**F- RATE INDICATORS**

CSW please complete for children with medical conditions, physical disabilities, and/or developmental delays then consult with PHN

Consult with MCMS (Medical Case Management Services) for all F-rated cases

**Forward a 149A to the appropriate CCS paneled and/or appropriate pediatric specialty treating physician(s) and request they complete the form and return it along with all available medical records documenting the child’s status and needs.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Child’s Name: | |  | | | | | DOB: | | |  | | | | Date Completed: | | | |  |
|  | | | | | | | | | | | | | | | | | | |
| Age of Child: | |  | | Social Security # | | |  | | | | | Date of Initial Detention: | | | | | |  |
|  | | | | | | | | | | | | | | | | | | |
| CSW Name & File No: | | |  | | | | | | | | | | | | Phone #: | |  | |
|  | | | | | | | | | | | | | | | | | | |
| Funding type:  Foster Care/Youakim  AAP  CAL Works/TANF(AFDC)  SSI  None | | | | | | | | | | | | | | | | | | |
| Kin GAP | | | | | | | | | | | | | | | | | | |
| FFA Rate (specialized rate assessment should occur when adoption plan is activated (i.e.: home study is started or case referred to PRU for matching). | | | | | | | | | | | | | | | | | | |
| Current Rate:  Basic Rate  D rate  F1 rate  F2 rate  F3 rate  F4 rate | | | | | | | | | | | | | | | | | | |
| Dual Agency Rate $ | | | | |  | + supplement | | |  | | = | |  | | |  | | |
|  | Date of last Rate Assessment | | | | |  | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **For any box checked on this page, fill out the corresponding numbered section on pages 2, 3 or 4. Then complete the “Actions to be Taken” section on page 5.**  CHILD WILL RECEIVE APPROPRIATE DUAL AGENCY RATE IF ELIGIBLE FOR REGIONAL CENTER SERVICES UNLESS CHILD IS ELIGIBLE FOR A HIGHER F-RATE (i. e. children age 0-3 receiving Regional Center Early Start Services shall receive the “under 3” Dual Agency rate of $942/month unless qualifying for a higher F-rate (ie F2, F3, F4) | | | | | | | | | | | | | | | | | | |

| **Physical / Medical – F Rate** | | **Developmental Delay – F Rate Rate** | | |
| --- | --- | --- | --- | --- |
| 1. | Asthma/Respiratory Problems/ Apnea Monitor | 18. | Child age 0-3 with Developmental Delay (in Regional Center Early Start Program eligible for $942 dual agency rate) but who may be eligible for F2, F3 or F4 rate | |
| 2. | Seizures | 19. | Mental Retardation | |
| 3. | Prenatal Drug/Alcohol Exposure | 20. | Autism | |
| 4. | Vision or Hearing Problems | 21. | Cerebral Palsy | |
| 5. | Ambulation | 22. | Children with Epilepsy/Seizure Disorder | |
| 6. | Bladder/Bowel Control Problem (not age appropriate) | 23. | Speech Delay or Disorder | |
| 24. | **Dual Agency Rate** | |
| 7. | Hygiene Problem | a. | Child age 0-3 with Developmental Delay (in Regional | |
| 8. | Feeding/ Eating Difficulty/Special Diet/Food Allergies |  | Center Early Start Program) – child does not qualify for F2, F3 or F4 rate | |
| 9. | Children who require Developmental therapy | b. | Child age 0-3 eligible for regional center services | |
| 10. | Surgical/ Wound Care/Artificial Limb |  | with diagnosed permanent developmental disability | |
| 11. | Diabetes | c. | Child age 3 or older eligible for regional center | |
| 12. | Hemophilia |  | *(See Policy #0900-511.12 Regional Center Foster* | |
| 13. | IV/Central line |  | *Rates for Dual Agency Children if box a, b, or c is* *checked)* | |
| 14. | Life threatening illness requiring strict monitoring for communicable/non-communicable diseases. | | |  |
| 15. | Medical Treatment |  |  | |

| **Physical / Medical – F Rate** | | | **Developmental Delay – F Rate Rate** | |
| --- | --- | --- | --- | --- |
| 16. | A) Emotional/Behavioral problem in addition  to other F-rate condition | |  |  |
| 18. | B) Multiple medical problems requiring  multiple appointments, treatment, specialists  etc. | |  |  |
| 17. | Other |  | | |

