

## Difficulty of Care

Effective 1/1/08

### Point Value

Each type of problem on the checklist would be assigned to the level that most closely describes it. The scoring is based on a point system. There are three levels - each level has a point value and each point is worth \$6.00.

<u>Level</u>	<u>Point Value</u>	<u>Dollar Amount</u>
1	2	\$12
2	5	\$30
3	10	\$60

### Training Incentive Allowance

Each 20 hours of training completed and verified qualify the caregiver for one training level. Each training level is worth \$21. The maximum number of training levels eligible for the allowance is four; i.e., 80 hours of training.

### Excessive/Unusual Medical Transportation

Mileage for specialized medical care that cannot be readily obtained in the caregiver's home community may be reimbursed at the rate of 25¢ per mile.

### Maximum

The maximum Difficulty of Care level that can be paid is \$1014/month – this would be for a child whose point score is 155 or more and who is placed with a foster caregiver who has completed 80 hours of training.

FOSTER CAREGIVER'S TRAINING LEVEL	DIFFICULTY OF CARE MAXIMUM RATE
No qualifying training	\$930
20 hours of training completed	\$951
40 hours of training completed	\$972
60 hours of training completed	\$993
80 hours of training completed	\$1014

### Request for Difficulty of Care Rating - Child's Age Birth through 2 Years

<p><i>Check One (1) Box Below:</i></p> <p><input type="checkbox"/> New</p> <p><input type="checkbox"/> Restore</p> <p><input type="checkbox"/> Renewal - No Change</p> <p><input type="checkbox"/> Renewal - Improved</p> <p><input type="checkbox"/> Renewal - Deteriorated</p>	<p><input type="checkbox"/> Early Review - FP moved - diff. county</p> <p><input type="checkbox"/> Early Review - Change in Placement</p> <p><input type="checkbox"/> Early Review - Improved</p> <p><input type="checkbox"/> Early Review - Deteriorated</p> <p><input type="checkbox"/> Reconsideration</p> <p><input type="checkbox"/> Other _____</p>	<p>Foster Home Located in</p> <p><input type="checkbox"/> Contra Costa County</p> <p><input type="checkbox"/> Other (enter county below)</p> <p>_____</p>
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Child's Name	Foster Parent's Name	DOC Start Date	Drug Exposed Child <input type="checkbox"/> yes <input type="checkbox"/> No
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BEHAVIOR/PROBLEM	WHAT FOSTER PARENT WILL DO	HOW OFTEN
SEIZURES		
INFECTIOUS DISEASE		
FEEDING		
ELIMINATION		
SLEEP PATTERN		
MUSCLE TONE		
MEDICAL APPOINTMENTS, THERAPY, EMERGENCIES		
MEDICALLY FRAGILE		
RESPIRATORY PROBLEMS		

BEHAVIOR/PROBLEM	WHAT FOSTER PARENT WILL DO	HOW OFTEN
SPECIALIZED EQUIPMENT		
IRRITABILITY		
HYPERREFLEXIA		
TREMORS		
POOR SOCIAL INTERACTION		
SHORT ATTENTION SPAN		
HYPERACTIVITY		
LOW TOLERANCE FOR CHANGE		
AGGRESSION TOWARD OTHERS		
AGGRESSION TOWARD SELF		
OTHER		

\_\_\_\_\_  
Social Worker

\_\_\_\_\_  
Date

\_\_\_\_\_  
Foster Parent

\_\_\_\_\_  
Date

## Difficulty of Care Behavioral Checklist - Child's Age 3 through 5 Years

Child's Name	DOB	SW PCN
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### EMOTIONAL CARE NEEDS QUALIFYING FOR DOC

PROBLEM	LEVEL 1	LEVEL 2	LEVEL 3
ATTENTION SEEKING	<input type="checkbox"/> Demanding, clinging, constant crying, reversion to infantile behavior. FP must provide extra comfort and attention. <input type="checkbox"/> Tantrums more than 3 times/week and is not easily distracted from tantrum behavior <input type="checkbox"/>	<input type="checkbox"/> At least daily tantrums - very difficult to get child to cease behavior, refusal to follow basic rules. FP must provide constant limit setting <input type="checkbox"/>	N/A
ABNORMAL STRUCTURE/SUPERVISION	<input type="checkbox"/> Child cannot play alone or with peers for any period of time without adult supervision. Activities must be closely monitored with <input type="checkbox"/>	<input type="checkbox"/> Child extremely anxious when not involved in structured activity; upset when change in routine. FP must supervise regimented routine <input type="checkbox"/>	<input type="checkbox"/> FP can never leave child unattended; must give constant direction to child and supervise all activities <input type="checkbox"/>
SLEEP DISTURBANCE	<input type="checkbox"/> Nightmares 2-5 times/week; child needs comforting to get back to sleep <input type="checkbox"/>	<input type="checkbox"/> Nightmares/night terrors every night <input type="checkbox"/>	<input type="checkbox"/> Child terrified of sleeping - becomes very agitated at bedtime, acts out, etc. <input type="checkbox"/>
ENURESIS	<input type="checkbox"/> Nightly loss of control <input type="checkbox"/> Daytime loss of control	N/A	N/A
ENCOPRESIS	N/A	<input type="checkbox"/> At least weekly. Extra laundry and cleaning <input type="checkbox"/>	<input type="checkbox"/> Pattern of smearing feces <input type="checkbox"/>
AGGRESSIVE TO OTHERS	N/A	<input type="checkbox"/> Aggressive/assaultive. FP must protect other children <input type="checkbox"/>	<input type="checkbox"/> Same as level 2 <u>and</u> chronic, extreme destruction of property. Specify: _____ <input type="checkbox"/>
SEXUAL BEHAVIOR	<input type="checkbox"/> Inappropriate; needs guidance <input type="checkbox"/> Masturbates excessively <input type="checkbox"/>	<input type="checkbox"/> Child initiates talk of sex, sees daily activities in sexual terms; is inappropriate with adults. FP must monitor closely <input type="checkbox"/>	<input type="checkbox"/> Child has a history of initiating sexual activity with other children on more than 1 occasion; sexually aggressive and FP must supervise peer contact to protect other children <input type="checkbox"/>
SCHOOL PROBLEMS	<input type="checkbox"/> Child presents discipline problems, needs special education. FP has school contact at least weekly around behavioral issues <input type="checkbox"/>	<input type="checkbox"/> Child presents discipline problems, needs special education classes. FP has school contact at least 3 times weekly. Child may need to be restrained or sent for time out. <input type="checkbox"/>	N/A
EMOTIONALLY DISTURBED	<input type="checkbox"/> Excessively dependent; or passive with lack of response <input type="checkbox"/>	<input type="checkbox"/> Suicidal ideation; inappropriate behaviors, unresponsive and withdrawn. FP must monitor closely; work with therapist <input type="checkbox"/>	<input type="checkbox"/> Extreme, bizarre behaviors; suicidal; severe chronic depressions or danger to others. FP must monitor, control medications and be in constant contact with therapist <input type="checkbox"/> Diagnosed autism <input type="checkbox"/>
FP PARTICIPANT IN PSYCHOTHERAPY	<input type="checkbox"/> At least every other week	<input type="checkbox"/> At least weekly	<input type="checkbox"/> At least twice weekly

