



Early Intervention Program

PROTOCOL MANUAL

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DEPARTMENT OF HEALTH
Sherlita Amler, M.D., Commissioner

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Chapter 1: Referral

Westchester County Department of Health
Early Intervention Program
Referral Procedure

I. POLICY DESCRIPTION

The earliest possible identification of infants and toddlers with disabilities is a primary Early Intervention Program objective. This procedure correlates to the Public Health Law §2542.3 and EIP regulations 10 NYCRR 69-4.3(c) for referral to Early Intervention Program. The WCDH Referral Form can be found on the Department of Health website at: <http://health.westchestergov.com/information-for-providers>

II. PROCEDURE:

Responsible Party	Action
Primary Referral Source	<p>1. Primary referral sources shall, within two working days of identifying an infant or toddler who is less than 3 years old and suspected of having a disability or at risk for a developmental delay, refer the infant or toddler to the municipality, unless the child has already been referred or the parent objects. (10 NYCRR 69-4.3(a))</p> <p>Primary referral sources include:</p> <ul style="list-style-type: none"> • Early Intervention provider agencies; • Hospitals; • Pediatric and/or primary healthcare providers; • Day care programs; • Local health units; • Local school districts; • Department of Social Services (DSS); • Public health facilities; • Early Childhood Direction Centers; • Operators of any clinic approved under Article 28 of Public Health Law, Article 16 or 31 of the Mental Hygiene Law. <p>Note: Parents may refer their children to EIP at any time. (see number 4)</p> <p>2. Referral to the EIP should be based on two categories.</p> <p style="margin-left: 20px;">a. Suspected of having a delay</p> <ul style="list-style-type: none"> ▪ The child has a condition with a known likelihood of leading to a developmental delay such as Down Syndrome, a birth weight of less than 1,000 grams (2.2 pound), failure of two hearing screenings or a confirmed hearing or vision loss; ▪ Additional conditions provided at 10 NYCRR 69-4.3 (e); ▪ The results of a developmental screening or diagnostic procedure(s), directed experience, observation or impression of the child’s developmental progress that suggest a possible delay; ▪ Parent/caregiver is requesting an evaluation, or has provided information indicating the possibility of delay or disability. <p style="margin-left: 20px;">* Children who meet the above criterion will be referred to the Early Intervention Program where they will receive:</p> <ul style="list-style-type: none"> ▪ Initial Service Coordination (ISC), ▪ A Multidisciplinary Evaluation (MDE), if found eligible, an ▪ Individualized Family Service Plan (IFSP).

	<p>b. At risk for delay:</p> <ul style="list-style-type: none"> ▪ Children who are not suspected of having a disability and do not have a diagnosed condition with a high probability of delay, but are at increased risk for developmental delay because of specific biomedical risk factors or other risk criteria (PHL §2541 (1), 10 NYCRR 69-4.3 (f)); ▪ Children with suspected abuse or neglect, in the DSS system; ▪ Children evaluated and found not eligible for the Early Intervention Program. <p>* Children who meet the above criterion will be referred to the public health nurse for developmental monitoring/surveillance.</p> <p>3. The primary referral source does not need written consent from the parent to make a referral to the EIP. However, a referral cannot be made if the parent objects.</p> <p>a. If a parent objects to the referral, a referral source should:</p> <ul style="list-style-type: none"> ▪ Maintain written documentation of the parent’s objection and follow-up actions; ▪ Provide the parent with the name of the EIP and information on how to make a referral if parent wishes to contact the program in the future; ▪ Make reasonable efforts to follow-up with the parent within two (2) months and, if appropriate, refer the child at that time unless the parent objects. <p>4. Referrals by non Early Intervention provider referral sources are made to the Westchester County EIP by:</p> <p>a. Faxing the Early Intervention Program Referral Form directly to the Children With Special Needs Unit (914) 813-5093; or</p> <p>b. Calling the WCDH CSN Unit (914) 813-5094</p> <p>Note: A child’s referral should be submitted via only one method, fax or phone, not both.</p> <p>5. If the Early Intervention Program Referral Form is faxed, the primary referral sources should keep a copy of the faxed transmittal of the Referral Form.</p> <p>a. Primary referral sources are responsible for ensuring the confidentiality of all information transmitted at the time of the referral.</p> <p>6. Referrals made by New York State Department of Health Early Intervention providers must be made via the New York Early Intervention System (NYEIS). (See Unit 2 Referral and Intake of the NYEIS user manual)</p>
<p>Early Intervention Support Unit</p>	<p>1. Referrals will be processed within forty eight (48) hours of receipt.</p> <p>a. Any referral made 45 days or less before the child turns three years old is automatically closed in NYEIS (if submitted electronically). Or, will not be entered into NYEIS (if called or faxed).</p> <p>2. Once the referral is processed, Early Intervention will:</p> <p>a. <i>Assign an ISC Agency in NYEIS</i></p> <p>b. <i>Assign an EIOD in NYEIS</i></p>

Initial Service Coordination Agency Supervisor	<ol style="list-style-type: none"> 1. Required to check NYEIS for new requests for ISC every business day. (See Unit 2 of the NYEIS User Manual). 2. ISC agencies are required to accept or reject ISC assignment within one business day of receiving the request.
Initial Service Coordinator	<ol style="list-style-type: none"> 1. Send a letter of introduction and welcome packet to the parent welcoming the family to the Westchester County Early Intervention Program, giving the name and telephone number of the ISC and basic information about the EI process, and include a copy of <i>Westchester County Early Intervention Program Notice of Child and Family Rights</i>.

Early Intervention Program Referral Form

Referral Date: _____

Fax: (914) 813-4452

Phone: (914) 813-5094

Section 1. REQUIRED INFORMATION

CHILD'S NAME: (Last, First, Middle)		DATE OF BIRTH: MM/DD/YYYY / /	
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	CHILD'S ADDRESS: (Street, Apt #)	CITY:	Zip Code:
RACE (may select more than one if applicable) <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native American or Alaskan <input type="checkbox"/> Hawaiian or Pacific Islander		ETHNICITY: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	
Parent/Guardian: _____		TELEPHONE: Home: () Cell: ()	
Relation to Child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other, Specify _____		Work: ()	
Alternate Contact: _____		DOES FAMILY NEED INFORMATION IN ANOTHER LANGUAGE: [] NO [] YES, IDENTIFY:	
Telephone: () _____			
Relation to Child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other, Specify _____			

Person Presenting Referral to Early Intervention

NAME:		AGENCY or FACILITY, if any:	
ADDRESS: (Street, Apt #)	CITY:	STATE:	Zip Code:
TELEPHONE: () _____		FAX: () _____	
Referral Source: <input type="checkbox"/> Community Program or EI Agency <input type="checkbox"/> Parent/Family <input type="checkbox"/> Foster Care <input type="checkbox"/> Primary Health Care Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Other, Specify _____			

Reason for Referral (Check Only One)

- EARLY INTERVENTION: Child with a suspected or known developmental delay or disability OR Child who missed or failed Newborn Hearing Screening.**
- DEVELOPMENTAL MONITORING/SURVEILLANCE by the Public Health Nurse: Child is developing typically but may be "at risk" for atypical development.**

Comments: _____

Section 2. WITH INFORMED PARENTAL CONSENT

PRIMARY CARE PHYSICIAN:		PHONE:
BIRTH HOSPITAL:	LOCATION:	
BIRTH WEIGHT: Pounds: _____ Ounces: _____ OR Grams: _____	Gestational Age: _____ weeks	DIAGNOSIS if known:

FOR USE BY WCDH STAFF ONLY:

COMMENT: _____

Instructions for Completing the Early Intervention Program Referral Form
(Please do not fax with the referral form)

Write legibly or type all referral information. The referral form is divided into two sections.

Section 1 – Contains information fields that **must** be included when making a referral to the Westchester County Early Intervention Program (EIP). Section 1 does not require parental consent to submit this information. **This section should be filled out completely for the referral to be accepted.**

Note: Family has the right to refuse to have their child referred to EIP.

Section 2 – Contains information that should be transmitted only with informed parental consent. Consent can be verbal or taken from another consent form used by the referring agency.

Although Section 2 requires parental consent, the information contained in these sections is important for appropriate routing of the referred and assignment of Initial Service Coordinator (ISC). Therefore, it is recommended that all sections be completed if possible.

Information on this form must be typed or printed legibly.

Section 1

1. Write the child's full name, last name first. Write the child's date of birth in two (2) digit month, day and four digit year (e.g. 03/25/2009).
2. Check the box indicating the child's gender and write the full address where the child resides, including the city and the zip code.
3. **Race and Ethnicity.** Check the appropriate box for each section. *More than one racial designation for a child can be selected.*
4. Write the name of the child's parent/guardian, last name first. On the right side, write the telephone numbers where the parent/guardian can be contacted.
5. Write the name of an alternative caregiver (such as the foster parent) or contact person and that person's telephone number. Check the appropriate box to indicate the relationship to the child and specify what that is if "other" is checked.
6. Indicate if the family needs information in another language. If yes, write the language needed, this information will assist in determining whether a bilingual ISC needs to be assigned.
7. **Person Presenting Referral to Early Intervention.** Write the name, agency of facility (if any), address telephone and fax numbers of the person referring the child to WCDH EIP and completing this form. Check the appropriate box for *Referral Source* reflecting the person who is actually making the referral. Additional information can be added in the *Comments* box.
8. **Reason for Referral.** Check Early Intervention or Developmental Monitoring. If the child is being referred because there is a particular concern, write that information in the *Comments* box (See Appendix A).

Section 2

9. Write the name of the child's primary health care provider and his/her telephone number.
10. Write the name of the hospital in which the child was born and the location, e.g., address, city and state/country.
11. Write the child's birth weight in pounds and ounces or grams. Include the gestational age in weeks, if known.
12. If the child has a known diagnosis, write that here (e.g., Down syndrome, cerebral palsy, etc.). General concerns can be written in the *Comments* box.

NOTE: If there are questions about completing the form or making the referral, call WCDOH EIP at (914) 813-5061 or (914) 813-5094.

Appendix A – Reason for Referral Clarification

Section 1 contains the **REASON FOR REFERRAL BLOCK**. The individual referring the child must indicate whether the child is being referred to EIP or Child Find **Developmental Monitoring**. The following indicators should assist with deciding which **REASON FOR REFERRAL BOX TO CHECK**.

EARLY INTERVENTION: Child with a suspected or known developmental delay or disability.

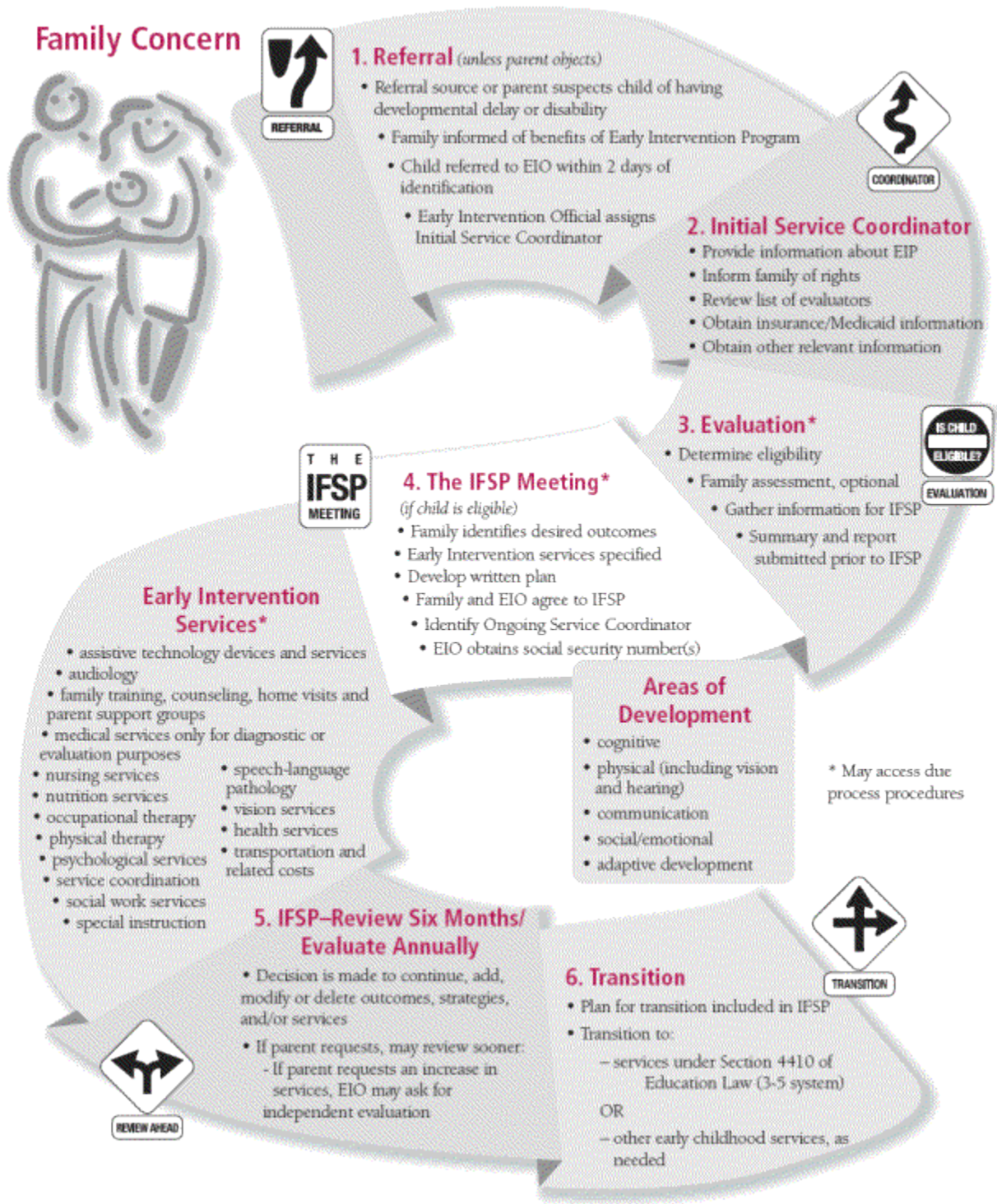
This referral is sent to the Westchester County EIP for a Multidisciplinary Evaluation (MDE). Check this box for a child with developmental delay(s) and/or a diagnosed physical or mental condition with a high probability of a future developmental delay. The child should meet one or more of the following criteria:

- The child has a condition with a known likelihood of leading to a developmental delay such as Down Syndrome, a birth weight of less than 1,000 grams (2.2 pounds), failure of two (2) hearing screenings or has a confirmed hearing or vision loss;
- The results of a developmental screening or diagnostic procedure, direct experience, observation, and perception of the child’s developmental process indicate that he or she is not developing similarly to same age peers; or
- Parent or caregiver is requesting an evaluation or has provided information that indicated the possibility of a developmental delay or disability;
- **Child missed or a failed newborn hearing screening or re-screening (not rescreened within seventy-five (75) days).**

DEVELOPMENTAL MONITORING BY THE PUBLIC HEALTH NURSE: Child is developing typically but may be “at risk” for atypical development. Check this box for a child who meets one more of the risk criteria listed below:

Neonatal Risk Criteria	Post-Neonatal Risk Criteria	Other Risk Criteria
<ul style="list-style-type: none"> • Birth Weight 1,000 – 1,500 grams • Gestational age less than 33 weeks • NICU stay of (10) days or more CNS insult/abnormality • Asphyxia (5 min APGAR less than 4) • Growth deficiency/nutrition problems (e.g., SGA) • Presence of Inborn Metabolic Disorder • Maternal prenatal alcohol abuse • Congenital malformations • Hyper- or hypotonicity • Hyperbilirubinemia (above 15 mg/d) • Hypoglycemia (serum glucose less than 20 mg) • Maternal prenatal abuse of illicit substances • Prenatal exposure to therapeutic drugs with known risk • Venous lead level more than 19 mcg/dl • HIV infection • Maternal PKU 	<ul style="list-style-type: none"> • Parental developmental disability or mental illness • Suspected/family history of hearing impairment • Suspected/family history of vision impairment • Other risk criteria identified by referral source (describe) • Parental concern re: development • Questionable score on Developmental/sensory screen • Illness/trauma with CNS Implications and ICU more than ten (10) days • Serous Otitis Media within three (3) months • Growth deficiency/nutritional problems, F.T.T, iron deficiency 	<ul style="list-style-type: none"> • No prenatal care • Homelessness • Questionable score on Developmental/Sensory screen • History of child abuse or neglect • No well child care by six (6 months) • Concern re: parenting due to poor bonding, impairment in psychological/interpersonal functioning • Significant immunization delay • Parental drug or alcohol abuse • Perinatally/congenitally transmitted Infection (e.g., HIV, hepatitis b, syphilis) • Parental developmental disability or mental illness • Other risk criteria identified by referral source (describe)

Early Intervention Steps



Parent/guardian consent is required for evaluation, IFSP, provision of services in IFSP, and transition.

Family Resources

Service Coordinators should review these resources with families and assist families in identifying the resources that could benefit them. This is not an exhaustive list and it's the service coordinators responsibility to explore and link families with additional resources when appropriate. Documentation of this activity should be maintained in the IFSP and service coordinators billing notes.

COMMUNITY RESOURCE	PHONE NUMBER
<p><u>Westchester County Department of Health (WCDH) – Early Intervention Program Developmental Monitoring Unit -</u> Developmental Monitoring Specialist assists families in tracking their child's development from birth to 3 for children (At Risk) for developmental delays and disabilities.</p>	(914) 813-5094 Contact: Referral Unit
<p><u>Speech Therapy – Low Cost Speech Clinics –</u></p> <ol style="list-style-type: none"> 1) Iona College Contact Person: Maria Armiento-DeMaria 2) Mercy College Contact Person: Marilyn Oxenberg 3) New York Medical College Contact Person: Kathleen Kaiser 	(914) 633-2149 (914) 674-7742 (914) 594-4912
<p><u>Early Head Start</u> – A community based program for low income families with infants and toddlers and pregnant women. It seeks to enhance the development of very young children.</p>	(914) 592-5600 Ext. 115, 165
<p><u>WIHD Parent to Parent</u> – Meeting with other families to share information, to learn about a child like mine, information on child's disability, what it means, working with specialty providers/physicians.</p>	(914) 493-2635
<p><u>New York State of Health Marketplace – WCDH Navigators</u> Find out if you qualify for affordable health care, Medicaid, Child Health Plus or obtaining tax credits for buying health insurance through the New York State of Health Marketplace.</p>	(914) 995-6350
<p><u>United Way</u> – Get Help! We are here for you no matter what the circumstance. The 211 number is free and confidential multilingual information and referral help line for such things as food assistance, housing assistance, mental health services, and services for people with disabilities.</p>	211
<p><u>Child Care Council</u> – Connect parents to child care providers, help to obtain child care subsidies for housing, Child Health Plus resources to help pay for health care.</p>	(914) 761-3456
<p><u>Early Childhood Direction Center</u> – Offers free confidential and neutral information, referral, technical assistance and training center for families with children from birth to five. Will provide training on transition from EI-CPSE-kindergarten.</p>	(914) 493-2902
<p><u>Assistive Technology Loan Program</u> – Families and providers can call or visit to see if Assistive Technology devices, supplies and equipment are available for loan.</p>	(914) 493-7364 Contact: Beth Heyd
<p><u>Cabrini Immigrant Services</u> – Provides free immigration legal services as well as providing case management, advocacy and educational workshops.</p>	(914) 674-1937
<p><u>Family Ties</u> – Provides support services to families of children with social, emotional and behavioral challenges. Offers a wide range of support groups, advocacy services, parent coaching and connections to community resources. All services are free.</p>	White Plains (914) 995-5238 Yonkers Office (914) 964-2063
<p><u>WCDH Children with Special Health Care Needs - CSHCN</u> is an information and referral service for families with special needs from birth through 21 years of age. Advocates for families in an effort to assure that children in need of special services are able to receive them without undue financial hardship.</p>	(914) 813-5076
<p><u>New York State Early Intervention Program</u> – A Parent's Guide http://www.health.ny.gov/publications/0532</p>	
<p><u>Westchester County Early Intervention Program</u> – Information and Parent Satisfaction Survey http://health.westchestergov.com/eip-early-intervention-program-sp-267</p>	

**Westchester County Department of Health
Children with Special Needs**

Patient Bill of Rights/Notice of Privacy Practices

I have been provided the opportunity to review the Westchester County Department of Health's Notice of Privacy Practices and Patient Bill of Rights prior to signing this document. The Notice of Privacy Practices for the Westchester County Department of Health is also provided on the Westchester County Department of Health's website at <http://health.westchestergov.com/>.

Record Retention Policy

In accordance with the State Archives and Records Administration, Early Intervention records are maintained by Westchester County until the child turns 21 years old, at which time the record will be destroyed. The county may however maintain a permanent record of the child and family's name and address, and the types and dates of services received without time limitation.

I acknowledge that Westchester County's Notice of Privacy Practices and Record Retention Policy have been reviewed with me.

Signature of Parent/Guardian

Relationship to Child

Date

Westchester County Department of Health

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice, please contact our Privacy Office at (914) 995-7499 or access our website at

<http://health.westchestergov.com/comments>

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. You may receive a revised Notice of Privacy Practices by accessing our website at <http://health.westchestergov.com/>, calling the office to request a revised copy be sent to you or asking for one at your next appointment.

I. Uses and Disclosures of Protected Health Information

- **Uses and Disclosures of Protected Health Information Based Upon Your Written Consent**

Your protected health information may be used and disclosed by WCHD staff and others outside of the WCHD that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to obtain payment for your health care services and as required in the conduct of daily operations of the WCHD.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with third party with which the WCHD has contracted for this purpose and/or a provider that has already obtained your permission to have access to your protected health information.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan or third

party payer may undertake before it approves or pays for the health care services we recommend for you.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of the WCHD. These activities include, but are not limited to, quality assessment activities, employee review activities, training of professional students, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

- **Uses and Disclosures of Protected Health Information Based upon Your Written Authorization or Opportunity to Object**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described in the next section. You may revoke this authorization, at any time, in writing, except to the extent that the WCHD has taken an action in reliance on the use or disclosure indicated in the authorization.

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

- **Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object**

We may use or disclose your protected health information in the following situations without your consent or written authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. This may include judicial or administrative proceedings, in response to a subpoena, discovery request or other lawful process.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability to: a health oversight agency for activities authorized by law to perform audits, investigations or inspections; a public health authority that is authorized by law to receive reports of abuse or neglect; a person or company required by the Food and Drug Administration to report adverse events, defects or problems; a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.

Disclosure may also be made to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.

II. Your Rights

Unless otherwise required by law, your health record is the physical property of the WCHD, but the information in it belongs to you and you have the right to have your health information kept confidential. You, or a person legally authorized to act for you have the right to:

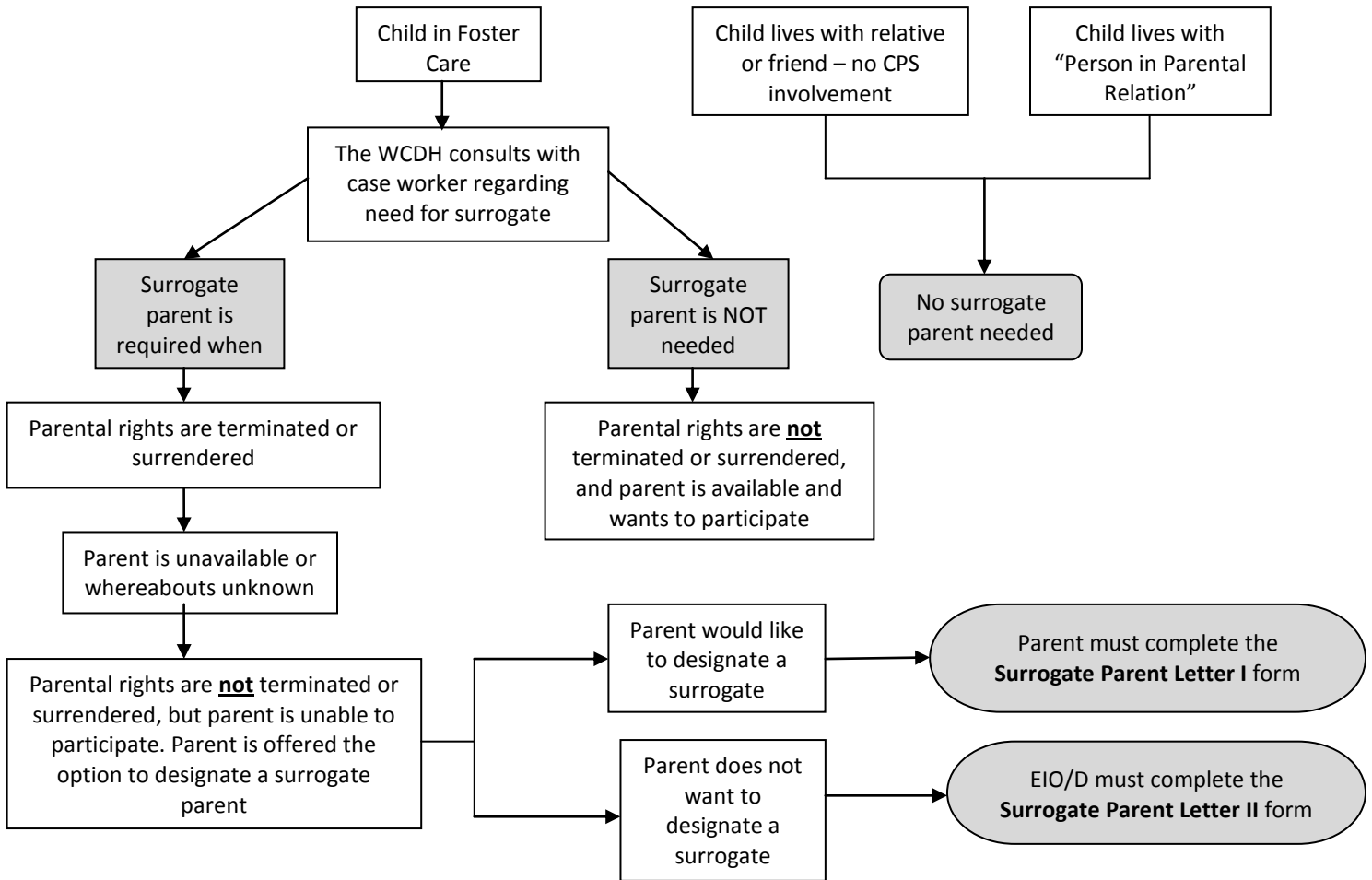
- Inspect and copy your protected health information for a reasonable fee; if denied, you have the right to seek a review of the denial.
- Request a restriction of your protected health information, but the WCHD is not required to agree to a restriction that you may request.
- Request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests.
- Have your provider amend your protected health information.
- Receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for the purpose other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with WCHD by notifying our Privacy Officer or the Secretary of the Department of Health and Human Services of your complaint. We will not retaliate against you for filing a complaint.

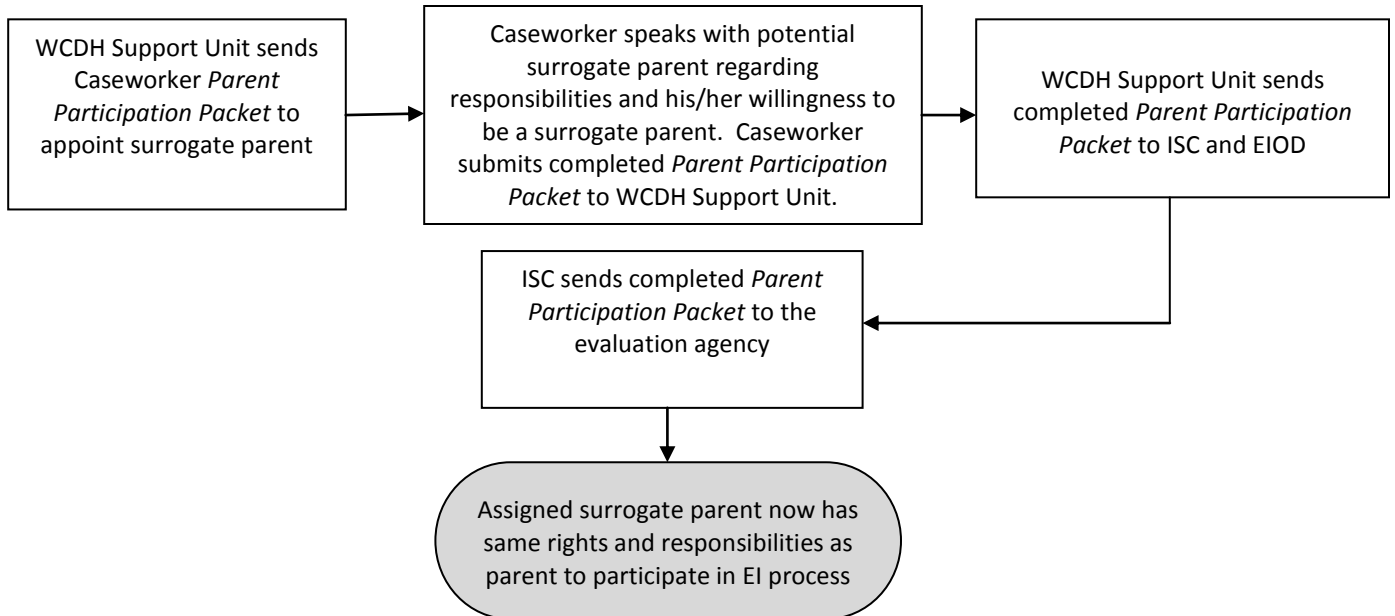
This notice was published and becomes effective in April 14, 2003.

Chapter 2: Foster Care and Surrogacy

**WESTCHESTER COUNTY EARLY INTERVENTION PROGRAM
 DETERMINING NEED FOR A SURROGATE PARENT & ASSIGNMENT
 OF SURROGATE PARENT IN EARLY INTERVENTION**



IF THE APPOINTMENT OF A SURROGATE PARENT IS REQUIRED



Westchester County Department of Health
Early Intervention Program
Procedure for Surrogate Parent Assignment

I. Policy Description

When the child's parents are unavailable to participate in the IFSP process due to life circumstances, which may include the child's placement in foster care, the Department of Social Services (DSS) representative or caseworker works in consultation with Westchester County Department Health's (WCDH) Early Intervention Official (EIO) or Designee (EIOD) to assess whether a surrogate parent is needed. If a surrogate parent needs to be appointed, the assignment must be made before a Multidisciplinary Evaluation (MDE) is conducted or there are any modifications made to Individualized Family Service Plan (IFSP). The surrogate parent becomes the only person authorized to sign the **Parental Consents for Evaluations and IFSP Services**.

