Child Welfare and CalAIM: Toolkit for Counties

Resources for county child welfare agencies to leverage Medi-Cal and CalAIM

April 2025

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CWDA
Advancing Human Services for the Welfare of *All* Californians

CFPIC
Celebrating 20 Years

Today's Goals

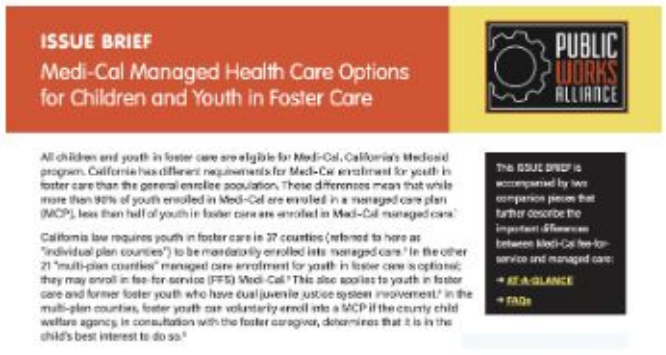
1. Discover resources available to support child welfare agency decisions related to Medi-Cal enrollment for children and youth in foster care
2. Review resources on connecting children and youth to Enhanced Care Management and other Medi-Cal CalAIM benefits
3. Get tips to use the materials for staff training and to update workflows to maximize Medi-Cal services for children and families

Toolkit Contents

1. **Medi-Cal Managed Care for Children and Youth in Foster Care Issue Brief**
2. **FFS vs Managed Care at-a-Glance Comparison**
3. **Medi-Cal Enrollment FAQ**
4. Decision Making Tool
5. Logic Model/Theory of Change
6. Example referral workflows
7. Case Studies to support staff training
8. Sample Releases of Information and Consent Form

Understanding Medi-Cal Managed Care

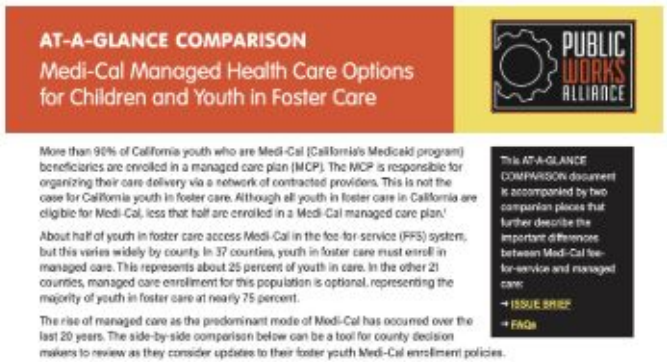
Download Public Works Alliance Materials Here:
https://publicworksalliance.org/child-welfare-and-medi-cal


ISSUE BRIEF
Medi-Cal Managed Health Care Options for Children and Youth in Foster Care

Issue Brief

This issue brief provides background on Medi-Cal managed care and FFS options for youth in foster care, including a number of recent changes to managed care that may improve access to and quality of care for youth in foster care. This paper can help county social workers and staff better understand both options to make enrollment decisions that best serve each youth.

Read more


AT-A-GLANCE COMPARISON
Medi-Cal Managed Health Care Options for Children and Youth in Foster Care

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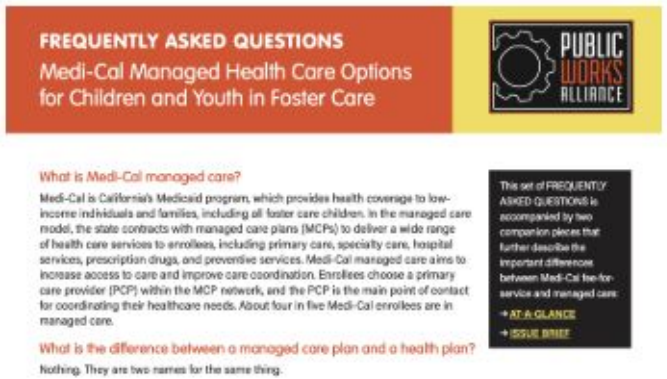
At-A-Glance

This paper provides a side-by-side comparison of Medi-Cal fee-for-service and managed care plan delivered services as a tool for county decision makers to review as they consider updates to their foster youth Medi-Cal enrollment policies.

Read more


FREQUENTLY ASKED QUESTIONS
Medi-Cal Managed Health Care Options for Children and Youth in Foster Care

What is Medi-Cal managed care?

What is the difference between a managed care plan and a health plan?

Nothing. They are two names for the same thing.

FAQs

This paper attempts to respond to the questions that often create barriers for counties as they are making Medi-Cal decisions for children and youth in foster care.

Read more

Understanding Medi-Cal Managed Care

Download Public Works Alliance Materials Here:
https://publicworksalliance.org/child-welfare-and-medi-cal

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Inter-County Transfer Scenarios

Single plan/County Organized Health System (COHS), mandatory county ➜ multi-plan optional county

Initially, the youth will be defaulted into fee-for-service. The social worker, in consultation with the child's caregiver, must determine if it is in the child's best interest to:

A. Enroll in one of the Medi-Cal MCPs available in the residence county, or

B. Enroll in fee-for-service.

Multi-plan optional county ➜ multi-plan optional county

Initially, the youth will be defaulted into fee-for-service. The social worker, in consultation with the child's caregiver, must determine if it is in the child's best interest to:

A. Remain in the same Medi-Cal MCP if it is available in the new residence county,

B. Enroll in a new/different MCP, or

C. Enroll in fee-for-service.

Single plan, mandatory county ➜ COHS or single plan, mandatory county

The child/youth will be required to enroll into the single MCP in the new residence county.*

If Kaiser is available in that new county and they choose to enroll in Kaiser, they will need to do so by going through Health Care Options (via phone or online), or calling the Medi-Cal Ombuds office.

Multi-plan optional county ➜ COHS or single plan, mandatory county

The child/youth will be required to enroll into the single MCP in the new residence county.*

If Kaiser is available in that new county and they choose to enroll in Kaiser, they will need to do so by going through Health Care Options (via phone or online), or calling the Medi-Cal Ombuds office.

Kaiser enrollment

Kaiser offers Medi-Cal enrollment to foster youth in 32 counties. If a youth is enrolled in Kaiser in one county and moves to a new county of residence where Kaiser is an option, then:

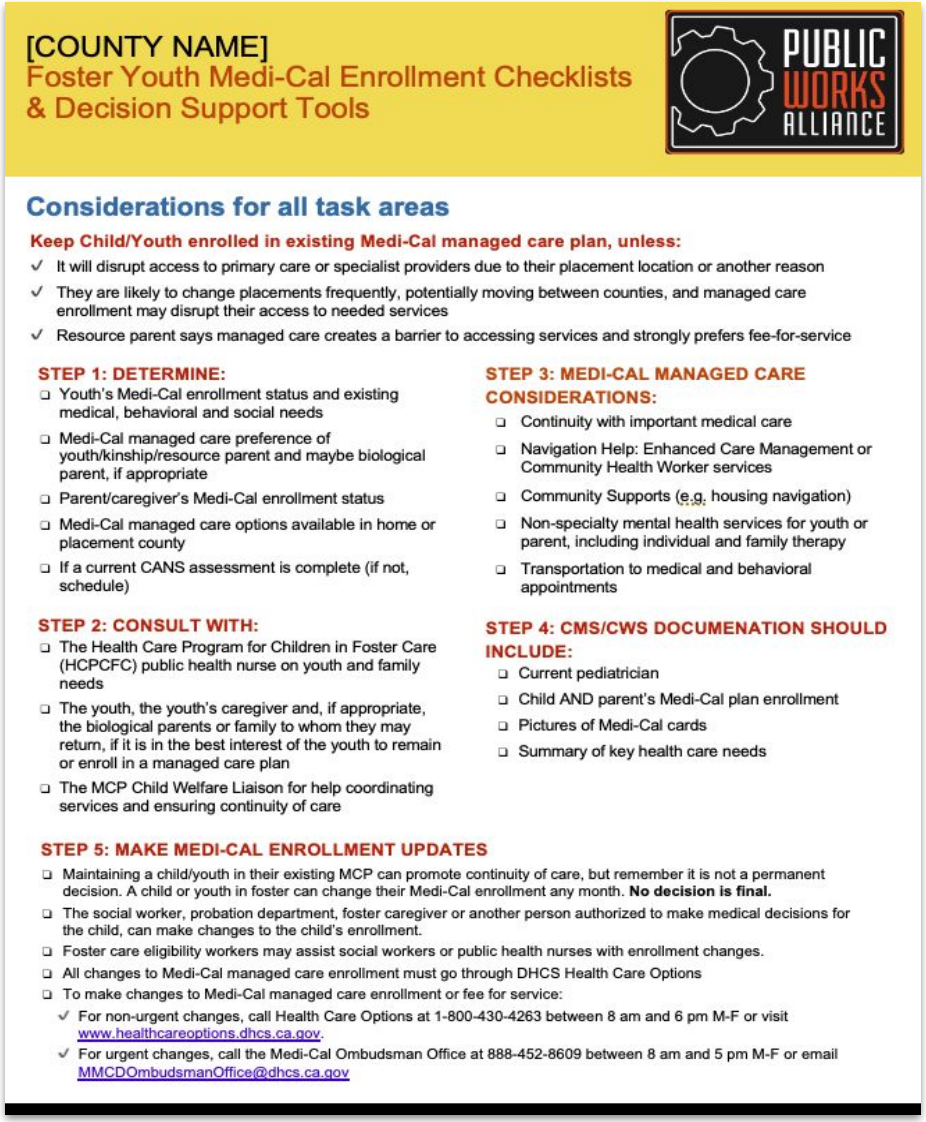
» The social worker and caregiver must work with Health Care Options to select Kaiser in the new residence county.

If a youth is enrolled in Kaiser in one county and moves to a new county of residence where Kaiser is **not** an option, then the youth will have to disenroll from Kaiser and be enrolled in one of the mandatory MCPs or fee-for-service.

Decision Support Tools

Guides for county agencies to customize to support decision making and processes.

Download [here]



[COUNTY NAME]
Foster Youth Medi-Cal Enrollment Checklists
& Decision Support Tools

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Considerations for all task areas

Keep Child/Youth enrolled in existing Medi-Cal managed care plan, unless:

- ✓ It will disrupt access to primary care or specialist providers due to their placement location or another reason
- ✓ They are likely to change placements frequently, potentially moving between counties, and managed care enrollment may disrupt their access to needed services
- ✓ Resource parent says managed care creates a barrier to accessing services and strongly prefers fee-for-service

STEP 1: DETERMINE:

- ❑ Youth's Medi-Cal enrollment status and existing medical, behavioral and social needs
- ❑ Medi-Cal managed care preference of youth/kinship/resource parent and maybe biological parent, if appropriate
- ❑ Parent/caregiver's Medi-Cal enrollment status
- ❑ Medi-Cal managed care options available in home or placement county
- ❑ If a current CANS assessment is complete (if not, schedule)

STEP 2: CONSULT WITH:

- ❑ The Health Care Program for Children in Foster Care (HCPCFC) public health nurse on youth and family needs
- ❑ The youth, the youth's caregiver and, if appropriate, the biological parents or family to whom they may return, if it is in the best interest of the youth to remain or enroll in a managed care plan
- ❑ The MCP Child Welfare Liaison for help coordinating services and ensuring continuity of care

STEP 3: MEDI-CAL MANAGED CARE CONSIDERATIONS:

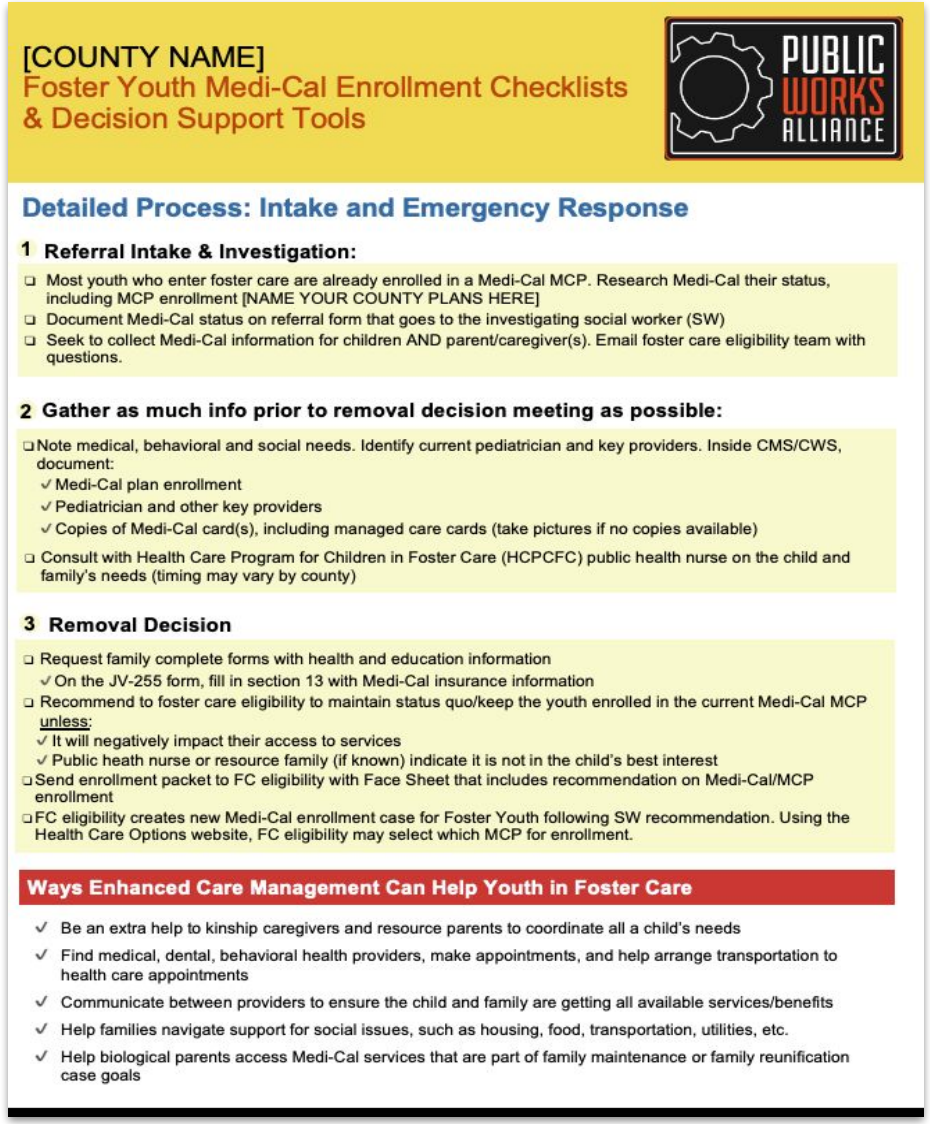
- ❑ Continuity with important medical care
- ❑ Navigation Help: Enhanced Care Management or Community Health Worker services
- ❑ Community Supports (e.g. housing navigation)
- ❑ Non-specialty mental health services for youth or parent, including individual and family therapy
- ❑ Transportation to medical and behavioral appointments

STEP 4: CMS/CWS DOCUMENATION SHOULD INCLUDE:

- ❑ Current pediatrician
- ❑ Child AND parent's Medi-Cal plan enrollment
- ❑ Pictures of Medi-Cal cards
- ❑ Summary of key health care needs

STEP 5: MAKE MEDI-CAL ENROLLMENT UPDATES

- ❑ Maintaining a child/youth in their existing MCP can promote continuity of care, but remember it is not a permanent decision. A child or youth in foster can change their Medi-Cal enrollment any month. **No decision is final.**
- ❑ The social worker, probation department, foster caregiver or another person authorized to make medical decisions for the child, can make changes to the child's enrollment.
- ❑ Foster care eligibility workers may assist social workers or public health nurses with enrollment changes.
- ❑ All changes to Medi-Cal managed care enrollment must go through DHCS Health Care Options
- ❑ To make changes to Medi-Cal managed care enrollment or fee for service:
  - ✓ For non-urgent changes, call Health Care Options at 1-800-430-4263 between 8 am and 6 pm M-F or visit www.healthcareoptions.dhcs.ca.gov.
  - ✓ For urgent changes, call the Medi-Cal Ombudsman Office at 888-452-8609 between 8 am and 5 pm M-F or email MMCDOmbudsmanOffice@dhcs.ca.gov



[COUNTY NAME]
Foster Youth Medi-Cal Enrollment Checklists
& Decision Support Tools

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Detailed Process: Intake and Emergency Response

1 Referral Intake & Investigation:

- ❑ Most youth who enter foster care are already enrolled in a Medi-Cal MCP. Research Medi-Cal their status, including MCP enrollment [NAME YOUR COUNTY PLANS HERE]
- ❑ Document Medi-Cal status on referral form that goes to the investigating social worker (SW)
- ❑ Seek to collect Medi-Cal information for children AND parent/caregiver(s). Email foster care eligibility team with questions.

2 Gather as much info prior to removal decision meeting as possible:

- ❑ Note medical, behavioral and social needs. Identify current pediatrician and key providers. Inside CMS/CWS, document:
  - ✓ Medi-Cal plan enrollment
  - ✓ Pediatrician and other key providers
  - ✓ Copies of Medi-Cal card(s), including managed care cards (take pictures if no copies available)
- ❑ Consult with Health Care Program for Children in Foster Care (HCPCFC) public health nurse on the child and family's needs (timing may vary by county)

3 Removal Decision

- ❑ Request family complete forms with health and education information
  - ✓ On the JV-255 form, fill in section 13 with Medi-Cal insurance information
- ❑ Recommend to foster care eligibility to maintain status quo/keep the youth enrolled in the current Medi-Cal MCP unless:
  - ✓ It will negatively impact their access to services
  - ✓ Public heath nurse or resource family (if known) indicate it is not in the child's best interest
- ❑ Send enrollment packet to FC eligibility with Face Sheet that includes recommendation on Medi-Cal/MCP enrollment
- ❑ FC eligibility creates new Medi-Cal enrollment case for Foster Youth following SW recommendation. Using the Health Care Options website, FC eligibility may select which MCP for enrollment.

Ways Enhanced Care Management Can Help Youth in Foster Care

- ✓ Be an extra help to kinship caregivers and resource parents to coordinate all a child's needs
- ✓ Find medical, dental, behavioral health providers, make appointments, and help arrange transportation to health care appointments
- ✓ Communicate between providers to ensure the child and family are getting all available services/benefits
- ✓ Help families navigate support for social issues, such as housing, food, transportation, utilities, etc.
- ✓ Help biological parents access Medi-Cal services that are part of family maintenance or family reunification case goals

What's coming next?

- **CINS, BICS and MEDS:** Training slide deck on checking Medi-Cal eligibility in MEDS
- **ECM and Consent Deep Dive**: Guidance for specific scenarios to improve coordination at the individual and population levels
- **Metrics that Matter:** Applying shared data between county child welfare systems and managed care plans to improve outcomes

Full Circle
Health Network

Theory of Change: ECM as a prevention and support tool for child welfare-involved children, youth and families

March 2025

Theory of Change: Why have it and how to use it

1. **Communication and planning tool**: Creates a map of the logical sequence of steps leading to the desired outcomes and impact to use as a communication tool to align stakeholders.
2. **Clarify goals and assumptions**: Make explicit the desired outcomes and underlying assumptions about how change occurs to achieve them.
3. **A blueprint for action:** Guide teams to stay on course and make informed decisions about program activities.
4. **Facilitate evaluation**: A framework for evaluation by *identifying measurable indicators of success.*
5. **Drive systems change:** Articulate how change is expected to occur, identify opportunities for collaboration and leverage efforts for systemic change.
6. **Improve decision-making:** A framework for making strategic decisions and prioritizing actions that are most likely to contribute to desired outcomes.

ECM For Child Welfare - FCHN Theory of Change

Inputs

Child Welfare Agencies (CWA)
- Defined referral pathways with MCPs
- Staff education/direction on ECM referrals
- Data on CW cases/status

MCPs
- Contracts with Full Circle
- Defined referral pathways w/CWA
- Linked data to define shared population
- Population health data

Full Circle Health Network
- Medi-Cal Managed Care Plan (MCP) contracts
- Contracted providers w/ CW experience
- Defined referral pathways
- Tech for documentation, reporting

Community-based Providers
- Culturally concordant, knowledgeable staff
- Effective ECM service delivery
- Accurate documentation in EHR

Children & families
- Consent for CW to make a referral
- Consent to participate

Community Partners
- Knowledge on how to make a referral for services for supporting instead of reporting

Activities

Infrastructure between MCPs and CWAs
- Data sharing/use agreements between partners
- Develop processes to identify children/families and implement referrals (including consent process)
- Agree on streamlined referral pathways
- Build awareness among staff
- Provide training & support to referrers

Full Circle Health Network
- Engage providers & resources
- Train providers on all aspects of ECM
- Quickly assign referrals to best fit provider and ensure linkage; close the loop with referring entity, support case step-up/down
- Continuous quality monitoring & improvement of service delivery
- Meet all MCP compliance requirements
- Training to community partners to build awareness

Direct Service Providers
- Engage child/family and develop trust and reduce barriers to services
- Obtain consent to participate & communicate with care team based on child/family preferences
- Complete 360-degree assessment & child/family centered plan
- Support care plan goal achievement
- Link child/families to medical, behavioral and social services

Short-term Outcomes

Access, utilization, engagement
- Increased referrals to ECM
- Increased engagement & enrollment in ECM
- Families engaged early in services

Child & Family Experience
- Receive services from providers who reflect them, know their community, are trauma-informed
- Trust ECM providers and comfortable seeking/consenting to services
- Satisfied with ease of connecting
- Feel respected and supported by providers delivering care

Provider Experience
- Smooth onboarding & support building ECM capacity
- Understand program expectations & have tools to execute

Partnerships & sustainability
- Effective & mutually beneficial collaboration between CWA, MCPs, providers, community resources

Intermediate Outcomes

Access, utilization, engagement
- ECM becomes a tool in CWA prevention plans
- ECM increases child/family access to timely services (medical, BH, dental, social, etc)
- Adequate child/family engagement in care plans

Child & Family Experience
- Positive experience w/ services and would recommend to others
- Successfully get linked to achieve medical, BH, dental, social service needs and goals
- Achieves CW case goals
- Educate & empower TAY/NMD to navigate their health plan
- Feel supported after CW case ends and prevent

Provider Experience
- More, diverse ECM providers
- Improved job satisfaction due to ease of operations & families have more support

Partnerships & sustainability
- SWs feel they have extra support for families and recommend ECM to each other as a helpful tool

Long-Term Outcomes

Access, utilization, engagement
- Prevent system involvement; increase success of FM, speed up FR, support NMD transition to independence
- Improvements in health quality: well child visits & immunizations
- Improvements in health equity: reduced access and outcome disparities by race or ethnicity

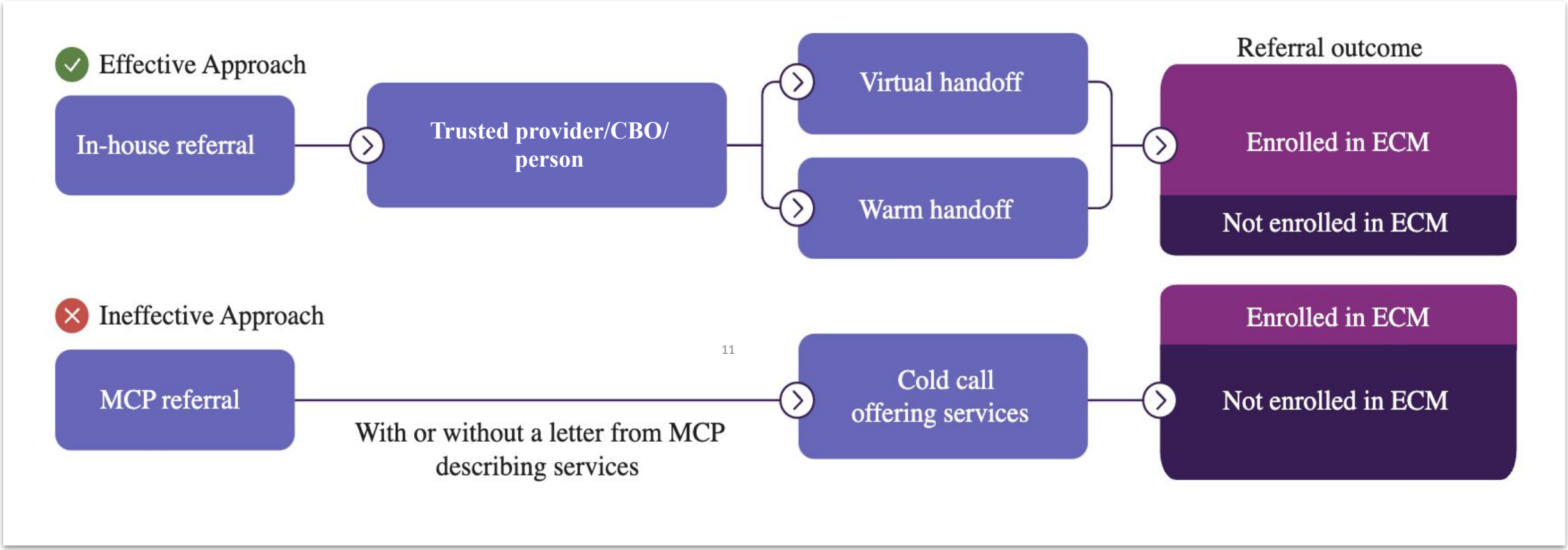
Child & Family Experience
- Greater trust in Medi-Cal system
- Reduced trauma impact of system involvement
- Improved connections to support systems that support long-term

Provider Experience
- Greater diversity in MCP networks due to increased CBO participation

Partnerships & sustainability
- CWA leverage all available Medi-Cal services for children/families and MCPs provide priority pathways for system-involved families

ECM Referral Approach

Research shows the best way to connect families to ECM is for referrals to come from <u>trusted</u> sources.



Source: Rand Corporation, Oct. 2024

ECM Referral Approach

Counties can send referrals directly to community providers to streamline the process.

Social worker (SW) — Initial Referral

- Tells parent/caregiver about ECM
- Seeks permission to send a referral to a local ECM provider
- Uses closed loop referral system or emails agency & requests services in child/parent/caregiver preferred language

Provider —Intake

- Receives referral & connects with parent/caregiver
- Explains ECM and gets consent to participate
- Collects info needed for MCP referral (authorization request): submits to MCP
- Starts intake/assessment process
- Notifies County SW of referral status

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Managed Care — Authorization

- Processes community referral/auth request within 5 days
- Notifies provider of decision

Lead Care Manager — Service Delivery

- Creates ECM care plan goals based on assessment
- With permission, communicates with existing service providers like public health nurse, pediatrician and behavioral health
- Helps make medical, behavioral or dental appointments
- Arranges transportation to key appointments
- Links family to supports for concrete needs like transitional housing provider, hygiene banks, childcare
- Option to link parent/caregiver to additional support from Community Health Worker

Source: Full Circle Health Network White Paper February 2025

Example in Practice: L.A.

GLENDORA OFFICE WORKFLOW

1. Children's Social Worker (CSW) receives list of eligible children/youth

2. CSW conducts outreach to the caregiver and discusses child/youth eligibility and benefits of ECM

3. Caregiver agreeable to referral?
   3a. If No, CSW continue to support as needed
   3b. If Yes, CSW completes the "ECM interest form" and "802 form" using the "other" field and includes ECM referral in the note

4. CSW reviews the list of ECM providers in the area with caregiver and select ECM provider of their choice
   4a. OPTIONAL: CSW contacts the ECM provider for a consult call with the family

5. CSW send "ECM interest form" and "802 form" to selected ECM provider and e-mail a copy to ecmhelp@dcfs.lacounty.gov

L.A. Consent & referral forms

COUNTY OF LOS ANGELES — DEPARTMENT OF CHILDREN AND FAMILY SERVICES

COMMUNITY BASED SUPPORT PROGRAMS

CONSENT TO RELEASE AND EXCHANGE INFORMATION

1. Case Name	2. Case Number
3. Parent's/Guardian's Names *(if different from Case Name)*	4. Date of Birth
5. Parent's/Guardian's Names *(if different from Case Name)*	6. Date of Birth
7. Name(s) of Children 1 2 3 4 5 6	8. Date(s) of Birth

9. CONSENT STATEMENT

I/we understand that as a necessary part of my/our participation in the Community Based Support Program(s), the agencies involved must have access to records pertaining to my/our family. Therefore, I/we give permission to the Department of Children and Family Services (DCFS) to release, disclose, and/or exchange information about myself and my child(ren) listed above with a Community Based Agency and the participating agencies which may include, but are not limited to: the Departments of Health Services, Mental Health, Public Social Services and Education; and the school systems. This consent includes both written and oral communication related to social, medical, developmental, psychological, educational, behavioral and other individual and family issues.

This signed consent form will remain in effect for the duration of my/our family's participation in the Community Based Support Program(s) indicated in #14 below.

10. Signature of Parent(s) Guardian(s)	11. Date of Signature
12. Children's Social Worker (CSW) Signature	13. Date of Signature

14. Select Program Authorized for Referral:

- ☐ Adoption, Promotion & Support Services (APSS)
- ☐ Child Abuse Prevention, Intervention & Treatment (CAPIT)
- ☐ Family Preservation Program (FPP)
- ☐ Partnership for Families (PFF)
- ☐ Prevention and Aftercare Services (PnA)
- ☐ Other: _____

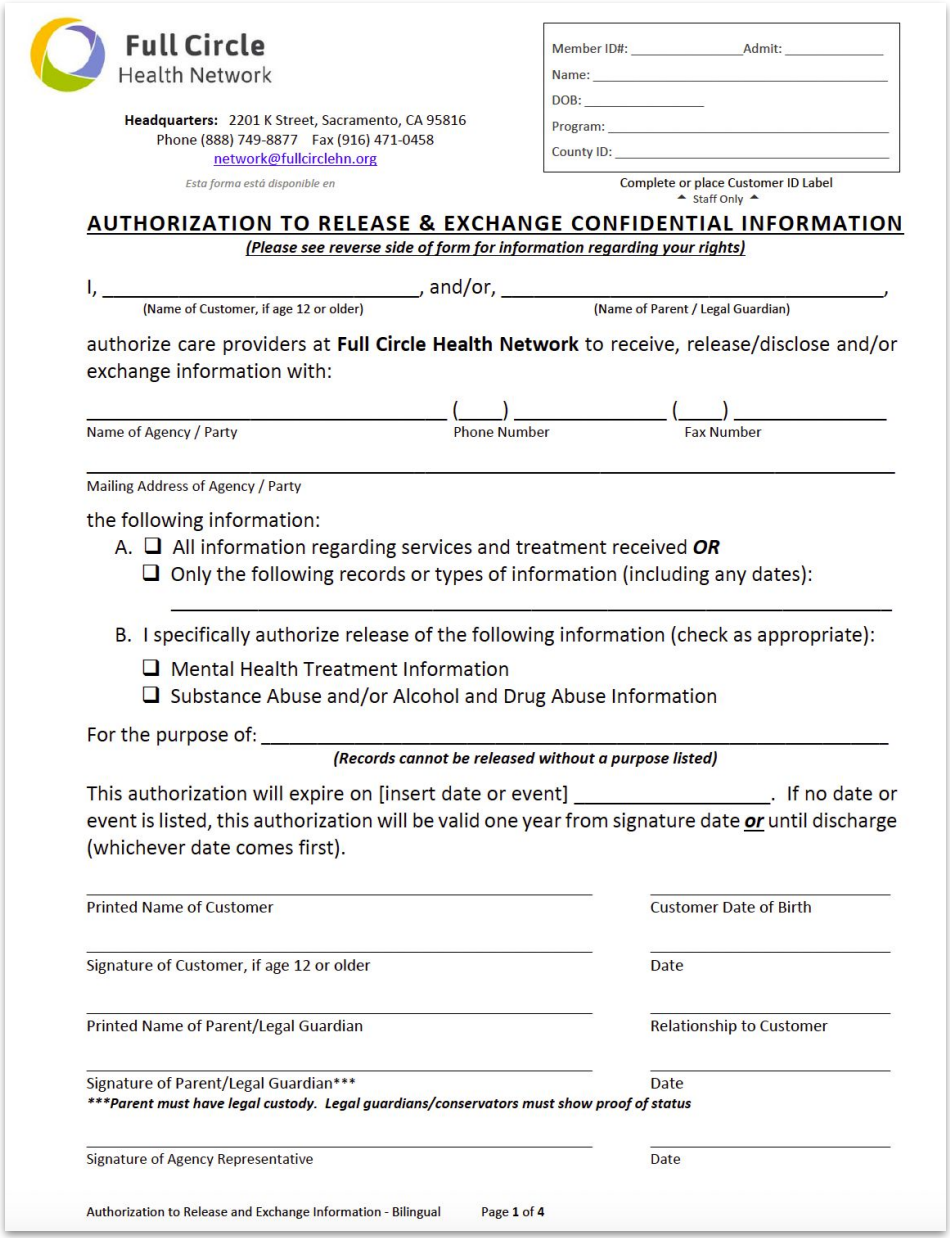
DCFS Regional Office Pilot Project for Enhanced Care Management

Enhanced Care Management (ECM) Interest Form

Today's Date:

1. Child's Name: Click or tap here to enter text.
2. Child's Date of Birth: Click or tap here to enter text.
3. Child's Insurance Plan (e.g., L.A. Care, HealthNet, etc.): Click or tap here to enter text.
4. Child's Medi-Cal Number (if available): Click or tap here to enter text.
5. Parent/Guardian Name: Click or tap here to enter text.
6. Parent's/Guardian's Phone Number:
   Home: Click or tap here to enter text.
   Cell: Click or tap here to enter text.
   Other: Click or tap here to enter text.
7. Parent's/Guardian's E-mail Address: Click or tap here to enter text.
8. Children's Social Worker (CSW) Contact Information:
   Name: Click or tap here to enter text.
   Phone Number: Click or tap here to enter text.
   E-mail Address: Click or tap here to enter text.
9. Additional Information:
   Please include anything else you would like to share about the family and/or child needs (e.g., housing, food, hospitalization follow-up, medical services, dental services, mental health support, etc.):
   Click or tap here to enter text.
10. ECM Provider Selected: Click or tap here to enter text.

