



CHILDREN AND FAMILY SERVICES

150 SOUTH LENA ROAD SAN BERNARDINO CA 92415-0515

COUNTY OF SAN BERNARDINO
HUMAN SERVICES

DEANNA AVEY - MOTIKEIT
DIRECTOR

San Bernardino County Specialized Care Rates (Effective 01/08)

TIER 1			
AGE	BASIC RATE	INCREMENT	TOTAL PER MONTH
0 – 4 Years	\$446	\$79	\$525
5 – 8 Years	\$485	\$79	\$564
9 – 11 Years	\$519	\$79	\$598
12 – 14 Years	\$573	\$79	\$652
15 – 18 Years	\$627	\$79	\$706

TIER 2			
AGE	BASIC RATE	INCREMENT	TOTAL PER MONTH
0 – 4 Years	\$446	\$184	\$630
5 – 8 Years	\$485	\$184	\$669
9 – 11 Years	\$519	\$184	\$703
12 – 14 Years	\$573	\$184	\$757
15 – 18 Years	\$627	\$184	\$811

TIER 3			
AGE	BASIC RATE	INCREMENT	TOTAL PER MONTH
0 – 4 Years	\$446	\$399	\$845
5 – 8 Years	\$485	\$399	\$884
9 – 11 Years	\$519	\$399	\$918
12 – 14 Years	\$573	\$399	\$972
15 – 18 Years	\$627	\$399	\$1,026

TIER 4			
AGE	BASIC RATE	INCREMENT	TOTAL PER MONTH
0 – 4 Years	\$446	\$525	\$971
5 – 8 Years	\$485	\$525	\$1,010
9 – 11 Years	\$519	\$525	\$1,044
12 – 14 Years	\$573	\$525	\$1,098
15 – 18 Years	\$627	\$525	\$1,152

TIER 5			
AGE	BASIC RATE	INCREMENT	TOTAL PER MONTH
0 – 4 Years	\$446	\$683	\$1,129
5 – 8 Years	\$485	\$683	\$1,168
9 – 11 Years	\$519	\$683	\$1,202
12 – 14 Years	\$573	\$683	\$1,256
15 – 18 Years	\$627	\$683	\$1,310

TIER 6			
AGE	BASIC RATE	INCREMENT	TOTAL PER MONTH
0 – 4 Years	\$446	\$840	\$1,286
5 – 8 Years	\$485	\$840	\$1,325
9 – 11 Years	\$519	\$840	\$1,359
12 – 14 Years	\$573	\$840	\$1,413
15 – 18 Years	\$627	\$840	\$1,467



GREGORY C. DEVEREAUX
County Administrative Officer

BRAD MITZELFELT First District
JANICE RUTHERFORD . Second District
JOSIE GONZALES.....Fifth District

Board of Supervisors

NEIL DERRY Third District
GARY C. OVITT Fourth District

COUNTY OF SAN BERNARDINO SPECIALIZED CARE RATE (SCR) PACKAGE

Introduction

If the child being considered for placement **does not** fit the criteria below, then the SW completes this SCR Package:

- Is within the normal range for physical development for his/her age
- Is within the normal range for emotional, social, behavioral development
- Shows the expected level of separation anxiety following the removal from home
- Presents only mild symptoms as a result of abuse/neglect experienced in the home
- Shows the expected degree of posttraumatic stress associated with experiencing any abuse/neglect
- Has no problems or very minor problems in the educational setting
- Has no medical problems or conditions except for the expected childhood illnesses, and/or other occasional illnesses, which are routinely treated by any pediatrician or any general or family practice physician
- Has the expected behavioral problems for the age and developmental level, and responds well to ordinary and reasonable parenting practices by the substitute care providers

Definition/Purpose of Specialized Care Rate (SCR)

The Specialized Care Rate (SCR) is a combination of the Basic Foster Care rate and the Specialized Care Increment (SCI). SCR is paid for children placed in:

- Licensed Foster Family Homes
- Licensed Small Family Homes (Tier 6 Only)
- Non-Related Legal Guardian Homes
- Approved Relative Homes
- Approved Non-Relative Homes

The purpose of the Specialized Care Rate (SCR) is to pay the care provider for the extra care needed for children with health and/or behavior problems.