A surrogate parent is appointed when:

- A child has no available parent or person acting in place of a parent that can be identified.
- The whereabouts of the parent is unknown
- The child is a Ward of the State, (a foster care child in the custody and guardianship of the local Commissioner of Social Services).

The surrogate parent has the same rights and responsibilities as the parent in the Early Intervention Program and represents the child in all matters related to:

- Screening, evaluation, and assessment of the child;
- Development and implementation of the IFSP, including 6 Month and Annual Reviews;
- The ongoing provision of Early Intervention services;
- The right to request mediation or an impartial hearing in the event of a dispute;
- Any other rights established in the Early Intervention Program.

If the child is not in foster care and there is a "person in parental relation," that person may sign all consents including the Parental Consent for Evaluation, and a surrogate parent does not need to be assigned. According to the Early Intervention Regulation (10 NYCRR 69-4.16), a person in parental relation means:

- 1) The child's legal guardian;
- 2) The child's standby guardian after their authority becomes effective pursuant to Section 1726 of the Surrogate's Court Procedure Act;
- 3) The child's custodian; a person shall be regarded as the custodian of a child if he or she has assumed the charge and care of the child because the parents or legally appointed guardian of the minor have died, are imprisoned, are mentally ill, or have been committed to an institution, or because they have abandoned or deserted the child, are living outside the state, or their whereabouts are unknown;
- 4) Persons acting in the place of a parent such as a grandparent or stepparent with whom the child lives, as well as persons who are legally responsible for the child's welfare;
- 5) Exception this term does not apply to children who are a "ward of the state" and does not include a foster parent.

If the child is in foster care, and the parental rights have not been terminated or voluntarily surrendered, the service coordinator must ensure that the caseworker has made a good faith effort to contact the parents in order to determine whether or not a surrogate parent is needed.

II. Procedure

Responsible Party	Action
Caseworker (DSS or Private Agency) EIOD ISC	<p>For children in foster care, or where a parent wishes to designate a surrogate parent, the steps below should be followed in a timely manner so that an IFSP meeting can be convened within 45 days of the initial referral. All steps must be thoroughly documented to ensure that all necessary activities have been carried out expeditiously.</p> <ol style="list-style-type: none"> I. Referral Process <ol style="list-style-type: none"> A. When DSS or the caseworker from a private agency (i.e. Leake & Watts) refers a child to WCDH-EIP, the caseworker will use the following procedure: <ol style="list-style-type: none"> 1. When the caseworker identifies the child as having a possible developmental delay, s/he must make a referral to WCDH within 2 business days. 2. Upon receipt of the referral of a child in foster care, WCDH/EIP sends out to the caseworker the Parent Participation Packet. B. When someone other than the caseworker makes the referral (such as the foster parent or child's doctor), the EIP Support Unit sends the child's caseworker notification of the referral and the Parent Participation Packet. Caseworker must complete the appropriate forms in the Parent Participation Packet and fax it to the attention of the EIP Support Unit at 914-813-5093. C. The caseworker should make a good faith effort to contact the biological parent(s) in the most expedient way possible to: <ol style="list-style-type: none"> 1. Explain the reasons for wanting to refer the child; 2. Ask whether they have any objections to the referral; 3. Determine their availability to participate in the IFSP process. <p><u>Confidentiality of Foster Care Family and Surrogate Parent</u> It is important when communicating with the Early Intervention child's biological or non custodial parent that confidentiality of the foster care parent and surrogate parent is maintained. The Service Coordinator must consult with DSS, or the foster care agency, where appropriate, to document in writing, if information sent to the biological parent may contain information regarding foster and surrogate parent.</p> <p>If the biological parent is not to receive information as to the foster and surrogate parent, all references, including location, name and telephone numbers, must be redacted (inked out) in any documents sent to the biological parent. This is the responsibility of the Service Coordinator or foster care caseworker when sending out information to the biological parent.</p>

- I. Different Scenarios Involving the Parents and How to Proceed
 - A. Parent agrees to the referral and wishes to participate in the process, the Initial Service Coordinator mails the WCDH/EIP Welcome Packet. *If the parent is unresponsive, the ISC should call the foster care caseworker to discuss whether the assignment of a surrogate parent has become necessary, and if so, who should be assigned.*
 - B. Parent refuses referral, caseworker must notify the service coordinator in writing and the service coordinator will then close the case in EIP.
 - C. If the parent wishes for their child to participate in EIP but the parent wishes to have a surrogate parent, the caseworker completes the appropriate forms in the **Parent Participation Packet**.
 - D. When the child is in foster care, the parent is unavailable, and the child has no person in parental relationship the EIO/D assigns a surrogate parent.

- II. Selection of Surrogate Parent in accordance with EIP regulation 10 NYCRR 69-4.16 (f)
 - A. The early intervention official shall select a surrogate parent who is qualified and willing to serve in such capacity and who:
 - has no interest that conflicts with the interests of the child;
 - has knowledge and skills that ensure adequate representation of the child;
 - if available and appropriate, is a relative who has an ongoing relationship with the child or a foster parent with whom the child resides;
 - is not an employee of any agency involved in the provision of early intervention or other services to the child, provided however that a person who otherwise qualifies to be a surrogate parent is not considered an employee solely because he or she is paid by a public agency to serve as a surrogate parent; and
 - has been selected, for any child who is a ward of the state or for any child whose parent is unavailable and who is in the care and custody of the local social services commissioner, in consultation with the local commissioner of social services or designee.
 - B. The Service Coordinator shall inform the surrogate parent all the rights and responsibilities in participating in the EI process.
 - C. The Service coordinator shall inform EI providers of the designation of the surrogate parent. The surrogate parent maintains the same rights and responsibilities as the parent and represents the child in all matters related to the provision of early intervention services.

	<p>III. When the Child is Found Eligible for the EIP</p> <p>A. The service coordinator should ensure all EI providers have the approved Surrogate Parent Assignment Forms and that they are aware of any communication restrictions.</p> <ul style="list-style-type: none">– For children in KIDS the Surrogate Parent Assignment forms should be faxed to all EI providers working with the family.– For children in NYEIS the Surrogate Assignment Forms should be attached in IFSP section. <p>B. When reviewing the IFSP, the EIOD will in consultation with the service coordinator and foster care caseworker, determine whether there have been any changes in circumstances that warrant a review of the appointment of the surrogate parent.</p> <p>C. If a change in surrogate parent is found to be necessary, the EIOD will appoint a new surrogate.</p>
--	---

Parent Participation Packet

INTRODUCTION LETTER

Date:

Name of Contact Person

Social Service Agency

Street Address

City, State Zip Code

Dear:

RE: _____ / _____ / _____
Name of Foster Child Date of Birth EI Referral Date

The child listed above has been referred to Early Intervention for service coordination, evaluation and possible therapeutic services. The Early Intervention law requires:

- Reasonable effort be made to include parents, if available, in the decision process. If the biological parents are not available EIO is to appoint a surrogate parent who is not an employee of an agency involved in the provision of services to the child;

And

- The parent or surrogate parent chooses the evaluator, and if the child is eligible, an Individualized Family Service Plan (IFSP) meeting will be held 45 calendar days of referral to determine services.

Please complete the Parent Choice/Participation Letter and return it as soon as possible.

- If, when you contacted the birth parent(s) to inform him/her of the plan to refer the child to Early Intervention, he/she indicated a desire to participate in the IFSP process, please check the appropriate items in section A of this form.
- If the birth parent whose parental rights have not been terminated or voluntarily surrendered objects to the referral, please check the box in section B and return it to me immediately so that we can withdraw the referral.
- If the parent is unable to participate in the IFSP process but would like to designate someone to be a surrogate parent, please check the box in section E. The parent should call the ISC to discuss the surrogate choice. If the parent does not designate someone, the Early Intervention Program will assign a surrogate as provided for NYS Regulation 69-4.16.

If you have any questions please call the Initial/Ongoing Service Coordinator _____ at _____ and leave a telephone number and times when he/she may reach you.

If you have additional concerns you may call _____, the EIOD at _____

Please complete the information listed on the attached form and either fax or send it within 2 days of the above date.

Yours truly,

WCDH Community Health Worker, or
Initial Service Coordinator

CC: Child's File
EIOD
ISC

PARENT CHOICE/PARTICIPATION LETTER

TO: _____ DATE: _____
Service Coordinator

FROM: _____ / _____ / _____
Agency Telephone Number

RE: _____
Name of Foster Child Date of Birth

Complete either A, B, C, D, or E

A. Parent Wishes to Participate

- We have been able to reach the biological parent and she/he wishes their child participate in the Early Intervention Evaluation process. You may reach _____ at the following address and telephone number: _____

OR

- We have reached the biological parent. They have been informed this is a voluntary process and consent may be withdrawn at any time. She/he has signed the consents (attached) for this child to participate in the Early Intervention evaluation process.
- Parent Consent to Release and Receive Information (Required)
 - Assignment of Benefits and Medical Information Release Form (Required)
 - Parent Selection of an Evaluator (Required)
- They wish to be informed when the IFSP is held. You may reach _____ at the following address and telephone number: _____

B. Parent Refuses to Participate

- Parent refuses the referral. Please withdraw the referral and close EI case. We have explained to the parent that she/he may be reconsidered and participate until the child is three.

C. If, at a Later Date, the Parent Objects to the Referral

- The Initial Service Coordinator is notified in writing and the case will be closed.

D. Parent Cannot be Reached and Caseworker Requests Appointment of Surrogate

- We have tried to reach the biological parent through telephone and letter and have not received a response. We therefore agree that a surrogate needs to be appointed.

OR

E. Parent Requests Appointment of Surrogate Parent

- She/he/they has (have) been informed of their rights and agree(s) to have a surrogate act on their behalf of their child. They are aware that this permission may be withdrawn at any time. Their written request for a surrogate parent is attached (Surrogate Parent Letter I). However, the parent can also contact the ISC and complete the Surrogate Parent Letter I over the phone.

IMPORTANT NOTE: The Westchester County Department of Social Services or _____ (name of Foster Care Agency) is requesting that any written information sent to non Early Intervention providers and/or the biological/non-custodian family regarding this child:

- May contain the reference/information regarding the surrogate and foster care parents

OR

- Shall not contain any reference/information of the surrogate and foster care parents. In this case all information must be sent to WCDSS or foster care agency, if appropriate. WCDSS or the foster care agency is responsible for reviewing and redacting all information regarding the surrogate parent and/or foster care parent in order to protect the confidentiality of the surrogate/foster care parent. In addition, WCDSS or the foster care agency is responsible for ensuring the appropriate signature for release and consents and transmittal of information regarding transition to the Committee on Preschool Special Education process.

Please call me at (_____) _____ if you have any questions.

Name of Social Service Contact: _____

Address: _____

**SURROGATE PARENT DESIGNATION BY PARENT
SURROGATE PARENT LETTER I**

Child's Name: _____ Date of Birth: _____

Also known as: _____

I, _____, am the biological/adoptive and
Print Full Name

legal parent of the above-named child. I acknowledge that I am unable to participate in the Early Intervention evaluation and treatment process.

It has been fully explained to me that I may voluntarily designate another suitable person to act for me as my child's surrogate (substitute) parent, that is, someone who may make decisions regarding Early Intervention services, while I am unable to do so and that this person may not be an employee of any agency which provides services to my child. I understand that I can withdraw or change this designation at any time. I am aware that the foster care parent is not considered an employee of the foster care agency, and therefore may be appointed as a Surrogate Parent.

I hereby request the Westchester County Department of Health Early Intervention Official Designee (EIOD) appoint a surrogate parent to act on the behalf of my child.

OR

I hereby designate _____,
Surrogate's Full Name

Relationship _____

Surrogate's Address: _____ Apt # _____

City/State: _____ Zip Code: _____

Surrogate's Telephone Number: _____
Home Work

Date: _____

**Signature of Parent

**Check if applicable:

This form was completed by _____
Name and Title

Agency Address Telephone #

The name of the surrogate parent was provided by the parent during a telephone conversation with an Early Intervention staff member or with the caseworker. Therefore, no parental signature could be obtained.

**SURROGATE PARENT ASSIGNMENT BY EIOD
SURROGATE PARENT LETTER II**

RE: Child's Name: _____ Last First _____ DOB: _____

Foster Care Agency: _____ Caseworker's Name: _____

Address: _____ Date: _____

Dear: _____ / _____
Service Coordinator Agency

After consulting with my supervisor, it has been agreed that

Print Full Name of Surrogate Parent Relationship to the Child (i.e. foster care parent)

Address Telephone

may be assigned as the surrogate parent for the above-named child. The Early Intervention Program has been discussed with her/him, and s/he is willing to be the child's surrogate parent. I have explained to the above person her/his rights and responsibilities in Early Intervention. Please review and approve this form and return it to me at the address below at your earliest convenience.

IMPORTANT NOTE: The Westchester County Department of Social Services or _____ (name of Foster Care Agency) is requesting that any written information sent to non Early Intervention providers and/or the biological/non-custodian family regarding this child:

- May contain the reference/information regarding the surrogate and foster care parents
- OR**
- Shall not contain any reference/information of the surrogate and foster care parents. In this case all information must be sent to WCDSS or foster care agency, if appropriate. WCDSS or the foster care agency is responsible for reviewing and redacting all information regarding the surrogate parent and/or foster care parent in order to protect the confidentiality of the surrogate/foster care parent. In addition, WCDSS or the foster care agency is responsible for ensuring the appropriate signature for release and consents and transmittal of information regarding transition to the Committee on Preschool Special Education process.

Yours truly,

Signature of Caseworker Printed Name

Agency Address

Telephone Number Fax Number

WCDH OFFICE USE ONLY

Approved Denied

Signature of EIO Date

Copy of approval/denial is to be sent to the Service Coordinator and the child's caseworker. The service Coordinator is to send a copy to the surrogate parent when approved.

Chapter 3: Service Coordination Responsibilities

New York State Department of Health
Bureau of Early Intervention
Guidance Document

**Billing for Initial and Ongoing Service Coordination
Activities in the Early Intervention Program
Revised December 2013**

<http://tinyurl.com/kcju8z4>

Click on- *Clarification: Billing for Initial and Ongoing Service Coordination*

Westchester County Department of Health
Early Intervention Program
Initial Service Coordinaton Responsibilities

I. POLICY DESCRIPTION:

Upon referral to the Early Intervention Official of a child thought to be an eligible child, the Early Intervention Official shall promptly designate an Initial Service Coordinator..... The Initial Service Coordinator shall promptly arrange a contact with the parent in a time, place and manner reasonably convenient for the parent and consistent with applicable timeliness requirements. NYS Regs 69-4.7 (a)(b).

II. PROCEDURE:

Responsible Party	Action
Initial Service Coordinator (ISC)	<p>Contact the parent/caregiver within two (2) days of the child’s referral to the Early Intervention Program in order to set up an intake by phone or in a meeting at a time and place of convenience to the family within seven (7) business days.</p> <p><u>Initial Meeting with the Parent(s)/Caregiver(s):</u></p> <ol style="list-style-type: none"> 1. Introduce the role of the Service Coordinator (SC) to the parent /caregiver 2. Give a brief overview of the New York State Early Intervention Program (EIP) <ol style="list-style-type: none"> a. Inform parent of their rights and responsibilities in the EIP 3. Review the contents of the Welcome Packet including: <ol style="list-style-type: none"> a. The Early Intervention Program <i>A Parent’s Guide</i> b. Westchester County Department of Health <i>Notice of Child and Family Rights</i> c. NYSDOH EIP Insurance Requirements 4. If the child is in Foster Care: <ol style="list-style-type: none"> a. Refer to the <i>WCDH EIP Procedure Manual, Chapter 2- Foster Care and Surrogacy</i> 5. Obtain the parent’s signature on: <ol style="list-style-type: none"> a. <i>Parental Consent to Initiate Service Coordination</i> b. <i>Notice of Privacy Practices/Record Retention Policy</i> c. <i>Parent Selection of Evaluation Agency</i> d. <i>Parental Consent to Obtain/Release Information (if applicable)</i> 6. Explain to the family that services are at no cost to parents and the use of Medicaid and/or third party insurance for payment of services is required under the EIP: <ol style="list-style-type: none"> a. Collect insurance policy information from parent, and obtain appropriate insurance consents (refer to the <i>NYSDOH Insurance Toolkit, Revised 5/17</i>). 7. Inform parents that they will be asked to provide the Social Security numbers for their child and themselves at the IFSP meeting, if their child is found eligible for EI services: <ol style="list-style-type: none"> a. Only the EIOD is authorized to collect Social Security information. 8. Ensure the accuracy of the following information on the child’s home page: <ol style="list-style-type: none"> a. <i>Childs Information</i> b. <i>Family Information</i> c. <i>Primary Care Physician</i> d. <i>If parent has communication exceptions ensure it is documented</i> 9. If the child does not have health insurance assist the parent in identifying and applying for benefit programs (i.e New York State of Health Marketplace- WCDH Navigators at (914) 995-6350).

10. Ask the parent(s) if he/she would like assistance in identifying and applying for other benefit programs for which the family may be eligible, such as WIC, SSI, etc.
11. Explain the evaluation and screening process to the family, including location, types of evaluations performed, and setting for evaluations.
 - a. Provide the parent with a list of evaluation agencies approved by NYSDOH.
12. If the child was previously receiving EI services in another NYS county:
 - a. Refer to the NYEIS user manual *Unit 7 Transfer Transition*.

After the Initial Meeting with Parent/Caregiver:

1. Contact the selected evaluation agency to arrange for the child's evaluation.
2. Assign the evaluation agency in NYEIS.
3. Attach the following documents to the Child's Integrated Case in NYEIS:
 - a. Foster Care and Surrogacy Forms when applicable (refer to *Chapter 2- Foster Care and Surrogacy*)
 - b. Parental Consent to Initiate Service Coordination
 - c. Parent Selection of Evaluation Agency
 - e. Parental Consent to Obtain/Release Information (if applicable)
 - d. Notice of Privacy Practices/Record Retention, Signed Acknowledgement
 - e. Applicable Insurance Consents
4. Enter insurance information into the NYEIS insurance section and fax insurance collection form and consents to the WCDH insurance collection unit at 914-813-4194. For further guidance refer to:
 - a. The NYEIS user manual, *Unit 10 Municipal Administration*
 - b. The *NYSDOH Insurance Toolkit (Revised 5/17)*
5. Follow-up with the evaluator and parents to ensure that the evaluations are proceeding in a timely manner.

After the Evaluation:

1. Ensure that the family understands the results of the evaluation, and assist them in obtaining clarification from the evaluation team, if needed.
2. If the child is found ineligible for the EIP, discuss the following options with the parent:
 - a. The case can be closed
 - b. The parents can request a re-evaluation
 - c. The parents can exercise their due process rights
 - d. The child can be referred to their primary care physician or a WCDH Public Health Nurse for Developmental Monitoring/ Surveillance (see [Family Resources](#))
 - e. Review [Family Resource](#) page with parents.
3. If the child is found eligible for EIP:
 - a. Discuss the Individualized Family Service Plan (IFSP) meeting with the family, including:
 - i. The composition of the IFSP team
 - ii. Parental right to invite participants of their choice
 - iii. Importance of parent/caregiver involvement in the IFSP process
 - iv. Right to select an Ongoing Service Coordinator (OSC)
 - v. The range of options for service delivery
 - vi. The IFSP team will make the final decisions about the services
 - vii. Remind the parent/caregiver that their participation on the EIP is voluntary
 - b. Stress to the family that their priorities, concerns and resources shall play a major role in the establishment of outcomes and strategies among the parent, evaluator, service coordinator and the EIOD.
 - i. Assist the family in identifying their concerns, priorities, and

	<p>resources.</p> <p>ii. With parent’s verbal consent complete this section of the IFSP document.</p> <p>4. Arrange for an IFSP meeting.</p> <hr/> <p>Note:</p> <ul style="list-style-type: none">• Ensure that the Evaluation Agency forwards the results of the evaluation to the parent(s) in sufficient time for review prior to the IFSP meeting.• Ensure that the Evaluation Agency completes and submits the MDE packet in NYEIS. <hr/> <p><u>After the IFSP Meeting:</u></p> <ol style="list-style-type: none">1. ISC is responsible to ensure that all required documents have been collected.2. ISC submits the completed child’s record to the EIOD.
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WESTCHESTER COUNTY DEPARTMENT OF HEALTH
EARLY INTERVENTION PROGRAM
PARENTAL CONSENT TO INITIATE SERVICE COORDINATION

Child's Name: _____
Last First

Child's DOB: ____/____/____

I have been informed by the Early Intervention Initial Service Coordinator (ISC) of the various programs and services the Early Intervention Program (EIP) can provide to my child. I have also been informed that in order to provide such services it will be necessary for the Program to coordinate and exchange information with appropriate service providers.

I consent to the planning and coordination of services for my child.

Signature of Parent/Guardian Date ____/____/____

Signature of Initial Service Coordinator Date ____/____/____

Service Coordinator Must Complete:

Date ISC agency received assignment from WCDOH: ____/____/____

Date ISC provided parent(s) the EIP Parent's Guide: ____/____/____

Date ISC reviewed "Your Parent's Rights in the EI Program": ____/____/____

Date ISC reviewed list of evaluation sites and discussed choice of evaluation site with parent: ____/____/____

Name of evaluation site selected by parent: _____

Date referral made to evaluation site: ____/____/____

WESTCHESTER COUNTY EARLY INTERVENTION PROGRAM
INSTRUCTIONS FOR COMPLETION
PARENTAL CONSENT TO INITIATE SERVICE COORDINATION

All fields on this form must be completed at the initial meeting with the family. At this meeting, the parent confirms that s/he gives permission to initiate service coordination. If the Initial Service Coordinator (ISC) is not able to meet with the parent, s/he should mail this consent form to the parent, preferably with a self-addressed, stamped envelope. **This action should be documented in the service coordination activity notes.**

For a child in foster care, the assigned surrogate parent or the biological parent would be the appropriate person to sign this form.

A copy of this form remains with the ISC and must be placed in the child's service coordination case record.

This form is attached to the child's "Integrated Case Home Page" in NYEIS. Refer to the **ISC Responsibilities Policy**.



WESTCHESTER COUNTY DEPARTMENT OF HEALTH
EARLY INTERVENTION PROGRAM
PARENT SELECTION OF EVALUATION AGENCY

Child's Name: _____
Last First MI

DOB: ____/____/____ Date of Referral: ____/____/____

My initial service coordinator has reviewed all options for evaluations and provided me with a list of NYSDOH approved evaluation agencies in Westchester County.

I have been informed that I will be involved in my child's evaluation, I will receive the results of all evaluations, and that a copy of all evaluations will be forwarded to _____, my assigned Early Intervention Official Designee (EIOD). If my child is eligible for the Early Intervention Program, the evaluations will assist in developing my child's Individualized Family Service Plan (IFSP).

I choose _____ as the evaluation agency that will determine my child's eligibility for the Early Intervention Program. In the event that this evaluation agency does not have availability I choose _____, _____.

(Evaluation Agency 2nd choice) (Evaluation Agency 3rd Choice)

Signature of Parent/ Surrogate Parent Date: ____/____/____

Insurance

New York State Department of Health
Early Intervention Program

Service Coordination Insurance
Tool Kit for Service Coordinators

<http://tinyurl.com/kcju8z4>

Office for People with
Developmental
Disabilities (OPWDD)
Notification

New York State Department of Health
Early Intervention Program

**Notification to the Office for People with Developmental Disabilities
Tool Kit for Service Coordinators**

<http://tinyurl.com/kcju8z4>

Transition

New York State Department of Health
Early Intervention Program

Service Coordination Transition Toolkit

Tool Kit for Service Coordinators

<http://tinyurl.com/kcju8z4>

Westchester County Department of Health Children with Special Needs
Early Intervention Program

CPSE CHECKLIST FOR EARLY INTERVENTION TRANSITIONING PACKET

School District:	Date:
Child's Name:	DOB:
EIOD Name:	Phone #: 914 813-
Ongoing Service Coordinator:	Agency
	Agency #:

Service	Frequency/Duration	Agency

The following evaluations were completed for the above named child while in the Early Intervention Program.
Evaluations one year or older are not included.

Type of Evaluation	Date of Evaluation

Other documents included:

- Notification to CPSE
- Evaluation/Record Transmittal consent

Please Note: The most recent progress reports from each provider of service will be provided by your service coordinator.

Office use only Date Mailed _____	Mailed by: _____ <small>Initials</small>
---	--

CPSE MEETING REPORT

Child's Name: _____ DOB: _____

School District: _____ Chairperson _____

EI Representative Name: _____ DATE: _____

Type of Meeting: CPSE _____ Combination CPSE/Transition _____

EI History Provided: Yes No Transition/ EI Progress Notes Provided: _____

Child Found Eligible for CPSE Yes No Projected Start Date of CPSE Services _____

CPSE Services _____; _____; _____; _____;

Anticipated Review Prior to Initiation of CPSE Services Yes **Date** _____ No

Final Date of Services in Early Intervention _____

Notification of End Date of EI Services

PROVIDER	AGENCY	DATE NOTIFIED

If Child Found Not Eligible Were Resources Provided to Family Yes No

If Yes, By Whom _____

CPSE DID NOT CONVENE

REASON/FOLLOW-UP _____

Additional Comments: _____



Individualized Family Service Plan (IFSP)

New York State Department of Health
Early Intervention Program

**Service Coordination IFSP Implementation
Tool Kit for Service Coordinators**

<http://tinyurl.com/kcju8z4>

**Westchester County Early Intervention Program
ONGOING SERVICE COORDINATOR SUMMARY REPORT
(6 Month /Annual Review)**

Child's Name:	DOB:	
OSC Name:	Agency Name:	
IFSP Start/End Date:	IFSP Type:	Date of Report:

SUMMARY REPORT: Specify Service Coordination Activities for Monitoring Services as per IFSP, Family Feedback on Service Delivery, EI & Non-EI Issues Effecting Service Delivery, Changes in Family Dynamics/Situation Effecting Services, General Statement of Progress. (If more space needed, attach another copy of this form)

SERVICE STATUS REPORT (List services for which providers have not been found and efforts made to fill service mandates.)

I certify that the above services were provided in accordance with the child's IFSP.

Ongoing Service Coordinator's Signature: _____ Date _____

(Circle One) 6 month 12 month

Child's Name: _____ <div style="display: flex; justify-content: space-around; width: 100%;"> (Last) (First) </div>	D.O.B.: ____/____/____
---	------------------------

For Parent/Caregiver to Complete with Service Coordinator:

Service: _____

- | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Have you seen changes in your child's skills - Development as a result of EI services?

_____ | No
Progress | Little
Progress | Moderate
Progress | Great
Progress | Reached
Goal |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been given an opportunity to participate in your child's IFSP? Have you been taught skills, or given ways to help support your child's growth?

_____ | Never | A Few Times | Half the Time | Most of
the Time | Every Week |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you and the therapist/teacher review which activities are working well and which are not working well? Do you and the therapist/teacher review the IFSP outcomes?

_____ | Never | A Few Times | Half the Time | Most of
the Time | Every Week |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. <u>For home/community based services:</u>
Were the therapists or teachers flexible about scheduling services for you and your child? If you were not routinely available during your child's session, did the therapist arrange a time to enable you to participate in a session?

<u>For facility toddler groups:</u>
Did the teacher or therapist keep in touch with you? How did the teacher/therapist communicate with you? (e.g. communication book, your visit to center, phone call)

_____ | No | Little | Some | Great Deal | |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. What are your current concerns/priorities about your child? Are there new skills you would like to learn?

_____ | | | | | |

Comments: _____

Signature of Parent/Caregiver: _____ Date: ____/____/____

Signature of Service Coordinator: _____ Date: ____/____/____

INSTRUCTIONS FOR COMPLETING OSC PARENT PROGRESS REPORT

Parents and caregivers are important members of the Early Intervention team. The Early Intervention Program wants to know how you view your child's progress and the services that he/she is receiving. We appreciate your feedback and we value your input.

1. Your Service Coordinator will complete this form with you (the Parent, Guardian or Surrogate) every six months after your child's IFSP, for each therapist or teacher working with your family.
2. For each question, put a check in the box below the statement that is closest to your opinion. Feel free to add any additional comments under the questions or at the bottom of the form.
3. Answer as completely as possible.
4. You (the Parent, Guardian or Surrogate) and your Service Coordinator should sign and date the form(s). If completed over the phone, the Service Coordinator should sign and provide the date and time of the phone conference.
5. When completed, give the form(s) to your Service Coordinator. The Service Coordinator will keep them with your child's file and submit them to the Early Intervention Official Designee (EIOD).

