central Line (Broviac Catheter) | <input type="checkbox"/> | Positioning Equipment  |
| <input type="checkbox"/> | Colostomy                       | <input type="checkbox"/> | Splints, Casts, Braces |
| <input type="checkbox"/> | Feeding Pump                    | <input type="checkbox"/> | Suctioning Equipment   |
| <input type="checkbox"/> | Gastrostomy Tube (G tube)       | <input type="checkbox"/> | Tracheostomy**         |
| <input type="checkbox"/> | Ileostomy                       | <input type="checkbox"/> | Ventilator             |
| <input type="checkbox"/> | Jejunostomy                     | <input type="checkbox"/> | Nasogastric Tube       |
| <input type="checkbox"/> | Other, explain:                 |                          |                        |

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\* If the child is on an apnea monitor, explain the frequency and severity of alarm:

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\*\* If the child has a tracheostomy, explain the frequency that suctioning is required:

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C. Diet

- Regular diet for children of similar ages
- Special diet prescribed for this child; list the diet, and when it will be reviewed again by medical personnel, (Attach copy of Doctor's instructions and Doctor's description of prescribed diet).

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D. Medications

- No special medications.
- Medications prescribed; ① list medications; ② describe how given if not orally and date of next review. Include oxygen and amounts in the table below.

Drug	Strength	Dosage	Purpose	Prescribing Doctor
Ritafin	20 mg	1 a day	Hyperactivity	Dr Smith

E. Medical follow-up required for the conditions listed in Part I-A Medical/Physical Conditions above:

☺

None

- |    |                                     |                                 |
|----|-------------------------------------|---------------------------------|
| 1. | Name of regular doctor/pediatrician | Anticipated frequency of visits |
|    | _____                               | _____                           |
| 2. | Name of specialist/clinics          | Anticipated frequency of visits |
|    | _____                               | _____                           |
|    | _____                               | _____                           |
| 3. | Name of Lab or Specialized Tests    | Frequency/ Dates                |
|    | _____                               | _____                           |
|    | _____                               | _____                           |

F. Other required therapies or interventions

NICU Developmental Follow-up Clinic      Appointment Frequency: \_\_\_\_\_

1. Therapy or intervention provided by specialists  
 Check all that apply, the location where the therapy is provided and how often

Therapy	Provided by Caretaker	Provided by Specialist	At Home	Out of Home	How Often?
<input type="checkbox"/> Occupation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Vision (for visually impaired)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Hearing (for hearing impaired)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Infant Stimulation/Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

For therapies provided by the foster parent, explain what is done for the child:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

County Use Only

G. Does the child have seizures or a history of seizures?

- No
- Yes: Complete 1 and 2 below.

1. Frequency of Seizures (check one)

- ☺  0 - History of seizures; last seizure \_\_\_\_\_
- ☺  1 - No more than 1 per month
- ☺  2 - At least 1 per week
- ☹  3 - At least 1 per day

2. Severity of Seizures (check one)

- ☺  1 - Seizures do not include loss of consciousness
- ☺  2 - Seizures include, loss of consciousness but seizure does not last more than 10 minutes; no apnea
- ☹  3 - Loss of consciousness with apnea; last more than 10 minutes; or medical treatment needed to stop seizure

If 1, 2, or 3 is checked, explain measures being taken to prevent/modify the medical condition. Attach letter from Doctor verifying seizure condition.

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H. Does the child have a higher risk of catching or transmitting infectious diseases?

- No
- Yes; Complete 1, 2, and 3 below.

1. Child's Risk of Transmitting an Infectious Disease (check one)

- ☺  0 - Has no infectious disease
- ☺  0 - Has or may have an infectious disease but the foster parent can control its spread by:
  - ☺  1 - Taking usual hygiene measures
  - ☺  2 - Taking more than usual hygiene measures
  - ☹  3 - Must use special handling of all the child's fluids and secretions to control spread

If 1, 2, or 3 is checked explain measures being taken to prevent/modify the medical condition. Attach supporting documentation from a doctor that states a condition exists that requires special handling.

