

Case Conference Description and Format

Conference Type	When to Hold	Attendees	General Purpose	Conference Materials & Pre-Conference Preparation	Guideline and References
Specialized Foster Care Rate	When licensed foster parents, Relatives/NERFM and non-related Legal guardians (NLRG) provide care and supervision above the level that is normally expected, the social worker can request a Specialized Care Rate Committee meeting. Reviews are usually done at six month or yearly intervals. The social worker will be notified of these by the Specialized Care Rate Coordinator. If the child's needs change the SW can request a review at any time.	Specialized Care Rate Coordinator, social worker, Foster Care nurse and Foster Care Eligibility supervisor.	The Specialized Care Rate (SCR) is an amount paid to a Substitute Care Provider (SCP) on behalf of children requiring specialized care due to non-standard medical, behavioral or emotional problems. FFA and group homes are not eligible for this specialized care rate.	The social worker confers with the substitute care provider to determine the child's special needs. SW completes the MCDSS 837 template in the CMS/CWS and forwards it to the SCR coordinator to be scheduled for a case conference. SW will bring the case file along with any supporting documentation for the 6 special needs domains: medical, developmental, behavioral, emotional, educational and social.	P&PL# pending ACL 98-27 ACL 93-85 ACIN 1 113-00- CFL 00/01-18 WIC 11461 (a) (e) (1) AB 1391 MPP 11-45



Mendocino County Health and Human Services Agency
Social Services

"Creating a Community of Safe and Independent Families and Individuals"

Susana Wilson ♦ Branch Director

**Family and Children's Services Division
Becky Wilson, Deputy Director**

October 13, 2009

Placement Caregiver
201 North Street
Willits, CA 95490

Subject: Foster Care Out-of-Home Care Placement Assessment

Dear Placement Caregiver,

Please be advised that Mendocino County Foster Care staff have completed their review of the Foster Care Out-of-Home Care Placement Assessments for **children** which authorized a specialized rate for each child through **09/30/09**. Staff has determined that Specialized Care Plans are no longer needed for these children.

The basic Foster Care rate for **child** is **\$446.00** per month and for **child** it is **\$485.00** per month. Checks for October 2009 will be issued to you on November 10, 2009 for these two children. On behalf of the Mendocino County Health and Human Services Agency, we would like to thank you for participating in this program.

If you have any questions, please contact the children's Social Worker, Victoria Plattner, at 456-3723.

Sincerely,

Gretchen Lyne, PHN

Enclosures

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**COUNTY OF MENDOCINO
HEALTH & HUMAN SERVICES AGENCY
SOCIAL SERVICES**

**FAMILY AND CHILDREN'S
SERVICES BRANCH**

TITLE:
Foster Care Specialized Care Rate Review

Policy & Procedure Letter #:
issued:
revised:

REFERENCES:
ACL 98-27, ACL 93-85, 08-01
ACIN 1 113-00
CFL 00/01-18, AB 1391, WIC 11461 (a) (e) (1)
MPP 11-45

Approved by:

Signature _____

CMS Section(s):

Resource person(s):
Gretchen Lyne
Robert Fredrickson

Key Words:
Special Care Rates (SCR)
Substitute Care Provider (SCP)
Foster Care Out of Home Care Specialized Care Rate
Assessment (MCDSS 837)

PURPOSE

A Specialized Care Rate (SCR) amount will be paid to a Substitute Care Provider (SCP) on behalf of AFDC-FC children requiring specialized care due to non-standard medical, behavior or emotional problems.

BACKGROUND

The specialized care rate is authorized in addition to the basic foster care payment when foster parents provide care and supervision above the level that is normally expected. The Specialized Care Rates are payable to licensed Foster homes, relatives/NREFM's and non-related legal guardians (NRLG).

DEFINITIONS

Specialized Care Rate: An amount authorized in addition to the basic foster care payment.

Substitute Care Provider: Person designated to care for a child under protective custody.

Foster Care Out of Home SCR Assessment: Review of child's special needs by SCR Committee on an annual or as needed basis.

