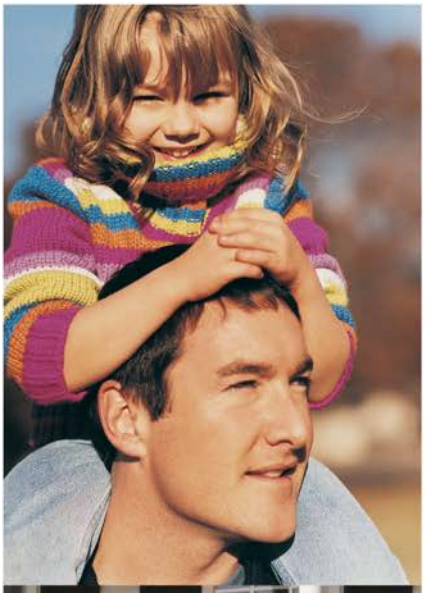

Resource Center for Family-Focused Practice

Level of Care **Rate Determination Protocol** Training for Trainers

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Resource Center for Family-Focused Practice

Level of Care **Rate Determination Protocol** Training for Trainers

Course Description

A new rate structure for Home-Based Foster Care (HBFC) was necessitated with the passage of the Continuum of Care Reform (CCR). In response, a Level of Care (LOC) Protocol has been developed for use by county child welfare and probation placement workers. A LOC matrix using five domains (Physical, Behavioral/Emotional, Health, Educational and Permanency/Family Services Domain), separately scored, and designed to promote best practices in meeting the individual needs of children/youth in the foster care system. The LOC matrix allows staff to use a strengths-based approach using current resources to identify the individual needs of foster children and matching those needs to a (HBFC) rate, including if applicable, an Intensive Services Foster Care (ISFC) rate, to support a placement in a family setting. This is a move away from rates determined based on the age of the child/youth.

The participants for this training for trainers' will receive materials to support their county in implementation of the Level of Care Matrix These resources will include a PowerPoint presentation, trainer notes, vignettes and activities for practice, resources and a review of the considerations counties may want to consider when implementing this tool.

Upon completion of the Training for Trainers Participants will be able to:

- describe the five domains on the LOC Matrix, and when to apply the rate using the static criteria
- complete the Level of Care Matrix and demonstrate use during class activities
- identify the available materials and resources to use in the completion of the LOC Matrix
- given the materials provided, create a plan for the delivery of a training to agency or other county staff on the intent, completion and scoring of the LOC and consider implications of county specific practice

Audience

The goal of this training for trainers is to provide counties with training material and knowledge to support internal capacity to train on the newly created Level of Care Matrix. Participants should include county level trainers, experienced placement workers and officers and regional training academy staff. Participants are expected to provide training and procedural support in their counties to maximize county specific implementation efforts. Participants should make every effort to be informed of their current practice in rate establishment, rate approval, protocols for authorizing payment or challenging recommended rates.

Instructors

John Dufresne, Program Manager, Resource Family Support (RFS)/WRAP/Mental Health/Substance Abuse/DV/Family Drug Court/Emergency Response, Fresno County Department of Social Services

Bridgette Hernandez, MSW, MS, Regional Manager, Riverside County Department of Public and Social Services, Children's Services Division, Centralized Placement Region

Ahmed Nemr, Social Service Consultant III, Continuum of Care Reform Branch, California Department of Social Services

Dr. Shauna Rossington, DBA, LMFT (Nevada & Oregon), Executive Director, Mountain Circle Family Services, Inc.

Rachel Swaykos, Policy Analyst, Child Welfare Services, Policy and Program Support, County of San Diego Health and Human Services Agency

Cheryl Treadwell, Chief, Foster Care Audits and Rates Branch, California Department of Social Services

Steven Wells, Protective Services Supervisor, Child Welfare Services, County of San Diego Health & Human Services Agency

Acknowledgement

Without the efforts of the following groups, county agencies and staff, this project would not have been completed or have the input needed to support the work child welfare and juvenile probation does on behalf of children and families.

Child Welfare Directors Association

County Behavioral Health Directors Association

Fresno County Child Welfare

Glenn County Child Welfare

Humboldt County Child Welfare

Los Angeles County Child Welfare

Mariposa County Child Welfare

Riverside County Child Welfare

Riverside County Juvenile Probation

Santa Clara County Juvenile Probation

San Diego County Child Welfare

Solano County Juvenile Probation

Dr. Rossington, Mountain Circle Family Services, Inc.

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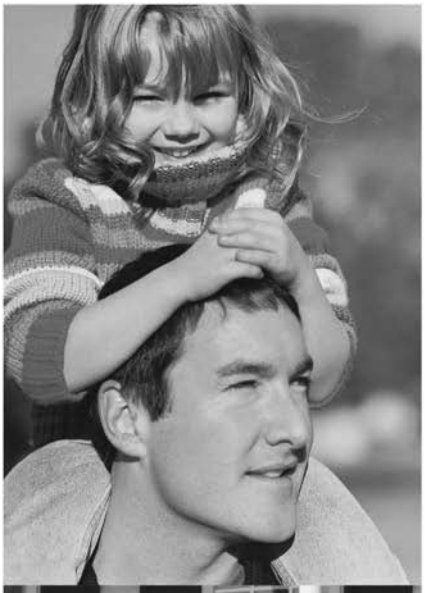

Resource Center for Family-Focused Practice

Level of Care **Rate Determination Protocol** Training for Trainers

Powerpoint & Notes

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This training is for the designated representatives from individual counties and other partners who are supporting the implementation for the Level of Care (LOC) overview, scoring matrix tool and scoring process

- Todays presentation will be an adapted version to participants for their use in training.
- Participants are asked to indicate on the various posters around the room to indicate there level of knowledge in the following areas allowing trainers at a glance to determine where their emphasis is needed
    - Providing training
    - Knowledge on the intent of CCR
    - Domains on many of the assessment tools used
    - Knowledge of their county's current processes and procedures to assign a rate for resource families and/or the FFA if relevant..

- Materials provided for each participant are in the bound booklet: They include:
    - PowerPoint
    - Trainers key points
    - Resources
    - Suggested activities and materials

Each participant will also have pro

- Also provided for each session include:
    - A copy of the Acceptability Study as a resource to answer questions
    - Posters representing CCR

- Thank participants for their willingness to support the CCR efforts on behalf of the children, you and family they serve.

- Provide participant information such as directions to the restroom, food locations, breaks and other logistic.

- Ask them to complete the activity indicating knowledge on topics during the break.

❖ A copy of the agenda and training day should be provided to participants

❖ These are included in the trainers resource section and include:

LOC Rate Protocol Instruction Guide

Level of Care Matrix Tool (legal size)

Level of Care Matrix Tool scoring sheet

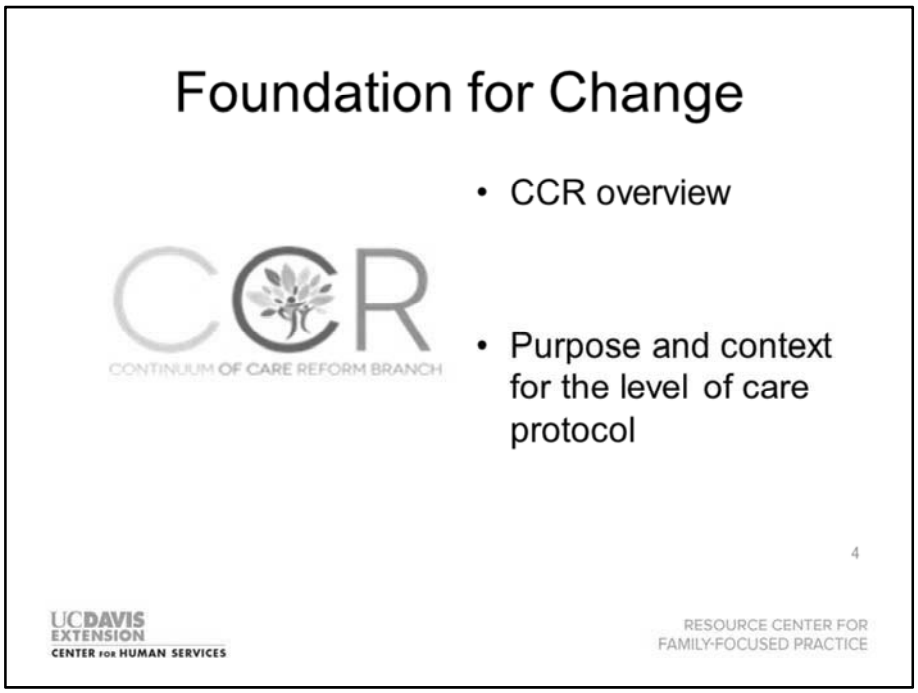
Resource Family Reporting Tool

Probation vignettes

CWS vignettes

County worksheet

All County Letters: 16-84 for CFT's, 16-79 and 17-11

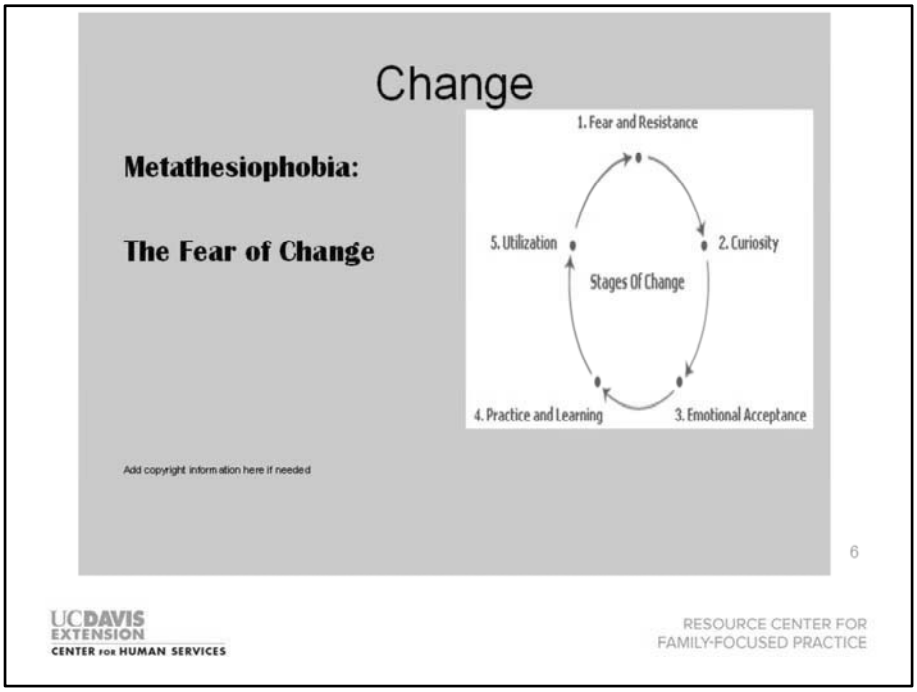


- CCR legislation and intent to align the rating system with the intent to reduce congregate and support the use of:
  - family like settings,
  - Strength-based approach,
  - Standardized,
  - Support care expecttions for resource families

- This process is standardized as much as possible. However, it may result in case carrying staff having a larger role in supporting the establishment of a rate. It is ESSENTIAL to use the resources available assessments, cft meetings, professionals or team input, file documentation and the resource parent tool as much as possible to mitigate concerns or actions that result in increased workloads or stress. The tool mimics the intent of CCR that all things done on behalf of the child and family is made with their input and as a team. The establishment of the rate is the same.

- Trainers should message here and all throughout the training that this tool is a shift in the criteria to establish a rate. It DOES NOT require a change in the policy and procedures individual counties use for rate setting. It ma be a good time to do so but the intent is to minimize the impact on county staff. A discussion at the end of the training will allow for individual conversations to occur.

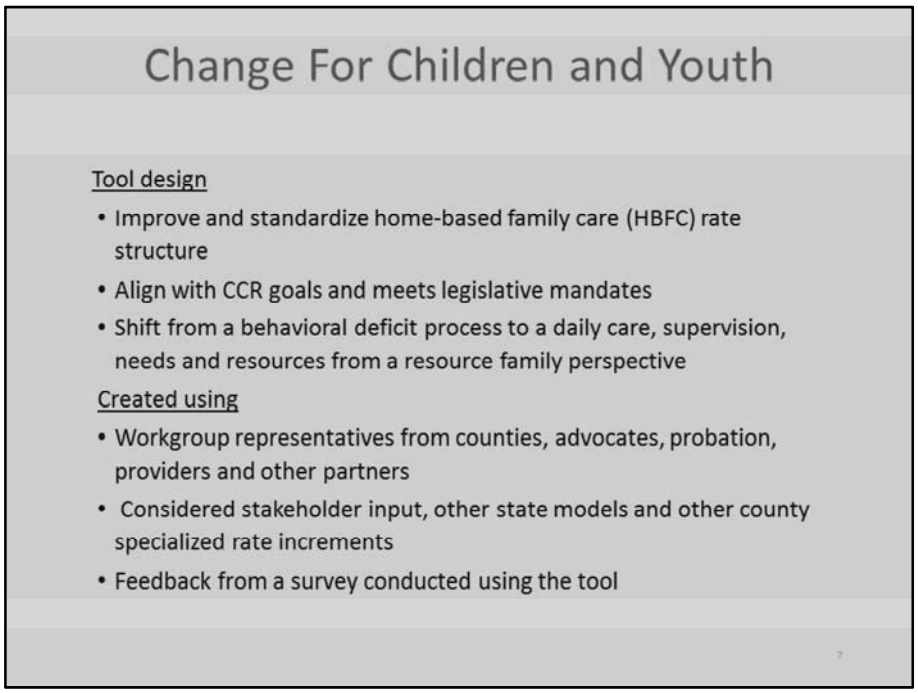
- PROVIDE THE COUNTY WORKSHEET HANDOUT AND ASK PARTICIPANTS TO REVIEW AND CONSIDER AS THEY HEAR THE INFORMTION.



What does “metathesiophobia” mean? The origin of the term is Greek, meta- meaning “change” and -phobos meaning “fear.” Simply stated, this is the fear of change. We all have fear of change on some level. With change, we generally experience two conflicting emotions: we feel excitement at the prospect of something new and different, while simultaneously experiencing a feeling of resistance. We naturally resist change because we fear what we don’t know and this change is a big unknown.

How many were on Facebook in 2009? How many times has Facebook gone through a facelift, or the iPhone? We all groan, say we hate it, and now how many of you even remember how these entities worked or operated? And probably now that we have adjusted to the change, we probably would say, “Yes, this is way better!”

There is a big idea here– better services for children, youth, and families. These services will be generated through the Child and Family Team meetings, which is the cornerstone to the LOC matrix tool. The CFT is about us remembering that the individuals who will be sitting in that room, birth families, resource families, case managers from the FFAs, teachers, therapist, CWS and Probation workers all know something we do not, which this is hard for us social workers to hear, because we are “know-it-alls.” Birth familes will have knowledge about what motivates their family dynamics, resource parents will know what motivates children and youth to change, and so on and so on. Enter these CFTs with open minds, as allies, as advocates. We are entering an era of changing outcomes for children, youth, and families in California and it is a radical change. There will be the nay-sayers, but be the voice which will embrace this change and give hope, because change starts with hope, hope is the intent of CCR, and if we do this we will have changed outcomes for the next generation and generations to come because of what will happen in this room today. Understand your fear and resistance, embrace your curiosity and emotional acceptance, find determination in practice and learning, and whole heartedly implement utilization. This is my charge to each and everyone one of you sitting in this room today.

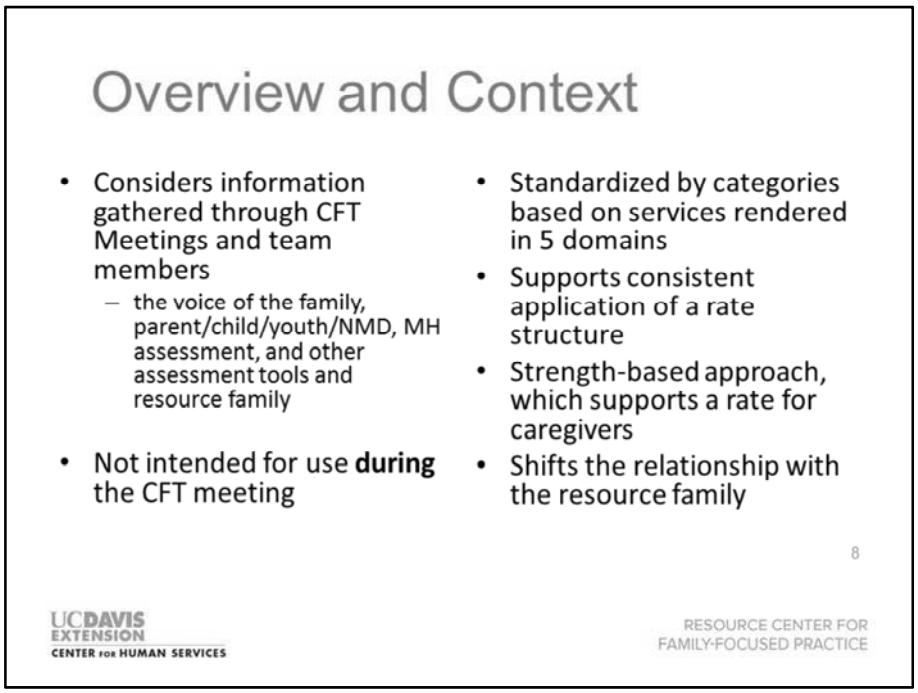


❖ Tool and rate setting is designed to support consistent state-wide application of a rate structure. Previously rates were based on age of child/youth and increases in rates were determined by counties. This resulted in over 50 various models.
- Now provides standardized categories across all levels of care and across the state
- Updates the 31 year old rate assignment process we are currently using.
- Clean up legislation is pending

❖ CCR goal to reduce congregate care use by ensuring services are available to children in home based family care based.
- This new tool:
  - Allows for rates to be increased if a resource family is willing to provide a **broader range of services**
  - Is **strength based** and supports a rate for caregivers based on what the caregiver can or will do to meet the child's unique needs
  - Provides a rate to support **enrichment activities** and unique needs of the child.
  - Based on the needs of the child and is **flexibility** for individual children.

❖ Is designed to draw from information from case carrying or resources already in use in counties. This includes information from other CFT, MH assessment and other assessment tools (SDM, Family Strengths and Needs, PACT, TOPS, CANS, Jais, depression scales, etc.) The goal is to identified the rate necessary to support the daily care needs for each child considering their unique situation.

❖ **Trainer note**: it is important at this time to ensure the audience understands that this a is change in the way rates are determined to attend to the intent of the CCR. It is tailored to each child and in context with the capacity and resources available with each resource family.



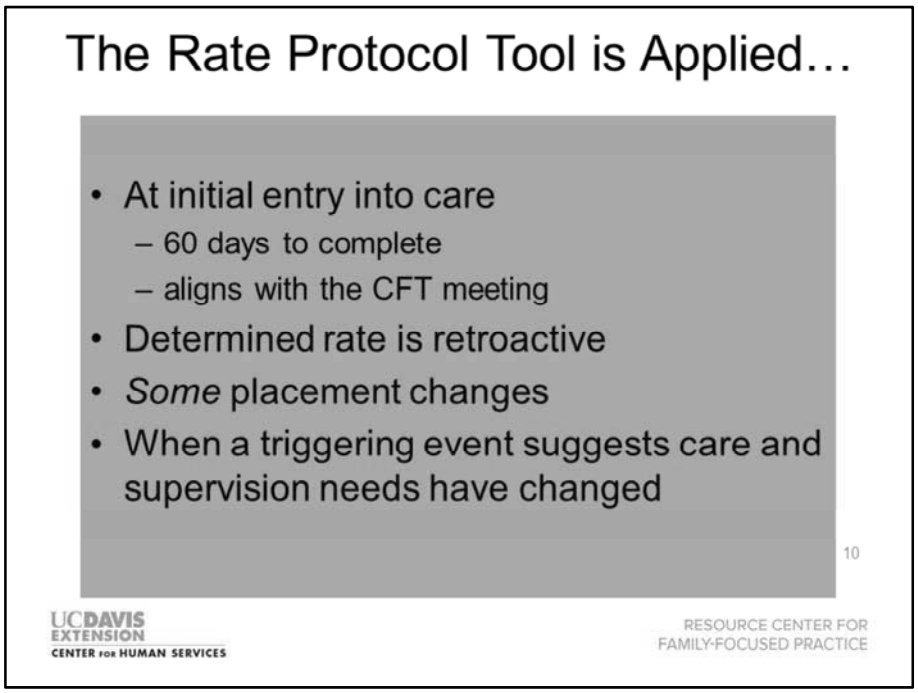
- The goal is to identify the rate necessary to support the daily care need for each child/youth considering their unique situation
- Aligns with the full range of resources and documentation to inform on the completion of the rate setting tool.
- Provides a for rationale for resource parents to inform on the daily needs of the child/youth more frequently allowing for a better understanding of needs and strengths
- Is designed to draw from information from case carrying or resources already in use in counties. This includes information from:
    - CFT meetings and team,
    - Aligns with MH assessment and other assessment tools (SDM, Family Strengths and Needs, PACT, TOPS, CANS, Jais, depression scales, etc.) range of resources and documentation to support the rate determination

What Placements are Impacted?