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County Use Only

2. Child's Risk of Contracting an Infectious Disease (check one)
- ☺  0 - At no increased risk of contracting an infectious disease
  - ☹  0 - At an increased risk of contracting an infectious disease:
  - ☺  1 - Can go out to medical appointments, therapy, etc.
  - ☹  2 - Should remain at home as much as possible
  - ☹  3 - At GREAT RISK of contracting an infectious disease and foster parent(s) must use special handling of contacts, toys, foods, etc.

If 1, 2, or 3 is checked, explain measures being taken to prevent/modify the medical condition. Attach supporting documentation from a doctor that states a condition exists that requires special handling.

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Part II - Physical Care

A. Does the child have feeding/eating problems?

- No
- Yes: Complete 1, 2, 3, and 4 below:

1. Child's Suck/Swallow Coordination (check one)
- ☺  0 - Has no problem with sucking and swallowing
  - ☺  1 - Has more problems with choking than other children same age but the foster parent can handle the problem with occasional special feeding techniques
  - ☹  2 - Chokes and gags easily and the foster parent must use special feeding techniques to handle the problem
  - ☹  3 - Chokes and gags easily and the foster parent must use a nasogastric tube, gastrostomy tube, or pump to feed

If special feeding techniques are needed, describe medical condition causing feeding/eating problems, and what must be done to prevent/modify the feeding/eating problems.

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County Use Only

2. Length of Time it Takes to Feed the Child (check one)

- ☺  0 - Takes about the same amount of time as for other children the same age
- ☺  1 - Takes somewhat longer than for other children the same age
- ☹  2 - Takes substantially longer than for other children the same age
- ☹  3 - Requires individualized feeding that takes more than 45 minutes

If 1, 2, or 3 is checked, explain why it takes so long to feed the child and what the foster parent is doing to reduce the time of feeding:

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3. How Often the Child must be feed (check one)

- ☺  0 - Every 4 hours or more but no night feedings
- ☺  1 - Every 4 hours with night feedings
- ☹  2 - Every 3 hours with night feedings
- ☹  3 - Every 2 hours with night feedings

If 1, 2, or 3 is checked, explain why the child must be fed so often and what makes the pattern of frequency outside the range of "normal":

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4. Vomiting/Reflux Problems (related to medical conditions listed in Part I. A. above) (check one)

- ☺  0 - No problems
- ☺  1 - Occasional problems
- ☹  2 Vomits at least 2 times daily; or requires medication for vomiting
- ☹  3 Same as 2 above and vomiting affecting adequate weight gain

Explain what caretaker must do to prevent/modify behavior:

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County Use Only

B. Does the Child have Problems with Elimination?

- No
- Yes; Complete 1 and 2 below.

1. Bladder Control/Problems (check one)

- 0 - No problems
- 1 - Prone to urinary tract infection; requires increased fluids
- 2 - Crede needed to empty bladder
- 3 - Has vesicotomy/urethrostomy/ileal conduit

2. Bowel Control/Problems (check one)

- 0 - No problems
- 1 - Chronic constipation needing an occasional suppository
- 2 - Chronic diarrhea or runny stools; or needs daily bowel program to maintain elimination
- 3 - Colostomy/ileostomy

Explain what foster parent must do to prevent/modify condition. Describe measures being taken to resolve and identify reason for problems with elimination:

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C. Does the Child have Problems Sleeping at Night (11:00 P.M. to 6:00 A.M.) compared with other children the same age? (check one)

- 0 - No problems
- 1 - Up one time at night
- 2 - Up 2 times during the night
- 3 - Up 3 or more times at night

If 1, 2, or 3 are checked, explain why the child is waking up, what the child is doing when awake and what the foster parent must do to get the child back to sleep. Indicate how many days a week this occurs:

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County Use Only

D. Does the Child have Problems with Muscle Tone?

- No
- Yes; if yes, complete 1, 2, and 3 below

1. Child has (check one):

- ☺ Hypotonia (floppy, low tone)
- ☹ Hypertonia (tight, stiff, high tone)
- ☹☺ Combination of hypotonia/hypertonia

2. Location of motor dysfunction:

- ☺ No problem
- ☹ Monoplegia
- ☹ Hemiplegia
- ☹ Diplegia
- ☹ Triplegia
- ☹ Paraplegia
- ☹ Quadriplegia