HYPERACTIVE	<input type="checkbox"/> Diagnosed Attention Deficit Disorder - highly active and demanding of attention from family members <input type="checkbox"/>	<input type="checkbox"/> Activity level can be controlled with medication. Cannot function without medication <input type="checkbox"/>	<input type="checkbox"/> Constant movement and restlessness. Cannot be controlled with medication. Child up at night, wanders through house. <input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Difficulty of Care Behavioral Checklist - Child's Age Birth through 2 Years

Child's Name	DOB	SW PCN
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PHYSICAL CARE NEEDS QUALIFYING FOR DOC

PROBLEM	LEVEL 1	LEVEL 2	LEVEL 3
SEIZURES	<input type="checkbox"/> History, but none currently or no more than monthly <input type="checkbox"/> No loss of consciousness <input type="checkbox"/>	<input type="checkbox"/> At least weekly <input type="checkbox"/> Loss of consciousness less than 10 minutes; no apnea <input type="checkbox"/>	<input type="checkbox"/> At least daily <input type="checkbox"/> loss of consciousness more than 10 minutes; with apnea; or medical treatment needed to stop <input type="checkbox"/>
INFECTIOUS DISEASE	<input type="checkbox"/> Known or suspected, but usual hygiene measure adequate <input type="checkbox"/> Increased risk for contracting, but able to go out to medical appointments, etc. <input type="checkbox"/>	<input type="checkbox"/> Known or suspected and more than usual hygiene measures needed <input type="checkbox"/> Increased risk for contracting, so should remain in home as much as possible <input type="checkbox"/>	<input type="checkbox"/> Known or suspected, requiring specialized handling of all body fluids <input type="checkbox"/> Great risk for contracting - specialized handling of food, contacts, toys, etc. is needed <input type="checkbox"/>
FEEDING	<input type="checkbox"/> Some choking; occasional special handling needed <input type="checkbox"/> Takes 31-40 minutes to feed <input type="checkbox"/> Every 4 hours with night feeding <input type="checkbox"/> Occasional vomiting, not serious <input type="checkbox"/> Special diet/food preparation <input type="checkbox"/>	<input type="checkbox"/> chokes or gags easily; frequent special handling needed <input type="checkbox"/> Takes 41-50 minutes to feed <input type="checkbox"/> Every 3 hours with night feedings <input type="checkbox"/> Vomits at least twice daily; or requires medication for vomiting <input type="checkbox"/>	<input type="checkbox"/> Requires feedings by N/G, GTT, JT and/or pump <input type="checkbox"/> Takes 51+ minutes to feed <input type="checkbox"/> Every 2 hours with night feedings <input type="checkbox"/> Same as Level 2; <u>and</u> affecting adequate weight gain <input type="checkbox"/>
ELIMINATION	<input type="checkbox"/> Prone to urinary tract infections, needs increased fluids <input type="checkbox"/> Chronic constipation/occasional suppository <input type="checkbox"/>	<input type="checkbox"/> crede needed to empty bladder <input type="checkbox"/> Chronic diarrhea/runny stools; or constipated and needs daily program <input type="checkbox"/>	<input type="checkbox"/> Has vesicostomy/uretrostomy/iliac conduit <input type="checkbox"/> colostomy/ileostomy <input type="checkbox"/>
SLEEP PATTERN (11pm - 6am)	<input type="checkbox"/> Under 6 months of age <u>and</u> up 4 times/night <input type="checkbox"/> Over 6 months of age <u>and</u> up 2 times/night <input type="checkbox"/>	<input type="checkbox"/> Under 6 months of age <u>and</u> up 5 times/night <input type="checkbox"/> Over 6 months of age <u>and</u> up 3 times/night <input type="checkbox"/>	<input type="checkbox"/> Under 6 months of age <u>and</u> up 6 times/night or more <input type="checkbox"/> Over 6 months of age <u>and</u> up 4 times/night or more <input type="checkbox"/>
MUSCLE TONE	<input type="checkbox"/> Impacts on care and/or some developmental delay; need to monitor <input type="checkbox"/>	<input type="checkbox"/> Requires special handling; follow up with therapy recommendations at home <input type="checkbox"/>	<input type="checkbox"/> Same as Level 2; <u>and</u> requires special equipment for feeding, positioning, bathing, etc. <input type="checkbox"/>
THERAPY, MEDICAL APPOINTMENTS, EMERGENCIES	<input type="checkbox"/> Average more than one per week	<input type="checkbox"/> Frequent emergencies in addition to above average appointments	<input type="checkbox"/> Daily treatment required (Comment on anticipated duration)
MEDICALLY FRAGILE	N/A	<input type="checkbox"/> Born with serious congenital defects having long-term implications. Close monitoring and medical supervision needed <input type="checkbox"/> High SIDS risk <input type="checkbox"/>	<input type="checkbox"/> Born with major congenital defects that are life-threatening. Constant care and supervision needed; surgery pending or post surgical care. <input type="checkbox"/>
RESPIRATORY PROBLEMS	<input type="checkbox"/> Frequent colds, respiratory infections including ear infections <input type="checkbox"/>	<input type="checkbox"/> Asthma <input type="checkbox"/>	<input type="checkbox"/> BPD <input type="checkbox"/>
SPECIALIZED EQUIPMENT	<input type="checkbox"/> apnea monitor, splints, cast, braces or positioning equipment <input type="checkbox"/>	<input type="checkbox"/> Aspiration, Suctioning, Ventilator or Mist Tent <input type="checkbox"/>	<input type="checkbox"/> Oxygen, Pulmonaid, Broviac Catheter, Tracheostomy <input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Difficulty of Care Behavioral Checklist - Child's Age Birth through 2 Years (Cont'd)