Instructions

The CFS Social Worker obtains the Specialized Care Rate (SCR) for a child with special needs by completing the necessary forms for Assessment, Rate Determination and Payment Authorization.

Use the following forms to assess the child's special needs; determine the appropriate specialized care rate; document the Care Provider's agreement to provide specialized care/complete the required training; and, authorize the SCR payment.

SCR FORM	SIGNED/DATED BY...	COPY TO:
CFS 152 SCR Tier # Tier Assessment Checklist	NO signatures required (Date of Assessment, Care Provider Name, Address, Phone ONLY)	Original – CFS Case File Copy – Foster Care Unit Copy – SCR Facilitator
CFS 152-R SCR SCR Rates	NO signatures required; Rate Determination ONLY	NO copies required; Reference ONLY
DCS 152-A SCR SCR Letter of Agreement/ Training Requirements	– Care Provider – Social Worker	Original – Care Provider Copy – DCS Case File Copy – SCR Facilitator
CFS 152 SCR Specialized Care Rate (SCR) Payment Authorization	– Social Worker (All Tiers) – Supervisor (All Tiers) – SCR Facilitator (Tiers 4, 5 & 6)	Original – Foster Care Unit Copy – Care Provider Copy – CFS Case File Copy – SCR Facilitator
	For <i>retroactive</i> (SCR eligibility prior to the current calendar month) <i>payment</i> (All Tiers): – CWSM (Up to 6 months) – Deputy Director (More than 6 months)	
CFS 152-B SCR Documentation of Completed SCR Training	Care Provider at reassessment (no later than every twelve months or six months for medically fragile children)	Original – Care Provider Copy – CFS Case File Copy – SCR Facilitator

TIER 1 (SCI = \$79)

ASSESSMENT – SW REASSESSES CHILD **EVERY TWELVE (12) MONTHS**

Child's Name

DOB

For this Tier the child must have one or more of the behavioral or health conditions or a combination of both conditions listed below. **Diagnosis** and **Symptomology** are included in the description of the conditions. (Check ✓ all that apply.)

The SW may review Tier 2 for appropriateness if the child has more than two of the following behavioral or health conditions.

Behavior – Child requires **additional supervision** beyond basic care and direct services for emotional, mental, behavioral or developmental disability.

<input type="checkbox"/> Educational impairment (below grade or age-appropriate developmental level normal)	
<input type="checkbox"/> Mild and undiagnosed emotional, mental, behavioral or developmental disability	
<input type="checkbox"/> Care provider transports child to weekly therapy appointments, classes or rehabilitation program	
<input type="checkbox"/> Documented behavior including biting, hitting, and nighttime bedwetting age 3-5	
<input type="checkbox"/> Other:	
Frequency:	Duration:

Health – Child has **minimal** physical condition requiring medical follow-up, care and direct services. Child determined NOT to meet criteria for Special Health Care Needs.

<input type="checkbox"/> Care provider transports child to weekly medical and/or therapy appointments, classes or rehabilitation program	
<input type="checkbox"/> Mild asthma (Use of inhaler)	
<input type="checkbox"/> Small burns, first or second degree, (less than 2 inches in diameter) requiring dressing changes twice a day	
<input type="checkbox"/> Lice or scabies requiring disinfecting of the home	
<input type="checkbox"/> Special diet requiring minimal diet changes	
<input type="checkbox"/> Other:	
Frequency:	Duration:

_____ **Date of Assessment**

(Tier 1 requires 2 training sessions every 12 months. At least 1 must be Category A.)

Care Provider Name: _____

Care Provider Address: _____

Care Provider Phone: _____

(Required **CFS 152 SCR** approval signatures – **SW** and **SSSP**)

TIER 2 (SCI = \$184)

ASSESSMENT – SW REASSESSES CHILD **EVERY TWELVE (12) MONTHS**

Child's Name

DOB

For this Tier the child must have one or more of the behavioral or health conditions or a combination of both conditions listed below. **Diagnosis** and **Symptomology** are included in the description of the conditions. (Check ✓ all that apply.)

The SW may review Tier 3 for appropriateness if the child has more than two of the following behavioral or health conditions.