3. Impact of muscle tone on physical care and/or development

- ☺ 0 - No impact on care or development
- ☹ 1 - Appears to be some impact on physical care and/or there will be developmental delay; development should be monitored
- ☹ 2 - There is impact on physical care and/or development; child requires special handling; foster parent must follow through with therapy recommendations at home
- ☹ 3 - Same as 2 above and child requires special equipment for feeding, positioning, transporting, and bathing

Explain what foster parent must do to treat problem and improve muscle tone.  
Describe impact on care provider:

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County Use Only

Part III - Behaviors (Compared to other children the same age)

1. Irritability (including poor self-calming, prolonged periods of crying seemingly without a reason, etc.) (check one)
- ☺  0 - No problems
  - ☺  1 - Occurs but readily controlled with specialized handling, intervention or supervision by the foster parent
  - ☹  2 - Occurs and is difficult to control but will respond to sustained specialized intervention, handling, or supervision by the foster parent
  - ☹  3 - Occurs frequently and requires almost continuous specialized intervention, handling, or supervision by the foster parent

If 1, 2, or 3 is checked, explain behavior, frequency, and what caretakers must do to prevent/modify behavior and improve child's self-calming abilities:

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2. Hypereflexia (extreme jumpiness, startles very easily, arches the body in response to noises or handling; etc.) (check one)
- ☺  0 - Not a problem
  - ☺  1 - Occurs but readily controlled with specialized handling, intervention or supervision by the foster parent
  - ☹  2 - Occurs and is difficult to control but will respond to sustained specialized intervention, handling, or supervision by the foster parent
  - ☹  3 - Occurs frequently and requires almost continuous specialized intervention, handling, or supervision by the foster parent

If 1, 2, or 3 is checked, explain behavior, frequency, and what foster parent must do to control it:

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County Use Only

3. Jitteriness, tremors, or jerky movements (check one)
- ☺  0 - No problems
  - ☺  1 - Occurs but readily controlled with specialized handling, intervention or supervision by the foster parent
  - ☹  2 - Occurs and is difficult to control but will respond to sustained specialized intervention, handling, or supervision by the foster parent
  - ☹  3 - Occurs frequently and requires almost continuous specialized intervention, handling, or supervision by the foster parent

If 1, 2, or 3 is checked, explain behavior, frequency, and what foster parent must do to prevent/modify behaviors:

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4. Poor social interaction with care giver (does not make eye contact, does not nestle or cuddle, does not respond well to holding, nestling, or cuddling, etc.) (check one)
- ☺  0 - Not a problem
  - ☺  1 - Occurs but readily controlled with specialized handling, intervention or supervision by the foster parent
  - ☹  2 - Occurs and is difficult to control but will respond to sustained specialized intervention, handling, or supervision by the foster parent
  - ☹  3 - Occurs frequently and requires almost continuous specialized intervention, handling, or supervision by the foster parent

If 1, 2, or 3 is checked, explain behavior, frequency, and what foster parent must do to improve interaction:

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**\*\*Complete remainder of form if child is 18 months or older\*\***

**County Use Only**

**Part IV - Behaviors (Compare the child to other children the same age)**

1. Short attention span (can't keep attention on one object, or person, or activity, etc.) (check one)
- ☺  0 - No problems
  - ☺  1 - Occurs but readily controlled with specialized handling, intervention or supervision by the foster parent
  - ☹  2 - Occurs and is difficult to control but will respond to sustained specialized intervention, handling, or supervision by the foster parent
  - ☹  3 - Occurs frequently and requires almost continuous specialized intervention, handling, or supervision by the foster parent

If 1, 2, or 3 is checked, explain behavior, frequency, and what foster parent must do to prevent/modify behaviors and improve/increase attention span:

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2. Hyperactivity (easily excitable, restless, in constant motion, etc.) (check one)
- ☺  0 - Not a problem
  - ☺  1 - Occurs but readily controlled with specialized handling, intervention or supervision by the foster parent
  - ☹  2 - Occurs and is difficult to control but will respond to sustained specialized intervention, handling, or supervision by the foster parent
  - ☹  3 - Occurs frequently and requires almost continuous specialized intervention, handling, or supervision by the foster parent

If 1, 2, or 3 is checked, explain behavior, frequency, and what foster parent must do to prevent/modify behavior:

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County Use Only

3. Inability to accept a change in routine (has temper tantrums, is restive, must always know what will happen next, etc.)(check one)