Chapter 4: Evaluation

Multidisciplinary Evaluation (MDE) vs Screenings

	Screening	Multidisciplinary Evaluation (MDE)
Description	<ul style="list-style-type: none"> • A brief overview of child's functioning to identify areas of concern 	<ul style="list-style-type: none"> • A comprehensive look at child's developmental and health history • Assessment of current functioning in the 5 developmental domains
Purpose	<ul style="list-style-type: none"> • To determine whether a child is functioning within acceptable limits or needs further evaluation • To identify specific areas that may need to be addressed by in-depth evaluation • To identify or rule out a very specific concern (e.g. hearing loss) 	<ul style="list-style-type: none"> • To obtain information about a child's functioning across 5 developmental domains • To determine if there is a significant delay/disorder, and if intervention is warranted • To establish initial and ongoing eligibility for Early Intervention services • To provide developmental and other information necessary to help shape recommendations for intervention • To learn and understand parent's resources, priorities and concerns
Domains	<ul style="list-style-type: none"> • A domain of specific concern <u>or</u> • Several domains 	<ul style="list-style-type: none"> • Must include all 5 domains – Cognitive, Physical, Communication, Social/Emotional and Adaptive
Evaluation Personnel	<ul style="list-style-type: none"> • Must be conducted by a qualified personnel 	<ul style="list-style-type: none"> • Must be conducted by qualified personnel from at least two different disciplines, one of whom shall be a specialist in the area of the child's suspected delay or disability • Evaluators must have sufficient expertise to assess all five domains, and have expertise to evaluate a particular domain in depth, as needed • Any member of the MDE team can perform parent interview
Documents Required (procedure related)	<ul style="list-style-type: none"> • Parental Consent(s) for evaluation(s) • Associated MDE NYEIS pages • Summary of MDE/Screening • Screening report 	<ul style="list-style-type: none"> • Parental Consents for evaluations • Associated NYEIS pages • Evaluation reports • Parent Interview and optional Family Assessment • Summary of MDE/Screening • Health assessment • Other sources of information (w/ parent consent; e.g., medical records)

Westchester County Department of Health Early Intervention Program Medical Form

Child's Name: _____ **Date of Birth:** _____

Parent's Name: _____

Address: _____

Immunization History:

	Birth – 2 Months	4 Months	6 Months	12-18 Months	18-24 Months	24-30 Months	30-36 Months
(DtaP) Diphtheria, Tetanus, Pertussis							
(IPV) Polio							
(Hib) Haemophilus Influenzae type b							
(Hep B) Hepatitis B							
(MMR) Measles, Mumps, Rubella							
(PCV) Pneumococcal Conjugate							
Chickenpox (Varicella)							

Testing: Lead: _____ **Results:** _____ **TB:** _____ **Results:** _____

Date of Last Physical Exam: _____ (Ht.) _____ inches _____ % (Wt.) _____ lbs. _____ %

Ophthalmology: _____ **Results:** _____

Audiology: _____ **Results:** _____

Referrals to other physicians: _____

Please describe below or attach description of child's medical history that has an identified or potential impact upon his developmental growth: Birth defects, prematurity, addiction, respiratory/cardiac compromise, seizure activity, feeding difficulties, other pre-natal or neo-natal difficulties or history of accidents, injuries, hospitalization, etc.

Please describe child's current medications, medical needs or concerns including allergies, if any:

Please describe any emotional, social or behavioral problems of which you are aware:

I hereby recommend that this child receive services from Early Intervention that may include occupational therapy, physical therapy, speech, social work, and/or assistive technology services; if found eligible as per EI NY State Regs. and as per the IFSP.

Physician's Name: _____

Address: _____

_____ **Phone #:** _____

Signature: _____ **Date:** _____

INTEGRATED EVALUATION SUMMARY FOR CORE EVALUATION (ONLY)

(Please Type)

CHILD'S NAME: _____ DOB: _____ C.A. _____

CHILD RESIDES WITH: _____ RELATIONSHIP TO CHILD: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

WCDH EIOD: _____

INITIAL / ONGOING SERVICE COORDINATOR: _____

Circle One

AGENCY: _____

AREAS OF CONCERN: _____

HEALTH STATUS: _____

<u>EVALUATION TYPE</u>	<u>DATE</u>	<u>LOCATION</u>	<u>EVALUATOR NAME/AGENCY</u>	<u>ASSESSMENT INSTRUMENTS</u>
------------------------	-------------	-----------------	------------------------------	-------------------------------

1. _____

2. _____

3. _____

4. _____

SUMMARY OF RESULTS – To include information on prior outside evaluations that is appropriate to eligibility.

COGNITIVE (*curiosity and interest, early objective use, imitation, play schemes, problem solving, early concepts*)

COMMUNICATION (*expressive and receptive language levels, oral motor functioning*)

ADAPTIVE (*attachment status, self-help skills*)

SOCIAL-EMOTIONAL (relatedness, regulation of attention, behavior, and emotion)

PHYSICAL (fine and gross motor, motor planning, regulation of sensory input)

MUST BE COMPLETED BY EVALUATION AGENCY

THE RESULT OF THIS EVALUATION (CORE AND SUPPLEMENTAL) INDICATE THAT THIS CHILD IS (Circle one) IS NOT ELIGIBLE TO RECEIVE SERVICES UNDER THE WCDH EARLY INTERVENTION PROGRAM BASED ON SDOH ELIGIBILITY CRITERIA AS PER THE ATTACHED EVALUATION DATA SHEET
--

FUNCTIONAL OUTCOMES ARE SKILLS THE CHILD NEEDS TO MASTER IN ORDER TO FUNCTION DURING FAMILY/COMMUNITY ROUTINES AND ACTIVITIES (PLAY, MEAL TIMES, BED TIMES, SOCIAL RELATIONSHIPS) (NOTE: According to NYS Reg. Sec.69-4.8(a)(4)(iv) evaluators should avoid making recommendations for frequency and duration of specific services.)

COGNITIVE:

- 1.
- 2.
- 3.
- 4.

COMMUNICATION:

- 1.
- 2.
- 3.
- 4.

ADAPTIVE:

- 1.
- 2.
- 3.
- 4.

SOCIAL-EMOTIONAL:

- 1.
- 2.
- 3.
- 4.

PHYSICAL/HEALTH STATUS:

- 1.
- 2.
- 3.
- 4.

THE FOLLOWING COMMUNITY RESOURCES AND/OR SUPPORTS WOULD BENEFIT THIS CHILD AND FAMILY:

- 1.
- 2.
- 3.
- 4.

COMPLETED BY: _____

TITLE: _____ AGENCY: _____ DATE: _____

Chapter 5: Individualized Family Service Plan (IFSP)

IFSP for Children in NYEIS

PROCEDURE FOR CHILDREN IN NYEIS COMPLETING THE IFSP & CREATING SERVICE AUTHORIZATIONS

Individualized Family Service Plan

➤ IFSP Details

- Meeting (Yes/No) - *Must be Yes for initial and annual IFSP, which must be conducted in person.*
- Enter IFSP Meeting Date – *Actual date of meeting*
- Other (Click if yes)
- Parental Consent Obtained
 - *Yes must be entered to indicate that the parental/surrogate consent to release information to EI providers has been obtained on the **IFSP Meeting Consent for Services**. Consent with original signatures must be maintained by EIOD in the child's paper record.*
- Signed Copy of IFSP on file
 - *Yes must be entered to indicate that the **IFSP Meeting Consent for Services** form has been signed by the parent/surrogate and attached in the IFSP attachment section of the IFSP*
- Reason for IFSP Delay
 - *Must be completed if IFSP was convened more than 45 days from date of referral. Choose the appropriate reason from the drop-down list.*
- Clinically Appropriate Visits Per Day Must Not Exceed
 - *The daily visit limitation should equal the number of services authorized per child including service coordination. For example if PT, OT and SI are authorized it would be **4**, to include SC.*

➤ Child's Level of Functioning

The SC should pre-populate these domains using the information from evaluations/progress notes and discussion with the family. The EIOD is responsible to ensure all domains are discussed at the IFSP and the SC is responsible, at the time of the meeting to enter any additional information that is discussed, in the appropriate domain.

- Physical Development, including vision and hearing
- Cognitive Development
- Communication Development
- Social or Emotional Development
- Adaptive Development

➤ Child's Current Setting

This section should be completed by the SC prior to the IFSP meeting

- Describe where the child spends most of his or her time during a typical day.

- Document where the child spends most of his/her time during a typical day
- Indicate if the child is in foster care and whether he/she has visits with the birth parent at the foster care agency
- Indicate the languages that the child hears most of the day
- Indicate if the child is in Daycare/Childcare Program or if another party assists with childcare i.e. babysitter, grandparent.

➤ Family Strengths

Prior to the IFSP meeting the SC shall inform the parent that their priorities, concerns and resources shall play a major role in the establishment of outcomes and strategies.

- Parental Consent Obtained
 - Choose Yes or No
- Describe the family’s strengths, priorities, concerns and resources that will enhance the child’s development.
 - Information may be obtained from family assessment or discussion with family either prior to or during the IFSP meeting.
 - Discussion with parent should include child’s daily routines and activities such as meal time, bath time, nap time, family outings, transitioning from one activity to another, sleeping, etc.
 - Which routines/activities are enjoyable or difficult for the child or family?
 - Which activity(ies) do they want to focus on in EI?
 - What is the most important to family (priority)?
 - Help identify strengths the family already has and identify additional resources needed by the family.

➤ Outcomes

- List desired outcomes of the early intervention services to include criteria and procedures that will be used to determine progress.
 - Functional outcomes are statements of the changes or results that are expected to happen for the child and family as a result of EI services. The outcomes should relate to the child’s developmental needs, the family’s concern and geared toward the child’s ability to function during everyday activities.
 - EIOD will discuss that outcomes are:
 - Related to everyday routines, activities and priorities identified while discussing family strengths;
 - Designed to help the parent/surrogate encourage the child’s development;
 - All team members at the IFSP meeting should collaborate in developing these outcomes.

➤ ABA Services

- Will any services provided to the child use ABA methodology?

- Choose yes or no
- If yes , who will provide ABA services
 - Currently no agencies are approved to use ABA aides, select “Qualified Personnel Only”
- Comments:
 - Ensure that this section documents that the parent has been given the **NYSDOH EIP Clinical Practice Guideline, Autism/Pervasive Developmental Disorders** and that the IFSP team discussed with the parent that based on the clinical guideline, “It is recommended that intensive behavioral programs include a minimum of approximately 20 hours per week of individualized behavioral intervention using ABA techniques (not including time spent by parents).” This guidance remains in place until further guidance is issued by NYSDOH.
- Natural Environment – NYSDOH EI regulations Sec. 69-4.1(af), defines natural environment as settings that are natural or normal for the child’s age peers who have no disability, including the home, a relative’s home when care is delivered by the relative, child care setting, or other community setting in which children without disabilities participate.
 - Are all services being provided in the child’s natural environment?
 - Choose yes or no
 - If No, explain
 - Explain why the service(s) cannot be delivered where the child spends most of his/her time
 - The rationale needs to be specific, detailed and developmentally sound
 - This information is required by the Individuals with Disabilities Education Act (IDEA).
 - If any service is being provided in group setting without typically developing peers, explain why the IFSP agrees this is appropriate.
 - Explain why the IFSP team agrees that this is the appropriate plan for this child. For example, does the child have special needs that can best be met in a structured group developmental setting?
 - If child is in daycare, list ways the qualified professionals will train daycare providers to accommodate the needs of the child.
 - For example the interventionist will communicate with the daycare staff...
- Transportation Needs
 - Transportation Needed?
 - Choose yes or no
 - Transportation should only be considered when services are not provided in the home

- Caregiver able to provide transportation?
 - Choose one of the following options:
 - *No Transportation needed* - e.g. family lives close to location of services and says they will walk there.
 - *Caregiver - Public transportation* - Parent/Guardian will receive one free unlimited-use Metro Card each month during the authorized service period to transport their child to and from the program/service.
 - *Caregiver – Private Car* - Parent/Guardian will be reimbursed for driving their child to and from their approved program/service provided the correct documentation is provided.
 - *Caregiver cannot provide* - IFSP team should determine whether a school bus or taxi fare reimbursement is an appropriate option.
 - If a taxi fare reimbursement is authorized, a responsible adult must accompany the child and the parent/guardian will be reimbursed for the cost to transport their child to and from his/her program or service.
 - If a school bus is approved the Bus Transportation Authorization Form must be completed and submitted to WCDH transportation unit.

The transportation method selected must be consistent for each day the child is scheduled to attend the program/service. For example you cannot receive a Metro Card and parent mileage reimbursement. Whichever option is selected at the IFSP it must be written in the comments section of the IFSP.

- Unable to provide transportation reason:
 - *If the caregiver cannot provide transportation, a detailed response must be documented. For example family does not have a car or other means to transport child.*
- Non-EI Services Needed
 - Enter any Non-EI Services needed by Child/Family
 - *List other services that may be needed to support the child and family outcomes*
 - *Specifically indicate if this will be an OSC follow-up activity.*
- Public Programs
 - Enter any public programs the child/family may be eligible for such as:
 - *Child Health Plus A or B, WIC, Waiver Programs, Section 8 Housing...*
 - *Specifically indicate if this will be an OSC follow-up activity.*
- Meeting Attendees
 - Enter all EI participants that attended EI meeting such as Parents, EIOD, Service Coordinator and Evaluator

- For each list the participant’s Name, Role and Agency Name
- All meeting attendees must sign the NYEIS attendance sheet, please note if anyone attend by phone.

➤ Other Meeting Participants

- Enter any other IFSP meeting participant including name and agency/organization
 - Individuals invited by the parent(s)/surrogate(s)
 - CPSE Administrator
 - Foster Care Case Worker
 - For each list the Role and Agency Name
 - All meeting attendees must sign the NYEIS attendance sheet, please note if anyone attend by phone.

➤ Parent Resources

- Is parent eligible for other sources of respite?
 - Choose yes or no
- If Yes, what sources?
 - Enter the sources
 - Indicate if family expressed need for EI respite services or if the family is eligible or has applied for other sources of respite, such as through OPWDD. (Respite is only temporary relief, if the family needs long-term services the OSC should assist them in accessing other supports in the community.)
- Has the family applied for this Respite?
 - Choose yes or no
- If Yes, date of application
- Respite Status
 - Select the status of the application from the drop down list.
- If No, Explain
 - If family is not eligible for sources of respite outside of EIP, explain why and document the attempts made to obtain respite.

➤ Transition Services

This section needs to be completed if the IFSP is the IFSP closest to the child’s second birthday. All children exiting the EIP are required to have a transition plan. The service coordinator is responsible to upload all completed transition documents (Transition Plan A or B, Notification to CPSE...) to the child’s integrated case in NYEIS.

Identify services/activities necessary to support the child’s transition to CPSE or other community services.

- Transition to CPSE discussed?
 - Choose yes or no
 - If IFSP is the IFSP closest to the child’s second birthday, Transition must be discussed and the **NYEIS Transition Section** must be completed.

- *Explain to the parent the steps to a smooth CPSE transition including dates for Notification, Transition Conference and Referral. It is important that the parent understand that it is the parent's responsibility to refer their child to CPSE to be evaluated. The OSC will assist with the follow-up. Parent must be informed that services will end the day before the child's third birthday, unless the child is found eligible for services under section 4410 prior to his/her third birthday*
- Transition to other Early Childhood and Support Services discussed
 - *Choose yes or no*
 - *List the options that have been discussed with the parent in which the parent shows interest. This may include Head Start, Preschool, play groups and/or childcare.*
- Date Transition discussed with parents
 - *Enter the date of the discussion (this date can be before the IFSP meeting)*
- Procedures to prepare child for changes in service delivery, including steps to help the child adjust to and function in a new setting.
 - *If yes is selected, what steps can be taken to assist in the child's transition.*
 - *For example, SC and interventionist(s) may begin talking to the child and family about changes in services and settings; provide referrals or literature to the family; suggest visiting possible sites or contacting community agencies.*
- Did parent consent to allow communication with personnel who will be providing services to the child to facilitate a smooth transition?
 - *Choose yes or no*
- If Yes, enter steps to prepare personnel for the child's transition
 - *Include activities such as contacting new teachers/therapists by phone, sending reports, etc.*
- Other activities that the IFSP participants determined necessary to support the transition of the child.
 - *Include information such as names of those who might assist, such as current interventionists, community agencies...*

➤ Transfer

Complete this section only if family will be moving to another NYS municipality in the coming IFSP period.

- Expected Transfer Date
 - *Enter the anticipated move date*
- Receiving Municipality
 - *Select the NYS county from the drop down list*
- Transfer Comments

- Enter any information about the parents' expected move such as address, phone number, whether parent has contacted EI or CPSE in the new municipality.

➤ Late Services

The Delay status must be completed when the IFSP team is aware that some or all services will be delayed beyond 30 days after the start date of the IFSP.

- Delay Status
 - Choose All Services will be delayed or Some services will be delayed
- Delay Reason
 - Use the drop down list to pick the most appropriate reason.

If an individual service is delayed unexpectedly after the IFSP is authorized, a task will be generated to the rendering provider's Service Authorization Work Queue to provide the reason for Delay.

➤ IFSP Comments

This section should be used by EIODs or service coordinators to enter any items discussed at the IFSP meeting that may not have been written in other sections such as:

- *The parent's choice of service coordination agency*
- *Approved services and including type/method/frequency/location...e.g. Speech Therapy 2xweek for 45 at child's home.*
- *Approved supplemental evaluations.*
- *Services offered and discussed by the EIOD that the parent turned down and the reason.*
- *For children receiving ABA services be sure to document the IFSP team's discussion with the parent that the IFSP can be amended to increase or decrease the amount of ABA therapy hours based on the child's and family's individual needs. Document the discussion about the minimum recommended 20 hours per week of ABA and that the parent has received the **NYSDOH EIP Clinical Practice Guideline, Autism/Pervasive Developmental Disorders.***
- *If the child is in foster care, how the birth parent will be involved in EI services (if applicable).*
- *Indicate anything that requires the OSC's immediate follow-up, such as obtaining prescriptions.*

Click SAVE

After saving IFSP the system will bring you to *Individualized Family Service Plan Home* page.

Creating Service Authorizations

- Create Ongoing Service Coordination Authorization in NYEIS
- On *IFSP home page*, Under Manage, Click, *Add Service Authorization*

- Category
 - Use the drop down menu to select *Service Coordination*
 - **Click Search**
- Select *Service Coordination*
- Enter the *Provider Agency Name* **or** enter % *Wildcard* to get a list of providers. **Click Search**
 - Search results will be listed
 - Select the *Provider agency based on the family's choice*
- *Service Coordination Details* skip this section unless you know the name of the service coordinator
- *Start Date* and *End Date* will be pre-populated, for *Units* enter 120.
- In the *Comments* section document the specific areas where the *OSC* will assist the family such as:
 - *Applying for Public Program*
 - *Applying for other non-EI services needed by child/family*
 - *Monitoring all services, including co-visit*
 - *Locating bilingual services, if needed*
 - *Assisting family with Transition*
- **Click *Create Service Authorization***

IFSP Team discusses types of services which could best achieve the outcomes developed and the discussion regarding family strengths and natural environments.

- EIOD and Parent agree on the service plan to be authorized
- A Service Authorization is created for a maximum period of six (6) months
- Service Coordinator Creates the Service Authorization(s) in NYEIS for each service type agreed on by the IFSP team
- On *IFSP home page*, under *Manage*, click *Add Service Authorization*
 - Category
 - Use the drop down list to select the appropriate category. Select *General* for OT, PT, Special Instruction...
 - **Click Search**
 - Select Service Type & Method
 - *Select correct service type & method, e.g. ST - Basic*
 - Qualified Personnel
 - *Select Qualified Personnel*
 - *Some EI services can be delivered by different Qualified Personnel (e.g. special instruction). To select more than one Qualified Personnel, hold the **Ctrl** key and click each Qualified Personnel role to add to record.*
 - Location Type
 - *Use drop down menu to select the location where the service will be delivered.*
 - *If other than child's home or provider location, address must be entered.*
 - Group Type
 - *If the service will be provided in a group setting, this must be completed.*
 - Service Intervention Methodology

- Choose ABA, when applicable
- When creating authorizations in which the methodology is ABA please refer to the **WCDH Sample for Creating ABA Service Authorizations Grid**. This is only a sample. The configuration of the weekly schedule is at the discretion of the ABA team and family.
- If other than home or provider location please enter address
 - If other than child's home or provider location, address must be entered.
 - **Click Next button**
- Select Provider & Location
 - If the provider is not yet identified, **Click Continue** without selecting a provider agency. The status will display as **Awaiting Provider/Vendor Assignment**, when submitted.
- OR**
- If provider has been identified, enter the Provider Agency or enter % Wildcard to get a list of providers. Click **Search**
- Select the Provider Agency, **Click Continue**
- Script Recommendation Provided By
 - Select the appropriate profession if the service requires a script
 - Before EI services begin a script is required for OT, PT, nursing and health related services.
 - An order or Referral from a licensed speech pathologist is required for ST.
- **Script recommendation on file; Start Date; End Date**
 - **DO NOT** complete until the script, order or referral has been obtained.
 - The information must be entered when it is received. The information is then recorded by creating a SA amendment and selecting the **Data Entry Error** reason.
- Start Date and End Date
 - Are automatically populated by the system, but can be modified
- Number of Visits; Per
 - Indicate the number of visits; Day, Week, Month or IFSP period
- Number of Minutes Per Visit
- **Click Next button**
- Visits per day clinically appropriate for this SA must not exceed
 - In most cases **1** will be indicated to comply with billing rules
 - For children authorized for ABA services, indicate **4** to account for waiver considerations
- Make-Up Visits Allowed; Click on the checkbox
 - A total of 10 make-up visits **per** IFSP period will be authorized as a starting point.
 - If additional make-up visits are needed they may be requested as an Amendment
- Co-Visits- For group or team meetings where multiple Interventionists will meet at the same time, complete this section.
 - Co-Visits allowed- Click checkbox
 - Enter Number of co-visits

- From the drop down menu, select the *Per Period (day, week, month, IFSP)*
- Select *Qualified Personnel* who will participate. Press the **Ctrl** key for multiple entries.

- **Click *Create Service Authorization***

- Once Service Authorizations are created for all approved services, **Check Upfront Waiver Rules** to ensure all waivers appropriate for the service plan are approved. This is an EIOD function.
 - On *IFSP home page*, under *Manage*, click *Check Upfront Waivers Rules*
 - EIOD will be presented with, *Select Yes to run Upfront Waiver Rules on this IFSP*. Select *Yes*. The system will run Billing Violations and determine if any violations could potentially occur.
 - If any potential Billing Violations were found they will be listed.
 - EIOD will choose to *Manage* each billing violation to review details and approve or reject Upfront Waiver. EIOD must include a comment when **Approving** or **Rejecting** a Billing Rule Violation.
 - To view information about any waivers on an IFSP, a User can access the *Waiver* button from the *Navigation Bar* on the *IFSP Homepage*.
 - **Upfront Waiver Rules must run prior to having the EIOD, Submit the IFSP and associated SAs.**

NYEIS Transition Section (Found on the Navigation Pane of the Child’s Integrated Case)

- **Complete the transition section only if the IFSP is the IFSP closest to the child’s second birthday.**
- **NYEIS will only allow for a case to stay open after a child turns three (3) years old if the *Transitions* section has been completed and the child has been found eligible for CPSE.**
- On the Child’s *Integrated Home Page*, in the *Navigation Bar*, click *Transitions*
- Click on the *New* button
 - Select ***Transition to CPSE***
 - Under *Child Details* CPSE transition dates are prefilled by NYEIS
 - Is child potentially eligible for CPSE services?
 - *If No, no further information is required.*
 - *If Yes, continue with the questions below. Complete all questions that can be answered and enter applicable dates.*
 - **Click Save once the section is complete.**
- On the Child’s *Integrated Home Page*, in the *Navigation Bar*, click *Transitions*
- Click on the *New* button
 - Select ***Other Transition***
 - This section is to be completed for children who are not transitioning to CPSE, including children who have been found ineligible for CPSE.
 - Last Date for EI Services
 - *Enter date of the child’s last day in EI, due to aging out, moving, condition resolved...*
 - Complete the rest of the transition plan and any comments in box provided.

- **Click *Save* once the section is complete.**

Consents

EIOD/SC reviews all consents with parent and obtains required signatures. Following the IFSP meeting, attach the completed consents to the child's IFSP in the NYEIS system. The consents are also maintained in the child's paper file.

- *Individualized Family Service Plan (IFSP) Consent for Services*
 - *Instructions for Completion* of this form have been provided for any needed clarification.
- *NYEIS Individualized Family Service Plan (IFSP) Attendance Sheet*
 - All people who attended the IFSP sign this form.
 - If anyone participated by phone, print their name and indicate that they participated by phone.
- *Westchester County EIP Parental Consent to Obtain/Release Information (Selective Consent)*
 - To be used if the parent would like to send the IFSP or other EI documents to non-EI providers, such as the child's a Primary Care Provider or Childcare Provider.
 - If a parent does not want to sign the general *Consent to Release Information to EI Providers of Service* (part of *IFSP Meeting Consent for Services*) in order to limit the information EI providers can share with each other, then this selective consent must be completed.
 - This consent must be completed for each provider and the parent must specify the information that may be shared with and between interventionist(s).
 - In this instance in the NYEIS IFSP document under *IFSP Details*, when asked if, *Parental Consent Obtained*, the answer must be NO. This will limit EI Interventionist access to the child's record and the OSC must ensure to disseminate information to providers in paper format based on the parent's consent.

Final Review

Prior to EIOD approving the IFSP, EIOD is responsible to ensure that all necessary information is documented in the IFSP and Service Authorizations have been completed for all services agreed upon, including supplemental evaluations. EIOD is responsible to approve the IFSP in a timely manner.

Click *Approve* on IFSP home page

Westchester County Department of Health Sample for Creating ABA Service Authorizations Grid

Up to 20 hrs ABA Service Per Week

MON	TUES	WED	THUR	FRI	Total Hours	Authorization #
1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	7 hrs 30 min	1 Ext /Home 5XW
1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	7 hrs 30 min	1 Ext /Home 5XW
1 ext(1hr 30 min)	1 ext(1hr 30 min)				3 hrs	1 Ext /Home 2XW
		1 basic (45min)	1 basic (45min)	1 basic (45min)	2hrs 15min	1 basic/Home 3XW
4 hrs 30 min	4 hrs 30 min	3 hrs 45min	3 hrs 45min	3 hrs 45min	20 hrs 15 min	

Up to 20 hrs ABA Service Per Week

MON	TUES	WED	THUR	FRI	Total Hours	Authorization #
1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	7 hrs 30 min	1 Ext /Home 5XW
1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	7 hrs 30 min	1 Ext /Home 5XW
1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)			4hrs 30 min	1 Ext /Home 3XW
4 hrs 30 min	4 hrs 30 min	4 hrs 30 min	3hrs	3hrs	19 hrs 30 min	

Up to 15 hrs ABA Service Per Week

MON	TUES	WED	THUR	FRI	Total Hours	Total
1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	7 hrs 30 min	1 Ext /Home 5XW
1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	7 hrs 30 min	1 Ext /Home 5XW
3hrs	3hrs	3hrs	3hrs	3hrs	15 hrs	

Up to 10 hrs ABA Service Per Week

MON	TUES	WED	THUR	FRI	Total Hours	Total
1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	1 ext(1hr 30 min)	7 hrs 30 min	1 Ext /Home 5XW
1 basic (45min)	1 basic (45min)	1 basic (45min)	1 basic (45min)		3hrs	1 basic /Home 4XW
2hrs 15min	2hrs 15min	2hrs 15min	2hrs 15min	1hrs 30min	10 hrs 30 min	

** This is only a sample. Discussion on the number of ABA hours approved must meet the individual needs of child and family as per the IFSP.

** The configuration of the weekly schedule is at the discretion of the ABA team and family.

**Guidance on the use of the
DRAFT New York State Early Intervention Program
Individualized Family Service Plan (IFSP)**

Westchester County requires all information for children referred to the Early Intervention Program be entered electronically into NYEIS including all IFSP's. The **Draft IFSP** is a representation of data that is required in NYEIS. This document is to be used only in situations when a service coordinator is attempting to create an IFSP document and for unforeseen reasons is unable to access NYEIS.

When it becomes necessary to conduct an IFSP meeting using the **Draft IFSP** it is mandatory that the information from the meeting be entered into NYEIS as soon as the NYEIS problem is resolved. The **Draft IFSP** is **not** an official document and should therefore not be attached in NYEIS, stored in the child's record or shared with providers. Once the information has been entered into NYEIS, the **Draft IFSP** must be shredded.

DRAFT
New York State Early Intervention Program
Individualized Family Service Plan

CHILD'S NAME: _____ DATE OF BIRTH: ____/____/____
First Last

EIO/D: _____ Currently Assigned SC: _____

IFSP Type (circle one): Initial 6 Month 12 Month (Annual) 18 Month 24 Month (Annual) 30 Month

Meeting: _____ Yes _____ No

IFSP Meeting Date: _____

Other: _____ Yes _____ No

Parental Consent Obtained: _____ Yes _____ No **Signed IFSP on File:** _____ Yes _____ No

Reason for IFSP Delay:

Natural Disaster	Evaluator sent report late
Child Eligible through Mediation/Impartial Hearing	Family – missed/canceled evaluation or IFSP meeting
Converted Record	Family – problem scheduling evaluation
Due Process	ISC high case load
EIO/D encountered foster care system problem	Family – unresponsive/moved
EIO/D referred child late to ISC	ISC unable to facilitate transportation to evaluation and/or IFSP
EIO/D scheduling problem	Translation difficulty
Evaluator conducted late evaluation	Weather emergency declared

Clinically Appropriate Visits Per Day Must Not Exceed: _____

Child's Present Level of Functioning/What My Child Can Do

Provide a statement, based on objective criteria, of the child's present level of functioning in each of the following domains

❖ Physical Development, including vision and hearing:

❖ Cognitive Development:

Child's Present Level of Functioning/What My Child Can Do (continued)

Provide a statement, based on objective criteria, of the child's present level of functioning in each of the following domains

❖ Communication Development:

❖ Social or Emotional Development:

❖ Adaptive Development:

Child's Current Setting:

❖ Describe where the child spends most of his or her time during a typical day.

Family Strengths:

❖ Family strengths may only be entered if Parental Consent is obtained.

Parental Consent Obtained: _____ Yes _____ No

❖ Describe the family's strengths, priorities, concerns and resources that will enhance the child's development.

Outcomes:

List desired outcomes of the early intervention services to include criteria and procedures that will be used to determine progress.

[Empty box for listing desired outcomes of early intervention services]

ABA Services:

If any services will be provided to the child using ABA methodology, an ABA Plan must be included in this IFSP.

Will any services provided to the child use ABA methodology: _____ Yes _____ No

If Yes, who will provide ABA Services: _____

Comments:

Natural Environment:

Are all services being provided in child's Natural environment? _____ Yes _____ No

If No, explain:

If any service is being provided in group setting without typically developing peers, explain why IFSP team agrees this is appropriate.

If child in daycare, list ways the qualified professionals will train daycare providers to accommodate the needs of the child.

Transportation Needs:

Transportation needed? _____ Yes _____ No

Caregiver Able to Provide Transportation?

	No Transportation Needed		Caregiver-Private Car
	Caregiver-Public Transport		Caregiver cannot provide

Unable to Provide Transport Reason:

Non-EI Services Needed:

❖ Enter any Non-EI Services needed by Child/Family

Public Programs:

❖ Enter any public programs the child/family may be eligible for such as (Child Health Plus A and B, Medicaid (Adult), WIC, Lead Program, TANF, Section 8 Housing, Waiver Programs, CSHCN, OMH Services, OMRDD Services, Commission for the Blind & Visually Handicapped or Other).