POLICIES

The level of mild, moderate and intensive need(s) of the child is determined by a committee who will evaluate both the extent of the child's unique problems and what specifically the foster parent is doing to help address these problems. This committee also considers how much extra time and care are involved.

The committee will consist of the Foster Care nurse, SCR coordinator or designee, case-carrying social worker and Licensing supervisor. The committee will meet monthly. Licensed foster care homes, relative/NREFM' are reviewed on a yearly basis. NRLG cases will be reviewed every six months.

The case carrying social worker, Foster Care nurse and foster parent will work together to develop a plan that details the specific responsibilities of the foster parent to address the child's special needs. The Specialized Care Plan will include the following areas; Medical, Developmental, Behavioral, Emotional, Educational and Social.

The social worker creates a preliminary specialized care plan document based on this collaboration.

It is not appropriate to pay SCR for behaviors, no matter how troublesome, which are age appropriate. For example, babies who are irritable because they are teething; toddlers who get into everything; two year olds who have tantrums; preschoolers who break toys, mark walls or furniture and may not be fully toilet trained or teenagers who don't want to help with chores and challenge authority. While these behaviors may present problems for the foster parent, they still fall within the range of normal behavior.

It is understood in the SCR system that the rate will be reviewed at renewal or on an as needed basis to assess the child's medical, behavioral and emotional needs. Social workers should stress to the foster parents that in most cases the SCR is not a permanent occurrence. Some degree of improvement is anticipated as an outcome of the foster parent's extra care and supervision, resulting in a lower SCR payment level. The Substitute Care Provider should be encouraged to view the decrease of the SCR as an indicator of their success in working with the child.

The SCR is not to be used to secure or keep a placement for a minor and is not to be negotiated with the foster care provider.

Group Homes and Foster Family Agency's Intensive Treatment Foster Care rates (ITFC) are determined through The ICMAT/System of Care Committee and not the Specialized Care Rate Review committee.

State regulations require that the specialized care rate be paid in effect in the jurisdiction where the child currently resides.

SCR cannot be paid for the following:

- Care and supervision for age-related problems.
- Day Care, Nursery school or child care required because the foster parent is employed.
- Private or parochial school tuition, fees, etc.
- Regular transportation to school, training or job.
- Medical transportation when this is the only element of extra care.
- Expenses covered through other sources such as Medi-Cal, service connected funds or California Children Services including respite.
- Cost of prescription medication, medical equipment, and medical or therapeutic services.
- Wear and tear on the home.
- Shelter homes.
- Group Homes and Foster Family Agencies.
- Secure or keep a placement for a minor.
- Not to be negotiated with the foster care provider.

PROCEDURES

SCR Clerk will:

- Review SCR tracking log to determine which children require an SCR assessment review.
- Check SCR intake folder for initial intake assessments requests.
- Create a tentative meeting schedule with the names of children, conference date and available block of times for SCR reviews.
- Send a tentative meeting schedule to the social workers and supervisors at least three weeks in advance with a request to respond with the time they would like. Slots will be filled on a first come first serve basis.

One week before Case conference:

- Send a reminder and a final meeting schedule to SW and SCR Coordinator.
- Check with EFAS regarding effective dates of Specialized Care Plan, the current placement information and address of child.
- Enter the above information on the MCDSS 837 B

One day before case conference:

- Send a reminder to the SW, SW supervisor and the SCR Coordinator.

Prepare packet for SCR coordinator with the following forms:

- Last year's specialized care plan
- Completed MCDSS 837B
- Copy of previous care plan for each committee member for reference.

The SCR clerk will also enter the following information into the log after the case conference:

- Last Name
- First Name
- DOB
- Social Worker
- Health
- Behavior
- Renewal Date
- Placement

Social Worker will:

- Confer with the foster parent and the foster care nurse to determine the child's special needs.
- Complete the F-C Out of Home Care Placement Assessment (MCDSS 837A) (Att. 1) located in CWS/CMS template section.
- Indicate whether this is an initial or an updated review.
- Forward the completed MCDSS 837A to the SCR Clerk.