Any resource family providing a home-based family care

- County foster homes
- Foster Family Agency homes
- Relative caregivers
- Non-minor dependents
- Medically fragile children/youth

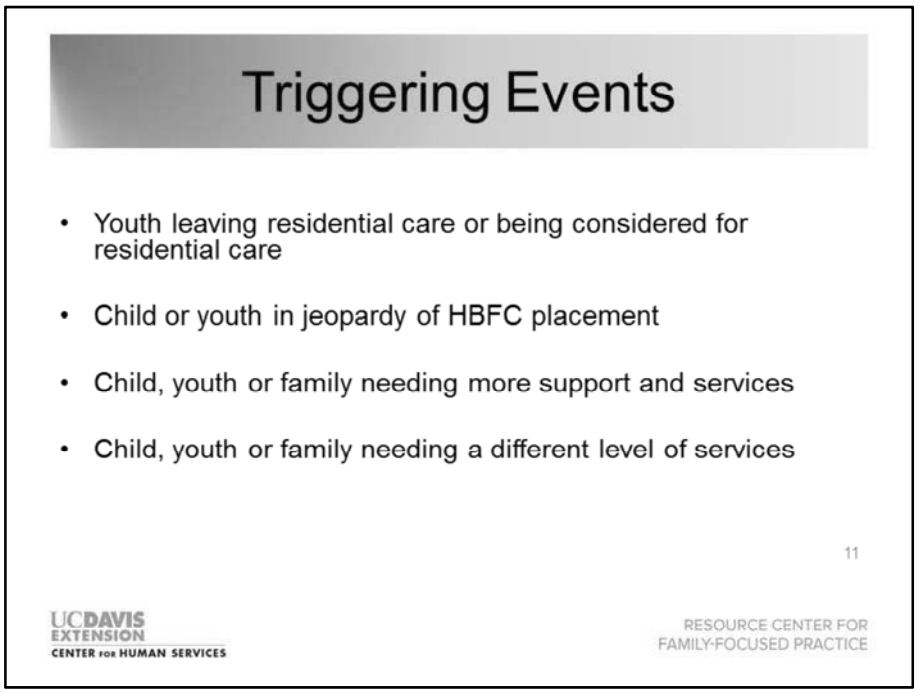
- The rate applies to all circumstances that the county provides foster care funding for a home-like setting.
- It DOES NOT APPLY to homes identified and paid solely through other agencies. Examples: regional centers or juvenile hall placement prior to court adjudication.
- When assessing where to place a youth being moved from juvenile hall, it may be appropriate to use, if enough information is known.



❖ Examples of placement changes include: moving to FFA age-based rate, FFH to another, stepping down from ISFC or STRTP)

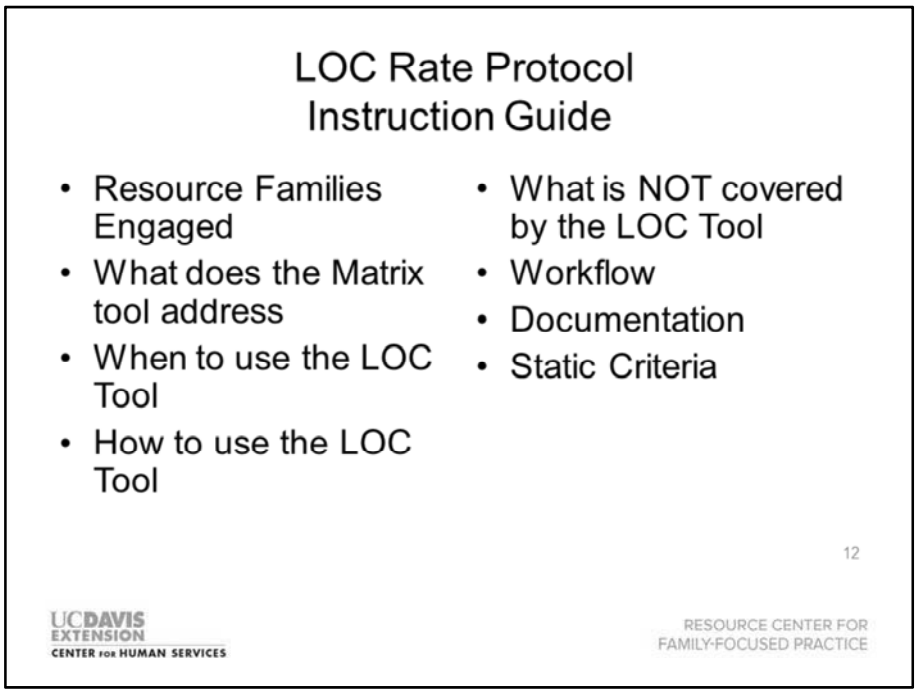
❖ The introduction of the rate setting is being staged into implementation. There is NO NEED to use the LOC matrix tool unless this is a new placement or if there is a triggering event.

This will be discussed next



❖ Similar to the events that would trigger a CFT meeting.

❖ **A good time to pause and ask questions to ensure understanding**



The level of care matrix rate setting tool is designed to engage resource families to provide input.

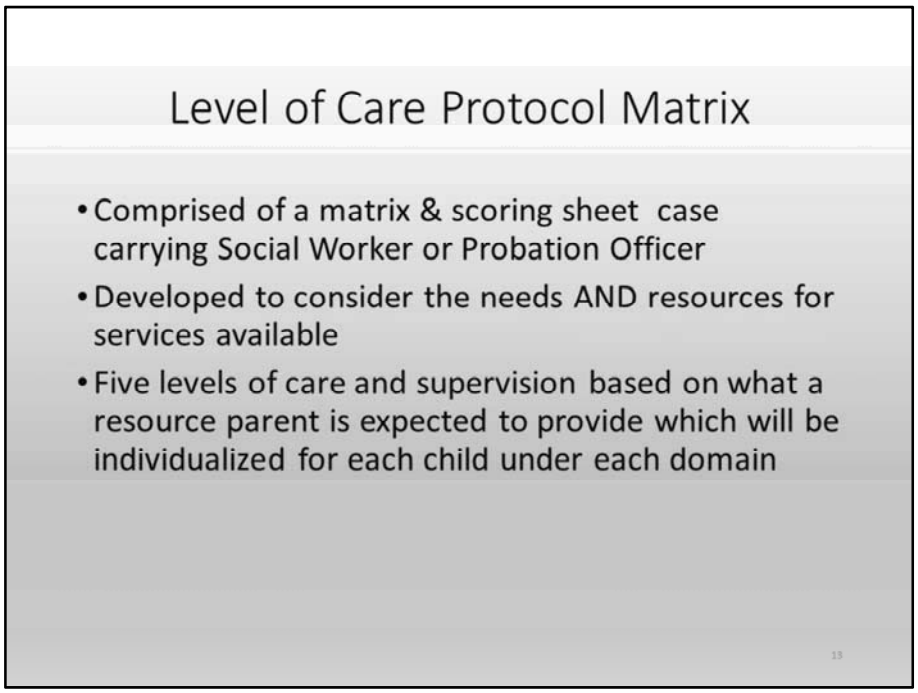
- The tool addresses the daily care activities being conducted by the resource family.

- The tool is required to be used within 60 days of placement, when a triggering event occurs.

- The Level of Care tool is NOT an assessment tool. Children with same diagnosis or behaviors may result in a different rate. The considerations for the daily care rate relates to the specific activities a resource family is providing. Other agencies with other funding or other people may be providing support.

- The use of the tool is subjective, as opposed to an age based rate. It is important that case carrying workers ensure the factors considered in completing this tool are documented.

❖ **A good time to pause and ask questions to ensure understanding.**



❖ Refer participant to the LOC Matrix handout

- A basic rate does not mean a child does not need any daily activities. It is based on a child of same age developing normally. For example, a three year old child would normally need assistance putting their clothes on and completing hygiene tasks.

- An assumption is made for the presentation of these domains that staff attending the training in the counties have a working understanding of the terms used.

- **Domains definitions have been adjusted based on the survey completed across the state.**

Physical Domain

Core Domain	Expectations				
Physical	Physical Domain is defined as actions in which the Resource Family must engage to meet the child's individual daily living needs, such as food, clothing, shelter, hygiene, community/social functioning, and extracurricular activities including teaching age appropriate life skills even when developmental delays are present. This does not include specific medical activities (see Health Domain). If the minor/nonminor dependent (NMD) is pregnant or parenting, consider the infant supplements, the Resource Family may need to provide to the minor/NMD in preparing for parenthood and/or to support the minor/NMD in parenting their child(ren).				
	Resource Family provides healthy meals, opportunities for daily activity, predictable sleep routine, and developmentally appropriate support for physical hygiene. And/or Resource Family provides support to assist the youth in developing life skills that are age/developmentally appropriate.	Resource Family is providing supervision, verbal cueing and/or physical assistance for at least one (1) ADL/IADL beyond what is age/developmentally appropriate on daily basis. And/or Resource Family arranges and/or facilitates developmental needs, i.e., speech, physical, and/or occupational therapy no more than once per month.	Resource Family is providing supervision, verbal cueing And/or direct physical assistance in at least two (2) different ADLs /IADLs beyond what is age/developmentally appropriate on a daily basis. And/or Resource Family arranges and/or facilities participation in developmental, speech, physical, and/or occupational therapy on average up to three times per month. And/or Resource Family must do check-ins with community/extra curricular activities to ensure continuity of ADL/IADL routines.	Resource Family is implementing and monitoring a plan of supervision, verbal cueing and/or direct physical assistance in at least three (3) different ADLs/IADLs beyond what is age/developmentally appropriate on a daily basis. And/or Resource Family arranges and/or facilitates participation in developmental, speech, physical, and/or occupational therapy on average at least 4 or more times monthly. And/or Resource Family accompanies the child and/or provides direct support to enable the child to participate in community/extra curricular activities.	Resource Family is providing supervision, verbal cueing, and/or direct physical assistance in at least six (6) ADL/IADLs beyond what is age/developmentally appropriate on a daily basis. And/or Resource Family provides the child constant supervision to enable the child to participate in community/extra curricular activities.
Points	**1**	**2**	**3**	**4**	**5**

Activities of Daily Living (ADLs) include: Transferring (e.g. walking And/or moving from place to place), use of upper extremities (hand, arms, fingers), bathing, grooming, menstrual care, dressing, feeding, And/or toileting.

Instrumental Activities of Daily Living (IADLs) include: managing finances, accessing transportation, shopping, preparing meals, using communication devices (e.g. phone), managing medications, And/or completing basic housework. IADLs apply to youth 14 years of age and older for purposes of the level of care.

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RESOURCE CENTER FOR FAMILY-FOCUSED PRACTICE

Physical Domain

Physical Domain is defined as actions in which the Resource Family must engage to meet the child's individual daily living needs, such as food, clothing, shelter, hygiene, community/social functioning, and extracurricular activities including teaching age appropriate life skills even when developmental delays are present. This does not include specific medical activities (see Health Domain). If the minor/nonminor dependent (NMD) is pregnant or parenting, consider the infant supplements, the Resource Family may need to provide to the minor/NMD in preparing for parenthood and/or to support the minor/NMD in parenting their child(ren).

Behavioral/Emotional Domain

Core Domain	Expectations				
Behavioral/ Emotional	Behavioral/Emotional domain is defined as actions in which the Resource Family must engage to promote resilience and emotional well-being for the child/youth, as well as encourages the child/youth to engage in prosocial behavior and activities developing healthy relationships. This does not include medication management for psychotropic medications (see Health Domain). If the minor/NMD is pregnant or parenting, consider the infant supplements, the resource Family may need to provide to support the minor/NMD in managing emotional health.				
	Resource Family provides direct supervision and support to address behaviors that are age/developmentally appropriate. And/or Resource Family supports the child through expected life stressors.	Resource Family is redirecting, prompting, and/or diffusing beyond what is age developmentally appropriate at least twice weekly. And/or Resource Family provides support at least twice monthly due to expected/unexpected life stressor and participate in services/activities as recommended. And/or Resource Family may provide enhanced observation.	Resource Family implements a therapeutic intervention plan as outlined by the child/youth's therapist and/or CFT Plan at least three time weekly: And/or Resource Family provides structured support for expected/unexpected life stressors with moderate symptoms and behaviors; including monitoring, observing and/or documenting. And/or Resource Family consults at least 4 times a month with therapist, social worker, and/or other professionals. And/or Resource Family provides observation during waking hours.	Resource Family implements a therapeutic intervention plan as outlined by the child/youth's therapist and/or the CFT Plan at least five times a week. And/or Resource Family facilitates/participates in therapeutic supports, including, but not limited to, outpatient and/or in-home therapeutic services. And/or Resource Family provides line-of-sight during waking hours and limited night supervision as needed, and may require assistance in providing this supervision.	Resource Family assists in the development and implements a daily therapeutic intervention plan to address their identified therapeutic and well-being needs as outlined by the child/youth's therapist and/or the CFT plan for a child which is necessary to maintain them safely in a Family-based setting. And/or Resource Family is engaged in and supports the child receiving WRAP, TBS, or other home-based therapeutic interventions. And/or Resource Family provides up to 24 hr. observation line-of-sight.
Points	**1**	**4**	**5**	**6**	**7**
Training: Resource families are expected to participate in child-specific training/coaching/mentoring based on the needs of the child/youth placed in their home.					

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RESOURCE CENTER FOR FAMILY-FOCUSED PRACTICE

Behavioral/Emotional Domain

Behavioral/Emotional domain is defined as actions in which the Resource Family must engage to promote resilience and emotional well-being for the child/youth, as well as encourages the child/youth to engage in prosocial behavior and activities developing healthy relationships. This does not include medication management for psychotropic medications (see Health Domain). If the minor/NMD is pregnant or parenting, consider the infant supplements, the resource Family may need to provide to support the minor/NMD in managing emotional health.

Educational Domain

Core Domain	Expectations				
Educational	Educational domain is defined as actions in which the Resource Family must engage to promote student achievement, foster educational excellence and equal access to services, and when required, responds to suspensions And/or expulsions. School-aged children/youth are defined as any child/youth who are attending and participating in early childhood educational programs through adult educational programs. If the minor/NMD is pregnant or parenting, consider the infant supplements and interventions support, the resource Family may need to provide to improve the school success of pregnant and parenting foster youth.				
	Resource Family is providing age and developmentally-appropriate support for the child's educational activities as defined below. Or For Non School-Age child, the resource Family obtains/provides additional support to the child to assist in participating in or benefiting from child care/preschool programs and/or obtains/provides additional support in coordination with the child care/preschool and ensure the child's continued attendance.	Resource Family is providing assistance beyond the basic activities on average up to 2 hours additional per week for school-aged children/youth. Or For a Non School-Age child, the resource Family provides up 2 hours additional support to the child to assist in participating in or benefiting from child care/preschool programs and/or providing additional support in coordination with the child care/preschool and ensure the child's continued attendance.	Resource Family is providing assistant beyond the basic activities on average up to 4 hours per week for school-aged children/youth. Or For a Non-School-Aged Child, the Resource Family provides up to 4 hours per week of engagement and coordination with child's daycare providers or educational facility including any issues regarding child's behavior that might put he/she at risk of being denied services at daycare or educational facility.	Resource Family is providing on average up to 6 hours per week for school-aged children/youth. Or For a Non School-Aged Child: Resource Families are encouraged to enroll children in high quality child care and preschool programs, which may be accessed through programs such as Head Start, the California Department of Education subsidized child care system, and through local school districts for Transitional Kindergarten programs. The Resource Family is also expected to provide up to 6 hours of non school-age activities and to engage in age appropriate activities that promote healthy development.	Resource Family is providing beyond the basic activities assistance on average up to 8 hours per week for school-aged children/youth. Or For a Non School-Aged Child: Resource Families are encouraged to enroll children in high quality child care and preschool programs, which may be accessed through programs such as Head Start, the California Department of Education subsidized child care system, and through local school districts for Transitional Kindergarten programs. The Resource Family is also expected to provide up to 8 hours of non school-age activities and to engage in age appropriate activities that promote healthy development. Or Resource Family is required to provide or arrange for the chronic or terminal health care needs based on the child/youth Case or Care Plan.
Points	1	2	3	4	5
	•Basic Level: Resource families will provide ongoing educational support to include assistance with arriving to school on time, completing homework, and special projects. The Resource Family is also expected, as part of regular parenting duties, to participate in parent-teacher conferences, attend Back to School Night and Open Houses, and communicate with the social worker And/or court prior to each court hearing on the J15 educational progress. The Resource Family should also encourage the child to read on his/her own (or read with them) and should ensure access to the Internet and other on-line technology to promote learning. •Educational Activities beyond the Basic Rate include: Volunteering or otherwise being present in the classroom; Assisting with and monitoring homework/school projects beyond what is age/developmentally appropriate; Activities to support IEP, SST, RST, Behavioral Support (504) Plans; Supporting participation in school-based extra-curricular activities (i.e. sports, music, theatre, etc.); Assistance in transitioning to college or vocational education/training (ex. college tours, completing applications, testing); Assisting the youth to participate in community-based, volunteer activities for extra credits; Identifying/acquiring and putting into action any remediation plans or activities when needed; Assisting in school enrollment, partial credits restoration; Providing home-based education. Educational activities also include obtaining, arranging, coordinating And/or maintaining special equipment, tools or devises required for the child to access his/her education and educational environment. These activities may vary depending on the child's case plan and whether the caregiver is designated as the Education Rights Holder. In the event that a child needs tutoring, instructions or educational therapy beyond what the resource Family can provide, the time arranging, coordinating, scheduling, And/or transporting the child to services will be credited to the Resource Family. •The Resource Family willingness to seek assistance to provide extra support for the LGBT youth educational milies. The Resource Family willingness to provide school readiness to ensure social/emotional support.				

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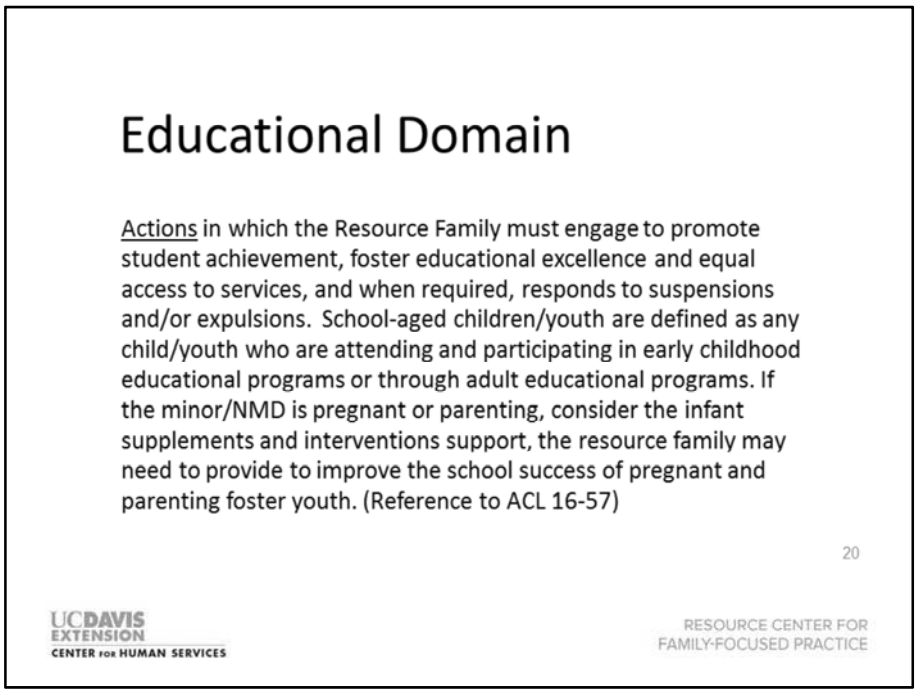
RESOURCE CENTER FOR FAMILY-FOCUSED PRACTICE

As a result of the survey, a child/youth with terminal illness an unable to attend school is represented on the matrix.



This has been adjusted per the survey

Health Domain

Core Domain	Expectations				
Health	Health domain is defined as actions in which the Resource Family must engage to promote the child's health and healthy sexual development by arranging and facilitating health care (i.e., **Child Health and Disability Prevention (CHDP) Program, medical, dental, vision, transgender needs), medication administration including psychotropic medications and/or monitoring, and ensuring access to services that address special health care needs. Resource Family addresses medically necessary or prescribed dietary/exercise/nutritional needs. If the minor/NMD is pregnant or parenting, The Resource Family should the need for attending prenatal care appointments, prenatal classes, breastfeeding classes, post-partum follow-up, etc. and utilize infant supplements.				
	Resource Family arranges routine well child-care based on CHDP and Dental schedule. And/or Occasional or short-term medication intended to treat typical childhood illness or injury which may require either over the counter or prescription medication. This also includes arranging for medication to be administered at school.	Resource Family arranges as needed an appointment with a healthcare specialists 4 times a year, including, but not limited to, orthopedics, orthodontia, neurology, endocrinology, medical/psychological care that support gender identity. And/or Resource Family must observe/record/report medication effects to MD and administers at least one medication as needed.	Resource Family arranges appointments with healthcare specialists more than 4 but fewer than 12 times per year, including, but not limited to, orthopedics, orthodontia, neurology, endocrinology and medical/psychological care that support gender identity. And/or Resource Family must observe/record/report medication effects to MD and administers at least one medication on a daily basis. And/or Resource Family monitors youth's self-administered medication, testing equipment, or the use of medical devices.	Resource Family arranges appointments with a healthcare specialist 12 times a year, including, but not limited to, orthopedics, orthodontia, neurology, endocrinology, psychiatrist and medical/psychological care that support gender identity. And/or Resource Family must observe/record/report medication effects to MD and administers multiple medications once. And/or Resource Family operates and monitors medically prescribed equipment.	Resource Family provides care to a child who has been diagnosed with a severe medical problem*, which requires in-home monitoring by medical professionals, direct medical treatments by the resource parent(s) And/or use of medical equipment multiple times per week.
Points	1	4	5	6	7

*This may include but is not limited to: A aspiration, suctioning, mist tent, ventilator, tube feeding, tracheotomy, symptomatic AIDS with complication, hepatitis, chemotherapy, indwelling lines, colostomy/ileostomy, or burns covering more than 10% of the body.