Meeting Attendees:

Enter all EI Participants that attended EI Meeting such as Parents, EIO/D, SC, Evaluator or Service Provider.

Other Meeting Participants:

Enter any other IFSP Meeting participants including name and agency/organization.

Parent Resources:

Is the family eligible for other sources of Respite? _____ Yes _____ No

If Yes, what sources: _____

Has the family applied for this Respite? _____ Yes _____ No

If Yes, date of application: _____

Respite Status: _____ Respite Application Pending

_____ Respite Application Approved

_____ Respite Application Rejected

If No, explain: _____

Transition Services:

Identify services/activities necessary to support the child's transition to CPSE or other community services

Transition to CPSE Discussed: _____ Yes _____ No

Transition to Other Early Childhood and Support Services Discussed: _____ Yes _____ No

Date transition discussed with Parents: _____

Procedures to prepare child for changes in service delivery, including steps to help the child adjust to, and function in, a new setting.

Did parent consent to allow communication with personnel who will be providing services to the child, to facilitate a smooth transition? _____ Yes _____ No

If Yes, enter steps to prepare personnel for the child's transition

Other activities that the IFSP participants determined necessary to support the transition of the child.

Transfer:

Transfer to another municipality

Expected Transfer Date: _____ Receiving Municipality: _____

Transfer Comments:

Late Services:

Delay Status: _____ All services will be delayed _____ Some services will be delayed

Delay Reason:

<input type="checkbox"/>	Natural Disaster	<input type="checkbox"/>	Intermittent Service and/or frequency per IFSP team...
<input type="checkbox"/>	Family – delayed response/consent for appointment	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Family – missed/canceled appointment	<input type="checkbox"/>	Provider scheduling problem/wait list
<input type="checkbox"/>	Family – problem scheduling appointment	<input type="checkbox"/>	Weather/Other emergency declared

IFSP Comments: (include approved services; type/method/frequency/location...service coordinator chosen)

❖ Indicates sections of the IFSP that the ISC is required to pre-populate in the NYEIS system based on the child's evaluations and the discussion with the family in preparation for the IFSP meeting. Following the IFSP meeting any additional information added to these sections will be entered into NYEIS by the EIOD.

Family Resources

Service Coordinators should review these resources with families and assist families in identifying the resources that could benefit them. This is not an exhaustive list and it's the service coordinators responsibility to explore and link families with additional resources when appropriate. Documentation of this activity should be maintained in the IFSP and service coordinators billing notes.

COMMUNITY RESOURCE	PHONE NUMBER
<p><u>Westchester County Department of Health (WCDH) – Early Intervention Program Developmental Monitoring Unit -</u> Developmental Monitoring Specialist assists families in tracking their child's development from birth to 3 for children (At Risk) for developmental delays and disabilities.</p>	(914) 813-5094 Contact: Referral Unit
<p><u>Speech Therapy – Low Cost Speech Clinics –</u></p> <ol style="list-style-type: none"> 1) Iona College Contact Person: Maria Armiento-DeMaria 2) Mercy College Contact Person: Marilyn Oxenberg 3) New York Medical College Contact Person: Kathleen Kaiser 	(914) 633-2149 (914) 674-7742 (914) 594-4912
<p><u>Early Head Start</u> – A community based program for low income families with infants and toddlers and pregnant women. It seeks to enhance the development of very young children.</p>	(914) 592-5600 Ext. 115, 165
<p><u>WIHD Parent to Parent</u> – Meeting with other families to share information, to learn about a child like mine, information on child's disability, what it means, working with specialty providers/physicians.</p>	(914) 493-2635
<p><u>New York State of Health Marketplace – WCDH Navigators</u> Find out if you qualify for affordable health care, Medicaid, Child Health Plus or obtaining tax credits for buying health insurance through the New York State of Health Marketplace.</p>	(914) 995-6350
<p><u>United Way</u> – Get Help! We are here for you no matter what the circumstance. The 211 number is free and confidential multilingual information and referral help line for such things as food assistance, housing assistance, mental health services, and services for people with disabilities.</p>	211
<p><u>Child Care Council</u> – Connect parents to child care providers, help to obtain child care subsidies for housing, Child Health Plus resources to help pay for health care.</p>	(914) 761-3456
<p><u>Early Childhood Direction Center</u> – Offers free confidential and neutral information, referral, technical assistance and training center for families with children from birth to five. Will provide training on transition from EI-CPSE-kindergarten.</p>	(914) 493-2902
<p><u>Assistive Technology Loan Program</u> – Families and providers can call or visit to see if Assistive Technology devices, supplies and equipment are available for loan.</p>	(914) 493-7364 Contact: Beth Heyd
<p><u>Cabrini Immigrant Services</u> – Provides free immigration legal services as well as providing case management, advocacy and educational workshops.</p>	(914) 674-1937
<p><u>Family Ties</u> – Provides support services to families of children with social, emotional and behavioral challenges. Offers a wide range of support groups, advocacy services, parent coaching and connections to community resources. All services are free.</p>	White Plains (914) 995-5238 Yonkers Office (914) 964-2063
<p><u>WCDH Children with Special Health Care Needs - CSHCN</u> is an information and referral service for families with special needs from birth through 21 years of age. Advocates for families in an effort to assure that children in need of special services are able to receive them without undue financial hardship.</p>	(914) 813-5076
<p><u>New York State Early Intervention Program</u> – A Parent's Guide http://www.health.ny.gov/publications/0532</p>	
<p><u>Westchester County Early Intervention Program</u> – Information and Parent Satisfaction Survey http://health.westchestergov.com/eip-early-intervention-program-sp-267</p>	

IFSP Consents

NYEIS Individualized Family Service Plan (IFSP) Attendance Sheet

CHILD'S NAME: _____ DATE OF BIRTH: ____/____/____
First Last

IFSP Meeting Date: _____

People who participated in this IFSP (Meeting Attendees):

_____ I give consent to share information in this IFSP with all IFSP members

Parent/Caregiver Signature: _____ Date: _____

Parent/Caregiver Signature: _____ Date: _____

Early Intervention Official/Designee: _____ Date: _____

Service Coordinator: _____ Date: _____

Evaluator: _____ Date: _____

Other: _____ Date: _____

Other: _____ Date: _____

New York State Early Intervention Program Individualized Family Service Plan (IFSP) Consent for Services

CHILD'S NAME: _____ DATE OF BIRTH: ____/____/____
First Last

IFSP Start/End Date: _____ IFSP Type: _____ Amendment:
(Check Box)

IFSP Attestations and Consents:

- I received a copy of A Parent's Guide when my child was referred to Early Intervention (EI). I understand my rights and I have received a verbal and written description of, *Notice of Child and Family Rights* at this IFSP meeting. I understand that:
 - I or an authorized representative can ask to read my child's file or request a change to the file.
 - I may refuse one or more services and continue to receive other EI services for my child or family.
 - I can contact my Service Coordinator or EIOD any time I have questions or concerns about this IFSP.
 - My child's services will be based on his or her continuing needs and eligibility. I will be notified if the EIOD makes any change to the IFSP. I have the right to mediation or impartial hearing if I disagree with any part of my child's IFSP.
- My family and I can use the services of the Early Intervention Program (EIP) to help my child achieve our IFSP outcomes.
- I understand I can arrange for additional services outside of this plan but that these services will not be paid for by the EI program.
- I understand that I have the right to select an ongoing service coordinator at the IFSP meeting or at any other time after the IFSP. I have chosen _____ as my Ongoing Service Coordinator.
Name Agency

Parent's Signature _____ Date: _____

I have participated in the development of this IFSP and agree to all parts of the plan. I give permission to the Westchester County Early Intervention Program to implement this plan with my family. **If consent to amend IFSP please indicate change:** _____

I do not agree with some aspects of this plan. I understand that I have due process rights that are described in the Parent's Guide and that have been explained to me at this meeting. I understand that disagreeing will not affect the other EI services. This is what I do not agree with: _____

Parent's Signature _____ Date: _____

Consent to Release Information to Early Intervention Providers of Service

- I understand that providers (including evaluators, service providers and service coordination) offering services to my child may need to exchange information to facilitate the development and implementation of my child's IFSP.
- I grant my consent for release of the EI Medical Form, Evaluations, IFSP's and Progress Notes to those providers as specified in the IFSP.
- I further understand that this release can be withdrawn at any time upon written notice to my Ongoing Service Coordinator. This release ends on the date of my next scheduled IFSP (or if sooner specify date ____/____/____).

Parent's Signature _____ Date: _____

NOTE: If Parent would like to send the IFSP to others working with their child, such as a Primary Care Provider or Child Care Provider complete the *Parental Consent to Obtain/Release Information* form. If a parent wants to sign a selective consent limiting the information EI service providers may share with each other do not complete the above box complete the *Parental Consent to Obtain/Release Information*.

EVALUATION REPRESENTATIVE:

I certify that I am a qualified professional as defined in the New York State Early Intervention Regulations, and that I am representing the Multidisciplinary Evaluation Team for the above named child. I further certify that I have personally evaluated this child and/or have read the complete multidisciplinary evaluation, am knowledgeable about the clinical needs of this child and family, and am able to answer any questions regarding the child's evaluations and assist in developing functional outcomes and short term objectives during the IFSP meeting.

Signature: _____ Date: _____

Early Intervention Official Designee (EIOD):

I certify that the services that I have authorized in this IFSP are based upon the review of the documentation provided by the evaluators/interventionists and the discussion that took place at this IFSP meeting as documented in the IFSP.

Signature: _____ Date: _____

INSTRUCTIONS FOR COMPLETION

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP) CONSENT FOR SERVICES FORM

This form is used at the conclusion of all IFSP meetings or when the IFSP is amended prior to the six month review period, to obtain the Parent's consent for services. This form allows all EI municipal staff, service providers and service coordinators to share information about the eligible child. Families may also indicate whether they have concerns with the IFSP.

IFSP Attestations and Consents

1. **First Parent Signature box, Agreement with Plan-** Signature of the parent(s) indicating that s/he has read the bulleted points and understands his/her rights and responsibilities. The EIOD must ensure that the parent understands his/her rights in the Early Intervention Program (EIP) and has received a copy of the *Notice of Child and Family Rights*. Also must indicate the name and agency of the service coordinator the parent has chosen.

2. **Second Parent Signature box, Agreement with Plan-** Signature of the parent(s) indicating agreement/disagreement with the plan outlined on the previous pages. Check the appropriate box and record any disagreement the parent(s) has with the recommended services on this page. The parent(s) must sign and date this form.

If the parent(s) and the EIOD do not agree on any part of the IFSP, the sections of the proposed IFSP that are not in dispute should be implemented. The parent(s) may exercise their due process rights to resolve the disputed areas. The EIOD and SC must ensure that the parent(s) understand their due process rights to request mediation or an impartial hearing. The parent should be referred to the EIP's *A Parent's Guide* for information on the mediation/due process forms and procedures.

Consent to Release Information to Early Intervention Providers of Service- The parent(s) signature here authorizes exchange of information regarding the child's EI records and service plan between all EI providers, service coordinators, evaluators and municipal staff. If a parent(s) chooses to sign a limited release, the *Consent to Release/Obtain Information* must be used.

Attestations and Consents-The evaluation representative and the EIOD must sign and date the IFSP attestation at the initial IFSP meeting. The EIOD must sign and date this page for each IFSP, indicating authorization of the plan.

Westchester County Early Intervention Program
Parental Consent to Obtain/Release Information

Child's Name: _____ Date of Birth: ____/____/____
Address: _____ Apt. #: _____
City/Town: _____ State: New York Zip Code: _____

I, (Parent/Guardian's Full Name) _____, seek services for my child from the Westchester County Early Intervention Program. I understand that the providers (including evaluators, service providers and service coordinators) offering Early Intervention (EI) services to my child and family may need to exchange information to develop and carry out the Individualized Family Service Plan (IFSP).

(Check one)

I authorize for the information below to be released I authorize for the information below to be obtained

Specific Information to be released/obtained:

EI Medical Form Multidisciplinary Evaluation Supplemental Evaluation(s) Specify: _____

 Individualized Family Service Plan Provider Progress Notes
 Session Notes Other: _____

I authorize for the information to be (check/complete either A or B):

A. Released to the Individual/Agency below:

_____ (Name/Organization)		_____ (Street Address/Apt #)
_____ (Telephone Number)	_____ (Fax Number)	_____ (City, State, Zip Code)

B. Obtained from the Individual /Agency below:

_____ (Name/Organization)		_____ (Street Address/Apt #)
_____ (Telephone Number)	_____ (Fax Number)	_____ (City, State, Zip Code)

The information will be sent to:

_____ (Name/Organization)		_____ (Street Address/Apt #)
_____ (Telephone Number)	_____ (Fax Number)	_____ (City, State, Zip Code)

C. The purpose of the requested information is to: (check all that apply)

- Establish Early Intervention eligibility
- Develop an Individualized Family Service Plan
- Start, coordinate and monitor Early Intervention services
- Inform the child's physician about my child's services
- Other: _____

I understand that this release can be withdrawn at any time upon written notice to my Service Coordinator. This release ends on the date of my next scheduled IFSP (or, if sooner, specify date ____/____/____).

Signature: _____ Date: _____

Relationship to Child: _____

NOTE: A reproduced copy of this signed form is deemed to have the same force and effect as the original. A new Consent to Release Information form must be signed at the initial IFSP meeting and at each IFSP review and annual meeting. BLANK CONSENT FORMS SHOULD NEVER BE SIGNED BY THE PARENT.

INSTRUCTIONS FOR COMPLETION
PARENTAL CONSENT TO OBTAIN/RELEASE INFORMATION

This form may be used to release Early Intervention (EI) information about the child, or to obtain information from agencies/individual outside the Early Intervention Program (EIP), (for example, physicians, hospitals, private therapists).

Note: A parent must never be asked to sign a blank *Parental Consent to Release/Obtain Information* form.

1. Complete the demographic information about the child at the top of the page.
2. Check whether this form is being used to either release information **or** obtain information.

Consent to Release Information must be completed at the following times:

- When a parent does not want to sign a general consent to release information for communication between EI service providers (*Consent to Release Information to Early Intervention Providers of Service*). This allows the parent to select which information can be shared between specific EI agencies/providers.
- Whenever a parent agrees to release information to a specific person, such as the child's healthcare provider.
- At each IFSP meeting, if applicable.

When a parent(s) decides to sign a selective release, each provider or individual must be specified on a separate form.

1. Check the appropriate box(s) to indicate the specific information to be released.
2. Complete "A" to indicate the name and contact information of the individual/agency that the information is being released to.
3. Check the appropriate box(s) at "C" to detail **the purpose of the requested information.**
4. If parental consent is for a limited period of time, specify the date by which the consents ends. If no date is specified, the consent will be valid until the next scheduled IFSP.
5. The parent/guardian/surrogate parent must sign and date this document and indicate his/her relationship to the child.

Consent to Obtain Information must be completed at any time in order to obtain information from the individual(s)/agency(ies) outside the EIP such as:

- To request an evaluation report conducted by a non-EI provider; or
- To request medical reports.

1. Check the appropriate box(s) to indicate the **specific information to be obtained.**
2. Complete "B" to indicate the name and contact information of the individual/agency that the information is being obtained from and the name and contact information of the individual/agency that the information is being sent to.
3. Check the appropriate box(s) listed under "C" to detail **the purpose of the requested information.**
4. If the parental consent is for a limited period of time, specify the date by which the consent ends. If no date is specified the consent will be valid until the next scheduled IFSP.
5. The parent/guardian/surrogate parent must sign and date this document and indicate his/her relationship to the child.

NOTE: A reproduced copy of this signed form is deemed to have the same force and effect as the original. The Consent to Release Information form must be signed at the initial IFSP meeting and at each Review and Annual IFSP meeting, if applicable.

Parental Consent to Use E-mail and/or Texting to Exchange Personally Identifiable Information

Parent’s Name: _____

E-mail Address: _____

Cell Phone: _____

Child’s Name: _____

D.O.B. _____

At your request, you have chosen to communicate personally identifiable information concerning your child’s early intervention treatment by e-mail without the use of encryption. Sending personally identifiable information by e-mail has a number of risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

- E-mail can be forwarded and stored in electronic and paper format easily without prior knowledge of the parent.
- E-mail senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake.
- E-mail sent over the Internet without encryption is not secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Backup copies of e-mail may still exist even after the sender and receiver have deleted the messages.
- Employers and online service providers have a right to check e-mail sent through their systems.
- E-mail can contain harmful viruses and other programs.

Parental Acknowledgement and Agreement

I acknowledge that I have read and understand the items above which describe the inherent risks of using **e-mail** to communicate personally identifiable information. Nevertheless, I, _____, authorize _____ whose e-mail address is _____ to communicate with me at my e-mail address, _____, or via texting to my cell phone concerning my child’s, _____, participation in the Early Intervention Program (EIP), including but not limited to communication regarding service delivery, his/her progress in the EIP and any other related matters. I understand that use of e-mail without encryption presents the risks noted above and may result in an unintended disclosure of such information.

(Optional) In addition, I give permission for members of my child’s treatment team to communicate personally identifiable information concerning my child with each other using **unencrypted e-mail or texting**. Early intervention team members who I give permission to use **unencrypted e-mail or to text** to communicate with each other about my child include:

- (1) _____ at the e-mail address _____ Phone to text _____
- (2) _____ at the e-mail address _____ Phone to text _____
- (3) _____ at the e-mail address _____ Phone to text _____
- (4) _____ at the e-mail address _____ Phone to text _____
- (5) _____ at the e-mail address _____ Phone to text _____

Parent’s Signature _____ Date _____

Consentimiento de los Padres para Intercambiar Información Personal Identificable a través del Correo Electrónico

Nombre del Padre(s): _____

Dirección de correo electrónico (email): _____

Nombre del Menor: _____ Fecha de nacimiento _____

A petición del interesado, usted ha escogido comunicar información personal identificable respecto al tratamiento de intervención temprana de su hijo(a) via correo electrónico (email) sin el uso de codificación de seguridad. Deseamos notificarle que enviar información personal identificable presenta varios riesgos de los que usted debe estar informado antes de darnos su consentimiento o permiso. Los riesgos incluyen, pero no se limitan a los siguientes:

- El email puede ser remitido y almacenado fácilmente en formato electrónico y en papel sin previo conocimiento del padre.
- Los remitentes pueden usar una dirección de email equivocada y la información personal identificable puede enviarse accidentalmente al destinatario equivocado.
- El email enviado via internet sin codificación de seguridad no es seguro y puede ser interceptado por terceros.
- El contenido del email puede ser cambiado sin conocimiento del remitente o del destinatario
- Pueden existir copias de seguridad del email aún después de que el remitente y el destinatario hayan borrado el mensaje.
- Los empleadores y proveedores de servicio en línea tienen derecho a checar los emails que se envían usando sus sistemas
- El email puede contener virus y otros programas dañinos.

Reconocimiento y consentimiento de los padres

Yo reconozco que he leído y entiendo los artículos antes mencionados, los cuales describen los riesgos inherentes del uso del email para comunicar información personal identificable. No obstante, Yo, _____ autorizo _____ con dirección de correo electrónico (email) _____ a que se comunique conmigo a mi dirección de correo electrónico (email) _____, con respecto a la participación de mi hijo(a) en el programa de intervención temprana (EIP por sus siglas en inglés), incluyendo, pero no limitado a la comunicación respecto a la obtención del servicio, su progreso en el EIP y cualquier otro asunto relacionado. Entiendo que el uso de email sin codificación contiene los riesgos como consta más arriba y puede resultar en una revelación imprevista de esa información.

(Opcional) Además, doy permiso a los miembros del equipo de tratamiento de mi hijo(a) para que entre ellos se comuniquen información personal identificable con respecto a mi hijo(a), usando correo electrónico sin codificación de seguridad. Los miembros del equipo de intervención temprana a quienes doy permiso para que se comuniquen entre ellos acerca de mi hijo(a) usando correo electrónico sin seguridad son los siguientes:

- (1) _____ con correo electrónico (email) _____
- (2) _____ con correo electrónico (email) _____
- (3) _____ con correo electrónico (email) _____
- (4) _____ con correo electrónico (email) _____
- (5) _____ con correo electrónico (email) _____

Firma del Padre _____ Fecha _____

Westchester County Early Intervention Program
Procedure for Conducting 6 Month and Annual IFSPs and
Documentation Required for the Use of an OTA, PTA and CFY

Effective April 1, 2014

I. Policy Description

The Individualized Family Service Plan (IFSP) shall be reviewed at six month intervals and shall be evaluated annually to determine the degree to which progress toward achieving the outcomes is being made and whether or not there is a need to amend the IFSP to modify or revise the services being provided or anticipated outcomes. Upon request of the parent, or if conditions warrant, the IFSP may be reviewed at more frequent intervals. (10 NYCRR 69-4.11(b))

IFSP reviews shall be conducted by an in-person meeting or other means agreed to by the parent which may include a telephone or video conference call or record review and written correspondence. (10 NYCRR 69-4.11(b)(1))

An IFSP meeting shall be conducted at least annually to evaluate the IFSP for the child and child's family, and, as appropriate, to revise its provisions. The results of any current evaluations conducted under Section 69-4.8 and any other information available from the ongoing assessment of the child and family, must be used in determining the services that are needed and will be provided. (10 NYCRR 69-4.11(b)(2))

The annual meeting to evaluate the IFSP and six month reviews must include the parent, EI/OD, Service coordinator, evaluator or a knowledgeable authorized representative, and any other person invited with parent consent... (10 NYCRR 69-4.11(b)(3))

Written notice must be given by the early intervention official to the parent of an eligible child ten working days before the early intervention official proposes or refuses to initiate or change the identification, evaluation, service setting, or the provision of appropriate early intervention services to the child and the child's family. (10 NYCRR 69-4.17(b)(1))

II. Procedure:

Responsible Party	Action
EI Interventionist	<ol style="list-style-type: none"> 1. Discusses the IFSP outcomes with the parent/surrogate to: <ul style="list-style-type: none"> – Determine if any changes to services are necessary – Review and develop outcomes with family – Include any new IFSP outcomes, or modifications to any current outcomes in the <i>Recommendations</i> section of the child’s progress note. <ul style="list-style-type: none"> ▪ For children in KIDS, complete the <i>Functional Outcome page</i> with the parent in preparation for the review/meeting and submit it along with your progress note to the OSC. ▪ For children in NYEIS, outcomes must be reviewed with the parent in preparation for the review/meeting. No additional paperwork is necessary. 2. Ensure the <i>Provider Progress Note(s)</i> with new/revised IFSP outcomes and/or requests for modification or the addition of EI services, are available to the Ongoing Service Coordinator (OSC) three (3) weeks before the expiration of the IFSP period. <ul style="list-style-type: none"> – For children in <i>KIDS</i> progress notes must be mailed/faxed to the OSC. – For children in <i>NYEIS</i> progress notes must be uploaded in the attachment section of the child’s current IFSP. Providers must notify the OSC when notes have been uploaded. 3. Please be aware authorization numbers expire the same day as the IFSP. It is imperative to ensure progress notes are completed and submitted in a timely matter. Without the progress note the pertinent information needed to discuss the child’s and/or family’s need for that service cannot be addressed by the IFSP team.
Ongoing Service Coordinator (OSC)	<ol style="list-style-type: none"> 1. OSC is responsible to ensure that all children’s 6 month IFSP reviews and Annual IFSP meetings are conducted prior to the expiration of the child’s current IFSP. If due to extenuating circumstances a child’s IFSP cannot be conducted prior to the end date of the current IFSP, the IFSP may be extended in accordance with the <i>WCDH EIP Extension Policy</i>. <ul style="list-style-type: none"> – If an IFSP is extended the OSC must have documentation in their notes as to why the extension was necessary. EIOD may request these notes when an extension is requested. 2. OSC completes 3 weeks before the expiration of the IFSP period: <ul style="list-style-type: none"> – Six (6) month <i>OSC Summary Report</i> for IFSP review meeting/ Twelve (12) month <i>OSC Summary Report</i> for the IFSP Annual meeting. – Six (6) month <i>OSC Parent Progress Report(s)</i> for IFSP review meeting/ Twelve (12) month <i>OSC Parent Progress Report(s)</i> for the IFSP Annual Meeting.

	<ol style="list-style-type: none"> 3. OSC gathers the following information 3 weeks before the expiration of the IFSP: <ul style="list-style-type: none"> – Six (6) month <i>Provider Progress Note(s)</i> (IFSP review meeting) and Twelve (12) month <i>Provider Progress Note(s)</i> (IFSP Annual Meeting) from each Interventionist for each service type. If OSC is unable to obtain progress note in preparation for the IFSP review/meeting the OSC must: <ul style="list-style-type: none"> ▪ Maintain documentation of all attempts to obtain the Provider Progress Note(s) ▪ Contact the EIOD to inform them that progress note(s) have not been obtained and the reason for delay. 4. For children in KIDS all progress notes completed/collected by the OSC must be mailed/faxed to the EIOD three (3) weeks prior to the expiration of the IFSP. 5. For children in NYEIS OSC must ensure all notes have been uploaded in the attachment section of the child’s current IFSP three (3) weeks prior to the expiration of the IFSP. OSC must notify the EIOD when all notes have been uploaded. 6. OSC must give a copy of all Progress Notes to the parent/surrogate prior to an IFSP review/meeting so that the family has time to review them in preparation for the meeting. 7. OSC schedules the IFSP review/meeting in settings and at times convenient to the parent. Sends out written notice of the IFSP meeting to family and other participants. <ul style="list-style-type: none"> – For the 6 month IFSP review the OSC discusses with the parent/surrogate if they would like a face to face meeting with the EIOD, a conference call with the EIOD present by phone or other means amenable to the parent. It is permissible to conduct a six-month review, by telephone or video conference. If there are no proposed changes to the IFSP and the parent is amenable, a record review is acceptable. – Full and complete documentation must be maintained in the child’s record clearly identifying the circumstances and options presented to and selected by the parent. – Annual meetings must be convened to review the IFSP and there are no provisions to allow for use of the telephone or video conferencing to conduct these meetings. Required participants for the annual review of the IFSP must meet in person to conduct this review.
EIOD	<ol style="list-style-type: none"> 1. EIOD is responsible to ensure that all children’s 6 month IFSP reviews and Annual IFSP meetings are conducted prior to the expiration of the child’s current IFSP. If due to extenuating circumstances a child’s IFSP cannot be conducted prior to the end date of the current IFSP, the IFSP may be extended in accordance with the <i>WCDH EIP Extension Policy</i>. <ul style="list-style-type: none"> – For children in Kids the EIOD will receive monthly reports indicating children whose IFSP reviews are upcoming. EIOD must notify the OSC of the upcoming review and document this in their case records. – For children in NYEIS the EIOD will receive a task to schedule an IFSP review, 6 weeks prior to the end of the child’s current IFSP.

	<p>EIOD is responsible to manage the task by:</p> <ul style="list-style-type: none"> - Clicking the <i>Task Id Number</i> - Click <i>Create IFSP Review</i> - Under <i>Details</i> complete as follows: <ul style="list-style-type: none"> - <i>Reviewer</i>: using the drop down menu choose EIOD - <i>Reason for Review</i>: using the drop down menu choose the type of review you are scheduling for example, <i>1st Review, 1st Annual...</i> - <i>Location</i>: leave blank - <i>Ignore all conflicts</i>: Click the box - Under <i>Time</i> complete as follows: <ul style="list-style-type: none"> - <i>All Day</i>: click the box - <i>Start</i>: enter the day the current IFSP ends - <i>Time</i>: leave Blank - <i>End</i>: enter the day the current IFSP ends (start and end date are the same date) - No other fields are required to be filled out. - Click <i>Save and Invite</i> - <i>Invite Attendee</i> screen appears, under <i>Details</i> complete as follows: <ul style="list-style-type: none"> - <i>Attendee</i>: choose <i>User</i>, to the right of the blank box click on the magnifying glass - A new screen appears type the OSC's last name and click <i>Search</i> - The OSC's name should appear on the bottom of the screen, click <i>Select</i> to choose the OSC. - Click <i>Save</i> <ul style="list-style-type: none"> - EIOD must document in their case notes that they sent notification to the OSC of the upcoming IFSP. <ol style="list-style-type: none"> 2. EIOD must ensure that all needed progress notes are received in preparation for the IFSP review/meeting. 3. EIOD is responsible to contact the OSC if progress notes are not submitted/uploaded to EIOD three (3) weeks prior to the expiration of the current IFSP period. 4. EIOD must follow-up with their supervisor if they are unable to obtain the necessary documentation needed in order to hold an IFSP review/meeting prior to the end date of the current IFSP.
EIOD/OSC	<ol style="list-style-type: none"> 1. Convene the Six (6) Month Review or Annual Meeting prior to the expiration of the current IFSP. 2. Inform parent(s) of their rights, as covered in the <i>Westchester County Early Intervention Program Notice of Child and Family Rights</i>, which must be given to the family at minimum yearly and whenever there is a change in service plan. When there is a change in the service plan or the EIOD does not agree to approve a proposed change the family must be provided with <i>Written Notice</i> and parental rights to due process must be reviewed. 3. EIOD and OSC will review OSC parent progress note, summary report and provider progress note(s) including revised outcomes.

4. Insurance information must be updated every 6 months and whenever there is a change in insurance. **All insurance information for children in KIDS and NYEIS must be faxed to the WCDH insurance collection unit at 914-813-4194.**

A. If the parents would like to exercise the option of a record review (cannot be done for an Annual or when there are any proposed changes to service plan):

i. For children in **KIDS**:

1. OSC must complete the following forms the day the EIOD and OSC confirm parental agreement to a record review:

- *Reason for Delay Data Sheet*
- *Data Change Form* (if applicable)
- Six Month IFSP *What My Child Can Do* form
- *IFSP Service Summary Sheet* (copy from previous IFSP)
- *IFSP Services Family Worksheet- Circle Page* (copy from previous IFSP)
- *Transportation Plan page*
- *Functional Outcome page(s)*
- *Family Resources and Needs page*
- Insurance Information

2. Upon completion of the 6 month review paperwork, the following must be reviewed/obtained:

- *Individualized Family Service Plan (IFSP) Consent for Services*
- *Parental Consent to Obtain/Release Information, if applicable*
- Transition Consents, when applicable
 - * See *NYSDOH Service Coordination Transition Toolkit*
- Insurance Forms
 - * Insurance information must be reviewed (updated if applicable) and sent to the EIOD and the child's EI service providers. See *NYSDOH Insurance Toolkit for Service Coordinators, Revised 2/14* for additional information.