###### Physical/Medical Problems which may qualify Children for the F Rate

1.  **Asthma/Chronic Respiratory Problems**

|  |
| --- |
| F1 - As needed medication/treatment supervised by caregiver |
| F2 - Daily medication/treatment supervised by caregiver; or  - Use of apnea or heart monitor (MUST BE CPR TRAINED); or  - Postural drainage and percussion required up to 3 times per day |
| F3 - Use of intermittent oxygen; or Postural drainage and percussion required 4 or more times a day |
| F4 - Use of continuous oxygen or ventilator dependent; or Tracheostomy |

2.  **Seizures**

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| --- |
| F1 - Controlled seizure disorder with medication(s) |
| F4 - Uncontrolled seizure disorder |

3.  **Prenatal Drug Exposure**

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| --- |
| F1 - Inconsolable crying/screaming up to 6 hours a day |
| F2 - Inconsolable crying/screaming up to 6 - 12 hours a day |
| F3 - Inconsolable crying/screaming over 12 hours a day |

4.  **Vision / Hearing Problems**

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| F1 - Eye Prosthesis |
| F2 - Legally blind or hearing impaired |
| F4 - Totally blind and/or profoundly deaf |

5.  **Ambulation**

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| --- |
| F1 - Over 2 years old, child requires prescribed orthopedic corrective devices, e.g. ankle. foot, orthotics that are time limited. |
| F4 - Over 2 years old, child requires wheelchair, gurney, leg braces, walker, etc. Any age with extensive casting |

6.  **Elimination (Bladder or Bowel Control Problem)**

- The conditions below may indicate a developmental delay; consider whether referral to Regional Center is appropriate.

- The condition below may also be a sign of an emotional/behavioral problem, consider whether a referral for a psychological evaluation would be appropriate.

|  |
| --- |
| F1 - 4 and older, not toilet trained due to medical problem nighttime enuresis/encopresis |
| F2 - 4 and older with no bladder and/or bowel control day and night due to a medical problem |
| F3 - Child requires use of appliance such as a colostomy bag or catheter tubes |
| F4 - Child has kidney disorder requiring dialysis |

7.  **Hygiene Problem**

* The conditions below can indicate a developmental delay, consider where referral to Regional Center is appropriate

|  |
| --- |
| F1 - Child age 4 – 7 assistance with hygiene such as bathing, dressing etc., non-extensive cast care, one extremity |
| F2 - Child age 8 and older unable to bath, dress, etc. unassisted due to a medical problem |

8.  **Feeding/Eating Difficulty**

|  |
| --- |
| F1 - Infants/children who need 30 – 60 minutes to feed due to a medical problem, E.G. GERD; or  - Children who need supervised self feeding due to a medical problem e.g. C.P or Down syndrome |
| F2 - Infants or children who require feeding time over 60 minutes due to a medical problem; or  - Children who cannot self-feed DUE TO A MEDICAL PROBLEM or  - Children who require a special diet (e.g. Due to diabetes or kidney problems) or intense monitoring e.g. Caring for a failure to thrive child.(FTT). |
| F3 - Children who require intermittent G-tube feeding, SPECIAL FEEDING; or  - Children who need a special diet requiring strict diet planning; or  - Children who have a documented severe food allergy requiring an EPI(nephren)-PEN |
| F4 - Children who require continuous G-tube feeding; or  - Children who need feeding through NG (nose) tube; or  - Children who require parenteral nutrition |

9.  **Children who Require Developmental Therapy**

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| --- |
| F1 - Caregiver performs prescribed infant stimulation, physical, occupational or speech therapy  **See attachment II for specific qualifiers** |

10.  **Surgical/Wound Care/Artificial Limb**

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| --- |
| F2 - Established cerebral shunt care; or  - Established prosthetic or missing appendage |
| F3 - New or revised shunt care (first 6 months after insertion or revision) Daily/Frequent dressing changes |
| F4 - Post multi-stage surgical care e.g. burn reconstruction |

11.  **Diabetes**

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| --- |
| F2 - Treatment of type II diabetes with oral hypoglycemic medications |
| F3 - Caregiver administration/supervision of insulin dependent/type I diabetic child |
| F4 - Newly diagnosed insulin dependent/type I diabetic child. (within the last 6 months) |

12.  **Hemophilia**

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| --- |
| F3 - Caregiver administration/supervision of Factor 8 treatment. |