** The Child Health and Disability Prevention (CHDP) Program helps to prevent or find health problems through regular, no cost, health check-ups. A check-up includes: · Health and developmental history · Physical exam · Needed shots · Oral health screening and routine referral to a dentist starting by age 1 · Nutrition screening · Behavioral screening · Vision screening · Hearing screening · Health information · Lab tests, which may include: anemia, lead, tuberculosis, and other problems, as needed · Referral to Women, Infants, and Children (WIC) program for children up to age 5.

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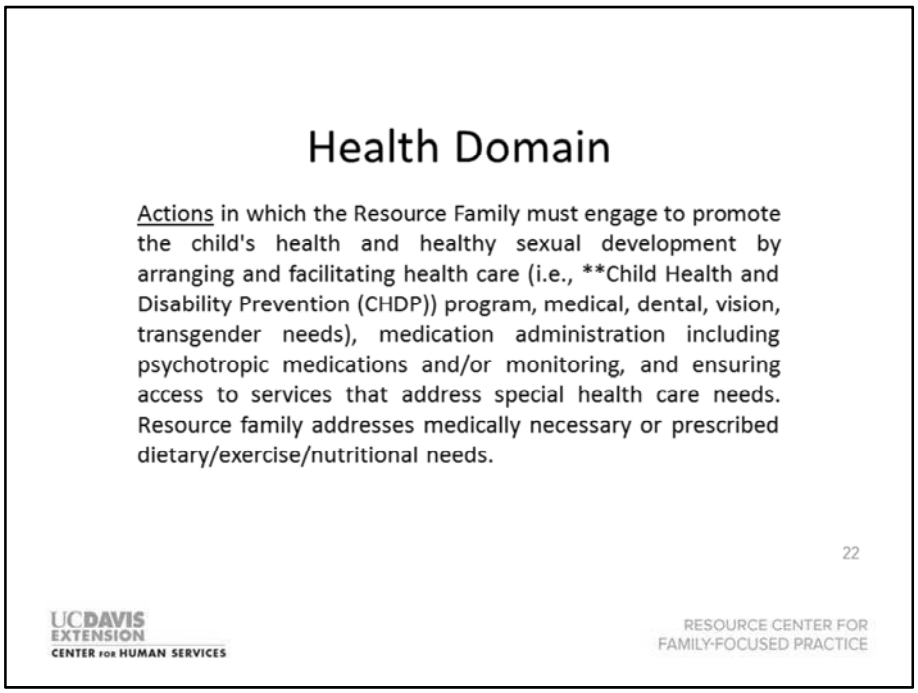

The Health domain is defined as actions in the resource parent engages in to promote the child's health. This includes ensuring the child receives regular preventative care, like well-child medical and dental exams, as well as appointments with health care professionals, doctors and specialists, to address basic health needs all the way through extensive needs of our medically fragile children.

This domain also accounts for the resource parent's monitoring and administration of medications including short-term medications needed for typical childhood illness/injury or daily medications to address ongoing medical conditions such as diabetes.

The Health domain also accounts for the activities the caregiver engages in to promote a child's healthy lifestyle and overall physical well-being including dietary and nutritional support.
(Reference to ACL 16-57)

Permanency/Family Services Domain

Core Domain	Expectations				
Permanency/ Family Services	Permanency/Family Services is defined as actions in which the Resource Family must engage to promote and facilitate visitation, communication, and the identification, development, and maintenance of lifelong, supportive connections with members of their biological and non-biological families and natural support systems. Permanency/Family Services also include efforts to connect the youth with their community of origin including connections with resources, cultural organizations, faith communities, identity-based communities such as the LGBTQ community and any other group or organization which promotes a sense of belonging, identity, and connection to culture. Consider the additional support the Resource Family may need to provide to the parenting minor/NMD to ensure the minor's/NMD's child(ren) maintains visitation with the non-custodial parent and extended Family members in addition to infant supplements benefits.				
	Permanency Activity is defined as: 1. An in-person visit with a parent, Family member, sibling or siblings, or other permanent connection. 2. Child-focused community and cultural engagement: includes efforts to arrange, schedule and facilitate connecting the youth with their community of origin including connections with resources, cultural organizations, faith communities, and any other group or organization which promotes a sense of belonging, identity, and connection to culture.				
	Resource Family arranges and/or facilitates (including reasonable in-county transportation and supervision) an in-person visit at least once (1) per week or once a month and will include child-focused community And/or cultural engagement activities as determined by the child and Family team. And/or Community and cultural engagement activities. And/or Resource Family participates in mentoring/coaching birth parents implementing Family visitation plans or other permanency related services for two (2) hours per week (to include transportation and travel time).	Resource Family arranges and/or facilitates (including reasonable in-county transportation and supervision) an in-person visit at least two (2) times per week and will include child-focused community and/or cultural engagement activities as determined by the child and Family team. And/or Community/cultural engagement activities. And/or Resource Family participates in mentoring/coaching birth parents implementing Family visitation plans or other permanency related services for four (4) hours per week (to include transportation and travel time).	Resource Family arranges and/or facilitates (including reasonable in-county transportation and supervision) an in-person visit at least three (3) times per week and will include child-focused community and/or cultural engagement activities as determined by the child and Family team. And/or community/cultural engagement activities. And/or Resource Family participates in mentoring/coaching birth parents implementing Family visitation plans or other permanency related services for at least six (6) hours per week (to include transportation and travel time).	Resource Family arranges and/or facilitates (including reasonable in-county transportation and supervision) an in-person visit at least four (4) times per week and will include child-focused community and/or cultural engagement activities as determined by the child and Family team. And/or community/cultural engagement activities. And/or Resource Family participates in mentoring/coaching birth parents implementing Family visitation plans or other permanency related services for at least eight (8) hours per week (to include transportation and travel time).	Resource Family arranges and/or facilitates (including reasonable in-county transportation and supervision) an in-person visit at least five (5) times per week and will include child-focused community and/or cultural engagement activities as determined by the child and Family team. And/or community/cultural engagement activities. And/or Resource Family participates in mentoring/coaching birth parents implementing Family visitation plans or other permanency related services for at least ten (10) hours per week (to include transportation and travel time). Or Resource Family is required to provide or arrange for the chronic or terminal health care needs based on the child/youth Case or Care Plan.
	The Resource Family assists the parent/guardian in improving their ability to support, care for and protect their child(ren) including any LGBTQ Family member, as well as actively promotes and facilitates other contact (e.g. Telephone, written communication) between the in-person visits.				
Points	**1**	**2**	**3**	**4**	**5**

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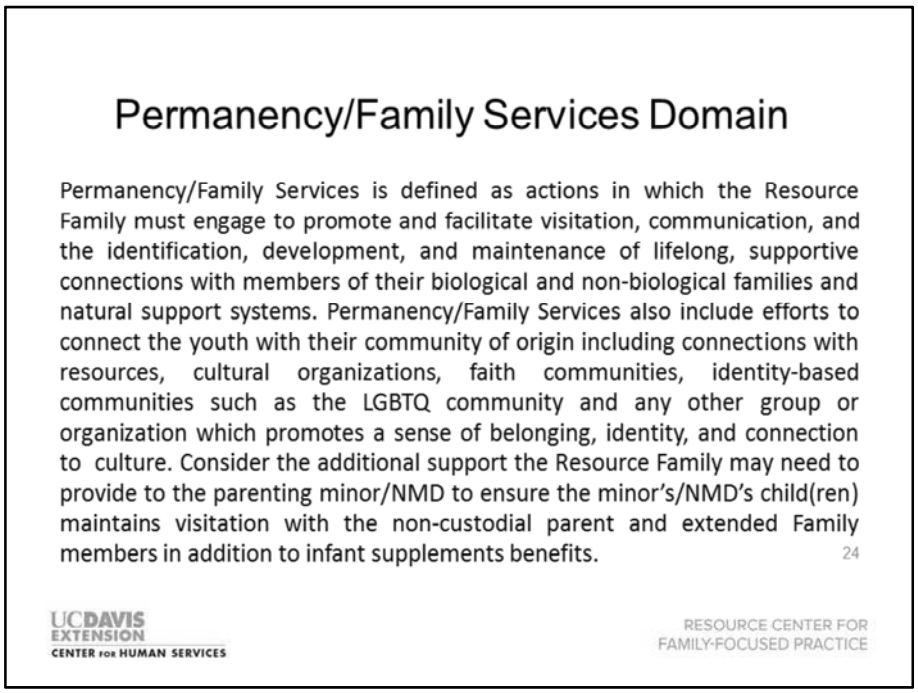
This domain has been adapted after the survey.



(Reference to ACL 16-57)

Static Criteria Domain

Static Criteria	Chronic indicators that warrant the granting of the Intensive Services Foster Care (ISFC) to ensure safe placement of a child, pending a full assessment. The county MAY apply these if the child meets any of the following:
Indicator	If the County Placing Agency is seeking placement for a youth with a history of any of the below within the past year and the County Placing Agency has not been able to identify a home-based Family care setting, the child/youth may qualify at the Intensive Services Foster Care (ISFC) level for a period of 60 days pending completion of an initial/updated assessment. After 60 days, the rate will be determined using the level of care protocol tool. ¨ Adjudicated violent offenses, significant property damage, And/or sex offenders/perpetrators ¨ Aggressive and Assaultive ¨ Animal Cruelty ¨ AWOL ¨ CSEC ¨ Eating disorder ¨ Fire Setting ¨ Gang Activity ¨ Habitual Truancy ¨ Psychiatric hospitalization(s) ¨ Severe mental health issues-including suicidal ideation and/or Self Harm ¨ Substance Use/Abuse ¨ Three or more placements due to the child's behavior *Due to Independent criteria, some behaviors/symptoms require automatic admission to an "Intensive" level of care regardless of combined score.

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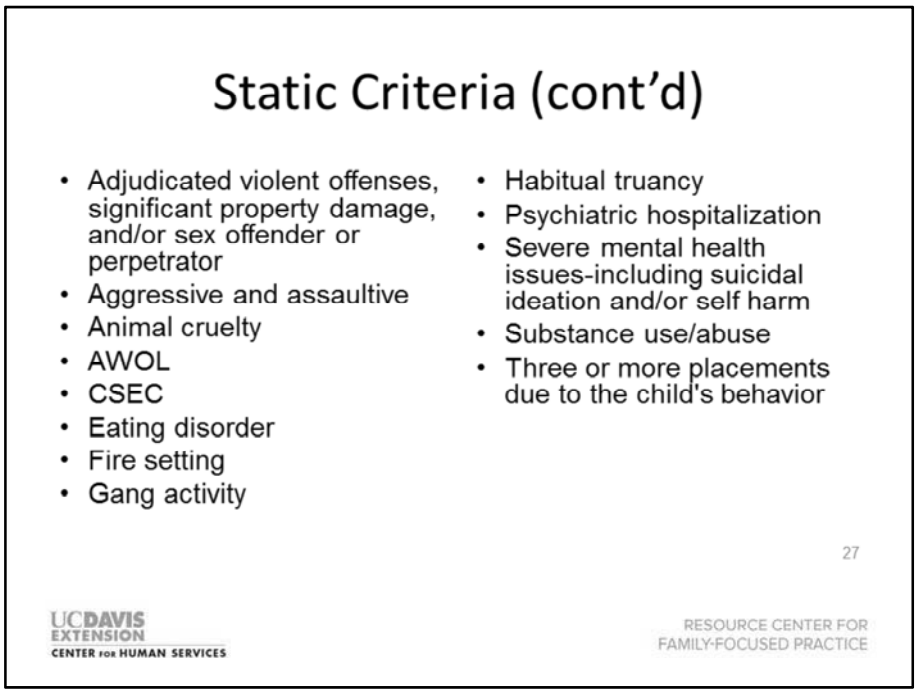
Static Criteria

- Chronic Indicators, which warrant immediate ISFC level to ensure safe placement of a child/youth pending a LOC rate determination
- Placing agency may choose to pay at an ISFC rate for youth who meet specified criteria.
- Static criteria must have occurred within the preceding 12 months
- ISFC rate will last up to 60 days pending completion of an initial/updated LOC rate determination.

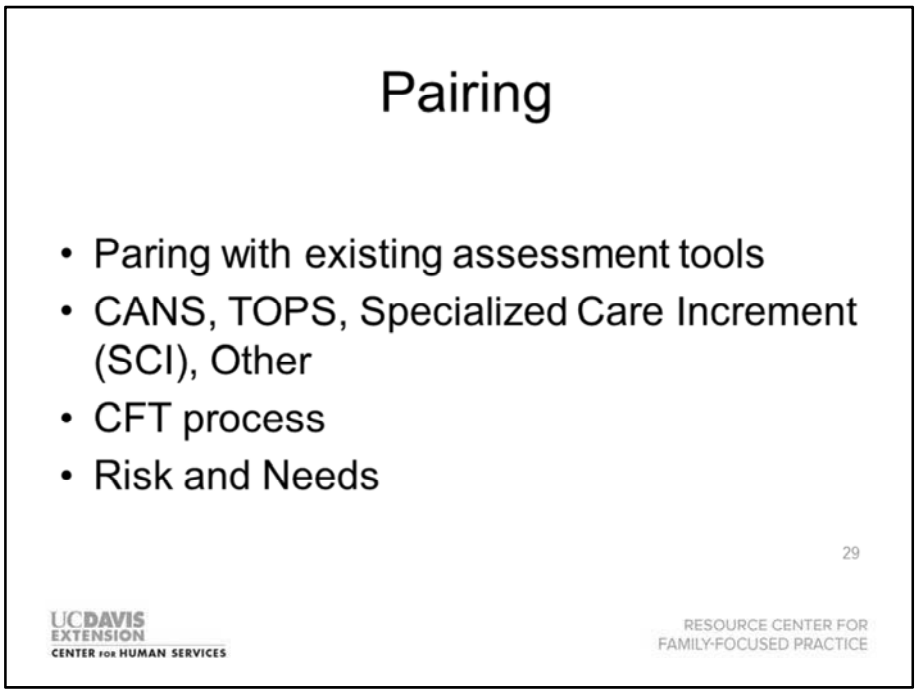


Simply having a history of one of these issues does not qualify a youth for the Static Rate. For example, a youth with a history of substance use that has not used for a year would no longer qualify.

The LOC Tool does not need to be completed once the static criteria is applied. The case carrying worker is granted another 60 days to complete the rate setting matrix. This allows for the period of time to secure targeted and appropriate assessments geared at determining the level of supervision and care needed.

Intensive Services

- Identifies child(ren)/youth with specific needs including Multi-Dimensional Treatment Foster Care, special health care or medical placements, Therapeutic Foster Care or other special placements.
- Can be time-limited based on the static criteria for urgent placement needs



Again, it is important for the intent of CCR to integrate to information from other tools and professionals to maximize the intent of the process. Here is where trainers should identify specific assessment tools or processes that will provide information to complete the matrix

Resource Parent Tool (Cont'd)

4a. Does the child have emotional/ behavioral challenges as diagnosed by a Licensed therapist or MD
☐ YES ☐ NO

4b. Check boxes below with the type of emotional/behavioral supports the child/family participates in. (check ALL boxes that apply) ☐ Child attends therapy ☐ Family Therapy ☐ Group therapy for child ☐ Support group for caregiver ☐ Wraparound (WRAP), TBS or other home based therapeutic services ☐ APSS (Adoption Promotion and Supportive Services) ☐ Parent Child Interactive Therapy (PCIT) ☐ Other (please describe) _____

4c. Check boxes below for any activities you do to support the child in addressing emotional/behavioral challenges. (check ALL boxes that apply):

☐ Taking/facilitating transportation of child to therapy appointments ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ time/week

☐ Talking to therapist, clinicians, social workers or other professionals ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ time/week

☐ Monitoring, observing, documenting child's behaviors ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ time per week

☐ Implementing therapeutic intervention/behavior plan ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ time per week

☐ Redirecting, prompting child and/or defusing behaviors ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ time per week

☐ Supporting the child through emotional outbursts/tantrums ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ time per week

☐ Cleaning due to bed-wetting and/or repairing damage to home ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ time per week

☐ Supervising/observing child, including line of sight ☐ occasional ☐ frequent ☐ all day ☐ 24 hours

5a. For a *SCHOOL-AGE CHILD*, how much time are you spending supporting and supervising the child for homework and/or other learning activities, beyond what is usually required for a child of the same age? Include time spent supporting the child in school-based activities, volunteering in the classroom, arranging tutoring, maintaining equipment, tools or devises so child can access education. Also includes assisting with college/financial-aid applications.

☐ **1-2 hours per week** ☐ **3-4 hours per week** ☐ **5-6 hours per week** ☐ **7-8 hours per week** ☐ **9 + hours per week**

5b. For a *NON SCHOOL-AGE CHILD*, check the boxes below for any support you are providing for the child to participate in/benefit from child care and/or preschool programs. (Check ALL boxes that apply).

☐ Enrolled child in Early Head Start/Head Start, Transitional Kindergarten program or other child development program.

☐ Read out loud to child ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+ times a week

☐ Provide additional support in coordination with child care/preschool including any issues regarding child's behavior that might put *he/she* at risk of being denied services at daycare or educational facility.

☐ Maintaining equipment, tools or devices for child to access education

☐ Respond to complaints from child care/preschool (circle # that applies) ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5+ times a month**

5c. How much time are you spending to advocate on behalf of the child with teachers or child care/preschool staff. This includes activities such as planning/participating in special education development and reviews, picking up child from school due to disciplinary issues, being present at school or speaking on the phone to school personnel, coordinating services (such as TBS) with school, and assisting in school enrollment and partial credit restoration.

☐ **1-2 hours per week** ☐ **3-4 hours per week** ☐ **5-6 hours per week** ☐ **7-8 hours per week** ☐ **9 + hours per week**

6a. Please check the boxes below to show the doctors or other healthcare specialists the child sees. (check ALL boxes that apply) ☐ Pediatrician for routine well-child care ☐ Dentist for routine well-child care

☐ Specialist (ex. neurologist, allergist, psychiatrist, orthodontist, etc.) ☐ **1-3** ☐ **4 - 5** ☐ **6 - 8** ☐ **9-11** ☐ **12 -14+ times a year**

☐ If your pediatrician/dentist provides specialty care for the child (beyond routine well-child appointments) please describe below, and indicate how many appointments a year you arrange with the pediatrician/dentist:

_____

_____

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Resource Parent Tool (Cont'd)

6b. Please check the boxes below that apply regarding medications prescribed by a doctor. This includes psychotropic medication for emotional/behavioral health.

☐ Observe, record, and/or report medication effects to doctor and administer:
☐ 1 medication as needed ☐ 1 medication daily ☐ 2 or more medications daily ☐ 2 or more medications more than once a day ☐ Monitor the child who takes the medication themselves

6c. For a child, who uses equipment and/or a medical device, check the box to show the care you provide.

☐ Monitor the child using medical device and/or testing equipment ☐ Operate and monitor the equipment and/or medical device

6d. For a child who has a severe medical and/or developmental health concern check the boxes to show the care needed. (check ALL boxes that apply):

☐ Child requires in-home monitoring by medical professional
☐ Child requires use of medical equipment multiple times per week
☐ Child with severe condition, including but not limited to, aspiration, suctioning, mist tent, ventilator, tube feeding, tracheotomy, symptomatic AIDS, hepatitis, chemotherapy, indwelling lines, colostomy/ileostomy, burns on more than 10% of body.

7a. How often are you supporting the child's visits and/or participation in community and cultural activities important to his/her cultural and communal identity? This includes transporting and staying at the visits/activities. (Check ALL boxes that apply and CHECK the number that shows the frequency of these activities.)