- ☺  0 - No problems
- ☺  1 - Occurs but readily controlled with specialized handling, intervention or supervision by the foster parent
- ☹  2 - Occurs and is difficult to control but will respond to sustained specialized intervention, handling, or supervision by the foster parent
- ⊗  3 - Occurs frequently and requires almost continuous specialized intervention, handling, or supervision by the foster parent

If 1, 2, or 3 is checked, explain behavior, frequency, and what foster parent must do to prevent/modify behavior and improve child's ability to accept change:

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4. Aggression toward others or property (violent episodes, attempts to hurt others or destroy property, etc.) (check one)

- ☺  0 - Not a problem
- ☺  1 - Occurs but readily controlled with specialized handling, intervention or supervision by the foster parent
- ☹  2 - Occurs and is difficult to control but will respond to sustained specialized intervention, handling, or supervision by the foster parent
- ⊗  3 - Occurs frequently and requires almost continuous specialized intervention, handling, or supervision by the foster parent

If 1, 2, or 3 is checked, explain behavior, frequency, and what foster parent must do to prevent/modify behavior:

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County Use Only

5. Self-destructiveness (tries to hurt self deliberately, does dangerous things without understanding they are dangerous)
- ☺  0 - No problems
  - ☺  1 - Occurs but readily controlled with specialized handling, intervention or supervision by the foster parent
  - ☹  2 - Occurs and is difficult to control but will respond to sustained specialized intervention, handling, or supervision by the foster parent
  - ☹  3 - Occurs frequently and requires almost continuous specialized intervention, handling, or supervision by the foster parent

If 1, 2, or 3 is checked, explain behavior, frequency, and what foster parent must do to prevent/modify behavior:

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**\*\* Complete remainder of form if child is 3-5 years old \*\***

**Part V - Self-Help (for children 3 to 5 years of age compared to other children the same age)**

1. Toilet Training (check one)
- ☺  0 - Toilet trained
  - ☺  1 - Can use the toilet when taken; has some control
  - ☹  2 - Can sometimes go when taken
  - ☹  3 - Has no control

If 1, 2, or 3 is checked, explain efforts to toilet train:

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2. Eating (check one)
- ☺  0 - Feeds self independently
  - ☺  1 - Feeds self with spillage
  - ☹  2 - Does not use utensils; feed self with fingers
  - ☹  3 - Does not feed self; needs to be fed

If 1, 2, or 3 is checked, explain efforts to train:

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County Use Only

3. Dressing (check one)

- ☺  0 - Dresses self, may need some assistance with difficult clothing
- ☹  1 - Cannot dress self, but usually cooperates with dressing
- ☹  2 - Requires total dressing and often resists

If 1 or 2 is checked, explain efforts to train:

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4. Personal Hygiene (check one)

- ☺  0 - Tends to own hygiene independently or with some supervision
- ☹  1 - Requires more assistance than most children
- ☹  2 - Requires foster parent to tend to personal hygiene all the time

If 1 or 2 is checked, explain efforts to train:

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**Part VI - Communication (for children 3 to 5 years of age compared to other children the same age)**

1. Ability to Communicate with Others (check one)

- ☺  0 - Talks and is able to verbally communicate needs
- ☹  1 - Use single word sentences only
- ☹  2 - Uses gestures to communicate with others
- ☹  3 - Does not speak or use gestures

If 1, 2, or 3 is checked, explain efforts to get the child to communicate. Describe conditions (medical, emotional) that may be causing difficulty in communication:

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County Use Only

2. Ability to Understand Others (check one)

- ☺  0 - Understands everything or almost everything others say
- ☺  1 - Understands simple conversation or instructions
- ☹  2 - Understands simple words
- ☹  3 - Does not speak or use gestures

If 1, 2, or 3 is checked, explain efforts to get the child to communicate:

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**Part VII - Social and Emotional Interaction (for children 3 to 5 years of age compared to other children the same age) (check one)**

- ☺  0 - Enjoys social play, games and interacting with others but may require some supervision
- ☹  1 - Plays with others but requires more than usual supervision
- ☹  2 - Does not interact at all or does not interact well with others; requires constant supervision and encouragement to play with others

If 1, 2, or 3 is checked, explain efforts to get the child to play/interact with others:

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**Part VIII - Psychiatric/Psychological Care (for children 3 to 5 years only)**

Does this child attend therapy? (Check one)

- ☺  No
- ☹  No, but this child should be in therapy. Explain what is being done to start child in therapy and who has been contacted:

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Has the above been discussed with Placement Worker?