Behavior – Child requires **increased supervision** beyond basic care and direct services for emotional, mental, behavioral or developmental disability.

<input type="checkbox"/> Impaired psychological functioning, or judgment	
<input type="checkbox"/> Mild conduct or behavior problems, such as ADHD (including non-medicated)	
<input type="checkbox"/> Educational impairment below 2 grade levels	
<input type="checkbox"/> Other:	
Frequency:	Duration:

Health – Child has **mild** physical condition requiring medical follow-up, care and direct service. Child determined NOT to meet criteria for Special Health Care Needs.

<input type="checkbox"/> Cast for hairline fracture or limb injury	
<input type="checkbox"/> Routine supervision and administration of prescribed medication and/or preparation of a medically prescribed special diet to treat mild medical conditions (including, but not limited to, premature infants); Monitoring of medication for side effects and/or biweekly medical appointments	
<input type="checkbox"/> Participation and related services/activities at home for medical treatment or therapy programs (physical, speech, etc.)	
<input type="checkbox"/> First and second degree burns larger than 2 inches in diameter requiring dressing changes at least twice a day	
<input type="checkbox"/> Weight management (above or below 15 – 20 pounds) and dietary issues (food allergies)	
<input type="checkbox"/> Other:	
Frequency:	Duration:

Date of Assessment

(Tier 2 requires 4 training sessions every 12 months. At least 2 must be Category A.)

Care Provider Name: _____

Care Provider Address: _____

Care Provider Phone: _____

(Required **CFS 152 SCR** approval signatures – **SW** and **SSSP**)

TIER 3 (SCI = \$399)

ASSESSMENT – SW REASSESSES CHILD EVERY TWELVE (12) MONTHS

Child's Name

DOB

For this Tier the child must have one or more of the behavioral or health conditions or a combination of both conditions listed below. **Diagnosis** and **Symptomology** are included in the description of the conditions. (Check ✓ all that apply.)

The SW may review Tier 4 for appropriateness if the child has more than two of the following behavioral or health conditions.

Behavior – Child requires **close supervision** beyond basic care and direct services for emotional, mental, behavioral or developmental disability.

<input type="checkbox"/> Child requires assistance with eating, dressing or personal hygiene beyond age-appropriate expectations	
<input type="checkbox"/> Serious conduct or behavior problems, such as ADHD (including non-medicated)	
<input type="checkbox"/> Intensive care due to cyclical emotional problems or developmental delay	
<input type="checkbox"/> Enuresis (Ages 5 – 8)	
<input type="checkbox"/> Other:	
Frequency:	Duration:

Health – Child has **moderate** physical condition requiring medical care and direct services and may require specific training of care providers prior to placement. Child determined NOT to meet criteria for Special Health Care Needs.

<input type="checkbox"/> Daily assistance with walking because of braces or wheelchair or dependency on a cane or similar prosthetic device	
<input type="checkbox"/> Close observation and medical care due to neurological and health problems or apnea monitor (for premature infant)	
<input type="checkbox"/> Moderate asthma (requiring medication)	
<input type="checkbox"/> Temporary medical condition rendering the child incapable of age-appropriate self-care or small child in a body cast	
<input type="checkbox"/> Communicable disease requiring close observation, medication and/or weekly medical visits	
<input type="checkbox"/> HIV+	
<input type="checkbox"/> Other:	
Frequency:	Duration:

Date of Assessment

(Tier 3 requires 6 training sessions every 12 months. At least 3 must be Category A.)

Care Provider Name: _____

Care Provider Address: _____

Care Provider Phone: _____

(Required **CFS 152 SCR** approval signatures – **SW** and **SSSP**)

TIER 4 (SCI = \$525) NON-SHELTER CARE

ASSESSMENT – SW REASSESSES CHILD EVERY TWELVE (12) MONTHS

Child's Name

DOB

For this Tier the child must have one or more of the behavioral or health conditions or a combination of both conditions listed below. **Diagnosis** and **Symptomology** are included in the description of the conditions. (Check ✓ all that apply.) **DIAGNOSIS REQUIRED**

The SW may review Tier 5 for appropriateness if the child has more than two of the following behavioral or health conditions.

