**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.

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

|  |
| --- |
| 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:       |

|  |
| --- |
| 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. [ ]  NoIf 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. [ ]  NoIf, 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:      |

|  |
| --- |
| 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 noticeReason for notice:       |
| There is an inability to identify placement due to recurring placement denials:[ ]  Yes [ ]  NoReasons for placement denials:       |
| Resources designed to meet the needs of the youth are unavailable:[ ]  Yes [ ]  NoDescribe:       |
| The child/NMD has barriers to placement: [ ]  Yes [ ]  NoIf Yes: Choose an item. If other, please describe:       |
| Child’s/NMD’s preferred placement:      |

|  |
| --- |
| 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 [ ]  NoIf yes, is the IHCP actively involved in the development of this funding request: [ ]  Yes [ ]  NoAre there Specialized Healthcare Needs (SHCN):[ ]  Yes [ ]  NoSpecify:       |
| 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 [ ]  NoPermanency 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 |
|  |
| 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 [ ] NoIf yes, specify limitations to funds or why you may not have access:       |

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

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

|  |
| --- |
| Signature of County Program Manager, Administrator, or Director/Chief Probation Officer |
| Printed Name |  | Signature |  | Date |
|  |  |  |  |  |
|  |  |  |  | Click or tap to enter a date. |
|  |  |  |  |  |

|  |
| --- |
| CDSS Response/Comments |
| [ ]  Approved [ ]  Denied Reason for denial:       Reviewed by:       Date:Click or tap to enter a date. |