- No  Yes

☺  Yes; child is currently attending therapy. Complete A through D below. (Attach documentation if available)

A. Type of Therapy: Art Therapy  Play Therapy  Sand Tray Therapy

B. Formal Diagnosis:

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<p>C. Name and Address of Therapist</p>    <p>Phone Number: _____</p>	<p>Frequency of Appoints:</p> <p><input type="checkbox"/> More often than weekly</p> <p><input type="checkbox"/> Weekly</p> <p><input type="checkbox"/> Every other week</p> <p><input type="checkbox"/> Monthly</p> <p><input type="checkbox"/> Other, Explain: _____</p> <p><input type="checkbox"/> Any therapy cost paid by caretaker? _____ Amount? _____</p>
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Who provides transportation to therapy? \_\_\_\_\_

D. Prescribed Medication:

Name of Drug	Strength	Dosage	Purpose	Prescribing Physician
Example: Ritalin	5 mg	2 tablet a.m.	Hyperactivity	Dr. Jones M.D.



**Sacramento County  
Special Needs Rate Assessment Form - Medical Problems**

This form will be used to determine if the child has special needs which require a special foster care rate. Please complete the form as accurately as you can. If you have questions or problems about this form, please call:

**(916) 875-5951 or  
(916) 876-7566**

Please line out any information that is incorrect in the label at the left and enter correct information below:

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- This is an initial application for an assessment for a special rate
- This is a review of a special rate already in effect; briefly explain how the child's behavior has changed in the past six months:

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**Part I - Medical Data**

This child is (Check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Developmentally Delayed | <input type="checkbox"/> Bed-Ridden                |
| <input type="checkbox"/> Physically Disabled     | <input type="checkbox"/> Neurological Disabilities |
| <input type="checkbox"/> Non-ambulatory          | <input type="checkbox"/> Epilepsy                  |
| <input type="checkbox"/> Other (describe below): |  |

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- I. Medical Diagnosis or medical/physical conditions that place this child at a higher risk of health problems:  
List all the medical or physical problems of this child:

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IV. Medical follow-up required for the conditions listed in Part I-A Medical/Physical Conditions above:

None

A. Name of regular doctor \_\_\_\_\_ Anticipated frequency of visits \_\_\_\_\_

B. Name of specialists/clinics \_\_\_\_\_ Anticipated frequency of visits \_\_\_\_\_  
 \_\_\_\_\_

C. Name of Lab or Specialized Tests \_\_\_\_\_ Frequency/date \_\_\_\_\_  
 \_\_\_\_\_

V. Other required therapies or interventions

A. Therapy or intervention provided by specialists or caretaker  
 Check all that apply, the location where the therapy is provided and how often

Therapy	Provided By:		At:		How Often?
	Foster Pt.	Therapist	Home	Ctr	
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Speech Therapy <input type="checkbox"/>	_____				
<input type="checkbox"/> Vision (for visually impaired)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Hearing (for hearing impaired)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

For therapies provided by the foster parent, explain what is done for the child:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

County Use Only

Part II - Medical Problems

A. Does the child have seizures or a history of seizures?

- No
- Yes; if yes complete 1 and 2 below:

1. Frequency of Seizures (check one)

- 0 - History of seizures; last seizure \_\_\_\_\_
- 1 - No more than 1 per month
- 2 - At least 1 per week
- 3 - At least 1 per day

2. Severity of Seizures (check one)

- 1 - Seizure does not include loss of consciousness
- 2 - Seizures includes loss of consciousness but seizure does not last more than 10 minutes; no apnea
- 3 - Loss of consciousness with apnea; lasts more than 10 minutes; or medical treatment needed to stop seizure

B. Enuresis (Bedwetting or wetting oneself which is the result of a physical problem described on page 1) (check one)

- 0 - Not a problem
- 1 - Minor problem, explain below
- 2 - Major problem; list # of times in last full calendar month

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C. Encopresis (Soiling oneself which is the result of a physical problem described on page 1) (check one)