Behavior - Child requires **frequent supervision**, training and personal care by the care provider because of physical handicaps, developmental disability or delay, impaired judgment, or adjustment difficulties due to separation and loss.

<input type="checkbox"/> Oppositional behavior such as trancies, aggressive behavior, sexualized activities, runaway behavior and/or active interest in pursuing gang activities	
<input type="checkbox"/> Antisocial behaviors, such as: stealing, fighting and substance abuse	
<input type="checkbox"/> Diagnosed condition such as eating disorders, hyperactivity, attention deficit, enuresis or encopresis, depression and expressed suicidal ideation	
<input type="checkbox"/> Frequent supervision due to a deficit in social skills such as aggressiveness with peers, poor hygiene, low insight into problems, rejection of rules requiring behavior modification	
<input type="checkbox"/> Other:	
Frequency:	Duration:

Health - Child has a **complex** documented medical condition requiring the care provider to receive specific medical training, which must be conducted and coordinated by trained medical personnel.

<input type="checkbox"/> Documented medical diagnosis which requires frequent supervision, follow-up/monitoring and frequent interventions	
<input type="checkbox"/> At-risk diagnosis requiring monitoring of deviations from normal growth and development	
<input type="checkbox"/> Exhibits frequent episodes of apnea bradycardia requiring apnea monitor and observation	
<input type="checkbox"/> Multiple oral medications that require monitoring, recording and frequent medical supervision	
<input type="checkbox"/> Requires a restricted diet/formula with specialized preparation and supervision of food intake	
<input type="checkbox"/> Requires weekly therapy appointments (speech therapy, physical therapy, occupational therapy) with foster parent performing daily at home therapeutic interventions	
<input type="checkbox"/> Unstable medical condition which requires intermittent oxygen and close assessment and monitoring	
<input type="checkbox"/> Infant is irritable, poor nippler and exhibits poor self-calming and reciprocal responses to caretaker	
<input type="checkbox"/> Diagnosed reflux that is controlled by special handling and medication	
<input type="checkbox"/> Other:	
Frequency:	Duration:

Date of Assessment

(Tier 4 requires 8 training sessions every 12 months. At least 4 must be Category A.)

Care Provider Name: _____

Care Provider Address: _____

Care Provider Phone: _____

(Required **CFS 152 SCR** approval signatures – **SW, SSSP** and **SCR Facilitator**)

TIER 5 (SCI = \$683)

ASSESSMENT – SW REASSESES CHILD EVERY TWELVE (12) MONTHS

Child's Name

DOB

For this Tier the child must have one or more of the behavior or health conditions or a combination of both conditions listed below. **Diagnosis** and **Symptomology** are included in the description of the conditions. (Check ✓ all that apply.) **DIAGNOSIS REQUIRED**

The SW may review Tier 6 for appropriateness if the child has more than two of the following behavioral or health conditions.

Behavior - Child requires **extensive supervision**, training and personal care because of acute physical handicaps, psychological impairment, developmental disability or delay, severely impaired judgment

<input type="checkbox"/> Emotionally impaired diagnosis requiring frequent supervision or specialized parenting or behavior modification due to socially irresponsible self-destructive or self-esteem issues, suicide ideation with attempts	
<input type="checkbox"/> Lacks ability to accomplish basic age appropriate social skills such as the use of bathroom facilities, grooming, dressing self, etc.	
<input type="checkbox"/> Requires supervision to prevent harm to self or others as directed by therapist	
<input type="checkbox"/> Diagnosed eating disorders which require weekly therapy and supervision	
<input type="checkbox"/> Substance abuse (Free from current usage but is influenced by peer pressure or poor self-esteem)	
<input type="checkbox"/> Diagnosed hyperactivity, impulsivity and/or inability to concentrate on age-appropriate tasks	
<input type="checkbox"/> Diagnosed oppositional behavior, unwilling to follow house rules, aggressive with care providers and peers, runaway behavior and/or behavior leading to failed placements	
<input type="checkbox"/> Other:	
Frequency:	Duration:

Health – Child has a **severe** documented medical condition requiring the care provider to receive specific medical training that must be conducted and coordinated by trained medical personnel