**FOR CHILDREN UP TO 18 MONTHS OF AGE**

BEHAVIOR	LEVEL 1 MILD: Can be readily controlled with specialized intervention.	LEVEL 2 MODERATE: Is difficult to control, but will respond to sustained specialized intervention	LEVEL 3 SEVERE: Requires almost continuous specialized intervention
IRRITABILITY: poor state changes, prolonged periods of crying	[ ]	[ ]	[ ]
HYPERREFLEXIA: exaggerated startle reflex, or response to stimuli, arching	[ ]	[ ]	[ ]
TREMORS: jerky movements	[ ]	[ ]	[ ]
POOR SOCIAL INTERACTION: poor eye contact, doesn't cuddle, not responsive	[ ]	[ ]	[ ]

**FOR CHILDREN OVER 18 MONTHS OF AGE**

BEHAVIOR	LEVEL 1 MILD: Can be readily controlled with specialized intervention.	LEVEL 2 MODERATE: Is difficult to control, but will respond to sustained specialized intervention	LEVEL 3 SEVERE: Requires almost continuous specialized intervention
SHORT ATTENTION SPAN: Inability to persist in attending to any one object, person or activity	[ ]	[ ]	[ ]
HYPERACTIVITY: Constant movement, over-excitability and restlessness	[ ]	[ ]	[ ]
POOR TOLERANCE FOR CHANGE: restiveness or disruption of typical functioning	[ ]	[ ]	[ ]
AGGRESSION TOWARD OTHERS: Violent episodes, injury to others or destruction of property	[ ]	[ ]	[ ]
AGGRESSION TOWARD SELF: Purposefully injuring self; no concept of danger.	[ ]	[ ]	[ ]

## Difficulty of Care Behavioral Checklist - Child's Age 12 through 18 Years

Child's Name	DOB	SW PCN
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### EMOTIONAL CARE NEEDS QUALIFYING FOR DOC

PROBLEM	LEVEL 1	LEVEL 2	LEVEL 3
ATTENTION SEEKING	<input type="checkbox"/> Demanding, clinging, constant crying, sleep disturbances, reversion to infantile behavior. FP must provide extra comfort and attention.  <input type="checkbox"/>	<input type="checkbox"/> Frequent verbal outbursts; defiant, refusal to follow basic rules. FP must provide constant and consistent limit setting  <input type="checkbox"/>	<input type="checkbox"/> Constant challenging and criticism of FP actions; attempts to undermine FP authority in home; child has know-it-all attitude, uses arrogance as primary defense  <input type="checkbox"/> Primary attachment to caretaker, few friends or peer activities; wants total attention of caretaker, overly jealous of other children in home  <input type="checkbox"/>
ABNORMAL STRUCTURE/ SUPERVISION	<input type="checkbox"/> Child is restless and cannot initiate own activities without direction; activities must be closely monitored  <input type="checkbox"/>	<input type="checkbox"/> Child becomes anxious and acts out whenever there is no structure or an established routine is changes; FP must supervise regimented routine  <input type="checkbox"/>	<input type="checkbox"/> Regularly puts self in dangerous situations  <input type="checkbox"/> FP can never leave child unattended.  <input type="checkbox"/>
ENURESIS	<input type="checkbox"/> Once or twice weekly <input type="checkbox"/> Nightly loss of control <input type="checkbox"/> Daytime loss of control	N/A	N/A
ENCOPRESIS	N/A	<input type="checkbox"/> At least weekly. Extra laundry and cleaning	<input type="checkbox"/> At least twice weekly. Extra laundry and cleaning
AGGRESSIVE TO OTHERS/ PROPERTY	<input type="checkbox"/> Verbally aggressive to peers and/or adults	<input type="checkbox"/> Aggressive/assaultive. FP must protect other children  <input type="checkbox"/>	<input type="checkbox"/> Same as level 2 <u>and</u> chronic, extreme destruction of property.  <input type="checkbox"/> History of firesetting with damage to property  <input type="checkbox"/>
SEXUAL BEHAVIOR	<input type="checkbox"/> Inappropriate; needs guidance <input type="checkbox"/> Masturbates excessively	<input type="checkbox"/> Child's conversation often revolves around sexual topics; child is sexually provocative with both adults and peers; FP must monitor closely  <input type="checkbox"/>	<input type="checkbox"/> Child has been sexually aggressive to peers or younger children or has initiated sexual involvement with adults; FP must monitor interactions with adults and supervise interactions with peers and younger children to protect them  <input type="checkbox"/> Promiscuous; at risk for STD and HIV  <input type="checkbox"/>
SCHOOL PROBLEMS	<input type="checkbox"/> Child presents discipline problems, special education. FP must provide help with lessons and has school contact at least weekly around behavioral issues.  <input type="checkbox"/> Tutoring 2 times weekly <input type="checkbox"/>	<input type="checkbox"/> Child presents discipline problems, special education classes. FP has school contact at least 3-4 times weekly  <input type="checkbox"/> Daily tutoring for a least one hour  <input type="checkbox"/>	N/A
EMOTIONALLY DISTURBED	<input type="checkbox"/> Excessively dependent; or passive with lack of response	<input type="checkbox"/> Suicidal ideation; inappropriate behaviors, unresponsive and withdrawn. FP must monitor closely; work with therapist  <input type="checkbox"/> Fascination with fire  <input type="checkbox"/>	<input type="checkbox"/> Extreme, bizarre behaviors; suicidal; severe chronic depressions or danger to others. FP must monitor, control medications and be in constant contact with therapist  <input type="checkbox"/> Diagnosed autism <input type="checkbox"/> Diagnosed eating disorder; e.g., anorexia, bulimia, etc.  <input type="checkbox"/>