- 0 - Not a problem
- 1 - Minor problem, explain below
- 2 - Major problem; list # of times in last full calendar month

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County Use Only

D. Feeding/Eating Problems:

- 0 - Not a problem
- 1 - Requires a special diet; list in the space below, the diet, and when it will be reviewed again by medical personnel;
- 2 - Tube or gavage feeding

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E. Hygiene

- 0 - Not a problem
- 1 - Needs help with bathing and personal hygiene, explain below
- 2 - Must be bathed, explain below

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F. Dressing/Devices

- 0 - Not a problem
- 1 - Needs help with dressing, explain below
- 2 - Needs help with braces, prosthetic devices), explain below

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G. Level of Care Required

- 0 - Care required does not interfere significantly with Foster Parent's other duties
- 1 - Care required limits the Foster Parent's ability to accept additional children, explain below
- 2 - Care required is exceptional, explain below
- 3 - Care required requires a trained nurse, explain below

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If this is a renewal or re-evaluation of special needs:

Explain how the child's condition or behavior has changed. Degree of change must be significant and result in a notable increase in services being provided.

**Part I – Psychiatric/Psychological Care**

Does this child attend therapy? (Check one)

- ☹ No
- ☹ No, but this child should be in therapy. Explain what is being done to start child in therapy and who has been contacted:

Has the above been discussed with Placement Worker?

- No  Yes
- ☹ Yes; child is currently attending therapy. Complete A and B below. (Attach documentation if available)

**A. Formal Diagnosis**

<p><b>B. Name and Address of Therapist</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Phone Number: ( ) - _____</p>	<p><b>Frequency of Appoints:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> More often than weekly</li> <li><input type="checkbox"/> Weekly</li> <li><input type="checkbox"/> Every other week</li> <li><input type="checkbox"/> Monthly</li> <li><input type="checkbox"/> Other; Explain: _____</li> <li><input type="checkbox"/> Any therapy cost paid by caretaker? _____ Amount? _____</li> </ul>
--	--

Who provides transportation to therapy? \_\_\_\_\_

**C. Prescribed Medication:**

Name of Drug	Strength	Dosage	Purpose	Prescribing Physician
<i>Example: Ritalin</i>	<i>5 mg</i>	<i>2 tablets a.m.</i>	<i>For Hyperactivity</i>	<i>Dr. Jones</i>

Part II - Behaviors Exhibited

County Use Only

A. Excessive Dependency (Needs constant reassurance, is always under foot, etc.) (Check one)

☺  0 - Not a problem

☹  1 - Minor problem

☹  2 - Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month - Day - Year)

B. Inability to relate to others. (Doesn't know how to get attention appropriately, has other problems getting along with other children or adults, etc.) (Check one)

☺  0 - Not a problem

☹  1 - Minor problem

☹  2 - Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month - Day - Year)

**County Use Only**

**C. Passivity, lack of responsiveness, withdrawn (Check one)**

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**D. School Problems (Check one)**

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**E. Difficulty with peers (fighting, etc.). (Check one)**

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

Part II - Behaviors Exhibited

County Use Only

M. Does child have problems with Elimination?

1. Enuresis (Bedwetting or wetting oneself) (Check one)

- ☺ 0 - Not a problem
- ☹ 1 - Minor problem
- ☹☹ 2 - Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior medical condition.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month - Day - Year)

2. Encopresis (Bowel Movements on self) (Check one)

- ☺ 0 - Not a problem
- ☹ 1 - Minor problem
- ☹☹ 2 - Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month - Day - Year)

\* Describe measures being taken to resolve and identify reason for problems with elimination (Enuresis and/or Encopresis).

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**County Use Only**

N. Very difficult or unusual behavior (Check one)

☺  0 – Not a problem

☹  1 – Minor problem

☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior medical condition.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**P. Other:** Describe any issues not already documented in this form. Give examples. Include the number of times behaviors are exhibited per month. Note what caretaker must do to prevent/modify behavior. List any other exceptional care or services or services provided for this child.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Foster Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If this is a renewal or re-evaluation of special needs:

Explain how the child’s condition or behavior has changed. Degree of change must be significant and result in a notable increase in services being provided.

**Part I – Psychiatric/Psychological Care**

Does this child attend therapy? (Check one)

- ☺ No
- ☹ No, but this child should be in therapy. Explain what is being done to start child in therapy and who has been contacted:

Has the above been discussed with Placement Worker?