Social Worker Assessment Meeting Attendance:

Social workers should make every effort to be available for the SCR assessment meeting. If a social worker is unable to attend, the social worker should ensure that a representative is sent to the meeting who has knowledge of the child and case.

If no representative is present at the meeting, the supervisor and program manager will be notified. The review will be postponed to the following month.

SCR Committee Responsibilities:

Review and makes final recommendations regarding the proposed SCR Care Plan (MCDSS 837A) using the rating system which is provided in the SCR MOU with the State.

SCR Coordinator will:

- Capture and give to SCR clerk any changes or recommendations in writing regarding the SCR Care Plan.
- Complete the MCDSS 837B including Foster Care Certification section including rate (see rate table on Pg 3.),
- Sign MCDSS 837B form and give to SCR clerk.

SCR Clerk will:

- Transfer information from MCDSS 837A to create a Specialized Care Plan document (MCDSS 837C)
- Enter rate on 837 B

Send to relative or Foster Family Home the following:

- One copy of SCR plan and 1 copy of cover letter with stamped return address, ATTN SCR clerk
- 2 copies of signed completed assessment form, B.

SCP will keep one copy and return on copy of form B

MCDSS 837B and 837C will also be given to:

- Social Worker
- EW
- SCR clerk

SCR Tracking Log

SCR Clerk will enter the following information into the log after the case conference:

- Last Name
- First Name
- DOB
- Social Worker
- Health
- Behavior
- Renewal Date
- Placement

Foster Care Eligibility worker will:

- Enter SCR information into ISAWS
- Send Notice of Action with effective date and amount of approved foster care payment and files copy in case.
- File MCDSS 837B in ISAWS case.

Basic Foster Family Home Rate with Specialized Care Rate effective January 1, 2008

	0-4 yrs	5-8 yrs	9-11 yrs	12-14 yrs	15-19 yrs
BASIC	\$446	\$485	\$519	\$573	\$627
MILD					
\$281	\$727	\$766	\$800	\$854	\$908
MODERATE					
\$495	\$941	\$980	\$1014	\$1068	\$1122
INTENSIVE					
\$635	\$1081	\$1120	\$1154	\$1208	\$1262



Mendocino County Health and Human Services Agency
Social Services

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Susana Wilson ♦ Branch Director

**Family and Children's Services Division
Becky Wilson, Deputy Director**

May 11, 2009

Placement Caregiver
200 Gardens Avenue
Ukiah, CA 95482

Dear Placement Caregiver,

Attached are two copies of a Foster Care Out-of-Home Care Placement Assessment authorizing a specialized rate for **child**. The authorized rate is from **5/6/09** to **11/30/09**.

The specialized care rate approved for this child is **\$1120.00 (\$485.00 + \$635.00)** per month. This authorized rate is for six months. This rate will be reviewed every six (6) months at your NRLG recertification and the rate may be subject to change at that time.

Please review the Specialized Care Plan. Then sign the Placement Assessment and return original signed Placement Assessment to me in the enclosed self-addressed stamped envelope.

Please note the specific interventions and services recommended for this child. The specialized care rate is provided to enable you to carry out or support these interventions and services as specified.

If you have any questions, please contact the child's Social Worker, Pat Atkinson, at 456-3732.

Sincerely,

Gretchen Lyne, PHN

Enclosures

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Recommended Placement:
Estimated Date of Placement:

Social Worker:	Date:
Supervisor:	Date:

PLACEMENT ASSESSMENT

Child:	Mendocino County HHSA Children's Services
Date Reviewed By Specialized Care Rate Committee	<input type="checkbox"/> Initial Review <input type="checkbox"/> Updated Review

DETERMINED LEVEL OF PLACEMENT

To Be Completed By Specialized Care Rate Committee:

- | | |
|--|--|
| <input type="checkbox"/> Basic Foster Care
<input type="checkbox"/> Health Related Specialized Care | <input type="checkbox"/> Behavior Related Specialized Care |
| <input type="checkbox"/> Mild
<input type="checkbox"/> Moderate
<input type="checkbox"/> Intensive | <input type="checkbox"/> Mild
<input type="checkbox"/> Moderate
<input type="checkbox"/> Intensive |

Effective Date:	To:
Placement:	
Address:	
HHSA Supervisor:	Date:

FOSTER CARE CERTIFICATION

I (We) have reviewed the description of _____ special needs and agree to provide the services as described and to accept the determined rate of \$ _____ per month.