PROBLEM	LEVEL 1	LEVEL 2	LEVEL 3
LAW VIOLATIONS	N/A	<input type="checkbox"/> Truant; minor infractions; shoplifting. Needs close supervision <input type="checkbox"/>	<input type="checkbox"/> Alcohol or drug use/abuse; assaultive; theft. FP has constant contact with police, school, probation. Handles community complaints <input type="checkbox"/>
FP PARTICIPANT IN PSYCHO-THERAPY	<input type="checkbox"/> At least every other week	<input type="checkbox"/> At least weekly	<input type="checkbox"/> At least twice weekly
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Request for Difficulty of Care Rating - Child's 12 through 18 Years

<b>Check One (1) Box Below:</b>		<input type="checkbox"/> Early Review - FP moved - diff. county <input type="checkbox"/> Early Review - Change in Placement <input type="checkbox"/> Early Review - Improved <input type="checkbox"/> Early Review - Deteriorated <input type="checkbox"/> Reconsideration <input type="checkbox"/> Other _____	Foster Home Located in <input type="checkbox"/> Contra Costa County <input type="checkbox"/> Other (enter county below) _____		
Child's Name		Foster Parent's Name		DOC Start Date	Drug Exposed Child <input type="checkbox"/> Yes <input type="checkbox"/> No
BEHAVIOR/PROBLEM	WHAT FOSTER PARENT WILL DO			HOW OFTEN	
SEIZURES					
INFECTIOUS DISEASE					
FEEDING					
BLADDER/BOWEL FUNCTIONING					
SLEEP PATTERN					
DEVELOPMENTAL DELAY					
MEDICAL APPOINTMENTS, THERAPY, EMERGENCIES					
MEDICALLY FRAGILE					
RESPIRATORY PROBLEMS					
SPECIALIZED EQUIPMENT					
PHYSICAL THERAPY					
NONAMBULATORY					

BEHAVIOR/PROBLEM	WHAT FOSTER PARENT WILL DO	HOW OFTEN
DIABETES		
OTHER PHYSICAL		
ATTENTION SEEKING		
ABNORMAL STRUCTURE/ SUPERVISION		
ENURESIS		
ENCOPRESIS		
AGGRESSIVE TO OTHERS/PROPERTY		
SEXUAL BEHAVIOR		
SCHOOL PROBLEMS		
EMOTIONALLY DISTURBED		
LAW VIOLATIONS		
FP PARTICIPANT IN PSYCHOTHERAPY		
OTHER EMOTIONAL		

\_\_\_\_\_  
Social Worker

\_\_\_\_\_  
Date

\_\_\_\_\_  
Foster Parent

\_\_\_\_\_  
Date

## Difficulty of Care Behavioral Checklist - Child's Age 12 through 18 Years

Child's Name	DOB	SW PCN
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### PHYSICAL CARE NEEDS QUALIFYING FOR DOC