3. OSC is responsible to ensure the timeliness of transition activities with the family in accordance with NYSDOH regulations.

4. Completed IFSP documents and signed parental consents must be sent to the EIOD via fax or mail prior to the start date of the IFSP.

ii. For children in **NYEIS**:

1. OSC must **clone** the active IFSP in NYEIS. The cloned IFSP will have a start date set to the day after the end date of the active IFSP being cloned.

- Since there is no meeting, the meeting date field

must be left blank.

- Editing the content of the IFSP is allowed.
2. OSC updates *Outcomes* and other pertinent fields (i.e. *Family Strengths, Transition Services...*) based on information obtained during the record review.
 3. For information that needs to be updated/changed:
 - **DO NOT delete the old information from the NYEIS field(s).**
 - Insert the updated information in the appropriate field above the old information.
 - Ensure the updated information is preceded by the date.
 - The updated information and old information must be separated by a line.
 4. OSC reviews/updates insurance information in the insurance section of NYEIS and uploads insurance documentation to the child's integrated page.
 - See *NYSDOH Insurance Toolkit for Service Coordinators, Revised 2/14* for additional information.
 5. OSC is responsible to ensure the timeliness of transition activities with the family in accordance with NYSDOH regulations.
 - Please remember that the *Transition Section* in NYEIS needs to be updated as activities occur.
 6. OSC *Submits* IFSP to EIOD NYEIS for *Approval*.
 7. Once IFSP is approved by EIOD, OSC will provide parent with *Approved* IFSP and obtain the following parental consents:
 - *Individualized Family Service Plan (IFSP) Consent for Services*
 - *Parental Consent to Obtain/Release Information, if applicable*
 - Transition Consents, when applicable
 - * See *NYSDOH Service Coordination Transition Toolkit*
 - Insurance Forms
 - * Insurance information must be reviewed (updated if applicable) and sent to the EIOD and the child's EI service providers. See *NYSDOH Insurance Toolkit for Service Coordinators, Revised 2/14* for additional information.
 8. Once parental consent has been obtained, OSC will attach consents to the IFSP page in NYEIS and notify the EIOD. Parental consent must be obtained prior to the start of the IFSP.

NOTE:

- Services cannot begin until parental consent has been obtained.

- For a record review no attendance sheet is required, therefore in *NYEIS*, the *IFSP Meeting Attendees* field should not be populated.
- The process for holding six-month reviews by record review must not delay agreement on the terms of the IFSP by the parent and the EIO/D, and the timely implementation of the IFSP.

B. If the parent would like a face to face meeting with the EIOD present (this is required for all Annual IFSPs) or would like a conference call with the EIOD and OSC participating;

- i. The EIOD must facilitate a team review and discussion of:
 - The current needs of the child and family
 - Progress towards achieving outcomes
 - The effectiveness of strategies used during intervention sessions
 - Any needed modifications of the outcomes or EI services.
- ii. Ask the parent if there are any changes in the child’s insurance coverage.
- iii. For children in ***KIDS***:
 1. OSC must complete:
 - *Reason for Delay Data Sheet*
 - *IFSP Attendance Sheet*
 - *Data Change Form* (if applicable)
 - *Summary of Development*, Annual IFSPs only
 - *What My Child Can Do* form, 6 month IFSPs only
 - *IFSP Service Summary Sheet*
 - *IFSP Services Family Worksheet*- Circle Page
 - *Transportation Plan page*
 - *Family Resources and Needs page*
 - *Functional Outcome page(s)*
 - Insurance Information
 2. The following consents must be reviewed with the family and obtained:
 - *Individualized Family Service Plan (IFSP) Consent for Services*
 - *Parental Consent to Obtain/Release Information, if applicable*
 - Transition Consents, when applicable
 - * See *NYSDOH Service Coordination Transition Toolkit*
 - Insurance Consent(s)
 - * Insurance information must be reviewed (updated if applicable) and sent to the EIOD and the child’s EI service providers. See *NYSDOH Insurance Toolkit for Service Coordinators, Revised 2/14* for additional information.
 3. When there is a face to face meeting with the EIOD present the EIOD is responsible to collect the IFSP and

consents.

4. When the EIOD is not participating in person the OSC is responsible to submit the IFSP along with consents to the EIOD via fax or mail within 2 business days.
 5. EIOD will promptly review all documents and submit to operations for processing.
- iv. For children in *NYEIS*:
1. For a **6 Month IFSP** meeting the previous IFSP may be cloned.
 - For detailed information on cloning/completing the IFSP and Creating Service Authorizations, refer to *Unit 6 of the NYEIS User Manual*.
 - Every field within the cloned IFSP needs to be reviewed and discussed with the IFSP team to ensure the information continues to be accurate.
 - For information that needs to be updated/changed:
 - * **DO NOT delete the old information from the NYEIS field(s).**
 - * Insert the updated information in the appropriate field above the old information.
 - * Ensure the updated information is preceded by the date.
 - * The updated information and old information must be separated by a line.
 2. For an **Annual IFSP** a new IFSP document must be created.
 3. OSC updates *Outcomes* and other pertinent fields (i.e. *Family Strengths, Transition Services...*) based on discussion with the family and information contained in the Provider Progress Note(s).
 4. OSC reviews/updates insurance information in the insurance section of NYEIS and uploads insurance documentation to the child's integrated page.
 - * See *NYSDOH Insurance Toolkit for Service Coordinators, Revised 2/14* for additional information.
 5. OSC is responsible to ensure the timeliness of transition activities with the family in accordance with NYSDOH regulations.
 - Please remember that the *Transition Section* in NYEIS needs to be updated as activities occur.
 6. The following consents must be reviewed with the family and obtained:
 - Individualized Family Service Plan (IFSP) Consent for Services
 - Parental Consent to Obtain/Release Information, if applicable
 - Transition Consents, when applicable
 - * See *NYSDOH Service Coordination Transition Toolkit*

	<ul style="list-style-type: none"> - Insurance Forms <ul style="list-style-type: none"> * Insurance information must be reviewed (updated if applicable) and sent to the EIOD and the child's EI service providers. See <i>NYSDOH Insurance Toolkit for Service Coordinators, Revised 2/14</i> for additional information. 7. When there is a face to face meeting with the EIOD present the EIOD will upload consents and applicable forms. 8. For a 6 month IFSP review/meeting when the EIOD is not participating in person the OSC is responsible to attach parental consents and any applicable forms to the IFSP section in NYEIS and <i>Submit</i> the IFSP to the EIOD for <i>Approval</i>. 9. EIOD is responsible to review the IFSP, <i>Check Upfront Waivers Rules</i> and accept or reject the submitted IFSP prior to the start date of the IFSP. <hr/> <p>NOTE:</p> <ul style="list-style-type: none"> ▪ Federal and State Regulations require that an Annual IFSP meeting must be convened in person and there are no provisions to allow for the use of the telephone or video-conferencing.
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Use of an OTA, PTA, CFY to provide EI services

<p>EI Provider Agency</p>	<ol style="list-style-type: none"> 1. When assigning an OTA, PTA or CFY to provide services to a family the agency must disclose to the family the credentials of the interventionist who will be directly providing service to their child and that the interventionist is working under the supervision of a licensed therapist. 2. If the family agrees to receive services, the agency must notify the EIOD and the service coordinator that an OTA, PTA or CFY is providing services under the supervision of a licensed OT, PT or SLP. 3. The agency must submit to the EIOD and OSC the details regarding the supervision, including the name and license number of the supervising qualified personnel and the frequency of observation, treatment and assessment by the supervising qualified personnel so that this information may be added to the IFSP to avoid confusion or future disagreement. <hr/> <p>Please Note:</p> <ul style="list-style-type: none"> • Any questions regarding supervision requirements for an OTA, PTA or CFY should be addressed to the NYS Education Department, Office of Professions at 518-474-3817 or http://www.op.nysed.gov/ .
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OSC/EIOD	<ol style="list-style-type: none"><li data-bbox="459 109 1443 310">1. The IFSP must be amended to include that an OTA, PTA or CFY will be providing EI services. The IFSP must also include the name and license number of the supervising qualified personnel and the frequency of observation, treatment and assessment by the supervising qualified personnel to avoid confusion or future disagreement.<li data-bbox="459 319 1443 436">2. The amended IFSP must be reviewed with the family and the parent/surrogate must sign a new IFSP Consent form prior to the delivery of service by an OTA, PTA or CFY.
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**WESTCHESTER COUNTY EARLY INTERVENTION PROGRAM
PROCEDURE FOR EXTENDING THE IFSP
FOR CHILDREN IN NYEIS**

**For children in KIDS the protocol for extending the IFSP remains unchanged.*

I. POLICY DESCRIPTION:

Extensions in NYEIS can only be made for 30 days at a time, with a maximum of two 30 day extensions. Parents must be informed that an IFSP review/meeting can be scheduled at any time during this 60 day period if the IFSP needs to be amended. Parental consent and signature must be obtained for each 30 day extension. The use of extensions by Service Coordinators and EIODs will be monitored.

The Westchester County Early Intervention Program (EIP) recognizes the following circumstances when a current IFSP period may require an extension.

- A. It is the expectation of the EIP that the Six Month Review and Annual Individualized Family Service Plan (IFSP) meetings occur prior to the expiration of the current IFSP. It is recognized, however, that extenuating circumstances may interfere with the timely scheduling of these meetings and authorization of services. In these circumstances the EIOD and parent may agree to extend the current IFSP period for up to 30 days the first time, and 30 days at a time thereafter, with no changes to the service plan, so service can continue without interruption. In these cases, the next IFSP period will be diminished by the amount of the extension. **A current IFSP must be present in NYEIS in order to avoid gaps in services.**

- B. When a child is found eligible for services by the Committee on Preschool Special Education (CPSE) and there are **60 days or less** to what would have been the end of the original 6 month IFSP period and no changes are requested, the IFSP may be extended twice. The IFSP may be extended in 30 day increments until what would have been at least the end of the original 6 month IFSP period. There is a maximum of two extensions before an IFSP meeting/review is required.

Example:

*Ellen's DOB is 3/20/11 her current IFSP is effective for the period of 11/18/13 until 3/19/14. Ellen has **been found eligible** for services by the CPSE. Ellen will stay in EI until her effective age out date of 8/31/14. The IFSP may be extended twice to what would have been the original 6 month IFSP end date of 5/18/14. Since it is more than 60 days until the child ages out of the program an IFSP review must be conducted which will then bring the IFSP end date to 8/31/14.*

- C. When a child is aging out of the EIP and there is a gap of **60 days or less** between when the IFSP ends and the date the child will transition out of EI **AND** no changes to the existing IFSP are being requested the IFSP can be extended.

Examples:

1. Robert has **been found eligible** for services by the CPSE. Robert will stay in the EIP until his effective age-out date of 8/31/14. Robert's current IFSP is effective for the period 2/5/14 to 8/5/14. His next IFSP Review is due 8/6/14 which is less than 30 days from the date of his transition out of the EIP (8/31/14). His IFSP and current services can be extended from 8/6/14 to 8/31/14.
2. Tammy is **found not eligible** for services by the CPSE. She has an IFSP for the period 12/3/13 to 6/4/14 and is due for an IFSP Review. Her DOB is 8/1/11. She will age out on the 7/31/14 (the day before her 3rd birthday). Her IFSP and current services can be extended from 6/5/14 to 7/31/14.

- D. When a child is found eligible for CPSE and there are **more than 60 days** beyond what would have been the end of the original 6 month IFSP period, an IFSP review must be conducted. The IFSP will then be cloned. An extension may also be required.

Example:

Matthew's DOB is 4/15/11 his current IFSP is effective for the period of 2/24/14 until 4/14/14. Matthew has **been found eligible** for services by the CPSE. Because there are more than 60 days beyond what would have been the end of the original 6 month IFSP period an IFSP review must be conducted and the IFSP cloned. The newly cloned IFSP end date will be 8/23/14. One extension will be necessary to bring the effective end date of services to 8/31/14.

II. PROCEDURE:

Responsible Party	Action
Ongoing Service Coordinator (OSC)	<p>Monitors all cases to ensure that services are extended where appropriate to prevent gaps in services.</p> <p><u>Circumstance A:</u></p> <ol style="list-style-type: none"> 1. Initiates an extension of services when a Review or Annual IFSP meeting is not held prior to the expiration date of the IFSP. <ol style="list-style-type: none"> a. See <i>Unit 6: Individualized Family Service Plan and Service Authorization of the NYEIS User Manual</i>. 2. Ensures that an IFSP Review or Annual meeting is scheduled within 30 days of requesting the extension. <p><u>Circumstance B:</u></p> <ol style="list-style-type: none"> 1. Extend the IFSP in 30 day increments until what would have been at least the end of the original 6 month IFSP period.

- a. When a child
 - Has been found **eligible** for services by the CPSE;
 - And**
 - There are 60 days or less to what would have been the end of the original 6 month IFSP period.
 - b. Parental consent is required when the child has been found CPSE eligible and the IFSP is extended beyond the child's 3rd birthday. Consent confirms parental agreement to continue in EI beyond the child's third birthday.
2. Attach the following documents to child's current NYEIS IFSP:
 - *IFSP Consent for Services Form*
 - *CPSE meeting Report Form*
 - *IFSP Transition Plan (Form A)*.
 - * See *NYSDOH Service Coordination Transition Toolkit*
 3. An IFSP review must then be conducted. Please refer to Westchester County's *Procedure for Conducting 6 Month and Annual IFSPs and Documentation Required for the Use of an OTA, PTA and CFY*.

Circumstance C:

1. Initiate an extension to extend services to the last EI eligible date.
 - a. When a child
 - Has been found **eligible** for the CPSE;
 - Has been found **ineligible** for the CPSE; or
 - The parent has not referred the child for CPSE services therefore the child must exit EI the day before his/her third birthday;
 - And**
 - The child is leaving the EIP within 60 days or less beyond the existing authorized IFSP period.
 - b. Parental consent is required when the child has been found CPSE eligible and the IFSP is extended beyond the child's 3rd birthday. Consent confirms parental agreement to continue in EI until the child's last EI eligibility date.
2. Attach the following documents to child's current NYEIS IFSP:
 - *IFSP Consent for Services Form (CPSE eligible only)*
 - *CPSE meeting Report Form – if applicable*
 - Final/Discharge Progress Notes
 - *IFSP Transition Plan (Form A or B)*.
 - * See *NYSDOH Service Coordination Transition Toolkit*

	<p><u>Circumstance D:</u></p> <ol style="list-style-type: none"> 1. Conduct an IFSP review. May be a record review if the parent is amendable and there are no proposed changes to the IFSP service plan. <ol style="list-style-type: none"> a. Parental consent is required when the child has been found CPSE eligible. Consent confirms parental agreement to continue in EI until the child’s last EI eligibility date. 2. Attach the following documents to child’s newly cloned NYEIS IFSP: <ul style="list-style-type: none"> • <i>IFSP Consent for Services Form</i> • <i>CPSE meeting Report Form</i> • <i>IFSP Transition Plan (Form A)</i> <ul style="list-style-type: none"> * See <i>NYSDOH Service Coordination Transition Toolkit</i> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Note:</p> <ul style="list-style-type: none"> • Children for whom changes to the existing plan are being requested must have an IFSP <u>meeting</u> to make any changes to the IFSP. </div>
<p>Provider Agency</p>	<ol style="list-style-type: none"> 1. Review assigned cases in NYEIS regularly to track the end date for all authorized services.

Chapter 6: Service Delivery

**Westchester County Early Intervention Program
Session Note Policy & Procedure
For Children in KIDS/NYEIS
Effective 6/1/13**

I. POLICY DESCRIPTION:

Providers of Early Intervention must maintain and make available to the municipality and the State Department of Health (SDOH) upon request, complete financial records and clinical documentation related to the provision of early intervention services including information and documentation necessary to support billing to third party payors (including the medical assistance program) and the State, and to permit a full fiscal audit by appropriate State and municipal authorities. (NYCRR 69-4.9(g)(6))

Agency and individual providers must maintain Early Intervention Program records for each eligible child that includes documentation necessary to support claims to third party payors, including the medical assistance program, and to the Department for reimbursement of early intervention services. (NYCRR 69-4.26(a)(15))

“Session notes specifically document that the early intervention provider delivered certain diagnostic and/or treatment services to a child and/or caregiver on a particular date. Session notes also assist payors, parents, early intervention providers and municipalities in assessing the extent to which services are helping the child/family to achieve the goals contained in the IFSP. Session notes must be completed by all qualified personnel (i.e. special educator, physical therapist, social worker, etc.) delivering the early intervention services authorized in a family’s IFSP for *each service delivered.*” (NYS DOH EIP Memorandum 2003-1)

The session note is also a valuable clinical tool to document how well previous activities worked for the family and child, what occurred during the session, what strategies and natural routines were used, and what learning activities are planned next. The session note can be used by the parents/caregiver as a reference tool, and can help support collaboration and communication among the other interventionists working with the child on the same functional outcomes.

II. PROCEDURE:

Responsible Party	Action
EIP Interventionists	<p>1. Document information regarding all scheduled sessions (held or cancelled) on the <i>Westchester County Early Intervention Program Session Note</i>.</p> <ul style="list-style-type: none"> a. The session note must be completed in its entirety. b. The session note must be completed as close to the conclusion of the visit as possible <ul style="list-style-type: none"> i. Sessions should be delivered at the duration specified in the IFSP and should not end early to complete the session note. Case recording, training, supervisory conferences ...are not separately billable activities. <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Note: The duties of the provider are discussed in Social Service Law at 18 NYCRR Section 504.3. Providers must prepare and maintain contemporaneous records that demonstrate the provider’s right to receive payment under the Medicaid program. (“Contemporaneous” records means documentation of the services that have been provided as close to the conclusion of the session as practicable.)</p> </div>

- c. A separate session note must be written for each service type that an interventionist is delivering.
- d. A separate session note must be written by each interventionist for authorized co-visits, and team meetings.
- e. Each interventionist must retain a copy of this session note and ensure that their corresponding provider agency(ies) receive a copy.
- f. Ensure that the parent/caregiver receive a copy of the session note(s) when requested.

Note:

- Demographic information (child's name, DOB, Authorization #, interventionist name, discipline...) may be entered in preparation for the session.
 - Session notes may be corrected if each strikethrough is initialed and dated by the interventionist.
 - Session note corrections will be questioned if the corrections create the appearance of impropriety.
- g. When a session cannot be held for a family or provider reason:
 - i. Session notes must be completed for every session that was cancelled/not held.
 - ii. The reason for the non-delivery of service must be indicated.
 - iii. A single session note can be completed to indicate a range of absences or cancellations such as in the case of vacations.
2. Ensures session notes are signed by the parent/caregiver and the interventionist at the end of each session. This is required for the provision of all services, **except** toddler developmental groups.
 - a. Parents should never be asked to sign a blank session note.
 3. Provides the family with a copy of the session note for their use as a reference tool and/or record of services when requested by the parent/caregiver.
 - a. The family should receive a copy of their session note as close as possible to the corresponding visit.
 4. Submits session notes to the authorized service provider.
 - a. Independent contractors must keep original session notes and submit copies to the provider agency.
 - b. Employed interventionist submit original session notes to the authorized provider agency.
 5. Makes all session notes available when requested by parents; the interventionist's supervisor or by their provider agency; and by Westchester County Department of Health Early Intervention Program and the New York State DOH .

Service Provider Agency	<ol style="list-style-type: none">1. Bills for services provided based upon the receipt and review of Interventionist's session notes.2. Reviews session notes to ensure that:<ol style="list-style-type: none">a. Services were provided in accordance with IFSP service authorizations in terms of service type, frequency and duration;b. Session notes demonstrate that services were delivered in compliance with regulatory requirements and include information necessary for reimbursement for services, as noted above (See I. Policy Description).3. Upon request, expeditiously provide session notes to WCDH EIP and NYSDOH EIP.4. Upon request, provide session notes to parents within:<ol style="list-style-type: none">a. Ten (10) business days upon receipt of request; andb. Five (5) business days when requested as part of a mediation or impartial hearing.
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**WESTCHESTER COUNTY EARLY INTERVENTION PROGRAM
INSTRUCTIONS FOR COMPLETION OF
SESSION NOTES**

GENERAL DIRECTIONS	
<p>The interventionist must complete this form for each session completed and document whenever a session is cancelled and the reason for the cancellation on the form. A copy must be submitted to the interventionist's provider agency for billing purposes.</p> <p>All Session Note fields are mandatory. Refer to the Session Note Policy</p>	
DEMOGRAPHIC/AUTHORIZATION INFORMATION	
Child's Name:	Information must be the same as in KIDS/NYEIS (do not use nickname).
DOB:	Enter child's date of birth.
Sex:	Enter the sex of the child (M, F).
Authorization #:	Enter Authorization # for the child and service being provided.
Interventionist Name:	Print the name of the interventionist who is completing this form.
Credentials:	Interventionist's discipline/credentials, e.g. speech therapist (Speech/Language Pathologist MS CCC/SP) special educator (MS Ed.) etc.
National Provider ID (NPI):	Write the National Provider ID (NPI). [See NY State regulations from June 2010]
Service Type:	IFSP authorized service delivered by the interventionist, e.g., Speech, Physical Therapy.
Session Date:	Date session was held.
IFSP Service Location:	This is the location the IFSP indicates the service is to be provided (i.e. facility etc.)
Time:	Exact duration of session. From begin time to end time . AM/PM must be indicated in order to support billing.
ICD 10 Code:	The relevant ICD 10 code as indicated on the child's evaluation.
HCPCS Code (if applicable):	Enter the Level II HCPCS code for the service or product provided by a non-health care interventionist (for example, Special Educator).
CPT Code(s):	<p>Enter the CPT code(s) as indicated by the interventionist's professional association.</p> <ul style="list-style-type: none"> • Depending on the CPT code, a session may require more than one. For example, if the same service was provided for a 30 minute session and the CPT code is for 15 minutes of service, the CPT code would be listed twice. (See Early Intervention Memorandum 2003-1).
Session Cancelled:	<p>When a session is cancelled:</p> <ol style="list-style-type: none"> 1. Indicate that the session was cancelled and document the reason under question #1.2. This is a make-up session for: If this session is a make-up session, check this box and indicate the date of the missed session.
Session Participants:	Check the box that indicates the session participants. Specify others not listed (e.g. siblings)
Parent/Caregiver unable to participate	Indicate the reason the parent/caregiver was not able to participate.
Question #1 to #5 support the interventionist in their work with the parent/caregiver and the child.	

<p>1. Describe the progress/response that the child has made toward the IFSP outcomes since the last session. Incorporate Parent/caregiver feedback.</p>	<p>The information in this section guides what will be worked on during the current session. In this session, the interventionist must document:</p> <ol style="list-style-type: none"> 1. The progress the child had made since the last visit (i.e., generalization to other routines, ease of doing, obstacles encountered, etc.) after observing the child & parent/caregiver in the routine and talking with the parent/caregiver. 2. Document feedback from the parent/caregiver as to what strategies worked and did not work. <p>The interventionist may also update information about the child/family if there are changes in medical or developmental status or in community services.</p>
<p>2. IFSP Functional Outcome(s) and Objective(s) addressed during this session:</p>	<p>Document the IFSP functional outcomes(s) and objective(s) that were worked on in this session with the child and parent/caregiver.</p> <p>Note: Ongoing discussion with the parent/caregivers about what their concerns, priorities and resources currently are will help guide the functional outcome or objective that will be worked on.</p>
<p>3. Routine Activities worked on during the session:</p> <p>Strategies used within the Routine Activities:</p>	<p>The session note must include documentation that services are being delivered within the context of the family’s natural routines and are functional for the child.</p> <ol style="list-style-type: none"> 1. The routines must be specific to the family’s cultural and social environment and are of a concern and priority for them. 2. The routine activities should include but are not limited to those listed in the functional outcomes in the IFSP. 3. It is expected that a range of family routines be documented when appropriate. Routines should not be limited to “play routines”. <p>Check off all those that were used during the session or write in the daily routine if it is not listed. Routine activities may include:</p> <ul style="list-style-type: none"> ● Activities of Daily Living (ADL) Routines which cover hygiene routines, food routines, & dressing routines; ● Play/Socialization routines; ● Community/Family routines; ● Song/Rhyme Routines; ● Book Routines; and <p>Indicate the strategies used to help the families/caregivers successfully support the child’s participation in daily activities. The following are examples of strategies:</p> <ul style="list-style-type: none"> ● Positive reinforcement at all levels; ● Parent models –child imitates; ● Verbal cues only; ● Gesture with verbal cues; ● Physical prompts; ● Hand-over-hand; ● Increased opportunities to practice; ● Modification of social or physical environment; ● Positioning; ● Adaptation of materials; ● Use of Assistive Technology; and ● Discrete trail instruction

<p>4. How did you coach (techniques) the parent/caregiver?</p> <p><i>If the parent/caregiver was unavailable, how did you work with the child and communicate with the parent/caregiver about the session?</i></p>	<p>Each family learns in different ways. Some families may not choose to participate in a session while others may choose to participate. Check off <u>all</u> coaching techniques used during the session. If a technique is not listed, please check “other” and describe the technique(s). Some techniques utilized to coach the parent/caregiver include but are not limited to the following items:</p> <ul style="list-style-type: none"> • Observed parent/caregiver and child performing activities • Discussed activity with parent/caregiver • Assisted parent/caregiver • Giving the parent a picture illustrating the way to position the child after demonstrating the method • Demonstrated parent/caregiver activity • Interventionist modeled and explained the strategy and provided feedback as parent tried the activity with the child • Videotaped learning activity and reviewed with parent • Observed parent/caregiver and child performing activities and both the parent/caregiver and the interventionist provided feedback during the session • Reviewed communication tool with parent/caregiver • Identified the methods and sequence of the activity for the parent • Generalized the strategy to other routines with the parent <p>Document the strategies that were used to work with the child when the parent/caregiver was not available or chose not to participate in the session. Indicate the methods used to communicate these strategies to the parent/caregiver.</p>
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<p>5. What learning activities did the parent/caregiver agree to do with the child before the next visit</p>	<p>A learning activity is a combination of the strategy embedded within the routine activity. Outline the sequence of the learning activity (ies) for the parent/caregiver that they have agreed to do until the next visit. Indicate here if the parent/caregiver did not agree to work on a learning activity with the reason if given and what efforts were made by the interventionist to engage the parent/caregiver.</p> <p>During each visit, the interventionist and the parent/caregiver determine and collaborate together on deciding which learning activities:</p> <ul style="list-style-type: none"> • Will be integrated into the child and family’s natural routines based on family’s comfort level and that fit seamlessly into the family’s daily routines. • Will be used to build upon the child and family’s strengths and competencies. • The family can use without the presence of the interventionist. <p>Include the following information if applicable:</p> <ul style="list-style-type: none"> • If the child is authorized an AT device, describe how the family will use the device as part of the child’s daily routine. • The framework of the strategies and whether they may be used across other natural routines when the child and family feel they have been successful. • Include recommendations of other interventionists working with the parent/caregiver and child whenever possible.
<p>Parent/Caregiver Signature and Relationship to the child:</p>	<p>The parent/caregiver signs the session note and indicates his/her relationship to the child at the end of the session. The date used is the date that the parent reviews/signs the completed note. A parent must not be asked to sign an incomplete note. *This does not apply to toddler development groups.</p>
<p>Interventionist Signature, Date and License/Certification number:</p>	<p>The interventionist signs the session note and adds his/her credentials. If certified, write “certified” and do not indicate number. The date that the session note was signed is then entered.</p> <p>This field may also include the signature, License/Certification number of a supervisor in the case of student interns, CFYs, OTAs, and PTAs, as applicable. A date should also be indicated.</p>

SESSION NOTE

Child's Name: _____ **DOB:** ____/____/____ **Sex:** Male Female **Authorization #:** _____

Interventionist's Name: _____ **Credentials:** _____ **NPI #:** _____ **Service type:** _____

Session Date: ____/____/____ IFSP Service Location: _____ Time: From ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM To ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date Note Written: ____/____/____ ICD-10 code: _____ HCPCS (if applicable): _____ 1st CPT code: _____ 2nd CPT code: _____ 3rd CPT code: _____ 4th CPT code: _____ <input type="checkbox"/> Session cancelled-reason listed in #1 <input type="checkbox"/> This is a make-up session for a missed session on ____/____/____ Session Participants: <input type="checkbox"/> Child <input type="checkbox"/> Parent/Caregiver <input type="checkbox"/> Other: _____ <input type="checkbox"/> Parent/Caregiver unable to participate during session due to: _____	Session Date: ____/____/____ IFSP Service Location: _____ Time: From ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM To ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date Note Written: ____/____/____ ICD-10 code: _____ HCPCS (if applicable): _____ 1st CPT code: _____ 2nd CPT code: _____ 3rd CPT code: _____ 4th CPT code: _____ <input type="checkbox"/> Session cancelled-reason listed in #1 <input type="checkbox"/> This is a make-up session for a missed session on ____/____/____ Session Participants: <input type="checkbox"/> Child <input type="checkbox"/> Parent/Caregiver <input type="checkbox"/> Other: _____ <input type="checkbox"/> Parent/Caregiver unable to participate during session due to: _____
1. Describe the progress that the child has made toward the IFSP outcomes since the last session. Include parent/caregiver feedback.	1. Describe the progress that the child has made toward the IFSP outcomes since the last session. Include parent/caregiver feedback.
2. IFSP Functional Outcome(s) and Objective(s) addressed during this session.	2. IFSP Functional Outcome(s) and Objective(s) addressed during this session.
3. Routine Activities worked on during the session: <input type="checkbox"/> Activities of Daily Living (ADL) <input type="checkbox"/> Play/Social <input type="checkbox"/> Community/Errand <input type="checkbox"/> Other(s): _____ Strategies used within the Routine Activities: <input type="checkbox"/> Modeling <input type="checkbox"/> Cues <input type="checkbox"/> Prompts <input type="checkbox"/> Positioning <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Other(s): _____	3. Routine Activities worked on during the session: <input type="checkbox"/> Activities of Daily Living (ADL) <input type="checkbox"/> Play/Social <input type="checkbox"/> Community/Errand <input type="checkbox"/> Other(s): _____ Strategies used within the Routine Activities: <input type="checkbox"/> Modeling <input type="checkbox"/> Cues <input type="checkbox"/> Prompts <input type="checkbox"/> Positioning <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Other(s): _____
4. How did you coach the parent/caregiver? <input type="checkbox"/> Observed Parent/Caregiver and child during routines <input type="checkbox"/> Parent/Caregiver tried activity, feedback exchanged <input type="checkbox"/> Demonstrated activity to Parent/Caregiver <input type="checkbox"/> Other: _____ <i>If the parent/caregiver was unavailable, how did you communicate with them about the session?</i>	4. How did you coach the parent/caregiver? <input type="checkbox"/> Observed Parent/Caregiver and child during routines <input type="checkbox"/> Parent/Caregiver tried activity, feedback exchanged <input type="checkbox"/> Demonstrated activity to Parent/Caregiver <input type="checkbox"/> Other: _____ <i>If the parent/caregiver was unavailable, how did you communicate with them about the session?</i>
5. What learning activities did the parent/caregiver agree to do with the child before the next visit:	5. What learning activities did the parent/caregiver agree to do with the child before the next visit:
Parent/Caregiver Signature: _____ Date: ____/____/____ Relationship to Child: _____	Parent/Caregiver Signature: _____ Date: ____/____/____ Relationship to Child: _____
Interventionist Signature: _____ Date: ____/____/____ License/Certification #: _____	Interventionist Signature: _____ Date: ____/____/____ License/Certification #: _____

**WESTCHESTER COUNTY EARLY INTERVENTION PROGRAM
SESSION NOTE**

Agency: _____

Invoice #: _____

Child's Name: _____ **DOB:** ____/____/____

Sex: Male Female **Authorization #:** _____ **Service Coordinator:** _____

Interventionist's Name: _____ **Credentials:** _____

National Provider ID #: _____ **Service type:** _____ **Frequency:** _____ mo wk

Session Date: ____/____/____ **IFSP Service Location:** _____ **Date Note Written:** ____/____/____

Time: From ____:____ AM PM To ____:____ AM PM

ICD-10 code: _____ **HCPCS (if applicable):** _____

1st CPT code: _____ **2nd CPT code:** _____ **3rd CPT code:** _____ **4th CPT code:** _____

Session cancelled-reason listed in #1

This is a make-up session for a missed session on : ____/____/____

Session Participants: Child Parent/Caregiver Other: _____

Parent/Caregiver unable to participate during session due to:

1. Describe the progress that the child has made toward the IFSP outcomes since the last session. Include parent/caregiver feedback.

