COUNTY OF SAN LUIS OBISPO
DEPARTMENT OF SOCIAL SERVICES
CHILD WELFARE SERVICES
Devin Drake ***Director***

LEVEL OF CARE (LOC) - RESOURCE PARENT TOOL

Resource Parent - Thank you for taking the time to help us understand the needs of the child/Non-Minor Dependent (NMD) placed in your home. The information you share about the child/NMDs needs is an important factor in the assessment of services and supports for the child/NMD. If there are two Resource Parents caring for the child/NMD, please include the activities you both do in support of them.

The questions below reflect activities consistent with parental expectations and various skills, and may account for efforts applied to meet any needs beyond what is appropriate for the child/NMDs age. Please complete this questionnaire in the manner that best describes the care you are currently providing to the child/NMD. We appreciate your input.

Date of Report: **Case Carrying Social Worker:**

Child Name		Case Number	
Gender Identity		Current Age	
Resource Parent Name		Date of Placement in this home	
Address:	City:	State:	Zip:
Home Number		Cell Phone	

PHYSICAL DOMAIN

The child/NMD may need assistance with basic self-care tasks or activities of daily living (ADL).

a. Are you helping the child/NMD with any of the following independence, physical or life skills? (check all that apply)

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

b. How are you helping the child/NMD with these skills? (check all that apply)

- ☐ Supervision of activities
- ☐ Verbal cueing as needed
- ☐ Some physical assistance
- ☐ Complete physical assistance

c. How many ADL's do you assist the child/NMD with daily?

☐ 1 ☐ 2 ☐ 3 ☐ 4+

Does the child/NMD have a visual or auditory impairment that requires extra care & supervision?

☐ Yes ☐ No

a. **If yes, indicate level of severity and amount of time spent assisting child/NMD**

☐ Moderate Assistance (2-4 hours/day) ☐ Complete assistance (4+ hours/day)

Do you arrange and/or facilitate the child/NMD attending speech therapy, physical therapy and/or occupational therapy?

☐ Yes ☐ No

a. **If yes, how often do you arrange/facilitate the child/NMD attending speech therapy, physical therapy and/or occupational therapy?** (Indicate number of appointments per month)

☐ 1-2 ☐ 3 ☐ 4-5 ☐ 6 ☐ 7-8 ☐ 9+

Do you provide support and/or assistance to the child/NMD so they can participate in community and/or extra-curricular activities? (check all that apply)

☐ Check-in to make sure child/NMD receives needed assistance/support with skills while participating in community/extra-curricular activities

☐ Go with the child/NMD to community/extra-curricular activities to provide direct support to the child

☐ Participate in community/extra-curricular activities due to the child/NMDs need for constant support or supervision to participate

FOR YOUTH AGE 14 OR OLDER, COMPLETE QUESTIONS BELOW:

Are you assisting the youth with any of the listed life skills? (check all 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
☐ Youth receives needed assistance/ support with skills in community/ extra-curricular activities

a. **How are you helping the youth with these skills? (check all that apply)**

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

b. **How many skills do you assist the youth with daily?**

☐ 1 ☐ 2 ☐ 3 ☐ 4+

BEHAVIORAL/EMOTIONAL

Does the child/NMD have behavioral/emotional challenges as diagnosed by a licensed therapist or doctor?

☐ Yes ☐ No

Does the child/NMD and family participate with any of the following supports? (check all that apply)

☐ Support group for resource family
☐ Wraparound (WRAP)
☐ Tri-Counties Regional Center (TCRC)
☐ In-Home Behavioral Services (IHBS)
☐ Intensive Care and Coordination (ICC)
☐ Adoption Promotion and Supportive Services (APSS)
☐ Parent Child Interactive Therapy (PCIT)
☐ Other (please describe) _____

Do you support the child/NMD in addressing behavioral/emotional challenges listed below?

☐ Yes ☐ No

If yes, do you assist with the following?

- Taking/facilitating transportation of child/NMD to therapy appointments
  ☐ N/A ☐ 1 ☐ 2 ☐ 3 ☐ 4+ per month
- Talking to therapist, clinicians, social workers or other professionals
  ☐ N/A ☐ 1 ☐ 2 ☐ 3 ☐ 4+ per month
- Monitoring, observing, documenting child/NMDs behaviors
  ☐ N/A ☐ 1 ☐ 2 ☐ 3 ☐ 4+ per month
- Implementing therapeutic intervention/behavior plan
  ☐ N/A ☐ 1 ☐ 2 ☐ 3 ☐ 4+ per month
- Redirecting, prompting child/NMD and/or defusing behaviors
  ☐ N/A ☐ 1 ☐ 2 ☐ 3 ☐ 4+ per month
- Supporting the child/NMD through emotional outbursts/tantrums
  ☐ N/A ☐ 1 ☐ 2 ☐ 3 ☐ 4+ per month
- Supervising/observing child/NMD, including line of sight
  ☐ N/A ☐ Occasional ☐ Frequent ☐ All day ☐ 24 hours

Does the child/NMD runaway? ☐ Yes ☐ No (If yes, indicate frequency, duration and intervention required)

_____

_____

Do you provide 2-4 hours a day of extra care & supervision due to the following behaviors?

- ☐ Hyperactivity, not controlled by medication
- ☐ Frequent loss of emotional control, defiance towards adults
- ☐ Destructive to household property due to behavioral issues
- ☐ Depression, anxiety or fear
- ☐ Other (please describe) _____

Do you provide 4 + hours a day of extra care & supervision due to the following behaviors?

