MISSOURI DEPARTMENT OF SOCIAL SERVICES CHILDREN’S DIVISION

Level of Care Determination Form

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| Name of Assessor:      | Date Completed:       |
| Email:       | Phone Number:       |
| Youth’s Name:       | DCN:       |
| Youth’s Current Placement Name:       | Type of Placement:       | DVN:       | Date Placed:       |
| Selection/Screening Team Members in Attendance:       |
| **Presenting Behaviors Not Included in the CPSI Checklist (check all that apply):** |
| [ ]  **Destructiveness**[ ]  **Poor social skills**[ ]  **Eating challenges** | [ ]  **Personal hygiene** [ ]  **Soiling**[ ]  **Bedwetting** | [ ]  **Other:**      [ ]  **Other:**      [ ]  **Other:**       |
| **Please describe the youth’s presenting behaviors, provide specific examples, onset and duration, and other relevant details such as possible triggers for each checked box above as well as descriptive information to support the CSPI assessment scoring, include dates:**      |
| **What is the youth’s permanency plan? Describe parental and other relatives’ involvement, progress and barriers in reaching timely permanency. Provide the concurrent permanency plan, if applicable.**       |
| **Please list any placement considerations needed for this youth (i.e., travel, visitation arrangements).**       |
| **What type of family will best fit this youth’s needs? (i.e. home with no young children/pets, two parent family, etc.)**      |  |
| **When we think about the situation this family/youth is facing:** |  |
| **What are we worried about?** | **What’s working well?** | **What needs to happen?** |  |
|       |       |       |  |
| **Level of Care (LOC) Determination and Approval:**[ ]  Traditional Foster Home [ ]  \*Medical Foster Home (CS-10 determination form; \*LOC staffing not required, Supervisor can approve)[ ]  Elevated Needs Level A [ ]  Elevated Needs Level B[ ]  Treatment Foster Care (Submit completed CS-9 packet and approved CD-137 form to TFC Agency)  |
|  [ ]  Relative TFC [ ]  Traditional TFC [ ]  Transition (Parent(s)/Other) [ ]  Subsidy In-home |
| Is there already a TFC placement provider identified? [ ]  Yes [ ]  No If relative, are they licensed? Yes [ ]  No [ ] [ ]  Will the TFC agency need to complete the relative home assessment/licensure? Yes [ ]  No [ ] Does Not Meet Criteria/Other-Explain:       |
| TFC Caregiver:       | DVN:       | Address:       | Phone:       |
| Licensing Worker:       | Phone:       | Email:       |
| [ ]  Refer for Residential- Submit completed CS-9 packet and LOC Determination form, CD-137 to the RCST Please describe how the child’s needs are unable to be met in a community setting: |
| Signature of Assessor:       | Date:       |