PROBLEM	LEVEL 1	LEVEL 2	LEVEL 3
SEIZURES	<input type="checkbox"/> History, but none currently or no more than monthly. <input type="checkbox"/> No loss of consciousness <input type="checkbox"/>	<input type="checkbox"/> Partially controlled. Close supervision needed. Medication changing <input type="checkbox"/> At least weekly <input type="checkbox"/> Loss of consciousness less than 10 minutes; no apnea <input type="checkbox"/>	<input type="checkbox"/> Uncontrolled; constant supervision needed; care following seizures needed <input type="checkbox"/> At least daily <input type="checkbox"/> loss of consciousness more than 10 minutes; with apnea; or medical treatment needed to stop <input type="checkbox"/>
INFECTIOUS DISEASE	<input type="checkbox"/> Known or suspected, but usual hygiene measure adequate <input type="checkbox"/> Increased risk for contracting, but able to go out to medical appointments, etc. <input type="checkbox"/>	<input type="checkbox"/> Needs specialized hygienic procedures; e.g., STD <input type="checkbox"/> Known or suspected and more than usual hygiene measures needed <input type="checkbox"/> Increased risk for contracting, so should remain in home as much as possible <input type="checkbox"/>	<input type="checkbox"/> Needs extreme hygienic procedures; e.g. hepatitis <input type="checkbox"/> Known or suspected, requiring specialized handling of all body fluids <input type="checkbox"/> Great risk for contracting -- specialized handling of food, contacts, toys, etc. is needed <input type="checkbox"/>
FEEDING	<input type="checkbox"/> Needs some help cutting up food <input type="checkbox"/> Some choking; occasional special handling needed <input type="checkbox"/> Occasional vomiting, not serious <input type="checkbox"/> Special diet/food preparation <input type="checkbox"/>	<input type="checkbox"/> Must be hand fed <input type="checkbox"/> chokes or gags easily; frequent special handling or special food preparation needed <input type="checkbox"/> Vomits at least twice daily; or requires medication for vomiting <input type="checkbox"/>	<input type="checkbox"/> Requires feedings by N/G, GTT, JT and/or pump <input type="checkbox"/> Same as Level 2; <u>and</u> affecting adequate weight gain <input type="checkbox"/>
BLADDER/BOWEL FUNCTIONING	<input type="checkbox"/> Prone to urinary tract infections, needs increased fluids <input type="checkbox"/> Chronic constipation/occasional suppository <input type="checkbox"/>	<input type="checkbox"/> crede needed to empty bladder <input type="checkbox"/> Chronic diarrhea/runny stools; or constipated and needs daily program <input type="checkbox"/>	<input type="checkbox"/> Has vesicotomy/uretrostomy/ileal conduit <input type="checkbox"/> colostomy/ileostomy <input type="checkbox"/>
DEVELOPMENTAL DELAY	<input type="checkbox"/> Can learn some self-care with constant repetitive training and instruction. <input type="checkbox"/>	<input type="checkbox"/> Cannot perform <b>age-appropriate</b> functions or can only do so with assistance. Specify _____  <input type="checkbox"/>	<input type="checkbox"/> Requires total care. Cannot communicate verbally. Foster parent must bathe, dress, diaper. <input type="checkbox"/>
MEDICAL APPOINTMENTS, THERAPY, EMERGENCIES	<input type="checkbox"/> Average more than one per week	<input type="checkbox"/> Frequent emergencies in addition to above average appointments	<input type="checkbox"/> Daily treatment required (Comment on anticipated duration)
MEDICALLY FRAGILE	N/A	<input type="checkbox"/> Born with serious congenital defects having long-term implications. Close monitoring and medical supervision needed <input type="checkbox"/>	<input type="checkbox"/> Born with major congenital defects that are life-threatening. Constant care and supervision needed; surgery pending or post surgical care. <input type="checkbox"/>
RESPIRATORY PROBLEMS	<input type="checkbox"/> Frequent colds, respiratory infections including ear infections <input type="checkbox"/>	<input type="checkbox"/> Asthma <input type="checkbox"/>	<input type="checkbox"/> Frequent bouts of pneumonia or other lung disease requiring periodic hospitalization <input type="checkbox"/>
SPECIALIZED EQUIPMENT	<input type="checkbox"/> Splints, cast, braces or positioning equipment <input type="checkbox"/>	<input type="checkbox"/> Aspiration, Suctioning, Ventilator <input type="checkbox"/>	<input type="checkbox"/> Oxygen, Pulmonaid, Mist Tent, Broviac Catheter, Tracheostomy <input type="checkbox"/>

PROBLEM	LEVEL 1	LEVEL 2	LEVEL 3
PHYSICAL THERAPY	N/A	<input type="checkbox"/> Requires at least one hour per day of regimen prescribed by physical therapist <input type="checkbox"/>	<input type="checkbox"/> Requires 2-3 hours per day of exercise regimen prescribed by physical therapist <input type="checkbox"/>
NON-AMBULATORY	<input type="checkbox"/> Needs some help with dressing and attending to personal hygiene <input type="checkbox"/>	<input type="checkbox"/> With help, can perform some functions <input type="checkbox"/> Requires special handling; follow up with therapy recommendations at home <input type="checkbox"/>	<input type="checkbox"/> Needs total care <input type="checkbox"/> Same as Level 2; <u>and</u> requires special equipment for feeding, positioning, bathing, etc. <input type="checkbox"/>
DIABETES	<input type="checkbox"/> Diabetes under control and child takes primary responsibility. FP supervises diet, blood sugar monitoring and injections <input type="checkbox"/>	<input type="checkbox"/> Diabetes under control but child does not take primary responsibility. FP responsible for child's diet, blood sugar testing and injections <input type="checkbox"/>	<input type="checkbox"/> Brittle diabetic. Need for ongoing medical follow-up <input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## Difficulty of Care Behavioral Checklist - Child's Age 3 through 5 Years

Child's Name	DOB	SW PCN
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### PHYSICAL CARE NEEDS QUALIFYING FOR DOC