I (We) understand that the child's progress and the rate will be reviewed at least every twelve months. The next review is scheduled for _____ .

Foster Parent Signature	Date
Foster Parent Signature	Date



Mendocino County Health and Human Services Agency
Social Services

"Creating a Community of Safe and Independent Families and Individuals"

Mary Elliott ♦ Branch Director

**Family and Children's Services Division
Rebecca Wilson, Deputy Director**

P.O. Box 839 727 South State Street Ukiah, CA 95482 Phone: 707-463-7900 Fax: 707-463-7979

SPECIALIZED CARE PLAN CHECKLIST

Child: _____

Foster Parent: _____

Information sent to Care Provider/Guardian:

- Original Specialized Care Plan
- Original Placement Assessment- to be signed and returned to Specialized Care Clerk
- Copy of Placement Assessment- to be retained by Care Provider
- Stamped return envelope (to return original, signed Placement Assessment)
- Letter to Care Provider/Guardian
- Date Mailed _____

Information sent to Social Worker

- Copy of Specialized Care Plan
- Copy of Placement Assessment- signed by Care Provider/Guardian and CHDP Nurse
- Copy of Letter to Care Provider/Guardian
- Date sent to Social Worker _____

Information sent to Eligibility Worker

- Copy of Placement Assessment 837. When original signed Placement Assessment is returned by Care Provider(s)/Guardian, give original signed document to Eligibility Worker
- Copy of Specialized Care Plan for NRLG/Guardianship Children
- Date Sent to Eligibility Worker _____

Information retained in Foster Child's Specialized Care Plan case folder

- Specialized Care Plan
- Placement Assessment signed by Care Provider(s)/Guardian and CHDP Nurse
- Copy of letter(s) to current/former Care Provider(s)/Guardian
- Notes from meetings

Information sent to Foster Care Nurse

- Specialized Care Plan
- Date Sent to Foster Care Nurse _____



Mendocino County Health and Human Services Agency
Social Services

"Creating a Community of Safe and Independent Families and Individuals"

Stacy Cryer ♦ Branch Director

**Family and Children's Services Division
Becky Wilson, Deputy Director**

Octubre 28, 2010

Foster Parent Address

Estimado Foster parent y Foster Parent,

Se adjuntan dos copias de la evaluación de la colocación de cuidado de crianza temporal fuera del hogar que autoriza una tarifa especial para **Child Name**. La tarifa autorizada es valida de **8/1/10** hasta **7/31/11**.

La tarifa de cuidado especializado aprobado para este niño es de **\$ 941.00 (\$446.00 + \$495.00)** por mes. La tarifa autorizada es de un año a partir de esta fecha. Habrá una nueva evaluación al final de este periodo y **la tasa estará sujeta a cambio en esa fecha.**

Por favor revise el Plan De Cuidado Especializado. Luego firmé la Evaluación de Colocación y regrese la copia original firmada en el sobre adjunto con mí dirección y estampilla.

Por favor, tenga en cuenta las intervenciones específicas y servicios recomendados para este niño. La tarifa de cuidado especializado se provee para que pueda llevar a cabo e apoyar estas intervenciones y servicios como se especifican.

Si usted tiene alguna pregunta, por favor póngase en contacto con la trabajadora social del niño SOCIAL WORKER, al PHONE NUMBER.