13.  **IV/Central Line**

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| --- |
| F4 - Medication/chemotherapy is administered through an IV or central line |

14.  **Life threatening illness requiring strict monitoring for communicable/non communicable diseases**

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| --- |
| F 1 - Prophylactic medications for tuberculosis.  F3 - Documented remission of disease; or  - Caregiver administration/supervision of medications for potentially life threatening illness, e.g. cardiac conditions; or  - Universal precautions needed for illnesses Hepatitis B,C;or  - Drug resistant conditions requiring strict medication regimen. |
| F4 - Daily monitoring required, e.g. organ transplant, aplastic anemia, immune deficiency disorder, cancer, leukemia, etc.; or  - Also for reverse precautions.; or  - HIV/AIDS positive blood test.  **See attachment II for specific qualifiers** |

15.  **Medical Treatment**

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| --- |
| Level 1 - Administration of topical medications for severe/chronic conditions, e.g. eczema. |
| Level 2 - Administration of injectable medication for chronic conditions |

16.  **A) Children Who Have an Emotional Behavioral Problem in Addition to One or More of the Conditions Listed Above**

*First consider if the child’s emotional/behavioral problems are severe enough to qualify for the D rate*

|  |
| --- |
| Increase F Rate by 1 level If the child is receiving an F rate for any of the conditions described above and has a documented emotional/behavioral problem |
| **Criteria**: – Child must be 3 or older and enrolled in and attending a treatment program  – Foster Care Payments: emotional/behavioral problem must be documented by the Department of Mental Health.  – AAP Payments: documentation is not required to be from Department of Mental Health; documentation may be from *any* psychologist/psychiatrist. |

**B) Children with multiple medical conditions requiring the caregiver to attend multiple appointments, administer multiple treatments or visit multiple specialists. Consideration may be given to increase the rate one level above the highest medically related activity up to level 4**

17.  **Other**

|  |
| --- |
| Indicate any other physical/medical problems the child has below. See your Supervisor and Public Health Nurse to discuss services and/or funding that might be available for the child based on this condition. |
|  |

Attach additional pages if necessary to provide additional information about the child’s condition and specialized care activities to be provided by the caregiver.

#### Rates for Children with Developmental Disabilities

CHILD WILL RECEIVE THE APPROPRIATE DUAL AGENCYRATE IF RECEIVING REGIONAL CENTER SERVICES UNLESS CHILD IS ELIGIBLE FOR A HIGHER F-RATE (i. e. child is 0 – 3 years old, receiving Early Start services and not yet determined to have a qualifying developmental disability, but has a medical/physical condition that warrants an F-2, F-3 or F-4 rate)

18.  Children Age 0-3 with Developmental Delay (diagnosis must be completed by Regional Center)

|  |  |
| --- | --- |
| Level 1- | Children age 0-3 receive Regional Center Early Start Services shall receive the “under 3” Dual Agency rate of $942/ month unless they qualify for a higher F rate (ie F2, F3 or F4) or unless their disability is diagnosed by Regional Center as permanent prior to age 3 in which case they shall receive the Dual Agency rate of $2106. |

19.  Children who are diagnosed with mental retardation (diagnosis must be completed by Regional Center)

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| Level 1 - Children age 3 and older with mild mental retardation |
| Level 2 - Children with moderate mental retardation |
| Level 3 - Children with severe mental retardation |
| Level 4 - Children with profound mental retardation |

20.  Children who are Autistic (diagnosis must be completed by Regional Center)

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| --- |
| Level 2 - Children with mild autism |
| Level 3 - Children with moderate autism |
| Level 4 - Children with full syndrome autism |

21.  Children with Cerebral Palsy (diagnosis must be completed by Regional Center)

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| --- |
| Level 1 - Children with mild to moderate cerebral palsy |
| Level 3 - Children with severe cerebral palsy (significantly impairs activity) |
| Level 4 - Children with severe cerebral palsy which precludes activity (significantly impairs activity) |

22.  Children with Epilepsy/Seizure Disorder (diagnosis must be completed by Regional Center)

- also see “Seizures” section under Physical/Medical Problems Which Qualify Children for the F rate

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| --- |
| Level 1 - Epilepsy/seizure disorder |

23.  Children with Speech Delay or Disorder and **NOT** receiving Regional Center Services

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| --- |
| Level 1 Caregiver is prescribed by physician or Regional Center to perform speech therapy |