2. IFSP Functional Outcome(s) and Objective(s) addressed during this session.

3. **Routine Activities worked on during the session:** Activities of Daily Living (ADL) Play/Social
 Community/Errand Other(s) : _____

Strategies used within the Routine Activities: Modeling Cues Prompts Positioning
 Assistive Technology Other(s): _____

4. How did you coach the parent/caregiver? Observed Parent/Caregiver and child during routines

Parent/Caregiver tried activity, feedback exchanged Demonstrated activity to Parent/Caregiver

Other: _____

If the parent/caregiver was unavailable, how did you communicate with them about the session?

5. What learning activities did the parent/caregiver agree to do with the child before the next visit:

Parent/Caregiver Signature: _____ **Date:** ____/____/____

Relationship to Child: _____

Interventionist Signature: _____ **Date:** ____/____/____

License/Certification #: _____

PROVIDER PROGRESS NOTE

Page ___ of ___

(Circle One) 6 month 12 month Amendment Discharge

Child's Name: _____ IFSP Period: From ___/___/___ To ___/___/___
(Last) (First)
D.O.B.: ___/___/___
Provider Agency Name: _____ Name of Interventionist: _____
License #/Certification : _____ Discipline: _____

Each Interventionist should receive a copy of this child's IFSP and evaluations immediately upon assignment to work with the child. It is the joint responsibility of the Service Coordinator and the service agency supervisor to ensure prompt delivery of these documents to the interventionist, and it is the responsibility of the interventionist to follow up with his/her agency supervisor if the documents are not received within two weeks of assignment.

Service Type/Frequency/Duration: _____ Therapist's Service Start Date: ___/___/___

If there are any gaps in service delivery (i.e., 3 or more consecutively scheduled visits), describe length and reason for gap in service delivery. _____

IFSP OUTCOME(S): _____ **RATE OF PROGRESS IN THIS TIME PERIOD**

	No Progress	Little Progress	Moderate Progress	Great Deal of Progress	Outcome Achieved
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How did you work with the family to help the child reach this outcome? _____

IFSP OUTCOME(S): _____ **RATE OF PROGRESS IN THIS TIME PERIOD**

	No Progress	Little Progress	Moderate Progress	Great Deal of Progress	Outcome Achieved
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How did you work with the family to help the child reach this outcome? _____

IFSP OUTCOME(S): _____ **RATE OF PROGRESS IN THIS TIME PERIOD**

	No Progress	Little Progress	Moderate Progress	Great Deal of Progress	Outcome Achieved
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How did you work with the family to help the child reach this outcome? _____

PROVIDER PROGRESS NOTE

(Circle One) 6 month 12 month Amendment Discharge

Child's Name: _____ IFSP Period: From ___/___/___ To ___/___/___ (Last) (First)
--

1. Provide a description of progress; in addition, please estimate the percentage of delay at the end of the 6 month and 12 month period and state how that was determined, e.g., criterion referenced instrument, developmental checklist, or clinical opinion. (Standard deviation scores or formal evaluations are not required.)

2. List any factors that limit the collaboration between parent and interventionist. How have you addressed these factors? Be specific.

3. How have you used feedback from the family to help you modify how you work with the family? Be specific and provide examples.

4. Recommendations (include here any new IFSP outcomes, or changes in strategies and activities):

I certify that I have received a copy of the child's IFSP (and evaluation if available). I have provided the services described above in accordance with the frequency and duration mandated by IFSP, and have worked toward addressing the relevant outcomes set forth in the IFSP. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of Interventionist completing report: _____ Date: ___/___/___

License #/Certification : _____

PROGRESS NOTE INSTRUCTIONS

Please Note: Effective April 1, 2014, Westchester County EIP has eliminated the requirement for quarterly progress notes.

1. Providers must complete progress notes in preparation for the child's 6 month and Annual IFSP(s). Notes need to be completed and submitted to the child's OSC **three (3) weeks prior** to the expiration of the child's current IFSP period.
2. Progress Notes are also required to be completed:
 - When an interventionist is recommending a change in the current IFSP
 - When an interventionist is recommending a supplemental evaluation
 - Upon discharge from the EIP
 - Upon discharge from an EI interventionist's caseload
 - Upon request of an EIOD
3. The form should be completed as follows:

PAGE 1 – Interventionist

Circle the appropriate reason for the report.

Child's Name: Make sure that the child's name is the same as the EI record.

IFSP Period: The term of the current IFSP.

DOB: Child's date of birth

Provider Agency Name: Agency for which the interventionist works.

Interventionist: Name of the interventionist who is completing this progress note.

License#/Certification: Indicate license # or if certified write "certified" and do not indicate number

Discipline: Interventionist's discipline, e.g. Speech therapist, Occupational therapist, etc.

Service Type: The service the interventionist is delivering.

Authorization Frequency: How often the service is authorized.

Service Start date: The date on which the interventionist began his or her work with the child.

If gaps in service delivery: Document the extent and reason.

IFSP Outcomes: The outcomes from the IFSP that have been addressed during the 6 month period. Similar outcomes may be grouped, e.g., outcomes that require similar skills, etc.

Rating: How much progress has been made in achieving the IFSP outcome(s) noted.

How did you work with the family: The techniques and strategies used with the family to achieve the outcome.

Repeat as needed for all outcomes that are applicable to the interventionist completing the form. Use additional sheets as needed.

PAGE 2 – Interventionist

Question 1. Describe the child's progress and level of functioning. Estimate the percentage of delay, and describe how you determined it. This can be done based on clinical opinion; the ongoing work and regular informal assessment of the child's needs; and/or the use of a developmental checklist or criterion referenced instrument. Formal evaluations are not necessary. Standard deviation scores may be used, but are not necessary. Age equivalents may be used, if used appropriately.

Question 2. List any issues or factors that have limited the collaboration between the interventionist and those who are an important part of the child's daily life. Describe the steps taken to overcome the particular barriers. Have these strategies been successful, or are new plans needed to help the family become involved?

Question 3. Provide information about the parent/caregiver feedback to the therapist regarding how well the activities worked when the therapist was not present. Were modifications based on this feedback successful, or are further modifications necessary?

Questions 4. Make recommendations for new IFSP outcomes, changes in strategies and activities, and continuation, termination, or change in type of service for the next 6 months. Recommendations for service must be consistent with the need documented in Question #3. Recommendations should include plans for parent/caregiver involvement.

Answer all questions completely.

REVIEW THE ATTESTATION – If, for any reason, the interventionist does not have the child's IFSP, cross out and initial that part of the attestation: "I certify that I have received a copy of the child's IFSP (and evaluation if available)..." Indicate below the attestation what has been done or will be done to obtain a copy of the child's IFSP. No other part of the attestation may be crossed out.

Sign and date the report. Include interventionist's license#/certification.

Chapter 7: Respite

Westchester County Department of Health
Early Intervention Program
Respite Services

Early Intervention Respite Services

The Early Intervention Program includes provisions for respite services for families of eligible children. Respite services are reimbursed via special funds from the State Department of Health to municipalities on an annual basis. Westchester County Department of Health will prioritize the allocation of respite hours to those families with the greatest need based on the criteria in NYSDOH Early Intervention Regulations §69-4.18.

Respite is temporary relief for parents/guardians from care giving responsibilities. It is intended to provide support to parents/guardians who may otherwise be overwhelmed by the intensity and constancy of care giving responsibilities that may be necessary for an infant/toddler with special needs.

Respite is Not:

1. To replace or supplant those services which other agencies would supply. (That is, the daycare or homemaker services supplied by Department of Social Services (DSS) and/or Mandated Preventative Services (MPS) for eligible families);
2. To replace or substitute for ongoing daycare or baby-sitting during hours when parents are working;
3. To replace normal child or family care for non-eligible family members (i.e. child care for non-disabled children so the parent/guardian can be with the disabled child; or for a mother's helper);
4. To replace or supplement nursing services under Care At Home or other waiver programs;
5. To replace or substitute for routine babysitting.

Determining Eligibility for Respite Services

Application for respite services will be determined based on:

- (1) *severity of child's disability and needs;*
- (2) *potential risk of out-of-home placement for the child if respite services are not provided;*
- (3) *lack of access to informal support systems (e.g. extended family, supportive friends, community supports, etc.);*
- (4) *lack of access to other sources of respite (e.g. family support services under the auspices of the Office of People with Developmental Disabilities and respite provided through other state early intervention service agencies), due to barriers such as waiting lists, remote/inaccessible location of services, etc.;*

(5) *presence of factors known to increase family stress (e.g. family size, presence of another child or family member with disability, etc.); and*

(6) *the perceived and expressed level of need for respite services by parent (NYSDOH Early Intervention Regulations § 69-4.18).*

The availability of respite and the family's needs and eligibility for such services will be discussed by the IFSP team at the Individualized Family Service Plan (IFSP) meeting, 6-Month Review or at any time a need is identified. If the family meets eligibility criteria for respite services, the Ongoing Service Coordinator for the family will submit the following completed forms to the EIOD:

- RESPITE REQUEST FORM
- RESPITE MODEL REQUEST FORM

EIOD and IFSP team will:

1. Review the respite request.
2. Determine whether the respite application meets eligibility criteria.
3. If approved, EIOD completes the RESPITE SERVICE PLAN section of the request form which delineates number of hours authorized, and the start and end dates for respite service and submits the plan to WCDH EIP operations staff.
 - WCDH operations staff will create the Respite authorization in NYEIS and generate an authorization letter to send to the approved respite provider. WCDH staff will upload the Respite Request Form and the Respite Authorization letter to the child's current IFSP in NYEIS. For children in KIDS the original will be returned to the EIOD and a copy will be sent to the OSC.
4. If Respite is not approved the EIOD sends a denial letter to the family and OSC along with WCDH Notice of Child and Family Rights.
 - OSC will work with the family to link them with appropriate community resources.
 - If there is a change in the individual needs of the child and family the OSC works with the family to reapply for respite services.

Upon receipt of the RESPITE SERVICE PLAN and AUTHORIZATION LETTER, Respite Provider Agency will:

1. Contact the parents by phone within five (5) business days.
2. Inform the parents about the procedures they will be required to follow.
3. Monitor the start and end dates of the respite services as indicated on the AUTHORIZATION LETTER and RESPITE PLAN.

No payments will be made to provider agencies for Respite hours that exceed the number of hours authorized or that occur outside the end date indicated on the AUTHORIZATION LETTER and RESPITE PLAN.

Billing claims for Early Intervention Respite Services must be submitted to:

Westchester County Department of Health
Early Intervention Program/Operations Unit
145 Huguenot Street 7th Floor
New Rochelle, NY 10801

Claims must include the following:

1. Westchester County Department of Health Provider Invoice Form
2. Monthly Respite Service Status Report
3. Copies of agency specific forms that either the family or respite worker completes in order to report and claim the Respite hours used

RESPITE REQUEST FORM

(To be completed by the Ongoing Service Coordinator.)

CHILD'S NAME(S): _____ DOB: _____

PARENT'S NAME: _____ IFSP DATES (START/END): _____

EIOD: _____ Ongoing Service Coordinator: _____

Agency: Westchester County Dept. of Health Agency: _____

Telephone #: 914-813- _____ Telephone #: _____

DATE OF SUBMISSION: _____ RESPITE MODEL REQUESTED: _____

NEW EXTENSION RE-APPLICATION*

RESPITE SERVICE PLAN
(This section to be completed by the EIOD.)

RESPITE PROVIDER AGENCY: _____

*START DATE: _____ END DATE: _____

* Please note gap in authorized service dates. (Check if applicable on re-application)

TOTAL RESPITE HOURS: _____

RECOMMENDED RESPITE SCHEDULE: _____ HOURS PER WEEK OR MONTH
(pick one)

RECOMMENDED RESPITE DURATION: _____ WEEKS OR MONTHS
(pick one)

OTHER RECOMMENDATIONS/COMMENTS: _____

APPROVED DENIED, DOES NOT MEET CRITERIA Resubmit with additional information

Date Reviewed: _____

CC: EIOD
CSN Operations
Ongoing Service Coordinator
Respite Provider Agency

For CSN Operations Use Only

\$ _____ + \$ _____ X _____ X _____
Family Rate/Hr Agency Admn Fee/Hr # of hours # of wks/mos

Total Respite = \$ _____

Amount allocated to each sibling = \$ _____

RESPITE REQUEST FORM

(To be filled out by Ongoing Service Coordinator in collaboration with family.)

The state law which established the Early Intervention Program included provisions for respite services to eligible children. The Westchester County Department of Health will prioritize the allocation of respite hours to those families with the greatest need based upon the following criteria: (1) severity of child's disability and needs; (2) potential risk of out-of-home placement for the child if respite services are not provided; (3) lack of access to informal supports; (4) lack of access to other sources of respite; (5) presence of factors known to increase family stress; and (6) the perceived and expressed level of need for respite services by parent [PHL Article 25 Title II-A Section 69-4.18].

Reminder: Family members are not reimbursed as respite providers.

Child's Name: _____

If this is a **re-application** for respite, elaborate on the details of the CURRENT situation which will justify the request for additional respite hours, including changes in family composition and child's needs since the last request. Please include the following information:

1. Explain, in detail, the severity of the child's disability and needs, including any current medical diagnosis and conditions that currently require treatment by a physician and/or parent and the frequency of treatment; behavioral intervention or management by the parent beyond the needs of a typically developing child; the level of care and involvement required by the child that is prompting the parent to request temporary relief of care-giving of the disabled child. Indicate the level of need based upon the respite criteria stated above.

2. Indicate what supports are currently available to the family such as: in-home child care; babysitter; nanny; extended family members in the area; community resources; Waiver programs; social services; etc. Explain in detail the programs that have been accessed and/or your plan to link families to informal and formal supports in their community with specific names of agencies and the service they will provide to the family. The information you provide in this section will update the IFSP team on current viable supports that are available to families.

3. Considering the above information and following a discussion of the purpose of respite with the family, please state how the family plans to use the respite time (e.g. attend a support group). This will be helpful to the IFSP team when deciding the appropriate number of respite hours.

RESPITE MODEL REQUESTED: _____

RESPITE PROVIDER'S NAME: _____

RESPITE PROVIDER'S RELATIONSHIP TO THE FAMILY: _____

Note: OSC documentation of the conversation with the parent(s) is required in the OSC notes.

RESPITE MODEL SELECTION FORM

※ ※ Indicate with an “X” the family’s respite model selection ※ ※

DAY RESPITE SERVICES

Model I: Family recruits own respite worker

- Model D-I (a):
Family recruits own respite worker and pays the worker; Contractor reimburses the family.
- Model D-I (b) – (RN):
Family recruits a Registered nurse and pays the nurse; Contractor reimburses the family.
- Model D-I (c) – (LPN):
Family recruits a Licensed Practical Nurse, pays the nurse, and Contractor reimburses the family.
- Model D-I (e) – (2 or more EI children in Family):
Family recruits own respite worker for Early Intervention eligible twins or two or more Early Intervention eligible children in the same family and Contractor reimburses the family. Hours are allocated to family, not individual children.

Model II – Provider Respite Worker

- Model D-II(a):
Contractor assigns respite worker to the family and pays the worker.
- Model D-II(b)-(RN):
Contractor assigns a Registered Nurse and pays the nurse.
- Model D-II(c)-(LPN):
Contractor assigns a Licensed Practical Nurse and pays the nurse.

Model III – Day Respite provided by and in home of Certified Family Care Provider

- Contractor provides family with a list of Certified Family Care Providers from which to choose.

Model IV – Facility Based Provider

- Contractor will provide respite in their facility.

OVERNIGHT RESPITE SERVICES

Overnight respite is limited to two (2) consecutive nights, twice per year, per family.

Model I: Direct Family Reimbursement

- Model OV-I (a):
Family recruits own worker for overnight respite care; Contractor reimburses the family.
- Model OV-I (b):
Family recruits own RN or LPN for overnight respite care; Contractor reimburses family.
- Model OV-I (c): (Two or more EI children in Family)
Family recruits own respite worker for Early Intervention eligible twins or two or more Early Intervention eligible children in the same family and Contractor reimburses the family. Hours are allocated to family, not individual children.

Model II: Provider Respite Worker

- Model OV-II (a):
Contractor assigns a respite worker to the family for overnight respite and pays the worker
- Model OV-II (b):
Contractor assigns RN, LPN, for overnight respite care. Contractor pays the RN or LPN
- Model OV-II (c): (Two or more children in Family)
Contractor assigns worker for two or more children in the family and pays the worker.

Model III – Facility Based Services

- Model OV-III:
Provider agency provides overnight respite in their facility.

Please Note: Availability of models contingent upon WCDH contracted agencies.

Robert P. Astorino
County Executive

Sherlita Amler, M.D.
Commissioner of Health

RESPITE DENIAL LETTER

Dear _____,

Date: _____

Your family recently applied for respite service under Westchester County Department of Health's Early Intervention Program. Respite is a temporary service available to Early Intervention Program families who are experiencing significant stress due to caring for their child with special needs. All applications are carefully reviewed. At this time, your application for respite does not meet the criteria for provision of respite services in accordance with NYSDOH Early Intervention Regulations § 69-4.18:

- (b) The provision of respite services for an eligible child and family shall be determined in the context of IFSP development, based on the individual needs of the child and family, and with consideration given to the following criteria:
- (1) severity of child's disability and needs;
 - (2) potential risk of out-of-home placement for the child if respite services are not provided;
 - (3) lack of access to informal support systems (e.g. extended family, supportive friends, community supports, etc.);
 - (4) lack of access to other sources of respite (e.g. Family Support Services under the auspices of the Office of People with Developmental Disabilities and respite provided through other State early intervention service agencies), due to barriers such as waiting lists, remote/inaccessible location of services, etc.;
 - (5) presence of factors known to increase family stress (e.g. family size, presence of another child or family member with a disability, etc.); and
 - (6) the perceived and expressed level of need for respite services by parent.

If your family would like to re-apply for respite at a future date, please contact your Ongoing Service Coordinator.

Regards,

Early Intervention Official Designee

cc: Ongoing Service Coordinator

MONTHLY RESPITE SERVICE STATUS REPORT

PROGRAM YEAR:

RESPITE AGENCY:

REPORTING MONTH/YEAR:

CHILD'S NAME	AUTHORIZATION NUMBER	AMOUNT AUTHORIZED		BILLED THIS MONTH		BILLED YEAR TO DATE		BALANCE	
		UNITS*	\$	UNITS*	\$	UNITS*	\$	UNITS*	\$
				TOTAL AMOUNT BILLED THIS MONTH					

* UNITS = HOURS

MONTHLY RESPITE SERVICE STATUS REPORT

PROGRAM YEAR: **B**

RESPITE AGENCY: **A**

REPORTING MONTH/YEAR: **C**

CHILD'S NAME	AUTHORIZATION NUMBER	AMOUNT AUTHORIZED		BILLED THIS MONTH		BILLED YEAR TO DATE		BALANCE	
		UNITS*	\$	UNITS*	\$	UNITS*	\$	UNITS*	\$
D	E	F	G	H	I	J	K	L	M
TOTAL AMOUNT BILLED THIS MONTH				N	O				

* UNITS = HOURS

INSTRUCTIONS FOR COMPLETING
THE MONTHLY RESPITE SERVICE STATUS REPORT

- A - Indicate the name of the Respite Agency
- B - Indicate the Program Year which is being reported. The Respite Program Year always runs from October 1st of one year to September 30th of the following year.
- C - Indicate the month and year which is being billed.
- D - Indicate the child's name.
- E - Indicate the child's Authorization Number for Respite.
- F - Indicate the amount of units (hours) authorized for the child.
- G - Indicate the dollar amount of Respite authorized for the child.
- H - Indicate the amount of units (hours) billed this month for the child.
- I - Indicate the dollar amount billed this month for the child.
- J - Indicate the amount of units (hours) billed year-to-date for the child.
- K - Indicate the dollar amount billed year-to-date for the child.
- L - Indicate the balance of units (hours) left for the child [Amount Authorized minus Amount Billed Year-To-Date].
- M - Indicate the balance of dollars left for the child [Amount Authorized minus Amount Billed Year-To-Date].
- N – Indicate the amount of units (hours) billed this month for the child.
- O - Indicate the dollar amount billed this month for the child.

Note: Attach additional sheets as needed to complete the monthly billing. Providers are not required to use the Westchester County Monthly Respite Service Status Report form. They may submit their own form as long as it contains the same information.



WESTCHESTER COUNTY DEPARTMENT OF HEALTH

INVOICE For Children with Special Needs Providers

INVOICE # **000**

VENDOR # **A**

VENDOR NAME **B**

CONTRACT # **C**

PAYMENT **D**
ADDRESS _____

SERVICE DATE	DESCRIPTION OF SERVICE	QUANTITY	UNIT PRICE	AMOUNT
E	F	G	H	I
				J

VENDOR CERTIFICATION

I certify that the above bill is just, true and correct, that no part thereof has been paid except as stated and that the balance is actually due and owing, and that taxes from which the County is exempt are excluded. By submission of this Invoice the Vendor hereby agrees to retain on file any and all documentation supporting this claim for the longer of a period of three years or the period specified by written agreement between the County and the Vendor. Vendor further agrees upon request to make such documentation available for audit and inspection during normal business hours.

 K
DATE

 L
SIGNATURE

 M
TITLE

 N
FED ID # / SOCIAL SECURITY NO.

 O
VENDOR PHONE NO.

 P
VENDOR FAX NO.

DOH USE ONLY

INSTRUCTIONS FOR COMPLETING THE PROVIDER INVOICE:

A - VENDOR #	Can be found on your Westchester County Check Stub
B - VENDOR NAME	Agency name
C - CONTRACT #	Can be found on your agency's executed contract
D - PAYMENT ADDRESS	Indicate agency address to which the check will be mailed to
E - SERVICE DATE	Month and year you are billing for (i.e. July 2014). There is no need to write out each individual service date.
F - DESCRIPTION OF SERVICE	Respite
G - QUANTITY	Indicate the total amount of units (hours) agency is billing for
H - UNIT RATE	Indicate the rate per hour
I - AMOUNT	Indicate the total dollar amount (Quantity x Unit Rate)
J - TOTAL	Indicate the total amount billed on that particular invoice (add all the totals in the amount column).
K - DATE	Indicate the date the invoice was prepared and signed
L - SIGNATURE	Indicate the agency administrator or designee preparing the invoice
M - TITLE	Indicate the title of the person signing the invoice
N - FED ID #/ SOC SEC #	Agency Federal Tax ID Number
O - VENDOR PHONE NO.	Agency telephone number
P - VENDOR FAX NO.	Agency fax number

Note: You may retain the PINK copy for your records. The WHITE and YELLOW copies of the Provider Invoice must accompany the required back-up documents.

Chapter 8: Assistive Technology

New York State Department of Health
Bureau of Early Intervention

Assistive Technology

Overview and Process: A Provider's Perspective

www.pcghumanservices.com

Early Intervention Assistive Technology Process

- The need for an Assistive Technology Device (ATD) is identified during the IFSP meeting and the ATD is placed in the IFSP. The Service Coordinator (SC) incorporates updates in the child's record when needed and creates authorizations for ATD visits.
- The SC and therapist assist the family to obtain the ATD. When feasible, the ATD will be obtained on loan through the Technology Related Assistance for Individuals with Disabilities (TRAID).Center. Otherwise, the therapist completes a ***NYS Early Intervention Program Assistive Technology Medical Necessity Justification Form*** (Justification Form) and sends this with the physician's orders to the SC. The SC mails the original ATD request to the EIOD for approval.
- The EIOD reviews the ATD request for completeness and approves the Assistive Technology Device by signing the bottom of the Justification Form. The EIOD gives the ATD request to CSN Operations.
- Operations staff creates the service authorization and forwards the ATD request to the PCG Assistive Technology Coordinator (ATC).
- The ATC obtains competitive pricing, selects ATD vendor and communicates that information to CSN Operations.
- The ATD vendor will collaborate with the therapist/facility/family for measurements, etc. when necessary. ATD vendor receives a purchase authorization from the ATC and fabricates the device or processes the order.
- ATC forwards a copy of the purchase authorization and the delivery/dispensing information to Operations and this is distributed to the EIOD for inclusion in the child's record.
- ATC forwards a copy of the purchase authorization and the delivery/dispensing information to the SC who will notify the parent and therapist of the estimated delivery/dispensing date.
- The ATD vendor and therapist will collaborate and coordinate on the delivery date. Upon delivery of the ATD, the Individual Rendering Provider/Therapist is responsible for completing the ***NYS Early Intervention Program AT Notification of Item Delivery, Condition and Status Form*** (sample form and directions attached) with the parent and forwarding this to the child's SC no later than two (2) weeks after the device has been delivered.
- The Service Coordinators forward the ***NYS Early Intervention Program AT Notification of Item Delivery, Condition and Status Forms*** directly to the Municipality Operations staff via the secure Assistive Technology Fax line- 914-813-4453. FORMS ARE NOT SENT TO THE EIOD
- The Municipality Operations staff notifies the PCG ATC and distributes to the EIOD for inclusion in the child's record.
- The PCG ATC releases payment to the ATD vendor.
- In future visits, the therapist and SC should discuss with the family any question or concerns regarding the device and that the device is providing the desired benefit for the child.
- Routine adjustments or questions should be directed to the ATD vendor by the family in consultation with the therapist. Concerns regarding the quality of the device should be directed to the SC who will communicate to the ATC and keep the EIOD informed.

Contact Information:

PCG Assistive Technology Coordinator (ATC) – Sherree Sinclair – ssinclair@pcgus.com

NYS Early Intervention Program Assistive Technology Medical Necessity Justification Form

Service Providers: The Individual Rendering Provider must complete the form below for each requested category of Assistive Technology Devices (ATD). Service providers should contact their regional TR Aid Center and/or Municipality Lending Closet to determine ATD availability and document the outcome in order for the ATD category to be considered for authorization through the EIP. Submit this completed form, the physician's order/recommendation, and the most current Progress Note written by the Individual Rendering Provider who is recommending the ATD to the child's Service Coordinator within 1 week of obtaining all of these required elements. A complete submission is required in order to support Medicaid and private insurance billing. If additional pages are included, indicate which question is being answered.

Service Coordinators: Fax the completed ATD packet to the assistive technology contact or Early Intervention Official in your municipality.

Child's Name: _____	DOB: ____/____/____
EI #: _____	Service Type: _____
Service Location: _____	
Child's Diagnosed Condition(s): _____	
ICD-9 Code(s): _____	
Individual Rendering Provider's Name: _____	
Credentials: _____	
<p>1. On what date did you contact the TR Aid Center Loan Closet and/or Municipality Lending Closet & which did you contact? (required) _____</p> <p><input type="checkbox"/> A short-term loan will be provided until the requested device, if approved, is ordered and delivered to the family.</p> <p><input type="checkbox"/> A long-term loan will be provided for the duration of the child's anticipated use.</p> <p style="margin-left: 40px;">▪ Anticipated provision date: _____</p> <p style="margin-left: 40px;">▪ Anticipated length of loan: _____</p> <p><input type="checkbox"/> TR Aid/Municipality Lending Closet was contacted - device is not available.</p>	
<p>2. Requested ATD category/device:</p> <p>2a. List each accessory of the ATD device requested. Justify why each accessory is required to meet the child's current functional skills and ensures the child's safe and functional use of the ATD:</p> 	
<p>3. List the existing and new (if necessary) functional IFSP outcomes that the requested ATD will address:</p> 	
<p>4. Describe how the ATD will help the child increase, maintain or improve his/her functional capabilities and meet his/her unique developmental needs and the IFSP functional outcomes:</p> 	
<p>5. Indicate any precautions related to the child's medical/developmental condition(s) that may impact the safe use of the device:</p> 	

6. Describe how the ATD will be integrated into the child's and the family's natural routines (include the settings where the device will be used, the routine activities, and the frequency with which the device will be used):

7. What lower-tech devices have you and the family discussed or used prior to this request? Explain why they are not appropriate for this child:

8. Identify any other ATD's and/or adaptive items currently used by other Individual Rendering Providers, family, or by you, and describe how the requested ATD may be used with them and any other requested ATD:

9. Describe how you will collaborate with the other Individual Rendering Providers serving this child and family (in the same setting or across settings) in the use of the proposed ATD category (if no other Individual Rendering Providers are serving this child, write "Not Applicable"):

10. List the parents/caregivers that require training on the device, and list the specific items that need to be addressed in that training to ensure the parents'/caregivers' safe and functional use of the ATD:

I understand and agree that if any ATD equipment is authorized for my child, I will not use the delivered device or allow my child to use the device until my therapist has instructed me in its safe and appropriate use.