Atentamente,

Gretchen Lyne, PHN

Documento Adjunto: Evaluación de Colocación

747 S. State St. PO BOX 839 Ukiah, CA 95482 (707) 463-7900 FAX (707) 463:7979	825 S. Franklin St. PO BOX 1306 Fort Bragg, CA 95437 (707) 962-1102 FAX (707) 962:1110	WISC Center 221 S. Lenore Ave. Willits, CA 95490 (707) 456-3700 FAX (707) 456:3701	Willits Family Resource Center 221 C S. Lenore Ave. Willits, CA 95490 (707) 456-3710 FAX (707) 456:3735	Ukiah Family Resource Center 10 Cherry Ct. Ukiah, CA 95482 (707) 463-4018 FAX (707) 468:3492
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EVALUACIÓN DE COLOCACIÓN

Niño/a: CHILD NAME	Mendocino County HHSA Children's Services
Fecha de revisión por el Comité de Tarifas de Cuidado Especializado DATE	<input checked="" type="checkbox"/> Revisión Inicial <input type="checkbox"/> Revisión Actualizada

NIVEL DE COLOCACIÓN DETERMINADO

El Comité de Tarifas de Cuidado Especializado debe llenar esta parte del formulario:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Cuidado De Crianza Temporal Básico
<input checked="" type="checkbox"/> Cuidado Especializado Relacionado Con La Salud
<input type="checkbox"/> Leve
<input checked="" type="checkbox"/> Moderado
<input type="checkbox"/> Intenso | <input type="checkbox"/> Cuidado Especializado Relacionado con el Comportamiento
<input type="checkbox"/> Leve
<input type="checkbox"/> Moderado
<input type="checkbox"/> Intenso |
|---|--|

Fecha de Vigencia: 8/1/10	Hasta: 7/31/11
Colocación: FOSTER PARENT y FOSTER PARENT	
Domicilio: FOSTER PARENT ADDRESS	
Supervisor de HHSA:	Fecha:

CERTIFICACIÓN del CUIDADO DE CRIANZA TEMPORAL

Yo (Nosotros) hemos leído las necesidades especiales de CHILD NAME y nos comprometemos a proporcionar los servicios descritos y aceptamos la tarifa determinada de \$941.00 (\$446.00 + \$495.00) por mes.

Yo (Nosotros) entendemos que el progreso del niño y la tarifa se revisara al menos cada doce meses. La próxima revisión esta prevista para el 7/31/11.

Firma del padre de crianza temporal	Fecha
Firma del padre de crianza temporal	Fecha

SPECIALIZED CARE CHECKLIST – CHILD’S AGE 12 THROUGH 18 YEARS

CHILD’S NAME	D.O.B.	CASE NUMBER
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PHYSICAL CARE NEEDS

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 feeding 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/ureterostomy/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. 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"/> Frequent bouts of pneumonia or other lung diseases 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, Pulmanaid, Mist Tent, Broviac Catheter, Tracheostomy <input type="checkbox"/>
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"/>

Sub-Total

Sub-Total

Sub-Total

SPECIALIZED CARE CHECKLIST – CHILD’S AGE 12 THROUGH 18 YEARS

Child's Name	D.O.B.	CASE NUMBER
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EMOTIONAL CARE NEEDS

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 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"/>	<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 fire setting with damage to property <input type="checkbox"/>
SEXUAL BEHAVIOR	<input type="checkbox"/> Inappropriate; need 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 at least one hour <input type="checkbox"/>	<input type="checkbox"/> Child has serious attendance problems – frequently truant
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.
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"/>

_____ Sub-Total _____ Sub-Total _____ Sub-Total

**For each category such as “Seizures”, “Infectious Disease,” etc., only one level can be allowed (level 1, 2, or 3).
If more than 1 box is checked in each level, count only 1 in total.**

DRUGS AND ALCOHOL	LEVEL 1	LEVEL 2	LEVEL 3
	<input type="checkbox"/> Known or suspected exposure	<input type="checkbox"/> Known or suspected exposure physical/behavioral needs require more than usual care and/or supervision	<input type="checkbox"/> Verified prolonged exposure with physical/behavioral attributed to exposure
			<input type="checkbox"/> Newborn/infant who tests positive for heroin or other substance in blood stream
			<input type="checkbox"/> Displays symptoms of fetal alcohol syndrome

DOMESTIC VIOLENCE	LEVEL 1	LEVEL 2	LEVEL 3
	<input type="checkbox"/> Known or suspected exposure to the effects of domestic violence	<input type="checkbox"/> History of exposure to domestic violence and known or suspected exposure immediately prior to removal	<input type="checkbox"/> History of exposure to domestic violence. Child displays symptoms of trauma or acts out physically