PROBLEM	LEVEL 1	LEVEL 2	LEVEL 3
SEIZURES	<input type="checkbox"/> History, but none currently or no more than monthly. <input type="checkbox"/> No loss of consciousness <input type="checkbox"/>	<input type="checkbox"/> Partially controlled. Close supervision needed. Medication changing <input type="checkbox"/> At least weekly <input type="checkbox"/> Loss of consciousness less than 10 minutes; no apnea <input type="checkbox"/>	<input type="checkbox"/> Uncontrolled; constant supervision needed; care following seizures needed <input type="checkbox"/> At least daily <input type="checkbox"/> loss of consciousness more than 10 minutes, with apnea; or medical treatment needed to stop <input type="checkbox"/>
INFECTIOUS DISEASE	<input type="checkbox"/> Known or suspected, but usual hygiene measure adequate <input type="checkbox"/> Increased risk for contracting, but able to go out to medical appts., etc. <input type="checkbox"/>	<input type="checkbox"/> Needs specialized hygienic procedures; e.g., STD <input type="checkbox"/> Known or suspected and more than usual hygiene measures needed <input type="checkbox"/> Increased risk for contracting, so should remain in home as much as possible <input type="checkbox"/>	<input type="checkbox"/> Needs extreme hygienic procedures; e.g hepatitis <input type="checkbox"/> Known or suspected, requiring specialized handling of all body fluids <input type="checkbox"/> Great risk for contracting - specialized handling of food, contacts, toys, etc. is needed <input type="checkbox"/>
FEEDING	<input type="checkbox"/> Must be hand fed <input type="checkbox"/> Some choking; occasional special handling needed <input type="checkbox"/> Occasional vomiting, not serious <input type="checkbox"/> Special diet/food preparation <input type="checkbox"/>	<input type="checkbox"/> chokes or gags easily; frequent special handling or special food preparation needed <input type="checkbox"/> Vomits at least twice daily; or requires medication for vomiting <input type="checkbox"/>	<input type="checkbox"/> Requires feedings by N/G, GTT, JT and/or pump <input type="checkbox"/> Same as Level 2; <u>and</u> affecting adequate weight gain <input type="checkbox"/>
BLADDER/BOWEL FUNCTIONING	<input type="checkbox"/> Prone to urinary tract infections, needs increased fluids <input type="checkbox"/> Chronic constipation/occasional suppository <input type="checkbox"/>	<input type="checkbox"/> crede needed to empty bladder <input type="checkbox"/> Chronic diarrhea/runny stools; or constipated and needs daily program <input type="checkbox"/>	<input type="checkbox"/> Has vesicotomy/uretrostomy/ileal conduit <input type="checkbox"/> colostomy/ileostomy <input type="checkbox"/>
DEVELOPMENTAL DELAY	<input type="checkbox"/> Can learn some self-care with constant repetitive training and instruction. <input type="checkbox"/>	<input type="checkbox"/> Cannot perform <b>age-appropriate</b> functions or can only do so with assistance. Specify: _____ _____ <input type="checkbox"/>	<input type="checkbox"/> Requires total care. Cannot communicate verbally. Foster parent must bathe, dress, diaper. <input type="checkbox"/>
MEDICAL APPOINTMENTS, THERAPY, EMERGENCIES	<input type="checkbox"/> Average more than one per week	<input type="checkbox"/> Frequent emergencies in addition to above average appointments	<input type="checkbox"/> Daily medical treatment required (Comment on anticipated duration)
MEDICALLY FRAGILE	N/A	<input type="checkbox"/> Born with serious congenital defects having long-term implications. Close monitoring and medical supervision needed <input type="checkbox"/>	<input type="checkbox"/> Born with major congenital defects that are life-threatening. Constant care and supervision needed; surgery pending or post surgical care. <input type="checkbox"/>
RESPIRATORY PROBLEMS	<input type="checkbox"/> Frequent colds, respiratory infections including ear infections <input type="checkbox"/>	<input type="checkbox"/> Asthma <input type="checkbox"/>	<input type="checkbox"/> BPD <input type="checkbox"/>
SPECIALIZED EQUIPMENT	<input type="checkbox"/> Splints, cast, braces or positioning equipment <input type="checkbox"/>	<input type="checkbox"/> Aspiration, Suctioning, Ventilator <input type="checkbox"/>	<input type="checkbox"/> Oxygen, Pulmonaid, Mist Tent, Broviac Catheter, Tracheostomy <input type="checkbox"/>

PROBLEM	LEVEL 1	LEVEL 2	LEVEL 3
PHYSICAL THERAPY	N/A	<input type="checkbox"/> Requires at least one hour per day of regimen prescribed by physical therapist <input type="checkbox"/>	<input type="checkbox"/> Requires 2-3 hours per day of exercise regimen prescribed by physical therapist <input type="checkbox"/>
NON-AMBULATORY	N/A	<input type="checkbox"/> With help, can perform some self-care functions; can move with assistance of special equipment; e.g., motorized wheelchair <input type="checkbox"/> Requires special handling; follow up with therapy recommendations at home <input type="checkbox"/>	<input type="checkbox"/> Needs total care <input type="checkbox"/> Same as Level 2; <u>and</u> requires special equipment for feeding, positioning, bathing, etc. <input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Request for Difficulty of Care Rating - Child's 3 through 5 Years

<p><i>Check One (1) Box Below:</i></p> <p><input type="checkbox"/> New</p> <p><input type="checkbox"/> Restore</p> <p><input type="checkbox"/> Renewal - No Change</p> <p><input type="checkbox"/> Renewal - Improved</p> <p><input type="checkbox"/> Renewal - Deteriorated</p>	<p><input type="checkbox"/> Early Review - FP moved -diff. county</p> <p><input type="checkbox"/> Early Review - Change in Placement</p> <p><input type="checkbox"/> Early Review - Improved</p> <p><input type="checkbox"/> Early Review - Deteriorated</p> <p><input type="checkbox"/> Reconsideration</p> <p><input type="checkbox"/> Other _____</p>	<p>Foster Home Located in</p> <p><input type="checkbox"/> Contra Costa County</p> <p><input type="checkbox"/> Other (enter county below)</p> <p>_____</p>
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Child's Name	Foster Parent's Name	DOC Start Date	Drug Exposed Child <input type="checkbox"/> yes <input type="checkbox"/> No
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BEHAVIOR/PROBLEM	WHAT FOSTER PARENT WILL DO	HOW OFTEN
SEIZURES		
INFECTIOUS DISEASE		
FEEDING		
BLADDER/BOWEL FUNCTIONING		
SLEEP PATTERN		
DEVELOPMENTAL DELAY		
MEDICAL APPOINTMENTS, THERAPY, EMERGENCIES		
MEDICALLY FRAGILE		
RESPIRATORY PROBLEMS		
SPECIALIZED EQUIPMENT		
PHYSICAL THERAPY		

BEHAVIOR/PROBLEM	WHAT FOSTER PARENT WILL DO	HOW OFTEN
NONAMBULATORY		
OTHER PHYSICAL		
ATTENTION SEEKING		
ABNORMAL STRUCTURE/ SUPERVISION		
ENURESIS		
ENCOPRESIS		
AGGRESSIVE TO OTHERS/PROPERTY		
SEXUAL BEHAVIOR		
SCHOOL PROBLEMS		
EMOTIONALLY DISTURBED		
FP PARTICIPANT IN PSYCHOTHERAPY		
HYPERACTIVE		
OTHER EMOTIONAL		

\_\_\_\_\_  
Social Worker

\_\_\_\_\_  
Date

\_\_\_\_\_  
Foster Parent

\_\_\_\_\_  
Date

## Difficulty of Care Behavioral Checklist - Child's Age 6 through 11 Years

Child's Name	DOB	SW PCN
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### EMOTIONAL CARE NEEDS QUALIFYING FOR DOC

PROBLEM	LEVEL 1	LEVEL 2	LEVEL 3
ATTENTION SEEKING	<input type="checkbox"/> Demanding, clinging, constant crying, sleep disturbances, reversion to infantile behavior. FP must provide extra comfort and attention. <input type="checkbox"/> Tantrums more than 3 times/week and is not easily distracted from tantrum behavior <input type="checkbox"/> Verbally aggressive to peers and/or adults <input type="checkbox"/>	<input type="checkbox"/> At least daily tantrums - very difficult to get child to cease behavior, refusal to follow basic rules. FP must provide constant limit setting <input type="checkbox"/>	N/A
ABNORMAL STRUCTURE/SUPERVISION	<input type="checkbox"/> Activities must be closely monitored <input type="checkbox"/>	<input type="checkbox"/> FP must supervise regimented routine <input type="checkbox"/>	<input type="checkbox"/> Regularly puts self in dangerous situations <input type="checkbox"/> FP can never leave child unattended. <input type="checkbox"/>
ENURESIS	<input type="checkbox"/> Once or twice weekly <input type="checkbox"/> Nightly loss of control <input type="checkbox"/> Daytime loss of control	N/A	N/A
ENCOPRESIS	N/A	<input type="checkbox"/> At least weekly. Extra laundry and cleaning	<input type="checkbox"/> Pattern of smearing feces
AGGRESSIVE TO OTHERS/PROPERTY	N/A	<input type="checkbox"/> Aggressive/assaultive. FP must protect other children <input type="checkbox"/>	<input type="checkbox"/> Same as level 2 <u>and</u> chronic, extreme destruction of property. <input type="checkbox"/> History of firesetting with damage to property <input type="checkbox"/>
SEXUAL BEHAVIOR	<input type="checkbox"/> Inappropriate; needs guidance <input type="checkbox"/> Masturbates excessively	<input type="checkbox"/> Child initiates talk of sex, sees daily activities in sexual terms; is inappropriate with adults. FP must monitor closely <input type="checkbox"/>	<input type="checkbox"/> Child has a history of initiating sexual activity with other children on more than one occasion; sexually aggressive and FP must supervise peer contact to protect other children <input type="checkbox"/>
SCHOOL PROBLEMS	<input type="checkbox"/> Child presents discipline problems, special education. FP must provide help with lessons and has school contact at least weekly around behavioral issues. <input type="checkbox"/> Tutoring 2 times weekly <input type="checkbox"/>	<input type="checkbox"/> Child presents discipline problems, special education classes. FP has school contact at least 3-4 times weekly <input type="checkbox"/> Daily tutoring for a least one hour <input type="checkbox"/>	N/A
EMOTIONALLY DISTURBED	<input type="checkbox"/> Excessively dependent; or passive with lack of response	<input type="checkbox"/> Suicidal ideation; inappropriate behaviors, unresponsive and withdrawn. FP must monitor closely; work with therapist <input type="checkbox"/> Fascination with fire <input type="checkbox"/>	<input type="checkbox"/> Extreme, bizarre behaviors; suicidal; severe chronic depressions or danger to others. FP must monitor, control medications and be in constant contact with therapist <input type="checkbox"/> Diagnosed autism <input type="checkbox"/>
LAW VIOLATIONS	N/A	<input type="checkbox"/> Truant; minor infractions; pattern of shoplifting. Needs close supervision <input type="checkbox"/>	<input type="checkbox"/> Alcohol or drug use/abuse; assaultive; theft. FP has constant contact with police, school, probation. Handles community complaints <input type="checkbox"/>

PROBLEM	LEVEL 1	LEVEL 2	LEVEL 3
FP PARTICIPANT IN PSYCHO- THERAPY	<input type="checkbox"/> At least every other week	<input type="checkbox"/> At least weekly	<input type="checkbox"/> At least twice weekly
HYPERACTIVE	<input type="checkbox"/> diagnosed Attention Deficit Disorder - very active; energy must be directed into positive channels <input type="checkbox"/>	<input type="checkbox"/> Can be controlled with medication. Cannot function without medication <input type="checkbox"/>	<input type="checkbox"/> Constant movement and restlessness. Cannot be controlled with medication. Child up at night, wanders through house. <input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Request for Difficulty of Care Rating - Child's 6 through 11 Years

<p><i>Check One (1) Box Below:</i></p> <p><input type="checkbox"/> New</p> <p><input type="checkbox"/> Restore</p> <p><input type="checkbox"/> Renewal - No Change</p> <p><input type="checkbox"/> Renewal - Improved</p> <p><input type="checkbox"/> Renewal - Deteriorated</p>	<p><input type="checkbox"/> Early Review - FP moved - diff. county</p> <p><input type="checkbox"/> Early Review - Change in Placement</p> <p><input type="checkbox"/> Early Review - Improved</p> <p><input type="checkbox"/> Early Review - Deteriorated</p> <p><input type="checkbox"/> Reconsideration</p> <p><input type="checkbox"/> Other _____</p>	<p>Foster Home Located in</p> <p><input type="checkbox"/> Contra Costa County</p> <p><input type="checkbox"/> Other (enter county below)</p> <p>_____</p>
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Child's Name	Foster Parent's Name	DOC Start Date	Drug Exposed Child <input type="checkbox"/> yes <input type="checkbox"/> No
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BEHAVIOR/PROBLEM	WHAT FOSTER PARENT WILL DO	HOW OFTEN
SEIZURES		
INFECTIOUS DISEASE		
FEEDING		
BLADDER/BOWEL FUNCTIONING		
SLEEP PATTERN		
DEVELOPMENTAL DELAY		
MEDICAL APPOINTMENTS, THERAPY, EMERGENCIES		
MEDICALLY FRAGILE		
RESPIRATORY PROBLEMS		
SPECIALIZED EQUIPMENT		
PHYSICAL THERAPY		
NONAMBULATORY		