<input type="checkbox"/> Documented medical diagnosis of at-risk condition requiring monitoring and extensive daily interventions	
<input type="checkbox"/> Has an ileostomy, vesicostomy, colostomy or other bowel and bladder modification(s) that requires constant care	
<input type="checkbox"/> Speech, physical or occupational therapy appointments more than once per week <u>and</u> at-home therapeutic interventions more than once per day	
<input type="checkbox"/> Highly restricted diet requiring specialized preparation and complex supervision of food intake	
<input type="checkbox"/> Uninterrupted oxygen that necessitates continuous assessment, monitoring and occasional oxygen level changes	
<input type="checkbox"/> Multiple oral or injectable medications necessitating continuous monitoring and recording with frequent medical follow-up (i.e.: diabetes & epilepsy)	
<input type="checkbox"/> Active HIV, Hepatitis (A, B and C) with medication and treatment	
<input type="checkbox"/> Intermittent gastrointestinal tube feedings and continuous attempts to nipple feed (such feeding methods and intake directly relate to infant's weight gain, which must be closely monitored)	
Frequency:	Duration:

Date of Assessment

(Tier 5 requires 10 training sessions every 12 months. At least 5 must be Category A.)

Care Provider Name: _____

Care Provider Address: _____

Care Provider Phone: _____

(Required **CFS 152 SCR** approval signatures – **SW, SSSP** and **SCR Facilitator**)

TIER 6 (SCI = \$840)

ASSESSMENT – SW REASSESSES CHILD EVERY TWELVE (12) MONTHS

Child's Name

DOB

For this Tier the child must have one or more of the behavioral or health conditions or a combination of both conditions listed below. **Diagnosis** and **Symptomology** are included in the description of the conditions. (Check ✓ all that apply.) **DIAGNOSIS REQUIRED**

If the child has more than two of the following behavioral or health conditions, the SW may review and consider placement alternatives with the SSSP.

Behavior - Child requires **constant supervision** and personal care because of severe physical handicaps, developmental disability or delay or severe judgment impairment that may endanger self or others

<input type="checkbox"/> Diagnosed emotional disturbance requiring therapeutic supervision to prevent child from serious self-destructive behavior	
<input type="checkbox"/> Diagnosed emotional condition in conjunction with a suicide attempt within the past year	
<input type="checkbox"/> Ongoing therapy in conjunction with therapeutic assistance from care provider	
<input type="checkbox"/> Constant therapeutic supervision due to diagnosed oppositional/aggressive behavior with others	
<input type="checkbox"/> Eneuretic OR encopretic behaviors in both awake and sleep hours	
<input type="checkbox"/> Diagnosed eating disorder with a physical impact requiring psychotherapy and constant monitoring	
<input type="checkbox"/> Current substance abuse	
<input type="checkbox"/> Diagnosed hyperactivity managed by medication and constant specialized care by care providers	
<input type="checkbox"/> Fire setting that endangers self or others	
<input type="checkbox"/> Sexually acting out behavior that endangers self or others	
<input type="checkbox"/> Other:	
Frequency:	Duration:

Health - Child has an **extreme** documented medical condition requiring the foster parent to receive specific medical training, which must be conducted and coordinated by trained medical personnel

<input type="checkbox"/> Documented medical diagnosis that requires exceptional interventions and monitoring (Interventions are sophisticated in nature and without this level of monitoring, condition would be serious, life threatening risk)	
<input type="checkbox"/> Continuous oxygen (Oxygen requirements are unstable and demand infrequent level changes; condition requires ongoing monitoring and close medical supervision)	
<input type="checkbox"/> Central intravenous line requiring daily care, assessment and monitoring with close medical supervision	
<input type="checkbox"/> Total parental nutrition (TPN) requiring intensive care and supervision	
<input type="checkbox"/> Renal dialysis	
<input type="checkbox"/> Tracheostomy	
<input type="checkbox"/> Requires a suction machine for oral and deep suctioning on an as-needed basis that demands continuous assessment and supervision	
<input type="checkbox"/> Dependency on frequent bladder catheterization requiring continuous assessment	
<input type="checkbox"/> Severe asthma, uncontrolled seizures and epilepsy (diagnosed)	
<input type="checkbox"/> Diagnosed medical condition requiring constant gastrointestinal tube feedings	
<input type="checkbox"/> Other:	
Frequency:	Duration:

Date of Assessment

(Tier 6 requires 12 training sessions every 12 months. At least 6 must be Category A.)