SPECIALIZED CARE CHECKLIST – CHILD’S AGE 6 THROUGH 11 YEARS

Child's Name _____	D.O.B. _____	CASE NUMBER _____
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PHYSICAL CARE NEEDS

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
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 feeding 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/ureterostomy/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. 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"/> Frequent bouts of pneumonia or other lung disease requiring periodic hospitalization <input type="checkbox"/> BPO
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, Pulmanaid, Mist Tent, Broviac Catheter, Tracheostomy <input type="checkbox"/>
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"/>

SPECIALIZED CARE CHECKLIST – CHILD’S AGE 6 THROUGH 11 YEARS

Child's Name	D.O.B.	CASE NUMBER
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EMOTIONAL CARE NEEDS

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 starting fires with damage to property <input type="checkbox"/>
SEXUAL BEHAVIOR	<input type="checkbox"/> Inappropriate; need 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 and 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 at 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"/>
FR PRCPT. 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 - 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"/>

_____ Sub-Total _____ Sub-Total _____ Sub-Total

For each category such as “Seizures”, “Infectious Disease,” etc., only one level can be allowed (level 1, 2, or 3).

If more than 1 box is checked in each level, count only 1 in total.

DRUGS AND ALCOHOL	LEVEL 1	LEVEL 2	LEVEL 3
	<input type="checkbox"/> Known or suspected exposure	<input type="checkbox"/> Known or suspected exposure physical/behavioral needs require more than usual care and/or supervision	<input type="checkbox"/> Verified prolonged exposure with physical/behavioral attributed to exposure
			<input type="checkbox"/> Newborn/infant who tests positive for heroin or other substance in blood stream
			<input type="checkbox"/> Displays symptoms of fetal alcohol syndrome

DOMESTIC VIOLENCE	LEVEL 1	LEVEL 2	LEVEL 3
	<input type="checkbox"/> Known or suspected exposure to the effects of domestic violence	<input type="checkbox"/> History of exposure to domestic violence and known or suspected exposure immediately prior to removal	<input type="checkbox"/> History of exposure to domestic violence. Child displays symptoms of trauma or acts out physically

SPECIALIZED CARE CHECKLIST – CHILD’S AGE BIRTH THROUGH 5 YEARS

CHILD’S NAME	D. O. B.	CASE NUMBER
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PHYSICAL CARE NEEDS

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. 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"/> Takes 31 - 40 minutes to feed <input type="checkbox"/> Every 4 hours with night feeding	<input type="checkbox"/> Chokes or gags easily; frequent special handling or special food preparation needed <input type="checkbox"/> Increased risk for contracting, so should remain in home as much as possible <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"/> Requires feeding by N/G, GTT, JT and pump <input type="checkbox"/> Same as Level 2; <u>and</u> affecting adequate weight gain <input type="checkbox"/> Takes 51 + minutes to feed <input type="checkbox"/> Every 2 hours with night feedings
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 - 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"/> High SIDS risk	<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"/> Asthma <input type="checkbox"/>	<input type="checkbox"/> BPD <input type="checkbox"/>
SPECIALIZED EQUIPMENT	<input type="checkbox"/> Splints, cast, braces or positioning equipment apnea <input type="checkbox"/> Monitor	<input type="checkbox"/> Aspiration, Suctioning, Ventilator <input type="checkbox"/>	<input type="checkbox"/> Oxygen, Pulmonaid, Broviac catheter, Tracheostomy <input type="checkbox"/>
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; I 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 3; <u>and</u> requires special equipment for feeding, positioning, bathing, etc.

