Santa Clara County
Social Services Agency
Department of Family and Children's Services

Special Care Increment (new) - Caregiver Information

GENERAL INFORMATION

Special Care Increment (SCI) payments are intended to ameliorate the impact on the caregiving family and some of the costs involved in caring for a special needs child.

The SCI methodology for each County in the State of California is established and audited by the State. If the child is placed out-of-county, regulations require that we follow the county of residence's SCI policies and rates. Similarly, if an out-of-county child is placed in a SCC home, the SCI paid must follow SCC's methodology and rates.

RFA homes, Licensed Foster Care homes, Relative & NREFM homes are all eligible for SCI payments.

SCI payments are provided whether or not the home is fully RFA approved.

All claims are reviewed by DFCS to ensure adherence to County/State/Federal requirements especially ensuring that adequate and appropriate documentation for each claim is included. Claims will be returned to the social worker if additional documentation is required or corrections to the paperwork is required.

Santa Clara County has implemented the new State SCI Matrix.

START DATES AND REDETERMINATIONS

The SCI start date is determined as the date the caregiving family first contacted the Social Worker and requested a SCI or discussed the extra care and supervision the caregiver is providing (which may be the first day of the placement). The SCI rate cannot be back-dated to any date previous to this. This is also the date used regardless of the length of time required to complete the SCI request and collect all needed documentation.

A SCI may be implemented for no more than 1 year. Towards the end of that period, if the child's condition(s) continues to impact the caregiving family, a new request for the next 1 year period may be submitted.

If the child's condition changes significantly at any time during the 1 year SCI period, a new SCI request will be submitted and the new rate will be implemented, using the date the caregiving family contacted the Social Worker regarding the change(s) as the implementation date. This is true should the child's condition either improve or decline.

SCI's are paid based on the caregiver's assessment of the child's impact of the caregiver's family, and verified with documentation from a 3rd party. SCI Claims must be signed by the caregiver certifying their claim is accurate and true to the best of their knowledge.

DOCUMENTATION
Regulations require that documentation be provided for each condition claimed on the SCI Matrix request.

*******A new requirement that the SCI Worksheets be used unless the provider refuses to complete this form.*******

Caregivers are responsible for gathering documentation for each condition claimed on the SCI request. Social workers provide to the caregiver any documentation they have readily available in the case file or CWS records.

Documentation must be certified by a third party, and cannot be certified by the caregiver, the child or any DFCS staff person. Only Medical professionals may provide documentation for medical conditions. Only qualified Medical professionals or certified providers may provide documentation for developmental delays. Medical professionals, therapists and qualified mental health/behavioral health providers may provide documentation for behavioral conditions.

Documentation must describe the child's CURRENT condition and not historical information.

Documentation of a child's CURRENT condition may not be more than 3 months older than the start date of the SCI.

If the child has a "permanent and unchanging condition" (for example, this is usually the case with Cerebral Palsy) have the Medical/Mental Health Professional include this statement in the document they provide and that document may be copied then attached to each successive SCI request.

Alternate types of documentation:
Below are examples of the types of documents that are acceptable. This is not an exhaustive list and other forms of documentation may be acceptable depending upon the condition and the document provided.

- Health Contact Forms (make sure they are readable).
- Letter, note or email from a Doctor, Therapist, or other Medical/Mental Health Professional (Most times a simple diagnosis statement is not sufficient as the severity of conditions vary greatly. This letter or note must be dated and have the provider's printed name, signature, and title).
- IEP or 504 Plan documents (only if the IEP specifically addresses the child's impact on the caregiving family and the home).
- Psychotropic medication may be documented with a very recent court document, photo of the prescription bottle, copy of the prescription scrip, note from an MD, therapist, etc.
- WRAP document which specifically lists the child's behaviors. Many of these documents list goals, but not actual behaviors or caregiver interventions. One example is "the child will behave safely while walking to and from school". This is too vague to document a behavioral problem. We need a document that states that the child is damaging cars while walking to and from school so the caregiver must accompany the child daily.