24.  **Dual Agency Rate and Supplement**

|  |
| --- |
| **REMINDER**   1. Child 0-3 with Developmental Delay (in Regional Center Early Start Program) – child does not qualify for F2, F3 or F4 rate    * “under 3 “ Dual Agency Rate of $942 2. Child 0-3 eligible for regional center services with a diagnosed permanent developmental disability    * Dual Agency Rate of $2,106. Children under 3 do not qualify for Dual Agency Supplement 3. Child age 3 and older eligible for regional center services    * Dual Agency Rate of $2,106. Additionally, the child may qualify for Supplement of $250, $500, 750 or $1,000) depending on the special needs of the child. |
| *See Policy #0900-511.12 Regional Center Foster Rates for Dual Agency Children* |

##### Actions To Be Taken

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| **Attach supporting documentation** such as physician’s diagnosis, prognoses and treatment plan, psychological evaluation, and specialized care activities to be provided by caregiver. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Caregiver and Child Qualification Section** *(to be completed by CSW)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Caregiver needs specific instructions and/or training on the child’s medical condition. Describe below the training needed, who (i.e. Regional Center, the pediatrician etc.) will provide training, referrals the CSW will provide, and when training will occur. Attach additional pages if necessary. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Caregiver has completed F-rate training  YES  NO Certificate Date       Training Certificate attached  YES  NO Reason: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Caregiver and back-up caregiver have completed child-specific training for child’s medical/developmental problems  YES   NO  Training certificate attached  YES  NO. Reason: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child meets the criteria for specialized health care needs (see policy #0600.505.10).  YES  NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If YES, does caregiver’s home meet the criteria?  YES  NO. If No, describe steps that will be taken. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PHN F-Rate Recommendations:** According to available information this child’s level of care appears to meet criteria for (check one): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F1  F2  F3  F4 Date of diagnosis       (attach documentation)  This child’s level of care does not appear to meet the criteria for a Specialized Care F-rate.  Additional PHN Recommendations:  Recommend transfer to MCMS  Recommend F-rate be re-evaluated in       months  No F-rate training documentation is attached. F-rate training or F-rate renewal training appears to be needed by caregiver.  No child-specific medical training documentation is attached. Child specific medical training appears to be needed by caregiver. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature of PHN: | | | | |  | | | | | | | | | | Date: | | | | | | | | | | | | | |  | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CSW Actions** – According to available information, this child’s level of care appears to meet criteria for the rate listed below: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (check one)  F1  F2  F3  F4 | | | | | | | | | | | |  | | | | | | /month for child. Effective Date | | | | | | | | | | |  | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Request retroactive payments. Date of diagnosis: | | | | | | | | | | | | |  | | | | | | (attach documentation). | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Refer child for additional services/evaluations (list) | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Current rate  F1  F2  F3  F4  Dual Agency Rate of $ | | | | | | | | | | | | | | | | |  | | | | | + supplement       effective date | | | | | | | |  | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Basic rate appears to be appropriate. This child’s level of care does not meet the criteria for a Specialized Care Rate | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Rate Review Requirements:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The next review to see if child’s condition has changed and to reevaluate the current foster care rate will be: **Date:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| For AAP the rate is re-certified every 2 years. The next re-certification date is **Date:** | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | |  |
| **Caregiver’s Agreement** (complete this section only if the F rate has been approved) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Rate will be (check one and fill in amount per month)  F1 | | | | | | | | | | | | | |  | | F2 | | | | |  | | | F3 | |  | | F4 | |  | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I understand that the amount and duration of the F-rate is subject to review at least every six months (every two years for AAP). The review may result in a change in the F-rate status for the child, i.e. increase, decrease, termination of payment and that I will receive a Notice of Action letter from DCFS if any such changes take place. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Caregiver’s Signature: | | | | | | | |  | | | | | | | | | | | | Date: | | | | |  | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature of CSW: | | | | | |  | | | | | | | | | | | | | | Date: | | | | |  | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature of SCSW: | | | | | | |  | | | | | | | | | | | | | Date: | | | | |  | | | | | | |  | | | | | |
| ARA and RA signatures are required for F3 or F4 rates | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature of ARA | | | | | | |  | | | | | | | | | | | | | Date: | | | | |  | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature of RA | | | | | | |  | | | | | | | | | | | | | Date: | | | | |  | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Approval of F | | | |  | Rate of $ | | | |  | per month: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |