**CHILD SPECIFIC FUNDING REQUEST**

**INSTRUCTIONS**:

* To be completed when requesting funding pursuant to WIC § 16001 for children and non-minor dependents (NMDs) with exceptional needs.
* Please fill out this request. An analyst will review to determine if Child Specific funding is appropriate to address the needs of the child/NMD.
* If available and appropriate, attach completed Qualified Individual (QI) Assessment.
* If request is related to a TA call, attach TA recommendation email and complete section 1 and sections 5-7 only.
* Submit completed form with relevant documentation to [RatesPolicy@dss.ca.gov](mailto:RatesPolicy@dss.ca.gov).

**Date of Request:** Click or tap to enter a date.

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| 1. **CHILD/NON-MINOR DEPENDENT INFORMATION** | |
| County Making this Request: Choose an item. | |
| Name: | Date of Birth:  Click or tap to enter a date. |
| CWS/CMS ID# (19-digit Client ID): | |
| Sexual Orientation: | Gender Identity/Expression: |
| Ethnicity (specify if more than one): | |
| Cultural Considerations that impact the child/ NMD’s placement or this Child Specific Funding request:(language, religious practices, traditions, spirituality, food preferences, etc.): | |
| Jurisdiction:  Child Welfare Probation | Regional Center Client:  Yes No |
| Title IV-E Eligible:  Yes No | Tribally Eligible:  Yes No |
| If this is a tribal child/NMD, has the tribe been consulted with in the development of this funding request?  Yes No Not applicable | |
| Current placement type: | |
| Recommended placement type: | |
| If you have requested funding for this placement previously, please provide an update on the child/NMDs progress in placement: | |

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| 1. **ASSESSMENT/RECOMMENDATION BASIS**   **Assessment must identify needs directly related to funding the placement type/services requested.** |
| Recommendations made by a Child and Family Team (CFT) for services/placement:  Yes, Date: Click or tap to enter a date.  No  If yes, summary of recommendations:  Frequency of CFT meetings:Choose an item.  Specify: |
| Clinical recommendation made by an Interagency Placement Committee (IPC):  Yes, Date: Click or tap to enter a date.  No |
| Qualified Individual (QI) Assessment:  Yes, Date: Click or tap to enter a date.  No  In Progress  N/A |
| System of Care (SOC) Technical Assistance (TA) Call (If within the last 3 months, attach notes and skip to sections 5 and 7):  Yes, Date: Click or tap to enter a date.  No |
| Other child/NMD-specific assessments or evaluations. For example, Regional Center Assessment or Educational Assessments, etc.:  Yes, Date: Click or tap to enter a date.  No  If, yes, please specify the assessment type: |
| Do the assessments support the placement recommendation?  Yes  No  Specify: |
| Please describe the exceptional needs identified in these assessments: |

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| 1. **PLACEMENT CHALLENGES** |
| There is a current 14-day notice for a placement change:  Yes  No  Intent to give notice  Same day notice  Risk of notice  Reason for notice: |
| There is an inability to identify placement due to recurring placement denials:  Yes  No  Reasons for placement denials: |
| Resources designed to meet the needs of the youth are unavailable:  Yes  No  Describe: |
| The child/NMD has barriers to placement:  Yes  No  If Yes: Choose an item. If other, please describe: |
| Child’s/NMD’s preferred placement: |

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| 1. **BEHAVIORAL HEALTH, DEVELOPMENTAL, MEDICAL, EDUCATIONAL AND RELATIONAL** |
| Check applicable services that apply to the child/NMD:  Behavioral Health  Developmental  Medical  Educational  Relational |
| Are relevant Mental Health Providers (MHPs), Substance Use providers and regional centers actively involved in the development of this request including participating in CFTs?  Yes  No |
| If the child/NMD has medical needs, is there Individualized Health Care Plan (IHCP) and an IHCP Team in place:  Yes  No  If yes, is the IHCP actively involved in the development of this funding request:  Yes  No  Are there Specialized Healthcare Needs (SHCN):  Yes  No  Specify: |
| List requested services or supports that are needed but unavailable to support the child/NMD in the least restrictive setting: |
| Please describe how this funding will be used to support the exceptional needs identified in the ASSESSMENT/RECOMMENDATION BASIS section. |
| There is an identified permanent family home that is the permanency goal for the child/NMD:  Yes  No  Permanency goal:  Child/NMD’s relationship to the identified home: |
| The child/NMD has intensive family finding needs:  Yes  No |
| The child/NMD and family have family engagement related needs:  Yes  No |
| The child/NMD has needs related to an individual or family member they can identify having a significant relationship with and/or a permanent connection to:  Yes  No |
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| 1. **FINANCIAL** |
| Identify the approximate/estimated costs associated with these needs:  $\_\_     \_ /month, or $\_      \_\_/per quarter or $\_\_     \_\_ one time cost. |
| When will cost begin? Click or tap to enter a date.  How long will funds be required? Choose an item. If reoccurring cost, what is the frequency of the reoccurring costs? For example, Quarters 1 through 3 (Please enter specific duration, cannot state “Ongoing”). |
| Are there any other existing funding sources such as Medi-Cal, WRAP, etc., that can cover these costs? Please note, this funding cannot supplant existing funding sources.  Yes No  If yes, specify limitations to funds or why you may not have access: |

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| 1. **NARRATIVE** |
| Please provide any relevant additional information that pertains to this request: |

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| 1. **SIGNATURES** | |
| Person completing this form/contact for questions: | Title: |
| Phone#: | Email Address: |

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| Signature of County Program Manager, Administrator, or Director/Chief Probation Officer | | | | |
| Printed Name |  | Signature |  | Date |
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|  |  |  |  | Click or tap to enter a date. |
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| CDSS Response/Comments |
| Approved  Denied Reason for denial:  Reviewed by:       Date:  Click or tap to enter a date. |