Parent/Caregiver Signature: _____ Date: ____/____/____

Individual Rendering Provider Signature: _____ Date: ____/____/____

License/Certification #: _____ Phone Number: _____

**NYS EARLY INTERVENTION PROGRAM
ASSISTIVE TECHNOLOGY MEDICAL NECESSITY FORM INSTRUCTIONS FOR COMPLETION**

GENERAL DIRECTIONS

The Individual Rendering Provider is required to complete this form for each device being requested and submit it to his/her EI agency's AT Agency Coordinator, if applicable, for submission to the child's Service Coordinator. The Individual Rendering Provider is responsible for contacting their regional TRAIID (Regional Technology Related Assistance for Individuals with Disabilities) Center or Municipality Lending Closet to inquire about device availability. Documentation of the outcome of this discussion is required for this device to be considered for authorization by the municipality EIP. If you attach additional pages, please indicate which question(s) you are answering. All questions are required and must be answered fully.

Child's Name, EI #, DOB,	Ensure that all identifying information is correct. The EI# is the child's reference number identified in NYEIS/KIDS. Information must match the information in NYEIS/KIDS (do not use alternate/nicknames).
Service Type, Service Location	Indicate the service type rendered by the recommending therapist and service location.
Child's Diagnosed Conditions, ICD-9 Codes	Indicate the child's diagnosed medical and/or developmental condition(s). ICD-9 codes are required to correspond to diagnosed conditions (e.g., ASD, 299.0).
Individual Rendering Provider's Name, Credentials	Provide the name and credentials of the current Individual Rendering Provider that is completing this form and recommending this device (e.g., speech therapist: Speech/language Pathologist, MS, CCC/SP). If you are a certified professional, indicate "certified" and <u>do not</u> write the certification number. OTAs must include the license number of their supervisor.
The TRAIID Center Loan Closet or Municipality Lending Closet	TRAIID Center Loan Closets or Municipality Lending Closets are equipped with ATD specifically for children eligible for the Early Intervention Program. Equipment from a loan closet may be provided to the child and family on either a short-term basis to determine the appropriateness of a device for the child or for the duration indicated in the child's IFSP. The availability of the device and timeframe of this loan is dependent on the Closet's resources. All devices loaned through the Closets must be returned to the Closets in accordance with the terms of the loan.

Question #1: Contact with the TRAIID/Municipality Lending Closet is a required part of all ATD requests.

1. On what date did you contact the TRAIID Center Loan Closet or Municipality Lending Closet?	Indicate the date of your call to the TRAIID Center Loan Closet/Municipality Lending Closet. Check off one of the following outcomes and add the relevant information. The TRAIID Center Loan Closet (TCLC)/Municipality Lending Closet has confirmed that: a. A short-term loan is available. b. A long-term loan is available. i. Provide the loaner begin date (from the Closet to the family) ii. Provide the Closet's timeframe (begin date to return date) for the loan of this device c. The device is unavailable for short-term or long-term loan by the Closet.
--	--

Questions #2 to #12: Document the ATD request and justify how it is necessary to maintain or improve the functional capabilities of the child.

- 2. Requested ATD category**
- Indicate the category of ATD requested for this child.
 - Refer to the chart below for examples of common ATDs (Note: This list is meant to provide examples and is not exhaustive).

	ATD Category
DME - Independent Mobility, Positioning, DME ADL, Seating and Transport Devices	Crawler Gait Trainer/Walker Orthopedic Car Seat Pediatric Wheelchair Positioning System and Wedges Seating Stander Adaptive Stroller Adaptive Toileting and Adaptive Potty Systems
DME - Head Support	Protective Helmet Un-mounted and Mounted Head Supports
Hearing	Hearing Aid(s) and Amplification Accessories FM System and FM System Accessories

Orthoses	Orthoses (KAFO, SMO, UCBL, AFO, Orth. Shoes) Orthoses (WHO, elbow) Orthoses (Theratogs/Benik/TLSO/Hip Holders/SPIO)
Vision	Eyeglasses (incl. sunglasses/protective)

2a. List each accessory of the ATD requested. Justify why each accessory is required to meet the child’s current functional skills and ensures this child’s safe and functional use of the ATD:

- a. List each requested accessory of the selected ATD.
- b. Justify the need for each individual accessory.
 - i. A justification is required to explain how each accessory will support this individual child’s functional abilities and skills and safe and optimal use of the device. For example, the Individual Rendering Provider may recommend a stander:
 - The Individual Rendering Provider must identify how the stander will support the child’s gross motor skills and functional abilities, and
 - Based on the identified functional capacities, the Individual Rendering Provider also determines all accessories required to meet the child’s safe and optimal use of the device

For example, the ATD category is Seating. Based on the needs of the child, a justification for each accessory for the Seating such as a pelvic harness, a head rest, or side pads should include how it supports the child’s skills and ensures the child’s safety and optimal utilization of the ATD.

If the therapist is unsure of the specific item(s) needed, the therapist should describe the child’s functional capabilities and what the therapist believes need to be supported or enhanced.

3. List the existing IFSP functional outcomes, as well as any new functional outcomes added since the IFSP, that the requested ATD category will address:

- a. ATD should facilitate the attainment of the IFSP functional outcomes included in the child and family’s Individualized Family Service Plan (IFSP).
 - i. Document the current IFSP functional outcome(s) that will be addressed with the requested device category and any new functional outcomes that will be developed related to this device.
 - ii. New outcomes are required to be written in the appropriate functional outcome format, using the following 6 components of a functional outcome:

Who: This is usually the child but may include the parent or family.

Will do what: This is what the child will do (that is reasonable for the next 6 months).

Criteria for success: This is how everyone on the team including the parents/caregivers will know that the outcome has been met. It should be observable. It should not be described in percentages or ratios or as more or less.

Under what condition: This is any specific situation or adaptation (e.g., physical prompt by parent, special spoon for meal times) that is reasonable. When this is not indicated in the outcome, it is assumed to be 100% independence.

Routine activity: This is an event that typically occurs during the child’s day and is individualized by the family’s culture and environment.

“So that”: This is what the family would like to achieve or the reason why it is important.

For example:

| Justin | will eat an entire meal | using an adaptive spoon | during all | meal times | so that he can feed himself.
(who) (will do what) (under what condition) (criteria for success) (routine activity) (why it is important to the family)

4. Describe how the ATD category will help the child increase, maintain or improve the child’s functional capabilities and meet his/her unique developmental needs and the IFSP functional outcomes:

- a. Document how the requested assistive technology category meets the child’s current and specific developmental needs, functional abilities, and family priorities.
 - i. Highlight how the requested device category will help increase, maintain, or improve the child’s functional capabilities.
 - ii. **This section should explain how the ATD device category is developmentally relevant to the child’s functional capacities and supports the achievement of the IFSP functional outcomes and family priorities.**

5. Indicate the precautions related to the child’s medical/developmental condition that may impact the safe use of the device:

- a. Document all confirmed and prospective contraindications for use of the selected device category; and
- b. Document how the child’s medical conditions and developmental status will affect how the device is used and/or how often it is used.

6. Describe how the ATD category will be integrated into the child’s and the family’s natural routines (include the settings where the device will be used, the routine activities, and the frequency with which the device will be used):

- a. The Individual Rendering Provider is required to assess and document how the ATD category will be used within the context of the family's natural routines, and with respect for the family's cultural, physical and social environments.
- b. In selecting a device category, the following criteria must be considered:
 - i. When the device category will be used by the child in each of a variety of settings (at home and in the community);
 - ii. How safety concerns will be addressed so that the device category will be safely used within each setting, including how it will be transported safely; and
- c. When the device category provides a dual function, (e.g., a seating device that also functions as a transport device, based on an interchangeable accessory), documentation is required to illustrate the family's ability to modify the device for safe dual functionality and ease of use.

7. What lower tech devices have you and the caregivers discussed or used prior to this request? Explain how they would or would not be appropriate for this child:

- a. ATD ranges from low technology to high technology.
- b. The Individual Rendering Provider must document the process by which the device range or level was chosen. This documentation should include:
 - i. A discussion of which lower technology device was considered and, as appropriate, used by the child and family on a trial basis. Describe the outcome(s) of using the lower technology device.
 - ii. The rationale for why a lower technology device category is not being proposed.

8. Identify any other ATD categories and/or adaptive items currently used by you, other Individual Rendering Providers, and parents/caregivers; and describe how the requested ATD category may be used with them and any other requested ATD devices:

- a. Consideration must be given to any other ATD that the child may already have or will obtain, to determine whether multiple devices are essential to meet the child's functional outcomes, and, if so, to ensure compatibility of the devices or systems with one another.
- b. The Individual Rendering Provider is required to identify and document any device categories currently used with the child by:
 - i. The recommending Individual Rendering Provider (you);
 - ii. The other Individual Rendering Providers on the team; and
 - iii. The parents/caregivers/family.
- c. When a device category other than the one being requested now is currently being utilized, the Individual Rendering Provider is required to document:
 - i. How the requested device category will be used in conjunction with any current device; and
 - ii. Who will use the requested device with the child (other Individual Rendering Providers, parents/caregivers, others).

9. Describe how you will collaborate with other Individual Rendering Providers (in the same setting or across settings) in the use of the proposed ATD category:

- a. Document what was discussed with the other Individual Rendering Providers (and with any other service providers) about:
 - i. The child's use of the device category in applicable settings/locations;
 - ii. The family's routine activities in which the device category should be used;
 - iii. The child's functional abilities and skills that the device category is intended to support; and
 - iv. For the EI team members, the IFSP functional outcomes the ATD category will address.

10. List the parents/caregivers that require training on the device, and list the specific items that need to be addressed in that training to ensure the parents'/caregivers' safe and functional use of the ATD category:

- a. Who are the parents/caregivers that will be trained on the requested device category?
- b. List all of the areas that the training will cover, including precautions to ensure the safe and effective use of the device category.

Signature

The parent/caregiver and the Individual Rendering Provider are both required to sign this form. Please include the Individual Rendering Provider's license # and direct contact information, such as a cellular phone number. Do not write in the provider agency's phone number.

**NYS EARLY INTERVENTION PROGRAM
 ASSISTIVE TECHNOLOGY NOTIFICATION OF ITEM DELIVERY, CONDITION & STATUS**

This form is required to document that the assistive technology device (ATD) has been delivered as authorized, and to document any issues with the device.

- The Individual Rendering Provider is responsible for completing this form with the parent **no later than one (1) service sessions** after the device has been delivered or at time of delivery.
- The Individual Rendering Provider or AT Agency Coordinator, if applicable, is responsible for sending this form to the child's Service Coordinator **no later than two (2) weeks** after the device has been delivered.
- Service Coordinators must fax this form to the assistive technology contact or Early Intervention Official of their municipality **within two 2 business days** of receipt.
- The Assistive Technology contact or Early Intervention Official will forward this form to the PCG Assistive Technology Coordinator **within 1 business day** of receipt (fax: 1-518-935-9258 or email: ssnclair@pcgus.com).

The Individual Rendering Provider must complete this section when the child/family receives the Assistive Technology Device.		
Child's Name (Last, First):	EI #:	DOB:
Individual Rendering Provider's Name:		Credentials:
Provider Agency:		
Source of Device(s): <input type="checkbox"/> Vendor <input type="checkbox"/> Hearing Aid/Vision Dispensary		
Category of device and exact name: _____		
Date of receipt: ____/____/____		
If item was purchased, was it received new? <input type="checkbox"/> Yes <input type="checkbox"/> No – explain in Section B		
Indicate the issues that affected the successful provision and utilization of the authorized device:		
<u>Delayed Delivery</u>		
<input type="checkbox"/> The device was not delivered on the designated delivery date		
Indicate the scheduled delivery date: ____/____/____		
<u>Incorrect/Incomplete Order</u>		
<input type="checkbox"/> Device received was not the device authorized <input type="checkbox"/> Missing authorized accessories <input type="checkbox"/> Needed accessories were not requested by Individual Rendering Provider		
<u>Device Condition</u>		
<input type="checkbox"/> Poor fit <input type="checkbox"/> Assembly problem <input type="checkbox"/> Other _____		
<u>Training on the use of the device</u>		
<input type="checkbox"/> Parent/Caregiver did not receive adequate training on the use of the device		
<u>Other</u>		
<input type="checkbox"/> Family refused device after authorization and/or provision <input type="checkbox"/> Vendor dispute <input type="checkbox"/> Other – describe below		
<u>Provide a detailed description of the issue:</u>		
<input type="checkbox"/> Device was delivered as ordered		<input type="checkbox"/> Parent/Caregiver received adequate training on the device
Parent/Caregiver Signature: _____		Date: ____/____/____
Individual Rendering Provider Signature: _____		Date: ____/____/____

**NYS EARLY INTERVENTION PROGRAM INSTRUCTIONS FOR COMPLETION
ASSISTIVE TECHNOLOGY NOTIFICATION OF ITEM DELIVERY, CONDITION & STATUS**

GENERAL DIRECTIONS

This form is required to document that the assistive technology device (ATD) has been delivered as authorized, and to document any issues with the device.

- The Individual Rendering Provider is responsible for completing this form with the parent **no later than one (1) service sessions** after the device has been delivered or at time of delivery.
- The Individual Rendering Provider or AT Agency Coordinator, if applicable, is responsible for sending this form to the child's Service Coordinator **no later than two (2) weeks** after the device has been delivered.
- Service Coordinators must fax this form to the assistive technology contact or Early Intervention Official of the municipality **within two 2 business days** of receipt.
- The Assistive Technology contact or Early Intervention Official will forward this form to the PCG Assistive Technology Coordinator **within 1 business day** when adverse delivery, condition or status issues are identified.

The Individual Rendering Provider must complete this section when the child/family receives the ATD.

Child's name, EI #, DOB	Make sure that all identifying information is correct. The EI # is the number that appears in NYEIS/KIDS. Information must match NYEIS/KIDS (do not use a nickname).
Individual Rendering Provider name, discipline, and provider agency	Print the name, discipline (e.g. speech therapist, special educator), and provider agency of the Individual Rendering Provider who is completing the form.
Source of the device	Indicate if the device was delivered by an ATD Vendor, or Dispensary.
Category of device and exact name	Provide the category (e.g., seating, stander) and full brand name and model of the device received.
Date of receipt	Provide the date the device was received.
If item was purchased, was it received new?	Purchased items must be provided new from vendors. Reconditioned or refurbished used items are not acceptable.
Please indicate any issues that may have affected the successful provision and utilization of the authorized device: <u>Delayed delivery</u> <u>Incorrect/incomplete order</u> <u>Device condition</u> <u>Other</u>	Check as many issues as apply.
Provide a detailed description of the issue	A full explaining is required for any issue indicated.
Device delivered as ordered/Training received	Check as apply
Parent/caregiver signature, Individual Rendering Provider signature	The parent/caregiver and the Individual Rendering Provider are required to sign the form. Please include the Individual Rendering Provider's provider agency name and contact information.

Chapter 9: Transportation

CHILD'S NAME _____

PRESCHOOL and EARLY INTERVENTION PROGRAM

TRANSPORTATION HANDBOOK

FOR PARENTS

The Westchester County Preschool/Early Intervention Transportation Program is managed by Westchester County Department of Health Children with Special Needs. We are pleased to provide you with this handbook as a guide to the transportation service options available. We hope this handbook will help you understand the procedures and answer any questions you may have. Please take a few moments to read this important information.

INSIDE:

- Transportation Service Options
- If You Choose Bus Service
- Bus Transportation Authorization Form (TAF)
- Bus Procedures

Transportation Service Options



Westchester County Department of Health (WCDH) provides Transportation Service for children with special needs as mandated by Section 4410 of the Education Laws of 1989, Title II-A of Article 25 of the Public Health Law and/or other applicable acts.

Transportation Service is defined as transportation of each child to and from the child's special needs program (the program or agency providing educational services to the child) using a vehicle that can accommodate the specific needs of the specific child. This includes County-provided school bus service in vehicles equipped with a radio, child-restraint seat and properly trained drivers and monitors; and parent transportation by personal car, public bus, or taxi. As the parent/guardian, you must discuss all available transportation service options with your Early Intervention Service Coordinator or your school district's Committee on Preschool Education (CPSE) Chairperson. Your school district is defined by the geographical area in which your family lives. Each school district has its own CPSE for children 3-5, which determines your child's special education needs.

Mileage Reimbursement and No-Cost Monthly Metro Cards are available to parents who choose to transport their child to/from an Early Intervention Toddler Development Group contained in the Individualized Family Service Plan (IFSP), or to the approved 4410 Special Education Preschool Program contained in the Individualized Education Plan (IEP). Parents who transport their child to/from Early Intervention services occurring at a facility (not a toddler development group) or parent-child group contained in the Individualized Family Service Plan (IFSP) may also receive Mileage Reimbursement, No-Cost Monthly Metro Cards, and in some cases, Taxi Fare Reimbursement.

County-Provided Bus Service is available to children attending an Early Intervention Toddler Development Group contained in the Individualized Family Service Plan (IFSP), or the approved 4410 Special Education Preschool Program contained in the Individualized Education Plan (IEP).

Whichever option is selected at the **IFSP or CPSE meeting**, it must be listed on your child's IFSP or IEP prior to the beginning of transportation services and it must be consistent for each day your child is scheduled to attend the program/service. You may not combine a Metro Card or transportation reimbursement and County-provided bus service.

Any necessary change in the selected transportation option must be communicated to either the Early Intervention Service Coordinator or your school district's CPSE Chairperson; and the appropriate paperwork completed prior to the beginning of the new service option.

Please ask your Early Intervention Service Coordinator or your school district's Committee on Preschool Education Chairperson for a copy of the WCDH brochure with information about Parent Transportation Reimbursement benefits.

If You Choose Bus Service

The Westchester County Department of Health Children with Special Needs-CSN must ensure safe and efficient transportation for all children approved for transportation service. Bus service will begin once the WCDH receives and reviews the following required documents:

- Your child's IFSP or IEP authorizing transportation service
- A properly completed Bus Transportation Authorization Form (TAF)

If the WCDH does not receive the required documents authorizing service, if they are incorrect or arrive late, BUS SERVICE WILL NOT BE AVAILABLE ON THE FIRST DAY OF PROGRAM.

Speak to your child's Early Intervention Service Coordinator to confirm that the correct paperwork is submitted in a timely manner. Or speak to your school district's CPSE to request that your child's meeting be scheduled in a timely manner and that all required documents have been completed and submitted to the WCDH.

Bus Service Facts:

- Your child will receive one round trip (from home to program, from program to home) on a vehicle equipped with child-restraint seats for all children. The vehicles will provide air conditioning as needed from May 1st through October 1st and be properly heated in cold weather months. The vehicles will be wheelchair accessible if necessary.
- Each vehicle will have one bus monitor who will assist your child with getting on, riding, and getting off the bus. The bus monitor is not permitted to help dress or feed your child while on the bus. Nor is he/she permitted to escort your child to or from the school bus.
- Medications are not permitted on the bus. If your child requires medication, it is your responsibility to bring your child's medication to the program.
- Bus routes are generally scheduled for 75 minutes or less. If your child lives a significant distance from the program, the scheduled time of the bus route may be up to 90 minutes. Factors such as traffic congestion/accidents or inclement weather may cause the bus route to take more than the scheduled amount of time. Parents should also keep in mind that buses often depart from the program several minutes after the program's dismissal time once all children have boarded the bus.
- **Scheduled pick-up and drop-off times are approximate.**

Bus Transportation Authorization Form (TAF)

A completed Bus Transportation Authorization Form (TAF) is required before your child can ride the school bus. Your school district or service coordinator will provide you with the TAF to complete. The TAF provides the following information:

- PICK-UP ADDRESS – Your home address. If you choose an address other than your home, the alternate address must also be located within Westchester County. **The pick-up address must be the same every day of the week.**
- DROP-OFF ADDRESS – Your home address or an alternate address within Westchester County. This address may be different from the pick-up address, but it **must be the same every day of the week.**
- EMERGENCY NUMBERS — in case we cannot reach you. This should be someone who knows your child and who has agreed to receive and assume responsibility for your child.
- MEDICAL INFORMATION — This is information you and your child’s physician feel is important for us to have in order to provide safe transportation. Complete this section to help us understand your child’s needs. Tell us if your child has special medical conditions such as seizures, temperature difficulties, allergies, etc., if your child takes medication regularly and what the medication is.
- Once a student’s trip is scheduled according to the information on the TAF, it can only be changed if the family moves to a new address or permanently changes to an alternate pick-up or drop-off address. **Temporary changes to pick up or drop off locations are not permitted; no forms can be accepted for temporary changes.**

Your child’s TAF must be up-to-date at all times. **Transportation service will stop if any significant information on the TAF is found to be incorrect.** Changes to bus routes cannot be made by submitting forms or requests directly to the bus driver/company. You must contact your school district or service coordinator as soon as possible to update the TAF if changes to any of the following occur:

- The pick-up or drop-off address
- The program location
- The program session time
- The name of the person(s) authorized to meet your child at the bus
- Telephone numbers for yourself or emergency contacts
- Your child’s medical needs

Your school district/service coordinator will complete a new TAF and submit the form to the WCDH. Changes to the pick-up and/or drop-off address or the program location may take up to 10 days to accommodate.

BUS PROCEDURES

You or an Authorized Caregiver must meet the bus:

- All children must be met at the school bus by a **parent/guardian** (a person legally responsible for the care of the child; may be parent, foster-parent, relative, The Department of Social Services) or **caregiver/responsible person** (individuals designated by the parent/guardian to care for the child who are **at least 14 years of age**) **listed on the TAF**.
- For the safety of your child the **bus driver is prohibited from releasing your child to someone not named on the TAF**. ID must be presented.
- If you or someone listed on the TAF are not available to meet the bus and the Bus Company cannot reach you or the emergency contacts, the Bus Company **must call 911 to report that no one is available to receive your child**.

Waiting For the Bus:

- The Bus Company will call you to give you the **approximate** scheduled pick-up and drop-off times for your child.
- Your child must be ready 10 minutes before the pick-up time. If occasionally your child is not ready at the scheduled pick-up time, the driver is not required to wait more than 5 minutes before continuing on the route. **The driver is not required to wait 5 minutes for your child each day**.
- If you are waiting more than 15 minutes from the scheduled pick-up time, and are not contacted by the Bus Company, please call the dispatcher.
- If the bus is late more than two (2) consecutive times, report this to your child's EI or preschool program for assistance.
- Changes in pick-up and drop-off times happen during the school year when children are added or leave the program. The Bus Company will notify you of any schedule changes.

Absence:

- The parent/guardian is required to **notify the Bus Company at least one (1) hour in advance** of the scheduled pick-up time if the child is going to be absent.
- If your child will not need the bus for several days because of a family vacation, etc., **you must call the Bus Company dispatch office (do not tell the bus driver)**. You must also notify the program. A minimum of one (1) day advance notification is requested.

No-Shows:

- If you fail to notify the Bus Company that your child will be absent, but do not meet the bus when it arrives at your home, this is considered a No-Show. **If your child is a No-Show for two (2) consecutive days, bus service will stop**. You may call the Bus Company to start service again.

- If it has been five days since the bus company has stopped your child's bus service due to No-Shows, you must contact your child's service coordinator or school district to request bus service. It will take 5-10 days for bus service to start again.

Inclement Weather:

Please listen to local radio or TV or search online for school delays or closing notifications. You may find school district and program closings by following these links to News 12 Westchester and WHUD Westchester: <http://westchester.news12.com/> <http://pamal.com/stormcenter/whud.php>

- If you are not sure about your child's program, contact the program directly.
- The WCDH follows the local school district closings throughout the county. If your school district is closed, the WCDH transportation service will also be canceled.
- If your child's program chooses to open and the WCDH does not provide bus service, you may drive your child to the program; **please be aware that you are responsible for round-trip transportation.**
- Please be aware that if bus service is provided in bad weather you should expect delays.

Complaints:

- If you have a complaint regarding bus service, e.g. routine lateness, attitude, etc., **you should report the problem to your child's program.**
- If the problem cannot be solved, the program will refer it to the WCDH Program Administrator.

When there is an accident:

Our most important mission is the safe transport of your child. If your child is in an accident, the following steps will be taken:

- The Bus Company immediately notifies WCDH and your child's program.
- During program hours, your child's program will contact you. After program hours, the Bus Company will contact you.
- Your child may be taken to the Emergency Room; the police officer(s) at the scene will determine if this is necessary.
- Since New York is a no-fault insurance state, **in the event that your child is involved in a school bus accident and requires medical treatment, the parent/guardian's automobile insurance is primary for all costs, including the emergency room.** This is a New York State Law.
- Should the parent/guardian not have automobile insurance, the bus company is responsible for insurance and possible post-accident costs.

NOMBRE DEL ESTUDIANTE _____

PROGRAMA PRESCOLAR Y DE INTERVENCIÓN TEMPRANA

MANUAL DE TRANSPORTE

PARA LOS PADRES

El Departamento de Salud del Condado de Westchester administra el Programa de Transporte Preescolar y de Intervención Temprana del Condado de Westchester. Nos complace proporcionarle este manual como una guía sobre las opciones de servicios de transporte que se encuentran disponibles. Esperamos que el mismo le sirva para entender los procedimientos y aclarar toda duda que pueda tener al respecto. Por favor tome algunos minutos para leer esta importante información.

ÍNDICE

- Opciones de transporte
- Si elige el servicio de transporte en autobús
- Formulario de autorización para transportar al estudiante en autobús (TAF)
- Procedimiento para tomar el autobús

Opciones de transporte



El Departamento de Salud del Condado de Westchester (WCDH, por sus siglas en inglés) proporcionará servicio de transporte a los niños con necesidades especiales de acuerdo con lo dispuesto en el Artículo 4410 de las Leyes de Educación de 1989, el Título II-A del Artículo 25 de la Ley de Salud Pública y/u otras leyes correspondientes.

El servicio de transporte se define como el llevar a cada menor de ida y vuelta al programa de necesidades especiales (la agencia o programa que proporciona servicios educativos al menor) en un vehículo que satisfaga las necesidades específicas del menor específico. Ello incluye el servicio de autobús provisto por el Condado en vehículos equipados con radio, asientos de seguridad y conductores y personal de vigilancia debidamente capacitados, y el transporte de los padres en carro de uso personal, autobús público o taxi. En su calidad de padre o tutor, usted tiene que hablar acerca de todas las opciones de servicios de transporte disponibles con el Coordinador de Servicios de Intervención Temprana que le corresponda, o con el Presidente del Comité de Educación Preescolar (CPSE, por su sigla en inglés). El distrito escolar que le corresponde está definido por el área geográfica en la que reside su familia. Cada distrito escolar tiene su propio Comité de Educación Preescolar para niños de 3 a 5 años, el cual determinará si su hijo/a tiene la necesidad de recibir servicios de educación especial.

El reembolso de millas recorridas y tarjetas MetroCard mensuales gratuitas se encuentra disponible para aquellos padres que decidan transportar a sus hijos a un programa de Desarrollo de Intervención Temprana delineado en el Plan Individual de Servicios Familiares (IFSP, por su sigla en inglés) o el programa 4410 aprobado de educación especial preescolar que se describa en el Plan de Individual de Educación (IEP, por su sigla en inglés). Los padres que transporten a sus hijos con el fin de recibir servicios de Intervención Temprana que ocurran en una institución (no en un grupo de desarrollo infantil) o a un grupo de padres y niños contenido en el Plan Individual de Servicios Familiares (IFSP) también podrán recibir el reembolso de las millas recorridas, tarjetas MetroCard mensuales gratis y, en algunos casos, el reembolso del costo del taxi.

El Condado provee servicio de transporte en autobús a aquellos niños que concurran a un Grupo de Desarrollo Infantil del programa de Intervención Temprana incluido en el Plan Individual de Servicios Familiares (IFSP) o el Programa de Educación Especial Preescolar 4410 incluido en el Plan Individual de Educación (IEP).

Cualquiera sea la opción que haya elegido en la reunión con el Comité de Educación Preescolar o la reunión para trazar el Plan Individual de Servicios Familiares, la misma debe figurar en dichos planes y debe ser la misma para cada día que su hijo/a tenga que concurrir al programa. No es posible combinar una MetroCard con reembolso por transporte y servicio de autobús del Condado.

Deberá informársele al Coordinador de Servicios de Intervención Temprana o al Presidente del Comité de Educación Preescolar de su distrito escolar sobre todo cambio realizado en la opción de transporte. Antes de comenzar a recibir servicios de acuerdo con la nueva opción seleccionada se deberá completar el papeleo necesario.

Solicite al Coordinador de Servicios de Intervención Temprana o al Presidente del Comité de Educación Preescolar de su distrito escolar una copia del folleto de información sobre los beneficios de reembolso de gastos de transporte que el Departamento de Salud del Condado de Westchester ofrece a los padres.

Si elige el servicio de transporte en autobús

La Oficina de Menores con Necesidades Especiales del Departamento de Salud del Condado de Westchester debe garantizar transporte seguro y eficaz para todos los niños que hayan sido aprobados para recibir servicios de transporte. El servicio de autobús comenzará una vez que el Departamento de Salud del Condado de Westchester reciba los siguientes documentos:

- El IEP o IFSP del niño en el cual se autorice el servicio de transporte
- El Formulario completo de Autorización para transportar al estudiante en autobús

Si el Departamento de Salud no recibiera los documentos requeridos para autorizar el servicio, están incorrectos o llegan tarde, EL SERVICIO DE AUTOBÚS NO ESTARÁ DISPONIBLE EL PRIMER DÍA DEL PROGRAMA.