Full Circle Consent Forms



Full Circle
Health Network

Headquarters: 2201 K Street, Sacramento, CA 95816
Phone (888) 749-8877 Fax (916) 471-0458
network@fullcirclehn.org

Esta forma está disponible en

Member ID#: _____ Admit: _____
Name: _____
DOB: _____
Program: _____
County ID: _____

Complete or place Customer ID Label
▲ Staff Only ▲

AUTHORIZATION TO RELEASE & EXCHANGE CONFIDENTIAL INFORMATION

(Please see reverse side of form for information regarding your rights)

I, _____, and/or, _____,
(Name of Customer, if age 12 or older) (Name of Parent / Legal Guardian)

authorize care providers at **Full Circle Health Network** to receive, release/disclose and/or exchange information with:

_____ (____) _____ (____) _____
Name of Agency / Party Phone Number Fax Number

_____
Mailing Address of Agency / Party

the following information:

A. ❑ All information regarding services and treatment received ***OR***
❑ Only the following records or types of information (including any dates):
_____

B. I specifically authorize release of the following information (check as appropriate):
❑ Mental Health Treatment Information
❑ Substance Abuse and/or Alcohol and Drug Abuse Information

For the purpose of: _____
(Records cannot be released without a purpose listed)

This authorization will expire on [insert date or event] _____. If no date or event is listed, this authorization will be valid one year from signature date ***or*** until discharge (whichever date comes first).

_____ _____
Printed Name of Customer Customer Date of Birth

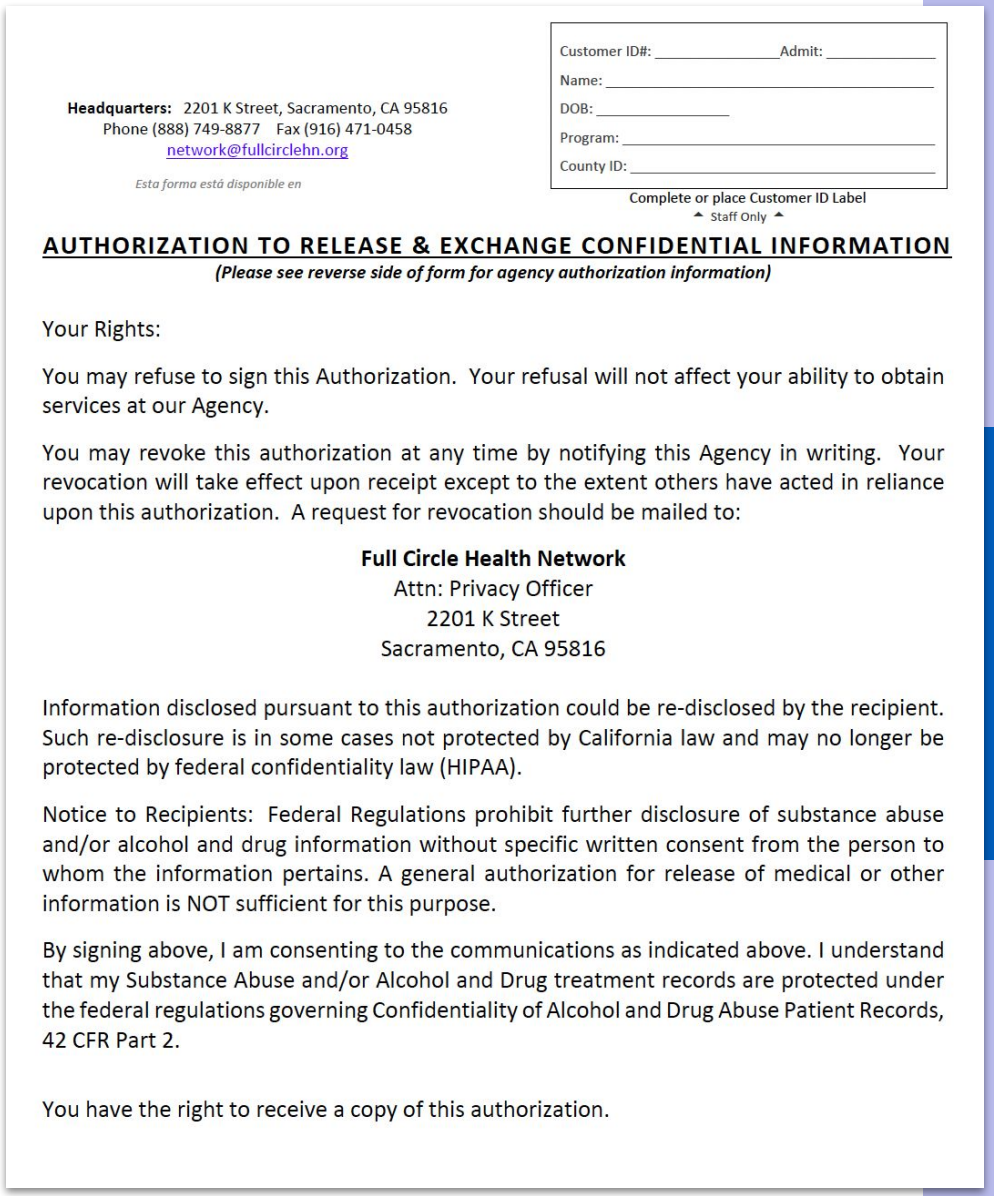
_____ _____
Signature of Customer, if age 12 or older Date