☐ Supporting the child's visits with his/her family, siblings and others ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ times per week
☐ Supporting the child in attending community and/or cultural activities ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ times per week
☐ Mentoring/coaching birth parents implementing family visitation plans ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ times per week

ADDTIONAL COMMENTS, CONCERNS AND/OR SUPPORTS:

WOULD YOU LIKE TRAINING OR OTHER SUPPORT IN ANY OF THE AREAS NOTED ABOVE? YES ☐ NO ☐
Please list those topic(s):

Resource Parent Signature: _____ Printed Name: _____ Date: _____
Social Worker Signature: _____ Printed Name: _____ Date: _____

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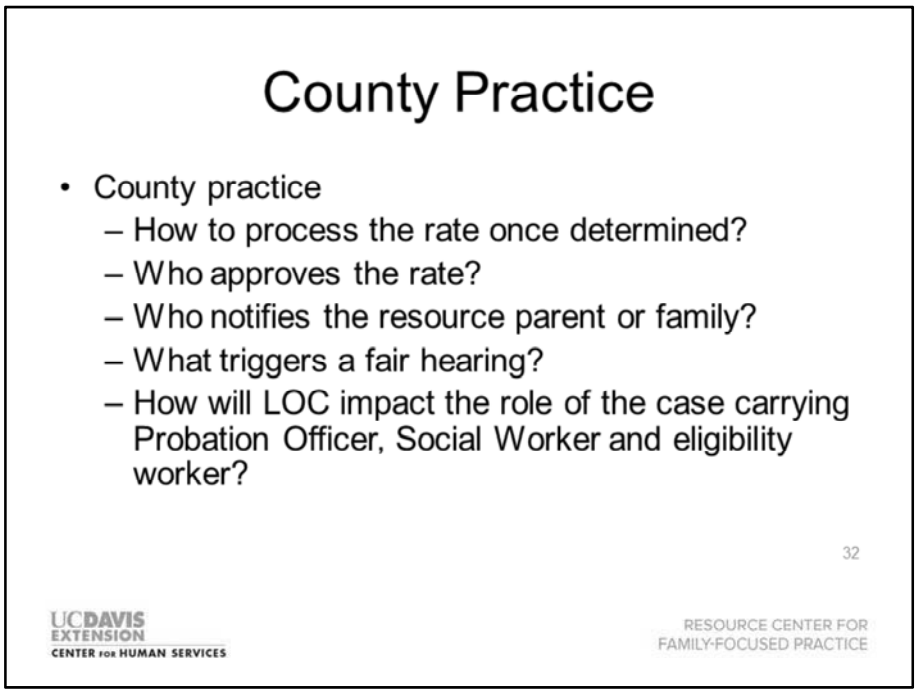
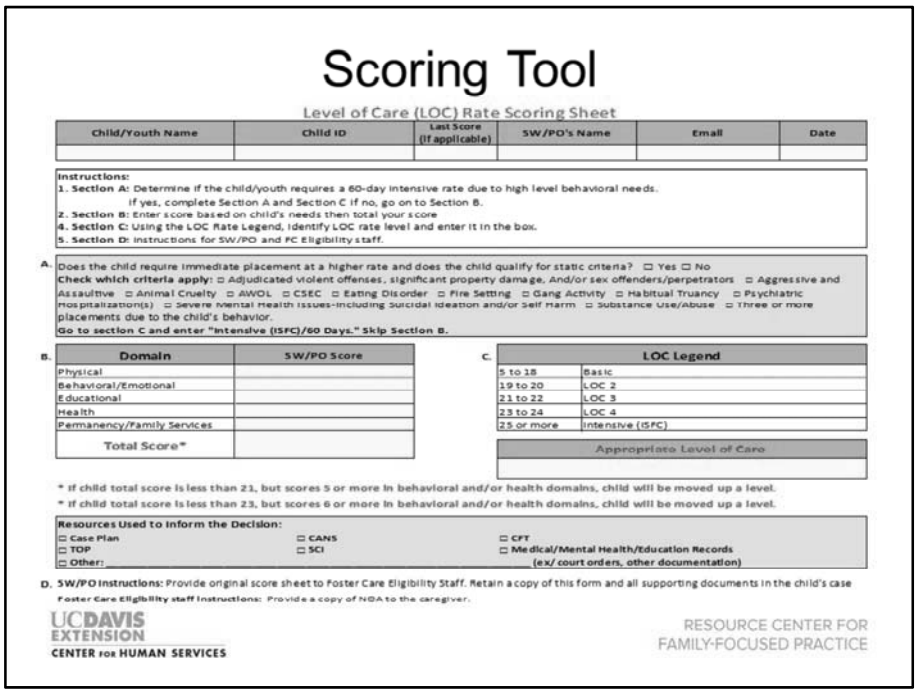


Ask participants to consider these things as the tool/scoring is reviewed. This will be discussed at the end of the training during and activity. This slide is to get participant thinking.



Scoring Tool

Level of Care (LOC) Rate Scoring Sheet

Child/Youth Name	Child ID	Last Score (If applicable)	SW/PO's Name	Email	Date

Instructions:
1. **Section A:** Determine if the child/youth requires a 60-day intensive rate due to high level behavioral needs.
   If yes, complete Section A and Section C if no, go on to Section B.
2. **Section B:** Enter score based on child's needs then total your score
4. **Section C:** Using the LOC Rate Legend, identify LOC rate level and enter it in the box.
5. **Section D:** Instructions for SW/PO and FC Eligibility staff.

A. Does the child require immediate placement at a higher rate and does the child qualify for static criteria? ☐ Yes ☐ No
Check which criteria apply: ☐ Adjudicated violent offenses, significant property damage, And/or sex offenders/perpetrators ☐ Aggressive and Assaultive ☐ Animal Cruelty ☐ AWOL ☐ CSEC ☐ Eating Disorder ☐ Fire Setting ☐ Gang Activity ☐ Habitual Truancy ☐ Psychiatric Hospitalization(s) ☐ Severe Mental Health Issues-including Suicidal Ideation and/or Self Harm ☐ Substance Use/Abuse ☐ Three or more placements due to the child's behavior.
Go to section C and enter "Intensive (ISFC)/60 Days." Skip Section B.

B.

Domain	SW/PO Score
Physical	
Behavioral/Emotional	
Educational	
Health	
Permanency/Family Services	
Total Score*	

C.

LOC Legend	
5 to 18	Basic
19 to 20	LOC 2
21 to 22	LOC 3
23 to 24	LOC 4
25 or more	Intensive (ISFC)

Appropriate Level of Care

* If child total score is less than 21, but scores 5 or more in behavioral and/or health domains, child will be moved up a level.
* If child total score is less than 23, but scores 6 or more in behavioral and/or health domains, child will be moved up a level.

Resources Used to Inform the Decision:
☐ Case Plan ☐ CANS ☐ CFT
☐ TDP ☐ SCI ☐ Medical/Mental Health/Education Records
☐ Other: _____ (ex/ court orders, other documentation)

D. **SW/PO Instructions:** Provide original score sheet to Foster Care Eligibility Staff. Retain a copy of this form and all supporting documents in the child's case
Foster Care Eligibility staff Instructions: Provide a copy of NOA to the caregiver.

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Prior to the pilot, a concern that some of the rates the resource family received were considered low. In many instances however, it was recognized that the “leveling up” criteria to increase the rate was not applied correctly.
This included the scoring conducted by social workers, probation officers and advocate groups.

Scoring Tool

- The scoring sheet is an outcome of the LOC Matrix and must be completed after determining the level of care in each domain.
- Things to consider while completing the scoring sheet:

1. Enter score based on child's needs then total your score
2. Using the LOC Rate Legend, identify LOC rate level and enter it in the box.
3. **Level up override:**
   a. If child/youth total score is less than 21, but scores 5 or more in behavioral and/or health domains, child will be moved up a level.

   b. If child total score is less than 23, but scores 6 or more in behavioral and/or health domains, child will be moved up a level.

- Please consider using the digital scoring sheet to avoid any errors in totaling the scores.

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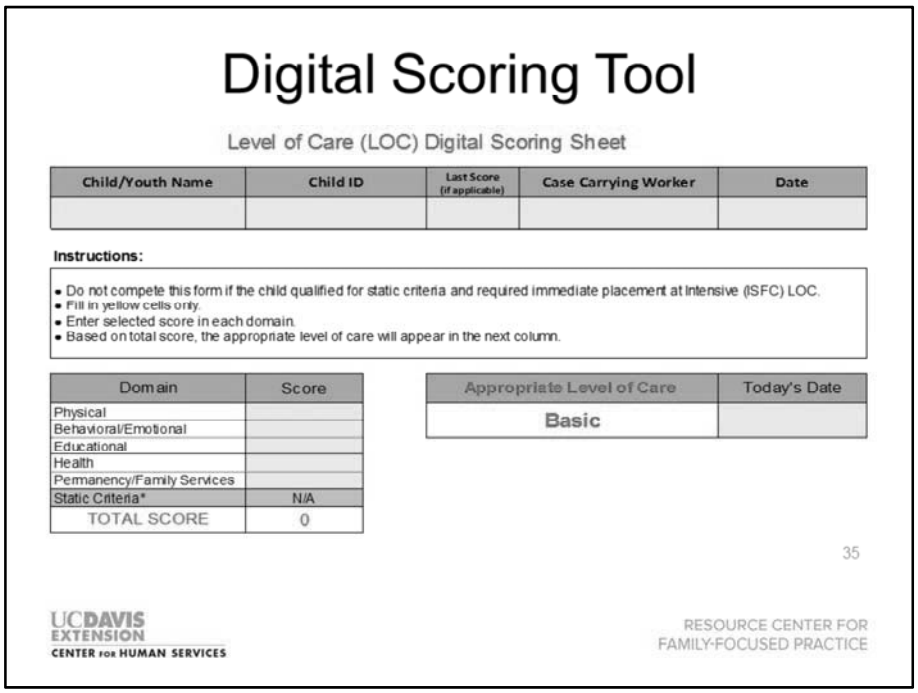

This automatically completed the calculations to assign a rate.

Vignettes

Use the County worksheet handed out earlier and have counties discuss the implication for the new rate determination tool on county practice.

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Thank you for
your participation!
If you have any questions, please send to:
ccr@dss.ca.gov
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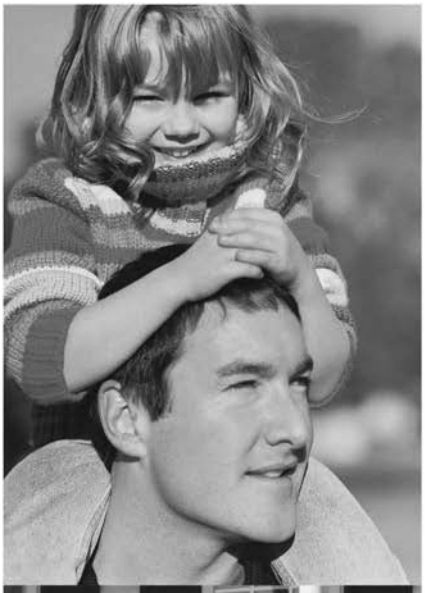

Resource Center for Family-Focused Practice

Level of Care **Rate Determination Protocol** Training for Trainers

Handouts

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Agenda

10:00am – 10:20am
Introduction of trainers, Agenda Review, Ice Breaker

10:20am – 11:00am
Overview of Level of Care (LOC) Matrix development

11:00am – 11:10am
Break

11:10am – 12:00pm
Level of Care domains and static criteria

12:00pm – 1:00pm
Lunch

1:00pm – 1:30pm
Resources to guide tool completion

1:30pm – 2:30pm
Scoring

2:30pm – 3:00pm
County discussion

Level of Care (LOC) Rate Protocol Instruction Guide

What is LOC Rate Protocol?

The LOC Rate protocol is designed to identify the foster care child/youth needs, the resource family expectations to meet these needs, and match those to the appropriate rate level. The Protocol consists of five domains that cover the primary care and supervision needs of the child/youth. Within each Domain there are different levels of expectations that correlate with a point system. The protocol allows the social worker/probation officer to score each domain based on the child/youth care and supervision needs to identify the appropriate Home-Based Family Care (HBFC) LOC rate, including if applicable, Intensive Services Foster Care (ISFC).

The LOC Rate Protocol and Triggering Events

Care and supervision needs will be identified based on five (5) core domains. The Core Domains in the protocol tool are: Physical, Behavioral/Emotional, Educational, Health and Permanency/Family Services. The LOC Rate Protocol is comprised of a Matrix, The Resource Parent(s) Report document to be completed by the caregiver, a Scoring Sheet which is to be completed by a Social Worker (SW) or Probation Officer (PO), and the Instruction Guide. The rate, once determined, will be documented by the SW or PO and provided to foster care eligibility staff on a CDSS scoring sheet.

When to use the LOC Protocol?

There is no annual LOC rate determination requirement. The SW/PO must use the LOC Protocol when one of the following triggering events occurs:

1. **Initial Foster Care Placement**: The Basic Level Rate will be paid upon initial foster care placement into a HBFC setting pending the completion of the LOC protocol unless the child meets an exception for an ISFC rate - the results of the LOC protocol is effective the date of initial placement. County staff has 60 days after initial placement to complete the LOC Rate Protocol.
2. **FFA – Moving from Age-Based Rates:** For a change in placement for any foster child/youth moving from an FFA home receiving a rate under the age-based rate structure to another FFA home (with a different FFA agency) or a relative/county home. If the LOC rate determination was not completed prior to the placement move, the Basic Level Rate shall be paid until the LOC Protocol is completed. If a move is planned, the social worker may begin the assessment prior to the child's placement change; otherwise the LOC Rate should be determined no later than 60 days after placement into the new home. The new LOC rate based on the LOC protocol is effective back to the date of the new placement.
3. **Other RF Placement Changes**: If an LOC rate determination has been performed and there are no changes to the child's needs, the prior LOC rate may be applied. If the LOC rate determination was not completed prior to the new placement, the Basic Level Rate is paid until the LOC determination is completed. The new rate is effective back to the date of placement.
4. **Transition from STRTP:** For a change in placement for any foster child/youth from an STRTP to a HBFC setting. If the LOC rate determination was not completed prior to the new placement, the Basic Level Rate shall be paid until the LOC Rate Protocol is completed. The new LOC rate based on the LOC Rate Protocol is effective back to the date of the new placement into the HBFC setting.
5. **Requested Changes from Caregivers:** When a caregiver, youth or SW/PO in consultation with the CFT (if available), indicates a child/youth's needs have changed, the new rate is effective the date of the completion of the LOC Rate Protocol as indicated on the form provided by the SW.
6. **Transition from ISFC/TFC:** When a child/youth is receiving ISFC or TFC and is ending those

services, the new LOC rate is effective the date the ISFC or TFC services end.

7. **Decrease in Rate:** In the instance when the rate decreases as a result of the LOC Rate Protocol and the child remains with the same caregiver, the effective date of the decrease will be in the first month following the determination in which adequate and timely notice can be provided.

How to use the LOC Rate Protocol?

The Child Welfare Social Worker (SW) or Probation Officer (PO) must consider all of the needs of the child in every domain and what services and support will be needed for quality supervision in a family setting. Those expectations are listed in the LOC Rate Protocol. The SW/PO should consider all available information including but not limited to the Child and Family Team (CFT), existing assessment content (i.e. CANS/TOP, etc.), insight from the Resource Parent Report in order to rate each domain thoroughly and accurately.

The SW/PO will use the accompanying scoring sheet to score each domain and arrive at a total score that converts into a level of care rate (see the attached LOC Rate Scoring Sheet).

Static Criteria (For New and Current Placements)

The Protocol recognizes that there are situations where a child/youth has recent experiences or events that present challenges for the SW/PO to place into a typical resource family home. The Protocol also includes an option for SW/PO to place at an ISFC rate (with supervision approval) for up to 60 days pending a full assessment (within this timeframe). This placement would be for a child/youth who's trauma or behaviors require enhanced supervision or intensive services. This option should only be exercised when no other appropriate and safe home-based placements can be found for the immediate placement of the child/youth. The initial 60 day placement may be extended upon manager approval.

LOC Scoring Sheet:

The scoring sheet is an outcome of the LOC Matrix and must be completed after determining the intensity of child's needs and expectations in each domain.

How to complete the scoring sheet:

- Section A: Determine if the child/youth requires a 60-day intensive rate due to high-level behavioral needs. If yes, complete Section A and Section C if no go on to Section B.
- Section B: Enter score based on child's needs then total your score.
- Section C: Use the LOC Rate Legend to identify LOC rate level and enter it in Section C.
- Section D: Check which resources used to inform the decision.
- Section E: Instructions for SW/PO and FC Eligibility staff.

Level up override:

- If child/youth total score is less than 21, but scores 5 or more in behavioral or health domains, child will be moved up a level.
- If child total score is less than 23, but scores 6 or more in behavioral or health domains, child will be moved up a level.

LOC Digital Scoring Sheet:

- The digital scoring sheet is designed to calculate the total score and identify the appropriate level of care including the level up override.
- Please consider using the digital scoring sheet to avoid any errors in totaling the scores and

identifying the appropriate level of care.

Additional Resources:

- ACL 17-11 (1/31/2017): Phase II implementation of the HBFC and STRTP Rates Structure and Conversion Process to the New Rate Structure
- ACL 16-84 (10/7/2016): Requirements and Guidelines for Creating and Providing a Child and Family Team
- ACL 16-79 (9/22/2016): Information about HBFC and STRTP Rates Structure and Conversion Process to the New Rate Structure
- ACL 16-57 (7/1/2016): Aid to Families with Dependent Children-Foster Care (AFDC-FC) California Necessities Index (CNI) Increases and Other Rate Increases
- LOC Webinar (3/14/2017): CCR Overview of the Level of Care Protocol

Level of Care (LOC) Rate Scoring Sheet

Child/Youth Name	Child ID	Last LOC (if applicable)		Case Carrying Worker		Today's Date
		Score	Date	Name:	Stacy Small	
Alex Young	1234-1234-1234-1234567	21	7/5/2017	Email:	ssmall@cdss.a.gov	9/6/2017

Instructions:

- **Section A:** Determine if the child/youth requires a 60-day intensive rate due to high level behavioral needs.
  If yes, complete Section A and Section C if no, go on to Section B.
- **Section B:** Enter score based on child's needs then total your score.
- **Section C:** Use the LOC Rate Legend to identify LOC rate level and enter it in Section C.
- **Section D:** Check which resources used to inform the decision.
- **Section E:** Instructions for SW/PO and FC Eligibility staff.

A. Does the child require immediate placement at a higher rate and does the child qualify for static criteria? ☐ Yes ☐ No

Check which criteria apply: ☐ Adjudicated violent offenses, significant property damage, And/or sex offenders/perpetrators ☐ Aggressive and Assaultive ☐ Animal Cruelty ☐ AWOL ☐ CSEC ☐ Eating Disorder ☐ Fire Setting ☐ Gang Activity ☐ Habitual Truancy ☐ Psychiatric Hospitalization(s) ☐ Severe Mental Health issues-including Suicidal Ideation and/or Self Harm ☐ Substance Use/Abuse ☐ Three or more placements due to the child's behavior.

Go to section C and enter "Intensive (ISFC)/60 Days." Skip Section B.

B.

Domain	SW/PO Score
Physical	
Behavioral/Emotional	
Educational	
Health	
Permanency/Family Services	
Total Score*	

LOC Legend	
5 to 18	Basic
19 to 20	LOC 2
21 to 22	LOC 3
23 to 24	LOC 4
25 or more	Intensive (ISFC)

C.

Appropriate Level of Care

*** If child total score is less than 21, but scores 5 or more in behavioral or health domains, child will be moved up a level.**

*** If child total score is less than 23, but scores 6 or more in behavioral or health domains, child will be moved up a level.**

D. Resources Used to Inform the Decision:

☐ **Case Plan** ☐ **CANS** ☐ **CFT**

☐ **TOP** ☐ **SCI** ☐ **Medical/Mental Health/Education Records**

☐ **Other:** _____ **(ex/ court orders, other documentation)**

E. SW/PO Instructions: Provide original score sheet to Foster Care Eligibility Staff. Retain a copy of this form and all supporting documents in the child's case file.
Foster Care Eligibility staff instructions: Provide a copy of NOA to the caregiver.

STATE OF CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

RESOURCE PARENTS REPORT: ACTIVITIES IN SUPPORT OF CHILD DATE OF REPORT:

CHILD'S NAME:	CURRENT AGE:	GENDER IDENTITY:	Case #:	DATE OF PLACEMENT IN THIS HOME:

RESOURCE PARENT NAME:	EMAIL ADDRESS:	
ADDRESS:	CITY:	STATE: ZIP:
HOME PHONE:	CELL PHONE:	CASE CARRYING WORKER:

Resource Parent - Thank you for taking the time to help us understand the needs of the child placed in your home. The information you share about the child's needs is an important factor in the assessment of services and supports for the child. If there are two Resource Parents caring for the child, please include the activities you both do in support of the child. The questions below reflect activities consistent with parental expectations and skills and may account for efforts applied to meet any needs beyond what is appropriate for the child's age. Please complete this questionnaire in the manner that best describes the care you are currently providing to the child. We appreciate your input.

1a. The child may need assistance with basic self-care tasks. Please check the boxes below if you are helping the child with any of these daily living skills. (check ALL boxes that apply)

☐ Feeding ☐ Toileting ☐ Putting on clothes ☐ Bathing ☐ Grooming ☐ Menstrual care
☐ Mobility (walking, standing, transferring to/from wheelchair) ☐ Use of upper extremities (hands, arms, fingers)

1b. How are you helping the child with these daily living skills? (check ALL boxes that apply)

☐ Supervision of activities ☐ Verbal cueing as needed ☐ Child needs some assistance ☐ Child is not able to complete without help from an adult

1c. How often do you assist the child with these daily living skills?

☐ 0-1 time a week ☐ 2-6 times a week ☐ Every day

2a. Do you arrange and/or facilitate the child attending speech therapy, physical therapy and/or occupational therapy? ☐ Yes ☐ No

2b. How often do you arrange/facilitate the child attending speech therapy, physical therapy and/or occupational therapy? ☐ 1-2 times a month ☐ 3 times a month ☐ 4 or more times a month

IF CHILD IS 14 OR OLDER, COMPLETE, QUESTIONS 2C, 2D, 2E.

2c. Please check the boxes below if you are assisting the child with any of the listed Instrumental Activities of Daily Living (IADLs). (check ALL boxes that apply)

☐ Managing finances ☐ Accessing transportation ☐ Shopping ☐ Preparing meals ☐ Using communication devices such as a phone, TTY etc. ☐ Managing medication ☐ Completing basic homework ☐ Transporting or facilitating attendance at ILP classes ☐ Supporting youth in job searches

2d. How are you helping the child with these Instrumental Activities of Daily Living (IADLs)? Check ALL boxes that apply

☐ Supervision of activities ☐ Verbal Cueing as needed ☐ Child needs some assistance) ☐ Child is not able to complete without help from an adult

2e. How often do you assist the child with these Instrumental Activities of Daily Living (IADLs)

☐ 0-1 times a week ☐ 2-6 times a week ☐ Every day

3. Check the boxes below if you provide support and/or assistance to the child so they can participate in community activities and/or extra-curricular activities. (check ALL boxes that apply)

☐ Check-in to make sure child receives needed assistance/support with Activities of Daily Living while participating in community/extra-curricular activities
☐ Go with the child to community/extra-curricular activities to provide direct support to the child
☐ To participate in community/extra-curricular activities the child needs my constant support or supervision to participate.
☐ **FOR CHILD 14 & OLDER** youth receives needed assistance/support with Instrumental Activities of Daily Living in community/extra-curricular activities

4a. Does the child have emotional/ behavioral challenges as diagnosed by a Licensed therapist or MD
☐ YES ☐ NO

4b. Check boxes below with the type of emotional/behavioral supports the child/family participates in. (check ALL boxes that apply) ☐ Child attends therapy ☐ Family Therapy ☐ Group therapy for child ☐ Support group for caregiver ☐ Wraparound (WRAP), TBS or other home based therapeutic services ☐ APSS (Adoption Promotion and Supportive Services) ☐ Parent Child Interactive Therapy (PCIT) ☐ Other (please describe) _____

4c. Check boxes below for any activities you do to support the child in addressing emotional/behavioral challenges. (check ALL boxes that apply:

☐ Taking/facilitating transportation of child to therapy appointments ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ time/week

☐ Talking to therapist, clinicians, social workers or other professionals ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ time/week

☐ Monitoring, observing, documenting child's behaviors ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6+** time per week

☐ Implementing therapeutic intervention/behavior plan ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ time per week

☐ Redirecting, prompting child and/or defusing behaviors ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ time per week

☐ Supporting the child through emotional outbursts/tantrums ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ time per week

☐ Cleaning due to bed-wetting and/or repairing damage to home ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ time per week

☐ Supervising/observing child, including line of sight ☐ occasional ☐ frequent ☐ all day ☐ 24 hours

5a. For a *SCHOOL-AGE CHILD*, how much time are you spending supporting and supervising the child for homework and/or other learning activities, beyond what is usually required for a child of the same age? Include time spent supporting the child in school-based activities, volunteering in the classroom, arranging tutoring, maintaining equipment, tools or devises so child can access education. Also includes assisting with college/financial-aid applications.

☐ **1-2 hours per week** ☐ **3-4 hours per week** ☐ **5-6 hours per week** ☐ **7-8 hours per week** ☐ **9 + hours per week**

5b. For a *NON SCHOOL-AGE CHILD*, check the boxes below for any support you are providing for the child to participate in/benefit from child care and/or preschool programs. (Check ALL boxes that apply).

☐ Enrolled child in Early Head Start/Head Start, Transitional Kindergarten program or other child development program.

☐ Read out loud to child ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5+ times a week**

☐ Provide additional support in coordination with child care/preschool including any issues regarding child's behavior that might put he/she at risk of being denied services at daycare or educational facility.

☐ Maintaining equipment, tools or devices for child to access education

☐ Respond to complaints from child care/preschool (circle # that applies) ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5+ times a month**

5c. How much time are you spending to advocate on behalf of the child with teachers or child care/preschool staff. This includes activities such as planning/participating in special education development and reviews, picking up child from school due to disciplinary issues, being present at school or speaking on the phone to school personnel, coordinating services (such as TBS) with school, and assisting in school enrollment and partial credit restoration.

☐ **1-2 hours per week** ☐ **3-4 hours per week** ☐ **5-6 hours per week** ☐ **7-8 hours per week** ☐ **9 + hours per week**

6a. Please check the boxes below to show the doctors or other healthcare specialists the child sees. (check ALL boxes that apply) ☐ Pediatrician for routine well-child care ☐ Dentist for routine well-child care ☐ Specialist (ex. neurologist, allergist, psychiatrist, orthodontist, etc.) ☐ **1- 3** ☐ **4 - 5** ☐ **6 - 8** ☐ **9-11** ☐ **12 -14+ times a year**

☐ If your pediatrician/dentist provides specialty care for the child (beyond routine well-child appointments) please describe below, and indicate how many appointments a year you arrange with the pediatrician/dentist:

_____

_____

6b. Please check the boxes below that apply regarding medications prescribed by a doctor. This includes psychotropic medication for emotional/behavioral health.

☐ Observe, record, and/or report medication effects to doctor and administer:

☐ 1 medication as needed ☐ 1 medication daily ☐ 2 or more medications daily ☐ 2 or more medications more than once a day ☐ Monitor the child who takes the medication themselves

6c. For a child, who uses equipment and/or a medical device, check the box to show the care you provide.

☐ Monitor the child using medical device and/or testing equipment ☐ Operate and monitor the equipment and/or medical device

6d. For a child who has a severe medical and/or developmental health concern check the boxes to show the care needed. (check ALL boxes that apply):

☐ Child requires in-home monitoring by medical professional

☐ Child requires use of medical equipment multiple times per week

☐ Child with severe condition, including but not limited to, aspiration, suctioning, mist tent, ventilator, tube feeding, tracheotomy, symptomatic AIDS, hepatitis, chemotherapy, indwelling lines, colostomy/ileostomy, burns on more than 10% of body.

7a. How often are you supporting the child's visits and/or participation in community and cultural activities important to his/her cultural and communal identity? This includes transporting and staying at the visits/activities. (Check ALL boxes that apply and CHECK the number that shows the frequency of these activities.)

☐ Supporting the child's visits with his/her family, siblings and others ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6+ times per week**

☐ Supporting the child in attending community and/or cultural activities ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6+ times per week**

☐ Mentoring/coaching birth parents implementing family visitation plans ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6+ times per week**

ADDTIONAL COMMENTS, CONCERNS AND/OR SUPPORTS:

WOULD YOU LIKE TRAINING OR OTHER SUPPORT IN ANY OF THE AREAS NOTED ABOVE? YES ☐ NO ☐

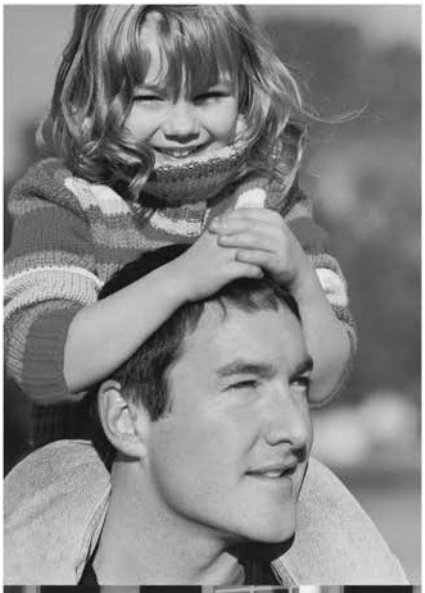
Please list those topic(s):

Resource Parent Signature: _____ Printed Name: _____Date: _____

Social Worker Signature: _____ Printed Name: _____Date: _____

Acronyms

ADL	Activities of Daily Living
AWOL	Away With Out Leave
CANS	Child and Adolescent Needs and Strengths Assessment Tool
CFT	Child and Family Team
CFTM	Child and Family Team Meeting
FFA	Foster Family Agency
ISFC	Intensive Services Foster Care
ITFC	Intensive Treatment Foster Care (will end December 2017)
RF	Resource Family
SCI	Specialized Care Increment
STRTP	Short Term Residential Therapeutic Program
TOPS	Treatment and Outcome Package



Resource Center for Family-Focused Practice

Level of Care **Protocol** Training for Trainers

Activities & Resources

UCDAVIS EXTENSION
CENTER FOR HUMAN SERVICES

Level of Care - Probation Scenarios

Probation Intervention Issue:

Marcus (now 16) was arrested at age 14 after he was caught showing a firearm to students on his school campus and stating that another student was “gonna get his”. He was declared a ward after he was adjudicated for possessing a firearm on school property and criminal threats. He sustained a probation violation for failure to attend a court-ordered community program, truancy, marijuana use, and fighting at school, and was then ordered placed in a group home facility to receive treatment which he did in June the previous year. He graduated from his current group home program on 8/25/17, and has moved in with his maternal aunt while his mother is transient and unable to provide a stable residence.

Information about Marcus:

Marcus began associating with a known criminal street gang when he was about 11, and reports he became a member of the gang when he was 13 years old. Marcus has an extensive history of suspensions and truancy from school, prior to his group home placement. Marcus was originally placed at a facility in state, but after several incidents, including two AWOLs, three positive drug tests for marijuana, and three fights with other youth, he was placed in an out-of-state facility. Since his placement in the out-of-state treatment facility, Marcus has not had any serious incidents. At his current group home he has been earning credits with a school credit recovery program, yet he is still one grade level behind in English. Marcus reports difficulty concentrating when there is a lot of noise and disruption around him and takes several hours on homework assignments. Marcus has an Individualized Education Program (IEP) meeting pending to identify ways to help him in school. Marcus completed anger management and gang intervention programs while at his current group home, and participated in individual and family therapy. Marcus’s aunt says he is usually withdrawn, but sometimes gets “jumpy”. Marcus has been diagnosed with Post-Traumatic Stress Disorder due to violence exposure while active in the criminal street gang. He has been prescribed Prozac (taken daily) to assist with his anxiety. Marcus attends therapy sessions weekly, with an additional family therapy session occurring monthly.

Permanent Plan:

Marcus’s mother is currently working towards obtaining an apartment where she and Marcus may live.

Relevant Probation Conditions:

- Do not associate with any known members of a criminal street gang.

- Random weekly drug testing.
- Monthly check-ins with his Probation Officer.
- Participate in therapy as directed by his therapist.

Marcus has additionally requested to be able to visit with his grandmother, who lives about one hour away, on a regular basis.

Probation Intervention Issue:

Simon (15) was arrested after he was found trespassing at the age of 14. He had 1 gram of methamphetamine on his person. He was originally granted probation under 725(a) WIC (formal, non-wardship probation), but was declared a ward after violating probation by running away from home and testing positive for methamphetamine. After several more probation violations for failing to participate in a court-ordered drug program, testing positive for methamphetamines, and running away, he was placed in a group home to receive treatment. Simon graduated from group home placement on 8/1/16 but his family has been unwilling to have him return home, instead he was sent to live with his paternal grandmother.

Information about Simon:

Simon is biologically male, but presents and identifies as female. Simon's family struggles with her gender orientation and refuses to call her by her chosen name of Reena, or refer to her with feminine pronouns. Reena's father has stated he won't allow her to reside in the home if she continues to identify as a female. While in therapy at the group home, Reena disclosed two prior suicide attempts which occurred a year prior. She has been identified as a victim of commercial sexual exploitation after disclosing incidents where she offered sexual acts in order to obtain shelter, drugs, and money on several occasions. She began using alcohol and marijuana at age 11, and progressed to using methamphetamine at the age of 14. Reena has a significant history of suspensions from school for drugs and fighting, and a history of truancy prior to her group home placement. While at the group home, Reena has been stable without concern for drug or alcohol use. She and her family began family therapy sessions, which continue on a bi-weekly basis, with individual therapy occurring weekly.

Permanent Plan:

Reena and her family will continue family therapy until such time as Reena and her family have established a plan on her returning to the family home.

Relevant Probation Conditions:

- Random weekly drug testing.
- Monthly check-ins with his Probation Officer.
- Participate in therapy as directed by her therapist.

Probation Intervention Issue:

Theodore (15) was arrested after his two younger sisters (6 and 9) disclosed several incidents of molestation, including genital touching and oral copulation over a two year span towards both siblings. Theodore has been declared a ward of the court and ordered to live with his maternal aunt and uncle, who have no other children in the home, as he may not reside with the victims.

Information about Theodore:

Theodore is an excellent student with a GPA of 3.5 and no known learning disabilities. He is described by his aunt and uncle as very respectful and extremely quiet. He is currently enrolled in a juvenile sex-offender program which he attends weekly, and includes group and individual therapy. Theodore recently disclosed molestation he experienced at the hands of a family friend when he was about the age of 6. Since his disclosure, Theodore has been more withdrawn.

Permanent Plan:

Theodore's parents and aunt have discussed the aunt becoming Theodore's legal guardian, but she has been hesitant to begin the process. Theodore and his parent continue to participate in family therapy in the hopes he may eventually come home one day.

Relevant Probation Conditions:

- No contact with any child under the age of 14 without supervision and Parental or Probation Officer permission
- Monthly check-ins with his Probation Officer.
- Participate in therapy as directed by his therapist.

Level of Care – Child Welfare Scenarios

Protective Issue:

Jacob (15), Evelyn (9), and Marcos (2) were removed from their mother, Diana, on 8/17/17. All three youth were removed from the mother by law enforcement after all three children witnessed a severe domestic violence incident between the mother and her partner, David, in which David struck Diana in the face with a bottle and was reported to have choked her on the couch until she lost consciousness. Jacob attempted to intervene to protect his mother, and David punched Jacob in the face, causing his right check to be bruised and swollen. Neighbors called the police, and upon their arrival, the police found the mother with a swollen eye and welts on both sides of her neck. Police also found dozens of empty and half empty beer bottles in the living room. The house was unkempt with pet feces in the carpet, minimal food, and dirty diapers overflowing in the trash. David appeared heavily intoxicated and was arrested and detained for public intoxication and corporal injury to a spouse. Diana was also intoxicated. Therefore, the children were taken into police custody and placed in foster care.

Information About The Children:

Jacob (15) was placed in the resource family home of Linda and Luke Johnson on 8/17/17. Jacob presents as well dressed, well groomed, and he is shy and soft spoken. Jacob was asked by his parents to care for his siblings and reports he has been primarily responsible for cooking meals, cleaning, doing laundry, and he reports he takes the city bus to school every day. Family members describe Jacob as “kind and very responsible. He has done everything for Evelyn and Marcos. He loves them very much.” Jacob is reported to have a severe stutter, for which he attends weekly speech therapy at school. Diana reports Jacob has a severe learning disability (dyslexia). He has an active Individualized Educational Plan (IEP) for his speech and learning disabilities. Jacob tries hard in school, but he is currently getting D’s and F’s in all of his classes. He receives tutoring at school daily and spends 2-3 hours per night to complete his homework. Jacob says he would have liked to have had more help on his homework while with his parents, but his mom and dad were “too busy fighting” to help him. Jacob recently served a 3 day suspension for cussing at a teacher after being asked why he had not turned in his assignments. Jacob, until recently, had been attending weekly therapy to address anxiety and depression. He was referred to therapy after telling his teacher he was overwhelmed and wanted to hurt himself and was evaluated for psychiatric hospitalization on 7/14/17. He is currently prescribed Lexapro (taken daily) to help with depression and mood instability. After the removal, Jacob has become more irritable and withdrawn. Mr. and Mrs. Johnson report Jacob has periods of time when he is more irritable (e.g. yells, cusses, slams doors) when he is not able to see or talk to his siblings. During his recent medical/dental check ups, Jacob was found to be generally very healthy with no diagnosed health conditions. His dental check up revealed no cavities. Jacob states he was a part of a local church youth group (meets weekly on Saturdays) near his family home and has requested he be able to attend church on Sundays mornings and the youth group activities on Saturday afternoons.

Evelyn (9) was placed in the resource family home of Sandra and Arturo Espinoza, Evelyn’s maternal aunt and uncle, on 8/17/17. Evelyn is playful, energetic, and very talkative. Mr. and Mrs. Espinoza report Evelyn is “clingy” and cries and tantrums whenever she is separated from them. Mrs. Espinoza is a stay-at-home mother, and she reports it often takes a few hours in the morning to get Evelyn ready for school because she cries and tantrums for approximately 45 minutes before eventually going to school. Mr. and Mrs. Espinoza report Evelyn has night terrors approximately twice per week,

and Mr. and Mrs. Espinoza report they are often up for several hours during the middle of the night helping to comfort her until she is able to go back to sleep. Evelyn also wets the bed 4-5 times per week. They are in the process of having her seen by a doctor to rule out organic causes of the bedwetting. Mr. and Mrs. Espinoza report they have to do laundry several times per week to assure Evelyn has clean bedsheets and clothing. The family participated in a Child and Family Team (CFT) meeting on 8/24/17 where it was determined Evelyn would be referred to in-home behavioral services and weekly individual therapy with a licensed therapist to help stabilize Evelyn's behavior. Mr. and Mrs. Espinoza agreed to meet with the therapist weekly to provide updates and participate in Evelyn's treatment. Evelyn attends 4th grade, is very intelligent, and she has a very supportive teacher, Ms. Loomis. Ms. Loomis reports Evelyn is eager to learn and does relatively well in school so long as she has 1:1 support and attention in the classroom. Evelyn is easily distracted and often gets up in the middle of class to talk to other students which is distracting to other children. Evelyn is easily redirected back to her work. Ms. Loomis reports Evelyn is approximately to grade levels behind in reading and math and could use some extra support at home to help her with her skills. She recommends working in a workbook for a few hours every night to help her with reading and math. Evelyn has been diagnosed with juvenile onset diabetes and sees an endocrinologist every three months. She receives blood sugar checks and insulin shots before every meal (3 times per day). During school days, the insulin shot for lunch is given by the school nurse.

Marcos (2) was placed in the resource family home of Darren and Lisa Wilson on 8/17/17. Marcos is a happy, smart, and physically active child who is meeting or exceeding all developmental milestones. Marcos is able to walk, climb stairs, and has a very large vocabulary for a child of his age. Marcos is well mannered and has a gentle disposition. He has periodic tantrums when he does not get what he wants, but Mr. and Mrs. Wilson report the tantrums are "normal for his age." Mr. and Mrs. Wilson report Marcos is enrolled in daycare which he attends four days out of the week. The daycare reports Marcos is friendly, generally shares well with the other children, and is mostly well behaved during the day. Marcos was taken for his well-child check up on 8/20/17, and he was found to be in good health. Marcos was slightly behind on immunizations, but he was brought to current at this appointment.

Visitation:
The Court has ordered the following visitation plan for the family:

- One visit for all three youth with the mother and father (to be held separately on separate days due to a criminal protective order in place.
- One additional sibling visit per week for Jacob, Evelyn, and Marcos. All three caregivers have agreed to conduct the sibling visits on Saturdays at a park or Chuck-E-Cheese.

Jacob has additionally requested to be able to continue to attend his youth group which is approximately a 20 minute drive from his currently placement.

County Practice

This overview of the Level of Care Matrix Rate Determination Tool and scoring process has been designed to start the process of implementation a more individualized rate in support of CCR in your county. The intent was to create a tool, which would not effect change in your county's current practice and protocols for current procedures in rate assignment. However, this may prompt changes. In order to prepare for assisting your county in planning, please take time to discuss and note the following impact this may have on your county

How to process the rate once determined? Will this change?

_____
_____
_____
_____
_____

Who provides secondary approval of the rate? Will this change?

_____
_____
_____
_____
_____

Who is informing the resource parent and FFA, if appropriate, on the rate determined or changes in the rate? Will this change?

_____
_____
_____
_____
_____

The process for triggering for a fair hearing? Will this change?

_____
_____
_____
_____
_____

The role of the case carrying Probation officer, Social worker and eligibility worker. Will this change?

_____
_____
_____
_____
_____

What steps will you take to guide your county in the implementation of the new rate protocol?

_____
_____
_____
_____
_____
_____
_____
_____
_____

What benefit do you see in implementing this new rate structure?

_____
_____
_____
_____
_____

What concerns do you have?

_____
_____
_____
_____
_____

Thank you for attending and what you do to support the children, youth, and families!

CDSS
WILL LIGHTBOURNE
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

EDMUND G. BROWN JR.
GOVERNOR

September 22, 2016

REASON FOR THIS TRANSMITTAL

[X] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[ ] Clarification Requested by One or More Counties
[ ] Initiated by CDSS

ALL COUNTY LETTER (ACL) NO. 16-79

TO: ALL COUNTY WELFARE DIRECTORS
ALL CHIEF PROBATION OFFICERS
ALL LOCAL MENTAL HEALTH DIRECTORS
ALL COUNTY ADOPTION AGENCIES
ALL ADOPTION DISTRICT OFFICES
ALL GROUP HOME PROVIDERS
ALL FOSTER FAMILY AGENCIES
ALL TITLE IV-E AGREEMENT TRIBES

SUBJECT: INFORMATION ABOUT THE CONTINUUM OF CARE REFORM (CCR) HOME-BASED FAMILY CARE (HBFC) AND SHORT-TERM RESIDENTIAL THERAPEUTIC PROGRAM (STRTP) RATES STRUCTURE AND CONVERSION PROCESS FROM THE OLD RATE STRUCTURE TO THE NEW RATE STRUCTURE

REFERENCE: ASSEMBLY BILL (AB) 403, CHAPTER 773, STATUTES OF 2015; SENATE BILL (SB) 831, STATUTES OF 2016; WELFARE AND INSTITUTIONS CODE (WIC) SECTIONS 11364, 11387, 11453, 11460, 11462, 11462.01, 11462.04, 11462.015, 11462.02, 11463, 16000, 16519.5, 16519.52, 16519.53, 16519.54, 16519.55, 18254, 18358.30, 18987.72; ACL 16-57; ACL 16-65

The purpose of this ACL is to provide information about the new HBFC and STRTP rate structures and to describe the first phase of implementation.