- ☐ Hyperactivity, not controlled by medication
- ☐ Probation behaviors (truant, stealing, committing crimes, physical aggression towards others, etc.)
- ☐ Depression, anxiety or fear
- ☐ Other medical condition requiring extra care more than 4 hours/day
- ☐ Other (please describe) _____

EDUCATIONAL

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?

NOTE: Include time spent supporting the child in school-based activities, volunteering in the classroom, arranging tutoring, maintaining equipment, tools or devices so the child can access education. Also includes assisting with college/financial-aid applications. (This applies to online, in-person, and blended learning programs)

- ☐ 0-1 hours per week
- ☐ 2 hours per week
- ☐ 3-4 hours per week
- ☐ 5-6 hours per week
- ☐ 7+ hours per week

For NON SCHOOL-AGE CHILD, what supports are you providing for the child to participate in/benefit from childcare and/or preschool programs? (check all that apply)

- ☐ Enrolled child in Early Head Start/Head Start, Transitional Kindergarten program or other child development program
- ☐ Read out loud to child
- ☐ Maintaining equipment, tools or devices for child to access education
- ☐ Spend time to support the child's participation in or benefiting from child care/preschool programs. Includes efforts in coordination with the child care/preschool to ensure the child's continued attendance and/or address behaviors that might put the child at risk of being denied services at daycare or educational facility.
  - ☐ 0-1 ☐ 2 ☐ 3-4 ☐ 5-6 ☐ 7+ hours per week
- ☐ Respond to complaints from child care/preschool _____ times per week

How much time are you spending advocating on behalf of the child with teachers or child care/preschool staff?

NOTE: 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.

☐ 0-1 ☐ 2 ☐ 3-4 ☐ 5-6 ☐ 7+ hours per week

HEALTH DOMAIN

Does your child/NMD's pediatrician/dentist provide specialty care beyond routine well-child appointments?

☐ No ☐ Yes, please describe services and frequency: _____

Do you arrange/facilitate medical appointments with specialists for the child/NMD (not including routine dental/physical)? (i.e. neurologist, allergist, psychiatrist, orthodontist, etc.)

☐ Child/NMD not currently seeing specialist(s)

☐ 1-2 medical appointments per year (within SLO County)

☐ 3-11 medical appointments per year (within SLO County)

☐ 12 medical appointments per year (within SLO County)

☐ 13-24 medical appointments per year (within SLO County)

☐ 3-4 medical appointments per month (within SLO County)

☐ 5+ medical appointments per month (within SLO County)

Do you arrange/facilitate out of county medical appointments for the child/NMD?

☐ None

☐ 1-2 medical appointment per year (outside of SLO County)

☐ 3 medical appointments per year (outside of SLO County)

☐ 4+ medical appointments per year (outside of SLO County)

Does the child/youth take medications prescribed by a doctor? This includes psychotropic medication for behavioral/emotional health.

☐ Yes ☐ No

a. **If yes, how many prescribed medications is the child/NMD currently take?**

☐ 1 medication, as needed (PRN)

☐ 1 medication, daily

☐ 2+ medications, daily

☐ 2+ medications more than once a day

☐ Monitor the child's self-administered medications(s)

b. How do you support the child/NMD with their medications?

- ☐ No assistance required
- ☐ Observation only
- ☐ Observe and/or administer, record, and/or report medication effects to doctor

What care do you provide for a child/NMD who uses equipment and/or medical devices?

- ☐ No medical devices currently used
- ☐ Monitor the child/NMD using medical device and/or testing equipment
- ☐ Operate and monitor the equipment and/or medical device

What care do you provide for a child/NMD who has a severe medical and/or developmental health? (check all that apply)

- ☐ Child/NMD requires in-home monitoring by medical professional
- ☐ Child/NMD requires use of medical equipment or devices multiple times per week
- ☐ Child/NMD has a severe condition, requiring caregiver intervention (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)

Does the child/NMD require extra care & supervision due to any of the following conditions?

- ☐ Enuresis/Encopresis (ages 6+) – ☐ Once per week ☐ Once per day ☐ 2+ times per day
- ☐ Positive toxicology screen at birth
- ☐ Prenatal drug and/or alcohol exposure
- ☐ Type 1 Diabetes (insulin dependent)
- ☐ Type 2 Diabetes (non-insulin dependent), requires special diet and close monitoring
- ☐ Failure to thrive due to mild feeding difficulties
- ☐ Chronic asthma, requiring close supervision, frequent inhaler administration or nebulizer treatments)

PERMANENCY/FAMILY SERVICES DOMAIN

Are you supporting the child/NMDs visits and/or participation in community and cultural activities important to their cultural and communal identity? This includes transporting and staying at the visits/activities (check all that apply)

- Supporting the child/NMDs visits with his/her family, siblings and others
  ☐ N/A ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 + times per month
- Supporting child/NMDs attending community and/or cultural activities
  ☐ N/A ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 + times per month
- Mentoring/coaching birth parents implementing family visitation plans
  ☐ N/A ☐ 2 ☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 11+ hours per week

ADDITIONAL INFORMATION

Additional comments, concerns, and/or support you can provide: _____

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Would you like training or other support in any of the areas noted above? ☐ **YES** ☐ **NO**

- **Please list those topic(s):** _____

  _____

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_____ _____

Resource Parent Name **Resource Parent Signature**

_____

Date Completed