BEHAVIOR/PROBLEM	WHAT FOSTER PARENT WILL DO	HOW OFTEN
OTHER PHYSICAL		
ATTENTION SEEKING		
ABNORMAL STRUCTURE/ SUPERVISION		
ENURESIS		
ENCOPRESIS		
AGGRESSIVE TO OTHERS/PROPERTY		
SEXUAL BEHAVIOR		
SCHOOL PROBLEMS		
EMOTIONALLY DISTURBED		
LAW VIOLATIONS		
FP PARTICIPANT IN PSYCHOTHERAPY		
HYPERACTIVE		
OTHER EMOTIONAL		

\_\_\_\_\_  
Social Worker

\_\_\_\_\_  
Date

\_\_\_\_\_  
Foster Parent

\_\_\_\_\_  
Date

## Difficulty of Care Behavioral Checklist - Child's Age 6 through 11 Years

Child's Name	DOB	SW PCN
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### PHYSICAL CARE NEEDS QUALIFYING FOR DOC

PROBLEM	LEVEL 1	LEVEL 2	LEVEL 3
SEIZURES	<input type="checkbox"/> History, but none currently or no more than monthly. <input type="checkbox"/> No loss of consciousness <input type="checkbox"/>	<input type="checkbox"/> Partially controlled. Close supervision needed. Medication changing <input type="checkbox"/> At least weekly <input type="checkbox"/> Loss of consciousness less than 10 minutes; no apnea <input type="checkbox"/>	<input type="checkbox"/> Uncontrolled; constant supervision needed; care following seizures needed <input type="checkbox"/> At least daily <input type="checkbox"/> loss of consciousness more than 10 minutes; with apnea; or medical treatment needed to stop <input type="checkbox"/>
INFECTIOUS DISEASE	<input type="checkbox"/> Known or suspected, but usual hygiene measure adequate <input type="checkbox"/> Increased risk for contracting, but able to go out to medical appointments, etc. <input type="checkbox"/>	<input type="checkbox"/> Needs specialized hygienic procedures; e.g., STD <input type="checkbox"/> Known or suspected and more than usual hygiene measures needed <input type="checkbox"/> Increased risk for contracting, so should remain in home as much as possible <input type="checkbox"/>	<input type="checkbox"/> Needs extreme hygienic procedures; e.g. hepatitis <input type="checkbox"/> Known or suspected, requiring specialized handling of all body fluids <input type="checkbox"/> Great risk for contracting - specialized handling of food, contacts, toys, etc. is needed <input type="checkbox"/>
FEEDING	<input type="checkbox"/> Needs some help cutting up food <input type="checkbox"/> Some choking; occasional special handling needed <input type="checkbox"/> Occasional vomiting, not serious <input type="checkbox"/> Special diet/food preparation <input type="checkbox"/>	<input type="checkbox"/> Must be hand fed <input type="checkbox"/> chokes or gags easily; frequent special handling or special food preparation needed <input type="checkbox"/> Vomits at least twice daily; or requires medication for vomiting <input type="checkbox"/>	<input type="checkbox"/> Requires feedings by N/G, GTT, JT and/or pump <input type="checkbox"/> Same as Level 2; <u>and</u> affecting adequate weight gain <input type="checkbox"/>
BLADDER/BOWEL FUNCTIONING	<input type="checkbox"/> Prone to urinary tract infections, needs increased fluids <input type="checkbox"/> Chronic constipation/occasional suppository <input type="checkbox"/>	<input type="checkbox"/> crede needed to empty bladder <input type="checkbox"/> Chronic diarrhea/runny stools; or constipated and needs daily program <input type="checkbox"/>	<input type="checkbox"/> Has vesicotomy/uretrostomy/ileal conduit <input type="checkbox"/> colostomy/ileostomy <input type="checkbox"/>
DEVELOPMENTAL DELAY	<input type="checkbox"/> Can learn some self-care with constant repetitive training and instruction. <input type="checkbox"/>	<input type="checkbox"/> Cannot perform age-appropriate functions or can only do so with assistance. <input type="checkbox"/>	<input type="checkbox"/> Requires total care. Cannot communicate verbally. Foster parent must bathe, dress, diaper. <input type="checkbox"/>
MEDICAL APPOINTMENTS, THERAPY, EMERGENCIES	<input type="checkbox"/> Average more than one per week	<input type="checkbox"/> Frequent emergencies in addition to above average appointments	<input type="checkbox"/> Daily medical treatment required (Comment on anticipated duration)
MEDICALLY FRAGILE	N/A	<input type="checkbox"/> Born with serious congenital defects having long-term implications. Close monitoring and medical supervision needed <input type="checkbox"/>	<input type="checkbox"/> Born with major congenital defects that are life-threatening. Constant care and supervision needed; surgery pending or post surgical care. <input type="checkbox"/>
RESPIRATORY PROBLEMS	<input type="checkbox"/> Frequent colds, respiratory infections including ear infections <input type="checkbox"/>	<input type="checkbox"/> Asthma <input type="checkbox"/>	<input type="checkbox"/> BPD <input type="checkbox"/>
SPECIALIZED EQUIPMENT	<input type="checkbox"/> Splints, cast, braces or positioning equipment <input type="checkbox"/>	<input type="checkbox"/> Aspiration, Suctioning, Ventilator <input type="checkbox"/>	<input type="checkbox"/> Oxygen, Pulmonaid, Mist Tent, Broviac Catheter, Tracheostomy <input type="checkbox"/>

PROBLEM	LEVEL 1	LEVEL 2	LEVEL 3
PHYSICAL THERAPY	N/A	<input type="checkbox"/> Requires at least one hour per day of regimen prescribed by physical therapist <input type="checkbox"/>	<input type="checkbox"/> Requires 2-3 hours per day of exercise regimen prescribed by physical therapist <input type="checkbox"/>
NON-AMBULATORY	<input type="checkbox"/> Needs some help with dressing and attending to personal hygiene	<input type="checkbox"/> With help, can perform some functions <input type="checkbox"/> Requires special handling; follow up with therapy recommendations at home <input type="checkbox"/>	<input type="checkbox"/> Needs total care <input type="checkbox"/> Same as Level 2; <u>and</u> requires special equipment for feeding, positioning, bathing, etc. <input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>