Care Provider Name: _____

Care Provider Address: _____

Care Provider Phone: _____

(Required **CFS 152 SCR** approval signatures – **SW, SSSP** and **SCR Facilitator**)

APPROVAL - SPECIALIZED CARE RATE (SCR) PAYMENT AUTHORIZATION

(ATTACH appropriate Tier Assessment Worksheet.)

Child's Name (PRINT)	DOB	AFDC-FC #
Care Provider Name: _____		
Mailing Address: _____		
City/State/Zip: _____		

SCR needed for:		
<input type="checkbox"/> 12 months	<input type="checkbox"/> Less than 12 months	<input type="checkbox"/> 6 months (Special Health Care Needs – SHCN)
From _____ To _____		

<input type="checkbox"/> Initial Authorization	<input type="checkbox"/> Change of Placement
<input type="checkbox"/> Re-Authorization	<input type="checkbox"/> Reassessment <input type="checkbox"/> Retroactive

Tier #	<input type="checkbox"/> 1 (SCI = \$79)	<input type="checkbox"/> 2 (SCI = \$184)	<input type="checkbox"/> 3 (SCI = \$399)
	SW PRINT/SIGN		OFFICE/PHONE _____ Date _____
	SSSP PRINT/SIGN		Date _____

Tier #	<input type="checkbox"/> 4 (SCI = \$525)	<input type="checkbox"/> 5 (SCI = \$683)	<input type="checkbox"/> 6 (SCI = \$840)
	SW PRINT/SIGN		OFFICE/PHONE _____ Date _____
	SSSP PRINT/SIGN		Date _____
	SCR FACILITATOR PRINT/SIGN		Date _____

Retroactive Approval (SCR eligibility prior to the current calendar month):	
<input type="checkbox"/> SCR required retroactive to (Date) _____	
Explain: _____	
<input type="checkbox"/> Up to 6 Months Retroactive	<input type="checkbox"/> More than 6 Months Retroactive
CWSM PRINT/SIGN	CFS Deputy Director PRINT/SIGN
Date	Date

Distribution: Original – FC Unit
 Copy – Care Provider
 Copy – CFS Case File
 Copy – SCR Facilitator

SAN BERNARDINO COUNTY CHILDREN AND FAMILY SERVICES
DOCUMENTATION OF COMPLETED SCR TRAINING
(Los Angeles County "D" and "F" Rate trainings are accepted by San Bernardino County.)

The required SCR training sessions specified on the **CFS 152-A SCR** and described below have been completed by:

Care Provider Name (PRINT): _____

These SCR training sessions meet the needs of:

Child's Name (PRINT): _____

Date: _____ Training Provided By: _____ Agency: _____ Telephone: _____ Type/Description of Training Completed: _____ _____ Signature of Trainer: _____ Title: _____
Date: _____ Training Provided By: _____ Agency: _____ Telephone: _____ Type/Description of Training Completed: _____ _____ Signature of Trainer: _____ Title: _____
Date: _____ Training Provided By: _____ Agency: _____ Telephone: _____ Type/Description of Training Completed: _____ _____ Signature of Trainer: _____ Title: _____
Date: _____ Training Provided By: _____ Agency: _____ Telephone: _____ Type/Description of Training Completed: _____ _____ Signature of Trainer: _____ Title: _____
Date: _____ Training Provided By: _____ Agency: _____ Telephone: _____ Type/Description of Training Completed: _____ _____ Signature of Trainer: _____ Title: _____
Date: _____ Training Provided By: _____ Agency: _____ Telephone: _____ Type/Description of Training Completed: _____ _____ Signature of Trainer: _____ Title: _____
Date: _____ Training Provided By: _____ Agency: _____ Telephone: _____ Type/Description of Training Completed: _____ _____ Signature of Trainer: _____ Title: _____

List all training on this form plus attach Certificates for Category A training to meet the Tier requirements.

Care Provider Signature: _____ **Date:** _____