PROBLEM	LEVEL 1	LEVEL 2	LEVEL 3
SLEEP PATTERN (11:00 P.M. - 6:00 A.M.)	<input type="checkbox"/> Under 6 months of age <u>and</u> up 4 times/night <input type="checkbox"/> Over 6 month of age <u>and</u> up 2 times/night	<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
MUSCLE TONE	<input type="checkbox"/> Impacts on care <u>and/or</u> 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"/>
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"/>
OTHER	<input type="checkbox"/>		

_____ Sub-Total _____ Sub-Total _____ Sub-Total

**SPECIALIZED CARE CHECKLIST – CHILD’S AGE BIRTH THROUGH 5 YEARS
EMOTIONAL CARE NEEDS**

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 supervise regimented routine. <input type="checkbox"/>	N/A
ABNORMAL STRUCTURE/ SUPERVISION	<input type="checkbox"/> Child cannot play alone or with peer s for any period of time without adult supervision. Activities must be closely monitored <input type="checkbox"/>	<input type="checkbox"/> Child extremely anxious when not involved in structured activity; upset when change in routine. FP must provide 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"/> Daily 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"/> 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 OR PRE-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 behavior; 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 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 - 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"/>
DRUGS AND ALCOHOL	LEVEL 1	LEVEL 2	LEVEL 3
	<input type="checkbox"/> Known or suspected exposure	<input type="checkbox"/> Known or suspected exposure physical/behavioral needs require more than usual care and/or supervision	<input type="checkbox"/> Verified prolonged exposure with physical/behavioral attributed to exposure <input type="checkbox"/> Newborn/infant who tests positive for heroin or other substance in bloodstream <input type="checkbox"/> Displays symptoms of fetal alcohol syndrome

_____ Sub-Total

_____ Sub-Total

_____ Sub-Total

DOMESTIC VIOLENCE	LEVEL 1	LEVEL 2	LEVEL 3
	<input type="checkbox"/> Known or suspected exposure to the effects of domestic violence	<input type="checkbox"/> History of exposure to domestic violence and known or suspected exposure immediately prior to removal	<input type="checkbox"/> History of exposure to domestic violence. Child displays symptoms of trauma or acts out physically

SPECIALIZED CARE CHECKLIST – CHILD’S AGE BIRTH THROUGH 5 YEARS (CONT’D)

FOR CHILDREN UP TO 18 MONTHS OF AGE

BEHAVIOR	LEVEL 1	LEVEL 2	LEVEL 3
	MILD: Can be readily controlled with specialized intervention	MODERATE: Is difficult to control, but will respond to sustained specialized intervention	SEVERE: Requires almost continuous specialized intervention
IRRITABILITY: Poor state changes, prolonged periods of crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HYPERREFLEXA: Exaggerated startle reflex, a response to stimuli, arching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TREMORS Jerky movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
POOR SOCIAL INTERACTION: Poor eye contact, does not cuddle, not responsive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR CHILDREN OVER 18 MONTHS OF AGE

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

_____ **Sub-Total** _____ **Sub-Total** _____ **Sub-Total**



Mendocino County Health and Human Services Agency
Social Services

"Creating a Community of Safe and Independent Families and Individuals"

Stacy Cryer ❖ Branch Director

**Family and Children's Services Division
Rebecca Wilson, Deputy Director**

P.O. Box 839 727 South State Street Ukiah, CA 95482 Phone: 707-463-7900 Fax: 707-463-7979

SPECIALIZED CARE PLAN

CHILD:

Date:

Caregiver:

Social Worker:

Current Rate:

Page 1 of 2

1. Medical

•

2. Developmental

*

3. Behavioral

4. Emotional

*

5. Educational

*

6. Social

*

Specialized Care Rate Calculation

	Column 1	Column 2	Column 3
Total from all pages:			

Mild

- 3-5 items in Column 1 OR
- 1-3 items in Column 1 and 1 item in Column 2 OR
- 2-3 items in Column 2 OR
- 1 item in Column 2 and 1 in Column 3 OR
- 2 items in Column 3

Moderate

- 6 items in Column 1 OR
- 4-5 items in Column 1 and 1-3 in Column 2 OR
- 3-4 items in Column 2 OR
- 2 items in Column 2 and 2 in Column 3 OR
- 3 items in Column 3

Intensive

- 7+ items in Column 1 OR
- 5+ items in Column 1 and 4+ in Column 2
- 5+ items in Column 2 OR
- 3 items in Column 2 and 3 items in Column 3
- 4+ items in Column 3

Calculated Rate: _____

SCR Coordinator

Date