Background

The California Department of Social Services (CDSS) is designated as the single organizational state entity which is authorized under existing state law to administer a state system for establishing rates in the Aid to Families with Dependent Children-

Foster Care (AFDC-FC) program.[1] The passage of AB 403 necessitates the implementation of a new rate setting system to support the goals of the CCR effort. Funding for a new rate structure was provided as part of the Fiscal Year (FY) 2016-17 Budget Act. This new rate structure will be implemented in two phases, with the first phase commencing on January 1, 2017. Phase II will implement on a date to be determined and information will be provided in a future ACL. Phase II rates will be paid prospectively and will not be paid retroactively to January 1, 2017. In addition, the new rate structure is considered "interim[2]" until January 1, 2020, unless a future enacted statute deletes or extends this date or establishes a final rate structure.

Once fully implemented, the new HBFC rate structure is designed to support children in family settings based on a core practice approach that uses a Child and Family Team to engage the child/youth and their families. County agencies, Foster Family Agencies (FFAs) and STRTPs will make available core services and supports (described below), that are tailored to meet the needs of child/youth and families.

AB 403 also creates a new licensing category referred to as STRTPs which will eventually replace the Group Home (GH) rate classification level (RCL) structure. As of January 1, 2017, the CDSS will no longer issue rates based on the GH RCL system for new providers. Current GH's may apply to be licensed as a STRTP. The STRTPs will provide an integrated program of core services, as specified, as well as therapeutic services. The Interim Licensing standards for STRTPs will be outlined in a separate ACL and new Mental Health Program Approval/Medi-Cal Certification requirements will be forthcoming from the Department of Health Care Services (DHCS).

AB 403 also requires the department to create a rate structure for FFAs and STRTPs that takes into consideration the delivery of individualized core services and supports which are trauma-informed and culturally relevant, and secured either through direct services or formal agreements with other agencies.[3] Core services and supports include but are not limited to: specialty mental health services for eligible children; transition support services for children/youth upon initial entry and placement changes; educational, physical and health supports; including extracurricular activities and social supports; support for transitional-age and non-minor dependent youth; permanency services including clinical permanency services to reunify or achieve adoption or guardianship and efforts to maintain or establish relationships with parents, siblings, extended family members, tribes (active efforts), or other relationships identified as important to the child or youth.

[1] WIC 11460(a).
[2] WIC 11462.
[3] WIC 11462 and 11463.

I. The New HBFC and FFA Rate Structure

This section describes the HBFC and FFA rate structure. Effective January 1, 2017, every individual applying to be a foster family, including relative caregivers, will be assessed and, if determined to meet applicable Resource Family Approval (RFA) standards, will be identified as a Resource Family (RFs) as described in ACL 16-10 and ACL 16-58.

There are three key highlights to note about the new HBFC rate structure as it applies to RFs and FFAs under Phase I implementation:

1) Age is no longer a sole factor to determine the amount of the basic foster care rate. There will be a single rate for all families.

2) The HBFC structure standardizes the basic rates paid for children/youth placed in approved, certified, licensed foster family homes or relatives and Resource Families. No longer is there a distinction between placement types and amounts paid.

3) FFAs will receive a rate that incorporates two new components: RFA activities and the provision of Services and Supports (S&S).

Phase II will provide for a tiered Level of Care (LOC) rate structure. Rate determinations will be based on a set of domains for each level based on frequency, duration and intensity of services delivered. A LOC Protocol tool will be used for the rate determination and is currently being developed by a workgroup. More information and implementation instructions will be provided in a subsequent ACL.

New Components of the FFA Rate Structure

Effective January 1, 2017, all FFAs will be required to implement RFA for new families, and all existing families will be required to convert to approval status under RFA by December 31, 2019.[4] Information on the RFA process for FFAs has been provided through Interim Licensing Standards. In addition, AB 403 reinforces the preference that children or youth with physical, emotional or behavioral health challenges remain in a home-based family care setting when possible.

As a result, two new components have been added to the FFA rate structure to support AB 403 objectives in Phase I: S&S and RFA. The S&S amount is intended to enhance the ability for FFA's to provide core services.

[4] Health and Safety Code 1517

The RFA amount is added to the rate to capture the administration of the psychosocial assessment and other required RFA activities. Additional changes to the FFA rate during Phase I are described on page five.

Intensive Treatment Foster Care (ITFC)

On January 1, 2017, the ITFC program described in WIC section 18358.30 will remain in effect and rates will continue to be paid for current or newly established ITFC programs per ACL 16-57 until further notice of Phase II implementation. AB 1997 (Stone, 2016), if signed into law, requires the department to implement a new interim rate structure for specialized programs that serve children with specific needs including intensive treatment and behavioral needs and specialized health care needs.[5] Further information regarding these changes will be provided in a subsequent ACL.

In Phase II of rate implementation, the programmatic aspects of ITFC will be modified so that it aligns with the new Intensive Services Foster Care (ISFC) rate structure. Under the new HBFC rate structure, the ISFC rate is intended to accommodate Multi-Dimensional Treatment Foster Care, special health care or medical placements, Therapeutic Foster Care (TFC), or other special placements. The ISFC will be a program that is also an alternative placement option to or a step-down from a residential setting. The new ISFC program will give the agency and county more flexibility to tailor the services to the needs of a child/youth, specifically for a child/youth that may be stepping down from residential care.

II. GHs and STRTPs

Pursuant to AB 403, the reliance on congregate care should be limited to short-term therapeutic interventions. Children/youth placed in STRTPs should receive the intensive services they need to stabilize and return home or step-down to a HBFC setting where the appropriate services can still be provided. No later than 12 months subsequent to licensure, STRTPs will be required to obtain a mental health contract and a Mental Health Program Approval/Medi-Cal Certification from the DHCS or a delegated county Mental Health Plan to ensure the provision of specialty mental health services for children placed into these facilities.

[5] WIC 18358.

In order to apply for the new STRTP rate, a STRTP must meet the following requirements:

- Obtain a letter of recommendation from either a host or placing county
- Submit an application to the Community Care Licensing Division (CCLD)
- Submit documentation regarding the status of accreditation
- Submit a new program statement and plan of operation

In order to be licensed as a STRTP and receive the STRTP rate, the facility must obtain a license from the CCLD and have a rate issued by the Foster Care Audits and Rates Branch (FCARB). The STRTPs will be required to obtain accreditation from an accreditation body identified by CDSS within two years of licensure and to provide a status update to CDSS at the 12 month and 18 month intervals subsequent to licensure. Additional information regarding licensing and program requirements will be provided in a future ACL.

III. Phase One Implementation for HBFC Placements, FFA Rates, STRTPs, Group Homes and Other Placements Types

The first phase of implementation begins January 1, 2017 and is described in this section. Phase II of the HBFC structure will be announced in a future ACL and future instructions will establish the tiered HBFC structure for RFs and FFAs, including the ISFC rate, address the use of the rate determination protocol and establish a Services-Only rate for FFAs and Community Based Organization (including STRTPs) that are contracted with a county placing agency to serve county-approved resource families, including relatives.

HBFC Basic Level Rate

Effective January 1, 2017, a basic level rate of $889 will be issued for all new placements of a child/youth in one of the following settings: Resource Families, county foster family homes (FFHs), Relatives (including both Federal and non-Federal relative cases and regardless of participation in the Approved Relative Caregiver Program), Nonrelative Extended Family Members home, and a Non-Minor Dependent in a Supervised Independent Living Placement. Counties may, in addition to the basic level, apply the SCI and clothing allowance. Families paid at a higher rate than the basic level rate (e.g. any additional SCI) may continue receiving those rates at county discretion. Counties will continue to provide written guidelines for their discretionary continuation of SCI rates and clothing allowances, and apply these guidelines equitably to determine a family's eligibility for SCI rates or clothing allowances. The educational travel stipend policy remains unchanged and should continue to be paid as determined by the county.

Current placements (cases existing prior to January 1, 2017) identified above that are receiving a basic rate less than the basic level $889 will, effective January 1, 2017, receive a rate increase up to the basic level rate of $889.

FFAs Rates

Effective January 1, 2017, all new and existing FFA RFs and certified families will be paid according to the rate structure displayed below. FFAs will be paid the total rate in the chart below. Phase I provides one flat rate for administration and incorporates the new components of RFA and S&S. These rates will be paid until instructions are issued that will establish the tiered HBFC structure for FFAs in Phase II.

Age	0-4	5-8	9-11	12-14	15-21
FFA Certified Family	$896	$954	$994	$1,032	$1,072
Social Worker	$340	$340	$340	$340	$340
Service & Supports	$156	$156	$156	$156	$156
RFA	$48	$48	$48	$48	$48
Administration	$672	$672	$672	$672	$672
Total	**$2,112**	**$2,170**	**$2,210**	**$2,248**	**$2,288**

STRTP and GHs

Effective January 1, 2017, the new STRTP rate is $12,036.00. For all out-of-state GH placements, the rate the county pays is based on the out-of-state GH rate; however, the rate paid cannot exceed the new STRTP rate. Any GHs that cannot readily convert to a STRTP may be granted an extension, at county request, to continue to receive their existing RCL rate. For further information regarding the extension request criteria, counties and providers should refer to ACL 16-65.

For GHs that successfully convert to an STRTP (i.e. CCLD licensure and a rate approved by the FCARB), FCARB will send a rate approval letter to inform both the county welfare and/or probation department and the new STRTP of the new rate and effective date of that rate. Additionally, FCARB will update the GH/STRTP facility rate listing on its website to assist counties in identifying the correct rate to be paid to GHs granted an RCL extension and STRTPs.

Kinship-Guardianship Assistance Program (Kin-GAP), Nonrelated Legal Guardian (NRLG) and Adoption Assistance Program (AAP) Placements

New placements of a child or youth (on or after January 1, 2017) who is determined to be eligible to receive assistance under Kin-GAP, the NRLG Program, and AAP will receive the basic level rate of $889.

The rate structure for families receiving AAP on behalf of an eligible child whose AAP agreement was signed prior to May 27, 2011 and whose adoption finalized prior to May 27, 2011 will not change. Consistent with existing law, AAP agreements signed on or after May 27, 2011 or for AAP eligible adoptions that were finalized on or after May 27, 2011, may be reassessed based on the changing needs of the child or the circumstances of the adoptive parent. Effective January 1, 2017, following a reassessment pursuant to the above, the AAP basic rate may be increased to the new basic level rate. Additional guidance on the HBFC rate structure and how it applies to AAP will be provided in a subsequent ACL.

The rate structure for families currently receiving Kin-GAP assistance payments or for NRLG cases where guardianship was established prior to or after May 1, 2011 will not change. Effective January 1, 2017, the Kin-GAP basic rate may be increased upon reassessment of the circumstances of the caregiver and the needs of the child for cases in which the kinship guardianship was established and dependency was terminated on or after May 1, 2011. Additional guidance on the HBFC rate structure and how it applies to Kin-GAP and NRLG's will provided in a subsequent ACL.

Out-of-State FFH Placements

Out-of-state FFH rates will remain the same. Counties will continue to pay the other state's rate as they do now.

Wraparound Rate

Commencing January 1, 2017, the Wraparound rate will be $8,573 which was calculated based on the average of the RCLs 10.5 and 13 in effect for the FY 2014-15. The California Necessities Index will continue to be applied to this rate. Any adjustments for federal placements will be made in accordance with the existing processes. For purposes of tracking and claiming, the Wraparound rate will be issued as an RCL 16 until phase two of the rate conversion is fully implemented.

IV. Level of Care Rate Protocol

The CDSS will provide further guidance regarding the LOC protocol via an ACL as stated above.

V. Fair Hearings and Noticing

As noted previously, CDSS has authority to establish statewide rates. This ACL transmits the new statewide rates for Phase I implementation effective January 1, 2017, that increase rates for families currently receiving a rate lower than the Basic Level rate. As such, this rate increase is not subject to a fair hearing. However, counties will be required to issue notice for these rate changes. Additional information regarding noticing will be provided in a forthcoming ACL. Upon Phase II implementation of the HBFC rate structure, rates will not be retroactive to January 1, 2017. The HBFC and STRTP claiming issues will be addressed in a subsequent County Fiscal Letter.

Please contact FCARB at (916) 651-9152 for any questions regarding the information in this ACL.

Sincerely,

Original Document Signed By:

GREGORY E. ROSE
Deputy Director
Children and Family Services Division

c: CWDA
CPOC

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

WILL LIGHTBOURNE
DIRECTOR

October 7, 2016

ALL COUNTY LETTER (ACL) NO. 16-84
MENTAL HEALTH SUBSTANCE USE DISORDER SERVICES (MHSUDS)
INFORMATION NOTICE NO. 16-049

TO: ALL COUNTY BEHAVIORAL HEALTH PROGRAM DIRECTORS
ALL COUNTY WELFARE DIRECTORS
ALL COUNTY FISCAL OFFICERS
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL CHIEF PROBATION OFFICERS
ALL TITLE IV-E AGREEMENT TRIBES
COUNTY WELFARE DIRECTORS ASSOCIATION OF CALIFORNIA
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CHIEF PROBATION OFFICERS OF CALIFORNIA
COUNTY COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES

SUBJECT: REQUIREMENTS AND GUIDELINES FOR CREATING AND PROVIDING A CHILD AND FAMILY TEAM

REFERENCE: ASSEMBLY BILL (AB) 403 and AB 1997 (CHAPTER 773, STATUTES OF 2015 and CHAPTER 612, STATUTES OF 2016) WELFARE AND INSTITUTIONS CODE 706.6, 832, 16501.1
PATHWAYS TO MENTAL HEALTH SERVICES – CORE PRACTICE MODEL GUIDE

Executive Summary

This ACL and MHSUDS Information Notice provides information and guidance regarding the use of child and family teaming to deliver child welfare services, as required by Assembly Bill (AB) 403, commonly known as the Continuum of Care Reform (CCR). Signed by Governor Jerry Brown in October 2015, the CCR makes sweeping changes to California's child welfare system, with implementation planned to occur in stages between now and 2021. The intent of the CCR is to have children and youth, who must live apart from their biological parents, live in a permanent home with a committed adult(s) who can meet their needs. The CCR changes also include, but are not limited to, providing services and supports to children, youth, and their families that reduce reliance on congregate care, thereby increasing placements in home-based settings.

One of the CCR's most fundamental principles is that child welfare services are most effective when delivered in the context of a child or youth and family-centered, child and family team (CFT) that shares responsibility to assess, plan, intervene, monitor and refine services over time. Welfare and Institutions Code, Section 16501.1 (c) and (d) require that county placing agencies convene a CFT meeting as defined in Section 16501 to identify supports and services that are needed to achieve permanency, enable a child to live in the least restrictive family setting, and promote normal childhood experiences. This requirement applies to all children and youth residing in a group home with an existing case plan or children and youth who come into the child welfare foster care placement after January 1, 2017, including probation youth in foster care and non-minor dependents.

Background

Team-based approaches are not new to California. Beginning in 1997 with Wraparound, team-driven service models such as Functional Family Therapy, Safety Organized Practice, and Team Decision Making have been in use across the state. More recently, the Pathways to Mental Health Services - Core Practice Model Guide provided a comprehensive description of a CFT that reflects what was already occurring in practice; combining the structure of professional interdisciplinary teams with the strengths-based and inclusive principles of family-centered care to make informed decisions. This state approved guide contains valuable guidance about effective CFT processes.

Evidence-based and promising practices in child welfare and probation increasingly rely on youth and family engagement and teaming processes as effective methods to support children, youth, and families and include system partners in the planning, delivery and management of necessary services. As team-based practices have grown in California, so has the recognition of their success in improving outcomes for children, youth, and their families. The CCR builds on this success to provide children and youth who come into contact with California's child welfare and probation systems with this strategy that improves safety, permanency, and well-being.

Child and Family Team Model Overview

A CFT is a group of individuals that includes the child or youth, family members, professionals, natural community supports, and other individuals identified by the family who are invested in the child, youth, and family's success. In addition to mandated participation of involved public agency representatives, the composition of the team is driven by family members' preferences. Successful CFTs include persons with natural supportive relationships with the family, so that the family's support system will continue to exist after formal services are completed. The CFT's role is to include family members in defining and reaching identified goals for the child. The individuals on the team work together to identify each family member's strengths and needs, based on relevant life domains, to develop a child, youth, and family-centered case plan. The plan articulates specific strategies for achieving the child, youth, and/or family's goals based on addressing identified needs, public safety, including following

related court orders, and building on or developing functional strengths. The CFT typically conducts and coordinates its work through a CFT meeting, which is discussed in detail below. It is important to recognize, however, that the CFT and a CFT meeting are not the same. The CFT is a group of people; a CFT meeting is a functional structure and process of engaging the family and their service teams in thoughtful and effective planning.

The CFT process reflects a belief that families have capacity to address their problems and achieve success if given the opportunity and supports to do so. Engagement with families is fundamental to the CFT process. Working with children, youth, and families as partners results in plans that are developed collaboratively and in a shared decision-making process. The family members hold significant power of choice when strategies are defined.

The CFT process reflects the culture and preferences of children, youth, and families, building on their unique values and capacities, and eliciting the participation of everyone on the team. It is important to recognize that at times the child, youth, and family have their own unique cultures. In those cases, care must be taken to integrate their cultures into the plan. Team members should help children, youth, and families recognize their strengths, and encourage them and support them to develop solutions that match their preferences. The team must respect and support the power of learning from mistakes when strategies do not work as intended so that the plan can be revised to improve outcomes.

Composition of Child and Family Teams

For children and youth in the child welfare or probation systems, the placing agency is responsible for engaging members of the CFT. The CFT composition always includes the child or youth, family members, the current caregiver, a representative from the placing agency, and other individuals identified by the family as being important. A CFT shall also include a representative of the child or youth's tribe or Indian custodian, behavioral health staff, foster family agency social worker, or short-term residential therapeutic program (STRTP) representative, when applicable. Other professionals that may be included are: youth or parent partners, public health providers, Court Appointed Special Advocates, school personnel, or others. In addition to formal supports, effective CFT processes support and encourage family members to invite the participation of individuals who are part of their own network of informal support. This may include extended family, friends, neighbors, coaches, clergy, co-workers, or others who the family has identified as a potential source of support.

Family members may be reluctant, for a variety of reasons, to identify and invite friends or neighbors to participate. Family members may be angry or ashamed of being involved with child welfare, behavioral health, or probation; they may subscribe to cultural norms that do not accommodate sharing of personal information with "outsiders." Engagement may also be challenging for families experiencing serious mental illness and/or substance use disorders, or further complicated by the historical or current impact of trauma.

Professionals can work to mitigate family member reluctance by being patient, offering reassurance and encouragement, and demonstrating respect and cultural humility. It is important to explain how the inclusion of others can directly support the family members to achieve their goals in order to exit child welfare or probation services in a timely and effective manner. Individuals with lived experience (e.g. parent partners, youth partners/mentors) can be useful by being mentors and advocates who have personally experienced many of the same challenges and feelings through their own contact with the child welfare, behavioral health, or probation system(s). The parent partner's or youth mentor's unique role often promotes clarity and understanding for the family.

As families move through the CFT process, family members will often come to recognize their own strengths and experience the power of strengths-based support that comes without judgment. Over time and with growing trust, reluctance may fade and inclusion of natural supports will grow. Team membership is intentionally flexible and dynamic, so team participants will continue to change as needs change. Identified natural supports will move into a more significant role, as professionals work towards transitioning out of the team.

Confidentiality

Confidentiality and information sharing practices are key elements throughout the CFT process, and they must be designed to protect children, youth and families' rights to privacy without creating barriers to receiving services. Section 832 of the Welfare and Institutions Code was added to promote sharing of information between CFT members relevant to case planning and providing necessary services and supports to the child, youth and family. To promote more effective communication needed for the development of a plan to address the needs of the child or youth and family, a person designated as a member of a child and family team may receive and disclose relevant information and records, subject to the child or youth and/or their parent or guardian signing a release of information.

When the CFT convenes, members will discuss and address any concerns related to sharing information openly and transparently. Working together as a team to discuss necessary information such as strengths and challenges, will help the family to determine specific goals, and implement a plan to meet those goals. Sharing relevant information allows families and professionals to build trust in each other and in themselves. This strengths-based, collaborative engagement with families is fundamental to the CFT process.

Child and Family Team Meeting

It is important to recognize that a CFT meeting does not represent the entire process, but is simply one part of a larger strategy, which involves children, youth, and families in all aspects of care planning, evaluation, monitoring and adapting, to help them successfully reach their goals.

It is **only a CFT meeting** if decisions about goals and strategies to achieve them are made with involvement of the child, youth, and family members. The child, youth, and family voice, choice, and preferences are an integral part of the CFT process.