_____ _____
Printed Name of Parent/Legal Guardian Relationship to Customer

_____ _____
Signature of Parent/Legal Guardian*** Date
******Parent must have legal custody. Legal guardians/conservators must show proof of status***

_____ _____
Signature of Agency Representative Date

Authorization to Release and Exchange Information - Bilingual Page 1 of 4



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Customer ID#: _____ Admit: _____
Name: _____
DOB: _____
Program: _____
County ID: _____

Complete or place Customer ID Label
▲ Staff Only ▲

AUTHORIZATION TO RELEASE & EXCHANGE CONFIDENTIAL INFORMATION

(Please see reverse side of form for agency authorization information)

Your Rights:

You may refuse to sign this Authorization. Your refusal will not affect your ability to obtain services at our Agency.

You may revoke this authorization at any time by notifying this Agency in writing. Your revocation will take effect upon receipt except to the extent others have acted in reliance upon this authorization. A request for revocation should be mailed to:

Full Circle Health Network
Attn: Privacy Officer
2201 K Street
Sacramento, CA 95816

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

Notice to Recipients: Federal Regulations prohibit further disclosure of substance abuse and/or alcohol and drug information without specific written consent from the person to whom the information pertains. A general authorization for release of medical or other information is NOT sufficient for this purpose.

By signing above, I am consenting to the communications as indicated above. I understand that my Substance Abuse and/or Alcohol and Drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2.

You have the right to receive a copy of this authorization.

Case Studies for Training

Download Full Circle case studies here.

CASE STUDY | Family Reunification

Sisters

Scenario

Two sisters ages 9 and 7 were removed from their home due to sexual abuse by their mother's boyfriend. The mother is an undocumented immigrant and Spanish is her primary language. The mother wants her children back ASAP, but had no family or supports. She needs a place where she and her children could live, but she has never rented an apartment before on her own.

Core Needs

Safety

Family & Relationships

Stable Housing

Emotional / Psychological

Medical

Dental

School

Social/Fun

NEED | NO NEED

Presenting Needs/ Child & Family Goals

- Help the mother find stable housing so she can reunify with her children
- Ensure family is enrolled in all available social services supports for utility support and food
- Connection to mental health services for the daughters to address trauma
- Connection to mental health services for the mother to address trauma
- Catch up on all physical health and dental appointments
- Afterschool activities and supports

Role of ECM Care Manager

- Community Supports referral to housing services agency to help family find, secure and sustain housing
- Ensure both sisters are linked to a specialty mental health services provider
- Help mom connect to a mental health provider
- Help both sisters update their assigned pediatrician and make appointments
- Help make dental appointments for both girls
- Identify and find resources for transportation if needed for appointment attendance
- Research youth enrichment programs and help girls enroll
- Refer mother to parenting resources

Expected outcomes

- Secure stable housing
- Speed up family reunification timeframe
- Linkage to MH services
- Once the family is reunified, stay with the case for an additional 5 months to maintain family stability

Full Circle Health Network

CASE STUDY | Permanent Placement Stability & Complex Health Support

Brothers

Scenario

Three brothers, ages 13 and 9 (twins), were removed from their adoptive grandmother for neglect and placed with their great aunt and uncle. Soon after the placement, the grandmother died unexpectedly. The older boy has short gut syndrome requiring a feeding tube and one of the younger boys (twins) has ADHD. The eldest sibling requires frequent medical care and hospital visits due to short gut syndrome. The aunt has learned to care for him. The boys are happy to be together but sad about grandma's death. They did not get to visit or say goodbye. Great aunt and uncle are in their 60's and are mentally and financially overwhelmed raising three young boys.

Core Needs

Safety

Family & Relationships

Stable Housing

Emotional / Psychological

Medical

Dental

School

Social/Fun

NEED | NO NEED

Presenting Needs/ Child & Family Goals

- Relative caregivers need additional financial support to supplement the cost of raising the boys.
- Connect brothers to grief counseling to process death of grandmother
- Medical management support/coordination for eldest sibling to maintain condition
- Afterschool and summer programs are needed for all siblings to maintain the adaptive skills needed to live successfully in the community.

Role of ECM Care Manager

- Help relative caregivers ensure they are receiving all financial and other assistance related to meeting boys' needs
- Provide resource linkage, program enrollment support and care coordination support to family
- Coordinate and centralize services among eldest brother's medical care team, ensure aunt understands who all the providers are and feels confident in working with them
- Identify and apply for local funding scholarships to help pay for extra-curricular activities for the boys
- Identify resources for educational tools for aunt and uncle
- Guide aunt and uncle through the process of getting an IEP for twin with ADHD

Expected outcomes

- Boys have outlets to process feeling about recent changes, including grandmother's death
- Aunt and uncle feel less overwhelmed and better able to manage the boys, including having a financial plan to meet the basic needs of the brothers moving forward
- Enrolled in school and enrichment programs, receive scholarships to help cover costs of extra-curricular activities
- Linkage to MH services

Full Circle Health Network

Recap

1. **Medi-Cal enrollment.** Child welfare agencies can use these tools to inform any policy/practice changes related to Medi-Cal managed care enrollment
2. **ECM connections.** Logic model, referral and consent examples can inform workflows and desired outcomes for connecting children and families to ECM and other Medi-Cal CalAIM benefits
3. **Staff Training**. Customize these materials to update your workflows and staff training