- No
- Yes

- ☺ Yes; child is currently attending therapy. Complete A and B below. (Attach documentation if available)

**A. Formal Diagnosis**

<p><b>B. Name and Address of Therapist</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Phone Number: ( ) - _____</p>	<p><b>Frequency of Appoints:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> More often than weekly</li> <li><input type="checkbox"/> Weekly</li> <li><input type="checkbox"/> Every other week</li> <li><input type="checkbox"/> Monthly</li> <li><input type="checkbox"/> Other; Explain: _____</li> <li><input type="checkbox"/> Any therapy cost paid by caretaker? _____ Amount? _____</li> </ul>
--	--

Who provides transportation to therapy? \_\_\_\_\_

**C. Prescribed Medication:**

Name of Drug	Strength	Dosage	Purpose	Prescribing Physician
<i>Example: Ritalin</i>	<i>5 mg.</i>	<i>2 tablets a.m.</i>	<i>For Hyperactivity</i>	<i>Dr. Jones</i>

**Part II – Behaviors Exhibited**

**County Use Only**

**A.** Excessive Dependency (Needs constant reassurance, is always under foot, etc.) (Check one)

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**B.** Inability to relate to others. (Doesn't know how to get attention appropriately, has other problems getting along with other children or adults, etc.) (Check one)

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**County Use Only**

**C. Passivity, lack of responsiveness, withdrawn (Check one)**

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**D. School Problems (Check one)**

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**E. Difficulty with peers (fighting, etc.). (Check one)**

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**County Use Only**

**F. Runs away (Check one)**

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**G. Steals (Check one)**

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**H. Illicit Drug Use (Check one)**

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**County Use Only**

**I. Destructive behavior (intentionally destroys property, etc.) (Check one)**

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**J. High Activity Level (Check one)**

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**2. Diagnosed Hyperactive by a doctor or therapist?**

- No  Yes

Please attach documentation.

**A. On Medication?**

- No  Yes; Medication: \_\_\_\_\_

Please attach documentation.

**County Use Only**

**K.** Sexual Activity (i.e., Excessive masturbation, sexual activities w/other children, objects or animals, etc.) (Check one)

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**L.** Self-destructive (Hurts or harms oneself, has an unusual number of harmful accidents, etc.) (Check one)

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

Date: \_\_\_\_\_  
(Month – Day – Year)

**Part II – Behaviors Exhibited**

**County Use Only**

**M.** Does child have problems with Elimination?

**1.** Enuresis (Bedwetting or wetting oneself) (Check one)

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior medical condition.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**2.** Encopresis (Bowel Movements on self) (Check one)

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

\* Describe measures being taken to resolve and identify reason for problems with elimination (Enuresis and/or Encopresis).

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**County Use Only**

N. Very difficult or unusual behavior (Check one)

- ☺  0 – Not a problem
- ☹  1 – Minor problem
- ☹  2 – Major problem requiring lots of effort

If 1, or 2 is checked, explain behavior, frequency, and what foster parent must do to prevent / modify behavior medical condition.

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Approximately when did this problem last occur?

Date: \_\_\_\_\_  
(Month – Day – Year)

**P. Other:** Describe any issues not already documented in this form. Give examples. Include the number of times behaviors are exhibited per month. Note what caretaker must do to prevent/modify behavior. List any other exceptional care or services or services provided for this child.

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Foster Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## SPECIAL NEEDS POINT SCALE HIGH RISK ASSESSMENT FORM

CHILD \_\_\_\_\_

AGE \_\_\_\_\_

DATE \_\_\_\_\_

**ITEM**

**POINTS**

**PART 1- Medical Data**

Supplemental

- |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| A. Medical/Physical conditions            | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| B. Medical equipment                      | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| C. Diet                                   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| D. Medications                            | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| E. Medical follow-up required             | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| F. Other required therapies/interventions | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Standard

- |  |   |   |   |   |   |   |   |
|--|---|---|---|---|---|---|---|
| G. Seizures                                |   |   |   |   |   |   |   |
| 1. Frequency                               | 1 | 2 | 3 |   |   |   |   |
| 2. Severity                                | 1 | 2 | 3 |   |   |   |   |
| H. Catching/Transmitting infection disease |   |   |   |   |   |   |   |
| 1. Transmitting                            | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. Contracting                             | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Part II - Physical Care**