For a child or youth in the child welfare or probation system, the placing agency worker is typically responsible for convening the initial CFT meeting, unless the team is already established by the other agency. The placing agency is responsible for coordinating with the family, other child and youth serving system partners, and others identified by the child, youth, and family to convene the team and initiate meetings. If the child, youth, and family already have an established team through another agency such as behavioral health, or program such as Wraparound, the placing agency will support the existing team process to expand and evolve so that the needs and services indicated under the child welfare or probation case are included. **Cross System planning and coordination will ensure that there is only one team process for any single family in care.**

When to Convene a CFT Meeting

For children and youth without an existing CFT, team membership should start to be identified as soon as possible. A CFT meeting shall be convened by the placing agency within the first 60 days of coming into foster care. A CFT meeting will be convened to discuss any placement changes and service needs for the child or youth in out-of-home care, and the team must be consulted to identify the most appropriate placement of the child or youth, while always considering the least restrictive placement option.

Children and youth in child welfare services are screened for potential behavioral health needs by the placing agency (at intake and every year thereafter). When behavioral health issues are identified or are a concern, even if services are not presently being provided, referrals to appropriate treatment professionals should be made so that the child or youth's needs can be assessed. Behavioral health professionals (which may include county staff or county contracted providers for children eligible or enrolled in Medi-Cal) are important CFT resources and their involvement is especially critical when:

- The team is unsure about a child or youth's need for Specialty Mental Health Services (SMHS); or whether the child or youth should continue receiving any SMHS;
- There is a need to provide information to the team or family regarding how the child or youth's behavior or functioning is impacted by their mental health status;
- The team is considering the need for placement for the child or youth in a family relative, non-related extended family member or any other family type setting, a STRTP, Foster Care, or Intensive Treatment Foster Care;
- The team is considering a recommendation for Medi-Cal Therapeutic Foster Care Services; and/or
- A child or youth is prescribed psychotropic medication(s) or psychotropic medication(s) is being considered for the child or youth.

CFT Meeting Frequency, Location, and Logistics

For children or youth in placement who are receiving Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) or Therapeutic Foster Care (TFC), a CFT meeting must occur at least every 90 days. For children and youth who are not receiving SMHS, the placing agency will convene a CFT meeting no less than once every six months. Best practice dictates that meetings should be held as frequently as needed to address emerging issues, provide integrated and coordinated interventions, and refine the plan as needed and, therefore, frequency of meetings and timeframes should be decided by CFT members.

The CFT meetings should be scheduled at times and locations convenient for family member participation. Meetings should be conducted in a way that establishes a safe environment that engenders trust and reflects the child, youth, and family's cultural preferences and norms. If needed, CFT meetings could include an interpreter or translator to ensure effective communication and clear understanding. The meetings should have a clear purpose and follow a structured format. Since services and supports to the family should always be individualized to meet their needs, CFT meeting frequency and duration will look different for each family.

CFT Meeting Preparation and Case Planning

It is important to prepare a child, youth, and family, as well as professionals, to participate in a CFT meeting. Either at the beginning or prior to the start of a meeting, an explanation of the purpose, people involved, or structure of the meeting should occur. This preparatory discussion should include an opportunity for all team members to ask questions and share concerns. Meeting agendas should be developed with the team and reflect the voice of the child, youth, and family.

During the development of a case plan, professionals should consider the family's ideas before making their own suggestions. Children, youth, and their families are the best experts about their own lives and preferences and their natural supports have valuable information and resources to share. Child, youth, and family member preferences should be taken into account in the decision making process, unless these preferences pose a child, youth, or community safety issue or conflict with court orders. Plans must be individualized, culturally responsive and trauma-informed. The team should routinely measure and evaluate child or youth and family member progress and emerging needs. Team meetings can help team members recognize when interventions and treatment plans are working and when they may require revision. The team's role in providing encouragement to continue the work to achieve family goals is a critical component of success.

Who Facilitates a CFT Meeting

Typically, the placing agency facilitates the CFT meeting. The placing agency may choose alternative individuals to facilitate such as another individual from the placement agency, a provider, an informal support, or any other team member as determined by the CFT. The role of the facilitator is one that helps to identify needed contacts, builds consensus within the team around collaborative plans, actively

supports the agenda, and ensures that the family voice and choice is heard throughout the entire teaming process. Facilitation training can be made available through CDSS. The decision of who should facilitate the CFT meetings should be a shared decision that includes the preferences of the child, youth, and family members, although local county practices may dictate who facilitates and may largely be influenced by the purpose of the meeting. Other team members may take on the role of the facilitator; however, coordination of care for the safety, permanency, and well-being of the child and youth will remain the responsibility of the placing agency. The involved public agency providers, along with family and team members, assess immediate safety, stabilization, and crisis support needs, developing an immediate and usable safety plan for the child, youth, and family to follow.

Inquiries

"Frequently Asked Questions" are included as an attachment to this ACL/MHSUDS Information Notice. Further information on confidentiality and documentation of CFTs will be forthcoming.

If you have any inquiries, please direct all CFT questions to the Integrated Services Unit, at (916) 651-6600, or via email at CWScoordination@dss.ca.gov or contact the DHCS, Mental Health Services Division, at (916) 322-7445 or email KatieA@dhcs.ca.gov.

Sincerely,

Original Document Signed By:

KAREN BAYLOR, Ph.D., LMFT
MSW
Deputy Director
Mental Health and Substance Use
Disorder Services
California Department of Health Care Services

Original Document Signed By:

Cheryl Treadwell For GREGORY E. ROSE,
Deputy Director
Children and Family Services Division
California Department of Social Services

Attachment

Attachment 1

Frequently Asked Questions (FAQ's) for Child and Family Teams

The California Department of Social Services (CDSS) and the Department of Health Care Services (DHCS) recognize the unique needs of children and youth in the child welfare and probation systems (hereinafter referred to as the placing agency) as well as children and youth receiving Specialty Mental Health Services (SMHS). Below you will find the most frequently asked questions specific to the child and family teaming process. If you do not find an answer to your question, please contact CDSS at CWSCoordination@dss.ca.gov or DHCS at KatieA@dhcs.ca.gov.

1.) When is a child or youth in the child welfare system required to have a Child and Family Team (CFT) meeting?

After January 1, 2017, a child or youth is required to have a CFT within the first sixty (60) days of entering into the child welfare or probation foster care placement. As defined in Welfare and Institutions Code, Section 16501, a CFT is also required for those children and youth residing in a group home or Short-Term Residential Therapeutic Program (STRTP) placement with an existing case plan. Best practice dictates that meetings should occur as soon as possible for, but not limited to, case planning purposes, placement determination, emancipation planning and/or safety planning.

The CFTs should also be in place for children and youth receiving certain Specialty Mental Health Services (i.e. Intensive Care Coordination and Intensive Home Based Services).

2.) How frequently does the CFT meet?

For children or youth in placement who are receiving Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), or Therapeutic Foster Care (TFC), a CFT meeting must occur at least every ninety (90) days. Children and youth in the child welfare or probation systems are required to have a CFT meeting at least once every six (6) months. Meetings should occur on an as-needed basis. For example, CFT meetings could occur once per month, depending on the needs of the child, youth, or family. In other instances, meetings may occur less often as agreed upon by the CFT.

For children and youth receiving Specialty Mental Health Services (SMHS) that require a CFT (ICC, IHBS, and services provided through the TFC services model), the CFT should reassess the needs of the child or youth, and adapt the plan to address changing needs in a timely manner, but not less than every ninety (90) days.

Urgent issues, such as safety concerns, risk of placement disruption, and/or ineffective support services, should be addressed immediately.

Attachment 1

Frequently Asked Questions (FAQ's) for Child and Family Teams

3.) Who initiates and schedules a CFT meeting?

The first CFT meeting is initiated and scheduled by the placing agency. Subsequent CFT meetings can be initiated by the child, youth, family, or another team member.

If the child or youth is dually involved, both the child welfare social worker and probation officer should have a conversation to identify and clarify the individual (social worker or probation officer) responsible for initiating and scheduling the first CFT meeting.

4.) What if my county has an existing team meeting process already in place?

As long as the teaming process is based on the values and principles of strengths-based, family-centered care and follows the guiding principles outlined in the attached All County Letter 16-84 and Mental Health Substance Use Disorder Services Information Notice 16-049, the county placing agency should support the existing team processes and incorporate efforts to ensure the current needs and services of the child, youth, and family are being met. Examples of some alternate teaming processes are: Multi-Disciplinary Teams (MDT's); Safety Organized Practice (SOP) Family Teams; Family Group Decision Making and Wraparound Child and Family Teams. The intention of the state's practice is to have **one** gathering that addresses the child or youth's needs in an efficient manner that also avoid confusion for the child, youth, and family.

5.) Can CFT meetings occur in conjunction with other processes or address other areas of need not already included in the CFT goals and/or objectives?

Yes. In order to help reduce duplicative efforts and leverage existing activities, the CFT meeting can occur in conjunction with other regularly scheduled meetings, when appropriate. Some examples are:

- Team Decision Making
- Case Planning/Permanency Review Meetings
- Transitional Independent Living Planning Meetings

6.) Does the CFT process end after one specific goal has been attained?

No. As long as the child or youth is in foster care the process does not end after one goal is attained because new goals are developed to address the child, youth, and family's changing and evolving needs. Goals are continually assessed and transition plans are established.

Frequently Asked Questions (FAQ's) for Child and Family Teams

If all goals are met and the family has a solid post-permanency plan in place with natural supports, the CFT may recommend that the family is able to transition out of formal services.

7.) If a CFT has been held, does the county still need to complete an interagency placement meeting?

Local county agreements and policies will determine if and how an interagency placement meeting will be held and whether it is necessary even with a CFT meeting occurring.

8.) Do all CFT's look the same?

No. Each CFT is unique and will build upon each child, youth, and families' strengths, values, and goals. In addition, the teaming process must also reflect the culture(s) and preferences of the child, youth, and family.

9.) How are CFT meetings scheduled?

The placing agency worker is responsible to ensuring that the initial CFT meeting is scheduled and coordinated with all CFT members to schedule time and location. Subsequent meetings are often scheduled at the end of each meeting when participants are present. Child, youth, family or team members may identify additional support members to be included. The facilitator will create plans with team members for inviting additional participants.

10.) Who facilitates CFT meetings?

Facilitation is a set of activities that supports the process of the Pathways to Well-Being Core Practice Model. It includes but is not limited to an initial identification of the needs and strengths of the child or youth and family through initial engagement activities; ensuring a comprehensive shared plan is developed and implemented that builds on strengths and identifies intervention necessary to address their needs. The facilitator may also manage the logistics of the meeting, including scheduling, ensuring participation of all team members, accountability for tasks and activities between meetings, and high levels of communication between members as required. Local county practices may differ, but the important point of facilitation is to ensure that CFT meetings are productive and inclusive.

The facilitation is typically done by the placing agency worker, however, local practice could contract this role to a community provider, or the CFT members

may decide that an informal support or team member can facilitate on-going meetings. Facilitation training can be made available through CDSS.

11.) Where should CFT meetings be held?

The CFT meetings are held in a location that is most convenient for the child, youth, and family. Best practice indicates that family homes are the preferred location, but the team must also take into consideration the needs of other team members.

12.) How are meetings scheduled?

The placing agency or assigned facilitator coordinates with all team members when scheduling meeting time(s) and location(s). Agenda items can be sent to the facilitator prior to a meeting. Subsequent meetings are often scheduled at the end of each meeting when participants are present.

Family or team members may identify additional support members to be included. Facilitators will create plans with team members for inviting additional participants.

13.) What if a participant is unable to attend the CFT meeting in person?

If a team member is unable to attend the CFT meeting in person (due to proximity issues or other conflicts), it is encouraged that s/he participate by video conferencing or phone. This option may be helpful when a child is placed in another county or when schedules do not allow in-person participation.

14.) What if a participant can't attend the CFT meeting in person, by phone, or by video conferencing?

Although it is encouraged for everyone on the team to participate, there will be times when not all of the team members are able to attend and the meeting should take place as scheduled. Before the CFT meeting ends, team members should identify someone to provide updates to absent team members in a timely manner.

15.) What specific circumstances may preclude a child or youth from participating in a CFT meeting?

When age-appropriate, a child or youth should always participate in a CFT meeting. Participation should be limited if the nature of the meeting's agenda is not suitable for the child or youth. Some examples may include: the focus of the meeting is only about the parent or parents' needs, or the main topic of discussion is of a sensitive adult nature. There may also be times when a child

or youth refuses to participate, or s/he does not feel comfortable attending. Further engagement of the child or youth may be needed to encourage their participation so that they have a voice within the team.

Safety is another consideration for the team, as a child or youth may become easily angered or agitated during the CFT meeting and may require support. If applicable, the child or youth's mental health provider may also recommend if it is not in the child or youth's best interest to attend the CFT meeting.

16.) How may a CFT look different for a Non-minor Dependent (NMD)?

The CFT will be driven by the NMD and team membership will be guided by him or her. The team meetings may have more focus on one or more of the following: housing, employment, education, support networks, and if the NMD has a child or children, parent support services.

17.) If the CFT cannot agree on placement, does the child, youth, and family or the placing agency make the final placement decision?

The placing agency must consider all of the CFT placement recommendations and reasons; however, it is the responsibility of the placing agency to determine the most appropriate placement in order to achieve public safety, child safety, permanency and well-being. The placing agency worker is also responsible for providing the court its findings and reasons for the placement recommendation. The placing agency worker must inform the CFT of his or her recommendation(s) and reasoning prior to the court hearing and after the judge has made the placement order.

It is recognized that sometimes an incident regarding public safety or other concerns may occur and an immediate decision regarding placement must be made by the probation agency or courts prior to receiving the team's input. When this occurs it is the responsibility of the placing agency to engage the CFT to inform members of this decision, and to document the rationale for any inconsistencies between the case plan and the CFT recommendations. Best practice is to engage CFT members in a facilitated CFT meeting.

18.) Does a mental health screening and mental health assessment need to be completed before the first CFT meeting?

A CFT should occur as soon as possible and adhere to Welfare and Institutions Code, Section 16501. The initial CFT meeting should not be delayed to accommodate a pending mental health screening, assessment, or pending referrals for services.

Attachment 1

Frequently Asked Questions (FAQ's) for Child and Family Teams

19.) Who is the responsible authority for verifying that team decisions and case planning adhere to required policies and safety recommendations?

The coordination of care for the public safety, safety, permanency, and well-being of the child and youth will be the responsibility of the placing agency with input from the children, youth, family, and team members. Follow-through on tasks, monitoring, and coordination are also important components in the process and is the responsibility of all CFT members.

CDSS
WILL LIGHTBOURNE
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

EDMUND G. BROWN JR.
GOVERNOR

January 31, 2017

REASON FOR THIS TRANSMITTAL

[X] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[ ] Clarification Requested by One or More Counties
[ ] Initiated by CDSS

ALL COUNTY LETTER (ACL) NO. 17-11

TO: ALL COUNTY WELFARE DIRECTORS
ALL CHIEF PROBATION OFFICERS
ALL LOCAL MENTAL HEALTH DIRECTORS
ALL COUNTY ADOPTION AGENCIES
ALL ADOPTION DISTRICT OFFICES
ALL GROUP HOME PROVIDERS
ALL FOSTER FAMILY AGENCIES
ALL TITLE IV-E AGREEMENT TRIBES
ALL OUT-OF-STATE GROUP HOMES

SUBJECT: PHASE II IMPLEMENTATION OF THE CONTINUUM OF CARE REFORM (CCR) HOME-BASED FAMILY CARE (HBFC) AND SHORT-TERM RESIDENTIAL THERAPEUTIC PROGRAM (STRTP) RATES STRUCTURE AND CONVERSION PROCESS FROM THE OLD RATE STRUCTURE TO THE NEW RATE STRUCTURE

REFERENCE: ASSEMBLY BILL (AB) 403, CHAPTER 773, STATUTES OF 2015; AB 1997, CHAPTER 612, STATUTES OF 2016; SENATE BILL (SB) 831, STATUTES OF 2016; WELFARE AND INSTITUTIONS CODE (WIC) SECTIONS 11364, 11387, 11453, 11460, 11461, 11462, 11462.01, 11462.04, 11462.015, 11462.02, 11463, 16000, 16121, 16519.5, 16519.52, 16519.53, 16519.54, 16519.55, 18358.30, 18987.72; ALL COUNTY LETTER (ACL) 11-51; ACL 16-52; ACL 16-54; ACL 16-55; ACL 16-57; ACL 16-65; ACL 16-79

The purpose of this ACL is to update information previously provided in ACL 16-79 about the new HBFC and STRTP rate structures and to describe Phase II rate implementation. All Phase II rates described in this letter will be paid prospectively effective December 1, 2017 and will not be paid retroactively to January 1, 2017.

Overview of the Phase II HBFC Level of Care (LOC) Rate Structure

This letter builds upon the HBFC Phase I letter in the following ways:

- Introduces the newly established HBFC LOC rate structure that will be used for Resource Families (RFs) and Foster Family Agencies (FFAs). Under the LOC rate structure, the age-based system will be replaced by a four-tiered rate structure and based on the child/youth's needs as determined by the LOC Protocol (with an exception for some children/youth in FFAs, as described below). The rates will include a Basic Level Rate, LOC 2, LOC 3 and LOC 4.

- Includes an Intensive Services Foster Care (ISFC) rate previously known as Intensive Treatment Foster Care (ITFC) that can be used to support Therapeutic Foster Care Services (TFC).

The new HBFC LOC rate structure is designed to support positive outcomes for children in home-based family settings using a core practice model that engages the child/youth and families using a Child and Family Team (CFT) approach. Rate determinations will be based on a LOC Protocol which uses a set of core domains describing the care needs for the child and the RFs level of expected supervision and supports. The use of the LOC Protocol will be required for determining the LOC rate. The California Department of Social Services (CDSS) is in the final stages of completing an LOC Protocol which is partially referenced in this letter.

The HBFC LOC rate structure applies to all RF homes, county Foster Family Homes (FFHs) and foster homes certified by an FFA that are in the process of becoming RF approved homes, Approved Relative Caregiver (ARC) homes (in both counties that have and have not opted into the ARC Program), Non-Relative Extended Family Members (NREFMs), Non-Minor Dependents (NMDs) residing in a HBFC family setting that is not a Supervised Independent Living Placement (SILP), Kinship Guardianship Assistance Program (Kin-GAP), Non-Related Legal Guardians (NRLGs) and Adoption Assistance Program (AAP) homes. Regardless, if a currently licensed/approved caregiver has undergone the RFA conversion process; those families will be eligible for the new rate as described in this ACL.

RF LOC Rates

As stated above, the new HBFC rate structure is comprised of a Basic Level Rate and three additional LOCs as described in Table A. All foster family applicants after January 1, 2017, including relative caregivers (of children both federally-eligible and non-federally eligible) will now be approved pursuant to the Resource Family Approval (RFA) process and will be known as a RF.

Upon Phase II implementation, Table A below represents LOC rates that can be paid directly to the RF. This includes county foster homes and foster homes certified by FFAs that have not yet converted to approval under the RFA process, ARC homes (in both counties that have and have not opted-in to the ARC Program), NREFMs and NMDs residing in a HBFC setting that is not a SILP. The rate to be paid must be based on an LOC Protocol completed upon initial placement of a child into foster care or triggered by the individual and changing needs of a child or youth.

FFHs, Relatives (including ARC), NREFMs and NMDs (excluding those residing in a SILP), Kin-GAP, NRLG and AAP

During Phase II, the new LOC rates will be used for all newly established RFs, FFHs, Relatives (including ARC), NREFMs and NMDs (not residing in a SILP), Kin-GAP, NRLG and AAP homes that will use Table A below:

Table A:

RF LOC Rates - Kin-GAP, NRLG and AAP			
Basic Level Rate	LOC 2	LOC 3	LOC 4
$889	$989	$1,089	$1,189

The CNI will be applied to this rate and more information about the application of the CNI will be in a forthcoming ACL.

Initial Placement with a RF

Upon initial foster care placement into a HBFC setting (other than an ISFC home), the county shall pay the Basic Level Rate, pending a full assessment. Once the assessment is completed, the LOC, if different than the Basic Level Rate, will be effective back to the initial date of placement. Exceptions to this include:

- If the child is immediately placed into an ISFC placement,
- The child has extenuating circumstances and qualifies for a temporary ISFC rate paid only to the resource family. See ISFC section below for additional information.

FFA Rates

Table B reflects the Phase I rate structure effective January 1, 2017, which currently applies to all existing FFA placements including all placements made prior to January 1, 2017 and for FFA placements made between January 1, 2017 and November 30, 2017. When Phase II LOC rates are implemented, the existing FFA placements as of December 1, 2017 will continue to use Table B until those children/youth exit the foster care system or a triggering event occurs as described below.

Table B:

FFA Rate Components – Phase I					
Age	0-4	5-8	9-11	12-14	15-21
FFA Certified Family Minimum Rate	$896	$954	$994	$1,032	$1,072
Social Worker	$340	$340	$340	$340	$340
Services and Supports	$156	$156	$156	$156	$156
RFA	$48	$48	$48	$48	$48
Administration	$672	$672	$672	$672	$672
Total	**$2,112**	**$2,170**	**$2,210**	**$2,248**	**$2,288**

A triggering event occurs when any foster child/youth moves to or from an FFA home or a relative/county FFH or a county-approved RFA home and is receiving a rate from Table B (the age-based rate structure), when this occurs, then Table C rates will apply. The new LOC rate is effective back to the date of the new placement.

