



STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES

Date: 3/25/04

DIFFICULTY OF CARE (DOC) WORKSHEET & AGREEMENT

Name of Child: Roneta Pascual Date of Birth: 12/28/01

I am requesting DOC payments for the higher level of care that I provide to the above named child. The types and amounts of additional care I provide are detailed in Part II of this DOC worksheet. The amount of time listed is for care provided only to this child. I do not provide care to any other child during the times listed. If the child participates in a group activity with other children, such as eating or homework time, only the portion of the time spent with this child on an individual basis is listed.

Caregiver _____ Date 3/25/04 Caregiver _____ Date 3/25/04

CRITERIA (Part I)

The Department bases its determination of the child's need for a higher level of care on the completed DOC Worksheet (Part II) on page 2 and the documentation from the treating professional(s).

CRITERIA: THE DHS SOCIAL WORKER MUST ENSURE THAT THE FOLLOWING CRITERIA ARE MET:

- ⊖ This child requires a higher level of care than usual for a child of this age due to physical, psychological, emotional or behavioral needs, which are being treated by a professional other than the Department social worker. Written verification from the treating professional must be attached; and
- ⊖ The services to be provided are necessary due to the child's identified needs; and
- ⊖ The child is under the placement responsibility of the Department, or has been placed via an Independent Placement Agreement (DHS 1614) with the Department, or had been under the Department's placement when legal guardianship or permanent custody was awarded to the current caregiver; and
- ⊖ The child is in an approved foster home, an approved adoptive or prospective adoptive home, or with legal guardians or permanent custodians, hereafter called caregivers; and
- ⊖ The caregivers have the training or experience to provide the specific services needed for the higher level of care, or will be obtaining the necessary training within one month of starting the DOC payment.

Name of Child:

Renee Pascoal

Date of Birth:

12/28/01

DOC WORKSHEET (Part II)

This information is the basis for determining DOC payments.

1 unit = 1 hour

MEDICAL / PHYSICAL CARE ACTIVITIES		UNITS/WEEK
<input type="checkbox"/>	Transport child to on-going medical or physical therapy or occupational therapy sessions	
<input type="checkbox"/>	Participate as part of a team with the doctors or therapists and the child	
<input type="checkbox"/>	Carry out the medical or physical/occupational therapy plan at home Specify activities:	
<input type="checkbox"/>	Monitor specialized medical equipment: carry out specialized medical procedures	
<input type="checkbox"/>	Provide additional assistance with toileting – excess time for a child this age	
<input type="checkbox"/>	Provide additional assistance with feeding – excess time for a child this age	
<input type="checkbox"/>	Provide additional assistance with dressing – excess time for a child this age	
<input type="checkbox"/>	Provide additional assistance with bathing – excess time for a child this age	
<input type="checkbox"/>	Other – Specify:	
TOTAL		
THERAPEUTIC / EMOTIONAL CARE ACTIVITIES:		
<input type="checkbox"/>	Transport child to therapeutic counseling – psychologists, psychiatrists, support groups, etc. Specify to whom: <u>Carmen Chaisson, Ph.D.</u>	2
<input type="checkbox"/>	Participate in therapeutic counseling with child or consult/share information with professionals	1
<input type="checkbox"/>	Carry out therapist's recommendations, activities, or method to modify child's behavior Specify activities: <u>de-escalate anxiety, separation episodes; assist through night terrors; redirect temper tantrums; 1:1 interaction</u>	24
<input type="checkbox"/>	Provide additional supervision needed due to child's identified concern. Specify type of supervision:	
<input type="checkbox"/>	Other – specify:	
TOTAL		27
ACADEMIC / EDUCATIONAL CARE ACTIVITIES:		
<input type="checkbox"/>	Assist child with special educational needs at home – hours in excess of 10 hours per week	
<input type="checkbox"/>	Transport child for tutoring	
<input type="checkbox"/>	Meeting with teachers/school personnel – hours in excess of 1 hour per week Specify reason for frequent meetings:	
<input type="checkbox"/>	Other – Specify:	
TOTAL		
AUXILIARY SERVICES:		
<input type="checkbox"/>	Other – Specify:	
TOTAL		27

Name of Child: Roneta Pascual Date of Birth: 12/28/01

Distribution: Original in Case Record; Copy to Caregiver

LINDA LINGLE
GOVERNOR



LILLIAN B. KOLLER, ESQ.
DIRECTOR
HENRY OLIVA
DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Central Child Welfare Services Unit 2
601 Kamokila Blvd., Suite 135
Kapolei, Hawaii 96707

Carmenne Chaisson, Ph.D

Dear Dr. Chaisson :

Child's Name & DOB: Ronela Pascual 12.28.01
Name of Caregiver(s): _____

_____ have requested Difficulty of Care (DOC) payments for the above named child. In addition to foster board payments, DOC payments are made to the caregiver(s) who provide(s) supervision and care to a child who requires a higher level of care due the child's physical, psychological, emotional, or behavioral needs, which are being treated by a professional. This care is over and above the care provided to an average child of this age. A professional operating within the scope of that profession must make a written assessment of the need and recommendation for services. Your name has been given to us by the caregiver(s). The following information is needed to make an eligibility determination within thirty days of the caregiver(s) request for DOC payments. Please submit the requested information to me at the above address by 3/30/04. If you have questions please call me at 692-7808. Thank you for your assistance.

Sincerely,

[Signature]
Social Worker

1) For what condition (diagnosis) are you treating the child?

Disorder, inhibited type

Reactive Attachment

A) Date you began treating the child:

2-11-04

B) Frequency of contact with the caregiver(s):

2 to 4 times per month

C) Frequency of contact with the child:

2 to 4 times per month

2) How long do you expect this child's condition to last? 1 year

3) What services do you expect the caregiver(s) to provide for this child that are over and above the care provided to an average child of this age? See enclosed worksheet for examples. This child demonstrated a speech delay and social delays on the P-ineland

This child demonstrates symptoms of reactive Attachment disorder, inhibited type. Caregivers provide extra care day and night to help this child de-escalate from extreme fear reactions, anxiety and

4) How much time per day/week/month is/are the caregiver(s) expected to spend providing this service that is over and above the care provided to an average child of this age? temper tantrums, sometimes holding the child for hours at night when she wakes screaming

This child requires one-on-one immediate interaction with a caregiver about 10 hours per day more than an average child her age.

5) When (month/approximate day/year) did the caregiver(s) initiate these services to this child?

4/03

6) Please include any reports or evaluations that would help us determine this child's eligibility for difficulty of care payments.

Please see attached report

The answers to the above questions are provided to the best of my knowledge.

Carmen Chassen, PhD
Signature of treating professional