Consulte con el Coordinador de Servicios de Intervención Temprana de su hijo para presentar los documentos necesarios en el plazo requerido, o hable con el Comité de Educación Prescolar de su distrito escolar para solicitar que la reunión de su hijo se fije puntualmente y que todos los documentos requeridos se hayan completado y enviado al Departamento de Salud del Condado de Westchester.

Información sobre los autobuses:

- Su niño recibirá un viaje de ida y vuelta (de casa al programa, del programa a su casa) en un vehículo equipado con asientos de seguridad para todos los niños. Los vehículos tendrán aire acondicionado según sea necesario desde el 1 de mayo hasta el 1 de octubre y contarán con calefacción apropiada durante los meses de frío. De ser necesario, los vehículos tendrán acceso para sillas de ruedas.
- En cada vehículo habrá un monitor que ayudará a los niños a subirse al autobús, a viajar y a bajarse del autobús. El monitor no tiene permitido ayudar a vestir o dar de comer a los niños, ni tiene permitido acompañar a los niños hasta el autobús, ni desde el mismo.
- No se permite transportar medicamentos en el autobús. Si su hijo debe tomar medicamentos, usted tendrá la responsabilidad de llevar los mismos al programa.
- El recorrido del autobús por lo general no dura más de 75 minutos. Si su hijo vive a una distancia considerable del programa, la duración del viaje podrá ser de hasta 90 minutos. Factores tales como la congestión del tráfico, accidentes o mal tiempo podrán causar que el viaje lleve más que el tiempo designado. Los padres deberán tener en cuenta que los autobuses a menudo parten del programa varios minutos después del horario de salida del mismo y una vez que todos los niños se hayan subido al autobús.
- **Los horarios de ida y vuelta son aproximados.**

Formulario de autorización para transportar al estudiante en autobús:

Se requiere que complete un Formulario de Autorización para transportar al estudiante en autobús (TAF, por sus siglas en inglés) antes de que su niño pueda viajar en autobús escolar. El distrito escolar o el coordinador de servicios le proporcionarán el formulario que debe completar. Dicho formulario provee la siguiente información:

- DIRECCIÓN DE SALIDA – La dirección de su casa. Si elige una dirección diferente, la misma también debe de estar ubicada dentro del Condado de Westchester. **La dirección de salida debe ser la misma para todos los días de la semana.**
- DIRECCIÓN DE LLEGADA – La dirección de su casa o una dirección alternativa que se encuentre dentro del Condado de Westchester. Esta dirección podrá ser diferente de la dirección de salida, pero **debe ser la misma para todos los días de la semana.**
- NÚMEROS EN CASO DE EMERGENCIA – si no podemos comunicarnos con usted. Esta persona debe ser alguien que conozca a su niño y que además esté de acuerdo en recibir a su hijo y hacerse responsable de él.
- INFORMACIÓN MÉDICA – Esta es la información que usted y el doctor de su hijo consideren que es importante que tengamos para poder proveer transporte seguro. Complete esta sección para ayudarnos a entender las necesidades de su niño. Díganos si su hijo tiene condiciones médicas especiales tal como convulsiones, dificultades relacionadas con la temperatura, alergias, etc., y también si toma medicamentos regularmente y cuáles son dichos medicamentos.
- Una vez que el viaje del estudiante se programe según la información que figure en el formulario, solamente se puede cambiar si la familia se muda a una nueva dirección o cambia permanentemente el lugar de donde se recogerá o se dejará al estudiante. **No se permitirá realizar cambios temporarios con respecto al lugar de donde se recoge o se deja al estudiante. No se aceptarán formularios para hacer cambios temporarios.**

El Formulario de Autorización para transportar al estudiante deberá estar al día en todo momento. **El servicio de transporte se suspenderá de inmediato si se determina que la información que figura en el Formulario de Autorización es incorrecta.** No se podrá realizar cambios a las rutas de autobuses por medio de la presentación de solicitudes directamente al conductor o a la compañía de autobuses. Usted deberá comunicarse con el distrito escolar o el coordinador de servicios tan pronto como sea posible para actualizar el formulario de autorización de haber cambios en cualquiera de los siguientes:

- Dirección de salida o dirección de llegada
- Ubicación del programa
- Horario de las sesiones del programa
- Nombre de la persona autorizada a encontrarse con su hijo en la parada del autobús
- Su número de teléfono o los contactos en caso de emergencia
- Las necesidades médicas de su hijo

El distrito escolar o el coordinador de servicios deberán completar un nuevo formulario de autorización (TAF, por sus siglas en inglés) y presentarlo ante el Departamento de Salud del Condado de Westchester. El realizar los cambios necesarios con respecto a la dirección de salida y/o llegada y a la dirección del programa podrá llevar un máximo de 10 días.

PROCEDIMIENTO PARA TOMAR EL AUTOBÚS

Usted o la persona autorizada debe esperar al bus:

- **Uno de los padres o el tutor** (Persona legalmente responsable del niño. Puede ser uno de los padres, padre/madre adoptivo, familiar, el Departamento de Servicios Sociales), **la persona que lo cuide o la persona responsable por el menor** (individuos designados por los padres o el tutor para cuidar al menor y que **tengan por lo menos 14 años de edad**) **cuyos nombres se encuentren en el Formulario de Autorización para Transportar al estudiante.**
- Por la seguridad de sus hijos, **el conductor del autobús tiene prohibido dejar a sus hijos con alguien cuyo nombre no figure en el Formulario de Autorización.** La persona deberá presentar su documento de identificación.
- Si usted o una de las personas cuyo nombre figura en el Formulario de Autorización no están disponibles para esperar el autobús y la Compañía de Autobuses no se puede poner en contacto con usted o algunos de los contactos de emergencia, la Compañía de Autobuses **deberá llamar al 911 para denunciar que no hay nadie disponible para recibir a su hijo/a.**

Al esperar el autobús:

- La Compañía de Autobuses lo llamará para decirle los horarios **aproximados** en que pasará a recoger y a dejar a su hijo/a.
- Su hijo/a debe estar listo por lo menos diez minutos antes de la hora en que el autobús pasará a buscarlo. Si de vez en cuando su hijo no está listo a la hora indicada, no se requiere que el conductor espere más de cinco minutos antes de continuar con la ruta. **NO se requiere que el conductor espere cinco minutos a su hijo todos los días.**
- Si se encuentra esperando más de quince minutos luego de transcurrida la hora indicada, y la Compañía de Autobuses no lo ha llamado, por favor llame al despachante.
- Si el autobús llegó tarde más de dos veces consecutivas, infórmele al programa preescolar o de intervención temprana para que lo asistan.
- A veces es necesario realizar cambios en los horarios durante el año lectivo a medida que se agregan o eliminan niños del programa. La Compañía de Autobuses le notificará sobre los mismos.

Ausencias:

- Se requerirá que uno de los padres o el tutor **le notifique a la Compañía de Autobuses por lo menos una (1) hora antes** de la hora fijada si el niño va a estar ausente.
- Si su hijo/a no va a necesitar el servicio de autobús debido a vacaciones familiares, etc. Solicitamos que nos notifique por lo menos con un día de anticipación. **Usted debe llamar a la oficina de la Compañía de Autobuses. No le informe al conductor.** Usted también deberá notificar al programa.
- Si usted no le notifica a la Compañía de Autobuses que su hijo estará ausente y no sale a esperar el autobús cuando llegue a su casa, se considerará que no se ha presentado. **Si no notifica que su hijo estará ausente y no sale a esperar el autobús dos (2) veces consecutivas, el servicio de autobús cesará.** Usted podrá llamar a la Compañía de Autobuses para reiniciar el servicio.
- Si han transcurrido cinco días desde que la Compañía de Autobuses le suspendió el servicio por la razón expuesta anteriormente, usted deberá ponerse en contacto con el coordinador de servicios o con

el distrito escolar para solicitar nuevamente el servicio de transporte. Llevará entre cinco y diez días reiniciar el servicio.

En caso de mal tiempo:

Escuche las estaciones de radio /locales, vea los canales de televisión locales o busque por Internet las notificaciones sobre el cierre de las escuelas. Por medio de los siguientes enlaces a News 12 Westchester y WHUD Westchester encontrará información relacionada con el cierre de distritos escolares y programas debido al mal tiempo: <http://westchester.news12.com/> <http://pamal.com/stormcenter/whud.php>

- Si no está seguro si el programa de su hijo operará normalmente, llame al programa directamente.
- El Departamento de Salud del Condado de Westchester se guía por las determinaciones de cada distrito escolar del condado. Si su distrito escolar cancela las clases por el día, el servicio de transporte del Departamento de Salud también se cancelará.
- Si el programa al que concurre su hijo decidiera abrir y el Departamento de Salud no proporcionara servicio de autobuses, usted podrá llevar a su hijo al programa. **Usted estará a cargo de transportar a su hijo/a de ida y de vuelta.**
- Recuerde que si se proporciona el servicio de transporte cuando haya mal tiempo, habrá retrasos.

Quejas:

- Si tiene alguna queja con respecto al servicio de transporte, por ejemplo que el autobús siempre llega tarde, la mala disposición de los empleados, etc., **debe informar al programa sobre el problema.**
- Si el problema no se puede resolver, el programa lo enviará al Administrador de Programa del Departamento de Salud del Condado de Westchester.

En caso de accidente:

La misión más importante que tenemos es transportar a su hijo/a de forma segura. Si su hijo/a se ve involucrado en un accidente, se seguirán los siguientes pasos:

- La Compañía de Autobuses inmediatamente le notificará al Departamento de Salud del Condado de Westchester y al programa de su hijo. Durante el horario del programa, el programa al que concurre su hijo se pondrá en contacto con usted. Luego del horario habitual, la Compañía de Autobuses se pondrá en contacto con usted.
- Es posible que sea necesario llevar a su hijo a la sala de emergencias. Los oficiales de policía que se presenten en la escena determinarán si ello es necesario.
- Ya que en Nueva York los seguros automovilísticos son sin culpabilidad, **en el caso que su hijo se vea involucrado en un accidente en el autobús escolar y requiera tratamiento médico, el seguro automovilístico de los padres o tutor será el primario para cubrir los costos, incluyendo la sala de emergencias.** Así lo establece la ley del Estado de Nueva York. Si los padres o tutor no tuvieren seguro automovilístico, la compañía de autobuses será responsable del seguro y posiblemente por los costos posteriores al accidente.

Transportation Forms

**CHILDREN WITH SPECIAL NEEDS
TRANSPORTATION PLAN - Early Intervention**

Child's Name: _____

Address: _____

Program/Service Provider Name: _____

Address: _____

Early Intervention Transportation Service Facts

Transportation for children receiving Early Intervention services is governed by New York State Department of Health Early Intervention Regulations, Section 69-4.19. In accordance with these regulations, a no-cost METRO CARD, MILEAGE REIMBURSEMENT, and TAXI FARE REIMBURSEMENT are options available to Westchester parents when they transport their own child to and from an Early Intervention service to enable the child and the child's family to receive Early Intervention services contained in the Individualized Family Service Plan (IFSP). Whatever option is selected, it must be consistent for each day of travel to the program.

Except for unusual situations where special permission is granted, parents will not be eligible to receive reimbursement for mileage or taxi fare or a metro card if their child is receiving any other form of County-provided transportation. For example, if a child is normally transported by school bus, the parent cannot be reimbursed for occasionally driving the child to or from the service location.

Mileage Reimbursement: Parents will be reimbursed for driving their child to and from the child's program/service. Reimbursement will be paid at the current county approved rate per mile, for one round trip per day between the city or town in which the child lives and the city or town in which the child's program/service is located as calculated by an online web mapping service (MapQuest or similar). Reimbursement for parking and tolls may also be provided when necessary and authorized by the County.

Metro Card: Parents will receive at no cost a monthly Metro Card to be used for transporting the child to and from the program/service.

Taxi Fare Reimbursement: Parents will be reimbursed for the cost to transport their child to and from the program/service by taxi each day.

I will transport my child to services as per the IFSP and select the following option:

Mileage Reimbursement Metro Card Taxi Fare Reimbursement

Parent's Printed Name: _____ Phone: _____

Parent's Signature: _____ Date: _____

Please note that once you have selected an option, you may only change your selection by contacting your service coordinator and completing another form.



Westchester County Department of Health
 CSN Early Intervention/Preschool - Bus Transportation Authorization Form

Robert P. Astorino, Westchester County Executive
 Sherlita Anler, MD, Commissioner, Department of Health

Choose one: New Student **Info Change** **and Reason for Change:** _____

Date of Completion: _____ Child's approximate weight (lb.): _____

Choose one: Early Intervention _____ and EIOD _____ or Preschool _____

Special Needs: WHEELCHAIR OXYGEN STROLLER OTHER (SPECIFY): _____

Child's Legal Last Name: _____ First: _____ M.I. _____

Sex: M F DOB (mm/dd/yyyy): _____

Legal Address: _____ Town: _____ Zip Code: _____

School District: _____

Parent/Guardian (or Foster Parent):

_____ Home Phone: _____ Cell: _____ Business: _____ Email _____
 Mother

_____ Home Phone: _____ Cell _____ Business: _____ Email _____
 Father

Program: _____ Address: _____

Start Date: _____ End Date: _____ Start Time: _____ End Time: _____

Choose one: Round Trip **Pick-up only** **Drop-off only**

EI - PICK-UP: M T W TH F

EI - DROP-OFF: M T W TH F

Pick up- If other than legal address		Drop off – If other than legal address	
NAME		NAME	
ADDRESS		ADDRESS	
CITY		CITY	
PHONE	CELL	PHONE	CELL
Additional persons authorized to receive child (MUST PRESENT ID)			
NAME:		RELATIONSHIP	CELL
NAME:		RELATIONSHIP	CELL
NAME:		RELATIONSHIP	CELL
Emergency Contact for child		Emergency Contact for child #2	
NAME		NAME	
RELATIONSHIP		RELATIONSHIP	
ADDRESS		ADDRESS	
CITY		CITY	
PHONE	CELL	PHONE	CELL

Based on the route and/or the location of provider, school routes can be up to 75 minutes one way.

 SIGNATURE OF SCHOOL DISTRICT /REPRESENTATIVE or EIOD

 DATE

 PARENT/GUARDIAN/SUROGATE SIGNATURE

 DATE

Escoja una: Nuevo Estudiante () Cambio de Información () Razón del cambio: _____

Fecha de Terminación: _____ Peso Aproximado del Niño: _____

Escoja una: Intervención Temprana _____ y EIOD _____ o Pre-escolar _____

Necesidades Especiales: SILLA DE RUEDAS () OXIGENO () COCHE DE BEBE () OTRO (Especificar): _____

Apellido Legal del Niño: _____ Nombre: _____ Inicial 2do Nombre.: _____

Sexo M () F () Fecha de Nacimiento (mm/dd/aa): _____

Dirección Legal: _____ Ciudad: _____ Código Postal: _____

Distrito Escolar: _____

Padres/Guardianes(o Padres Adoptivos):

_____ Teléfono de Casa: _____ Celular: _____ Negocio: _____ Correo Electrónico: _____

Madre

_____ Teléfono de Casa: _____ Celular: _____ Negocio: _____ Correo Electrónico: _____

Padre

Programa: _____ Dirección: _____

Fecha de Inicio: _____ Fecha de Finalización: _____ Hora de Inicio: _____ Hora de Llegada: _____

Escoja una: Ida y Vuelta () Sólo recoger () Sólo dejar ()

EI - PICK-UP: M T W TH F

EI - DROP-OFF: M T W TH F

Recoger- Si hay otra además de la dirección legal	Dejar – Si hay otra además de la dirección legal
Nombre:	Nombre:
Dirección	Dirección
Ciudad:	Ciudad:
Teléfono: Celular:	Teléfono: Celular:

Personas Adicionales para recibir al niño (Deben presentar identificación)

Nombre:	Relación:	Celular:
Nombre:	Relación:	Celular:
Nombre:	Relación:	Celular:

Contacto de emergencia para el niño	Contacto de emergencia para el niño #2
Nombre:	Nombre:
Relación:	Relación:
Dirección:	Dirección:
Ciudad:	Ciudad:
Teléfono: Celular:	Teléfono: Celular:

Basado en la ruta y/o ubicación del programa, las rutas escolares pueden tardar hasta 75 minutos de ida.

_____ / / _____ / /

Firma del representante del distrito escolar

Fecha

Padre/Guardián/Firma Sustituta

Fecha

Chapter 10: Procedural Safeguards

Westchester County Early Intervention Program Notice of Child and Family Rights

These are your family's rights, as defined by the federal law known as the Individuals with Disabilities Education Act (IDEA). Part C of IDEA provides for early intervention services for eligible infants and toddlers.

The Westchester County Early Intervention Program is designed to maximize family involvement and ensure parental consent in each step of the process from determination of eligibility through service delivery. Rights and procedural safeguards have been established to protect parents and children and to ensure that parents have a leadership role in services for their children. Participation is voluntary for you and your family. Please refer to the New York State, "The Early Intervention Program, A Parent's Guide" which was given to you by your initial service coordinator for more information about your rights and entitlements. This guide can be accessed via computer at <http://www.health.ny.gov/publications/0532/>.

You have the following rights:

1. The right to a timely multidisciplinary evaluation and assessment and the development of an Individualized Family Service Plan (IFSP) within forty-five (45) calendar days from referral to the Early Intervention Program;
2. If eligible under the Early Intervention Program, the right to appropriate early intervention services for your child and family as addressed in an IFSP;
3. The right to evaluation, assessment, development of IFSP, service coordination, and procedural safeguards at no cost;
4. The right to refuse evaluations, assessments, and services;
5. The right to be invited to and participate in all IFSP meetings;
6. The right to receive written notice ten (10) working days before a change is proposed or refused in the identification, evaluation, or placement of your child, or in the provision of services to your child or family;
7. The right to receive services in your child's natural environment to the maximum extent appropriate;
8. The right to maintenance of the confidentiality of personally identifiable information;
9. The right to review and, if appropriate, correct early intervention records;
10. The right to timely resolution of complaints including the right to mediation and due process hearings;
11. The right to file a complaint of alleged FERPA violations to:
Family Compliance Office
U.S. Department of Health
400 Maryland Avenue
Washington, D.C. 20202 -4605

Complaints to the Federal Compliance Office must be submitted no later than 180 days from the date the individual submitting the complaint first learned of the circumstances of the alleged violation. Complaints should contain specific allegations of fact giving reasonable cause to believe a violation had occurred, including relevant date; names and titles of those involved; a specific description of the record around which the alleged violation occurs; a description of any contact with any officials regarding the matter; and any additional evidence that would be helpful.

For further information and assistance related to early intervention record requirements contact:

New York State Department of Health
Early Intervention Program
Room 287 Corning Tower Building
Empire State Plaza, Albany, NY 12237-0618
(518) 473-7016

In addition to these general rights, you are entitled to be notified of specific procedural safeguards. These safeguards or rights include Parental Consent, Prior Notice, Examination of Records, Confidentiality of Information, Mediation, Administrative Due Process Hearings and the right to appoint a surrogate parent.

PARENTAL CONSENT

Consent means that:

- You have been fully informed of all information about the activity for which consent is sought, in your native language*, or mode of communication;
 - You understand and agree in writing to provision of the activity for which your consent is sought, and the consent describes the activity and lists the records (if any) that will be released and to whom;
 - You understand that granting consent is voluntary on your part and that you may cancel consent in writing at any time.
- * *Native Language, when used in reference to persons of limited English proficiency, means the language or mode of communication normally used by the parent of an eligible child.*

Your written consent is required:

- Before evaluation(s) and assessment(s) of your child are conducted;
 - Before early intervention services are provided; and before the exchange of any personally identifiable information*, except as required by law.
- * *Personally Identifiable Information includes: The name of your child or the name of other family members; The address of your child; A personal identifier, such as your child's or your own social security number; or a list of personal characteristics or other information that would make it possible to identify your child with reasonable certainty.*

If you do not give consent for any evaluation(s), assessment(s) or early intervention services, reasonable effort will be made to ensure that you:

- Are fully aware of the nature of the evaluation(s), assessment(s) or services that would be available;
- Understand that your child will not be able to receive the evaluation and assessment or services unless consent is given

As a parent of a child eligible for early intervention services, you may determine whether you will accept or refuse any early intervention service(s). You have the right to accept some evaluations and services while rejecting or stopping others. You may also refuse any service after first accepting it without jeopardizing other early intervention services.

PRIOR NOTICE

Written notice must be given to you ten working days before the Early Intervention Program, proposes or refuses to initiate or change the identification, evaluation, service setting, or the provision of early intervention services to your child and your family.

The notice must inform you about:

- The action that is being proposed or refused;
- The reasons for taking the action;
- All procedural safeguards that are available under the Early Intervention Program.

The notice must be:

- Written in language understandable to the general public and provided in your native language or the language normally used by you, unless it is clearly not feasible to do so.
- If your native language or other mode of communication is not a written language, the local lead agency shall take steps to ensure that:
 - The notice is translated orally or by other means to you in your native language or other mode of communication;
 - You understand the notice;
 - There is written evidence that the requirements of this section have been met.
 - If you are deaf, blind, or have no written language, the mode of communication must be that normally used by you (such as sign language, Braille, or oral communication).

EXAMINATION OF RECORDS

You must be given the opportunity to inspect and review records related to screening, evaluation, assessment, determination of eligibility, the development and implementation of IFSPs, individual complaints dealing with your child, and any other portion of the Early Intervention Program involving records about your child and your family.

If a parent would like to inspect and review their child's record or to obtain a copy of their child's record the parent should submit a written request to the Early Intervention Official. The request should include the date, the child's name, date of birth, name of person making the request and their relationship to the child. Written requests should be mailed to:

Marina Yoegel
Early Intervention Official
Westchester County Department of Health
145 Huguenot St. 7th Floor
New Rochelle, NY 10801

Request to Inspect and Review

Within 3 business days of receipt of the request the parent will be contacted to schedule the review at a time which is convenient for both Department of Health staff and the parent. Upon request, the record review may be arranged in conjunction with another meeting or discussion. If a parent is unable to submit a written request a verbal request will be accepted. A verbal request may be made by calling 914-813-5090.

Record Review:

- Active records may be reviewed as soon as the Early Intervention Official Designee (EIOD) assigned to your child's case is available to be present at the record review.
- If the case file has been closed and archived, it will take at least 10 business days to retrieve the record.
- A picture ID must be shown at the time of the record review.
- During this review any person viewing the record will be asked to sign a "Record Access Form"
- The EIOD will remain with the person reviewing the record to ensure understanding of its contents.
- No material contained in the record may be removed or destroyed.
- To **amend** anything in the record a written request must be submitted.
- Once the record has been reviewed, it will be returned to the appropriate secured area.

Parents may also authorize, in writing a representative to inspect and review the records unless such access is prohibited under State or federal law. If any record contains information about more than one child, information about other children receiving services must be protected. Only information pertaining to the child/family that made the request for record access or disclosure will be released.

Request to Obtain a Copy

The parent will be contacted within 3 business days of receipt of the request if any additional information is needed to process the request. WCDH will provide the copy of the requested record within 10 working days of the request (if the request is made as part of mediation or impartial hearing a copy will be provided within 5 days). If a third party requests a copy of an Early Intervention record, the request must be accompanied by a notarized release form signed by the parent. WCDH will not charge parents for the first copy of the record but may charge 25 cents per page for additional copies unless the fee prevents the parent from inspecting and reviewing the record. No fees will be charged for records related to evaluations and assessments or for the search and retrieval of records. If a parent is unable to submit a written request a verbal request will be accepted. A verbal request may be made by calling 914-813-5090.

Request an Amendment to the Early Intervention Record:

In accordance with NYS EI Regulations Section 69-4.17 (e); a parent has the right to present objections and request amendments to a record if a parent believes the information is inaccurate, misleading, or violates the privacy or other rights of the child. A parent may at any time present objections to the contents of the record to the EIO/D, evaluator, service provider or service coordinator, and request that amendments be made. A written or verbal request can be made

directly to the child's service coordinator, evaluator, service provider or the EIO. Requests made to the EIO should be sent to:

Marina Yoegel
Early Intervention Official
Westchester County Department of Health
145 Huguenot St. 7th Floor
New Rochelle, NY 10801

The EI provider will respond to the parent objection and request for amendments of the record within ten (10) working days.

- If the EI provider concurs with the parent, the record must be amended as requested and the parent should be notified in writing of the decision. The EI provider is responsible to notify the service coordinator of the approved amendment, so that all EI records are amended accordingly.
- If the EI provider does not concur with the parent's request to amend the record, the EI provider shall inform the Early Intervention Official (EIO). The EIO will notify the parent in writing of the decision and inform the parent of the right to an administrative hearing. The hearing will be conducted in accordance with early intervention program regulations, 10 NYCRR Section 69-4.17(e)(4).

The hearing will be conducted by an individual assigned by the municipality who does not have a direct interest in the outcome of the hearing. If the hearing results in the determination that the information is inaccurate, misleading, or otherwise in violation of the privacy or other rights of the child, the Early Intervention Program will amend the information accordingly and will inform you in writing.

If the hearing results in the determination that the information is not inaccurate, misleading, or otherwise in violation of the privacy or other rights of the child, you have the right to place a statement in your child's early intervention records that comments on the information and sets forth any reasons for disagreeing with the hearing decision. Any explanation placed in the early intervention records of the child under this section must be maintained by the Early Intervention Program as part of the early intervention records of the child, as long as the early intervention record or contested portion (that part of the record with which you disagree) is maintained by such agency; and if the early intervention records of the child or the contested portion are disclosed by such agency to any party, the explanation must also be disclosed to that party. The hearing will be conducted according to the procedures under the Family Education Rights & Privacy Act (FERPA), which is found in statute at 20 U.S. C. §1232g, and in regulations at 34 CFR Part 99.

CONFIDENTIALITY OF INFORMATION

All information on your child and family is confidential. The Early Intervention Program must have your permission to request information from or share information with other agencies, service providers, or professionals.

The following safeguards are in place to ensure confidentiality of records:

- The early intervention program protects the confidentiality of personally identifiable information at collection, storage, disclosure, and at all stages;
- At least one official is responsible for ensuring the confidentiality of any personally identifiable information;
- All persons collecting or using personally identifiable information receive training or instruction regarding the policies and procedures as they apply to confidentially regulations;
- The Early Intervention Program maintains, for public inspection, a current listing of the names and positions of those employees within the agency who have access to personally identifiable information;
- The Early Intervention Program informs parents when personally identifiable information collected, maintained, or used under the Early Intervention Program is no longer needed to provide services to the child;
- The Early Intervention Program must destroy any personally identifiable information in the child's early intervention record at the request of the parents (Early Intervention records of the child's name, address, phone number, and dates of early intervention services must be maintained);
- The Early Intervention Program gives you the opportunity to inspect and review any of your child's early intervention records that are collected, maintained, or used by the Early Intervention Program;
- Individual early intervention records are maintained until a child reaches the age of 21. All billing/financial records will be retained for 6 years.

INDIVIDUAL CHILD COMPLAINTS

Individual child complaint resolution involves the formal resolution of concerns and disagreement between a parent and the Early Intervention Program through the use of mediation and/or an administrative due process hearing. If you disagree on any aspect of your child's identification, evaluation, or placement, or of the provision of appropriate early intervention services to your child and family, you have the right to a timely administrative resolution of your concerns through mediation or administrative due process. As a parent, you may initiate an individual child complaint by submitting a written request for mediation and/or an administrative due process hearing. If mediation is unsuccessful, the due process hearing must be completed within 30 days of your original written request for resolution. If an agreement is reached through mediation, the due process hearing is cancelled.

**Westchester County - EARLY INTERVENTION PROGRAM
FAMILY RIGHTS HANDOUT
MEDIATION/IMPARTIAL HEARING/SYSTEM COMPLAINTS**

Dear Parent:

The following is the procedure for you to follow to request mediation, impartial hearing or to file a system complaint. The Procedure is detailed in the NYS “The Early Intervention Program, A Parent’s Guide” which was given to you at your initial home visit. The “Parent’s Guide” can be downloaded from the New York State Department of Health website <http://www.health.state.ny.us/publications/0532/rights1.htm>. The “Parent’s Guide” has sample letters for you to use.

Mediation

- The parent sends a letter to the Early Intervention Official requesting mediation.
- The parent and the Early Intervention Official must both agree on mediation.
- If there is agreement to go to mediation, the Early Intervention Official will advise the Community Dispute Resolution Center about the request.
- A mediator will be assigned.
- A mediation meeting will be scheduled within two weeks of the Early Intervention Official being contacted.
- The Early Intervention Official or designee and the parent must attend the mediation.
- The parent may bring an attorney and other persons they feel will present their case.
- The Early Intervention Official may also bring an attorney. Both parties must inform the other that an attorney will be present.
- Mediators are not experts in early intervention, but they are experts at mediation and understand the early intervention system.
- The mediation process must be completed with 30 days.
- Once mediation is finished, a written agreement is prepared. Any new services agreed to will be included in the IFSP.
- There is no cost to a family for mediation.
- If no agreement is reached the family may request an impartial hearing.

Impartial Hearing

- Impartial Hearing is another way for Early Intervention Officials and parents to settle disagreements about IFSP services or a disagreement about a child’s eligibility for services following an evaluation.
- Parents may request an impartial hearing even if they already have gone to mediation.
- A parent does not have to go to mediation before requesting an impartial hearing.
- Impartial Hearings are conducted by hearing officers who are administrative law judges assigned by the Department of Health.
- Early Intervention Officials and parents give testimony and may use witnesses to support their view.
- Parents may bring a friend, another parent, an advocate or an attorney.
- A decision must be reached within 30 days.
- A hearing officer’s decision is final, but either party is allowed to ask for a judicial review.
- The IFSP must be changed within 5 working days of the written or oral decision of the hearing officer.

System Complaints

- Parents have a right to file a systems complaint if they believe that the Early Intervention Official/Designee or service provider is not doing the job appropriately.
- To file a systems complaint the parent must write to the New York State Department of Health.
- The Department of Health will contact the parent to inform how the complaint will be handled.
- The Department of Health must complete the investigation within 60 days.
- The parent will receive a written response within 70 days.
- The Department of Health is responsible for ensuring that all steps to correct the problem are taken.