When a request for an assessment from a caregiver occurs and the child remains with the same caregiver this is also considered a triggering event, then Table C rates will apply. If the resulting new rate is lower than the previous rate, the new rate is effective in the first month following the month in which both determination and adequate and timely notice is provided; the effective shall be indicated on a form transmitted from the Social Worker (SW) to the eligibility worker.

All new FFA placements occurring on/after December 1, 2017 will be paid a rate based on the LOC rates displayed in Table C using the LOC Protocol. Payments will be pro-rated consistent with existing foster care payment processes.

Table C:

FFA Rate Components – Phase II December 1, 2017				
	Basic Level Rate	LOC 2	LOC 3	LOC 4
RF	$889	$989	$1,089	$1,189
Social Work	$340	$340	$340	$340
Social Services & Support	$156	$200	$244	$323
RFA	$ 48	$ 48	$48	$48
Administration	$672	$672	$672	$672
Total	**$2,105**	**$2,249**	**$2,393**	**$2,572**

The CNI will be applied only to the basic rate portion of the age-based rate and to the Basic Level Rate paid directly to the RF during Phase I and to LOCs 2-4 rates that are paid directly to the RF during Phase II. More information about the application of the CNI will be in a forthcoming County Fiscal Letter (CFL). In Phase II, there will no longer be a distinction between Non-Treatment and Treatment types of FFAs.

The LOC Protocol and Triggering Events

The LOC Protocol is a strength-based method designed to identify the individual care and supervision needs of children/youth that can be translated to an appropriate LOC rate to support their placement in a family setting. Care and supervision needs will be identified based on five (5) core domains. The Core Domains in the protocol tool are: Physical, Behavioral/Emotional, Educational, Health and Permanency/Family Services. The LOC Protocol is comprised of a matrix, a form to be completed by the caregiver, a scoring sheet which is to be completed by a SW or Probation Officer (PO), and an instructional guide. The LOC, once determined, will be documented by the SW or PO and provided to foster care eligibility staff on a CDSS form that is currently in development.

There is no annual LOC rate determination requirement. The SW/PO must use the LOC Protocol when one of the following triggering events occurs:

- **Initial foster care placement**: As stated previously, the Basic Level Rate will be paid upon initial foster care placement into a HBFC setting pending the completion of the LOC Protocol unless the child meets an exception for an ISFC rate as described below (new rate based on the results of the LOC Protocol is effective the date of initial placement).

- **FFA – Moving from Age-Based Rates:** As stated previously, for a change in placement for any foster child/youth moving from an FFA home receiving a rate under the age-based rate structure to another FFA home (with a different FFA agency) or a relative/county home. If the LOC rate determination was not completed prior to the placement move, the Basic Level Rate shall be paid until the LOC Protocol is completed. The new LOC rate based on the LOC Protocol is effective back to the date of the new placement.

- **Other RF Placement Changes**: For a change in placement for any foster child/youth to or from an FFA home paid under the LOC rate structure or to or from a relative or county home or, to or from a relative/county home to another relative/county home. If an LOC determination has been performed and there are no changes to the child's needs, the prior LOC may be applied. If the LOC rate determination was not completed prior to the new placement, the Basic Level Rate is paid until the LOC determination is completed. The new rate is effective back to the date of placement.

- **Transition from STRTP:** For a change in placement for any foster child/youth from an STRTP to a HBFC setting. If the LOC determination was not completed prior to the new placement, the Basic Level Rate shall be paid until the LOC Protocol is completed. The new LOC rate based on the LOC Protocol is effective back to the date of the new placement into the HBFC setting.

- **Requested Changes from Caregivers:** When a caregiver, youth or SW/PO in consultation with the CFT (if available), indicates a child/youth's needs have changed, the new rate is effective the date of the completion of the LOC Protocol as indicated on the form provided by the SW.

- **Transition from ISFC/TFC:** When a child/youth is receiving ISFC or TFC and is ending those services, the new LOC rate is effective the date the ISFC or TFC services end.

- **Decrease in Rate:** In the instance when the rate decreases as a result of the LOC Protocol and the child remains with the same caregiver, the effective date of the decrease will be the first on the month following the month in which both the determination and adequate and timely notice is provided.

The CDSS in partnership with counties and stakeholders will pilot the application and consistency of the protocol tool and will offer regional "train the trainer" workshops before the statewide release and use of the protocol tool. A future ACL will describe the workflow for the LOC protocol, including the responsibilities of how the SW or PO will gather information from various sources to assist with the determination of the appropriate LOC rate.

GHs and STRTPs

The effective date of the STRTP rate will be determined when the CDSS Foster Care Rates Bureau (FCRB) reviews and approves the rate application packet. To assist counties in determining when to pay the STRTP rate, the FCRB will issue a rate letter to the Provider and update its rates list for both GH's that have received an extension of their Rate Classification Level (RCL) rate and for STRTPs. Additionally, GHs granted an extension to continue to operate under the RCL system may convert to an STRTP at any time during the extension period. For example, a GH that received a six-month extension is ready to convert to an STRTP four months into the extension window, may do so. However, the effective date of the rate will be based on the date provided in the rate letter from the FCRB. Information on the GH extension process can be found in ACL 16-65. The STRTP rate is reflected in Table D below.

Table D:

STRTP Rate	
Rate	$12,036

The CNI will be applied to this rate and more information about the application of the CNI will be in a forthcoming ACL.

ITFC Conversion to ISFC

The ITFC rate described in WIC 18358.30 currently funds a placement option that provides intensive treatment services and supports which is currently limited to FFA certified families. Effective December 1, 2017, all ITFC, Multi-Dimensional Treatment Foster Care (MTFC) and TFC placements (existing and new) will be paid according to the amounts identified in Table E below. The ISFC rate is modified to add one new component (Social Services and Support). Under the new HBFC rate structure, the ISFC rate is intended for specialized programs that serve children with specific needs such as intensive treatment and behavioral needs and specialized health care needs. The ISFC rate will accommodate programs that serve as an alternative to or as a step-down from residential care such as: the current ITFC and MTFC programs, probation youth, special health care or medical placements, or TFC, or serve other specialty placements such as difficult sibling sets. All RFs (county FFHs, FFAs and relatives, etc.) will be eligible for the ISFC rate if they meet a level of specified training and competencies matched to the child's needs at this level.

The ITFC program currently is operated through FFA's; however, under AB 1997 and under the ISFC rate structure, counties have the flexibility to operate this program in any one of the following scenarios:

1) **FFA-based ISFC:** The FFA is paid the ISFC Rate of $6,003 in Table E and the FFA pays the RF the $2,321 portion;

2) **County-based ISFC:** Allows for the use of the payment to any RF based on the intensive needs of the child if they meet a level of specified training and competencies matched to the child's needs at this level and is based on the LOC Protocol. Under this option, the county is able to claim the ISFC rate which is typically paid to the FFA. The County receives the $6,003 in Table E and pays the RF the $2,321 portion. Under this option, the county is expected to provide the oversight and services otherwise provided by FFAs;

3) **TFC Model:** Either the FFA or the county may operate a TFC but does so as a licensed FFA agency. This option requires the FFA/county to also have a mental health contract with the RF to provide therapeutic foster care intervention under the supervision of a licensed clinician that is billable to Medi-Cal.[1] The FFA/county receives the $6,003 as a licensed FFA provider in Table E and pays the RF the $2,321 portion;

4) **Family-Only Rate:** Allows for county- use of the payment on an urgent, **time-limited** basis (up to 60 days) to any RF for children with urgent placement needs, or to any RF on an **on-going** basis, based on the intensive needs of the child if they meet a level of specified training and competencies matched to the child's needs at this level and the rate is based on the LOC protocol. The RF receives the $2,321 in Table F.

In all of the above scenarios, the amount paid to the RF ($2,321) will be the same and will equal the ISFC RF portion of the rate identified in Table E or Table F below. This portion of the rate amount is unchanged from the amount paid to the foster family under the previous ITFC rate. Further program policy guidance and clarification on ISFC will also be provided in a subsequent ACL which will include, but not limited to, areas of administrative and contracting requirements such as: Memorandums of Understanding agreements, in-home support counseling and caregiver training. A workgroup will be established to address what program areas need revision.

[1] Reference CDSS/DHCS All County Information Notice (ACIN) #I-52-16 and #16-031 regarding Therapeutic Foster Care (TFC) Services and Continuum of Care Reform (CCR).

Table E:

FFA or County ISFC Rate	
ISFC RF	$2,321
Administrative Costs	$3,482
Social Services & Support	$200
Total	**$6,003**

When the ISFC RF rate is used by a county to pay a resource parent, the ISFC RF Rate only is reflected in Table F below.

Table F:

ISFC RF Rate	
ISFC RF	$2,321

The CNI will be applied to the ISFC RF rate portion only in Table E and Table F. More information about the application of the CNI will be in a forthcoming ACL.

Kin-GAP

- The rate structure for all existing Kin-GAP cases in which dependency was dismissed prior to May 1, 2011, will not change and are reflected in Table G.
- Kin-GAP cases, where dependency was dismissed between May 1, 2011 and December 31, 2016, will receive the age-based rates identified in ACL 16-57. These rates are reflected in Table H.
- Kin-GAP cases, where dependency is dismissed on or after January 1, 2017, will be paid the Basic Level Rate of $889.
- In Phase II, Kin-GAP cases, where dependency is dismissed on or after January 1, 2017 (based on a LOC Protocol determination), will be eligible for LOC 2 – 4 rates reflected in Table A

NRLG

- The rate structure for all existing NRLG cases whose guardianship was established by the juvenile court prior to May 1, 2011, will not change and are reflected in Table G.
- NRLG cases where guardianship was established by the juvenile court between May 1, 2011 and December 31, 2016, will receive the age-based rates identified in ACL 16-57. These rates are reflected in Table H.

- NRLG cases where guardianship was established by the juvenile court on or after January 1, 2017 will be paid the Basic Level Rate of $889.

- In Phase II, NRLG cases, where guardianship was established on or after January 1, 2017 (upon completion of the LOC Protocol determination), will be eligible for LOC 2 – 4 rates reflected in Table A

Probate NRLG

- The rate structure for all existing probate NRLG cases, whose guardianship was established prior to May 1, 2011, will not change and are reflected in Table G.

- Probate NRLG cases, where guardianship was established between May 1, 2011 and December 31, 2016, will receive the age-based rate identified in ACL 16-57. These rates are reflected in Table H.

- Probate NRLG cases, where guardianship is established on or after January 1, 2017, as determined by the date the application requirements are met, are eligible only for the Basic Level Rate of $889.

Table G:

Kin-GAP, NRLG, Probate NRLG ***Prior to May 1, 2011***					
Age	Birth-4	5-8	9-11	12-14	15-21
Rate	$517	$562	$602	$664	$728

Table H:

Kin-GAP, NRLG, Probate NRLG ***May 1, 2011 thru December 31, 2016***					
Age	Birth-4	5-8	9-11	12-14	15-21
Rate	$707	$765	$805	$843	$883

The CNI will be applied to this rate and more information about the application of the CNI will be in a forthcoming ACL.

The instructions in this ACL supersede where applicable, the information in ACL 16-79. An Errata will be forthcoming to correct the information in ACL 16-79 as it pertains to Kin-GAP and NRLGs.

Adoption Assistance Placement (AAP)

- The rate structure for initial AAP agreement signed and with an adoption finalization prior to May 27, 2011 will not change. The 2007 and 2008 rate structures continue to apply.

- Initial AAP agreements signed prior to January 1, 2017 with an AAP basic rate based on the statewide structure effective May 27, 2011, may be renegotiated based on a reassessment of the child's needs and the circumstances of the adoptive parent(s) to the Basic Level Rate of $889 on or after January 1, 2017.

- The Basic Level Rate of $889 is effective for all initial AAP agreements signed on or after January 1, 2017.

- The Phase II LOC rates reflected in Table A are effective December 1, 2017 for all initial AAP agreements signed on or after this date.

    - Initial AAP agreements signed on or after January 1, 2017 with an AAP Basic Level Rate based on the rate of $889, may be renegotiated based on a reassessment of the child's needs and the circumstances of the adoptive parent(s) to the Phase II LOC rates reflected in Table A.

    - Initial AAP agreements signed *prior* to January 1, 2017 with an AAP Basic Level Rate based on the statewide structure effective May 27, 2011, may be renegotiated based on a reassessment of the child's needs and the circumstances of the adoptive parent(s) to the Phase II LOC rates reflected in Table A.

The CNI increase continues to be applicable and will be applied to all AAP basic rates. A separate ACL will be issued specific to AAP, should one occur, effective July 1st of each year.

Specialized Care Increment (SCI) Program

The county-optional, SCI program provides a supplemental payment added to the foster care basic rate to meet the special behavioral and/or medical needs for children/youth and to prevent placement disruption. The SCI was part of the programs that were realigned in Fiscal Year (FY) 2011-12, the county could provide an SCI to support a child in an FFH, ARC home, or certified FFH. Under AB 403, counties may continue the option of providing an SCI to a RF (including those with FFHs, relatives, NREFMs, RFs and certified family homes of FFAs, or non-relatives).

The SCI can be provided in addition to an LOC rate. If a child is receiving an LOC rate for a certain condition and/or care and supervision needs, this does not prevent counties, at their discretion, from providing the SCI in addition to the LOC rate for the same condition and/or care and supervision needs.

NMDs Residing in a SILP

The rate for an NMD residing in a SILP will not change and will remain at the Basic Level Rate of $889 during Phase II. Please refer to ACL 16-79 for more information. The CNI will be applied to this rate and more information about the application of the CNI will be in a forthcoming ACL.

Whole Family Foster Home (WFFH)

All dependent parents residing with their *non-dependent* child in a WFFH placement are eligible for the infant supplement per ACL 15-58.

Infant Supplement

All other Infant Supplement rates will remain the same per ACL 16-57 and will not be affected by Phase II rate implementation.

Unaccompanied Refugee Minors (URMs)

URM FFAs will continue to receive the age-based rate through Phase I. However, for Phase II, the URM FFAs will use Table C. The GHs operated by FFAs for the URM population will retain their GH license and RCL rate level. Please see ACL 16-03 for further information regarding URMs placements.

Notices of Action (NOAs)

Consistent with existing rate change and determination processes, NOAs, and any informal hearing provided by the County or formal State hearings, rights will continue to be afforded to families. Counties will notify families via a NOA explaining that their rate changed because of AB 403, a new law that authorizes rate changes (per WIC 11460, 11463, 11464, 11364, 11387 and 18358) and RFs are now subject to an LOC rate determination. CDSS has developed a NOA for county use and substitutions of the form are permitted.

The NOAs will provide an explanation to RFs of how and why rates are changing under the CCR rate restructuring in the event of:

- a rate increase,
- a rate decrease,
- a rate discontinuance.

Any rate determination that results in no rate change at all, the RF will be provided with adequate and timely notice given by the SW, PO or others designated by the county. The county shall inform the caregiver of the determination in writing. Additional information will be forthcoming in an ACL.

Information on the Services Only Rate will be provided in a forthcoming ACL.
A CFL regarding revised claiming will be issued upon Phase II implementation.
Please contact the Foster Care Rates Bureau at (916) 651-9152 for any questions regarding the information in this ACL.

Sincerely,

Original Document Signed By:

GREGORY E. ROSE
Deputy Director
Children and Family Services Division

Attachments

c: CWDA
CPOC

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NOTICE OF ACTION

For Resource Families, including homes certified by a Foster Family Agency, County Approved Relative Homes, Non-Relative Extended Family Members, Foster Family Homes, Non-Related Legal Guardians

Notice Date: _____
Case Name: _____
Number: _____
Worker Name: _____
Number: _____
Telephone: _____
Address: _____
_____
_____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

☐ The County has approved your Foster Care aid.

As of _____, the county is Approving your Foster Care aid
(Date)

of $ _____ per month.

This aid is for: _____.
(Name of Child)

As of _____, the county is Changing your Foster Care aid
(Date)

from $ _____ to $ _____.

This aid is for: _____.
(Name of Child)

Here's why: Your rate is based on a level of care determination as defined in AB 403 and WIC section 11461.

☐ Your case had a rate increase.

☐ Your case had a rate decrease.

☐ Your case has been issued an Infant Supplemental Payment.

☐ Your case has been issued a Supplemental Care Increment.

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NOTICE OF ACTION

For Resource Families, including homes certified by a Foster Family Agency, County Approved Relative Homes, Non-Relative Extended Family Members, Foster Family Homes, Non-Related Legal Guardians

Notice Date: _____
Case Name: _____
Number: _____
Worker Name: _____
Number: _____
Telephone: _____
Address: _____
_____
_____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

☐ The child has _____ income.
(Countable)

☐ _____ for _____
(Income Type) (Name of Child)

of $ _____ is effective _____.
(Date)

This is counted as _____income in the
(Earned/Unearned)

Foster Care budget calculation.

☐ Other: _____

☐ Your case has been discontinued.

As of _____, the county is Discontinuing your
(Date)

Foster Care aid.

Here's why:

☐ You are no longer providing foster care for: _____
(Name of Child)

☐ He/she is no longer living in your home/facility. The County will stop paying for Foster Care from the day the child leaves your home/facility.

☐ He/she no longer meets the age rules.

☐ The child has too much income.

☐ The child has too much property. See attached page.

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NOTICE OF ACTION

For Resource Families, including homes certified by a Foster Family Agency, County Approved Relative Homes, Non-Relative Extended Family Members, Foster Family Homes, Non-Related Legal Guardians

Notice Date: _____
Case Name: _____
Number: _____
Worker Name: _____
Number: _____
Telephone: _____
Address: _____
_____
_____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

If the County figured that the child's car or other vehicle was worth more than you think it's worth, you can give the County proof that it is worth less. Ask the County how. If you can prove it is worth less the child may get Foster Care aid.

☐ The legal guardianship was terminated.

☐ You moved out of the State of California.

☐ You did not return your completed redetermination paperwork.

☐ Other: _____

☐ Due to funding requirements, you may receive multiple checks for this benefit month. The sum of these checks will be equal to the amount listed above.

Rules: These rules apply. You may review WIC sections: 11460, 11461, 11463, 11463.23, and 16519.

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ CalFresh
☐ Child Care

While You Wait for a Hearing Decision for:

<u>Welfare to Work</u>:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

<u>Cal-Learn</u>:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

OR

- **Call toll free: 1-800-952-5253 or** for hearing or speech impaired who use TDD, **1-800-952-8349**.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ CalFresh ☐ Medi-Cal

☐ Other (list)_____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)**

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

NA BACK 9 (REPLACES NA BACK 8 AND EP 5) (REVISED 4/2013) - REQUIRED FORM - NO SUBSTITUTE PERMITTED

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NOTICE OF ACTION - CHANGE

For Kinship - Guardians Only

Notice Date: _____
Case Name: _____
Number: _____
Worker Name: _____
Number: _____
Telephone: _____
Address: _____
_____
_____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

☐ The County has approved your Kin-GAP aid.

As of _____, the county is Approving your Kin-GAP aid of
(Date)

$ _____ per month.

This aid is for: _____
(Name of Child)

As of _____, the county is Changing your Kin-GAP aid
(Date)

from $ _____, $ _____.

This aid is for: _____
(Name of Child)

Here's why: Your rate is based on a level of care determination as defined in AB 403 and WIC section 11461.

☐ Your case had a rate increase.

☐ Your case had a rate decrease.

☐ Your case has been issued an Infant Supplemental Payment.

☐ Your case has been issued a Supplemental Care Increment.

☐ The child has _____ income
(Countable)

☐ _____ for _____
(Income Type) (Name of Child)

of $ _____ is effective _____.
(Date)

This is counted as _____ income in the
(Earned/Unearned)

Kin-GAP budget calculation.

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NOTICE OF ACTION - CHANGE

For Kinship - Guardians Only

Notice Date: _____
Case Name: _____
Number: _____
Worker Name: _____
Number: _____
Telephone: _____
Address: _____
_____
_____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

☐ Other: _____

☐ Your case has been discontinued.

As of _____, the county is Discontinuing your
(Date)

Kin-GAP aid.

Here's why:

☐ You are no longer providing foster care for _____.
(Name of Child)

☐ He/she is no longer living in your home/facility. The County will stop paying for Kin-GAP from the day the child leaves your home/facility.

☐ He/she no longer meets the age rules.

☐ The child has too much income.

☐ The child has too much property. See attached page.

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NOTICE OF ACTION - CHANGE

For Kinship - Guardians Only

Notice Date: _____
Case Name: _____
Number: _____
Worker Name: _____
Number: _____
Telephone: _____
Address: _____
_____
_____

(ADDRESSEE)

Questions? Ask your Worker.

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☐ The legal guardianship was terminated.

☐ You moved out of the State of California.

☐ You did not return your completed redetermination paperwork.

☐ Other: _____.

☐ Due to funding requirements, you may receive multiple checks for this benefit month. The sum of these checks will be equal to the amount listed above.

Rules: These rules apply. You may review WIC section: 11364.

YOUR HEARING RIGHTS

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- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ CalFresh
☐ Child Care

While You Wait for a Hearing Decision for:

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- **Send or take this page to:**

OR

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HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ CalFresh ☐ Medi-Cal

☐ Other (list)_____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)**

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

NA BACK 9 (REPLACES NA BACK 8 AND EP 5) (REVISED 4/2013) - REQUIRED FORM - NO SUBSTITUTE PERMITTED