- |                               |   |   |   |   |   |   |   |
|-------------------------------|---|---|---|---|---|---|---|
| A. Feeding/eating problems    |   |   |   |   |   |   |   |
| 1. Suck/swallow coordination  | 1 | 2 | 3 |   |   |   |   |
| 2. Length of time to feed     | 1 | 2 | 3 |   |   |   |   |
| 3. Frequency of feeding       | 1 | 2 | 3 |   |   |   |   |
| 4. Vomiting/reflux problems   | 1 | 2 | 3 |   |   |   |   |
| B. Problems with elimination  |   |   |   |   |   |   |   |
| 1. Bladder control/problems   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. Bowel control/problems     | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| C. Problems sleeping at night | 1 | 2 | 3 |   |   |   |   |
| D. Problems with muscle tone  |   |   |   |   |   |   |   |
| 1. Impact on care             | 1 | 2 | 3 |   |   |   |   |

**Part III - Behaviors**

- 1. Irritability 1 2 3
- 2. Hyperflexia 1 2 3
- 3. Jitteriness, tremors or jerky movements 1 2 3
- 4. Poor social interaction w/care giver 1 2 3

**Part IV - Behaviors (18 months or older)**

- 1. Short attention span 1 2 3
- 2. Hyperactivity 1 2 3
- 3. Inability to accept change 1 2 3
- 4. Aggression toward others or property 1 2 3 4 5 6 7
- 5. Self-destructiveness 1 2 3 4 5 6 7

**Part V - Self Help (child 3-5 years old)**

- 1. Toilet training 1 2 3
- 2. Eating 1 2 3
- 3. Dressing 1 2
- 4. Personal hygiene 1 2

**Part VI - Communication**

- 1. Ability to communicate w/others 1 2 3
- 2. Ability to understand others 1 2 3

**Part VII - Social and emotional interaction** 1 2 3

**Part VIII - Psychiatric/psychological care**

Counseling 1 2 3 4 5 6 7

**Part VIII**

Other 1 2 3 4 5 6 7

**Effective Date** **Total Points** \_\_\_\_\_

\_\_\_\_\_ **Basic Rate** \_\_\_\_\_

**Next Review Date** **SpN Rate** \_\_\_\_\_

\_\_\_\_\_ **TOTAL RATE** \_\_\_\_\_

**If Age Change (before next review)**

Effective Date: \_\_\_\_\_

Basic Rate: \_\_\_\_\_

Special Needs Rate: \_\_\_\_\_

Reviewed By: \_\_\_\_\_

## SPECIAL NEEDS POINT SCALE CHILDREN AGES 5 - 18

CHILD \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

### PART I - Psychiatric/Psychological Care

Counseling	1	2	3	4	5	6	7
Psychotropic Medication	1	2	3	4	5	6	7

### PART II - Behaviors Exhibited

A. Excessive dependency	1	2					
B. Inability to relate to others	1	2					
C. Passivity	1	2					
D. School problems	1	2					
E. Difficulty with peers	1	2					
F. Runs away	1	2	3	4	5		
G. Steals	1	2					
H. Illicit drug use	1	2	3	4	5		
I. Destructive behavior	1	2	3	4	5		
J. High activity level	1	2					
K. Sexual activity	1	2	3	4	5		
L. Self-destructive	1	2	3	4	5	6	7
M. Elimination							
1. Enuresis	1	2					
2. Encopresis	1	2					
N. Very difficult/unusual behavior	1	2	3	4	5	6	7
P. Other, Medical, Medication, Services, LE	1	2	3	4	5	6	7

**Effective Date**  
\_\_\_\_\_

**Next Review Date**  
\_\_\_\_\_

**Total Points** \_\_\_\_\_  
**Basic Rate** \_\_\_\_\_  
**SpN Rate** \_\_\_\_\_  
**TOTAL RATE** \_\_\_\_\_

**If Age Change (before next review)**

Effective Date: \_\_\_\_\_  
 Basic Rate: \_\_\_\_\_  
 Special Needs Rate: \_\_\_\_\_  
 Reviewed By: \_\_\_\_\_

